

Cancer OGIM - 2021

Why change is needed

Despite significant progress in cancer survivorship over recent decades, detecting cancer earlier remains a top priority in the NHS Long Term Plan. Patients diagnosed early, at stages I and II, have the best chance of curative treatment and long-term survival. In County Durham, existing health inequalities result in poorer outcomes for cancer patients when compared to the England average, and also when comparing communities within the county. Health inequalities also impede access to screening and prevention services. Performance within treatment pathways and in quality measures varies geographically and by tumour group and is impacted by staffing capacity pressures in key clinical areas such as specialist nursing, oncology, and radiology.

Objectives

- By 2028, the proportion of cancers diagnosed at stages I and II will rise from around half now to three-quarters of cancer patients – early diagnosis improves patient outcomes, survivorship, and quality of life.
- By 2024 all main tumour group treatment pathways will adhere to the Rapid Diagnostic Centre (RDC) model by meeting the seven principles of RDC, including adopting Personalised Care and other quality measures.
- By 2024, stratified follow-up (SFU) will be in place for all clinically appropriate cancers, empowering patients to live well and manage ongoing surveillance post-treatment.

Goals

- Increase uptake across Primary Care of the new Serious Non-Specific Symptoms (SNSS) pathway, which was launched in Autumn 2020, and is the first phase of a four-year transformation programme to embed Rapid Diagnostic Centre (RDC) principles in all main tumour groups.
- Progress RDC across all main tumour groups, embedding the seven principles of RDC to improve patient outcomes and quality of care.
- Commence a lung case finding pilot to proactively detect lung cancers earlier in at-risk communities and reduce late/emergency presentations which are prolific in this complex tumour group.
- Raise greater awareness of symptoms of cancer to increase referral rates via primary care and diagnose cancer earlier, with focused efforts in the most vulnerable and at-risk communities and targeted, tumour specific messages such as three-week cough for lung cancer.
- Maximise the number of cancers that are identified through screening, with focused action to increase uptake in deprived, hard-to-reach and at-risk communities.
- Collaborate with key partners to maximise cancer prevention activities such as smoking cessation, healthy lifestyle promotion and reduce alcohol harm.
- Closer working with all partners and patients, carers, and families to support delivery of quality cancer care and aim to increase cancer survival levels to match or exceed that of England average.
- Collaborate with Primary Care Networks and strengthen existing links with Public Health partners to reduce health inequalities, improve diagnosis and treatment outcomes and deliver the best possible patient experience.
- Where appropriate, ensure every person diagnosed with cancer will have access to Personalised Care, including needs assessment, a care plan and health and wellbeing information and support.
- Embed and develop the new Faster Diagnosis Standard for cancer so that patients receive a definitive diagnosis or ruling out of cancer within 28 days
- Focus on quality of life, not just length of life.
- Continue to pilot innovation such as colon capsule endoscopy, use of the cytosponge tests and contribute to regional transformational programmes such as Community Diagnostic Hubs.

COVID - 19

Although cancer patients have been prioritised where possible throughout the pandemic, and services have continued to operate, the impact of Covid-19 on screening, diagnosis and treatment pathways is significant. Far fewer patients have presented to their GP with symptoms, resulting in fewer suspected cancer referrals and the opportunity to diagnose cancers earlier. Some tumour groups have recovered quicker than others, with lung, urology and head & neck cancers particularly affected regionally and locally. Nationally, some 50,000 cancers are estimated to be undiagnosed. The subsequent impact on stage shift and treatment outcomes is yet to be determined, but likely to be significant. Social distancing measures and staffing pressures reduced capacity in clinic/theatre at the height of the pandemic, creating backlogs and delays particularly in endoscopy and diagnostic imaging. Despite the challenges faced, there is progress to commend.

During 2020/21, clinical and operational teams in Durham implemented a new SNSS pathway, collaborated with neighbouring trusts on surgical hubs, delivered virtual appointments and rolled out a new postal FIT (faecal immunochemical test) service and triage process for symptomatic patients. Public awareness campaigns have begun to facilitate the restoral of referrals. Colon capsule endoscopy is being trialled by CDDFT clinicians. From 2021/22, this progress will be built upon by the initiatives set out below and a sustained focus on tackling health inequalities and supporting the most vulnerable at-risk communities to access cancer services as early as possible.

Triple Aim Outcome Measures

Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
Early Diagnosis: The proportion (%) of cancers diagnosed at Stage I and II.	Proportion of patients giving a high score to patient involvement question in the Five for Five (or CPES).	Vacancy rates in radiology, oncology and CNS.
Rapid Diagnosis: the proportion (%) of suspected cancer referrals meeting the new 28 Day Faster Diagnosis Standard.	Proportion of suspected cancer referrals achieving the 2ww standard.	Staff satisfaction scores in the Five for Five Survey.
The rates of cancer incidence across the Durham population.	Proportion of patients able to self-manage their condition.	

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities						
Develop and implement a lung case finding pilot, starting with the most at-risk cohorts in high deprivation/smoking/COPD communities, to identify lung cancer earlier (contributes to RDC).						
Continue to develop practice Cancer Champions and other key workers, further training around signs and symptoms & local campaigns targeting the most vulnerable at-risk communities including BAME and GRT.						
Monitor impact of FIT (faecal immunochemical test) and roll out local joint commissioning.						
Complete audits previously started to explore survivorship, emergency presentations and more.						
Utilise Care Navigator resource to support patients through the complexities of medical appointments and ensure target timescales are met across the pathway, including transfers of care between providers.						
Restore referral rates via 2WW/Primary Care to pre-pandemic levels, with focused action on hard-to-reach communities.						
Restore 62-day treatment target achievement to pre-pandemic levels.						
Contribute to regional transformation: Breast Service Managed Clinical Network; Oncology Review etc.						
2. Health Behaviours (Alcohol, Tobacco, Nutrition and Physical Activity)						
Target prevention, awareness and screening activities in most deprived communities and adapt to specific needs of those communities and vulnerable groups e.g. offenders, care leavers, drug/alcohol users, BAME, GRT, people with LD and MH conditions etc. Includes roll out of extended age groups in bowel screening.						
Ensure robust links with secondary care prevention and pre-habilitation.						
Fund and implement services and initiatives around the modifiable risk factors of cancer including tobacco control, healthy weight, alcohol harm and sexual health.						
Collaborate with PCNs, Cancer Champions, Cancer Awareness Workers, CRUK Facilitators, Social Prescribers and other colleagues to increase cancer screening uptake with a focus on vulnerable at-risk communities.						
Finalise Lynch Testing pathway to identify at-risk family members and implement surveillance.						
3. Personalised Care						
Embed End of Treatment Summaries key tumour groups and share content with patients and other care providers (initially breast and colorectal with all others to follow).						
Increase access to information and support for people affected by cancer across all settings.						
Completion of Cancer Care Reviews within 6 months of diagnosis.						
Continually improve patient/family/carer experience by acting upon feedback from surveys and continue to engage service users in service re-design and improvement across whole pathway including primary care.						
Implementation of co-ordinated personalised stratified follow up (PSFU) pathways in three additional cancer types (at least one by March 2022), in addition to breast, prostate and colorectal cancer and continue to support practices and secondary care to ensure patients post-treatment are safety-netted and supported to self-manage where appropriate.						
Work with relevant charities, voluntary and community sector organisations to establish support groups in areas or around cancer types where there are currently gaps.						
4. Mental Health and Learning Disabilities						
Train IAPT services and ensure pathways are developed to ensure people with cancer have access to knowledgeable and empathetic mental health services.						
Target prevention, awareness and screening activities in most deprived communities and adapt to specific needs of those communities and vulnerable groups e.g. people with learning disabilities.						
Ensure all awareness campaign literature and other patient-facing letters/materials are available in easy-read format and engage with LD networks when designing new pathways as appropriate.						
5. Children						
Continue to provide specialist cancer care for teenagers and young adults aged 16 to 24 years and children aged 0-15 (paediatric oncology), to improve cancer treatment outcomes, reduce morbidity arising from treatment and support the patient and family throughout their cancer journey and beyond (including transition from paediatric to adults services). NB these services are commissioned by NHS Specialist Commissioning. HPV vaccine uptake in children will be covered in screening planning.						
6. Digital						
Quality requirement within Practice funding schemes to use approved Cancer Care Review templates and introduction of treatment summaries to inform the Cancer Care Review.						
Develop the use of digital technology and remote monitoring solutions to enhance patient experience, including roll out of My Wellbeing Space app.						
7. Finance						
Northern Cancer Alliance (NCA) have announced an indicative 4-year budget for transformational initiatives, and this will be begin to be allocated from April 2020.						
Collaborate with partner organisations from Sunderland and South Tyneside to deliver shared objectives as an ICP Cancer Working Group and co-ordinate funding bids allocated to the Central ICP.						
Ensure long-term sustainability of programmes funded under transformational monies.						
8. Integration						
Continue to develop Joining the Dots, delivering Holistic Needs Assessments, Support Plans and Follow-up support and develop a new Macmillan Primary Care Nursing Service that is fully integrated into the wider cancer health and social care system.						
Further develop partnership working with PCNs, Public Health, Macmillan and CRUK to support schemes aimed at earlier diagnosis, quality of referrals and improved patient experience – such as QOF, PCN DES.						
Develop further integration of wider cancer health and care system via Right By You funding from Macmillan, ensuring that patient experience and outcomes are paramount.						
9. Cultural Change						
Ensure that prevention, patient experience and addressing health inequalities are prioritised in the cancer strategy, not just the constitutional diagnosis and treatment targets.						
Work collaboratively with neighbouring cancer localities (commissioners, providers, and public health) in new ways and across all boundaries to address universal challenges such as capacity and workforce.						