Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **9 June 2016**

Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL

Membership:

Councillors Victoria Holloway (Chair), Graham Snell (Vice-Chair), Gary Collins, Tony Fish, Angela Sheridan and Aaron Watkins

Ian Evans (Thurrock Coalition Representative) and Kim James (Healthwatch Thurrock Representative)

Substitutes:

Councillors Tim Aker, Jan Baker, Terry Piccolo and Joycelyn Redsell

Agenda

Open to Public and Press

Page

1. Apologies for Absence

2. Minutes **5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 16 February 2016.

3. Urgent Items

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4. Declarations of Interests

Queries regarding this Agenda or notification of apologies:

Please contact Jenny Shade, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **1 June 2016**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Vision: Thurrock: A place of **opportunity**, **enterprise** and **excellence**, where **individuals**, **communities** and **businesses** flourish.

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated “Good” or better
- Raise levels of aspiration and attainment so that residents can take advantage of local job opportunities
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Promote Thurrock and encourage inward investment to enable and sustain growth
- Support business and develop the local skilled workforce they require
- Work with partners to secure improved infrastructure and built environment

3. Build pride, responsibility and respect

- Create welcoming, safe, and resilient communities which value fairness
- Work in partnership with communities to help them take responsibility for shaping their quality of life
- Empower residents through choice and independence to improve their health and well-being

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- Enhance quality of life through improved housing, employment and opportunity

5. Promote and protect our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Inspire high quality design and standards in our buildings and public space

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 16 February 2016 at 7.00 pm

Present:	Councillors Graham Snell (Chair), Steve Liddiard (Vice-Chair), Yash Gupta (MBE), James Halden, Charlie Key and Tunde Ojetola Ian Evans, Thurrock Coalition Representative Kim James, Healthwatch Thurrock Representative
In attendance:	Ian Wake, Director of Public Health Les Billingham, Head of Adult Services Ceri Armstrong, Strategy Officer Mandy Ansell, (Acting) Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group Jane Itangata, Head of Mental Health Commissioning, Thurrock NHS Clinical Commissioning Group Sara Lingard, Contracts Manager, NHS England Jenny Shade, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

39. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee, held on the 12 January 2016, were approved as a correct record.

40. Urgent Items

There were no items of urgent business.

41. Declarations of Interests

Councillor Gupta declared a non-pecuniary interest in respect of Agenda Item 6 "Learning Disability Health Checks" as he was a carer.

42. Items Raised by HealthWatch

Kim James, the HealthWatch co-opted member, raised two items for the Committee's attention.

The Committee Members and Officers were asked for guidance on how best to proceed with the consultation process of the Positron Emission Tomography – Computed Tomography (PET-CT) scanner service that NHS England were proposing to undertake. A Public Meeting was scheduled to

take place in March 2016 at the Bee Hive Centre in Grays, but to date no information regarding the consultation had been received from NHS England. Kim stated that Thurrock residents should have the right to their comment on this consultation process and felt they were unable to do this with the lack of information available.

Ian Wake stated that they were also struggling to understand what the consultation was about and could not comment until this was to hand.

It was confirmed that Lyn Carpenter, Chief Executive, had written to NHS England asking for further details on the consultation process.

Councillor Liddiard stated that there was a need to support this local service and to encourage residents to attend all public meetings.

Councillor Halden commented that as a result of a Motion at Full Council a letter had been sent to the Secretary of State for Health with regards to the poor communication/engagement from representatives of NHS England and NHS commissioning, particularly with reference to the consultation on the PET CT Scanner which was viewed as an unsound consultation. Councillor Halden suggested further letters should be sent to NHS England.

Councillor Ojetola agreed that until the details of the consultation were known it was difficult to make any decision.

Kim James confirmed that she will be attending this public meeting in March.

The Chair requested that all consultation papers be available to the Health Overview and Scrutiny Committee by the end of February 2016.

Ian Wake stated that he was in the process of writing a further letter to NHS England requesting further information and registering the disappointment of the Health Overview and Scrutiny Committee.

A further item was raised by Kim James on the planning by NHS England of a number of public information events about the proposed changes to the specialised urology cancer service in Essex. These initial events were designed to inform members of the public about the proposed changes and the process that NHS England were required to follow.

Kim James concern was that no consultation process was being undertaken in Thurrock. No correspondence had been made with HealthWatch, who would have been more than happy to find accommodation to house this meeting and registered disappointment that Thurrock had, yet again, been missed out again on consultation events.

Mandy Ansell confirmed that she had also chased NHS England for information and registered CCG's disappointment that no public event was being held in Thurrock.

Councillor Halden suggested that the Council work jointly with Essex and Southend Health Overview & Scrutiny Committees to compare information received and find out what consultation processes had been undertaken in these areas.

The Chair agreed that this was a good idea and that Ian Wake should write again to NHS England and liaise with members of Essex and Southend Health Overview and Scrutiny Committees.

43. Learning Disability Health Checks

Sara Lingard, NHS England, presented the report that provided members with an update on the action plan to improve delivery of the enhanced service agreement with General Practitioners in Thurrock who deliver Learning Disability Health Checks.

Although the Appendix to the report showed a considerable improvement and activity undertaken in Quarter 3, uptake of Learning Disability Health Checks still remains unacceptably poor within Thurrock.

The report showed an increase of 2% up on 2014/15, Quarter 3 performance.

A further report will be available at the end of the financial year to identify activity undertaken in Quarter 4 and will be presented to the Health Overview and Scrutiny Committee.

NHS England reissued the Enhanced Service to all practices in December 2015 to clarify how practices should be recording their health checks on their systems. In some instances the wrong READ codes had been used on clinical systems which had resulted in some completed health checks not being identified by the payment system. At present, there is no facility for GPs to re-code manually. Any discrepancies therefore had to be undertaken by NHS England.

Even in some instances practices were not declaring the activity on the payment system which had resulted in a nil return.

Sara Lingard confirmed that these issues were being addressed as a matter of urgency.

South Essex Partnership NHS Trust (SEPT) were commissioned as an alternative provider to deliver health checks for this year only. SEPT were also providing training to practices where required. Currently they were providing support to 8 named practices in Thurrock. Sara Lingard confirmed that they were confident that SEPT would reach as many patients as possible.

It was confirmed that clear and concise letters had been sent to those patients that have not responded to previous letters and to those that do not attend (DNA) pre-booked appointments.

Sara Lingard also stated that there were discrepancies between patient lists held by practices and those held by social services and that further investigation into list validation was currently being undertaken by NHS England.

It was agreed by all members and co-optee members that the figures were disappointing and unacceptable. It was questioned by all how come year on year practices sign up to do the Enhanced Service but do not actually provide the service.

A debate between Members and NHS England took place and it was agreed that GPs should be encouraged not to sign up to the Enhanced Service if there was no intention of carrying out these health checks.

Sara Lingard stated that Service Level Agreement contained KPIs which were in place at practices and that penalties were issued.

The Chair stated that the problem of using the wrong codes was not consistent in the report figures as some practices had proved that they had completed checks successfully with no problems with coding.

Sara Lingard confirmed this was a training issue that depended on the level of training received at certain practices.

Councillor Halden stated his concerns regarding those practices in the report that had a 0% result. Yet still, year after year, that same practice applied to undertake the Enhanced Service and receive payment for this.

Sara Lingard confirmed that in the Service Level Agreement it stated that payment was not received upfront and was based on activity undertaken only.

Councillor Gupta commented that a health check had recently been undertaken on a family member and questioned how useful the health checks were and the quality of them. As a carer to that individual he felt carers should have a better understanding of the checks before they were carried out.

Councillor Liddiard stated that it was a good idea that carers were supplied with information regarding the health checks and to ensure that any extra checks were carried out.

Councillor Halden commented that how members were expected to have confidence in the system when a similar report had been brought to the Corporate Parenting Committee in December 2015 highlighting delays of Health Checks of Looked After Children undertaken by NHS England.

The Chair asked Sara Lingard to forward a copy of the Service Level Agreement to all members of the Health Overview & Scrutiny Committee members.

Les Billingham stated that this item had also been discussed at the Disability Partnership Board.

Mandy Ansell stated that the solution going forward was that CCG will have delegated authority to take control of commissioning an alternative provider to undertake the health checks. CCG had a track record of undertaking this commissioning for one year with good results.

Jane Itangata stated that support will be provided to CCG to ensure checks were carried out, ensure the quality of the checks is satisfactory and monitor any aftercare checks.

There will be a designated team in CCG who will be closer to the day to day responsibilities of practices and will be able to monitor performance issues.

The CCG Constitution will also be updated to reflect this change.

As of 1 April 2016 they would monitor those that have signed up for the Enhanced Service, commission the procurement provision and give patients the option on where the health check is undertaken. CCG would work in partnership with NHS England; be closer to the delivery to the areas of where the checks were being undertaken and then re-charge NHS England for those checks completed.

Sara Lingard commented that it was key for the CCG to negotiate with practices and encourage them not to sign up if they are not going to able to deliver the Enhanced Service.

At 8.12pm Councillor Halden left the Committee Room.

Ian Evans requested that a report on Learning Disability Health Checks is provided by the middle of next year to Health Overview & Scrutiny Committee members.

It was agreed by all Members that the Chair of the CCG was one of the practices signing up to the Enhanced Service year on year, but not undertaking any checks. Members agreed that this should be highlighted and looked into.

The Chair requested final outcome figures for 2015/16 from NHS England. Sara Lingard agreed to send these to the Chair.

RESOLVED

1. **That the Health Overview and Scrutiny Committee were asked to note the progress with the Learning Disability Health Checks by Thurrock General Practitioner Practices and future commissioning plans.**

2. That the item be added to the work programme for the 2016/17 municipal work programme.

44. Thurrock Joint Health and Wellbeing Strategy 2016 - 2021

The Officer presented the report which outlined that the Strategy focuses on prevention and early intervention to ensure that Thurrock people can "add years to life to life to years". The Strategy was goal-focused and contained outcomes that will make the most difference to the health and wellbeing of the population. Through consultation and engagement the following clear and concise goals were identified:

- Opportunity for all
- Healthier environments
- Better emotional health and wellbeing
- Quality care centred around the person
- Healthier for longer

The success of the Strategy will be measured through an Outcomes Framework, which will enable the Board, Overview and Scrutiny Committee and the public to identify whether the Strategy is being delivered.

Further work to be undertaken on the Strategy is the development of an action plan which will clearly set out action owners and will enable relevant organisations and individuals to be held to account for their part in delivering the Strategy.

Ian Wake stated that this would be a living document and outlined the importance of engagement. With this in mind, from May 2016, HealthWatch will be undertaking engagement work on the Strategy's five goals. Each goal will be engaged on in turn with the results feeding in to Health and Wellbeing Board meetings.

Ian Wake paid tribute to Kim James, HealthWatch Co-optee, for her contribution to the huge consultation process undertaken in Thurrock, with over 500 responses.

Kim James stated that from the start this document should be a living document and encouraged Officers to bring back to the Health Overview and Scrutiny Committee to monitor progress.

Councillor Ojetola asked Kim James to elaborate on what the consultation process consisted off as he was unaware of any consultation process taking place in his ward. There was also concern that a selection of people may not have been given the opportunity to engage.

Kim James stated that they had a very short space of time to undertake the consultation process and although a good response was received it was not possible to speak to everyone. A number of forums and community meetings were arranged, on-line surveys, advertisements were put in local papers,

visits to sheltered accommodation and hubs were also involved in the process.

Councillor Gupta stated that it was an excellent report but stated that the action plan should cover all health needs and identify how all residents would benefit.

The Chair agreed that it was an excellent and readable report and that this item should be returned to the Health Overview and Scrutiny Committee in the new municipal year.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee endorse the draft Thurrock Joint Health and Wellbeing Strategy and Outcomes Framework and by doing so recommend its approval by Cabinet and Council March.**

2. **That the Thurrock Joint Health and Wellbeing Strategy 2016-2021 be added to the work programme for the municipal year 2016-17.**

45. Work Programme

The Chair stated that this was the last Health Overview & Scrutiny Committee for this municipal year and that the work programme was now complete.

Councillors Gupta and Key stated that this was their last Health Overview & Scrutiny Committee and thanked the committee, members and officers for their contribution to a very effective committee.

The Chair thanked Members and Officers for their contribution and continued support to the Health Overview & Scrutiny Committees.

The Chair asked Member if there were any items to be added or discussed for the work programme for the next municipal year.

RESOLVED

1. **It was noted that the item Learning Disability Health Checks be added to the work programme for the 2016/17 municipal year work programme.**
2. **It was noted that the item Thurrock Joint Health and Wellbeing Strategy be added to the work programme for the 2016/17 municipal year work programme.**
3. **It was noted that the item PET-CT Scanner be added to the work programme for the 2016/17 municipal year work programme.**
4. **It was noted that the item Success Regime be added to the work programme for the 2016/17 municipal year work programme.**
5. **It was noted that the item Domiciliary Care be added to the work programme for the 2016/17 municipal year work programme.**

6. **It was noted that the item Core Offers be added to the work programme for the 2016/17 municipal year work programme.**
7. **It was noted that the item Health Hub be added to the work programme for the 2016/17 municipal year work programme.**
8. **It was noted that the item Health of Looked After Children be added to the work programme for the 2016/17 municipal year work programme.**

The meeting finished at 8.20 pm

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

9 June 2016	ITEM: 5
Health and Wellbeing Overview and Scrutiny Committee	
Specialised Commissioning – East of England Overview	
Wards and communities affected: None	**Key Decision:** Not Applicable
Report of: Jessamy Kinghorn, Head of Communications; Ruth Ashmore, Assistant Director of Specialised Commissioning	
Accountable Head of Service: Ruth Ashmore, Assistant Director of Specialised Commissioning – East of England	
Accountable Director: Catherine O'Connell, Regional Director of Specialised Commissioning	
This report is Public	

Executive Summary

This report provides an overview of the specialised commissioning function within NHS England and its current priorities for 2016/17. Specialised services account for around 14% of the total NHS budget and are often extremely complex, rare and usually high cost. NHS England has commissioned these services since April 2013.

The specialised nature of these services mean that they tend to be consolidated in fewer centres than other services to enable the development of sufficient skills and experience to provide safe, high quality care. There are some exceptions to this with specialised services such as chemotherapy widely available.

New technologies and drugs usually enter the NHS through specialised services which means these services need to be able to adapt to cope with changes in demand and the introduction of newer, more effective treatments, and to policy changes as more evidence becomes available. The NHS will continue to evaluate and, where appropriate, invest in new treatments and services.

The report provides a brief outline of the national direction of travel and the anticipated work programme within the East of England in relation to specialised services. It also outlines the regional specialised commissioning team's proposed approach to communications and engagement for complex service reviews.

The report is presented in a PowerPoint format as this has been found to be helpful in sharing information of this nature.

1. Recommendation(s)

1.1 The Committee is asked NOTE the contents of this report

2. Appendices to the report

2.1 PowerPoint Slides for Commissioning Specialised Services.

Report Author:

Head of Communications and Engagement, Specialised Commissioning, Midlands and East

Assistant Director, Specialised Commissioning Midlands and East

Commissioning Specialised Services in the Midlands and East

May 2016

What are specialised services?

- Complex, rare, high cost services, which are often a catalyst for innovation and pioneering clinical practice
- Over 140 services commissioned by 10 specialised commissioning teams across four regions
- All specialised services are commissioned to consistent national standards
- Policy is set nationally
- Clinical oversight and advice is provided through 42 Clinical Reference Groups organised into 6 national programmes of care:
  - Internal medicine
  - Cancer
  - Mental health
  - Trauma
  - Women and children
  - Blood and infection

https://www.england.nhs.uk/commissioning/spec-services/npc-crg/

What are specialised services?

- Specialised services tend to be for rarer conditions and those more costly to treat. They account for circa 14% of the total NHS budget, spending circa £15 billion per year.
- Four factors determine whether NHS England commissions a service as a prescribed specialised service:
  - The number of individuals who require the service;
  - The cost of providing the service or facility;
  - The number of people able to provide the service or facility;
  - The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for provision of the service or facility themselves.

Specialised Services: The story so far

Specialised services are fundamental to the values of the NHS, supporting people with rare and complex conditions, often at times when they are in greatest need.

The 2012 health and care reforms represented a significant change in the way that specialised services were commissioned. For the first time, we had one national commissioner, able to set standards for access and quality across the country. Specialised services now make up around ~£15bn a year of spending across 146 prescribed specialised services

The change was not easy, but much has been achieved over the last three years. We put in place national standards and service specifications, support by a national clinical architecture and a more consistent approach to prioritisation. We have also put in place national contracts, with better information and stronger financial control.

Specialised Services: The story so far

Despite progress, we need to go further. Variation in patient outcomes and access to services persists. The split in commissioning responsibility between NHS England and Clinical Commissioning Groups can mean fragmentation of the patient pathway and misalignment of incentives, particularly lack of focus towards prevention. At the same time, financial pressures from demographic change, new technologies, drugs and treatments escalate.

To meet these challenges specialised services must continue and accelerate transformation – with specialised care embedded in patient pathways, more personalised care and a stronger emphasis prevention, whilst ensuring best value from the limited resources available.

Vision: Future specialised services embedded in the delivery of the Five Year Forward View

The Five Year Forward View set out ambitions for the NHS of a more engaged relationship with patients, carers and citizens to promote wellbeing, prevent ill-health. Our ambitions for specialised services are no different , with specialised care fully integrated within the triple aims for health: better care, better health, better value.

Improving population health

To ensure specialised services are continuously improving health for all populations by focusing on the outcomes that matter most to patients, ensuring a stronger focus on prevention and connecting the commissioning of specialised services more strongly to the prevention and personalised medicine agendas.

High quality care system

To integrate specialised services within the pathway, by unlocking new models of provision and enabling more flexibility in how different models can be adapted by different areas, while at the same time spotlighting unwarranted variation between areas and meeting national outcome standards.

Maximising efficiency

To achieve financial sustainability, by maintaining a tight grip on the national spend and the focus on efficiency programmes, such as “right care”, but also by accelerating and supporting transformation to new models of commissioning and provision that can deliver better outcomes for less cost.

The Challenges for Specialised Commissioning

NHS in England

Inequalities in health

Ageing population

Growing population with chronic conditions

Financial challenge

Workforce pressures

Some specialist services being spread too thinly

Specialised Services

Growth in demand and cost

New technologies and treatments, including drugs and devices (80+ over the next three years)

Impact of policy changes

New models of delivery

Clinical engagement

Requirement for greater integration and single systems

Direction of Travel

- Development of National Strategy – contributing to the Five Year Forward View
  - Fewer, larger providers for some specialised elements of care
  - Hub and Spoke networks
  - New commissioning models – e.g. co-commissioning, Lead provider
  - Increased emphasis on performance and quality monitoring
  - Managed entrance of new drug and interventions

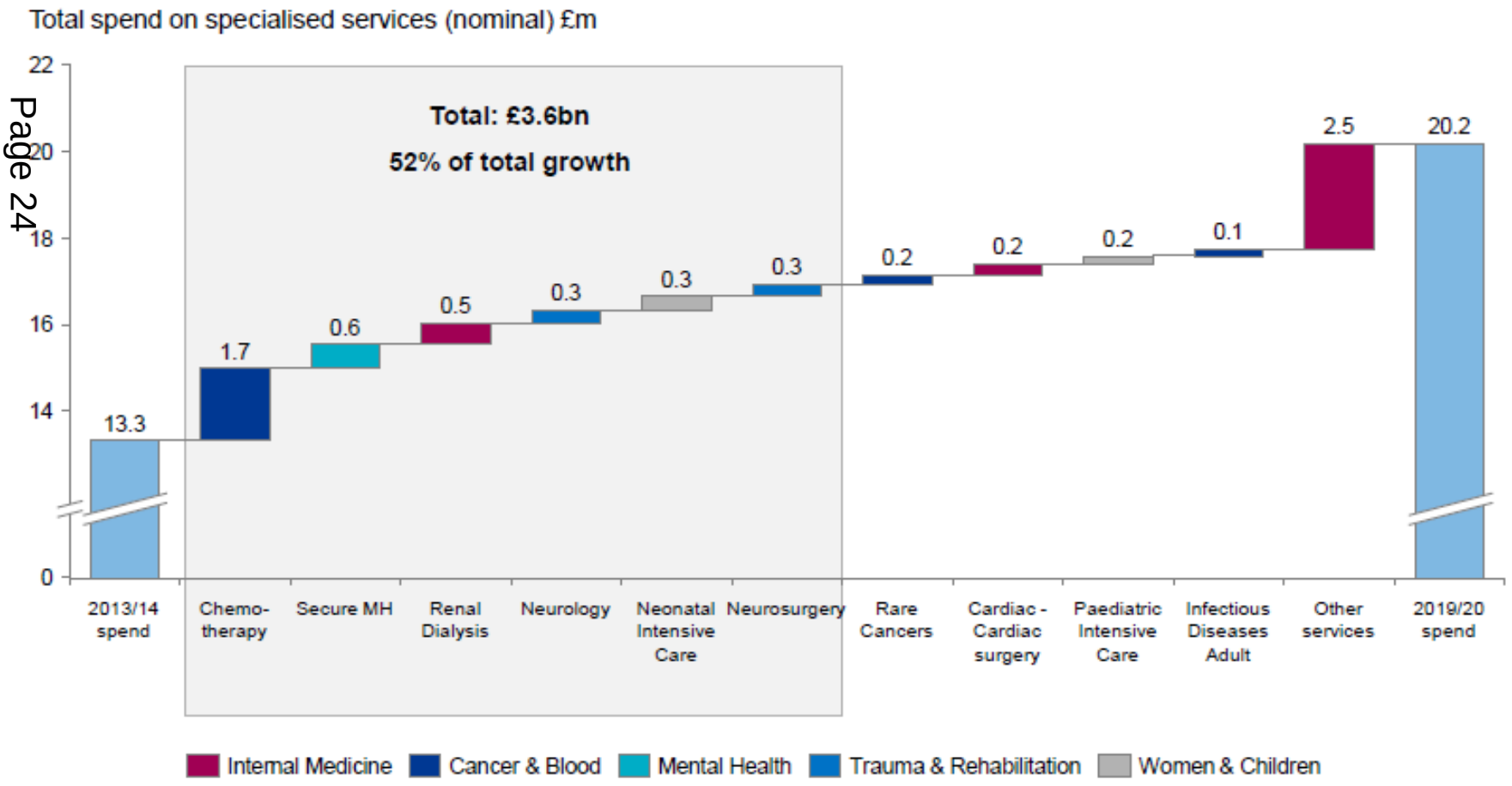
Top ten services

		Spend 2014/15	Spend growth
1	Chemotherapy	1,541,083,165	13%
2	High Cost Drugs (excl. antifungal / transplant)	433,815,763	11%
3	Rare Cancers	600,387,070	6%
4	Cardiac surgery	708,088,623	6%
5	Neurology	543,524,409	9%
6	Neonatal Intensive Care	709,799,068	6%
7	Paediatric Intensive Care	247,887,013	7%
8	Renal Transplantation	112,213,899	9%
9	Hepatology & Pancreatic	109,606,650	9%
10	Neurosurgery	530,402,892	7%

Source: Strategy Group analysis

What is driving growth?

Six services account for ~50% spend growth to 2019/20



Midlands and East - Key Facts

- £3.7 Billion Budget
- Population 17 Million
- 61 CCGs
- 72 Trusts
- 81 Contracts

- 17 STPs aligned to 3 specialised commissioning hubs

- **Top 4 contracts by value £M:**
  - University Hospital Birmingham FT (£350m)
  - Nottingham University Hospitals Trust (£264m)
  - Cambridge University Hospitals FT (£253m)
  - University Hospitals Leicester (£223m)

National Programmes of Care

NHS England

National Commissioning Intentions 2016/2017 for Specialised Services

Internal Medicine	Cancer	Mental Health	Trauma	Women and Children	Blood and Infection
Service Reviews: • Intestinal Failure CQUIN – developing a few high impact CQUINs that can support improvement across a range of services including increasing patient engagement in service change and self-management. Developing Payment approaches to best support patient care: • Complex Invasive Cardiology • Intestinal Failure • Renal Transplant Co-Commissioning opportunities: • Complex Invasive Cardiology • Specialised Rheumatology • Renal Dialysis • Specialised Endocrinology	Service Reviews: • Stereotactic Radiosurgery / Radiotherapy • PET-CT CQUIN – to focus on improving cancer outcomes. Implementing the Cancer Taskforce Strategy. Chemotherapy Algorithms – introduce a suite of algorithms reflecting best clinical evidence which will set out the chemotherapy treatments. Radiotherapy – publish a clinical commissioning policy statement to enable rapid implementation of changes in clinical practice.	Service Reviews: • CAMHS Tier 4 • Medium and low secure Mental Health Services Collaborative commissioning: • Children's Services • Perinatal Services • Offender Personality Disorder programme • Adult Secure Services • Transforming Care Developing Payment approaches to best support patient care for adult secure services.	Service Reviews: • Hyperbaric Oxygen Treatment • Paediatric Burns • Spinal Cord Injury • Prosthetics Service Transformation and Collaborative pathway management: • Adult Critical Care • Spinal Transformation Project Complex Rehabilitation commissioning.	Service Reviews: • Genomic Laboratory Services • Congenital Heart Disease • Paediatric surgery and Paediatric Intensive Care Collaborative Commissioning: • Vanguard to pilot joint working between CRGs and CCGs through complex obstetrics Developing Payment approaches to best support patient care.	Service Reviews: • Haemoglobinopathy • Specialised Infectious Diseases CQUIN: • Promoting greater patient engagement, peer support and self-management • Identifying and addressing variation in high cost drug usage Co-Commissioning opportunities: • Haemoglobinopathy • Hepatitis C • HIV • Infectious Diseases Review commissioning of high consequence infectious diseases with a view to ensuring preparedness arrangements for existing and emerging / new diseases.

Improving Value – developing ideas for improving value initiatives in support of annual efficiency savings of 2.4%

Emerging Priorities - 2016/17

Specialised Commissioning service reviews and procurements anticipated or planned in 2016/17. (Excludes 'business as usual,' collaborative commissioning, STPs, and national policy decisions.)

NHS England

Hub	Mental Health	Blood & Infection	Cancer	Internal Medicine	Trauma	Women's & Children's
National (requires regional and local implementation)	• CAMHS Tier 4 • Medium & Low Secure • Gender • Perinatal • Transforming Care (TC)		• Stereotactic Radiosurgery Procurement (SRP)	• Intestinal Failure (IF) • Congenital Heart Disease (CHD)	• Spinal Review	• Paediatric Burns • Paediatric Epilepsy Surgery
East of England	• CAMHS Tier 4 • Perinatal • TC	• Hep C ODN • HIV Essex procurement	• SRP • Essex Urology • Gynaecological Cancer Herts • Radiotherapy Review Herts • PET CT South Essex	• Vascular Stocktake • IF • CHD	• Neuro Rehabilitation	• Neonatal Critical Care • HDU PIC Transfer Service • Specialised Paediatric Capacity
West Midlands	• Procurement of CAMHS Tier 4 • TC	• HIV	• SRP • HPB • Skin • Head and Neck • Radio Pharmacology	• Vascular Stocktake • IF • CHD • Complex Invasive Cardiology: ICD	• Specialist Rehab Review • Neuro Rehab	• Neonatal Review • Spinal Surgery • Specialist Ear • Single Transport Service
East Midlands	• CAMHS Tier 4 • TC • Gender • High Secure • Perinatal		• SRP • Upper GI	• Vascular Stocktake • IF • CHD	• Rehabilitation Review	• Single Transport Service PIC/NIC • Neonatal Capacity Review

2016/17 in the East of England… slide 1/3

Service	What this involves	Size of Service	Timescale
CAMHS Tier 4	A review of current capacity and care closer to home for some young people that require mental health care as inpatients.		September 2016
Perinatal	A new Mother and Baby Unit for Anglia covering Cambridge, Norfolk and Suffolk; Extra beds for Essex, Bedfordshire and Hertfordshire.		March 2017
Transforming Care	We have set out a clear programme of work with other national partners, in Transforming care for people with learning disabilities – next steps, to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home.	Circa 102 patients	Five year Programme
Essex HIV Services	Re procurement of HIV element of services following Local Authority procurement of sexual health services.	Small numbers	September 2016
Stereotactic Radiosurgery Procurement	Procurement of new equipment and pathway for patients attending Mount Vernon Cancer Centre.		June 2016

2016/17 in the East of England… slide 2/3

Service	What this involves	Size of Service	Timescale
Essex Urology	Creating single specialised urological surgical unit to comply with national standards (currently Colchester and Southend hospitals provide this service but neither treats enough patients to meet the national standards).	150 operations. Patients will require inpatient stay but remainder of diagnosis and treatment will be at local hospital.	Early engagement complete, both trusts have put in proposals which will be evaluated in June 2016. Further public engagement prior to final decision in December 2016.
Radiotherapy Review Herts	Understanding the current capacity and needs for the next 10 years.		September 2016
PET CT South Essex	Moving from mobile to fixed site scanner and increasing capacity. Decision required over location – Basildon (hosts current service) or Southend	1,200 scans per year. One hour visit as part of diagnostic pathway.	Engagement complete end May. 209 public surveys, 40 patient surveys (conducted during patient appointments), 19 clinician surveys, 4 Clinicians meetings, 7 roadshows, 4 community group meetings over 3+ months. Decision expected July 2016. Implementation Dec 2016.
Vascular Stocktake	Regional review of vascular services against national standards may have implications for configuration of service in East of England		Preparations beginning for engagement October 2016. Decision expected March 2017.
Intestinal Failure	National procurement has revealed less activity than anticipated. May need some local engagement	104 patients within the East of England. Any change likely to affect maximum 15 patients	Outcome of procurement June. Implementation follows 6-12 months

2016/17 in the East of England… slide 3/3

Service	What this involves	Size of Service	Timescale
CHD	National Review of current patient pathways no changes expected for the East of England.		National work stream
Neuro Rehabilitation	Stock take of current patient pathways and capacity; working with CCGs.	To be determined	
Neonatal Critical Care	Scoping against the national template with a view about sustainability and staffing.		National Workstream
HDU PIC Transfer Service	Stocktake of current services and review of required capacity.		October 2016
Specialised Paediatric Capacity	Scoping of current capacity and 10 common patient pathways.		Work underway currently working with CUH to review current and future capacity.
Medium & Low Secure	Re-procurement of services		September 2016
Gender	Reduction in waiting lists for gender reassignment services.		
Spinal Review	Review of current pathway flows and capacity		National Timeline
Paediatric Burns	No change		National Timeline
Paediatric Epilepsy Surgery	No change as we don't have this service in the East of England. Currently patients access this from one of the national centres.	Small numbers of children and young people.	National Timeline

Approach to communications and engagement…1/3

DRAFT Communications and Involvement Approach to complex service change. Aligned to NHS England Assurance

Issue identifies need for service review or potential service change

Initial Assessment by Hub Management Team to identify possible impact of change

No / almost no patient impact, clinical and commissioner support

Hub team to implement with patient engagement as appropriate

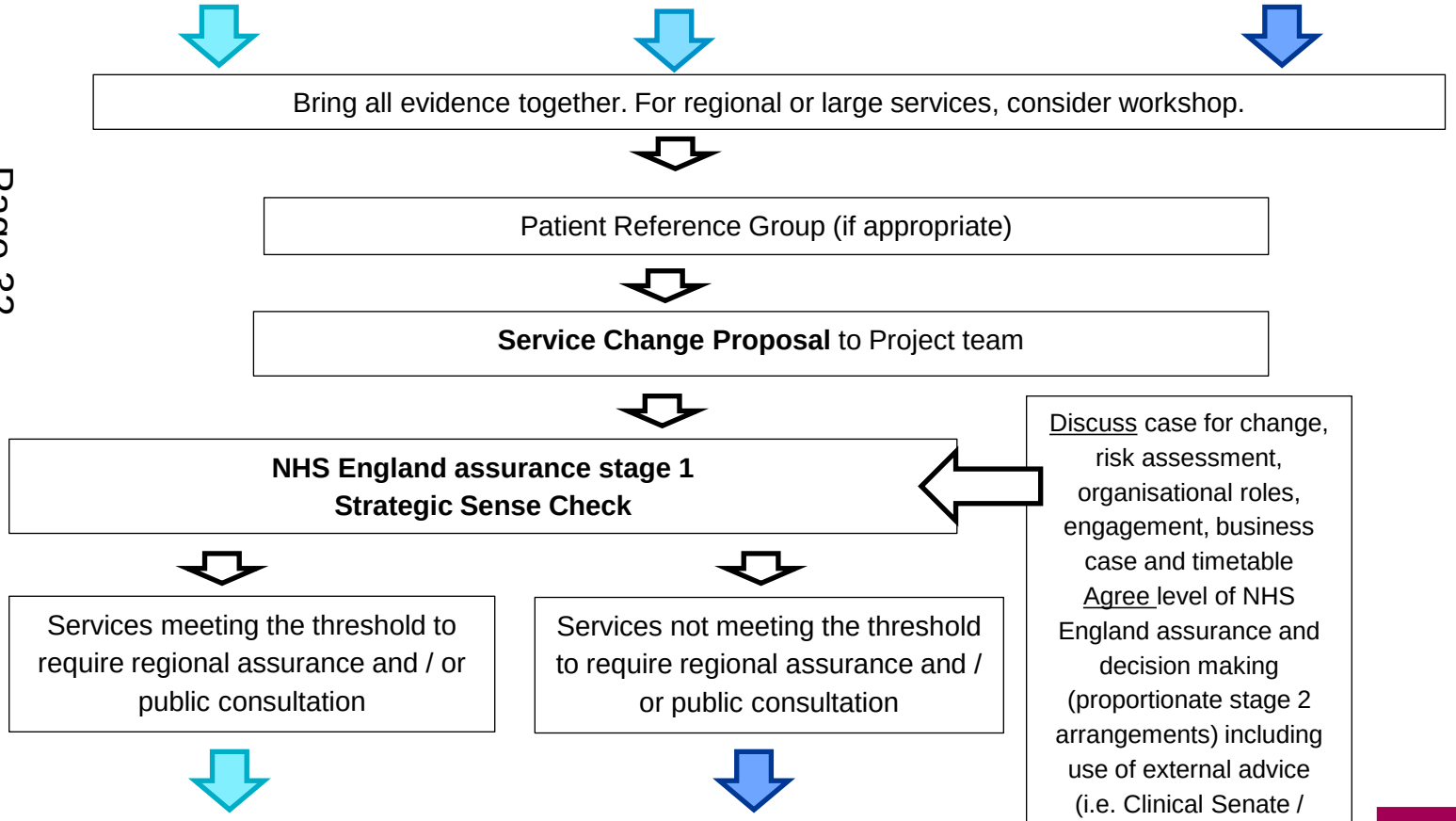
Some or significant patient impact / constitutes significant change / scale of change unclear

Early briefing of SMT, HOSC, clinical stakeholders and Healthwatch
Inclusion in Service Transformation Priorities; Early briefing of NHS England's assurance team

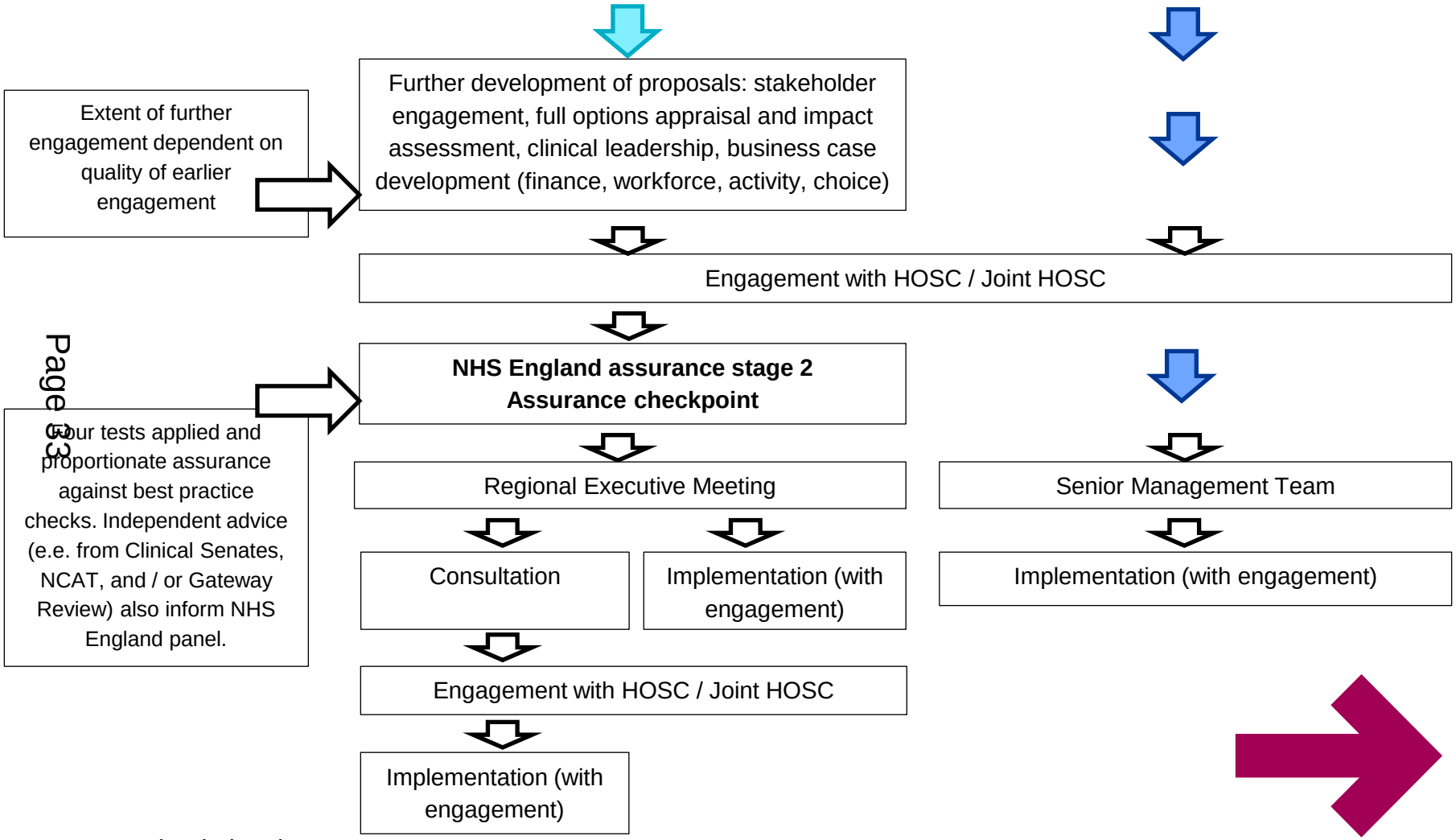
Establish project team and workstreams

Information	Clinical	Engagement
For example…	For example…	For example…
Gathering of service data / evidence	Data validation	Patient interviews /surveys
National /International best practice	Site visits	Public survey / roadshows
Evaluation against service specification	Clinical stakeholder workshop / meetings	Focus groups
Review of research	Survey	Third sector / community groups
Other related reviews	GP Forum visits	Stakeholder communication
	Expert view	Media

Approach to communications and engagement



Approach to communications and engagement



Midlands and East – Who's Who

- **Specialised Commissioning Senior Management Team**
  - Catherine O'Connell, Regional Director
  - Alison Taylor, Director of Finance
  - Geraldine Linehan, Clinical Director
  - Pol Toner, Nurse Director
  - Ruth Ashmore, Assistant Director, East of England
  - Christine Richardson, Assistant Director, East Midlands
  - Simon Collings, Assistant Director, West Midlands
  - Jessamy Kinghorn, Head of Communications and Engagement
  - Chantelle Heanue, Business Manager

9 June 2016	ITEM: 6
Health and Wellbeing Overview and Scrutiny Committee	
Public Health Grant	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Tim Elwell-Sutton, Consultant in Public Health	
Accountable Head of Service: Tim Elwell-Sutton, Consultant in Public Health	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

Significant year-on-year reductions have been made to the Public Health Grant given by the Department of Health to Local Authorities. For Thurrock, this amounts to a 9.65% reduction in the grant between 2015/16 and 2017/18. A number of steps have already been taken to ensure financial balance including re-negotiating existing contracts for Public Health services, making savings on staffing, and decommissioning some services. Together, these measures should ensure financial balance in 2016/17.

Looking forward to 2017/18, further planned cuts to the Public Health grant mean that Public Health faces a structural deficit of £342,000 if no further action is taken. Dealing with this projected shortfall will require a combination of service transformation, re-procurement and income generation. The recommended course of action is thought to provide the best opportunity to ensure financial balance within public health, whilst at the same time fulfilling all of its statutory functions and improving the health and wellbeing of the people of Thurrock.

1. Recommendation(s)

1.1 That the Health and Overview Scrutiny Committee note the contents of this report and endorses the measures taken to address the reduction in the public health grant.

2. Introduction and Background

2.1 Since 2013 a ring-fenced Public Health Grant has been provided to all top tier local authorities in order to commission mandated and discretionary Public

Health services. This report sets out the impact of reductions to the Public Health Grant for Thurrock in 2016/17 and 2017/18.

2.2 Public health services which local authorities are mandated to provide include:

- Appropriate access to sexual health services
- The National Child Measurement Programme
- NHS Health Check Assessments
- Appropriate public health advice to NHS commissioners (the 'core offer')
- Health Protection: the duty to ensure that there are plans in place to protect the health of the population and control serious communicable disease.

2.3 Other Public Health services, which are discretionary, but which improve and protect the health of the local population include:

- Public health services for children and young people (e.g. health visiting and school nursing)
- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Obesity prevention programmes
- Physical activity promotion
- Public mental health services
- Supporting, reviewing and challenging NHS England immunisation and cancer screening programmes
- Reducing the public health impacts of environmental risks

2.4 Since 2015 significant cuts have been applied to the Public Health Grant by the Department of Health. This included an in-year budget cut announced in June 2015, which amounted to a 5.2% reduction in Thurrock's Public Health grant and applied to the financial year 2015/16. Further cuts were made for 2016/17 and 2017/18 amounting to £2,034,852 over the two-year period.

Table 1

Year	Allocation (£s)	Variance from 2015/16 baseline (£s)	% reduction in grant from 2015/16 initial allocation
2015/16 baseline	12,543,426[1]	0	0
2015/16 'in year' reduction	11,888,108	-655,318	-5.22%
2016/17	11,619,000	-924,426	-7.37%
2017/18	11,333,000	-1,210,426	-9.65%

[1] Figure adjusted to account for FYE of additional award to cover the cost of 0 to 5 commissioning responsibilities inherited from NHS England from October 2015

2.5 Most Public Health spending is committed to commissioning what historically were classed as NHS clinical treatment services (see Table 2 below): the 0 to19 care pathway, drug and alcohol treatment services, and sexual health services. Most of these contracts were inherited from South West Essex PCT and hence are NHS standard contracts which run until March 2017, with a 12-month notice period. This means that Thurrock Council is unable to exit them prior to this date without incurring significant financial liability, including redundancy costs.

2.6 In addition to these contracts, a proportion of the Public Health Grant amounting to £1,750,001 is used to support Thurrock Council services including: occupational health; adult social care placements, equipment and supported living contracts; Children's Centres and the Early Offer of Help; and corporate recharges.

2.7 A number of steps have been taken to ensure that Public Health spending remains within budget. In particular, the Public Health team has negotiated changes to contracts with our service providers (especially the North East London Foundation Trust and AdAction) which have resulted in agreements to significantly reduce the cost of existing contracts. The provider organisations have shown considerable flexibility and good will but the opportunities to make further reductions in this way in future are limited.

2.8 The Director of Public Health (DPH) has also stopped all discretionary spend and decommissioned services where there is no financial liability or where financial liability is negligible in comparison to the contract value. He has also deleted four posts from the current Public Health establishment through not filling vacancies.

2.9 In addition, Directors Board agreed in March that funding of the Council's Occupational Health Service would no-longer be met from the Public Health Grant.

2.10 In addition, Directors Board agreed in March that funding of the Council's Occupational Health Service would no-longer be solely met from the Public Health Grant.

2.11 Taking into account all of the above actions and contract agreements, we project a £135,998 structural deficit for the Public Health Grant in 2016/17. This will be covered by a carry forward of £366,852 from 2015/16.

Table 4

Service/Programme	2015/16 baseline (£'000s)	2016/17 programmed spend (£'000s)	Cash releasing savings (£'000s)	% reduction	Mechanism	Impact / Comments
Drug and Alcohol Treatment	1,416	1316	100	7.06%	Contract renegotiation within term	No impact on levels of service delivered. 3% contract savings made in 15/16 which carry forward into 16/17. Provider has agreed to absorb the staff costs of Dual Diagnosis worker previously paid for from the PHG, and all prescribing and dispensing costs of the service
Children's Weight Management	234.5	223.5	11	4.69%	Decommissioning	All tier 1 child weight management community grants have been stopped
0 to 5 Public Health Nursing (Mandated)	3,888.05	3663.57	224	5.77%	Contract renegotiation within term	Some reductions in Health Visiting service KPIs have been agreed as part of the negotiation
5 to 19 Public Health Nursing	1,358	1,000	358	26.36%	Contract renegotiation within term with service reduction	Final saving achieved from negotiated reduction from the long-term work of the team on service benchmarking and remodelling with the Benson Model, new service model commenced in September 2015. Preventative mental health pilot has been decommissioned.
Community Mums and Dads	300	125	175	58.33%	Decommissioning	Service will cease in September 2016. Public Health are working with NELFT to remodel 0 to 5 service provision to ensure breast feeding continues to be supported
Parents First (Breast Feeding Support)	80	0	80	100.00%	Decommissioning	Decommissioning of a third sector organisation providing services that were duplicating other commissioned programmes
Adult Weight Management	122	114	8	6.56%	Decommissioning	The majority of Tier 1 community Adult Weight Management grants have not been renewed.
NHS Health Checks (Mandated)	329	253	76	23.10%	Contract re-negotiation within term with service reduction	Extension of contract negotiated alongside savings reductions. Reductions to payments to GPs and Pharmacies agreed. Underperformance in 15/16 to funding on a cost per case to be returned in 16/17.
Tobacco Control	467	392	75	16.06%	Contract re-negotiation within term with some service reduction on 4 week smoking quit numbers	Service benchmarked and transformed, with a negotiated reduction. New service is moving to more preventative model, with open access Stop Smoking Service and targeted work at patients with early onset smoking related ill-health. KPIs on service targets reduced as a result of cost saving. Underperformance in 15/16 to funding on a cost per case to be returned in 16/17.
Sexual Health Services (Mandated)	1657.45	1775.21	-118	-7.10%	Contract re-negotiation within term with some decommissioning *	Benchmarking and service transformation to an integrated sexual healths service led to £500K savings in 2015/16. The increase in budget from 2015/16 to 2016/17 has been caused by SH cross charging from London Providers, with which TBC are currently in dispute. Further savings have been achieved for 2016/17 be decommissioning Routine Cervical Screening by the provider which is already provided within GP practices
Community Health Improvement	190	0	190	100.00%	Decommissioning	The community grants and initiatives programme has been suspended.
TOTALS	**10,042**	**8,862**	**1,180**	**11.75%**		

* spend on sexual health has increased as a result of a significant increase in cross charging activity between from London Boroughs on a cost per case basis. (See below)

3. Issues, Options and Analysis of Options

3.1 The measures taken to date should ensure that Public Health does not overspend its Grant in 2016/17, though this will only be made possible by relying on a carry forward. Further reductions to the Public Health Grant in 2017/18 mean that we face a structural deficit of £342,000 if no further action is taken.

3.2 In addition to budgetary pressures, the DPH inherited a structure and staffing establishment that was not fit for purpose. In particular, the Council was not delivering a core offer to NHS Thurrock CCG (a mandated service), nor was it

able to discharge its statutory Health Protection duties due to a lack of appropriately trained senior staff.

3.3 Future development of the Public Health function, therefore, needs not only to results in financial sustainability but also ensure that all statutory functions are carried out successfully.

3.4 Attempting to make further savings through reducing the value of existing contracts is unlikely to be successful, given how much has already been cut from these contracts. Therefore, this is not a viable option.

3.5 The option being pursued by the DPH is to undertake a fundamental review of commissioning priorities. There are likely to be significant opportunities to deliver savings by transforming and integrating services between Public Health, other areas of the council and the CCG.

3.6 The DPH has, therefore, requested that the Public Health Leadership Team serve notice on all existing contracts and start a re-procurement process with a view to putting new contracts in place in 2017/18 at a value that covers the projected deficit.

3.7 The DPH is also about to go out to consultation on a new Public Health team structure. The new structure will boost senior capacity to ensure that statutory functions are fulfilled and to provide sufficient capacity to undertake the redesign and re-procurement of commissioned services.

3.8 Additionally, work will commence in 2016/17 to develop income-generation by marketing the specialist skills of the Public Health team in data analysis, health economics and risk modelling to outside organisations.

3.9 Through this combination of service transformation, re-procurement and income generation, the DPH believes it will be possible to cover the currently projected £342K structural deficit for 2017/18.

4. Reasons for Recommendation

4.1 The recommended course of action is thought to provide the best opportunity to ensure financial balance within public health, whilst at the same time fulfilling all statutory functions and improving the health and wellbeing of the people of Thurrock.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 This report has been considered by Directors' Board and the Adults, Housing and Health Departmental Management Team.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The actions set out in the report aim to ensure that the Council is able to fulfil its statutory Public Health duties and to improve the health and wellbeing of the people of Thurrock.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care & Commissioning

In the context of significant year-on-year cuts to the Public Health Grant, the actions set out in this paper are designed to ensure that Public Health spending stays within the limits of the Public Health Grant.

7.2 Legal

Implications verified by: **David Lawson**

Monitoring Officer and Deputy Head of Legal

There are no direct legal implications at this stage.

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

There are no direct diversity implications arising from this report.

Public Health Services are generally designed to reduce health inequalities and this will be taken into account in all the service re-design work outlined in this paper.

The Council will have due regard to the Equality Act 2010 when there are any major proposed actions or schemes for the reduction of air pollution in Thurrock.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

The restructure of the Public Health team will have some impact on staffing, though the overall capacity of the team will be increased.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- None

9. Appendices to the report

- None

Report Author:

Tim Elwell-Sutton

Consultant in Public Health

Public Health Team, Adults, Housing and Health Directorate

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9 June 2016	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Cancer Deep Dive (Health Needs Assessment) in Thurrock	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Funmi Worrell, Public Health Registrar	
Accountable Head of Service: Ian Wake, Director of Public Health	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

A Joint Strategic Needs Assessment/Cancer Deep Dive report was produced as part of the core Public Health offer to NHS Thurrock Clinical Commissioning Group (CCG).

It was originally requested by the CCG in recognition of our poor local performance against the 62 day wait cancer standard – a national target which requires CCGs to ensure that no patient with cancer waits longer than 62 days from initial referral by their GP with symptoms that require investigation, through diagnosis, to receiving their first treatment for cancer.

However, the scope was broadened to consider all elements of the cancer care pathway, from prevention, screening and referral through to diagnosis, treatment and survival.

The most common new diagnoses for cancer in Thurrock are breast, urological, lung and lower GI and that order. Thurrock has the highest rate of lung cancer new diagnoses in its ONS comparator population groups but the lowest rate of breast cancer. However there is little or no statistically significant difference between cancer incidences in different ONS comparator populations.

The most prevalent cancers in the Thurrock population (over a 20 year period) are breast, prostate, colorectal and lung, in that order. The number of people living with cancer in Thurrock over the next 20 years is predicted to rise significantly. This is due to a combination of factors including an ageing population, earlier diagnosis and better treatment. Mortality from cancer within the general population of Thurrock over the past five years is not statistically significantly different to England's or Essex.

A number of areas where discovered where joint working between the CCG, council and other partners could lead to improved outcomes for the population.

1. Recommendation(s)

1.1 That the Health Overview and Scrutiny Committee note the contents of this report.

1.2 HOSC should support the work done by public health, CCG colleagues and other partners to improve cancer services and outcomes in Thurrock.

2. Introduction and Background

2.1. Cancer is the single biggest cause of premature mortality amongst our population.

2.2 Mortality from cancer within the general population of Thurrock over the past five years is not statistically significantly different to England's or Essex.

2.3 Research suggests that at least one-third of all cancer cases are preventable.

2.4 Prevention offers the most cost-effective long-term strategy for the control of cancer. Tobacco use is the single greatest avoidable risk factor for cancer mortality worldwide, causing an estimated 22% of cancer deaths per year. In 2004, 1.6 million of the 7.4 million cancer deaths were due to tobacco use.

2.5 There has been no significant reduction in rates of smoking attributable hospital admissions over the past five years.

2.6 Thurrock has the highest rate of lung cancer new diagnoses in its ONS comparator population groups but the lowest rate of breast cancer. However there is little or no statistically significant difference between cancer incidences in different ONS comparator populations.

2.7 The most prevalent cancers in the Thurrock population (over a 20 year period) are breast, prostate, colorectal and lung, in that order. There are 2135 people in Thurrock, diagnosed with cancer in the last 20 years who are still alive.

2.8 Mortality from cancer within the general population of Thurrock over the past five years is not statistically significantly different to England's or Essex.

3. Issues, Options and Analysis of Options

3.1 **Overview of issues – Cancer is the single biggest cause of premature mortality in Thurrock.**

3.2 **Cancer Prevention: Smoking**

Prevention offers the most cost-effective long-term strategy for the control of cancer. Tobacco use is the single greatest avoidable risk factor for cancer mortality worldwide, causing an estimated 22% of cancer deaths per year.

3.3 It is estimated that between 21.1% to 22.8% of adults in Thurrock smoke, depending on the age range studied and the method of sampling. Thurrock has a smoking prevalence significantly greater than England's and many of its comparator populations.

3.4 Smoking is strongly positively associated with deprivation in Thurrock, and is therefore a key driver of health inequalities.

3.5 Thurrock has rates of hospital admissions and mortality attributable to smoking that are significantly greater than England's and many of its comparator populations.

3.6 There has been no significant reduction in rates of smoking attributable hospital admissions over the past five years:

- 86.6% of smokers have a record of an offer of help to quit smoking by their GP practice
- Fewer than 6% made a quit attempt through an NHS stop smoking service.
- There is significant variation between different GP practice populations and this cannot be explained by differences in deprivation levels between practice populations.

3.7 The Health and Social Care system in Thurrock is failing to have any significant impact on smoking prevalence in our local population through smoking cessation work. :

- It is estimated that less than 0.3% of smokers successfully quit long term in 2014/15 as a result of a commissioned stop smoking service.
- This is a product of both a failure of providers to identify and refer smokers into stop smoking services and a failure of stop smoking services to help sufficient people referred to them, to quit successfully long term.

3.8 **Cancer Screening**

Early identification of many types of cancer results in better treatment outcomes for patients. Cancer screening programmes aim to identify people likely to have cancer such that they can be referred for further diagnostic tests and if necessary for treatment.

3.9 National cancer screening programmes are delivered by the NHS. They are coordinated by the national office of the NHS Cancer Screening Programmes, part of Public Health England. Commissioning and monitoring of local programmes is the responsibility of a local team of Public Health England based within the NHS England East office.

3.10 **There are three cancer screening programmes:**

- the NHS Cervical Screening Programme
- the NHS Breast Screening Programme
- the NHS Bowel Cancer Screening Programme

3.11 **Cervical Screening**

- The mean 3.5 year screening cervical screening coverage of patients aged 25-49 across Thurrock is 71.7% which is above the minimum standard but below the target 80% rate
- However, there is unacceptable variation in screening coverage between GP practice populations.
- Only 17 of our 32 GP practices (53.1%) achieve screening coverage at the minimum standard of 70% and only two (6.25%) achieve screening coverage at the target rate of 80%.
- Performance on screening coverage for women aged 50-64 is better than those aged 24-49. The mean screening coverage in this cohort across the CCG is 76.2% and variation between practice populations is lower than that in younger women.
- Cervical screening coverage for women aged 25-49 is relatively strongly negatively associated with practice population deprivation and could therefore be said to be a driver for health inequalities.
- 11 practices have screening coverage that is both below the 70% minimum standard and significantly below what would be expected for their level of practice population deprivation. This warrants further investigation.

3.12 **Bowel cancer screening**

- The mean coverage rate for bowel cancer screening in Thurrock in the eligible population is 55%. This is below the national minimum standard of 60%.
- 26 of the 32 (81.26%) practice populations have screening coverage below the 60% target.
- There is considerable variation in uptake of bowel cancer screening between GP practice populations, with the lowest coverage being just over half of that in the population with the highest coverage rate.
- Given that GP practices have little involvement in this screening programme, the explanation for this is likely to a product of differences within the practice populations themselves. There is a strong negative association between bowel cancer screening coverage and deprivation. This is concerning as it is likely to be a driver of health inequalities related to cancer.

3.13 **Breast cancer screening**

- The mean screening coverage rate for breast screening of patients across Thurrock is 65.9% which is below the minimum standard of 70%.
- There is considerable variation in coverage between different practice populations. Only 11 out of the 32 practice populations (34.3%) achieve the minimum 70% coverage standard and none are screened to the target 80%.

3.14 **Early Identification and Referral of People with Suspected Cancer:**

- Timely and appropriate referral of patients with symptoms is essential to improving cancer survival in our population.
- One of the explanations in the published literature on the UK's poor cancer survival rates compared to other countries is that patients are referred for cancer treatment to late.
- Conversely, over-referral of patients who do not have cancer risks clogging up NHS care pathways with the "worried well" and diverting capacity away from treating promptly patients who do have cancer.
- The NHS has set a two week minimum waiting time for patients with suspected cancer to see a cancer specialist from GP referral.
- Overall, 7.8% of patients referred into the two-week wait cancer pathway were subsequently found to have cancer. This is lower than England's rate (8.4%) but not statistically significantly different.
- In one practice over 30% of patients referred into the two week pathway were subsequently diagnosed with cancer. This suggests a significant under referral of patients and warrants further urgent investigation.
- On a second metric to examine the appropriateness of referral of patients with suspected cancer into the two week wait pathway – the Indirectly Age Standardised Referral Ratio, there is also significant variation in between GP practices in Thurrock.
- Nine practices (28.1%) have referral ratios that suggest that they are under referring patients with suspected cancer and three practices (9.4%) have referral ratios that suggest they may be over-referring patients who do not have cancer.
- Three practices have scores on both metrics that suggest that they are failing to refer sufficient patients with suspected cancer into the two week wait pathway. This warrants further investigation.
- Over half of all patients treated for cancer in Thurrock did not receive a referral through the two-week wait pathway. This is not significantly different to England's rate, but still suggests that too few patients are having their cancer detected early enough.
- In terms of performance against the two-week waiting standard, Thurrock performs well with 95.6% of patients seeing a cancer specialist within two weeks of being referred into the pathway by their GP. This is second best performance in Thurrock's ONS comparator CCG group and statistically significantly better than the performance across England.

3.15 **Cancer Diagnosis and Treatment**

- Prompt diagnosis and treatment is key both to the efficacy of treatment and to minimising the distress of people diagnosed with cancer.
- There is significant variation between different GP populations in terms of rate of unplanned care admissions for cancer with 12 practices having rates significantly below the England mean and two practices significantly above and a 20 fold difference between the practice population with the highest and lowest rate.
- Cancer diagnosed and treated through an unplanned care hospital admission are likely to indicate late diagnosis and poorer patient outcomes.
- Cancer unplanned care admission rates are strongly positively associated with income deprivation levels in the practice population although the reasons for this are unclear.
- Explanations could include a greater level of under doctoring in deprived communities, a lower cancer screening coverage or a greater unwillingness of deprived populations to seek help early for cancer symptoms.
- For patients who are referred into local cancer care pathways Thurrock CCG performs in line with England and its comparator group CCGs on the 31 day wait performance cancer standard suggesting that once cancer is diagnosed, the vast majority of patients (97%) receive treatment within 31 days.
- Conversely only 68.4% of patients with cancer receive treatment within 62 days from their initial GP referral.
- This is the lowest percentage of patients when compared to Thurrock's ONS comparator CCGs and is significantly worse than the England mean of 84%.
- Furthermore the situation has deteriorated over the last 15 months.
- Delays in cancer treatment due to delays in diagnostics is likely to impact adversely on mortality rates of Thurrock patients and is unacceptable.
- Detailed category analysis on 62 day breach reports undertaken by the author between April 2014 and June 2015 suggests that 78% of all 62 day cancer wait breaches are potentially avoidable.
- The most common two reasons were either entirely or partly a function of the fragmentation of cancer pathways between multiple hospital sites across Essex.
- The most common reason was delays in access to diagnostics. This occurred either at one site or often because referral of patients between different sites was required in order to access to all diagnostic equipment in order to obtain an adequate diagnosis to begin treatment. This accounted for almost half of all breaches.
- Where specified, delays for MRI and CT scans and for TRUS featured commonly in breach reports categorised into this sub-category.

A theme running through many of the reports for breaches categorised as 'avoidable' was a lack of coordination of care of the patient.

The care pathway operates as a series of linked individual processes with staff only taking responsibility for their part of the pathway or process. As soon as one part of the pathway failed, the entire pathway failed and the delay occurred. Patients often appeared to be 'bounced' around different providers and different parts of the NHS system with no one individual taking responsibility for their journey through the pathway:

- The urological, lung, and upper gastrointestinal pathways give cause for significant concern:
- Over 50% of patients entering these pathways fail to receive treatment for cancer within the 62 day standard because of reasons that were potentially avoidable.
- 47% of patients with lung cancer experienced a potentially avoidable delay in diagnostics in the first quarter of 2014/15.

Cancer Survival

- Cancer one-year survival rates for both Thurrock and England have increased at largely the same yearly rate and by around 10% between 1996 and 2011, with Thurrock's one-year survival rate remaining slightly below that of England's.
- Whilst improving, one-year survival rates for both breast and colorectal cancer in Thurrock are amongst the lowest amongst in our ONS comparator group of CCGs.
- Over the last 20 years, patients diagnosed with in Thurrock have generally survived for shorted periods of time than England and many of our comparator CCGs

4. Reasons for Recommendation

4.1 HOSC is asked to note the contents of this report.

4.2 HOSC is asked to support the work that public health, CCG and other partners are doing in order to improve outcomes for those affected by cancer in Thurrock.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 This report has been presented to Thurrock CCG colleagues, who supported the recommendations made.

6. Impact on corporate policies, priorities, performance and community impact

6.1 This report should be used by the Council and partners to influence new ways of working and supporting policies and actions that aim to improve outcomes by those affected by cancer.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant, Social Care & Commissioning

There are no financial implications following the recommendations of this report.

7.2 Legal

Implications verified by: **David Lawson**

Monitoring Officer and Deputy Head of Legal

There are no direct legal implications at this stage.

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

There are no direct diversity implications arising from this report.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder

Implementing the recommendations of the report will help to improve the health of the population by diagnosing cancers earlier and treating them more quickly in order to improve cancer survival rates.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None.

9. Appendices to the report

Appendix 1 - Cancer Deep Dive

Report Author

Funmi Worrell
Public Health Registrar

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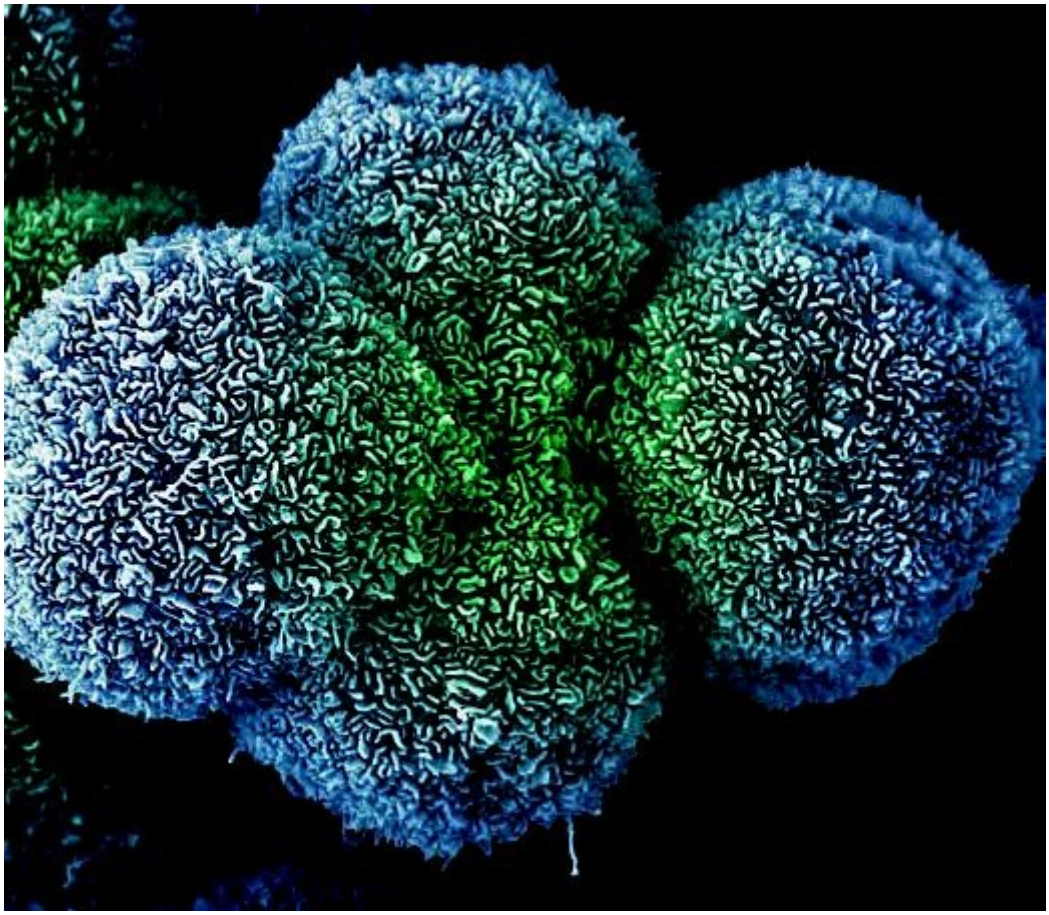
thurrock.gov.uk

NHS Thurrock Clinical Commissioning Group



Cancer Deep Dive

A Thurrock Joint Strategic Needs Assessment (JSNA) Product

Author: Ian Wake,
Director of Public Health

November 2015

CONTENTS

1. Introduction

Every day in the UK there are more than 900 people diagnosed with cancer. It is estimated that one in two of us will develop cancer within our lifetime. However cancer is no-longer necessarily a death sentence. The most recent research suggests that for the first time in history, more people in the UK will survive cancer than die from it.

Improvements in lifestyle, early diagnosis and treatment have all had a positive impact on delivering this statistic, yet the UK still benchmarks poorly when compared to many other developed western countries when it comes to cancer survival rates. In Thurrock, cancer is still the most common reason for premature death in our population and as such is an absolutely key public health priority.

This report has been produced as part of the core Public Health offer to NHS Thurrock Clinical Commissioning Group. It was originally requested by the CCG in recognition of our poor local performance against the 62 day wait cancer standard – a national target which requires Clinical Commissioning Groups to ensure that no patient with cancer waits longer the 62 days from initial referral by their GP with symptoms that require investigation, through diagnosis, to receiving their first treatment for cancer. However I have expanded the scope of the initial request to include a section on local cancer epidemiology, and then to consider all elements of the cancer care pathway, from prevention, screening and referral though to diagnosis, treatment and survival.

As with so many Public Health issues, it is only by considering the totality of the picture and then taking coordinated action across agencies, in conjunction with the general public can we hope to have the greatest impact. As such, the report makes clear recommendations for a range of stakeholders to implement to improve the situation and reduce the number of people in our population who die from cancer in the future.

Ian Wake
Director of Public Health

Please note, where the phrases 'statistically significantly greater than or less than' are used in this report, they refer to statistical significance at 95% CI.

2. Executive Summary

The Epidemiology of Cancer in Thurrock

Cancer is the single biggest cause of premature mortality amongst our population. The most common new diagnoses for cancer in Thurrock are breast, urological, lung and lower GI and that order.

Thurrock has the highest rate of lung cancer new diagnoses in its ONS comparator population groups but the lowest rate of breast cancer. However there is little or no statistically significant difference between cancer incidences in different ONS comparator populations.

The most prevalent cancers in the Thurrock population (over a 20 year period) are breast, prostate, colorectal and lung, in that order. There are 2135 people in Thurrock, diagnosed with cancer in the last 20 years who are still alive.

The number of people living with cancer in Thurrock over the next 20 years is predicted to rise significantly. This is due to a combination of factors including an ageing population, earlier diagnosis and better treatment.

Mortality from cancer within the general population of Thurrock over the past five years is not statistically significantly different to England's or Essex.

Cancer Prevention: Smoking

Research suggests that at least one-third of all cancer cases are preventable. Prevention offers the most cost-effective long-term strategy for the control of cancer. Tobacco use is the single greatest avoidable risk factor for cancer mortality worldwide, causing an estimated 22% of cancer deaths per year. In 2004, 1.6 million of the 7.4 million cancer deaths were due to tobacco use.

It is estimated that between 21.1% to 22.8% of adults in Thurrock smoke, depending on the age range studied and the method of sampling. Thurrock has a smoking prevalence significantly greater than England's and many of its comparator populations

Smoking is strongly positively associated with deprivation in Thurrock, and is therefore a key driver of health inequalities.

Thurrock has rates of hospital admissions and mortality attributable to smoking that are significantly greater than England's and many of its comparator populations. There were an estimated 1356 additional hospital admissions amongst our population in 2014/15 as a result of the levels of smoking prevalence in our population, resulting in an additional £3.8M of cost to NHS Thurrock CCG and an additional deaths that can be attributable to smoking prevalence.

There has been no significant reduction in rates of smoking attributable hospital admissions over the past five years.

Despite 86.6% of smokers having a record of an offer of help to quit smoking by their GP practice, fewer than 6% made a quit attempt through an NHS stop smoking service in the preceding 24 months to March 2015. There is significant variation between different GP practice populations and this cannot be explained by differences in deprivation levels between practice populations.

The Health and Social Care system in Thurrock is failing to have any significant impact on smoking prevalence in our local population through smoking cessation work. It is estimated that less than 0.3% of smokers successfully quit long term in 2014/15 as a result of a commissioned stop smoking service. This is a product of both a failure of providers to identify and refer smokers into stop smoking services and a failure of stop smoking services to help sufficient people referred to them, to quit successfully long term.

Cancer Screening

Early identification of many types of cancer results in better treatment outcomes for patients. Cancer screening programmes aim to identify people likely to have cancer such that they can be referred for further diagnostic tests and if necessary for treatment. A positive screen in a cancer screening programme is not equivalent to a cancer diagnosis, but suggests that further investigation is necessary to ascertain whether or not the patient has cancer.

National cancer screening programmes are delivered by the NHS. They are coordinated by the national office of the NHS Cancer Screening Programmes, part of Public Health England. Commissioning and monitoring of local programmes is the responsibility of a local team of Public Health England based within the NHS England East office.

There are three cancer screening programmes:

- the NHS Cervical Screening Programme
- the NHS Breast Screening Programme
- the NHS Bowel Cancer Screening Programme

The mean 3.5 year screening cervical screening coverage of patients aged 25-49 across Thurrock is 71.7% which is above the minimum standard but below the target 80% rate However there is unacceptable variation in screening coverage between GP practice populations. Only 17 of our 32 GP practices (53.1%) achieve screening coverage at the minimum standard of 70% and only two (6.25%) achieve screening coverage at the target rate of 80%. Performance on screening coverage for women aged 50-64 is better than those aged 24-49. The mean screening coverage in this cohort across the CCG is 76.2% and variation between practice populations is lower than that in younger women. All but three practices (90.6%) achieve the minimum 70% coverage standard and a quarter of all practices achieve screening coverage above the 80% target.

Cervical screening coverage for women aged 25-49 is relatively strongly negatively associated with practice population deprivation and could therefore be said to be a driver for health inequalities. 11 practices (Jones and Byrne, Balfour, Deshpande, Roy and Partners, Masson and Masson, Kadim, Joseph and Ptnr, Thurrock Health Centre, Chadwell, Appledore MC and Mukhopadhyay) have screening coverage that is both below the 70% minimum standard and significantly below what would be expected for their level of practice population deprivation. This warrants further investigation. The absolute low level of cervical screening coverage within the Mukhopadhyay practice coupled with the significant distance below what would be predicted for the level of practice deprivation is particularly concerning.

The mean coverage rate for bowel cancer screening in Thurrock in the eligible population is 55%. This is below the national minimum standard of 60%. 26 of the 32 (81.26%) practice populations have screening coverage below the 60% target. There is considerable variation in uptake of bowel cancer screening

between GP practice populations, with the lowest coverage rate (Sai Medical Centre) being just over half the that in the population with the highest coverage rate (Hassengate Medical Centre). Given that GP practices have little involvement in this screening programme, the explanation for this is likely to a product of differences within the practice populations themselves. There is a strong negative association between bowel cancer screening coverage and deprivation. This is concerning as it is likely to be a driver of health inequalities related to cancer.

The mean screening coverage rate for breast screening of patients across Thurrock is 65.9% which is below the minimum standard of 70%. Like the other cancer screening programmes previously discussed there is considerable variation in coverage between different practice populations. Only 11 out of the 32 practice populations (34.3%) achieve the minimum 70% coverage standard and none are screened to the target 80% coverage. The practice population with the poorest breast cancer screening coverage rate (Acorns) achieves a rate that is only just over half that of the practice population with the highest coverage. (Cheung). There is a reasonably strong negative association between breast screening coverage and practice population deprivation. The Abella, St. Clements, Purfleet Care Centre, Thurrock Health Centre and Acorns Medical Centre have screening coverage rates significantly below what would be predicted given this association. This warrants further investigation.

Early Identification and Referral of People with Suspected Cancer

Timely and appropriate referral of patients with symptoms that could indicate that they have cancer is essential to improving cancer survival in our population. One of the explanations in much of the published literature on the UK's poor cancer survival rates compared to other countries is that patients are referred for cancer treatment to late. Conversely, over-referral of patients who do not have cancer risks clogging up NHS care pathways with the "worried well" and diverting capacity away from treating promptly patients who do have cancer.

The NHS has set a two week minimum waiting time for patients with suspected cancer to see a cancer specialist from GP referral. This forms part of the NHS Constitution.

Overall, 7.8% of patients referred into the two-week wait cancer pathway were subsequently found to have cancer. This is lower than England's rate (8.4%) but not statistically significantly different.

At GP practice level, three practices have a cancer diagnosis rate following referral into the two week pathway that is significantly greater than England's rate. In one practice over 30% of patients referred into the two week pathway were subsequently diagnosed with cancer. This suggests a significant under referral of patients and warrants further urgent investigation.

On a second metric to examine the appropriateness of referral of patients with suspected cancer into the two week wait pathway – the Indirectly Age Standardised Referral Ratio, there is also significant variation in between GP practices in Thurrock. Nine practices (28.1%) have referral ratios that suggest that they are under referring patients with suspected cancer and three practices (9.4%) have referral ratios that suggest they may be over-referring patients who do not have cancer. Three practices have scores on both metrics that suggest that they are failing to refer sufficient patients with suspected cancer into the two week wait pathway. This warrants further investigation.

Over half of all patients treated for cancer in Thurrock did not receive a referral through the two-week wait pathway. This is not significantly different to England's rate, but still suggests that too few patients are having their cancer detected early enough.

In terms of performance against the two-week waiting standard, Thurrock performs well with 95.6% of patients seeing a cancer specialist within two weeks of being referred into the pathway by their GP. This is second best performance in Thurrock's ONS comparator CCG group and statistically significantly better than the performance across England.

Cancer Diagnosis and Treatment

Prompt diagnosis and treatment is key both to the efficacy of treatment and to minimising the distress of people diagnosed with cancer.

There is significant variation between different GP populations in terms of rate of unplanned care admissions for cancer with 12 practices having rates significantly below the England mean and two practices significantly above and a 20 fold difference between the practice population with the highest and lowest rate. Cancer diagnosed and treated through an unplanned care hospital admission are likely to indicate late diagnosis and poorer patient outcomes. Cancer unplanned care admission rates as strongly positively associated with income deprivation levels in the practice population although the reasons for this are unclear. Explanations could include a greater level of under doctoring in deprived communities, a lower cancer screening coverage or a greater unwillingness of deprived populations to seek help early for cancer symptoms.

For patients who are referred into local cancer care pathways Thurrock CCG performs in line with England and its comparator group CCGs on the 31 day wait performance cancer standard suggesting that once cancer is diagnosed, the vast majority of patients (97%) receive treatment within 31 days. Conversely only 68.4% of patients with cancer receive treatment within 62 days from their initial GP referral. This is the lowest percentage of patients when compared to Thurrock's ONS comparator CCGs and is significantly worse than the England mean of 84%. Furthermore the situation has deteriorated over the last 15 months. Considering these two metrics together suggests that there are serious and unacceptable delays occurring in Thurrock in the initial diagnosis of cancer. Delays in cancer treatment due to delays in diagnostics is likely to impact adversely on mortality rates of Thurrock patients and is unacceptable. This warrants further urgent investigation.

Detailed category analysis on 62 day breach reports undertaken by the author between April 2014 and June 2015 suggests that 78% of all 62 day cancer wait breaches are potentially avoidable. The most common two reasons were either entirely or partly a function of the fragmentation of cancer pathways between multiple hospital sites across Essex. The most common reason was delays in access to diagnostics. This occurred either at one site or often because referral of patients between different sites was required in order to access to all diagnostic equipment in order to obtain an adequate diagnosis to begin treatment. This accounted for almost half of all breaches. Where specified, delays for MRI and CT scans and for TRUS featured commonly in breach reports categorised into this sub-category.

A theme running through many of the reports for breaches categorised as 'avoidable' was a lack of coordination of care of the patient. The care pathway operates as a series of linked individual processes with staff only taking responsibility for their part of the pathway or process. As soon as one part of the

pathway failed, the entire pathway failed and the delay occurred. Patients often appeared to be 'bounced' around different providers and different parts of the NHS system with no one individual taking responsibility for their journey through the pathway.

The Urological, lung, and upper gastrointestinal pathways give cause for significant concern with over 50% of patients entering these pathways failing to receive treatment for cancer within the 62 day standard because of reasons that were potentially avoidable. 47% of patients with lung cancer experienced a potentially avoidable delay in diagnostics in the first quarter of 2014/15.

Cancer Survival

Cancer one-year survival rates for both Thurrock and England have increased at largely the same yearly rate and by around 10% between 1996 and 2011, with Thurrock's one-year survival rate remaining slightly below that of England's.

Whilst improving, one-year survival rates for both breast and colorectal cancer in Thurrock are amongst the lowest amongst in our ONS comparator group of CCGs. One year lung cancer one-year survival rates are around median compared to our ONS CCG comparator group, although are not improving at the same rate as other CCGs.

Over the last 20 years, patients diagnosed with in Thurrock have generally survived for shorted periods of time than England and many of our comparator CCGs

3. Recommendations

Prevention: Smoking

1. Public Health should undertake a comprehensive review of current commissioning arrangements on tobacco control with a view to significantly improving the impact that future providers are having on smoking prevalence in Thurrock and achieving a minimum 1% prevalence reduction per annum. This should be monitored as part of the outcomes framework in the Joint Health and Wellbeing Strategy refresh.

2. Thurrock CCG should amend current commissioning arrangements with NELFT, SEPT and BTUH, and Thurrock Council with its front line providers to include an obligation them routinely to identify and refer patients who smoke into Public Health commissioned stop smoking services. Minimum agreed numbers of referrals should be incorporated into all contracts and routinely performance managed.

3. Thurrock Council should train its front line staff in 'Making Every Contact Count' and include identification and referral of smokers into commissioned stop smoking services.

4. Public Health should commission its stop smoking provider to provide further support and training to front line practice staff to improve the conversion ratio of patients offered support to quit who go on to make a quit attempt through a commissioned stop smoking service.

Cancer Screening

5. The Public Health England team based in NHS England East office should investigate and seek to reduce the level of variation in coverage between GP practice populations on all three cancer screening programmes. Specifically:

5a. For cervical screening the following practice populations warrant further investigation

- Jones and Byrne, Balfour, Deshpande, Roy and Partners, Masson and Masson, Kadim, Joseph and Ptnr, Thurrock Health Centre, Chadwell, Appledore MC and Mukhopadhyay

5b. For bowel screening, the following practice populations warrant further investigation

- Sai Medical Centre, Tilbury Health Centre, Okoi, Thurrock Health Centre, Darenth Lane, St. Clements, Dilip Sabnis, Purfleet Care Centre, Joseph and Partner, Acorns Medical Centre, Appledore and Medic House, Mukhopadhyay, Shehadah, Kadim Primecare, Aveley Medical Centre,

5c. For breast screening, the following practice populations warrant further investigation

- Acorns Medical Centre, Thurrock Health Centre, Purfleet Care Centre, Health Centre Darenth Lane, Okoi and Partner, Tilbury Health Centre, Sai Medical Centre, St. Clements Health Centre, Bellworthy, Abela and Partner, Aveley Medical Centre

6. GPs and practice staff with screening coverage below target should seek opportunities to promote and encourage cancer screening programmes to all patients

7. NHS Thurrock CCG in conjunction with Thurrock Council Public Health Team should develop and implement a communications campaign promoting the importance of cancer screening programmes, with particular targeting of areas with low screening coverage

Early Identification and Referral of People with Suspected Cancer

8. The CCG in conjunction with Thurrock Council should undertake a coordinated communications campaign aimed at increasing patient knowledge of potential cancer symptoms and encouraging them to consult their GP at the earliest possible opportunity. This campaign should be targeted at practice populations with referral ratios below 80% or where unplanned admission rates for cancer are high.

9. Practices that have been identified as having referral ratios into the TWW pathway below 80% and/or cancer TWW positivity rates that are significantly greater than the England mean should review their clinical practice with regard to cancer referrals to ensure that they are identifying and referring patients with symptoms that could be cancer, sufficiently early.

10. Practices with that have been identified has having referral ratios into the TWW pathway above 120% and/or TWW cancer positivity rates that are significantly less than the England mean should review their clinical practice with regard to cancer referrals to ensure that they are not over referring patients.

Cancer Diagnosis and Treatment

11. The current configuration of cancer pathways is fragmented across multiple hospital sites. NHS England should work with CCGs across Essex to rationalise cancer diagnosis and treatment into fewer specialist centres

12. No one professional is accountable for a patient's journey through the system. The CCG should commission a 'care coordination' approach to cancer care with a single named accountable professional being responsible for monitoring a patient's journey and ensuring each part of the system works in a coordinated and high quality care

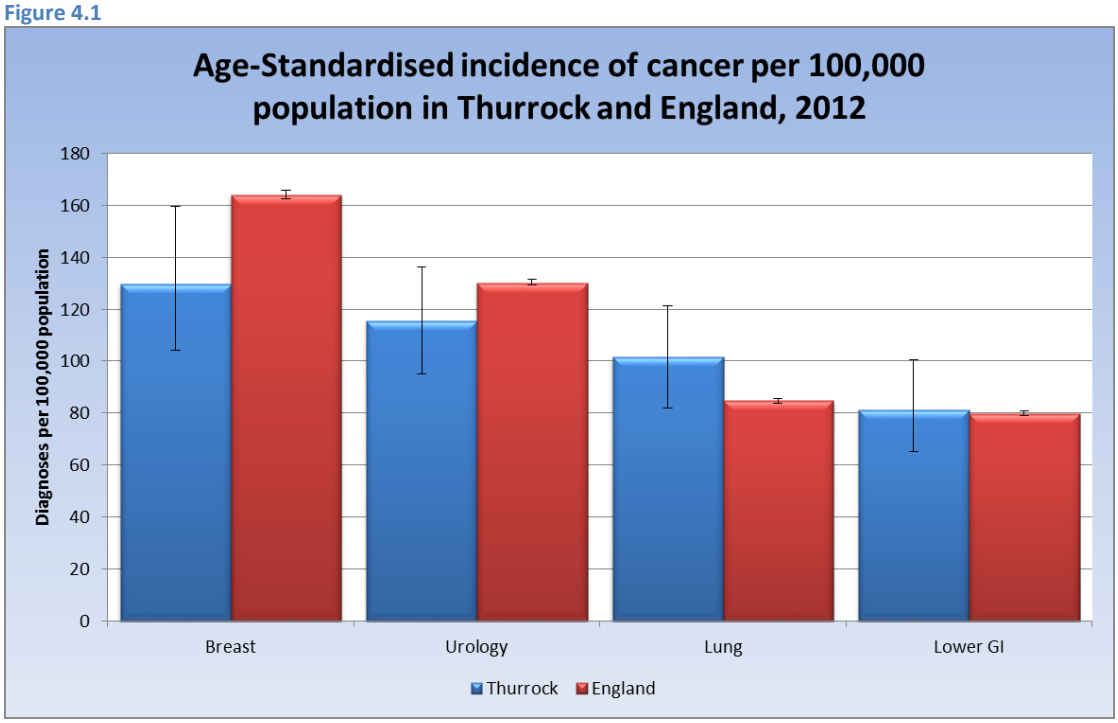
13. Delay in diagnostics in some tumour specific pathways is the primary reason for failure to meet the 62 day cancer waiting standard. The current level of delay for some types of cancer is unacceptable and may be unnecessarily compromising the efficacy of future treatment and causing distress to patients. The CCG, in association with the relevant providers should urgently review the following care pathways with a view to addressing delays in diagnostics: Urological, lung, upper and lower GI, haematological, head and neck, and gynaecological.

4. Cancer Epidemiology

4.1 Cancer Incidence

Cancer incidence is the rate of new cancer diagnoses within a given population and time period. It is a function largely of the health behaviour of the population and environment in which that population lives. Figure 4.1 shows the incidence of the four most common cancers in Thurrock and England in 2012 expressed as a rate per 100,000 population.

Figure 4.1



The most common new diagnosis of cancer in both Thurrock and England is breast, followed by urology (including prostate), lung and lower GI (bowel and colorectal).

Breast cancer incidence in Thurrock is statistically significantly lower in Thurrock than England (at 95% CI). Incidence for urological, lung and lower GI cancers is not statistically significantly different to England, although lung cancer incidence at 94% CI is significantly greater. This is likely to reflect the high prevalence of smoking in Thurrock compared to England.

Figures 4.2 to 4.6 show the incidence of the four most common types of cancer; breast, urological, lung and lower GI respectively for England, Thurrock and Thurrock CCG's Office for National Statistics (ONS) comparator CCGs. (These are CCGs serving populations with the most similar demographics to the population of Thurrock).

Figure 4.2

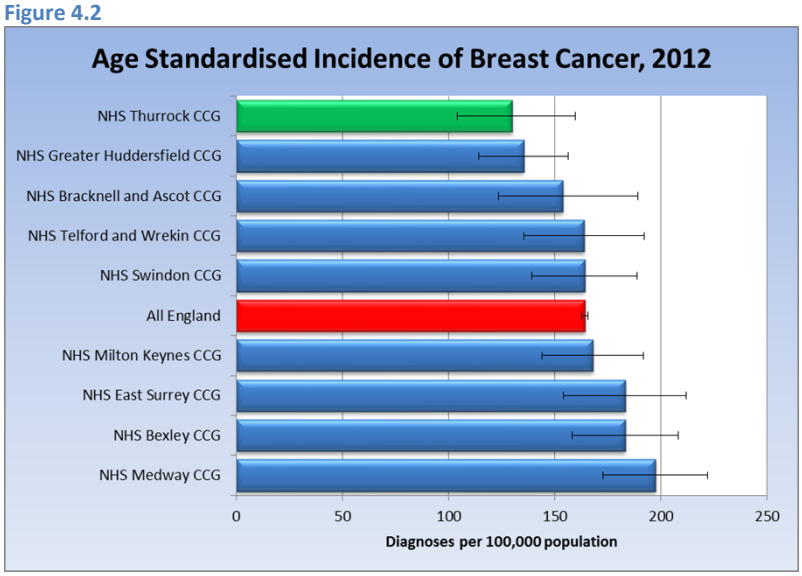


Figure 4.3

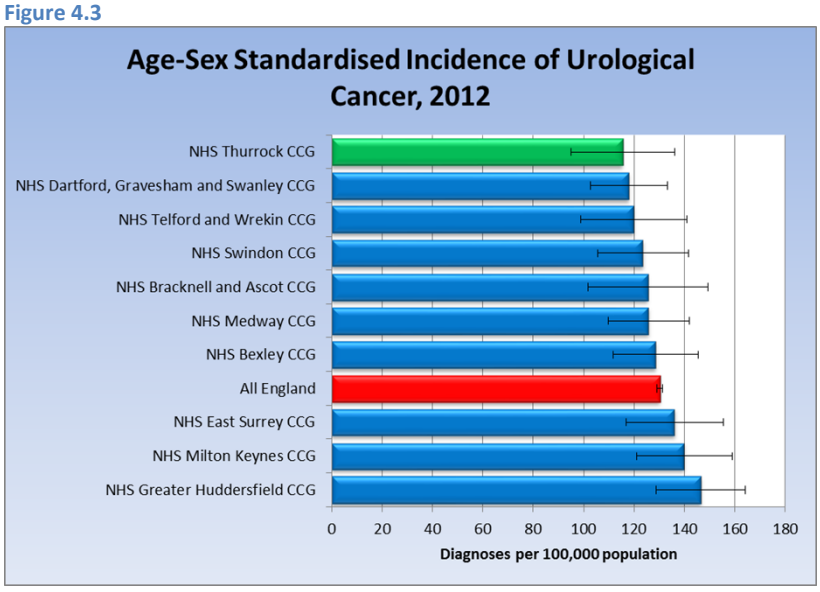


Figure 4.4

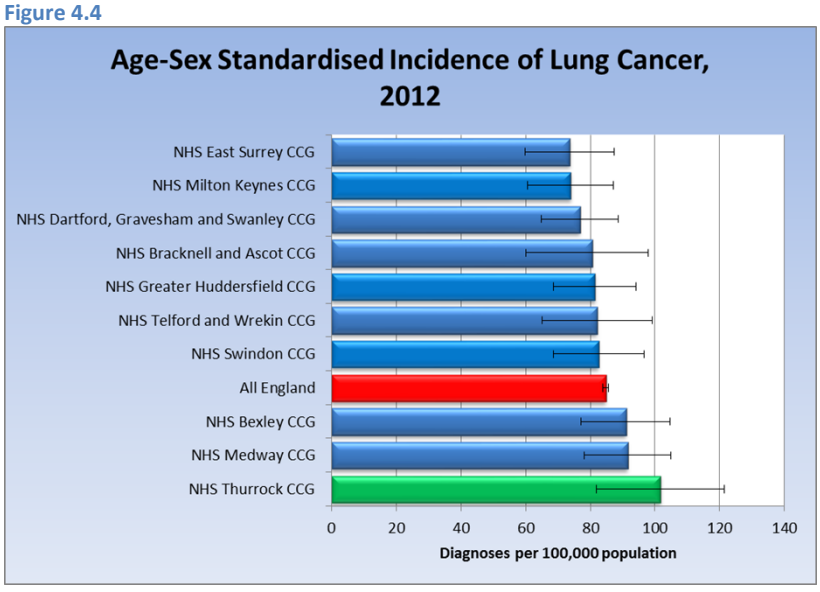
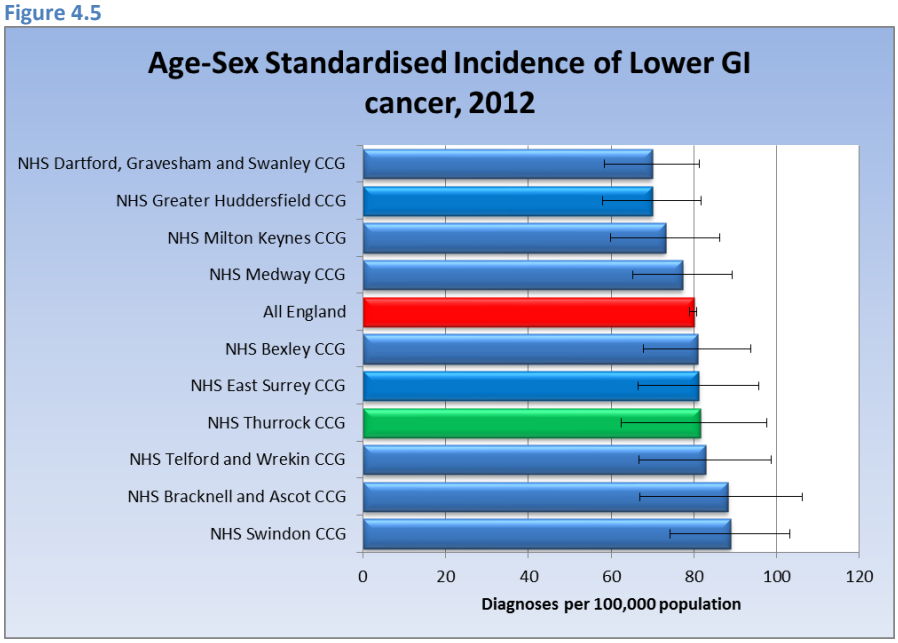


Figure 4.5

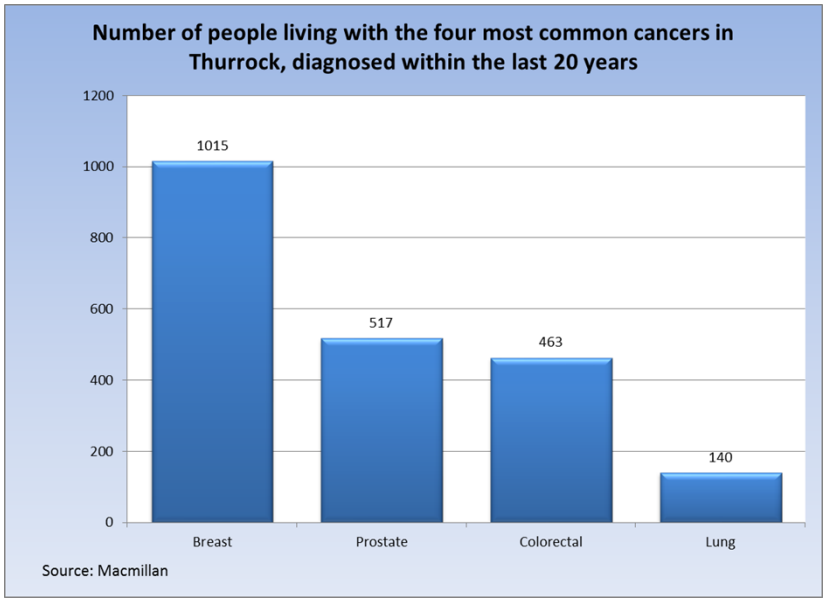


Thurrock has the lowest incidence of breast cancer compared to its ONS comparator populations, and a rate that is statistically significantly lower than England's and Medway's. It also has the lowest incidence of urological cancer, although this rate is not statistically significantly different to any of its comparator ONS populations or England's. Conversely, Thurrock's incidence of lung cancer is the highest in its ONS comparator group, although not statistically significantly different to any other population. Thurrock's incidence of lower GI cancer is also not statistically significantly different to any of its ONS comparator populations nor to England's.

4.2 Cancer Prevalence

Figure 4.6 shows the number of people in Thurrock that have been diagnosed with the four most common cancers in the last 20 years and are still alive. It can be used to asses cancer care needs of our population.

Figure 4.6



The most prevalent cancer is breast cancer, followed by prostate, colorectal and then lung. Prevalence will be a product of both cancer incidence (number of new cases per year) and survival.

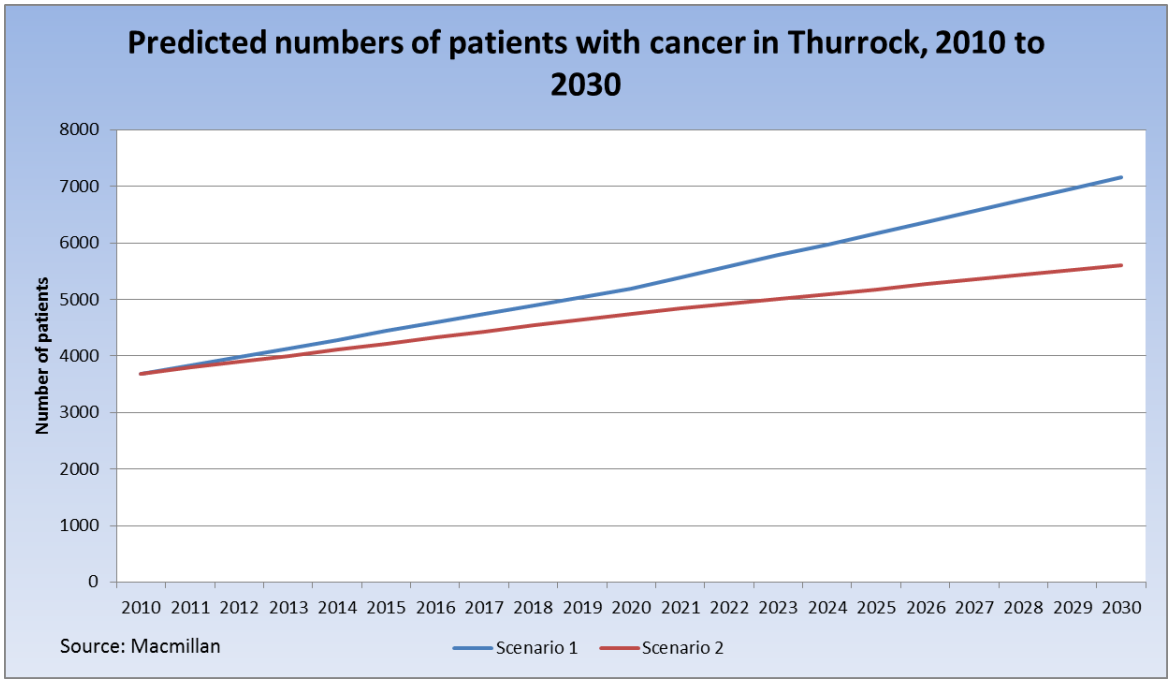
4.2.1 Future Predicted Prevalence

Cancer prevalence is predicted to increase into the future. This is a function of the growing and ageing population alongside the increasing number of people being diagnosed with and surviving cancer, together with changes in lifestyles (e.g. an increase in obesity but decrease in smoking) and a stronger focus on early diagnosis and treatment.

Figure 4.7 models two possible scenarios for future predicted numbers of patients with cancer in Thurrock from 2010 to 2030.

- Scenario 1: assumes people will continue to get and survive cancer at increasing rates in line with recent trends (except for prostate cancer), and the general population will continue to grow and age.
- Scenario 2: assumes people will continue to get cancer at the rate they do today, and that survival rates will remain as they are. The estimates are therefore driven by a growing and ageing population only.

Figure 4.7



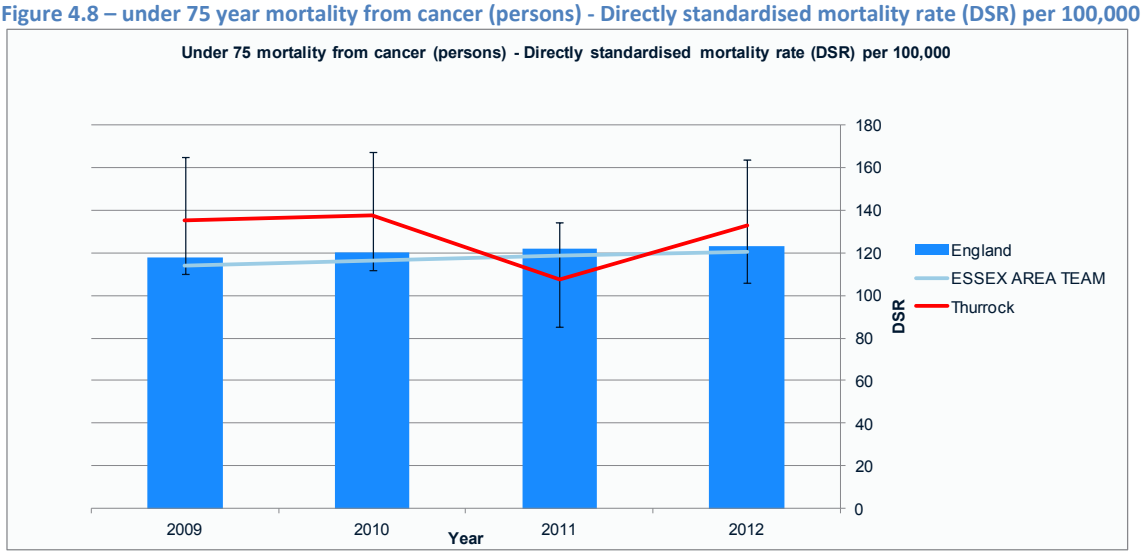
In scenario 1, numbers of patients living with cancer in Thurrock in time period from 2010 to 2030 is predicted to double, and in scenario 2, numbers of predicted to increase by 22%. Both scenarios have significant implications in terms of demands on local health and care systems.

4.3 Cancer mortality

4.3.1 All cancers

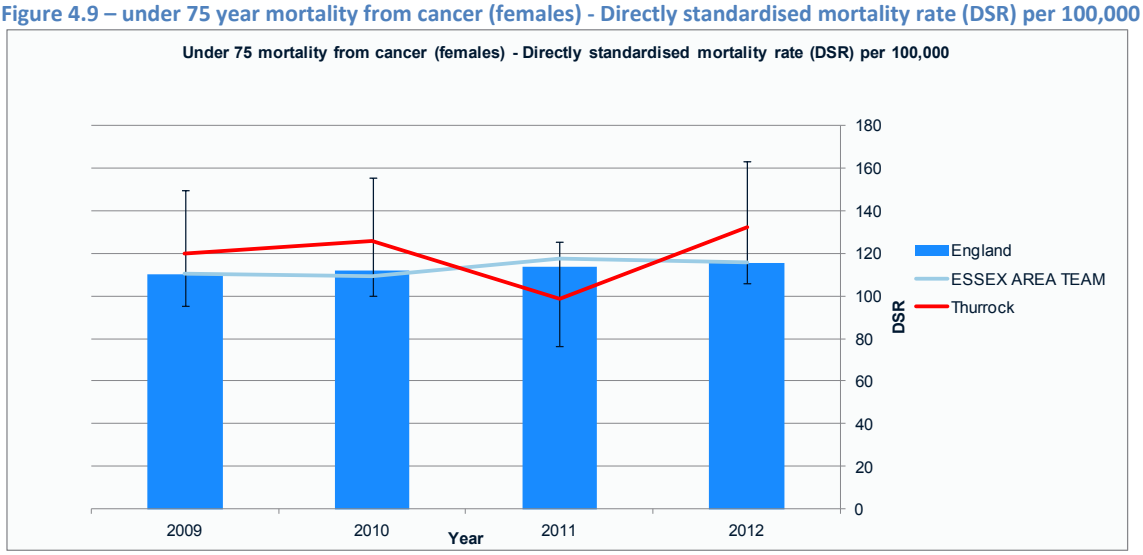
Figures 4.9-4.10 show the directly standardised mortality rates for under-75 year olds from cancer. These data highlight that deaths for women in Thurrock is slightly above the England and Essex rate. However the 95% confidence intervals for Thurrock indicate that this is likely to be due to random fluctuations over time and is not considered to be statistically significant

Figure 4.8 – under 75 year mortality from cancer (persons) - Directly standardised mortality rate (DSR) per 100,000



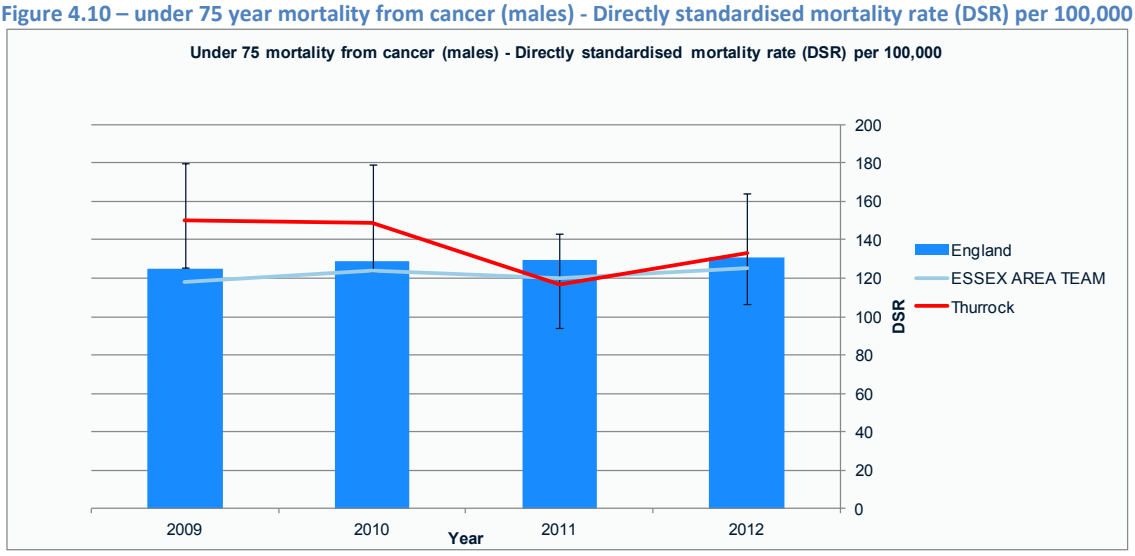
Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.9 – under 75 year mortality from cancer (females) - Directly standardised mortality rate (DSR) per 100,000



Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.10 – under 75 year mortality from cancer (males) - Directly standardised mortality rate (DSR) per 100,000

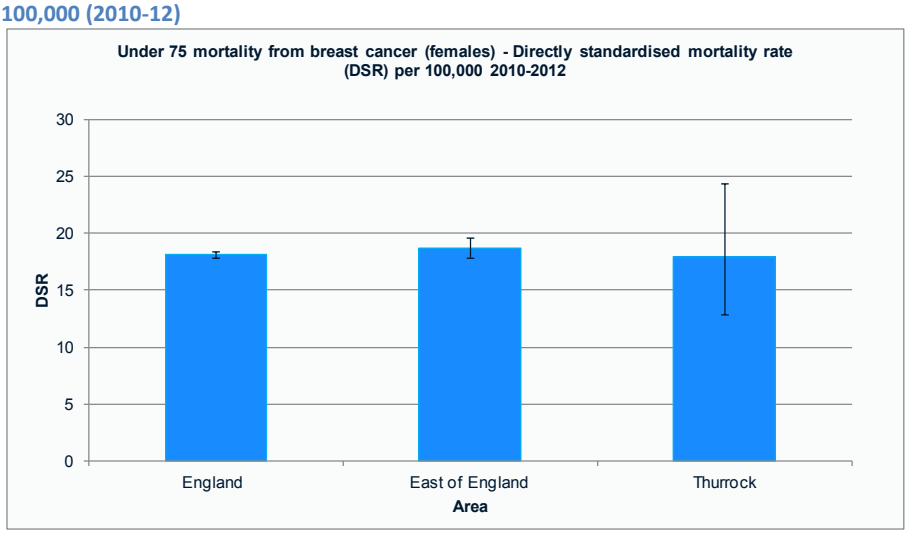


Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

4.3.2 Mortality from different types of cancer

Figure 4.11-14 shows under 75 mortality from different types of cancer and compares to England and East of England rates. There is no significant difference to England and east of England rates. DSRs for cervical cancer are considerably lower when compared to breast and prostate cancer rates for those aged under 75 years.

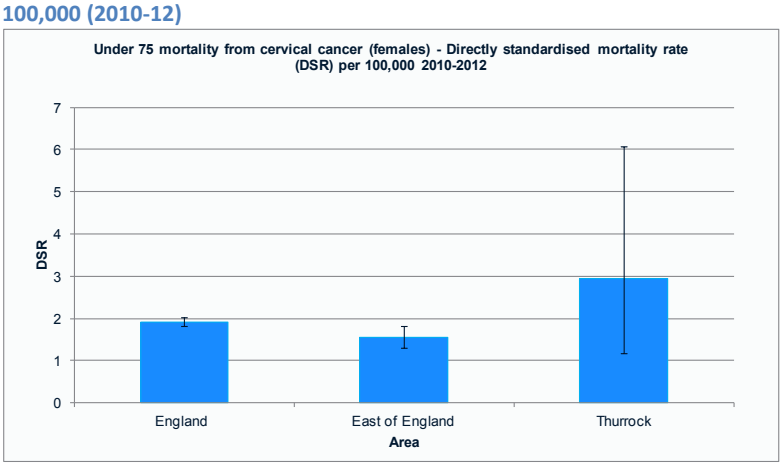
Figure 4.11 – under 75 year mortality from breast cancer (females) - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

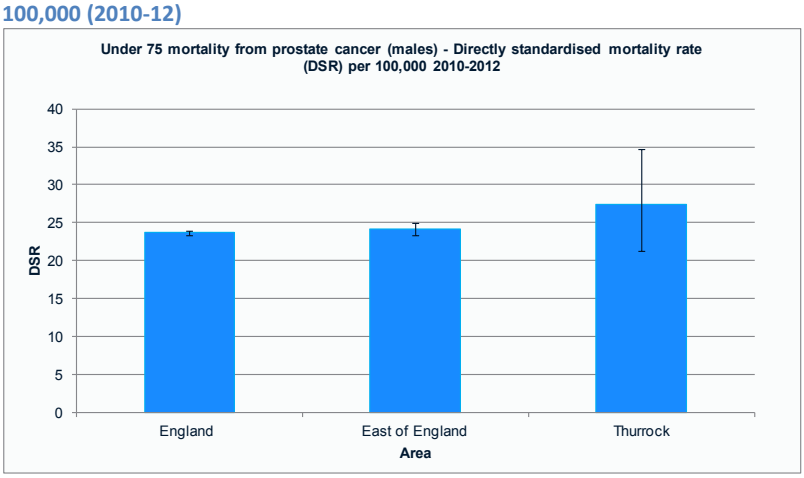
Figure 4.12 shows a higher mortality rate from cervical cancer in Thurrock when compared to England and East of England. However these data have wide confidence intervals (due to small numbers) so are not statistically significant. Similar findings for prostate (figure 6).

Figure 4.12 – under 75 year mortality from cervical cancer (females) - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



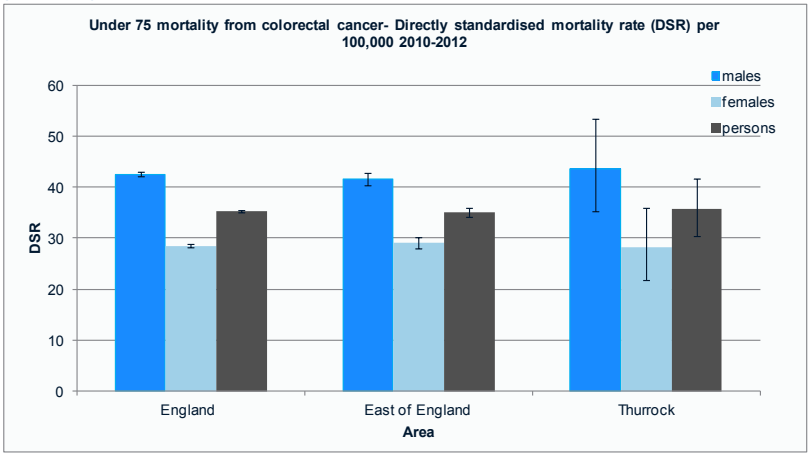
Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.13 – under 75 year mortality from prostate cancer (males) - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



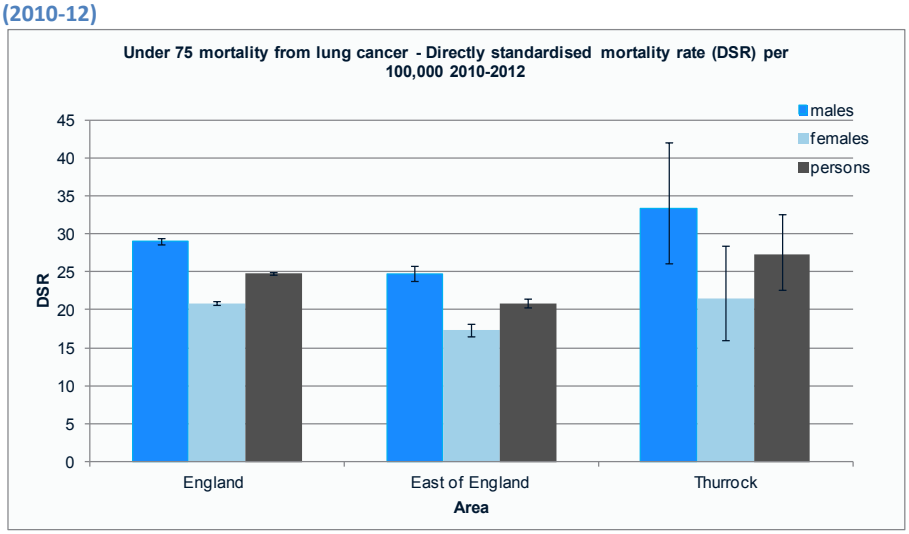
Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.14 – under 75 year mortality from colorectal cancer - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.15 – under 75 year mortality from lung cancer (females) - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

4.4 Summary of Cancer Epidemiology

The most common new diagnoses for cancer in Thurrock are breast, urological, lung and lower GI and that order.

Thurrock has the highest rate of lung cancer new diagnoses in its ONS comparator population groups but the lowest rate of breast cancer. However there is little or no statistically significant difference between cancer incidences in different ONS comparator populations.

The most prevalent cancers in the Thurrock population (over a 20 year period) are breast, prostate, colorectal and lung, in that order. There are 2135 people in Thurrock, diagnosed with cancer in the last 20 years who are still alive.

The number of people living with cancer in Thurrock over the next 20 years is predicted to rise significantly. This is due to a combination of factors including an ageing population, earlier diagnosis and better treatment.

Mortality from cancer within the general population of Thurrock over the past five years is not statistically significantly different to England's or Essex.

5. Cancer Prevention: Smoking

5.1 Introduction

Research suggests that at least one-third of all cancer cases are preventable. Prevention offers the most cost-effective long-term strategy for the control of cancer. There are five major modifiable factors that impact on cancer incidence:

- Tobacco consumption
- Diet, physical activity and obesity
- Alcohol consumption
- Infections
- Environmental factors such as air pollution

However, tobacco use is the single greatest avoidable risk factor for cancer mortality worldwide, causing an estimated 22% of cancer deaths per year. In 2004, 1.6 million of the 7.4 million cancer deaths were due to tobacco use.

Tobacco smoking causes many types of cancer, including cancers of the lung, oesophagus, larynx (voice box), mouth, throat, kidney, bladder, pancreas, stomach and cervix. About 70% of the lung cancer burden can be attributed to smoking alone. Second-hand smoke (SHS), also known as environmental tobacco smoke, has been proven to cause lung cancer in non-smoking adults. Smokeless tobacco (also called oral tobacco, chewing tobacco or snuff) causes oral, oesophageal and pancreatic cancer.

Ensuring that Thurrock CCG's commissioned provider patient facing staff and member GP practices support the reduction in smoking prevalence by proactively referring smokers to NHS quit services, is the single most important contribution the CCG could make to the cancer prevention agenda. As such, this section concentrates on the issue of smoking and smoking cessation in Thurrock.

5.2 Smoking Prevalence

Smoking prevalence is the proportion of smokers within our population within a given year. The actual estimated prevalence of smoking amongst Thurrock residents depending on the definition of what constitutes a smoker (i.e. how regularly an individual smokes a cigarette), the age of the population studied and the method of sampling.

Figure 5.1 shows the estimated prevalence of smoking in adults aged 18+ sampled through the Integrated Household Survey in 2014 for Thurrock and its CIPFA comparator populations. (These are local authority populations that have similar demographics to that of Thurrock's). Figure 5.2 shows the prevalence of smoking in 15 year olds in 2014/15 sampled through the WAY survey, for Thurrock and its CIPFA comparator local authority populations.

Figure 5.1

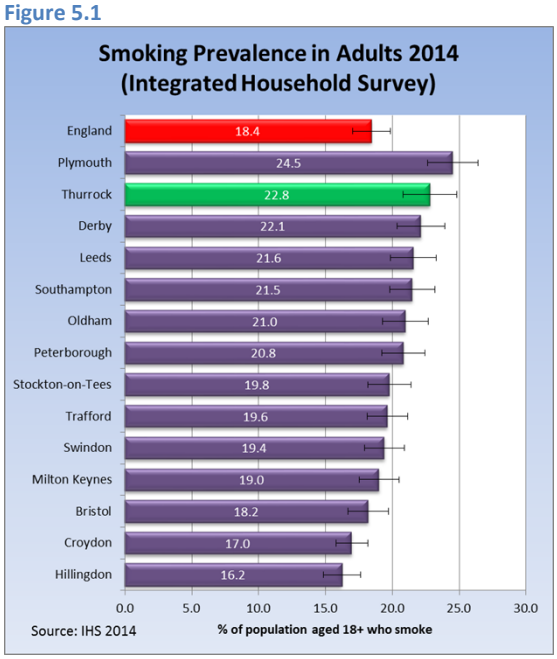
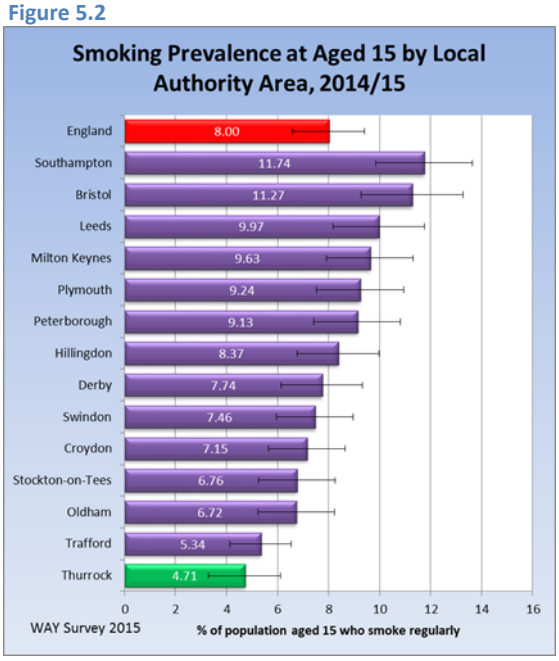


Figure 5.2



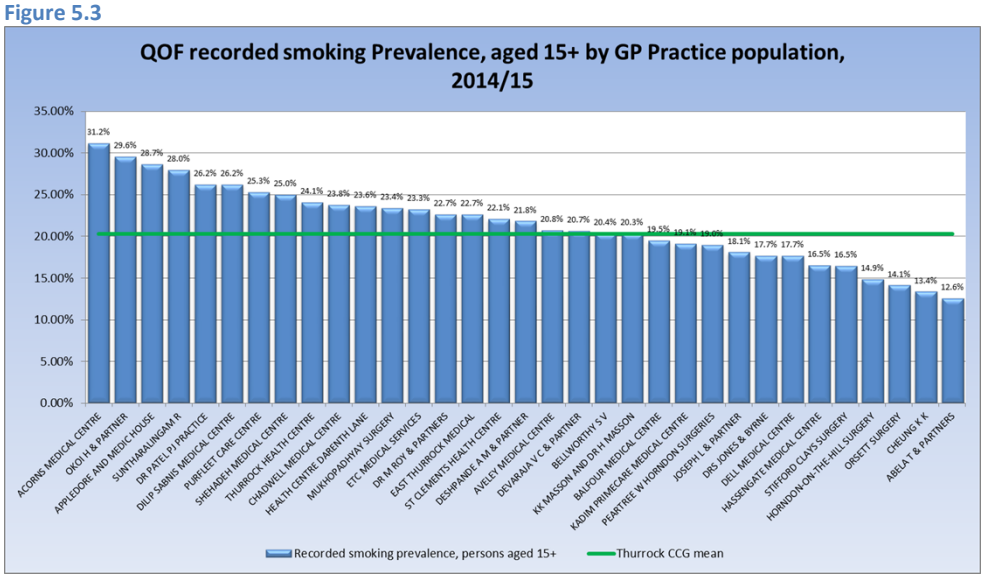
Thurrock's prevalence of smoking in adults aged 18+ is estimated to be 22.8% This is the second highest prevalence in compared to its CIPFA comparators, and statistically significantly greater than England's and seven of the 13 CIPFA comparators.

Conversely Thurrock's smoking prevalence amongst 15 year olds is estimated at 4.71%. This is the lowest compared to its CIPFA comparator populations and statistically significantly lower than England's and eight of its CIPFA comparators.

The incongruence between these two prevalence figures may suggest that Thurrock's population start smoking later than its comparators, or that once addicted, a smaller proportion are able to successfully quit.

Figure 5.3 shows the prevalence of smoking amongst CCG member practice populations and for Thurrock as a whole for those patients aged 15+.

Figure 5.3



The overall prevalence of smoking as reported through QOF (21.1%) is lower than that reported through the IHS. This may be due to differences in the age range of the population studied, and the fact that patients may be reluctant to admit to their GP or practice nurse that they are a smoker. There is considerable variation in prevalence between GP practice populations.

Figure 5.4 shows the QOF recorded prevalence in patients aged 15+ by quintile of practice population IMD deprivation score in 2014/15. Figure 5.5 shows the association between practice deprivation score and recorded smoking prevalence in patients aged 15+

Figure 5.4

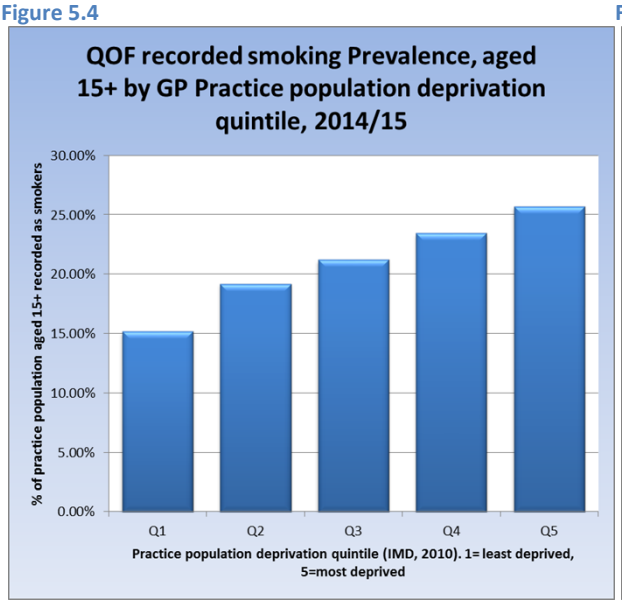
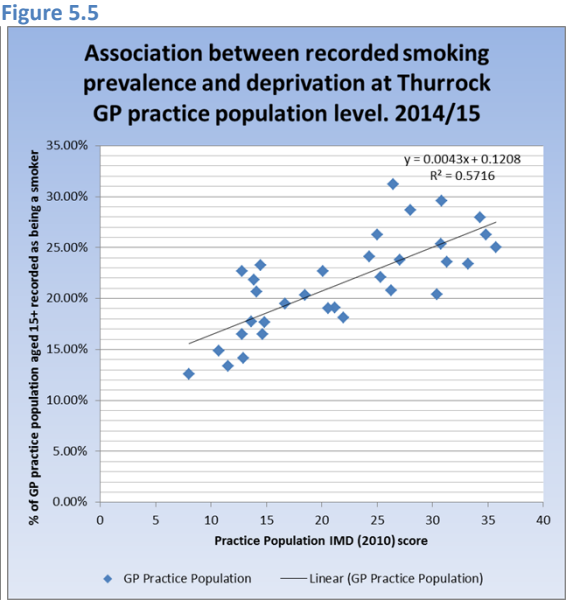


Figure 5.5

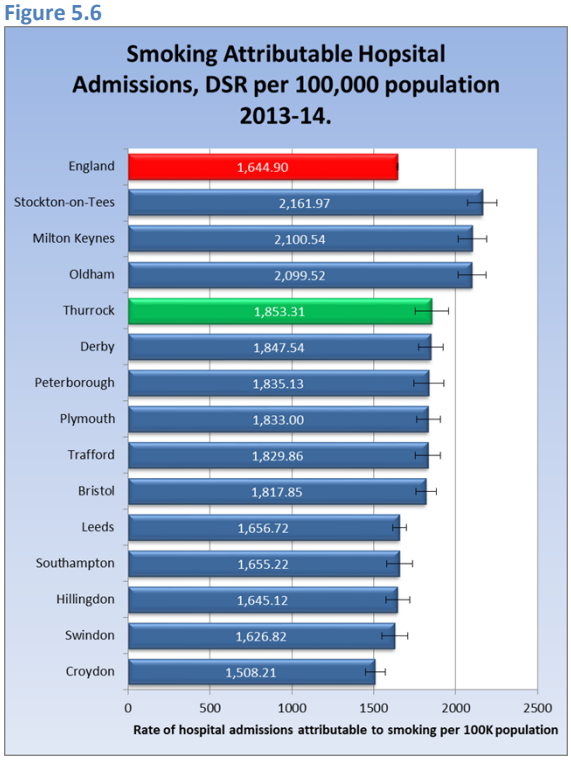


Figures 5.4 and 5.5 show a strong positive association between deprivation and smoking prevalence in Thurrock. This is in line with national published research suggesting that differences in smoking prevalence between affluent and deprived communities is a major driver of health inequalities.

5.3 Smoking Attributable Hospital Admissions

Figure 5.6 shows the directly standardised rate of smoking attributable hospital admissions per 100,000 population for England, Thurrock and Thurrock's ONS Comparators. Smoking attributable hospital admissions is an epidemiological concept that calculates the total number of excess admissions to hospital caused by the prevalence of smoking in a population.

Figure 5.6

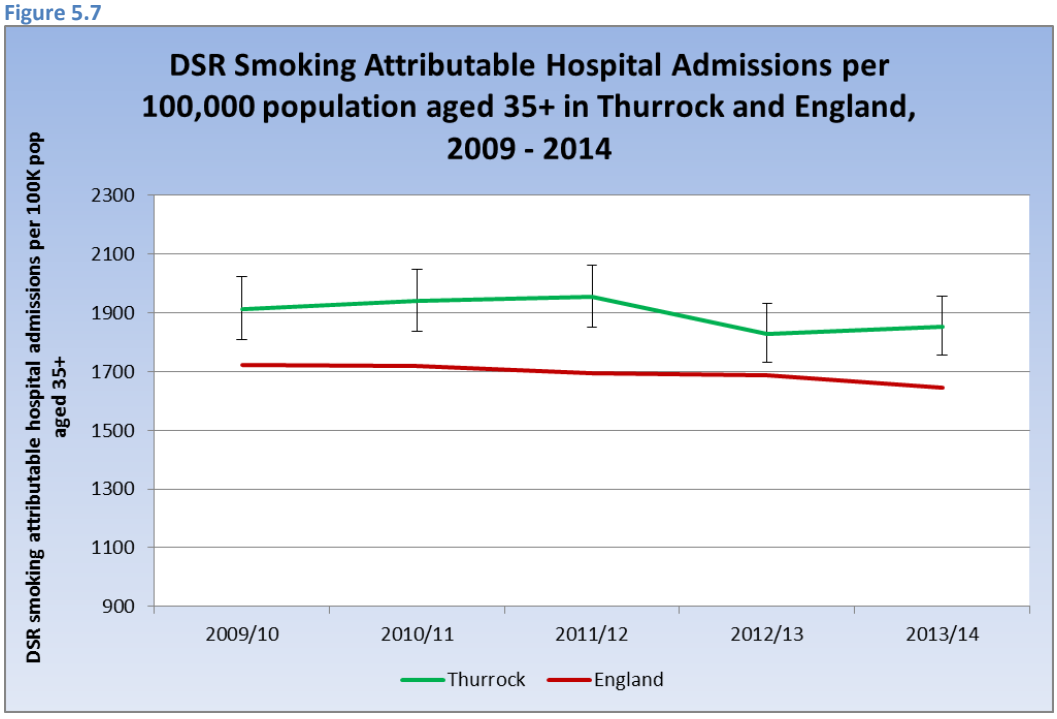


Thurrock has a directly standardised rate of smoking attributable hospital admissions that is significantly greater than England's and five of its comparator CCGs. This is likely to be a product of high overall smoking prevalence within the Thurrock population.

In Thurrock, in 2014/15 there were 1356 excess admissions as a result of smoking prevalence. At an average cost of £2800 per admission, this equates to almost £3.8M of excess spend in hospital admissions, charged to NHS Thurrock CCG that can be directly attributable to smoking.

Figure 5.7 shows the directly standards rate of hospital admissions per 100,000 population aged 35+ in Thurrock and England over time.

Figure 5.7

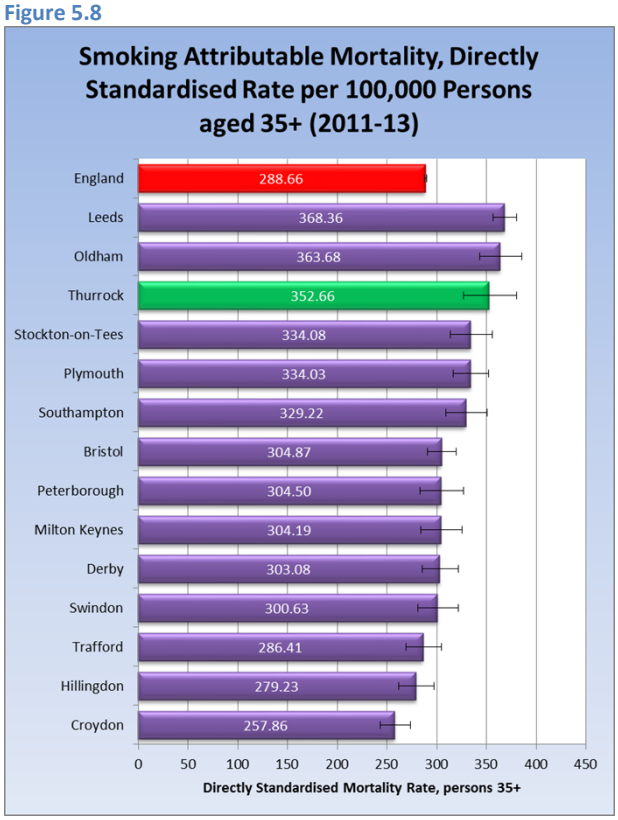


Thurrock has had a rate of smoking attributable hospital admissions that is significantly greater than England's for every year since 2009. There has been no significant decrease in the rate of smoking attributable hospital admissions in the population of Thurrock since 2009. This suggests a failure of the local health system to address successfully the issue of smoking in our local population over the last five years.

5.4 Smoking Attributable Mortality

Figure 5.8 shows the directly standardised rate of smoking attributable mortality per 100,000 populations for England, Thurrock and Thurrock's ONS comparator populations between 2011 and 2013 for those aged 35+. Smoking attributable mortality is an epidemiological concept that calculates the excess number of deaths within a population that can be attributable to smoking.

Figure 5.8



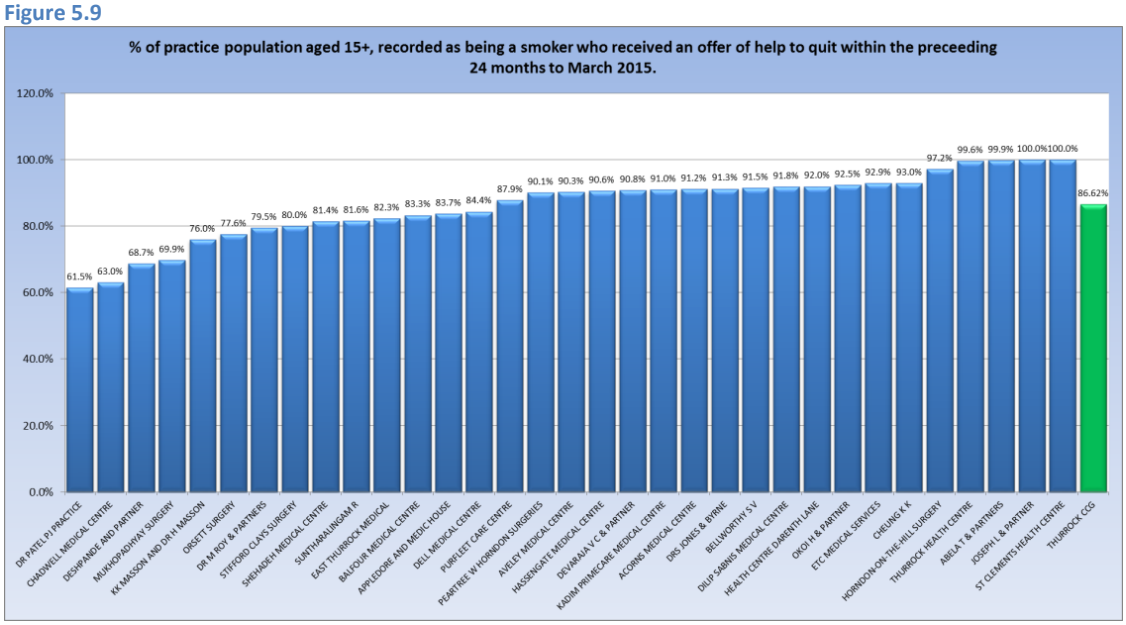
Thurrock has the third highest standardised rate of smoking attributable mortality compared to its ONS comparator populations, and a rate that is significantly greater than England's and eight of its ONS comparators. Between 2011 and 2013 there were 706 excess deaths in the Thurrock population that can be attributable to smoking prevalence within our population.

5.5 Smoking Cessation

The Quality Outcomes Framework (QOF) has targeted GP practices to offer support to patients recorded as smokers, to encourage them to quit for the last decade. Similarly Public Health has commissioned GP practices, pharmacists and NELFT to provide NHS stop smoking services to patients.

Figure 5.9 shows the percentage of recorded smokers at GP practice level who had a record of having received an offer of support to quit smoking in the preceding 24 months by their practice.

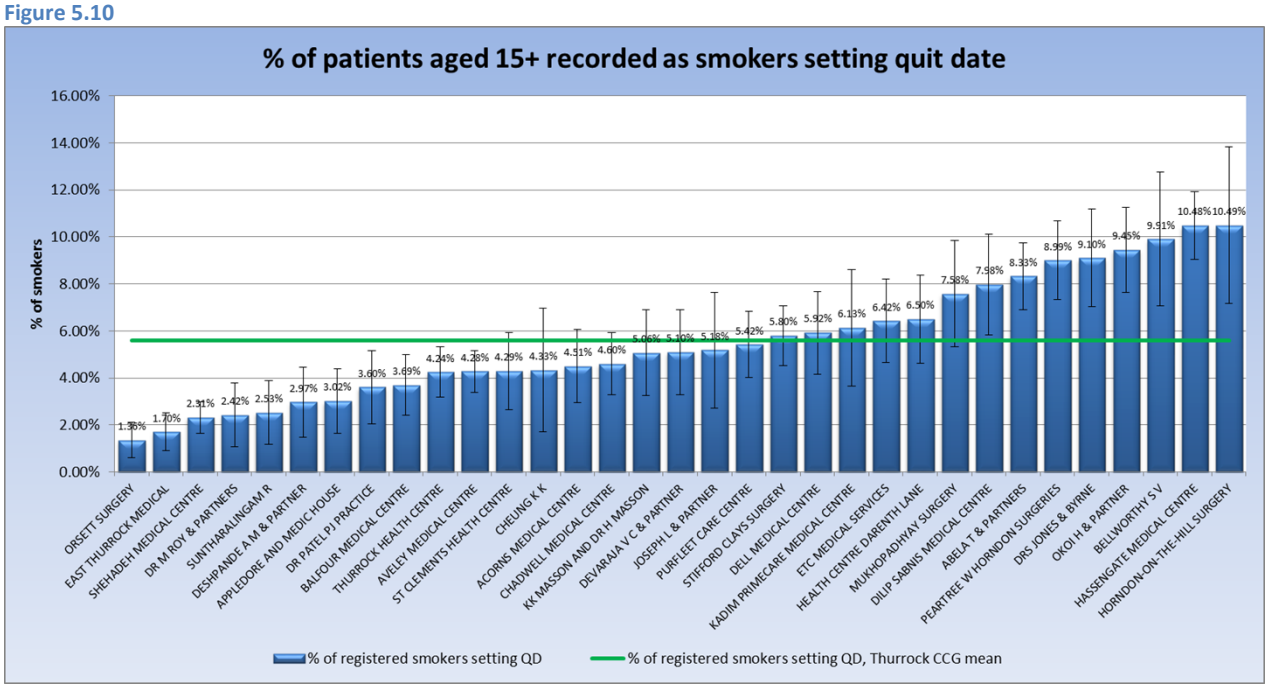
Figure 5.9



Overall, 86.2% of patients in Thurrock aged 15+ recorded as smokers received an offer of support to quit in the preceding 12 months to March 2015. However this varied considerably between different practices, from 61.2% to 100%

Figure 5.10 shows the percentage of patients aged 15+, recorded as smokers within each GP practice population who set a quit date using an NHS stop smoking service in 2014/15.

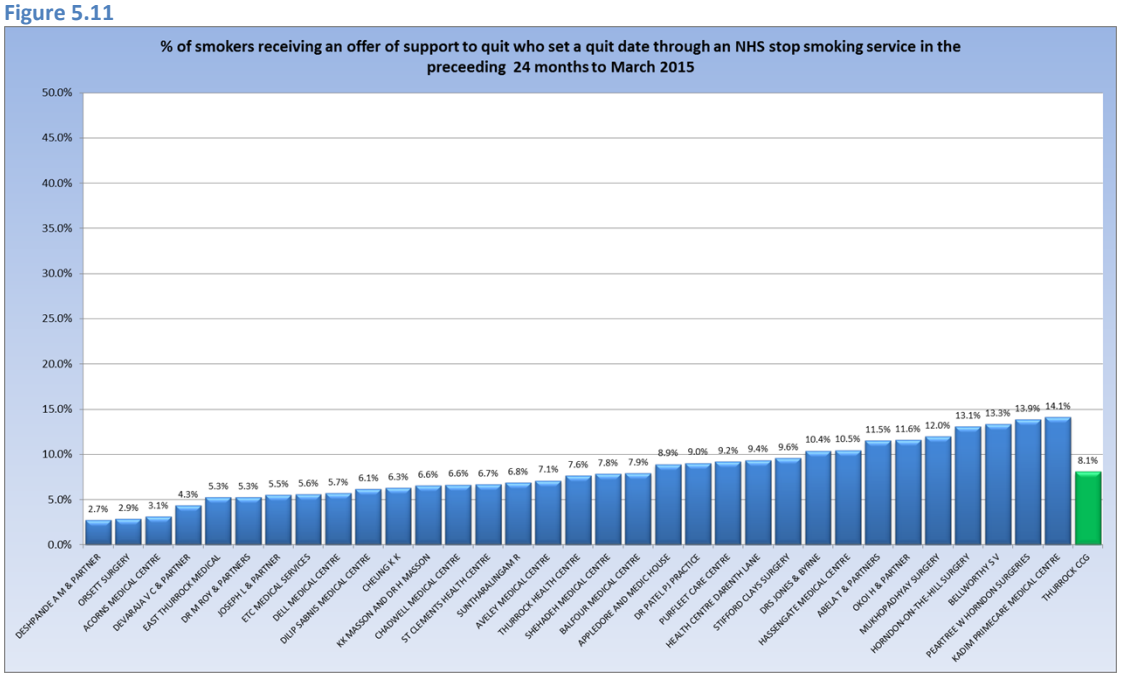
Figure 5.10



Research suggests that 75% of current smokers want to stop smoking. However only 5.8% of patients aged 15+ recorded as smokers set a quit date using an NHS stop smoking service in 2014/15. However there was considerable variation between GP practice populations and a more than seven fold difference between the practice population with the highest and lowest proportion of smokers setting a quit date through an NHS stop smoking provider.

Figure 5.11 shows the "conversion ratio" of smokers offered support to quit: smokers setting a quit date at GP practice population level.

Figure 5.11



Of smokers who were offered support to quit, 8.1% went on to make a quit attempt across all Thurrock GP practices. However there is again huge variation between different practice populations. Figure 5.12 examines the association between GP practice population deprivation score and the conversion ratio shown in figure 5.11

Figure 5.12

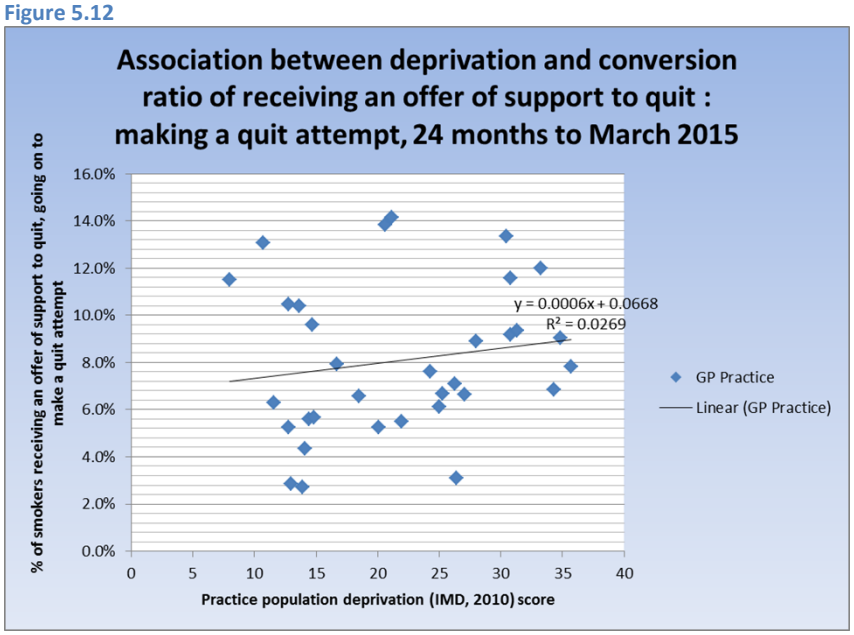


Figure 5.12 shows no significant association between practice population deprivation and conversion ratio from being offered support to quit to making a quit attempt. This may suggest a variation in the quality of the level 1 smoking cessation conversation between practice staff and patients at GP practice level and warrants further investigation.

Figure 5.13 shows the percentage of patients recorded as smokers who successfully quit smoking through an NHS stop smoking service in 2014/15. Figure Q shows the estimated percentage of patients aged 15+ recorded as smokers who will successfully quit permanently through an NHS stop smoking service.

Figure 5.13

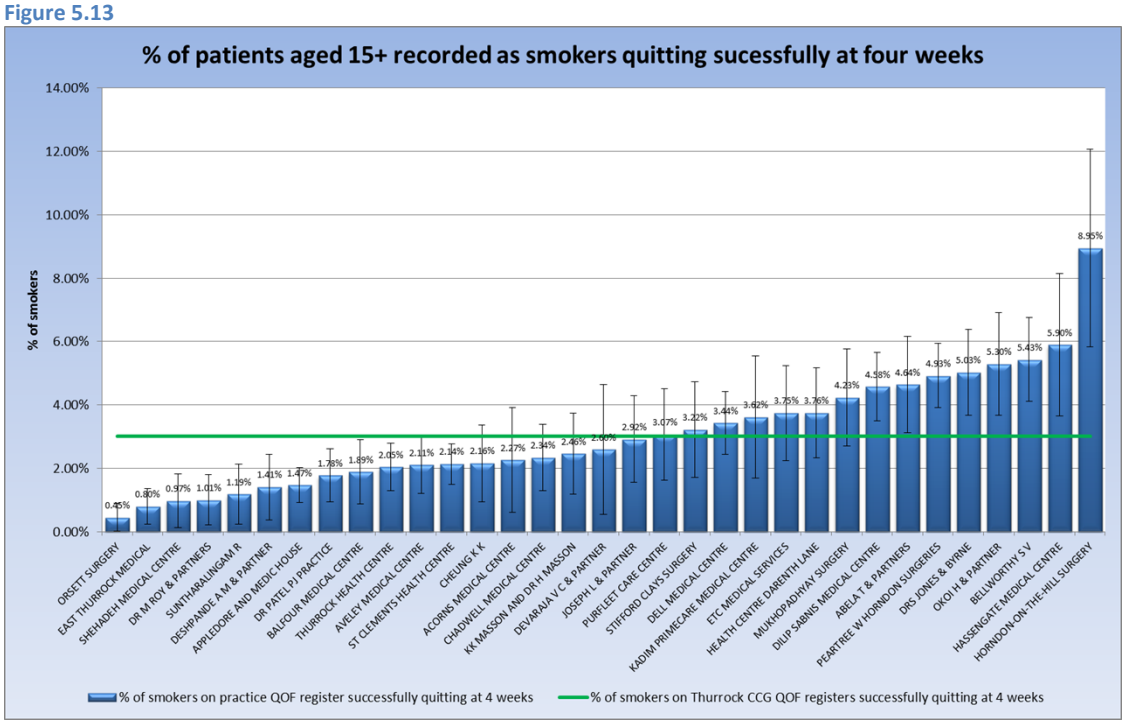
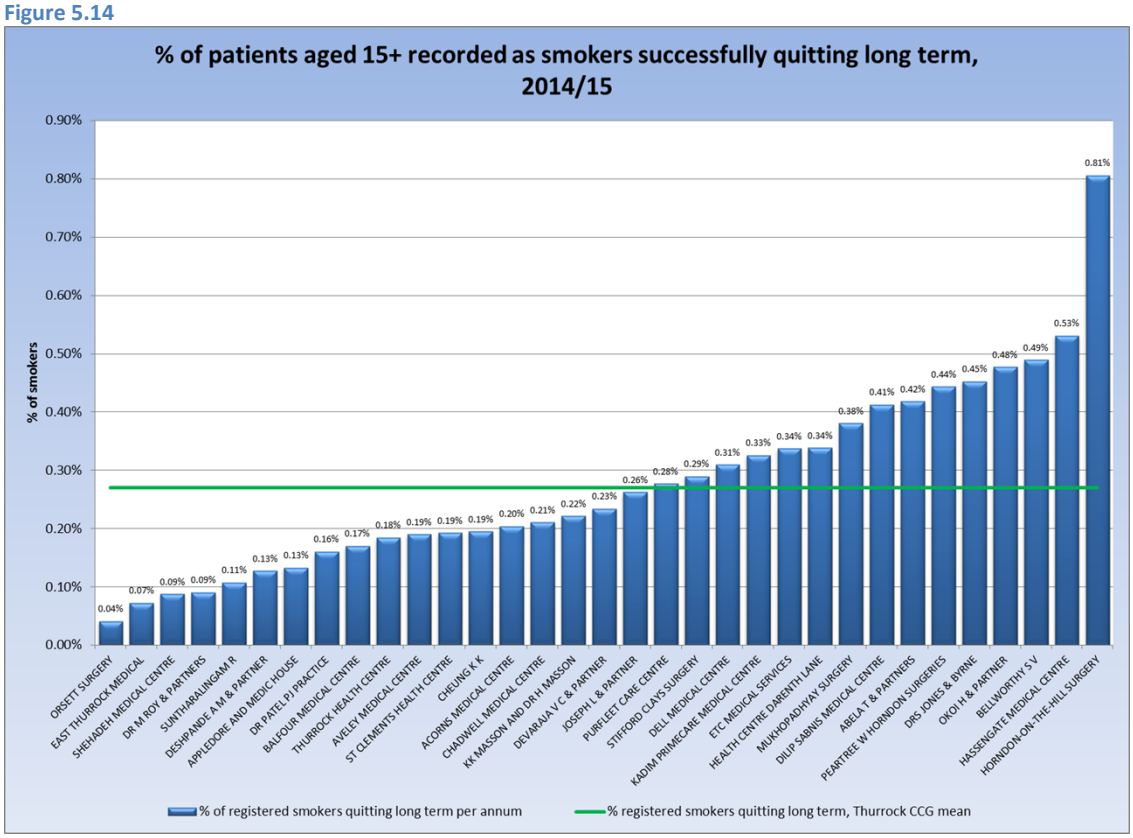


Figure 5.14



Both figures 5.13 and 5.14 show huge variation between different GP practice populations. In 2014/15, it is estimated that fewer the 0.3% of patients recorded as smokers will quit permanently as a result of

commissioned stop smoking services. This is a product of both a failure to refer sufficient smokers into NHS stop smoking services, and the impact of the services themselves on long term quit success. Modelling by the author suggests that only 74 smokers in Thurrock will successfully quit smoking permanently as a result of current commissioned stop smoking services. It can therefore be concluded that as a health and social care system, we are abjectly failing to have any significant impact on smoking prevalence in Thurrock as a result of the current commissioning arrangements. This warrants urgent further investigation and action.

5.6 Summary Prevention: Smoking

It is estimated that between 21.1% to 22.8% of adults in Thurrock smoke, depending on the age range studied and the method of sampling.

Thurrock has a smoking prevalence significantly greater than England's and many of its comparator populations

Smoking is strongly positively associated with deprivation in Thurrock, and is therefore a key driver of health inequalities.

Thurrock has rates of hospital admissions and mortality attributable to smoking that are significantly greater than England's and many of its comparator populations. There were an estimated 1356 additional hospital admissions amongst our population in 2014/15 as a result of the levels of smoking prevalence in our population, resulting in an additional £3.8M of cost to NHS Thurrock CCG and an additional deaths that can be attributable to smoking prevalence.

There has been no significant reduction in rates of smoking attributable hospital admissions over the past five years.

Despite 86.6% of smokers having a record of an offer of help to quit smoking by their GP practice, fewer than 6% made a quit attempt through an NHS stop smoking service in the preceding 24 months to March 2015. There is significant variation between different GP practice populations and this cannot be explained by differences in deprivation levels between practice populations.

The Health and Social Care system in Thurrock is failing to have any significant impact on smoking prevalence in our local population through smoking cessation work. It is estimated that fewer than 0.3% of smokers successfully quit long term in 2014/15 as a result of a commissioned stop smoking service. This is a product of both a failure to refer smokers into stop smoking services and the success of services to help people to successfully quit long term.

5.7. Recommendations: Prevention – Smoking

1. Public Health should undertake a comprehensive review of current commissioning arrangements on tobacco control with a view to significantly improving the impact that future providers are having on smoking prevalence in Thurrock and achieving a minimum 1% prevalence reduction per annum. This should be monitored as part of the outcomes framework in the Joint Health and Wellbeing Strategy refresh.

2. Thurrock CCG should amend current commissioning arrangements with NELFT, SEPT and BTUH, and Thurrock Council with its front line providers to include an obligation them routinely to identify and refer patients who smoke into Public Health commissioned stop smoking services. Minimum agreed numbers of referrals should be incorporated into all contracts and routinely performance managed.

3. Thurrock Council should train its front line staff in 'Making Every Contact Count' and include identification and referral of smokers into commissioned stop smoking services.

4. Public Health should commission its stop smoking provider to provide further support and training to front line practice staff to improve the conversion ratio of patients offered support to quit who go on to make a quit attempt through a commissioned stop smoking service.

6. Cancer screening

6.1 Introduction

Early identification of many types of cancer results in better treatment outcomes for patients. Cancer screening programmes aim to identify people likely to have cancer such that they can be referred for further diagnostic tests and if necessary for treatment. A positive screen in a cancer screening programme is not equivalent to a cancer diagnosis, but suggests that further investigation is necessary to ascertain whether or not the patient has cancer.

National cancer screening programmes are delivered by the NHS. They are coordinated by the national office of the NHS Cancer Screening Programmes, part of Public Health England. Commissioning and monitoring of local programmes is the responsibility of a local team of Public Health England based within the NHS England East office.

There are three cancer screening programmes:

- the NHS Cervical Screening Programme
- the NHS Breast Screening Programme
- the NHS Bowel Cancer Screening Programme.

Table 1 overleaf provides a breakdown of available datasets for cancer screening.

Table 1 – summary of National Cancer Screening Programme data available from NHS England

PROGRAMME	Name of indicator(s)	Definition	Standard	Target	How often	Data source	Level(s) of data available
Bowel cancer screening	Uptake	Proportion of eligible people adequately screened out of those invited for FOBt screening	≥60%		Quarterly & annually	Bowel screening hub	CCGs/ former PCT area / by provider
	Positivity rate	Proportion of people with a definitive FOBt outcome of 'abnormal' out of those who were adequately screened	2%		Quarterly & annually	Bowel screening hub	CCGs/ former PCT area / by provider
Breast cancer Screening	Coverage	Proportion of eligible women who have had a screening mammogram at least once in the previous three years	≥ 70%	≥ 80%	Annually	KC63	Former PCT area / by provider
	Round length	Proportion of eligible women whose first offered appointment is within the last 36 months of their previous screen	>90% within 36 months		Quarterly & annually	QA report / opensite	by provider
	Screen to normal	Proportion of women reported in period who received their results within 2 weeks	>90% within 2 weeks		Quarterly & annually	QA report / opensite	by provider
	Screen to assessment	Proportion of women actually assessed in reporting period within 3 weeks	>90% within 3 weeks		Quarterly & annually	QA report / opensite	by provider
Cervical cancer screening	Coverage	Percentage of women eligible women adequately screened in the last five years	≥ 70%	≥ 80%	Quarterly & annually	KC53	CCGs/ former PCT area / by provider
	14 day turnaround times (TAT)	Number of days from the date the sample was received by the laboratory to the date the report was issued by the laboratory	≥ 98% within 14 days		Quarterly & annually	QA report / opensite	Former PCT area / provider

6.2 Cervical screening

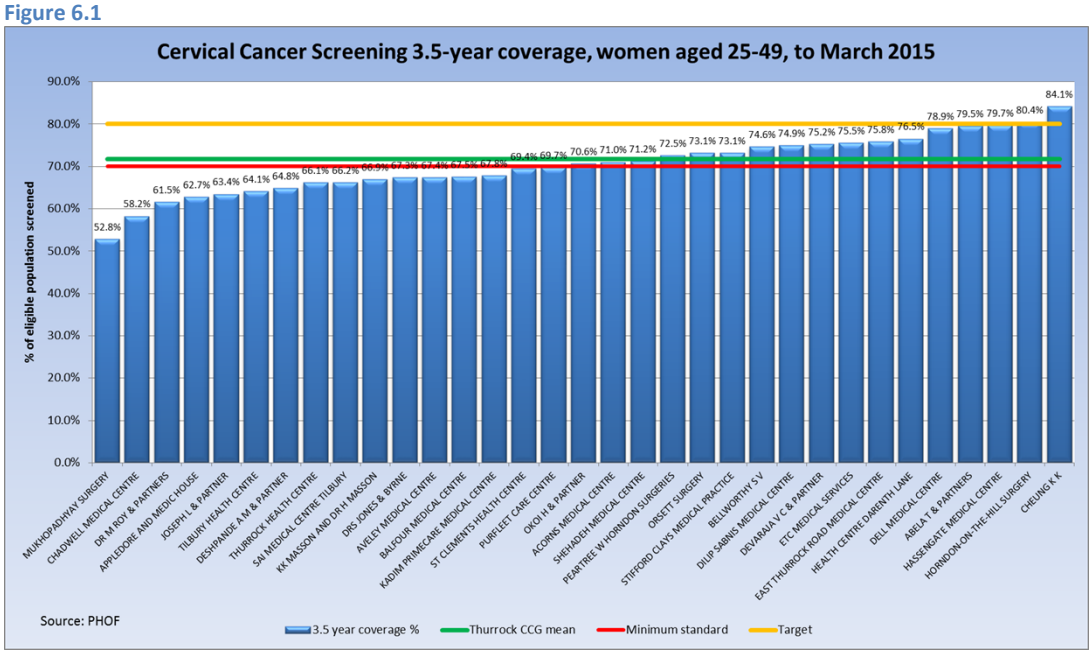
Cervical screening is provided by GP practices. The call-recall system for inviting eligible women for cervical cancer screening is coordinated Primary Care Support Services (PCSE) provided by Capita as Primary Care Support England. PCSE identifies the cohort of women eligible for screening and invites them to make an appointment to attend their GP practice. The cervical screening itself is provided within the patient's GP practice. The programme offers cervical cancer screening to women aged 25-49 every three years and to women aged 50-64 every five years.

6.2.1 Cervical cancer screening coverage in Thurrock

Cervical screening coverage is the percentage of eligible women 25 to 64 years screened adequately within the previous 3.5 or 5.5 years (according to age) on 31st of March.

Figure 6.1 shows the 3.5 year cervical cancer screening coverage for women aged 25-49 by GP practice population in Thurrock as of 31 March 2015, together with the mean rate for Thurrock CCG, the minimum standard and the target coverage rates.

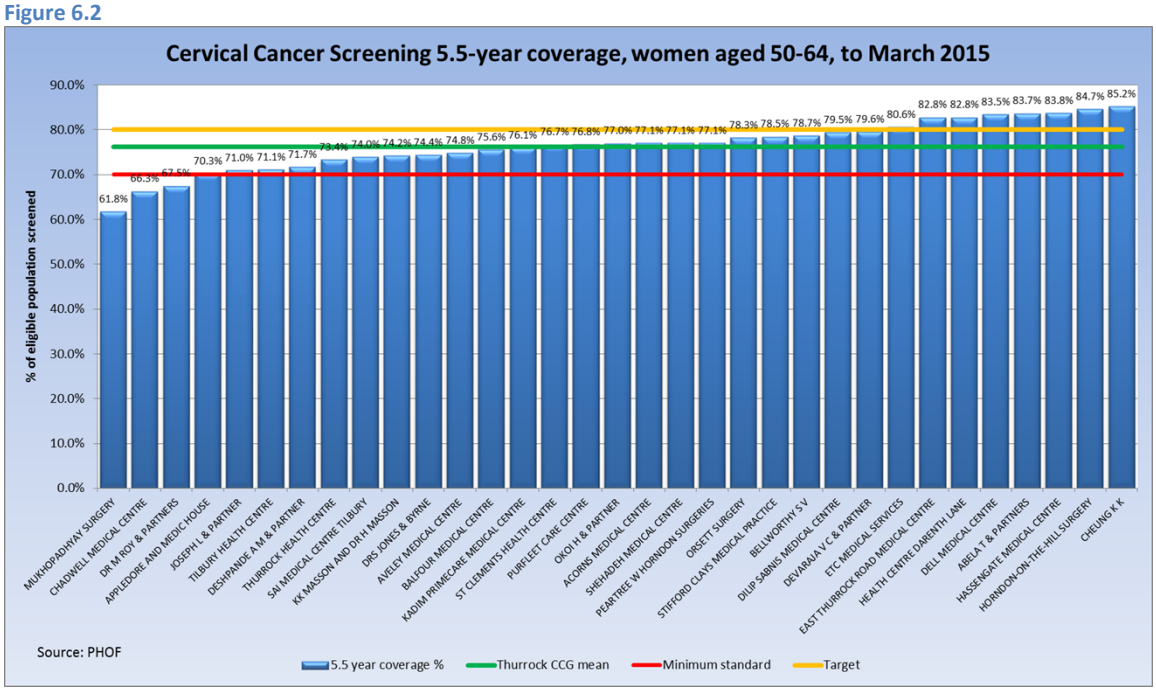
Figure 6.1



The mean screening coverage of patients in this cohort across Thurrock is 71.7% which is above the minimum standard but below the target 80% rate. However there is unacceptable variation in screening coverage between GP practice populations. Only 17 of our 32 GP practices (53.1%) achieve screening coverage at the minimum standard of 70% and only two (6.25%) achieve screening coverage at the target rate of 80%. Half of all practices fail to achieve cervical cancer screening coverage at the minimum 70% standard, potentially resulting in an increased risk of late diagnosis of cervical cancer in a significant proportion of the eligible screening cohort. This warrants further investigation.

Figure 6.2 shows the 5.5 year cervical cancer screening coverage for women aged 50-64 by GP practice population in Thurrock as of 31 March 2015, together with the mean rate for Thurrock CCG, the minimum standard and the target coverage rates.

Figure 6.2



Performance on screening coverage for women aged 50-64 is better than those aged 24-49. The mean screening coverage in this cohort across the CCG is 76.2% and variation between practice populations is lower than that in younger women. All but three practices (90.6%) achieve the minimum 70% coverage standard and a quarter of all practices achieve screening coverage above the 80% target.

6.2.2 Association between Cervical Cancer Screening Coverage and deprivation

Figures 6.3 and 6.4 show the association between Cervical Cancer Screening Coverage at GP practice population level and deprivation for women aged 25-49 and women aged 50-64 respectively together with confidence intervals (at 95% CI) around the 'line of best fit'.

Figure 6.3

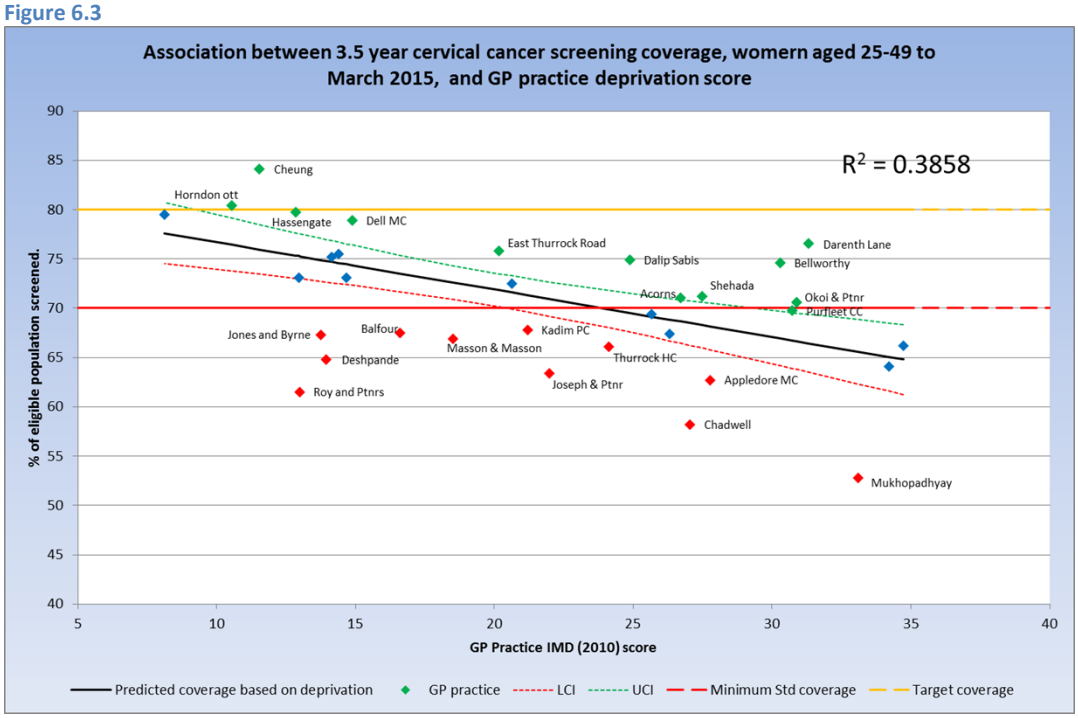
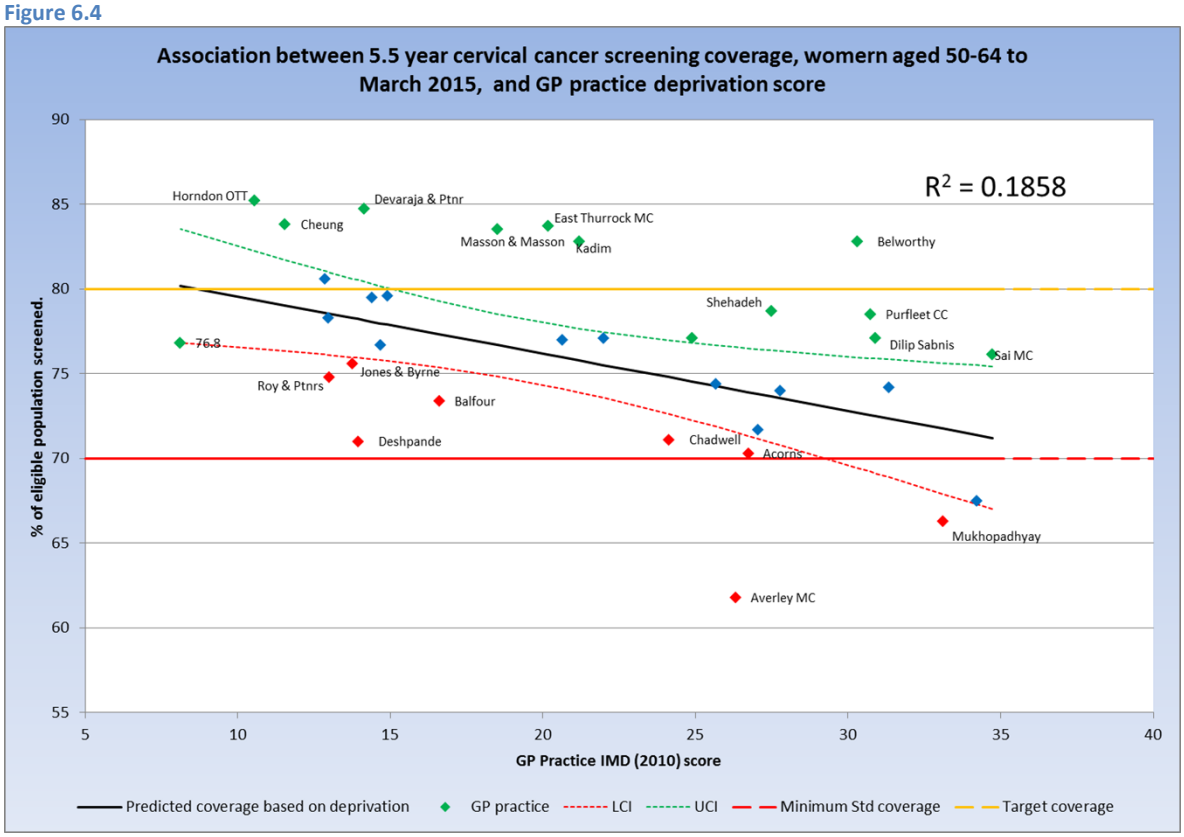


Figure 6.4



There is a reasonable association between practice population deprivation and cervical cancer screening coverage for the cohort of women aged 25-49 (figure 6.3) although this diminishes in women aged 50-64.

Practices marked with a green diamond (above the 95% CI of the line of best fit) have screening coverage that is statistically significantly greater than would be predicted for their level of population deprivation. Similarly practices marked with a red diamond (below the 95% CI of the line of best fit) have screening coverage that is significantly poorer than would be predicted for their level of population deprivation.

For the cohort of women aged 25-49, it is particularly worth noting that Dr. Belworthy and the Darenth Lane practice achieve screening coverage well above what would be expected for their levels of deprivation, despite serving very deprived populations. These 'positive deviants' are worth further investigation to ascertain whether they can share best clinical practice with other GP colleagues.

Similarly practice populations with red triangles, particularly those below the 70% minimum target line warrant further investigation. This is particularly urgent for Aveley Medical Centre and Mukhopadhyay.

6.3 Bowel Cancer Screening

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year.[1]

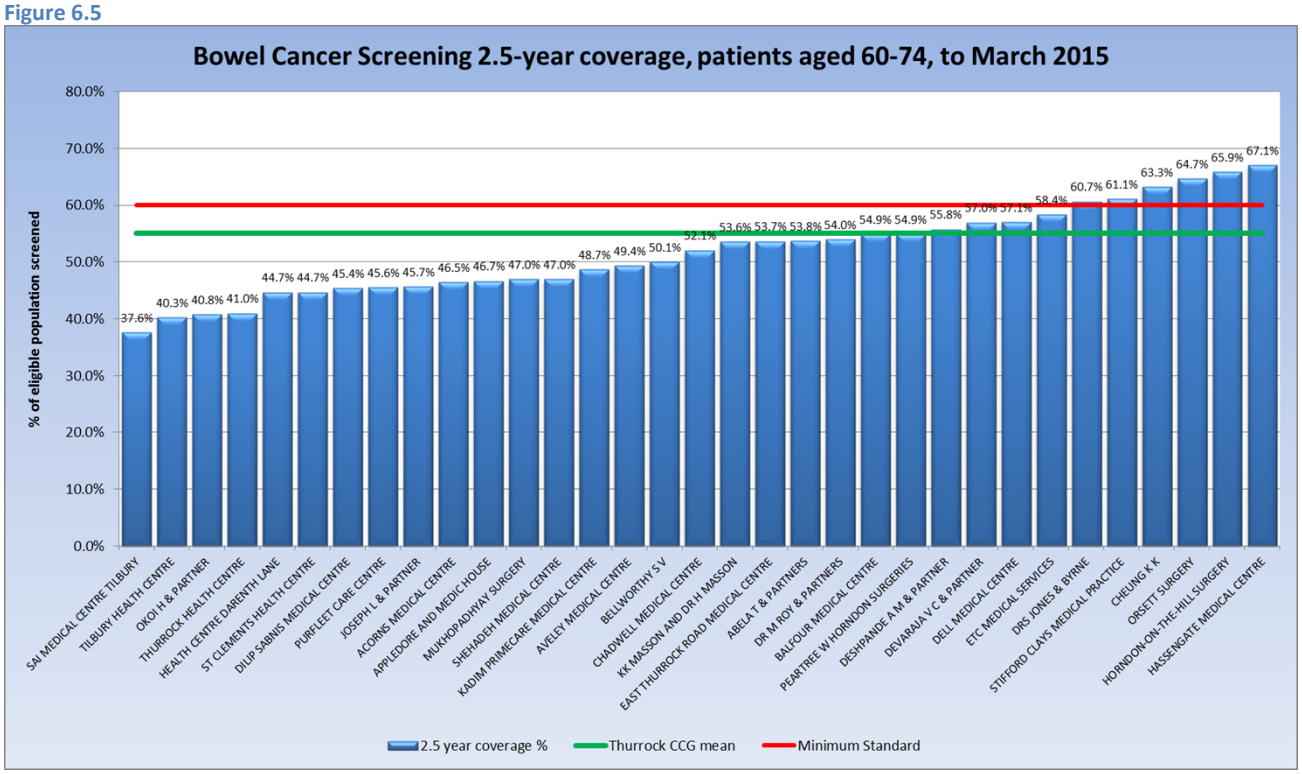
Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16 per cent[2] Men and women aged 60-74 are invited to participate in the bowel cancer screening programme every two years.

GP practices have very little to do with the Bowel Cancer Screening programme. Faecal occult blood testing (FOBt) kits are sent directly to patients from a centralised hub in Nottingham, who return them for screening. Those who screen positive are invited to attend the local Bowel Cancer Screening Programme Centre at Basildon Hospital for a colonoscopy.

6.3.1 Bowel Cancer Screening Coverage in Thurrock.

Figure 6.5 shows the 2.5 year bowel cancer screening coverage for patients aged 60-74 by GP practice population in Thurrock as of 31 March 2015, together with the mean rate for Thurrock CCG, the minimum standard and the target coverage rates.

Figure 6.5

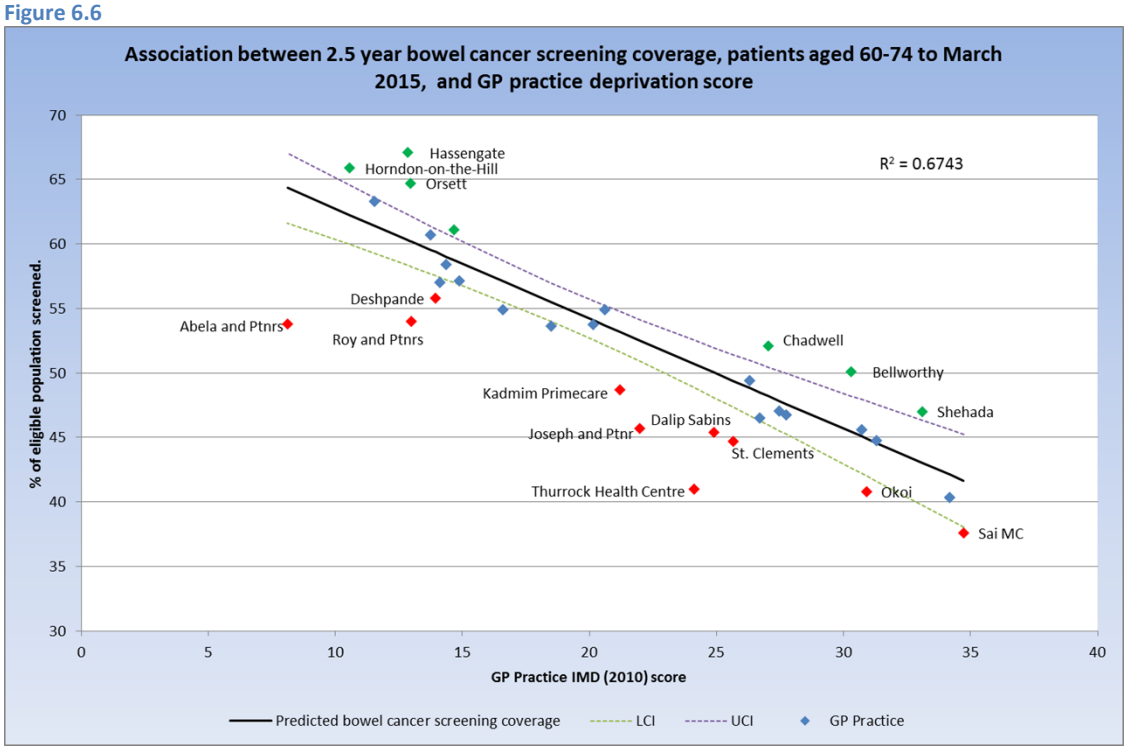


The mean coverage rate for bowel cancer screening in Thurrock in the eligible population is 55%. This is below the national minimum standard of 60%. 26 of the 32 (81.26%) practice populations have screening coverage below the 60% target. There is considerable variation in uptake of bowel cancer screening between GP practice populations, with the lowest coverage rate (Sai Medical Centre) being just over half the that in the population with the highest coverage rate (Hassengate Medical Centre). Given that GP practices have little involvement in this screening programme, the explanation for this is likely to a product of differences within the practice populations themselves.

Variation of this magnitude in uptake of the bowel cancer screening programme between different practice populations is concerning and warrants further investigation.

Figure 6.6 shows the association between bowel cancer screening coverage and GP practice population deprivation score.

Figure 6.6



There is a strong negative association between bowel cancer screening coverage and deprivation. This is concerning as it is likely to be a driver of health inequalities related to cancer. The black line (of best fit) predicts the level of screening coverage at a given deprivation level given the level of association between the two variables. Practices that lie above or below the two confidence intervals around this line can be said to have a screening uptake statistically significantly above (green diamonds) or below (red diamonds) what would be expected given the level of deprivation within their practice population.

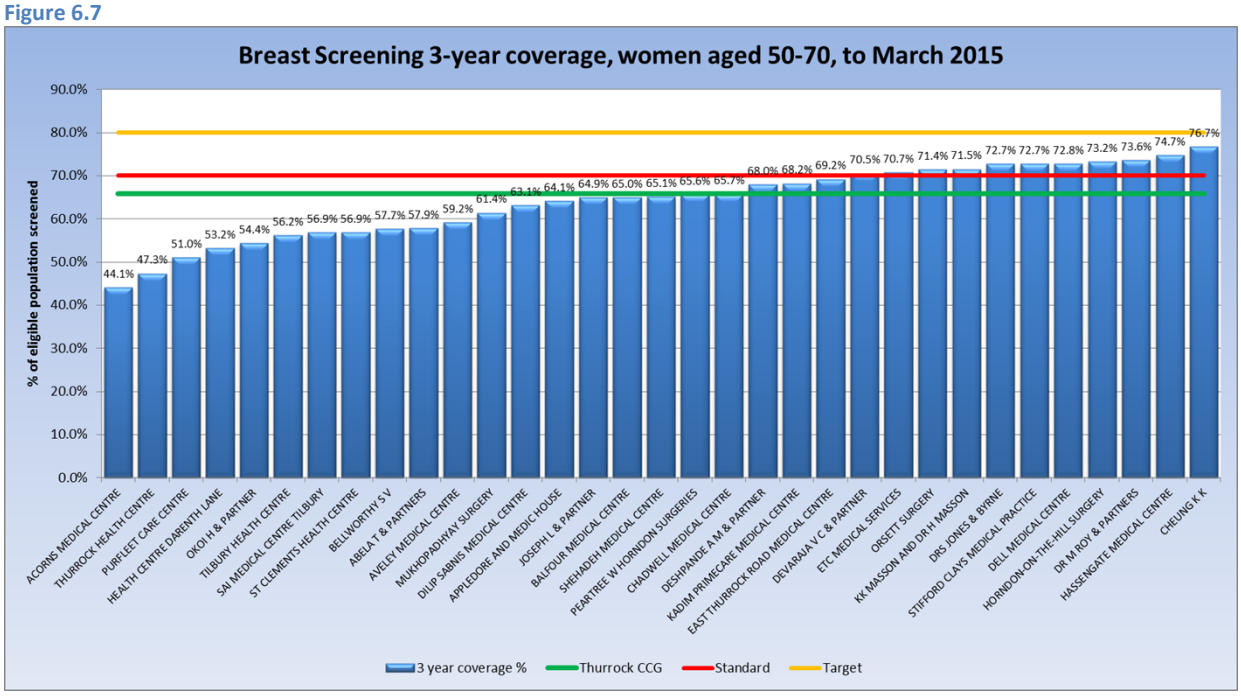
6.4 Breast Cancer Screening

The main objective of the NHSBSP is to reduce the mortality from breast cancer in women invited for screening. In the UK, women aged 50–70 years are invited for screening every three years. It is estimated that breast screening prevents up to 40% of breast cancer deaths in those women who attend for screening. This is because breast cancers can be detected and treated before symptoms are apparent.

The call-recall system for inviting eligible women for breast cancer screening is coordinated Primary Care Support Services (PCSE) provided by Capita as Primary Care Support England. PCSE identifies the cohort of women eligible for screening and sends their details of batches of women to the Southend Breast Screening Unit at Southend Hospital who is responsible for writing to them to invite them for screening. The screening (mammogram) itself is also provided by the same unit at Southend Hospital

Figure 6.7 shows the three year breast cancer screening coverage for patients aged 50-70 by GP practice population in Thurrock as of 31 March 2015, together with the mean rate for Thurrock CCG, the minimum standard and the target coverage rates.

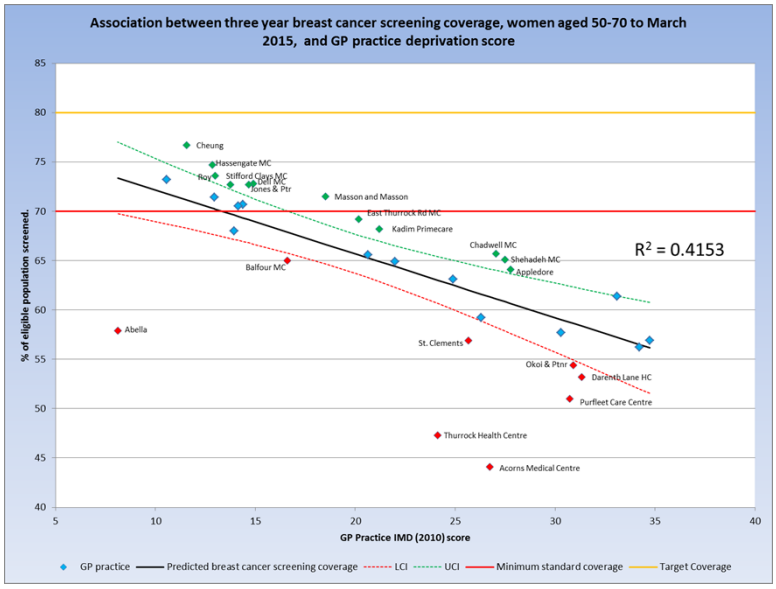
Figure 6.7



The mean screening coverage for this cohort of patients across Thurrock is 65.9% which is below the minimum standard of 70%. Like the other cancer screening programmes previously discussed there is considerable variation in coverage between different practice populations. Only 11 out of the 32 practice populations (34.3%) achieve the minimum 70% coverage standard and none are screened to the target 80% coverage. The practice population with the poorest breast cancer screening coverage rate (Acorns) achieves a rate that is only just over half that of the practice population with the highest coverage. (Cheung). As GP practices have little direct involvement in this programme, the variation between practice populations is likely to be a function of differences within the practice populations themselves. This variation warrants further investigation.

Figure 6.8 shows the association between breast cancer screening coverage and practice population deprivation.

Figure 6.8



There is a reasonably strong negative association between breast screening coverage and practice population deprivation. The black line (of best fit) predicts the level of screening coverage at a given deprivation level given the level of association between the two variables. Practices that lie above or below the two confidence intervals around this line can be said to have a screening uptake statistically significantly above (green diamonds) or below (red diamonds) what would be expected given the level of deprivation within their practice population.

Practices populations marked in red are of particular concern as their breast screening coverage is significantly lower than would be expected for their level of deprivation. This is particularly apparent for Abella, St. Clements, Purfleet Care Centre, Thurrock Health Centre and Acorns Medical Centre. This warrants further investigation.

6.5 Cancer Screening Summary

The mean 3.5 year screening cervical screening coverage of patients aged 25-49 across Thurrock is 71.7% which is above the minimum standard but below the target 80% rate However there is unacceptable variation in screening coverage between GP practice populations. Only 17 of our 32 GP practices (53.1%) achieve screening coverage at the minimum standard of 70% and only two (6.25%) achieve screening coverage at the target rate of 80%. Performance on screening coverage for women aged 50-64 is better than those aged 24-49. The mean screening coverage in this cohort across the CCG is 76.2% and variation between practice populations is lower than that in younger women. All but three practices (90.6%) achieve the minimum 70% coverage standard and a quarter of all practices achieve screening coverage above the 80% target.

Cervical screening coverage for women aged 25-49 is relatively strongly negatively associated with practice population deprivation and could therefore be said to be a driver for health inequalities. 11 practices (Jones and Byrne, Balfour, Deshpande, Roy and Partners, Masson and Masson, Kadim, Joseph and Ptnr, Thurrock Health Centre, Chadwell, Appledore MC and Mukhopadhyay) have screening coverage that is both below the 70% minimum standard and significantly below what would be expected for their level of practice population deprivation. This warrants further investigation. The absolute low level of cervical screening coverage within the Mukhopadhyay practice coupled with the significant distance below what would be predicted for the level of practice deprivation is particularly concerning.

The mean coverage rate for bowel cancer screening in Thurrock in the eligible population is 55%. This is below the national minimum standard of 60%. 26 of the 32 (81.26%) practice populations have screening coverage below the 60% target. There is considerable variation in uptake of bowel cancer screening between GP practice populations, with the lowest coverage rate (Sai Medical Centre) being just over half the that in the population with the highest coverage rate (Hassengate Medical Centre). Given that GP practices have little involvement in this screening programme, the explanation for this is likely to a product of differences within the practice populations themselves. There is a strong negative association between bowel cancer screening coverage and deprivation. This is concerning as it is likely to be a driver of health inequalities related to cancer.

6.6 Recommendations – Cancer Screening

1. The Public Health England team based in NHS England East office should investigate and seek to reduce the level of variation in coverage between GP practice populations on all three cancer screening programmes. Specifically:

1a. For cervical screening the following practice populations warrant further investigation

- Jones and Byrne, Balfour, Deshpande, Roy and Partners, Masson and Masson, Kadim, Joseph and Ptnr, Thurrock Health Centre, Chadwell, Appledore MC and Mukhopadhyay

1b. For bowel screening, the following practice populations warrant further investigation

- Sai Medical Centre, Tilbury Health Centre, Okoi, Thurrock Health Centre, Darenth Lane, St. Clements, Dilip Sabnis, Purfleet Care Centre, Joseph and Partner, Acorns Medical Centre, Appledore and Medic House, Mukhopadhyay, Shehadah, Kadim Primecare, Aveley Medical Centre,

1c. For breast screening, the following practice populations warrant further investigation

- Acorns Medical Centre, Thurrock Health Centre, Purfleet Care Centre, Health Centre Darenth Lane, Okoi and Partner, Tilbury Health Centre, Sai Medical Centre, St. Clements Health Centre, Bellworthy, Abela and Partner, Aveley Medical Centre

15. GPs and practice staff with screening coverage below target should seek opportunities to promote and encourage cancer screening programmes to all patients

16. NHS Thurrock CCG in conjunction with Thurrock Council Public Health Team should develop and implement a communications campaign promoting the importance of cancer screening programmes, with particular targeting of areas with low screening coverage

7. Early identification and referral of suspected cancer

7.1 Introduction

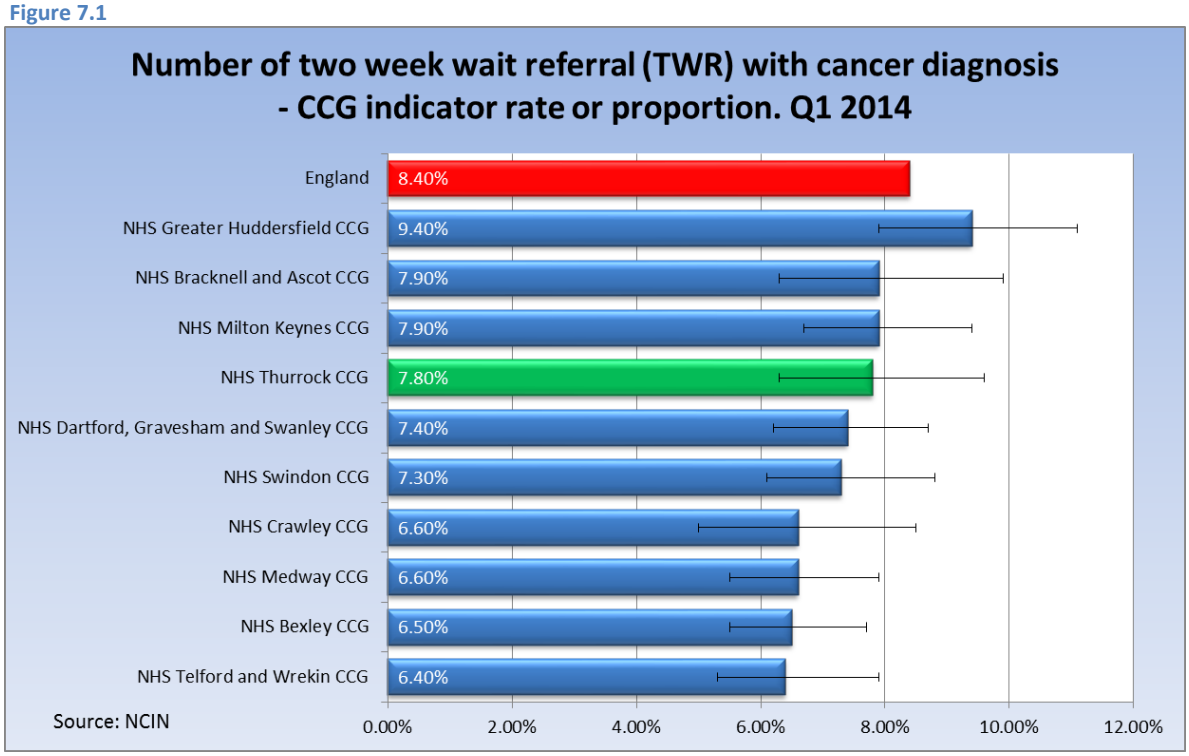
Timely and appropriate referral of patients with symptoms that could indicate that they have cancer is essential to improving cancer survival in our population. One of the explanations in much of the published literature on the UK's poor cancer survival rates compared to other countries is that patients are referred for cancer treatment to late. Conversely, over-referral of patients who do not have cancer risks clogging up NHS care pathways with the "worried well" and diverting capacity away from treating promptly patients who do have cancer.

The NHS has set a two week minimum waiting time for patients with suspected cancer to see a cancer specialist from GP referral. This forms part of the NHS Constitution.

7.2 Appropriateness of GP referral into the two-week wait pathway

Figure 7.1 shows the cancer positivity rate of two week wait referrals for Q1 2014

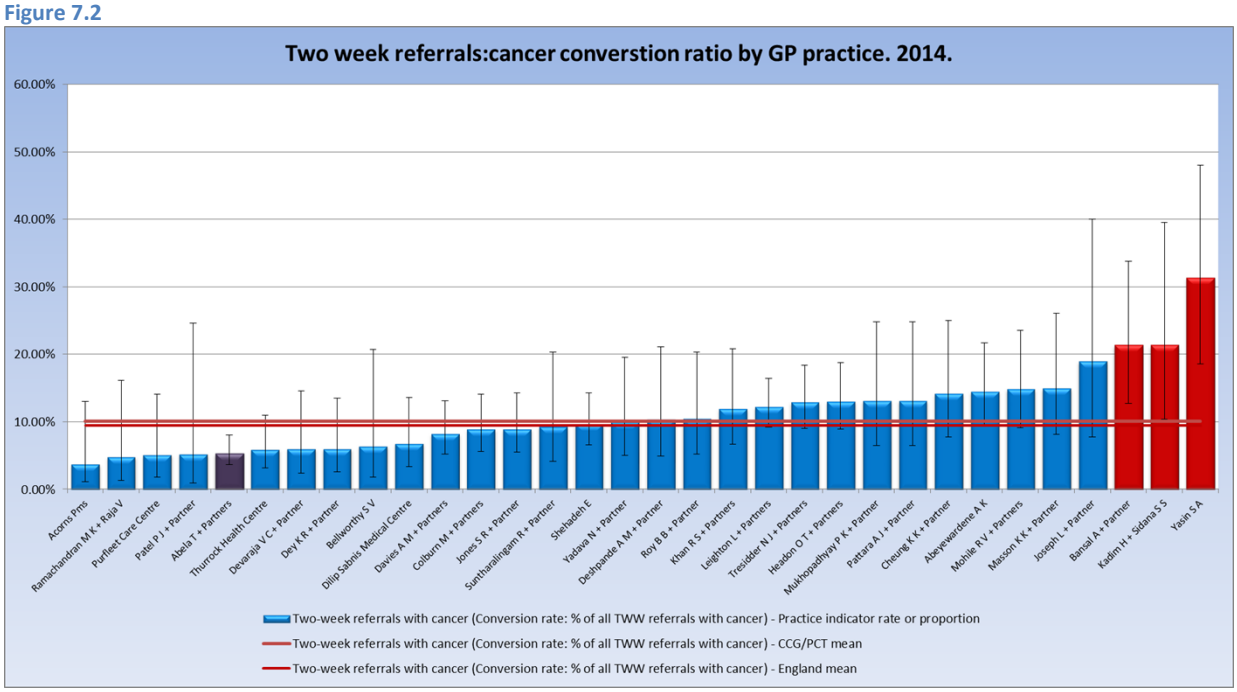
Figure 7.1



Thurrock's overall cancer positivity rate for two week wait referrals is 7.8%. This is not statistically significantly different to England's or any of its comparator CCGs (at 95% CI) and suggests that for the CCG as a whole, cancer referrals are appropriate.

Figure 7.2 shows the percentage of two-week wait referrals subsequently found to be patients with cancer by GP practice.

Figure 7.2



Again, there is significant variation between GP practices although some care needs to be taken in interpreting these results as the actual numbers of patients are small and so subject to statistical random variation.

However, one practice (Abela and Partners) has a cancer positivity rate from two week referrals that is statistically significantly lower than the national average. This may suggest an over-referral of patients into the pathway. Conversely, three practices (Bansal, Kadim and Yasin) have a cancer positivity rate that is statistically significantly greater than the national average and in the case of Yasin, over three times the national average. This may suggest a reluctance to refer patients that may have symptoms that could be cancer into the two-week wait cancer care pathway, a failure to identify potential cancer symptoms in patients or a reluctance of those practice populations with potential cancer symptoms to access primary care. This warrants further investigation.

Figure 7.3 shows the Indirectly Age Standardised two week wait referral ratio by GP practice in Thurrock in 2014. The ratio measures the actual versus the expected level of cancer referrals into the two-week wait care pathway for each practice population based on the demographic characteristics of that practice population. A GP practice that is making cancer referrals in line with what is expected for that practice population should have a referral ratio between 80 and 120%

Figure 7.3

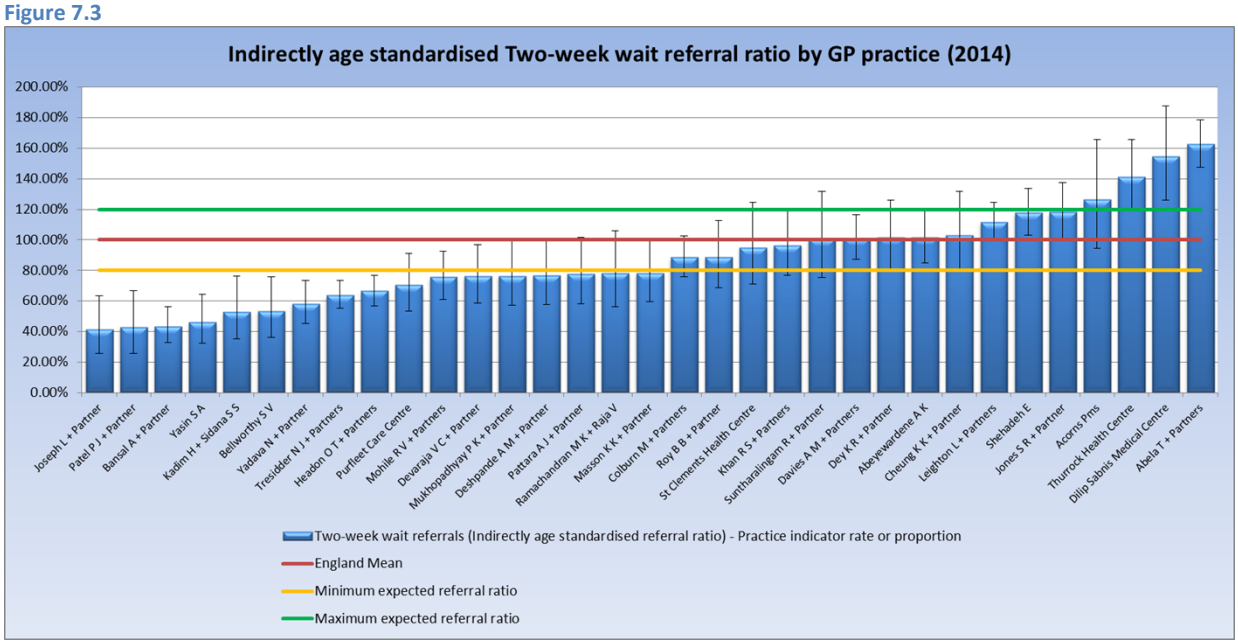


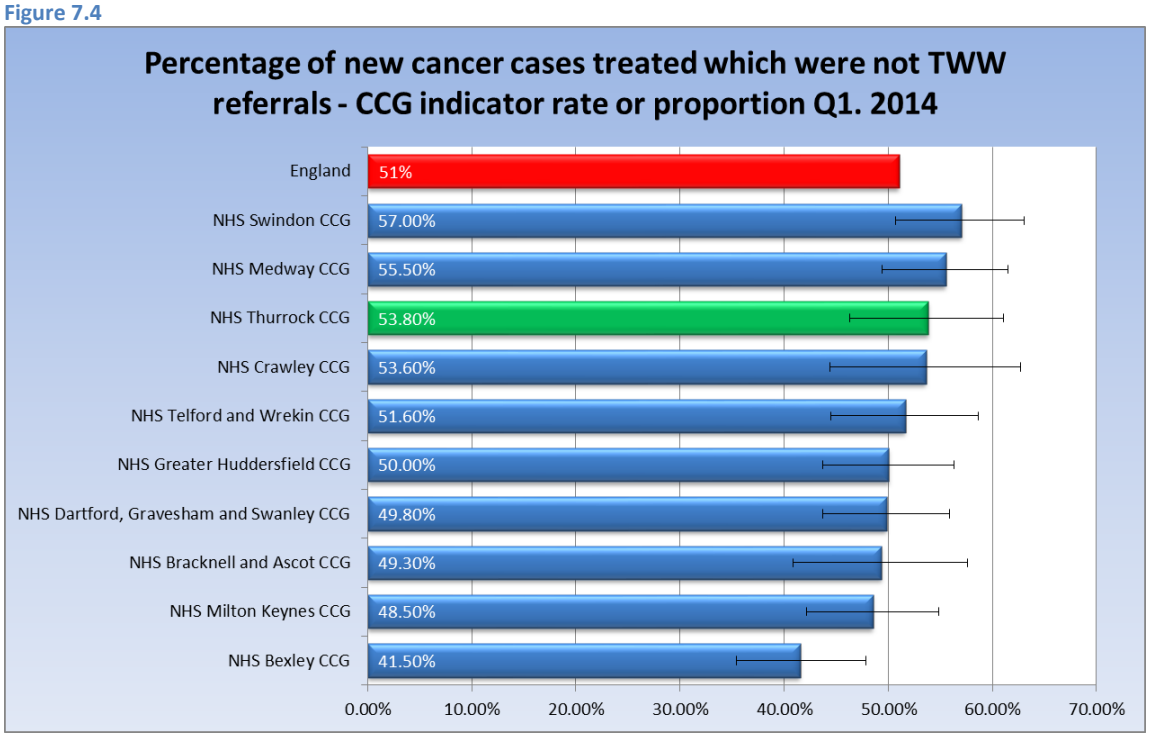
Figure 7.3 shows a significant variation in two-week wait referral ratios between different GP practices in Thurrock. Nine practices have indirectly standardised two-week wait referral ratios that are statistically significantly below 80% (at 95% CI). This suggests that these practices may be under-referring patients with cancer into the two week wait cancer care pathway. It is interesting and concerning to note that three practices, Bansal and Partner, Yasin and Kadim and Sidana, who have referral rates significantly below the minimum referral ratio, also have cancer TWWs positively rates significantly above England's (figure P). The reasons for this are unclear and could be a result of differences between practice population's willingness to recognise and seek help for cancer symptoms and/or differences in referral behaviour between clinicians working in different practices. However it warrants further urgent investigation.

Conversely three practices have referral ratios statistically significantly above 120%. These practices may be over-referring patients into the pathway. In the case of Abela and Partners, the high referral ratio is also congruent with a cancer positivity rate that is significantly below England's for patients referred into the two week wait pathway, providing stronger evidence that this practice may be over-referring patients.

7.3 Late detection of patients with cancer

Figure 7.4 shows the percentage of cancer treatments that were not two week referrals. A high percentage of cancer being treated outside the two-week wait referral pathway could suggest poor early detection.

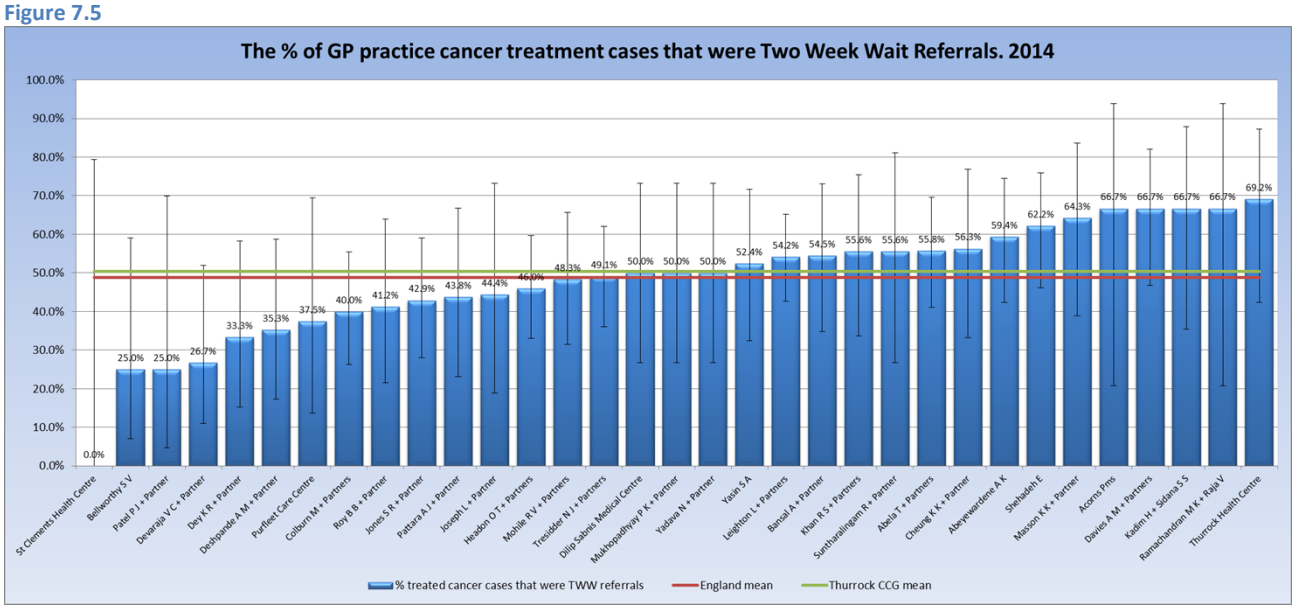
Figure 7.4



53.8% of patients with cancer in Thurrock were treated without coming through the two-week-wait referral pathway. This rate is not statistically significantly different to England's or any of Thurrock's comparator CCGs, although still identifies scope for improvement.

Figure 7.5 shows the percentage of patients treated for cancer in each GP practice population that were not two week referrals. Patients treated for cancer not referred through the two-week wait pathway are likely to be emergency presentations at A&E and are therefore less likely to have had their cancer detected at an early stage.

Figure 7.5

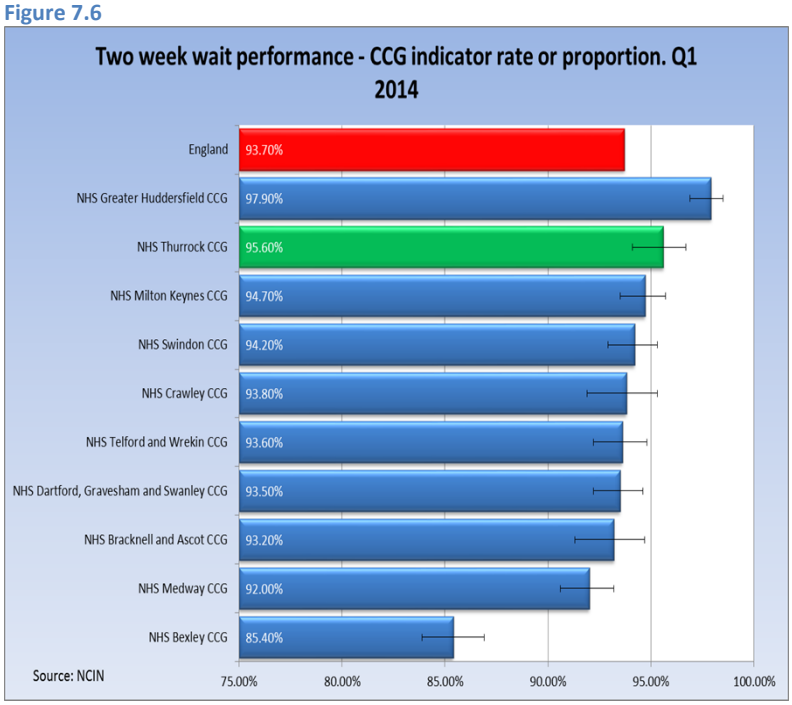


Whilst there is variation between different practice populations, the small numbers of patients involved from each practice results in no practice having a percentage that is statistically different to the England or Thurrock mean.

7.4 Performance against the two week wait referral cancer standard

Figure 7.6 shows performance on the two week wait standard for Thurrock CCG and its ONS comparator CCGs for Q1 2014.

Figure 7.6



Thurrock CCG performs well on the two week wait standard, with 95.6% of patients seeing a cancer specialist within two weeks of referral by a GP. This rate is statistically significantly better than that of England's and is the second best in the ONS comparator group of CCGs.

Figure 7.7

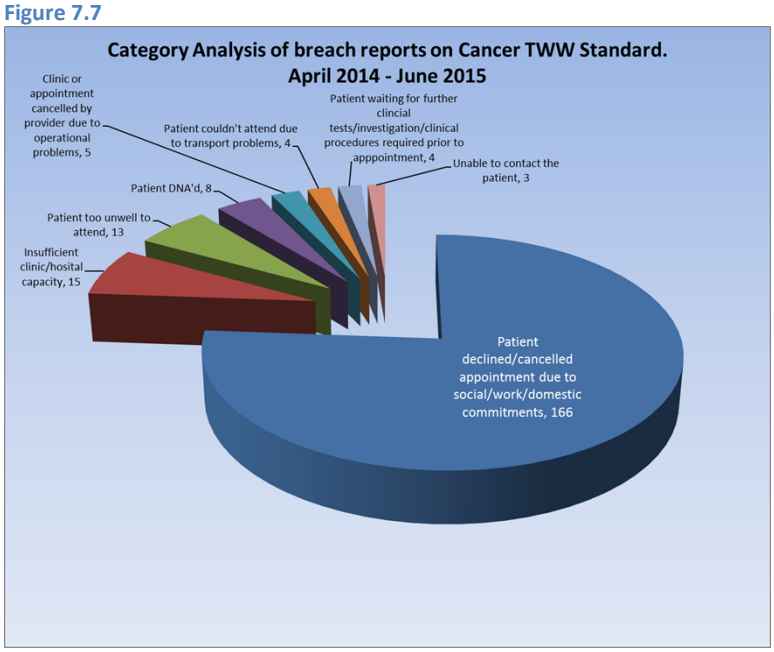


Figure 7.7 shows an analysis of reasons for two week wait breaches. By far the most common reason was that the patient declined the appointment offered due to other social/work/holiday commitments.

7.5 Summary: Early identification and referral of suspected cancer

Overall, 7.8% of patients referred into the two-week wait cancer pathway were subsequently found to have cancer. This is lower than England's rate (8.4%) but not statistically significantly different.

At GP practice level, three practices have a cancer diagnosis rate following referral into the two week pathway that is significantly greater than England's rate. In one practice over 30% of patients referred into the two week pathway were subsequently diagnosed with cancer. This suggests a significant under referral of patients and warrants further urgent investigation.

On a second metric to examine the appropriateness of referral of patients with suspected cancer into the two week wait pathway – the Indirectly Age Standardised Referral Ratio, there is also significant variation in between GP practices in Thurrock. Nine practices (28.1%) have referral ratios that suggest that they are under referring patients with suspected cancer and three practices (9.4%) have referral ratios that suggest they may be over-referring patients who do not have cancer. Three practices have scores on both metrics that suggest that they are failing to refer sufficient patients with suspected cancer into the two week wait pathway. This warrants further investigation.

Over half of all patients treated for cancer in Thurrock did not receive a referral through the two-week wait pathway. This is not significantly different to England's rate, but still suggests that too few patients are having their cancer detected early enough.

In terms of performance against the two-week waiting standard, Thurrock performs well with 95.6% of patients seeing a cancer specialist within two weeks of being referred into the pathway by their GP. This is second best performance in Thurrock's ONS comparator CCG group and statistically significantly better than the performance across England.

7.6 Recommendations: Early identification and referral of suspected cancer

1. The CCG in conjunction with Thurrock Council should undertake a coordinated communications campaign aimed at increasing patient knowledge of potential cancer symptoms and encouraging them to consult their GP at the earliest possible opportunity. This campaign should be targeted at practice populations with referral ratios below 80% or where unplanned admission rates for cancer are high.

2. Practices that have been identified as having referral ratios into the TWW pathway below 80% and/or cancer TWW positivity rates that are significantly greater than the England mean should review their clinical practice with regard to cancer referrals to ensure that they are identifying and referring patients with symptoms that could be cancer, sufficiently early.

3. Practices with that have been identified has having referral ratios into the TWW pathway above 120% and/or TWW cancer positivity rates that are significantly less than the England mean should review their clinical practice with regard to cancer referrals to ensure that they are not over referring patients.

8. Cancer Diagnosis and Treatment

8.1 Routes to Cancer Diagnosis

Figures 8.1 to 8.3 show the 'routes to diagnosis' for the three most common cancers; lung, colorectal and bowel in Thurrock and its comparator CCG populations between 2006 and 2010. As discussed in section 7, population outcomes for cancer will improve if a greater number of patients are diagnosed via screening or a managed presentation (TWW referral) as opposed to an emergency presentation, as cancer is more likely to be detected at an earlier stage.

Figure 8.1

	Directly age-standardised rate per 100, 000 population by route							Percentage by Route				
	Lung	Screen detected	Managed	Emergency presentation	Other	Number of cases		Screen detected	Managed	Emergency presentation	Other	
2006-2010	England		27.5	16.6	1.6	163,176			58%	38%	4%	
	Confidence interval		27.4 27.7	16.5 16.8	1.5 1.6				58% 58%	38% 39%	4% 4%	
	NHS Bexley CCG		30.1	16.5	1.8	759			59%	36%	4%	
	Confidence interval		27.3 32.9	14.6 18.5	1.2 2.5				56% 63%	33% 40%	3% 6%	
	NHS Bracknell And Ascot CCG		23.2	14.9	1.4	291			57%	39%	3%	
	Confidence interval		19.6 26.7	12.1 17.6	0.5 2.3				52% 63%	34% 45%	2% 6%	
	NHS Crawley CCG		20.0	18.6	1.9	247			48%	47%	4%	
	Confidence interval		16.4 23.6	15.2 22.0	0.8 3.0				42% 54%	41% 54%	3% 8%	
	NHS Dartford, Gravesham And Swanley CCG		27.8	14.7	2.2	742			60%	34%	6%	
	Confidence interval		25.2 30.4	12.9 16.5	1.6 2.9				57% 64%	31% 38%	4% 7%	
	NHS Greater Huddersfield CCG		25.9	18.5	1.4	715			55%	42%	4%	
	Confidence interval		23.4 28.5	16.4 20.6	0.9 2.0				51% 58%	38% 45%	3% 5%	
	NHS Medway CCG		27.2	18.4	2.2	744			55%	40%	5%	
	Confidence interval		24.6 29.9	16.3 20.5	1.5 2.9				52% 59%	37% 44%	4% 7%	
	NHS Milton Keynes CCG		26.5	17.9	1.9	567			56%	40%	4%	
	Confidence interval		23.6 29.4	15.5 20.2	1.1 2.6				52% 60%	36% 44%	3% 6%	
	NHS Swindon CCG		26.6	17.3	2.2	564			56%	39%	5%	
	Confidence interval		23.7 29.5	15.0 19.5	1.3 3.0				52% 60%	35% 43%	3% 7%	
	NHS Telford And Wrekin CCG		30.8	15.7	1.9	485			62%	34%	4%	
	Confidence interval		27.3 34.2	13.3 18.2	1.1 2.8				58% 67%	30% 38%	3% 6%	
	NHS Thurrock CCG		30.5	19.1	1.3	444			58%	39%	3%	
	Confidence interval		26.8 34.2	16.2 21.9	0.6 2.1				54% 63%	35% 44%	2% 5%	

For lung cancer, Thurrock has a rate of diagnosis per 100K population and percentages of cancers detected by each route that is largely the same as both England and its comparator group CCGs.

Figure 8.2

	Directly age-standardised rate per 100, 000 population by route Bordered cells indicate 3 SD outliers on respective funnel plots									Percentage by Route							
	Colorectal	Screen detected		Managed		Emergency presentation		Other		Number of cases	Screen detected		Managed		Emergency presentation		Other	
2006-2010	England	2.5		29.3		10.2		1.9		156,057	5%		66%		25%		4%	
	Confidence interval	*2.5*	*2.6*	*29.1*	*29.4*	*10.1*	*10.3*	*1.9*	*1.9*		*5%*	*5%*	*66%*	*66%*	*25%*	*25%*	*4%*	*4%*
	NHS Bexley CCG	1.7		27.7		9.3		2.3		640	3%		66%		26%		5%	
	Confidence interval	*1.0*	*2.5*	*25.1*	*30.4*	*7.9*	*10.7*	*1.5*	*3.0*		*2%*	*5%*	*62%*	*70%*	*22%*	*29%*	*4%*	*7%*
	NHS Bracknell And Ascot CCG	2.6		23.7		9.3		3.5		293	6%		60%		26%		9%	
	Confidence interval	*1.4*	*3.9*	*20.2*	*27.2*	*7.2*	*11.3*	*2.2*	*4.9*		*4%*	*9%*	*54%*	*65%*	*21%*	*31%*	*6%*	*12%*
	NHS Crawley CCG	1.2		24.7		9.1		2.3		223	2%		66%		26%		6%	
	Confidence interval	*0.1*	*2.2*	*20.7*	*28.6*	*6.8*	*11.5*	*1.0*	*3.5*		*1%*	*5%*	*60%*	*72%*	*20%*	*32%*	*3%*	*10%*
	NHS Dartford, Gravesham And Swanley CCG	1.2		27.6		8.8		2.1		648	2%		69%		23%		5%	
	Confidence interval	*0.6*	*1.7*	*25.1*	*30.2*	*7.4*	*10.3*	*1.3*	*2.8*		*2%*	*4%*	*66%*	*73%*	*20%*	*27%*	*3%*	*7%*
	NHS Greater Huddersfield CCG	2.1		27.7		9.5		1.8		624	4%		67%		25%		4%	
	Confidence interval	*1.3*	*2.9*	*25.0*	*30.3*	*8.0*	*11.0*	*1.1*	*2.5*		*3%*	*6%*	*63%*	*70%*	*22%*	*28%*	*3%*	*6%*
	NHS Medway CCG	1.8		27.9		10.3		2.0		649	4%		67%		25%		4%	
	Confidence interval	*1.1*	*2.5*	*25.3*	*30.6*	*8.7*	*11.8*	*1.2*	*2.7*		*3%*	*5%*	*63%*	*70%*	*22%*	*29%*	*3%*	*6%*
	NHS Milton Keynes CCG	1.0		30.2		10.8		3.2		558	2%		66%		25%		7%	
	Confidence interval	*0.4*	*1.7*	*27.2*	*33.3*	*9.0*	*12.6*	*2.2*	*4.2*		*1%*	*4%*	*62%*	*70%*	*21%*	*29%*	*5%*	*10%*
	NHS Swindon CCG	0.0		29.4		11.5		2.1		540			68%		27%		5%	
	Confidence interval			*26.4*	*32.4*	*9.6*	*13.3*	*1.3*	*3.0*				*64%*	*72%*	*24%*	*31%*	*3%*	*7%*
	NHS Telford And Wrekin CCG	1.2		33.1		11.1		1.5		469	2%		70%		25%		3%	
	Confidence interval	*0.5*	*1.9*	*29.5*	*36.6*	*9.0*	*13.1*	*0.7*	*2.2*		*1%*	*4%*	*66%*	*74%*	*21%*	*29%*	*2%*	*5%*
	NHS Thurrock CCG	3.3		28.1		11.4		1.8		380	7%		64%		26%		4%	
	Confidence interval	*2.0*	*4.7*	*24.6*	*31.7*	*9.1*	*13.6*	*0.9*	*2.7*		*5%*	*10%*	*59%*	*69%*	*22%*	*30%*	*2%*	*6%*

For colorectal cancer, Thurrock as a rate per 100,000 population and percentage of cancer detected by screening that is significantly greater than England's and many of its comparator CCGs and a rate and percentage of cancer detected by emergency presentation that is not significantly different to England's or other CCGs. This suggests that our bowel cancer screening programme may be more effective than in other areas and is good news in terms of population health outcomes for cancer.

Figure 8.3

	Directly age-standardised rate per 100, 000 population by route Bordered cells indicate 3 SD outliers on respective funnel plots									Percentage by Route							
	Female Breast Cancer	Screen detected		Managed		Emergency presentation		Other		Number of cases	Screen detected		Managed		Emergency presentation		Other	
2006-2010	England	38.4		71.2		3.9		6.0		191,120	28%		62%		5%		5%	
	Confidence interval	*38.1*	*38.7*	*70.8*	*71.6*	*3.8*	*4.0*	*5.9*	*6.1*		*28%*	*29%*	*62%*	*62%*	*5%*	*5%*	*5%*	*5%*
	NHS Bexley CCG	36.4		65.3		3.3		8.8		805	28%		61%		4%		7%	
	Confidence interval	*31.6*	*41.1*	*59.6*	*71.1*	*2.2*	*4.4*	*6.5*	*11.1*		*25%*	*31%*	*58%*	*64%*	*3%*	*6%*	*6%*	*9%*
	NHS Bracknell And Ascot CCG	36.6		71.2		4.4		14.0		457	25%		60%		5%		11%	
	Confidence interval	*29.9*	*43.3*	*62.7*	*79.6*	*2.5*	*6.2*	*10.1*	*17.9*		*21%*	*29%*	*55%*	*64%*	*3%*	*7%*	*8%*	*14%*
	NHS Dartford, Gravesham And Swanley CCG	43.2		69.4		3.4		8.9		922	31%		59%		4%		7%	
	Confidence interval	*38.1*	*48.2*	*63.5*	*75.2*	*2.3*	*4.6*	*6.7*	*11.1*		*28%*	*34%*	*56%*	*62%*	*3%*	*5%*	*5%*	*8%*
	NHS East Surrey CCG	42.1		60.8		3.4		13.3		635	31%		55%		4%		11%	
	Confidence interval	*36.1*	*48.0*	*54.4*	*67.1*	*2.0*	*4.7*	*10.1*	*16.5*		*27%*	*34%*	*51%*	*59%*	*3%*	*6%*	*8%*	*13%*
	NHS Greater Huddersfield CCG	34.7		69.9		3.6		5.3		799	27%		64%		4%		4%	
	Confidence interval	*30.1*	*39.4*	*63.9*	*75.9*	*2.3*	*4.8*	*3.6*	*7.1*		*24%*	*30%*	*61%*	*68%*	*3%*	*6%*	*3%*	*6%*
	NHS Medway CCG	43.2		66.0		2.9		5.8		862	33%		58%		4%		5%	
	Confidence interval	*38.2*	*48.2*	*60.2*	*71.8*	*1.9*	*3.9*	*4.1*	*7.6*		*30%*	*37%*	*55%*	*61%*	*3%*	*5%*	*4%*	*7%*
	NHS Milton Keynes CCG	34.4		71.5		4.1		8.8		748	26%		62%		4%		7%	
	Confidence interval	*29.6*	*39.2*	*65.0*	*78.0*	*2.7*	*5.6*	*6.5*	*11.1*		*23%*	*30%*	*59%*	*66%*	*3%*	*6%*	*6%*	*9%*
	NHS Swindon CCG	45.0		73.1		4.8		4.0		732	31%		61%		5%		3%	
	Confidence interval	*39.1*	*50.9*	*66.3*	*79.8*	*3.2*	*6.3*	*2.4*	*5.7*		*27%*	*34%*	*58%*	*65%*	*4%*	*7%*	*2%*	*5%*
	NHS Telford And Wrekin CCG	35.3		79.6		2.4		4.7		577	27%		67%		2%		4%	
	Confidence interval	*29.7*	*40.8*	*71.7*	*87.6*	*1.1*	*3.6*	*2.8*	*6.7*		*23%*	*31%*	*63%*	*70%*	*2%*	*4%*	*3%*	*6%*
	NHS Thurrock CCG	39.5		70.4		3.2		5.3		495	29%		62%		4%		4%	
	Confidence interval	*33.1*	*45.9*	*62.6*	*78.3*	*1.7*	*4.6*	*3.1*	*7.6*		*26%*	*34%*	*58%*	*67%*	*2%*	*6%*	*3%*	*7%*

For breast cancer, both standardised rate per 100K population and percentage of cancers detected via each route is statistically no different to England's or other CCGs.

It is however worth remembering that England benchmarks poorly when compared to other European countries on early detection of cancer and so figures A to C still identify significant scope for improvement

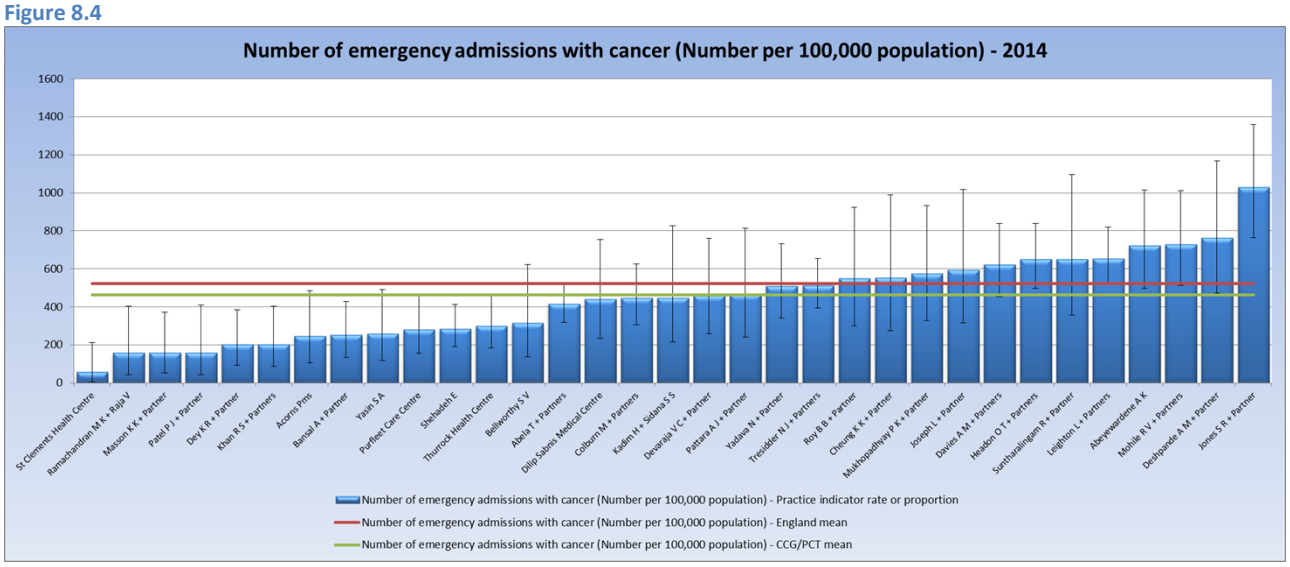
8.2 Diagnosis of Cancer following an Unplanned Care Admission

Figure 8.4 shows the rate of unplanned care admissions per 100,000 population for cancer in 2014 for each practice population. A high rate of unplanned care admissions for cancer suggests a poorer level of early detection of cancer within that practice population. There are many explanations for this including:

- Differences in the over-all prevalence of cancer in different practice populations
- Differences in the types of cancer that different practice populations are most at risk of
- Difference between practice populations in their access of cancer screening programmes
- Differences in the willingness of different practice populations to access primary care when they first notice symptoms
- Differences in referral behaviour of primary care clinicians when patients do present with symptoms.

As such interpretation of figure 8.4 needs to be made with some caution.

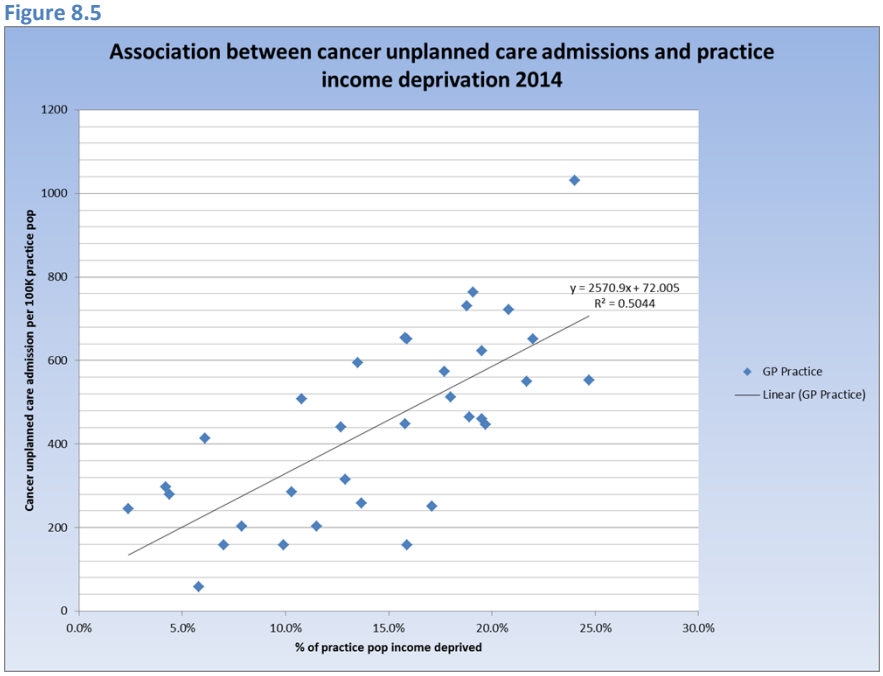
Figure 8.4



There is however significant variation between the rate of unplanned care admissions for cancer between different practice populations in Thurrock. The practice with the highest rate of unplanned care admissions (Jones and Partner) has a rate that is 20 fold that of the practice with the lowest rate of unplanned care admissions. (St. Clements). Ten practice populations have unplanned care admission rates that are statistically significantly lower than England's and two have rates that are statistically significantly greater. This may warrant further investigation.

Figure 8.5 shows the association between GP practice population unplanned care admission rates for cancer and practice population income deprivation.

Figure 8.5



There is a strong positive association between the percentage of the practice population classed as 'income deprived' and unplanned care admission rates for cancer. Just over half of the variation in unplanned care admission rates between practices can be explained by income deprivation levels within the practice population. This may suggest that differences in behaviour and underlying cancer prevalence between practice populations are a key driver of differences in unplanned care admission rates.

8.3 Cancer Waiting Times for Diagnosis and Treatment

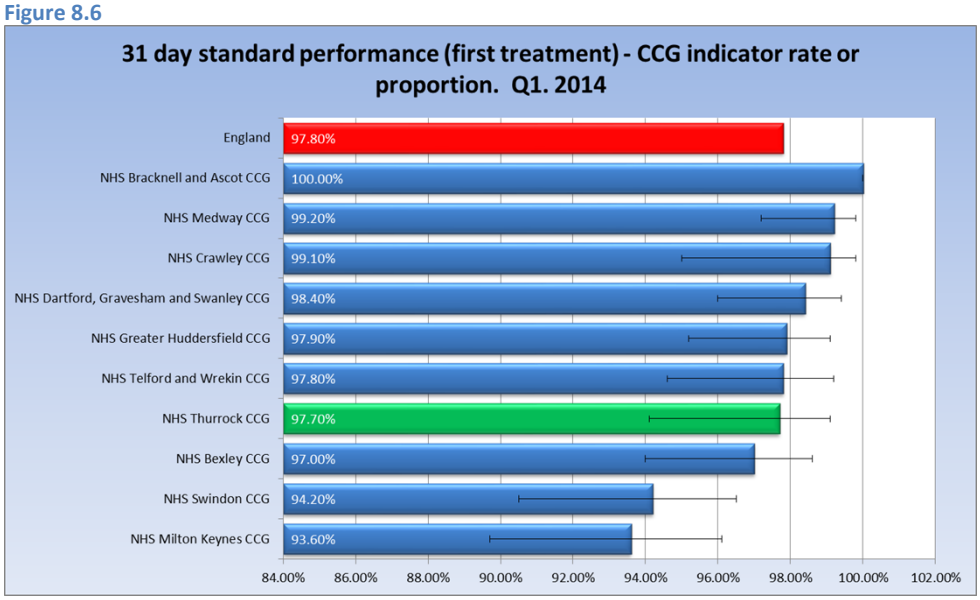
There are a number of maximum waiting time standards cancer treatment that CCGs are mandated to deliver and held accountable for through the NHS Operating and Performance Frameworks These include:

- 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 a course of radiotherapy;
- a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen;
- 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 for the first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers);
- a maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms
- a maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected.

8.3.1 Performance against 31 day cancer treatment waiting times

Figure 8.6 shows performance against the 31 day cancer waiting standard for first treatment for Thurrock CCG, England and Thurrock's ONS comparator CCGs. This is the time that a patient waits to receive first treatment after diagnosis and a decision to treat (DTT) has been made.

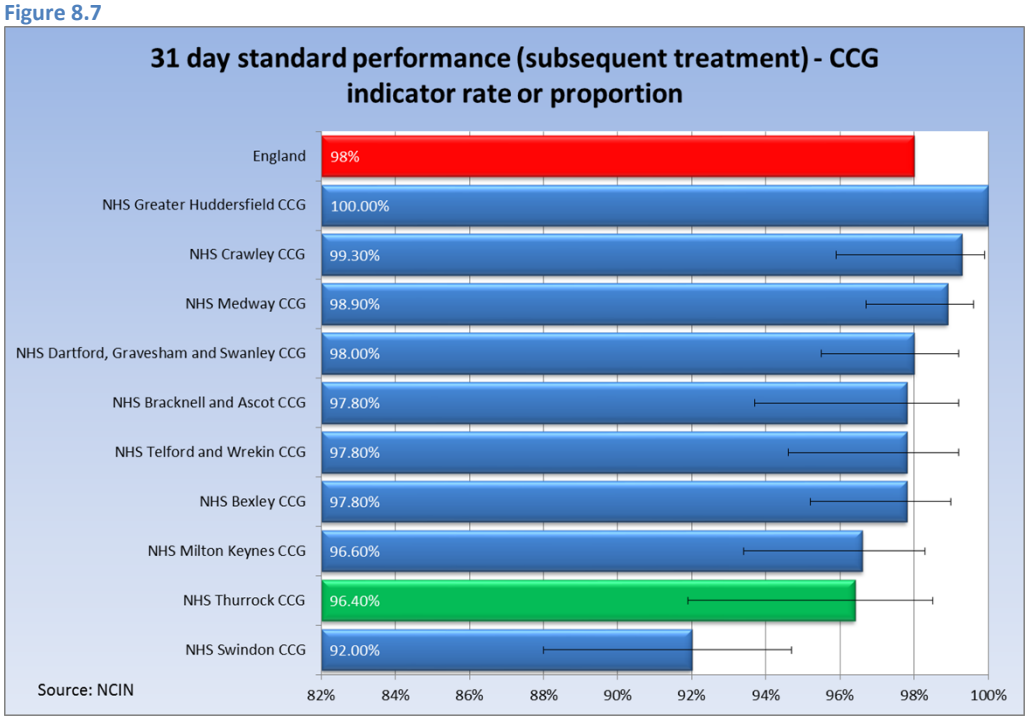
Figure 8.6



97.7% of cancer patients in Thurrock waited 31 days or fewer between initial GP referral and decision to treat their cancer for first treatment in Q1 2014. This is not statistically significantly different to England's performance or performance in an of Thurrock's ONS comparator CCGs.

Figure 8.7 shows performance against the 31 day cancer standard for subsequent cancer treatments for Thurrock CCG, its comparator CCGs and England in Q1. 2014.

Figure 8.7

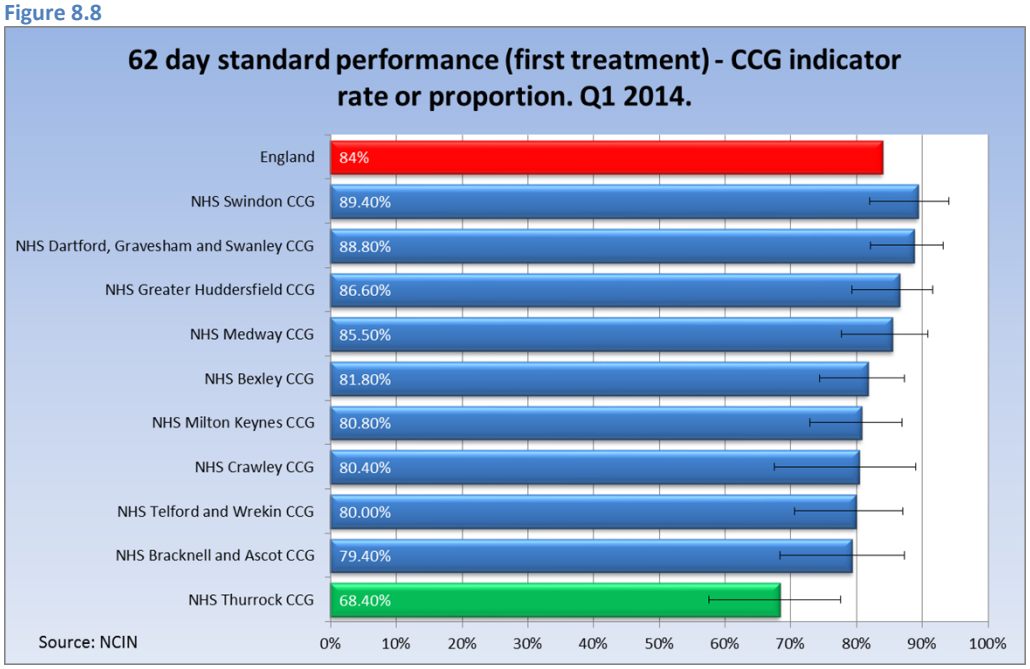


Thurrock's performance is not statistically significantly different to either England's or its ONS comparator CCGs at 95% CI. However it has the second poorest performance compared to its ONS comparator group CCGs.

8.3.2 62 Day Cancer Waiting time standard

Figure 8.8 shows performance against the 62 day cancer waiting time standard for Thurrock CCG, its comparator CCGs and England in Q1 2014.

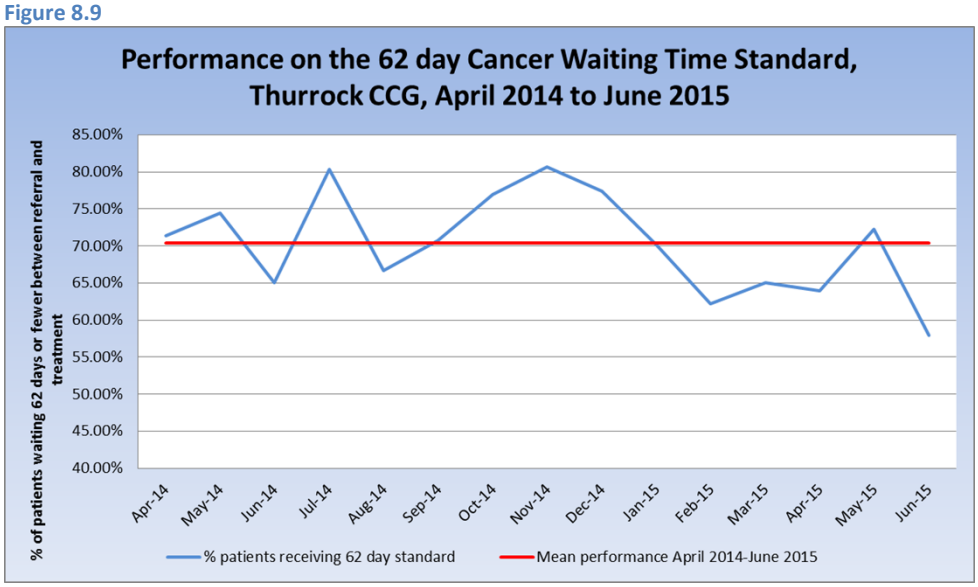
Figure 8.8



Only 68.4% of Thurrock cancer patients received their first treatment for cancer within 62 days of initial referral by their GP. This is statistically significantly worse than the rate for England and the poorest performance within the CCG's ONS comparator group. Given that performance on the two week wait target and 31 day wait target from decision to treat to the patient receiving first treatment, figure P suggests that something is going wrong in the system between the patient seeing a cancer specialist and the point of diagnosis and decision to treat. Delays in cancer treatment due to delays in diagnostics is likely to impact adversely on mortality rates of Thurrock patients and is unacceptable. This warrants further urgent investigation.

Figure 8.9 shows performance on a month by month basis from April 2014 to June 2015 on the 62 cancer waiting time standard for Thurrock CCG patients.

Figure 8.9



Performance has declined from November 2014. In June 2015, fewer than 60% of Thurrock patients with cancer received treatment within 62 days of referral by their GP.

8.3.3 Category Analysis on recorded reasons for 62 Day Breaches

Figure 8.10 shows category analyses undertaken on the 62 day cancer standard breach reports. Reports were categorised two categories (potentially avoidable, and unavoidable), and seven sub-categories

1. Potentially avoidable – Pathway referral delays/ pathway inefficiency
2. Potentially avoidable – Delays in diagnostics, or required referral across multiple sites to access all necessary diagnostics
3. Potentially avoidable – lack of clinic/hospital/bed capacity
4. Unavoidable – clinically complex case with unclear initial diagnosis
5. Unavoidable – patient initiated social or emotional related delays
6. Unavoidable – patient too ill for operation or treatment or receiving other medical treatment/operation
7. Unavoidable – patient DNA.

Figure 8.10

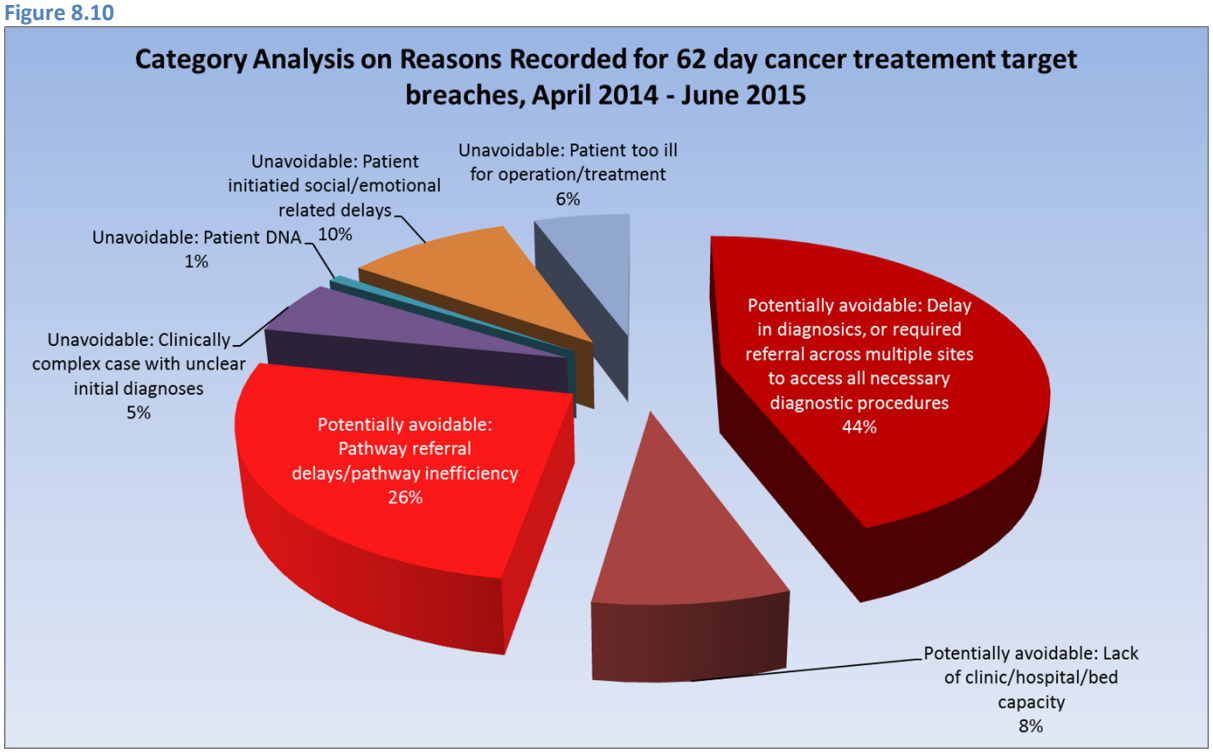


Figure 8.10 makes uncomfortable reading. 78% of all 62 day cancer treatment standard targets were breached for reasons that were potentially avoidable. Of all of the seven sub-categories, three most common were both classed as potentially avoidable.

The most common two reasons were either entirely or partly a function of the fragmentation of cancer pathways between multiple hospital sites across Essex. The most common reason was delays in access to diagnostics. This occurred either at one site or often because referral of patients between different sites was required in order to access to all diagnostic equipment in order to obtain an adequate diagnosis to begin treatment. This accounted for almost half of all breaches. Where specified, delays for MRI and CT scans and for TRUS featured commonly in breach reports categorised into this sub-category. What is striking from reading the individual breach reports is the number that stated that the breach was 'unavoidable because of the need to refer across multiple hospital sites'. However if adequate cancer diagnostics were provided in one specialist centre on one site, these breaches would not be unavoidable. In addition, a further 26% of breaches were explained simply by a lack of efficiency across the pathway. Again a common theme running through these breach reports was that referrals between different parts of a fragmented cancer pathway had not been made in a timely way. Too often, breach reports cited examples of referrals for treatment not being received until near the end of the 62 day wait.

What is striking from this analysis is that NHS Thurrock CCG is being held to account for a 62 day cancer wait target that at largely not within its gift to deliver given the current fragmentation of cancer care pathways across multiple hospital sites many of which are out of area. Rationalisation of diagnostics and treatment is required on in larger specialist cancer centres would seem to be the logical way to address the current fragmentation. This requires systems leadership from NHS England.

Lack of clinic/hospital or bed capacity was the third (although much rarer) reason given for avoidable breaches. Examples include lack of beds, cancellation of procedures due to staff absence and long waits for oncology clinics.

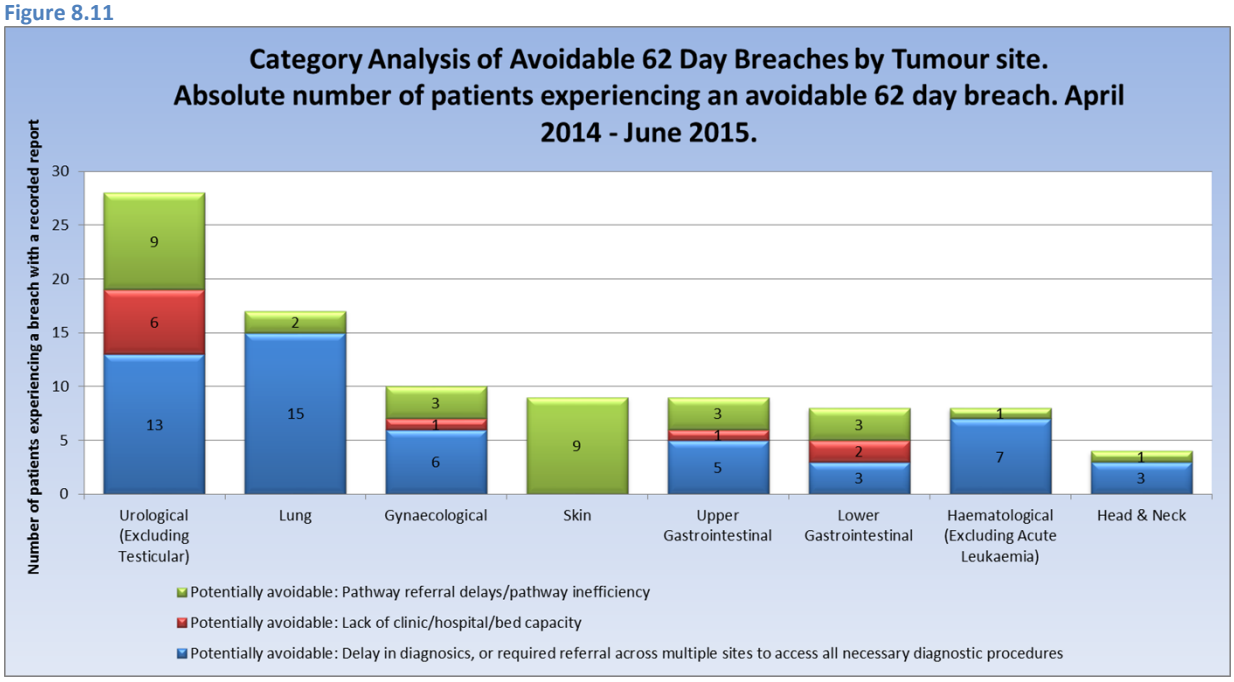
A theme running through many of the reports for breaches categorised as 'avoidable' was a lack of coordination of care of the patient. The care pathway operates as a series of linked individual processes with staff only taking responsibility for their part of the pathway or process. As soon as one part of the pathway failed, the entire pathway failed and the delay occurred. Patients often appeared to be 'bounced' around different providers and different parts of the NHS system with no one individual taking responsibility for their journey through the pathway. A care coordination approach to cancer with a single named accountable clinician taking responsibility for a patient's journey through the cancer pathway is required.

8.3.4 Category Analyses of Avoidable 62 Breaches by Tumour Pathway

To explore the above further, the three sub-categories of the 'Potentially avoidable Breach' category were analysed by tumour site.

Figure 8.11 shows the number of patients experiencing a 62 day breach classed as potentially avoidable by tumour site and sub-category.

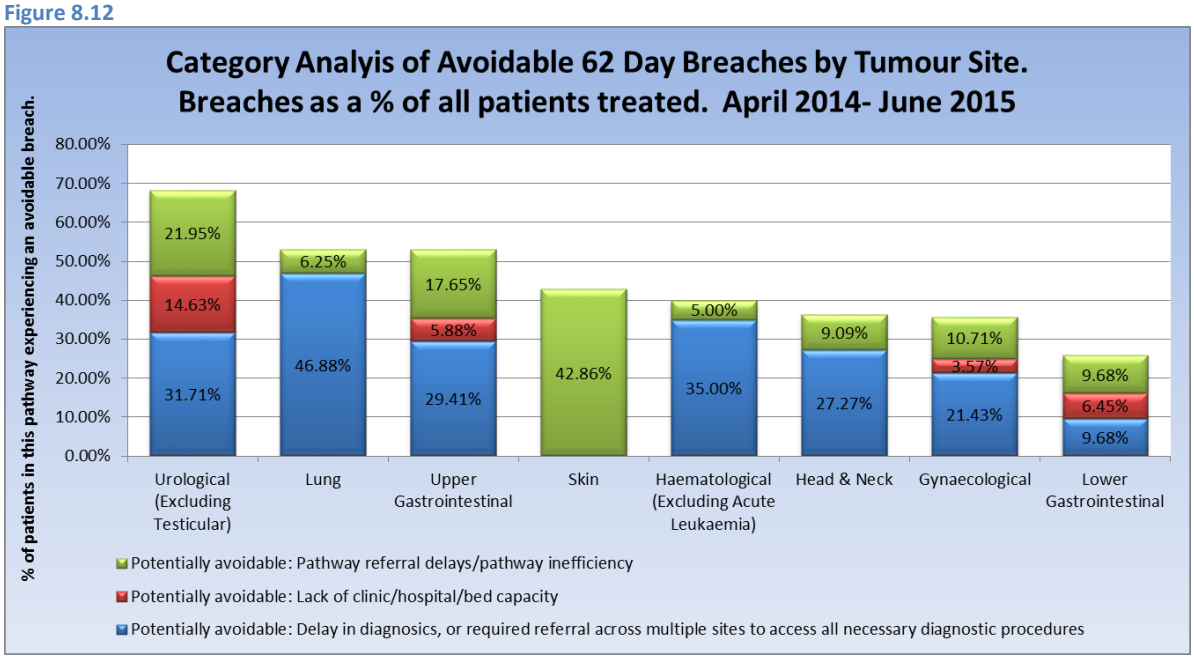
Figure 8.11



The tumour pathways with the greatest number of potentially avoidable 62 day standard breaches were Urological, lung, skin gynaecological, gastrointestinal, haematological and head and neck. Concentrating efforts on reducing avoidable breaches on these pathways in the order shown in figure Y will have the greatest impact on the CCG's 62 day cancer target.

Figure 8.12 shows the percentage of patients by tumour pathway experiencing an avoidable 62 day breach.

Figure 8.12



Patients are treated for Urological cancers, lung, upper gastrointestinal, skin, and haematological cancer are at greatest individual risk of experiencing a 62 day breach, with over 40% of patients in these four pathways failing to complete treatment within 62 days due to potentially avoidable reasons on the part of the NHS. Figure Z therefore gives an assessment of the *quality* of individual pathways against the 62 day standard. Over half of all patients in the urological, lung and upper GI care pathways failed to receive cancer care that met the 62 day standard because of reasons that were potentially avoidable. Delays in diagnostics or requirement to refer across multiple sites in order to access sufficient diagnostics was by far the most common reason, although the category 'pathway referral delays/inefficiency' may well also relate to reasons of diagnostics access which were not made clear on the breach report. This level of delay is unacceptable in terms of clinical quality for the population of Thurrock and warrants further investigation and action.

It is worth noting that the Urological pathway features as the poorest performing both in terms of absolute numbers of patients waiting more than 62 days, and the risk to an individual cancer patient of waiting more than 62 days for treatment. This pathway warrants immediate further investigation.

Considering figures 8.11 and 8.12 together, delays in diagnostics in the head and neck, lung, haematological, gynaecological and upper GI warrant immediate further investigation, as do referral protocols and pathway efficiency in the upper GI, lung and skin cancer pathways.

8.3.5 Patient Flows within and between Provider Trusts

The provider to whom the patient is first seen by is not necessarily the same one providing diagnosis or treatment for cancer. All of Thurrock patients with cancer between April 2014 and June 2015 were first seen by either Basildon and Thurrock University Hospital Trust or Southend University Hospital Trust. First treatment was then either provided by these two Trusts or a referral made for the patient receive first treatment at a different trust. In total, there were 14 different combinations of 'first seen' and 'first treatment' NHS provider trusts. The numbers of Thurrock patients in each combination together with the

numbers who had to wait over 62 days and hence the performance of the combination against the 62 day cancer standard is explored in table 2

Table 2

First Seen' Provider	First Treatment Provider	Number of patients	Total over target	Performance against 62 day cancer standard
SUHT	SUHT	22	0	100.00%
SUHT	Mid Essex Hospital Services Trust	4	0	100.00%
BTUH	University College London	2	0	100.00%
BTUH	BTUH	548	102	81.39%
BTUH	Guys and St.Thomas'	4	2	50.00%
BTUH	SUHT	181	97	46.41%
BTUH	Mid Essex Hospital Services Trust	32	22	31.25%
BTUH	BHRT	6	6	0.00%
BTUH	Cambridge University Hospitals Trust	6	6	0.00%
BTUH	Royal Marsden	4	4	0.00%
BTUH	Kings College Hospital	2	2	0.00%
BTUH	Royal Brompton and Harefield	2	2	0.00%
BTUH	North West London	2	2	0.00%
BTUH	Barts Health	2	2	0.00%

All patients who were first seen by Southend University Hospital Trust (SUHT) were treated within the 62 day cancer standard, although the absolute numbers of patients was small.

For patients seen at BTUH, 81.39% were treated within the 62 day cancer standard if their first treatment was also provided by BTUH. Where the system appeared to fail is where patients first seen at BTUH were treated by another provider. Less than half of patients first seen at BTUH and first treated at SUHT were treated within the 62 day cancer standard. This figure deteriorated to 31.25% for patients first treated at Mid Essex and to 0% for all other providers.

This level of performance is clearly unacceptable and warrants immediate further investigation.

Figures 8.13,8.14 and 8.15 explore performance against the 62 day cancer standard of the three combinations of 'first seen' and 'first treatment' with the greatest number of patients; BTUH-BTUH, BTUH-SUHT and BTUH Mid-Essex for different tumour groups. Pathways relating to tumour groups towards the left hand side of the graph should be investigated first. Head and neck, gynaecological, gastrointestinal, skin, lung and urological are of particular concern.

Figure 8.13

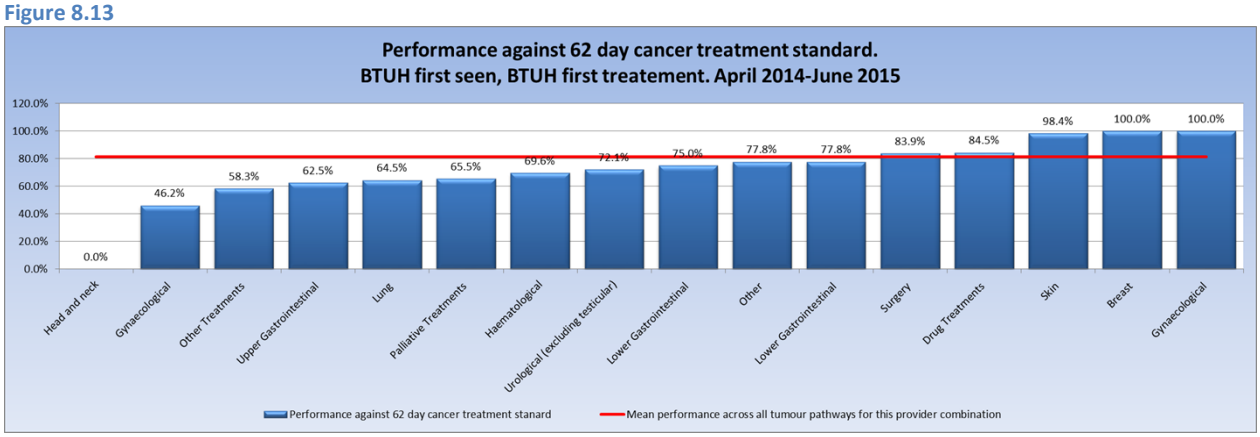


Figure 8.14

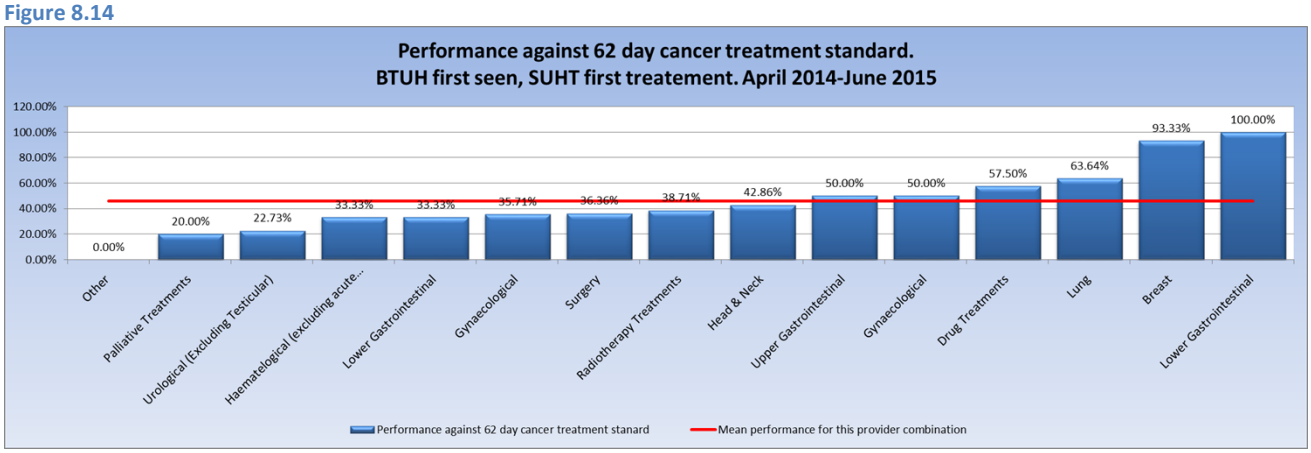
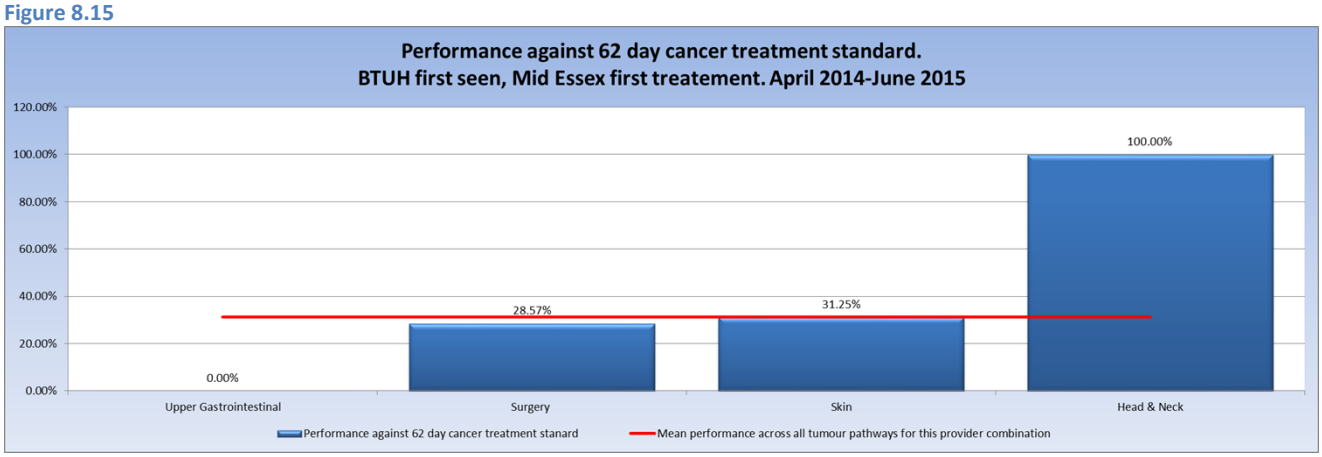


Figure 8.15



8.4 Summary: Cancer Diagnosis and Treatment

There is significant variation between different GP populations in terms of rate of unplanned care admissions for cancer with 12 practices having rates significantly below the England mean and two practices significantly above and a 20 fold difference between the practice population with the highest and lowest rate. Cancer unplanned care admission rates as strongly positively associated with income deprivation levels in the practice population although the reasons for this are unclear. Explanations could include a greater level of under doctoring in deprived communities, a lower cancer screening coverage or a greater unwillingness of deprived populations to seek help early for cancer symptoms.

The CCG performs in line with England and its comparator group CCGs on the 31 day wait performance cancer standard suggesting that once cancer is diagnosed, the vast majority of patients (97%) receive treatment within 31 days. Conversely only 68.4% of patients with cancer receive treatment within 62 days from their initial GP referral. This is the lowest percentage of patients when compared to Thurrock's comparator CCGs and significantly worse than the England mean of 84%. Furthermore the situation has deteriorated over the last 15 months. Considering these two metrics together suggests that there are serious and unacceptable delays occurring in the initial diagnosis of cancer. Delays in cancer treatment due to delays in diagnostics is likely to impact adversely on mortality rates of Thurrock patients and is unacceptable. This warrants further urgent investigation.

Detailed category analysis on 62 day breach reports undertaken by the author between April 2014 and June 2015 suggests that 78% of all 62 day cancer wait breaches are potentially avoidable. The most common two reasons were either entirely or partly a function of the fragmentation of cancer pathways between multiple hospital sites across Essex. The most common reason was delays in access to diagnostics. This occurred either at one site or often because referral of patients between different sites was required in order to access to all diagnostic equipment in order to obtain an adequate diagnosis to begin treatment. This accounted for almost half of all breaches. Where specified, delays for MRI and CT scans and for TRUS featured commonly in breach reports categorised into this sub-category.

A theme running through many of the reports for breaches categorised as 'avoidable' was a lack of coordination of care of the patient. The care pathway operates as a series of linked individual processes with staff only taking responsibility for their part of the pathway or process. As soon as one part of the pathway failed, the entire pathway failed and the delay occurred. Patients often appeared to be 'bounced' around different providers and different parts of the NHS system with no one individual taking responsibility for their journey through the pathway.

The Urological, lung, and upper gastrointestinal pathways give cause for significant concern with over 50% of patients entering these pathways failing to receive treatment for cancer within the 62 day standard because of reasons that were potentially avoidable. 47% of patients with lung cancer experienced a delay in diagnostics in the first quarter of 2014/15.

8.6 Recommendations: Cancer Diagnosis and Treatment

1) The current configuration of cancer pathways is fragmented across multiple hospital sites. NHS England should work with CCGs across Essex to rationalise cancer diagnosis and treatment into fewer specialist centres

2) No one professional is accountable for a patient's journey through the system. The CCG should commission a 'care coordination' approach to cancer care with a single named accountable professional being responsible for monitoring a patient's journey and ensuring each part of the system works in a coordinated and high quality care

3) Delays in diagnostics in some tumour specific pathways is the primary reason for failure to meet the 62 day cancer waiting standard. The current level of delay for some types of cancer is unacceptable and may be unnecessarily compromising the efficacy of future treatment and causing distress to patients. The CCG, in association with the relevant providers should urgently review the following care pathways with a view to

addressing delays in diagnostics: Urological, lung, upper and lower GI, haematological, head and neck, and gynaecological.

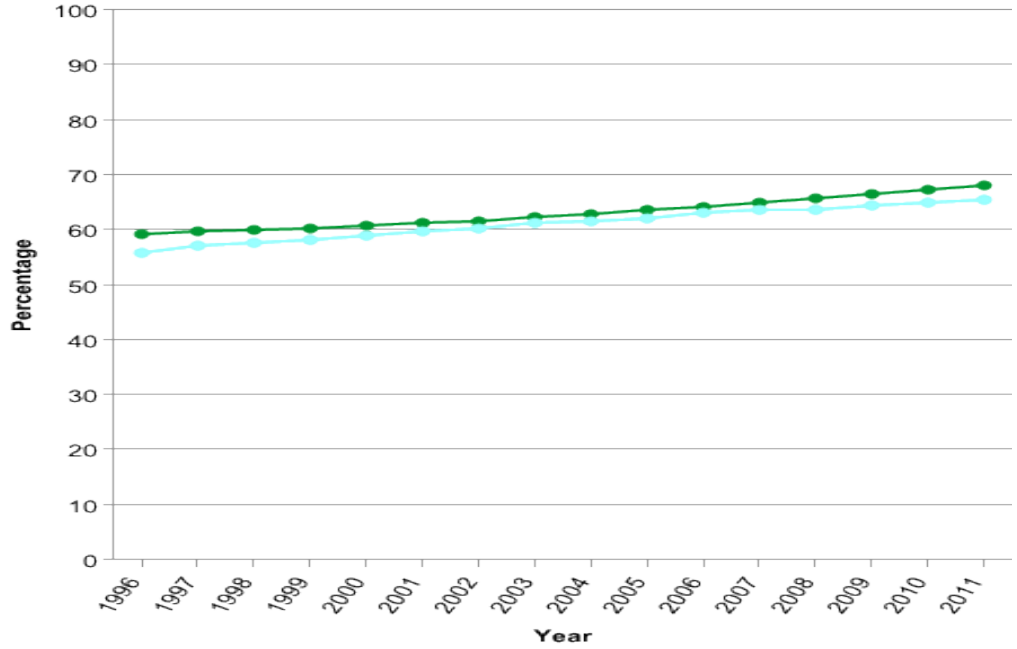
9. CANCER SURVIVAL

9.1 One year cancer survival rates

Figure A shows the one-year net survival index for all cancers for Thurrock and England over time. This is the percentage of patients with cancer, still alive one year after diagnosis.

Figure 9.1

One-year net cancer survival index, all cancers



Cancer one-year survival rates for both Thurrock and England have increased at largely the same yearly rate and by around 10% between 1996 and 2011, with Thurrock's one-year survival rate remaining slightly below that of England's.

Figures 9.2-9.4 show one year survival rate for the three most common cancers in Thurrock and in Thurrock CCG's ONS comparator group of CCGs over time. These are CCGs serving populations with demographics most similar to our own.

Figure 9.2

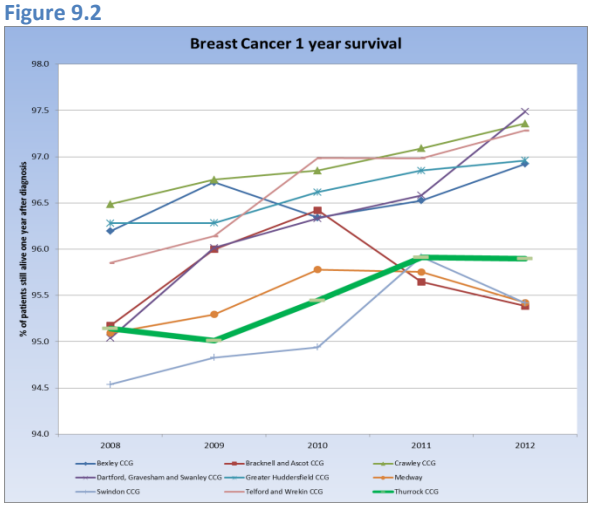


Figure 9.3

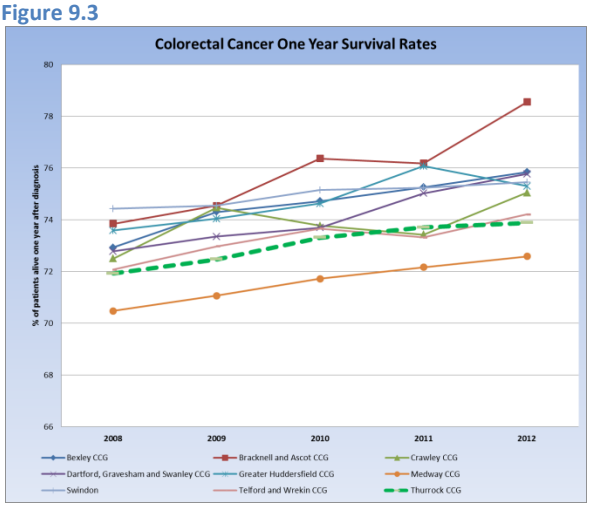
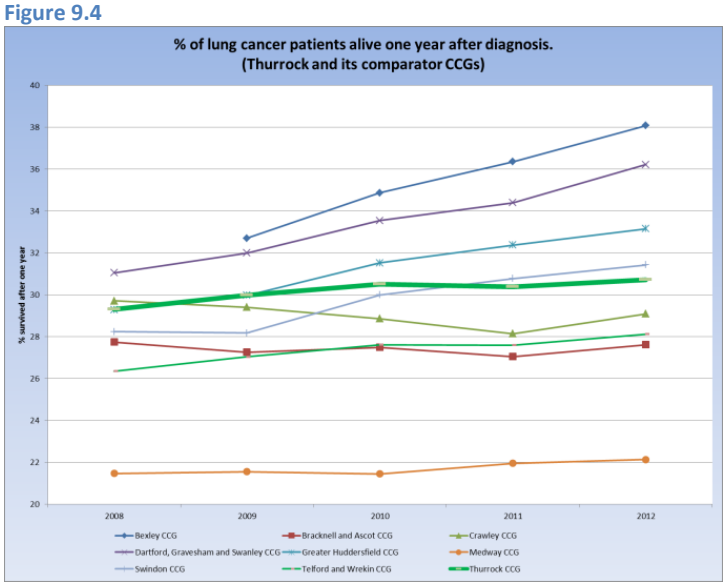


Figure 9.4



Whilst improving, one-year survival rates for both breast and colorectal cancer in Thurrock are amongst the lowest amongst in our ONS comparator group of CCGs. One year lung cancer one-year survival rates are around median compared to our ONS CCG comparator group, although are not improving at the same rate as other CCGs.

Our performance in terms of cancer survival rates are highly likely to be a product of all of the issues examined in the previous sections of this report.

9.2 Cancer five year survival rates

Figures 9.5, 9.6 and 9.7 show five year cancer survival rates for breast, lung and lower GI cancer respectively for Thurrock (SW Essex PCT) and England.

Figure 9.5

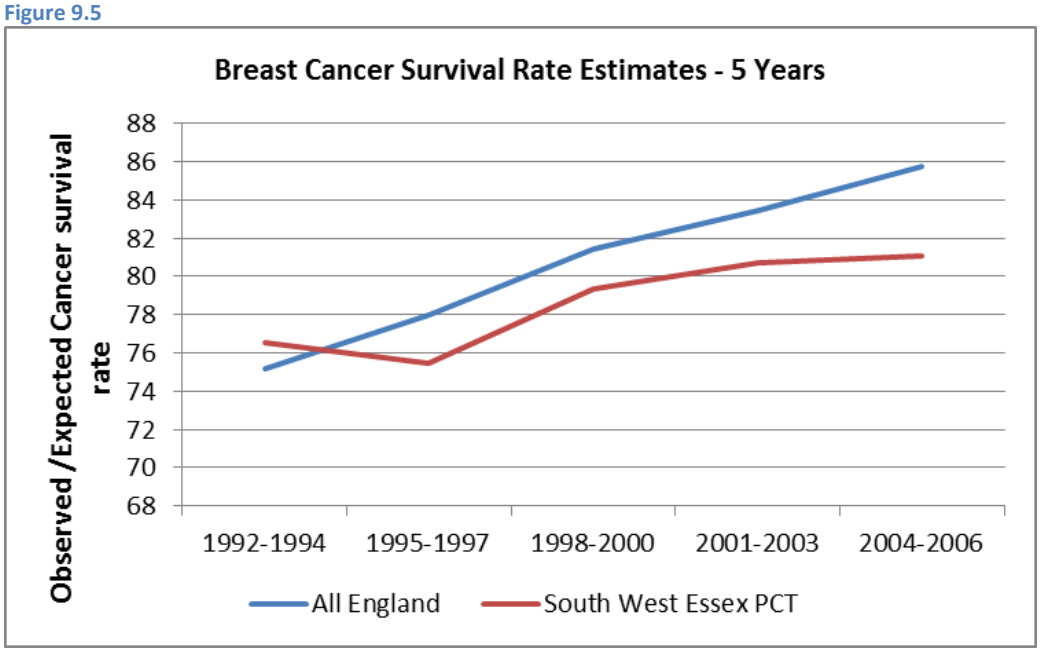


Figure 9.6

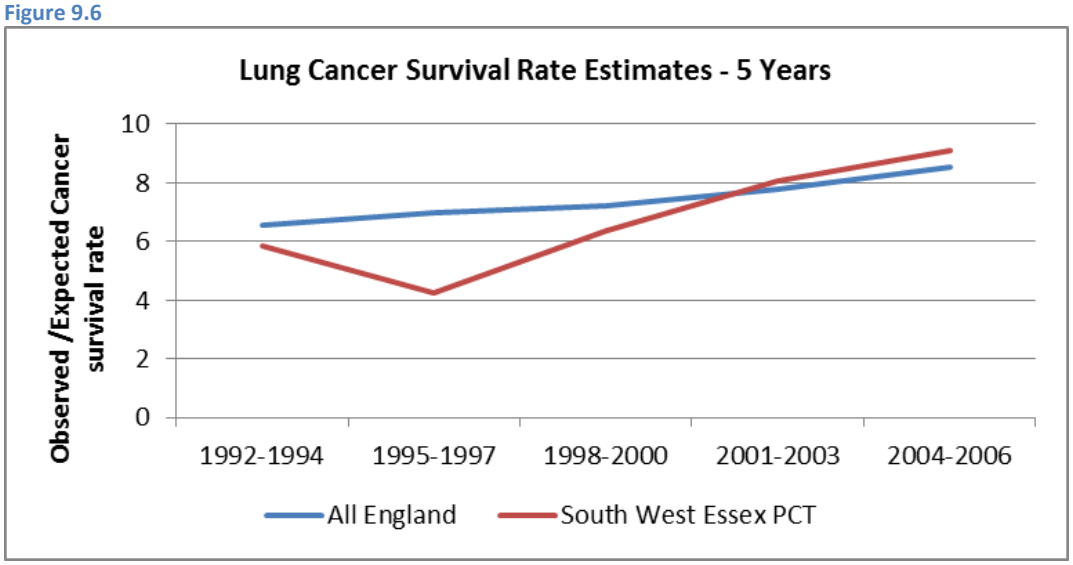
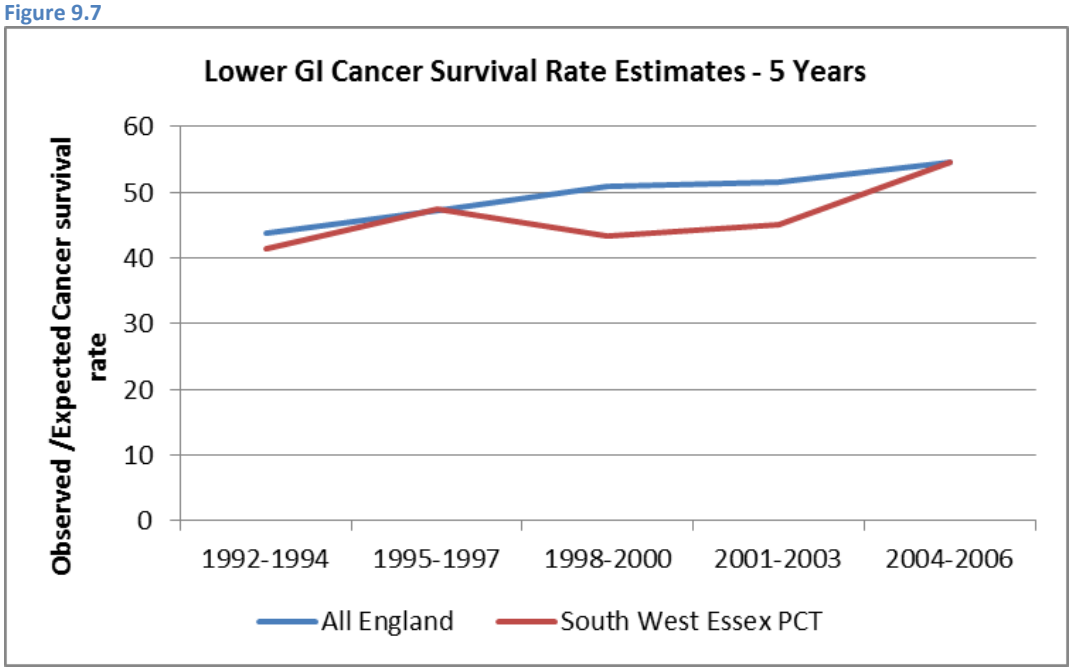


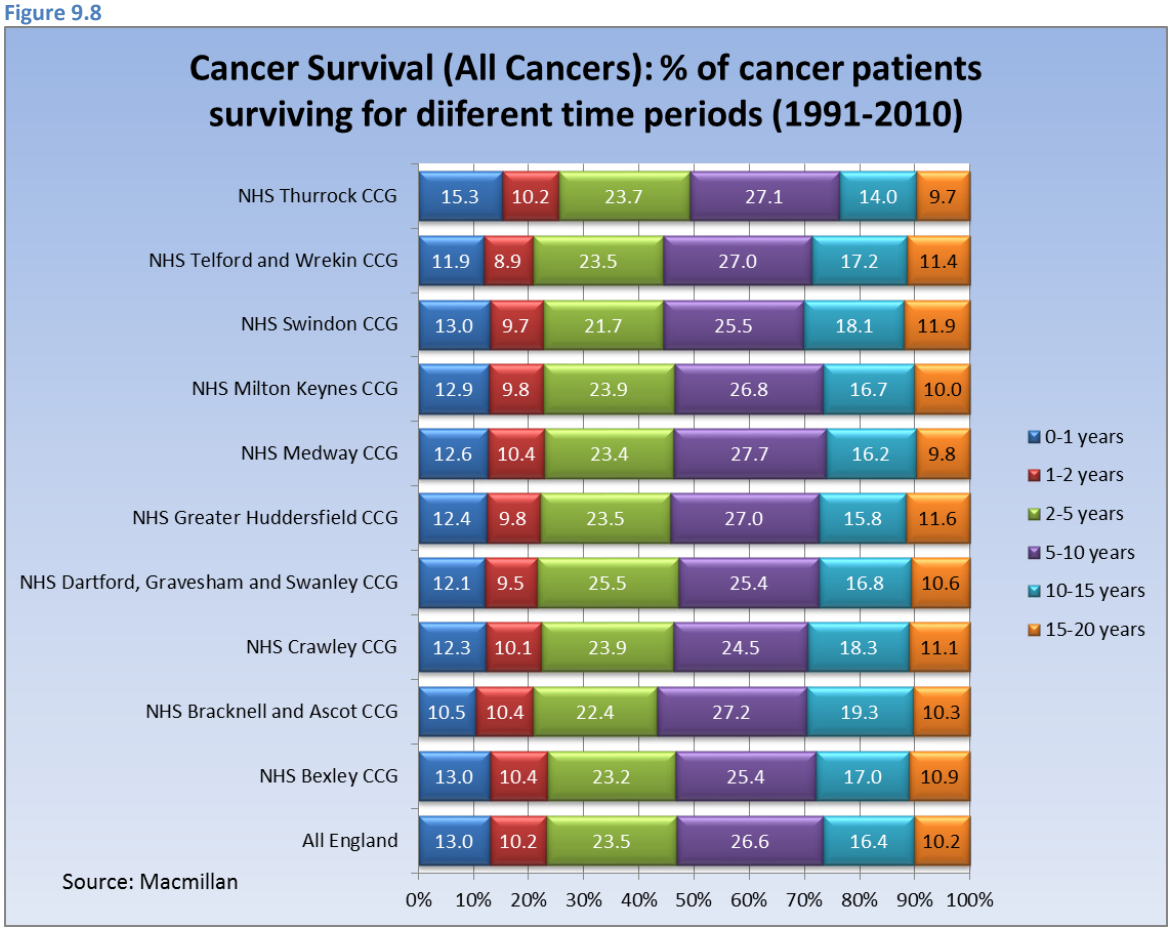
Figure 9.7



Figures 9.5-9.7 show five year lower GI and lung cancer to be largely in line with England's, with survival rates for breast cancer survival being below England's. However it should be noted that these data are almost ten years out of date now.

Figure 9.8 shows the length of time that patients survive cancer (for all cancers) in Thurrock, England and our ONS comparator CCG populations from 1991 to 2010.

Figure 9.8



Over the last 20 years, patients diagnosed with in Thurrock have generally survived for shorted periods of time than England and many of our comparator CCGs. 15.3% of patients diagnosed with cancer in Thurrock have survived no more than one year, compared with 13% in England. Conversely, after 15-20 years only 9.7% of patients with cancer in Thurrock have survived, compared to 10.2% for England and 11.9% for NHS Swindon. However, this will impart reflect historical factors that may have improved.

9.3 Cancer Survival Summary

Cancer one-year survival rates for both Thurrock and England have increased at largely the same yearly rate and by around 10% between 1996 and 2011, with Thurrock's one-year survival rate remaining slightly below that of England's.

Whilst improving, one-year survival rates for both breast and colorectal cancer in Thurrock are amongst the lowest amongst in our ONS comparator group of CCGs. One year lung cancer one-year survival rates are around median compared to our ONS CCG comparator group, although are not improving at the same rate as other CCGs.

Over the last 20 years, patients diagnosed with in Thurrock have generally survived for shorted periods of time than England and many of our comparator CCGs

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9 June 2016	ITEM: 8
Health & Wellbeing Overview and Scrutiny Committee	
Domiciliary Care	
Wards and communities affected: All	**Key Decision:** Non- Key
Report of: Catherine Wilson, Strategic Lead Commissioning and Procurement	
Accountable Head of Service: Les Billingham, Head of Adult Social Care	
Accountable Director: Roger Harris, Corporate director of Adults, Housing and Health	
This report is Public	

Executive Summary

The purpose of this report is to inform Health and Well Being Overview and Scrutiny Committee members about the current local and national domiciliary care situation and the effects that our current difficulties are having on service delivery in Thurrock. The report will outline the response made by the Council to fulfil the Local Authority's duty of care under the Care Act 2014 and its duty to prevent market failure by stabilising the market. The report will detail the reasons for a new direction of travel in developing a new service model to deliver support at home. A new approach will be an integral part of the second stage of Building Positive Futures which is our model for the transformation of adult social care. The second stage of this transformation is to ensure that people are enabled and supported to be Living Well in Thurrock and the support to individuals in their own homes and communities will be encompassed under a new model to be developed to ensure people are Living Well @Home. Services cannot remain as they are currently. The fragility of the market within domiciliary care means that services are of poor quality and lack capacity to meet growing demand

1. Recommendation(s)

Members are asked to:

1.1 Note the current situation as regards domiciliary care in Thurrock and the measures being taken by the Department to stabilise the situation;

1.2 Agree that a further report is brought back to Scrutiny Committee in September with a detailed proposal about how a new model of service will be developed when the contract finishes in 2017.

2. Introduction and Background

Domiciliary Care Market in Thurrock

2.1 Thurrock Council has experienced unprecedented challenges within the local domiciliary care market. In January 2015 it was evident that capacity within the commissioned domiciliary care providers was reducing - this was evidenced by an inability to transfer people's care from our in house Joint Reablement Team to any of our commissioned providers. This meant that the pressures on in-house services were increasing. The three contracted providers were, at that time, Manor Court Home Care (previously known as John Stanley), Sanctuary and Triangle. To support capacity the Council also had a number of spot purchase contracts with other providers - two of the most significant being Temp Exchange Limited and Professional Care. The challenge from the contracted providers was that the hourly rate of £13 was not sufficient to deliver the service. There are a number of concerns locally, replicated nationally, that are putting significant pressures on domiciliary care providers. These concerns are low wages, a perceived low status job and a lack of or little payment for mileage in between calls. The introduction of the National Living Wage in April of 2016 also led to significant cost pressures for local providers.

Locally the contract was let so that each successful agency could work in any part of Thurrock meaning a large area to cover which did not lend itself to getting to know the local community or to consistent responses from care workers. Most agencies run by not allowing travel time.

2.2 Concerns regarding the sustainability of domiciliary care were growing nationally through 2014, many local authorities pay hourly rates that providers think are unsustainable and this view was gaining momentum particularly through the UK Home Care Association. In a response to growing concerns Paul Burstow MP commissioned a report to examine the future of the homecare workforce. It was clear that there were national as well as local issues.

2.3 Thurrock Council began negotiations with providers to try and support the failing market, a proposal was made to offer what were termed resilience payments to each provider based on the number of hours delivered. In practical terms it would mean capacity could be added.

2.4 In August 2015 Sanctuary gave 6 months' notice to the Council, stating that the contract was no longer financially viable for them. Also at this time the Council was becoming increasingly concerned over the quality of some of the services on offer in particular from Temp Exchange. As a result the Council

imposed an embargo on Temp Exchange as a number of complaints had been received regarding quality of care delivered and a contract monitoring visit, by the Contract Compliance team had found a number of concerns over the quality of the service on offer. Thurrock Council reported its concerns to the Care Quality Commission (CQC). The subsequent CQC inspection resulted in the removal of Temp Exchanges registration as a domiciliary care provider from their Thurrock Office. 67 people were being supported by Temp Exchange which equated to 602 hours a week. After careful evaluation a decision was made to bring these hours back in house and add them to the Joint Reablement Team, it was also agreed that the care workers would be interviewed and placed on our bank of staff under variable hours contracts so that they could continue to work and add capacity to the Council service to deliver support.

2.5 It was therefore agreed to create Thurrock Care @Home as a new in-house provision to also encompass the Sanctuary hours which were 1018 a week supporting 129 service users and transfer the Temp Exchange hours of 602 a week to this service.

2.6 Having this new service managed by the Council has given us the ability to have more control. All of the issues, concerns and complaints have been acted upon and are being investigated. To support the safe delivery of the service and address the issues raised an independent consultant has been engaged to investigate all concerns and complaints. Thurrock Council is clear that poor quality is not acceptable and must be addressed. The safeguarding issues are undergoing separate safeguarding investigations.

2.7 To achieve this transfer and create the new service, has placed considerable pressures on Council staff all of whom have worked extremely hard over and above their contracted hours to ensure the service can be delivered.

3. Issues, Options and Analysis of Options

Thurrock Position and the National Picture

3.1 To inform our strategic commissioning approach it is important to understand the Thurrock position regarding domiciliary support and other services that support people to live at home. The adult social care budget is £47 million and of that £8 million + is currently spent on supporting people at home; this includes the in-house provision, commissioned domiciliary services and other services such as meals on wheels, equipment and assistive technology. In total 6,488 hours of domiciliary support are delivered a week which is 337,376 a year. It is vital that we start to look at a new direction of travel for the provision of these services.

3.2 As is evident domiciliary care providers nationally are in a state of crisis and realise through both the outcomes of the UK Homecare Association Report: The Homecare Deficit (March 2015) and the findings of the Burstow Commission Report: Key to Care (December 2014), that change is required. Recognising the current limitations that fundamental change is so difficult

when providers are in a cycle of trying to provide a service with the challenges of capacity, ability to recruit and retain staff, concerns about funding levels and working in Thurrock to a contract that we all recognise is not now fit for purpose we want to work with providers

3.3 Members will be aware that Adult Social Care produced its Market Position Statement (MPS) in 2015, a requirement of the Care Act 2014 to support market development and sustainability. As Members will also be aware the current health and social care economy is under severe strain - all areas of health and social care are facing unparalleled challenges e.g. there has been considerable media attention regarding the Essex Success Regime which is meant to tackle the significant financial overspend in the health economy across Essex. Other areas of social care are no different and combined with concerns over quality and viability, this is why we have to change the way we commission domiciliary care. The current model based on task and time with a framework agreement across the Borough is no longer fit for purpose.

3.4 As the MPS states Thurrock will see a significant increase in its older population, by 2022 there will be an 18% increase in people aged between 50 and 64 and a 26% increase in those aged 75 to 84. Demand will increase in real terms and the budget reductions Adult Social Care face will also increase meaning that from 2017 to 2020 we could be asked to find a further £6.5 million saving. To achieve any part of that saving there is no standstill position which is why we began the Transforming Adult Social Care agenda through Building Positive Futures. This has involved the development of a strength based approach to supporting service users and their carers. The developments have been really positive:

- Local Area Co-ordination: rather than providing a formal social care or health service the approach is to ask people "what would make a good life for you?", and help them find how best to lead that life in their local community.
- Stronger Together is a partnership that promotes local community activities that strengthen the connections between people. Stronger Together also encourages local people to have a greater say in what happens in their neighbourhood and to take control over where they live and the decisions that affect them.
- Homes and communities to support health and well-being this includes the development of specialised housing for older adults and for young people with autism spectrum disorders and learning disabilities who may need specially designed homes
- Integrated health and care services builds on the success of our Rapid Response and Assessment Team and Joint Re-ablement Team to provide a Single Point of Access to all health and care services.

3.5 The next phase of Transforming Adult Social Care is to ensure that people are further supported to Live Well in Thurrock in their local communities and a key part of this approach will be Living Well @Home. We have examined

approaches taken by other Local Authorities in particular, Suffolk, Wiltshire, Torbay and Calderdale we have spoken with their commissioning and operational teams and have been sent specifications, presentations and learning from the processes undertaken. They have all decided to take a smaller locality focus for delivery of domiciliary support, which is outcome focussed, they have all advised a staged approach to changing models of delivery to support communities individuals and providers the opportunity to work through the concept of change. At the centre of each service redesign was the fundamental question: what do people who require support really want. Each local authority has taken a differing view of what to include in a new service redesign. One has taken an integrated approach with Health, another has included equipment and assistive technology and another has taken the approach of using Individual Service Funds (which is where the provider holds the clients personal budget on account and they can draw it down when they want to) to support people to be in control of their own support without using direct payments.

3.6 An international view of change has also been reviewed; an approach in the Netherlands called the Buurtzorg Approach: Humanity over Bureaucracy. Again this focussed on simplifying the system and taking a much more locally based response, the founder of this approach Jos De Blok stated:

3.6.1 "We started working with different Countries and discovered that the problems are the same, the message every time is to start again from the *person's* perspective and to simplify the systems." (Journal of Research in Nursing 2015)

South Ockendon Pilot

3.7 To support the development of our redesign we have decided to implement a pilot in partnership with the community, the voluntary sector, health and housing to start again and look at new ways of working, this will be a pilot of the development of a redesigned model of support. The focus will be on a specific area of South Ockendon, with 75 people who receive some form of care and support, mainly domiciliary support, meals on wheels and equipment. Mapping of community assets will take place and a Good Neighbour Day is being organised to bring together the community and find out what skills people can offer. In offering domiciliary support we will start with each person and create a plan that will support them to have the outcomes they have met through a combination of approaches that best meet their needs. The vision is to have a local response that will be consistent and will connect the person to their local community. The first planning meeting has been held and the pilot will be documented and evaluated to inform the redesign of current approaches.

4. Reasons for Recommendation

4.1 To ensure that Health and Well Being Overview and Scrutiny Committee Members are fully aware of the current domiciliary care crisis both locally and

nationally and of the measures being taken by the Department to stabilise the local situation.

4.2 To ensure that Members are aware that the current service model is being redesigned and the options for future service delivery will be brought back to Health and Well Being Overview and Scrutiny Committee in September 2016

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 We have held two soft market testing days to discuss the current situation and how this could be changed with a different way of working. Providers and partner agencies have been very receptive to the idea of change and recognise that working in the current silos cannot be sustained.

5.2 We have also held an engagement day with adult social care operational staff and partners from health and across the Council. This again was very successful and again it was recognised that services as they currently are delivered for domiciliary care are not sustainable.

5.3 Both of these events illustrated one fundamental premise to any service is that it focusses on the person and the outcomes they want.

5.4 We have with the support of our Engagement Group designed an engagement approach to be undertaken with people who currently use services this will be very comprehensive and will enable us to include what is important for people who receive domiciliary care. Anecdotally and through the current issues raised through complaints it is that care and support are consistent, of high quality, does what they need and reduces isolation and loneliness, there will be a great deal to add to this as the engagement proceeds.

6. Impact on corporate policies, priorities, performance and community impact

6.1 Not applicable

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care & Commissioning

There are significant pressures facing Adult's Social Care. The 2016-17 budgets already reflect the Thurrock Care @ Home function being carried out in-house and increase in NLW. More long-term financial implications of further

transformation within the service will be provided within the update report in September.

7.2 **Legal**

Implications verified by: **Paul O'Reilly**

Projects Lawyer, Law & Governance

The Legal Services Officer has discussed the issues and potential service model options with the authors of the report and the Living Well team and can advise that all options are feasible and achievable under legal and procurement procedures and good practice. Legal Services will support the Living Well team throughout the pilot stage and the further procurement exercise as required to ensure the success of the project and reduction of risk to the Council.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

Community support provided through domiciliary care enables some of our borough's most vulnerable residents to remain independent, including older people, and people with disabilities. As highlighted by the pilot planned for Living Well at Home, it is essential that the voice of the resident drives the principles for how we transform the service in the future. A review will aim to improve efficiency whilst ensuring that the new offer remains person centred.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

Not applicable

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- None

9. Appendices to the report

- None

Report Author:

Catherine Wilson
Strategic Lead Commissioning and Procurement
Adults, Housing and Health

Mid and South Essex
Success Regime

Mid and South Essex Success Regime

A programme to sustain services and improve care

Progress update

Update no.3 – 12 May 2016

What's in this briefing

- Quick recap
- Progress update
- Workstreams in progress
- Next steps and milestones
- How to have your say
- Further information

Quick recap

The Success Regime brings national support to those areas in the country where there are deep-rooted, systemic pressures. Building on transformation that is already happening, it offers management support, financial support and a programme discipline to speed up the pace of change.

The Success Regime in mid and south Essex gives us the opportunity to realise the full potential of our workforce and provide the best of modern healthcare for local people.

Area and services involved

Service providers
Basildon and Thurrock University Hospitals NHS Foundation Trust
East of England Ambulance Service NHS Trust
Mid Essex Hospital Services NHS Trust
NELFT NHS Foundation Trust
North Essex Partnership University NHS Foundation Trust
Provide
Southend University Hospital NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust

Clinical commissioning groups (CCGs)
Basildon and Brentwood
Castle Point and Rochford
Mid Essex
Southend
Thurrock

Local authorities:
Essex County Council
Southend-on-sea Borough Council
Thurrock Council

All health and social care services are involved in the programme, including some 183 GP practices, community services, mental health and social care and hospital services.

Six areas for change

1. **Address clinical and financial sustainability of local hospitals by:**
    - Increasing collaboration and service redesign across three sites
    - Sharing back office and clinical support services.

2. **Accelerate plans for changes in urgent and emergency care, in line with national recommendations e.g.:**
    - Doing more to help people avoid problems and get the right help
    - Developing same day services and urgent care in communities, to reduce unnecessary visits and admissions to hospital
    - Designating hospital sites for specialist emergency care.

3. **Join up community-based services** – GPs, primary, community, mental health and social care – around defined localities or hubs.

4. **Simplify commissioning**, reduce workload and bureaucracy e.g.:
    - Reduce the number of contracts from around 300 to around 50
    - Commission services on a wider scale e.g. with one lead provider where several may be involved
    - Agree a consistent and common offer to focus on priorities and identify limits of NHS funding.

5. **Develop a flexible workforce** that can work across organisations and geographical boundaries.

6. **Improve information, IT and shared access to care records**.

Why we are doing this

We need to keep up with the pace of change and demands on health and care so that we can do more for people now and in the future. If we took no action, the current NHS deficit in mid and south Essex could rise to over £216 million by 2018/19, and we would not be able to meet year on year growing demands.

Our aim is to get the system back into balance by 2018/19 and deliver the best joined up and personalised care for patients. The kinds of changes we are looking to make have major benefits for patients, such as:

- More emphasis on helping people to stay well and tackling problems at an earlier stage to avoid crises.
- Joined up health and care services to provide more care for people at home and in the community, avoiding the need for a visit to hospital.
- New technologies and treatments to do more for people without the need to be in hospital, even in a crisis.
- When people do need the specialist care that only a hospital can provide, collaboration between hospitals and other services will ensure the best possible clinical staff and facilities.
- By redesigning some hospital services, the improvements in staffing levels and capability will mean safer, more effective, more compassionate care for patients.

Progress update

- An overall plan to develop options for change was published on 1 March. For further information, please visit: http://castlepointandrochfordccg.nhs.uk/success-regime
- The three acute hospitals have agreed arrangements in principle for working as a group with a joint committee to oversee collaboration. The joint committee arrangements are due for approval by Trust boards in May.

  Clare Panniker is lead chief executive for the committee. Clare is chief executive of Basildon and Thurrock University Hospitals NHS Foundation Trust and interim chief executive of Mid Essex Hospital Services NHS Trust. Professor Sheila Salmon, chair of Mid Essex Hospital Services NHS Trust, is the joint committee chair. Alan Tobias, chair of Southend University Hospital NHS Foundation Trust is vice-chair of the joint committee.
- The five CCGs are working on collaborative arrangements to be agreed over the summer to improve commissioning and reduce bureaucracy e.g. reducing the number of contracts for commissioning healthcare.
- Workstreams have been set up under the two broad headings of:
  - *Local Health and Care* – developing and integrating services in the community
  - *In Hospital* – involving further collaboration and service redesign between the three main hospitals in mid and south Essex.

  Other workstreams led by the Success Regime programme office include shared care records, communications and engagement and finance.

- Workstreams under Local Health and Care currently involve a range of clinicians and frontline staff from primary, community and social care, with plans to involve service users and voluntary and independent sector representatives.

- The In Hospital workstream currently has an acute leaders group of around 30 clinicians and service leaders. They have already held a listening event with service users and more will follow.

- Early discussions with stakeholders have so far involved, for example:

    - Healthwatch Essex, Thurrock and Southend
    - Lead officers and members of the three local authorities
    - Essex, Southend and Thurrock Health and Wellbeing Boards
    - Essex and Southend local authority scrutiny committees
    - Local MPs
    - CCG governing bodies and primary care practice members
    - Staff in CCGs and acute trusts

    The three Healthwatch bodies and Essex Health Overview and Scrutiny Committee organised an all-day conference on 18 April for patient experience and service user representatives. Involving around 70 people, the delegates discussed ways in which service users could be involved.

    In Your Shoes, a listening event took place on 28 April with around 30 clinicians and 30 service users. The event invited people to talk about their experiences in emergency care, what matters to them and how they would like to see improvements. Among various themes, the overall top priority for improving urgent and emergency care was considered by those who attended to be “access to GPs and prevention”.

Workstreams in progress

The following workstreams have been set up to tackle the priorities identified by the Success Regime diagnostic review, which took place towards the end of last year. Other workstreams will be added to the programme over the next year.

Local Health and Care – current workstreams

Frailty and End of Life care

- Initial focus is on the over 75 age group, but the work will expand at a later date to include care for adults of all ages with complex long term conditions
- The work is looking at:
    - Care at the interface between community and hospital, including the development of frailty assessment units
    - Identifying people at risk and systems to manage care around individuals
    - Proactive health and care, such as health and social care planning, falls prevention and support to care homes.

Workstream leads – Bryan Spencer, Jane Hanvey

Communications and engagement leads – Rachel Harkes (Frailty) rachelharkes@nhs.net and Romina Bartholomeusz (End of Life) romina.bartholomeusz@nhs.net
For further information contact rachelharkes@nhs.net

Redesign of Pain services and Dermatology

- Looking at options for shifting outpatient services from acute hospital settings to community services
- Pain and Dermatology have been identified by clinical leaders as areas that need to shift in line with clinical good practice and opportunities for improving patient outcomes
- Other potential services for similar moves will follow

Workstream leads – Dan Doherty, Ravi Suchak (Dermatology), Simon Thomson (Pain services)
Communications and engagement leads – Claire Hankey (Pain services) claire.hankey@southend.nhs.uk , Victoria Parker (Dermatology) Victoria.parker@meht.nhs.uk
For further information contact claire.hankey@southend.nhs.uk

"Common offer"

- Reviewing current commissioning policies and thresholds to improve consistency across mid and south Essex.

Workstream lead – Dan Doherty
Communications and engagement lead – Paul Ilett paulilett@nhs.net
For further information contact danieldoherty@nhs.net

Primary and community care

- Building on developments that are already taking place within the five CCG areas to join up primary, community and social care around GP practices.
- Looking at the benefits of groups of practices working together in localities.

Workstream lead – Ian Stidston
Communications and engagement lead – Claire Routh crouth@nhs.net
For further information contact Claire Routh crouth@nhs.net

In Hospital – current workstreams

Clinical services

Hospital clinicians from a range of professions and specialties are gathering evidence and service user insight to develop options for some services to work as single services across the three hospitals.

Broad principles for this work:

- Start from a service user perspective
- Avoid moving or replicating high fixed cost services: maintain some "givens"

- Ensure deliverability in 2-3 years: no major new builds, use of existing infrastructure
- Ensure clear rationale for any service redesign: if no clear rationale, then no change
- Design along pathways: move care between hospital and community, and increase integrated working
- Consider opportunities to incorporate technology and innovation

Criteria for service change:

- Better clinical outcomes: meet national recommendations and move towards best practice quality standards e.g. Royal Colleges
- Sustainable clinical workforce: move towards best practice workforce standards and improve training opportunities e.g. Royal Colleges
- Efficiency and productivity: deliver services at a lower cost, where possible
- Access: maintain appropriate access to services
- Interdependencies: maintain appropriate clinical adjacencies

Workstream leads – Ronan Fenton, Celia Skinner, Neil Rothnie
Communications and engagement lead – Wendy Smith wendy.smith60@nhs.net
For further information contact claire.hankey@southend.nhs.uk

Clinical support

- Building on current collaboration between the hospitals in terms of clinical support services
- Current scope includes Pharmacy, Radiology, Medical Physics, Pathology, Clinical Sterile Services

Workstream lead – Jon Findlay
Communications and engagement lead – Ian Lloyd ian.lloyd@btuh.nhs.uk
For further information contact Jon Findlay jon.findlay@southend.nhs.uk

Back office functions

- Looking at opportunities to share and standardise functions across the three hospitals
- Currently involves 11 sub-workstreams

Workstream lead – James O'Sullivan
Communications and engagement lead – Ian Lloyd ian.lloyd@btuh.nhs.uk
For further information contact ian.lloyd@btuh.nhs.uk

Next steps and milestones

May-Aug	Further detailed planning within workstreams, includes service user involvement
June/July	Wider patient, clinical and staff engagement
July	Update on options development and further engagement

Sep	Notification of details for consultation
Oct – Dec	Main consultation on proposed options for change
Jan 2017	Outcome of consultation
Feb	Discussions with HOSC and others prior to decision-making
March	Formal decisions for change
April and ongoing	Implementation

How to have your say

1. Send us your views in writing

   Please write to us at england.essexsuccessregime@nhs.net

2. Hold a discussion within your team, group or organisation

   Local trusts, CCGs and other organisations are arranging staff briefings. Check your staff news, talk to your line manager or contact your local Communications team.

3. Invite us to attend your meeting

   If you would like a representative to attend your meeting, please contact us on england.essexsuccessregime@nhs.net

Further information

http://castlepointandrochfordccg.nhs.uk/success-regime

If you would like further information, to arrange a meeting or you would like to send us your views, please write to us at england.essexsuccessregime@nhs.net

Key contact:
Wendy Smith, Interim Communications Lead

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Health Overview & Scrutiny Committee
Work Programme
2016/17

Dates of Meetings: 9 June 2016, 15 September 2016, 10 November 2016, 17 January 2017, 15 March 2017

Topic	Lead Officer	Requested by Officer/Member
9 June 2016		
Items raised by HealthWatch	Kim James	Kim James
PET CT Scanner	NHS England	Members
Public Health Grant	Ian Wake – Tim Elwell-Sutton	Officer
Thurrock Cancer Joint Strategy Assessment Needs	Ian Wake - Funmi Worrell	Officer
Success Regime	Andy Vowles, Project Director for ESR	Members
Domiciliary Care	Roger Harris / Catherine Wilson / Michelle Taylor	Members
15 September 2016		
Shaping the Council Budget Update - Change to the Fees and Charges	Sean Clark	
Items raised by HealthWatch	Kim James	
Regeneration, Air Quality and Health	Helen Horrocks	
Learning Disability Health Checks	Mandy Ansell	

Last Updated: April 2016

Integrated Healthy Living Centres	Ian Wake	
2016 Annual Public Health Report	Ian Wake	
2015/16 Complaints Summary	Ian Wake	
10 November 2016		
Shaping the Council Budget Update - Change to the Fees and Charges	Sean Clark	
Items raised by HealthWatch	Kim James	
Thurrock Joint Health and Wellbeing Strategy	Ceri Armstrong	
17 January 2017		
Shaping the Council Budget Update - Change to the Fees and Charges	Sean Clark	
Items raised by HealthWatch	Kim James	
15 March 2017		
Shaping the Council Budget Update - Change to the Fees and Charges	Sean Clark	
Items raised by HealthWatch	Kim James	