



Fylde Coast Strategy for Cancer 2016-2021



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Introduction

The Fylde Coast presents a varied and challenging demographic characterised by an ageing population and a higher than average burden of long term conditions with co-morbidities.

There are areas of extreme deprivation within the Fylde Coast, including the town of Blackpool, which has high levels of unemployment and transience whilst neighbouring Fylde Coast areas have a higher than average elderly population.

Life expectancy in some areas is markedly below the national and North West average with cancer as the second largest cause in reduction of life expectancy.

Approximately 1,000 people in Blackpool and 1030 people in Fylde & Wyre are diagnosed with cancer each year; approximately 500 Blackpool residents and 464 Fylde & Wyre residents die from the disease each year. Over the last 15 years there has been a steady increase in the incidence of cancer across all ages with the most common diagnoses in lung, breast, skin and bowel cancers across the Fylde Coast. With one in 3 diagnoses attributable to alcohol, smoking or obesity.

As diagnosis, treatment and advances in care improve survival rates, the number of people living with and beyond cancer increases. In Blackpool around 3,000 people are already living with a previous diagnosis of cancer.

As people are surviving and living with the consequences of cancer, there is a need to consider this condition as a long term condition. Living with other long-term conditions as well as cancer reduces people's chance of survival and increases their level of support needs.

Whilst outcomes are improving for Cancer, the Fylde Coast still has a number of significant challenges to improve consistency and outcomes for cancer patients and our vision over the next five years is to improve the outcomes for people effected by cancer and therefore the strategy aims to outline the changes required to make a demonstrable improvement in Cancer services, patient outcomes and experiences for the Fylde Coast over the next 5 years. The outcomes to be delivered from this framework are to:-

- Raising awareness of and improving earlier diagnosis to reduce the number of late presentations
- Promoting lifestyle changes to reduce cases of preventable cancers
- Improving survival rates, improve support services for those living with & beyond cancer
- Reducing variations in care between conditions
- Prompt treatment following diagnosis
- Implementing comprehensive holistic care and support for increasing numbers of

patients in recovery

- Improving patient experience of cancer services
- Providing the best possible quality of life, including end of life

Our objective is to work in collaboration with key partners to deliver integrated cancer services that are affordable, sustainable and effective. More specifically, working with partners to improve the 1 year and 5 year cancer survival rates, improve cancer waiting times (2 week, 31 days and 62 day waits), improve quality of life for the Fylde coast cancer patients, promote self-care and management of patients own care and identify and support the design and implementation of innovative cancer services

To drive forward the cancer agenda, 6 priority areas have been defined and include:-

1. Prevention (including awareness and early detection)
2. Investigation
3. Diagnosis
4. Treatment
5. Living With and Beyond Cancer
6. Palliative and End of Life Care (outlined in the Fylde Coast EOL Strategy 2016 - 2021)

A number of smaller work streams will underpin the delivery of the strategy, each with detailed action plans for delivery of elemental parts of the plan. Delivery against the aspirations of the plan will be monitored via the Cancer Steering Group for the Fylde Coast.

Summary

Challenges to Delivering Effective Cancer Care on the Fylde Coast

Deprivation

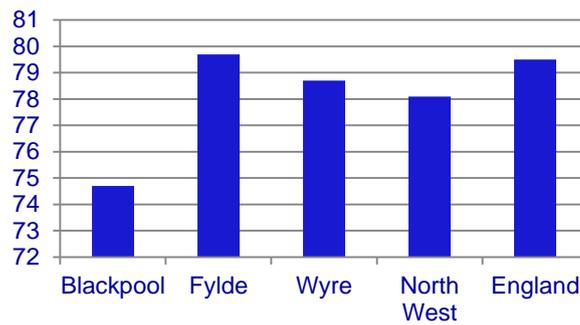
The Fylde Coast has considerable variations in levels of deprivation with some of the highest and lowest rankings in the country. Blackpool experiences considerable levels of disadvantage, and in 2013 ranked 4th most deprived of 354 local authorities in England. 46 out of 94 small areas within Blackpool are amongst the 20% most deprived in the country. There are no areas in Blackpool within the 20% most affluent in the country. Blackpool's relative position in the national deprivation rankings has worsened over the last 5 years from 12th most deprived in 2007 and 4th in 2013. Additionally, in the 2013 Indices, Blackpool ranked 1st for the concentration of deprivation.

Fylde and Wyre have a more varied picture with both having lower than average deprivation in general but with clusters of wards with high levels of deprivation, which are equally as high as Blackpool. In 2013 Fylde's ranking out of the 354 local authorities was 218th with Wyre's at 167th. An indication of the variation across the area is that Wyre local authority is ranked 61st for the concentration of deprivation whilst Fylde local authority is ranked 191st.

Life Expectancy Fylde Coast

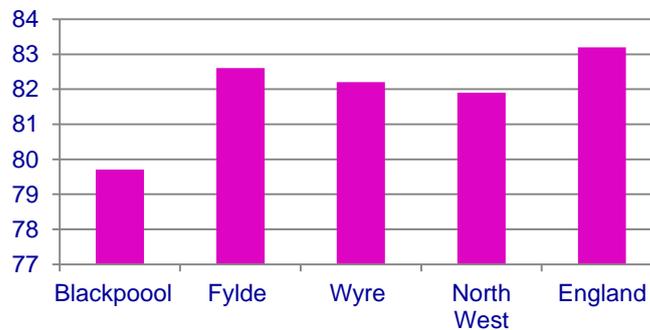
Life expectancy is one of the key indicators of health in a population; in the life expectancy for men in the 2012 – 2014 figures published by the Office for National Statistics¹ Blackpool, at 74.7 years and is the next to the lowest in England and the lowest in the North West. Whilst for Fylde male life expectancy is 79.7 years which is slightly higher than the national (79.5yrs) and Wyre at 78.7 years is still almost a year less than the national average.

Fylde Coast Male Life Expectancy 2012-14



Women can expect to live longer than men; however life expectancy for women in Blackpool is 79.6 yrs joint lowest in the North West and over 3 yrs less than the national average. Women in Fylde have a life expectancy of 82.6 yrs and women in Wyre have an expectancy of 81.9 yrs. All the figures for female life expectancy are below the national average of 83.2 years.

Fylde Coast Female Life Expectancy 2012 - 2014



Even within local areas there are considerable differences in life expectancy. In Blackpool men in the least deprived areas of the town can expect to live nearly 10 years longer than men in the most deprived areas. Similarly, for women this difference is eight and a half years. Not only do people in Blackpool live shorter lives, but also spend a smaller proportion of their lifespan in good health and without disability.

In Fylde and Wyre analysis of the latest ward level male life expectancy figures (2008-12)² indicates that within the Fylde & Wyre area the wards of Central, Jubilee Kirkham South, Mount, Pharos, Rossall and Warren all have life expectancies significantly below the England national average with five of the seven wards listed being in or around the Fleetwood area.

The female life expectancy figures indicate that once again the main areas of concern are around the Fleetwood area with the wards of Bourne, Jubilee, Kirkham South, Medlar-with-Wesham, Mount, Pharos, Rossall and Warren.

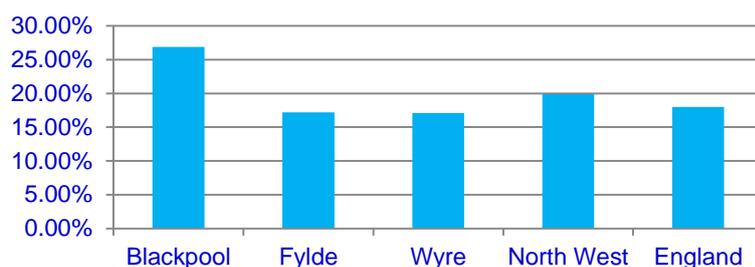
There is clear evidence that disadvantaged groups are more likely to have a cluster of unhealthy behaviours – smoking, drinking, low consumption of fruit and vegetables, low levels of physical activity. People in the most disadvantaged groups are significantly more likely to engage in all of these behaviours.

More than 4 in 10 cases of cancer are caused by aspects of our lifestyles which we have the ability to change. Tobacco remains the main risk factor, followed by obesity

1

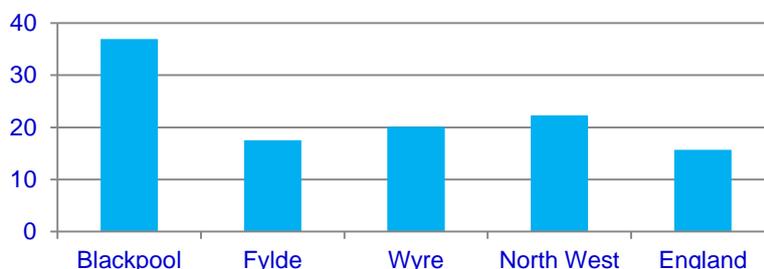
Smoking is the largest preventable cause of cancer, with an estimated 19% of cancer cases and more than a quarter of cancer deaths in the UK linked to exposure to tobacco smoke. Whilst Fylde and Wyre are just below the 18% national average Blackpool is almost 10% higher.

2014 Prevalence of smoking among persons 18yrs & over



Excessive alcohol consumption leads to around 12,800 UK cases of cancer each year and is linked to several different types of cancer. Alcohol consumption has increased dramatically over the last 50 years, with the Fylde Coast figures below reflecting this picture.

Under 75 mortality rate from Liver Disease considered preventable 2012 -14

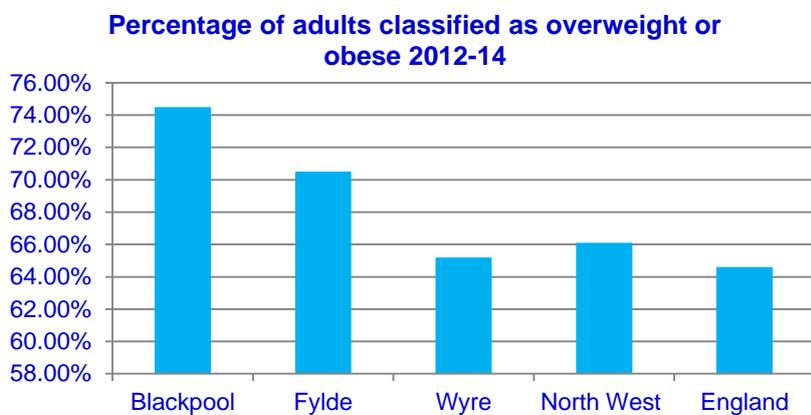


1. 1 Source; Figures calculated by ONS using ONS mortality data and mid-year population estimates 2012-14

2. Source: ONS ward level female life expectancy at birth 2008-2012

Obesity combined with low levels of activity and poor diet constitutes a critical challenge to the Health Economy. England is among the worst performers in obesity in Western Europe ³. The figure below demonstrates the position across the Fylde Coast communities in relation to the North West and national rates.

3.

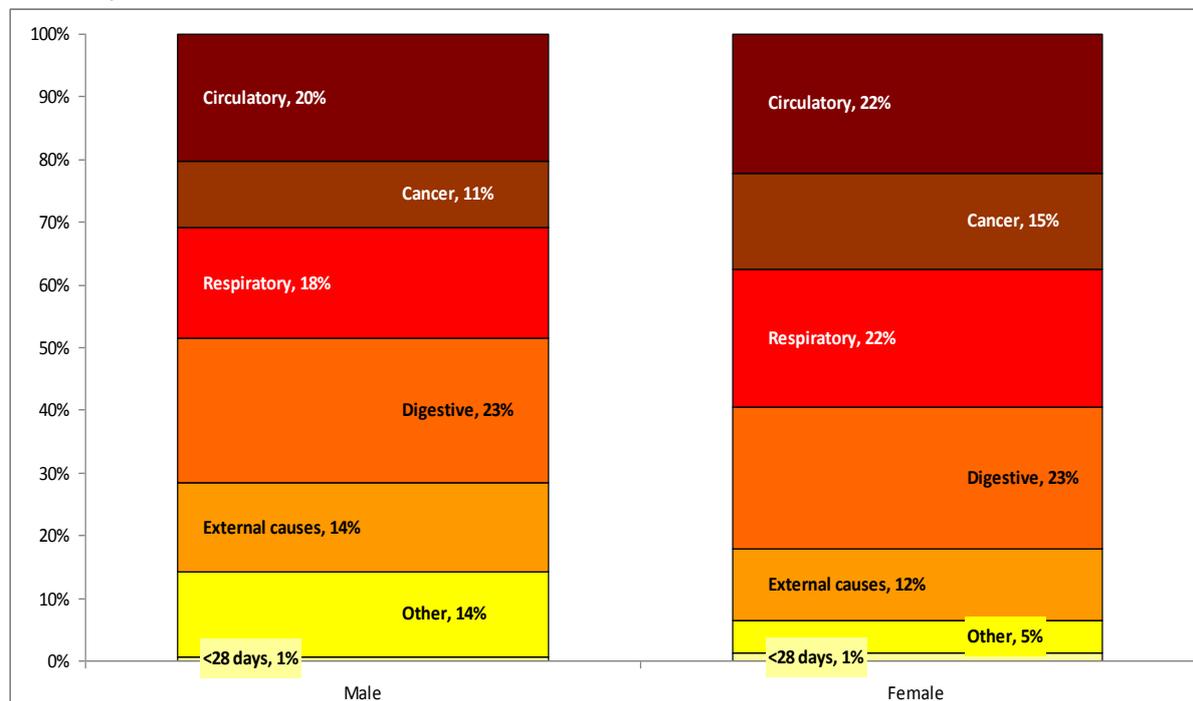


2

Causes of Deaths across Fylde Coast Health Economy

Blackpool

Between area inequalities: Life expectancy gap between Blackpool as a whole and England (Sarf chart showing the breakdown of the life expectancy gap between Blackpool as a whole and England as a whole, by broad cause of death, 2010-2012)⁴

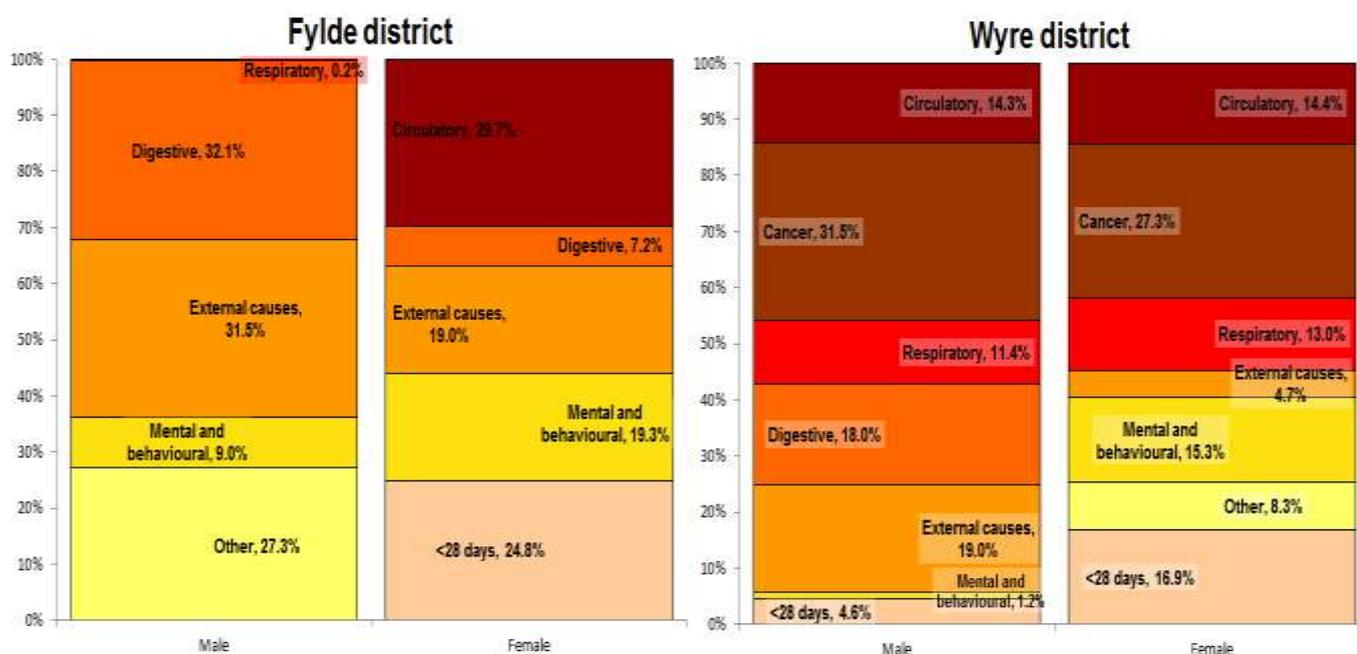


The key causes of shorter life expectancy in Blackpool are alcohol related diseases, circulatory disease, cancers (especially lung cancer), accidents and self-harm and respiratory diseases. Deaths in younger people contribute to a larger proportion of shorter life expectancy, as more years of life are lost. Over the last ten years death

3. *Achieving World-Class Cancer Outcomes A Strategy for England 2015-2020*

rates (for all ages and all causes) have fallen. Early deaths rates have also been falling for the two most common causes of death, circulatory disease and cancer which jointly make up almost 60% of all deaths. Although this is good news, death rates in Blackpool are higher than average and rates have not been falling as quickly as elsewhere.

Between area inequalities: Life expectancy gap between Fylde & Wyre as a whole and England (Scarf chart showing the breakdown of the life expectancy gap between Fylde & Wyre as a whole and England as a whole, by broad cause of death, 2010-2012)⁴



Fylde and Wyre

The data demonstrates that the key cause of shorter life expectancy in women in Fylde is circulatory disease whereas in Wyre it is cancer. Shorter life expectancy within the male population, again for the Fylde area, are digestive and external causes whereas in Wyre it is cancer. There is a marked difference between the cause of shorter life expectancy between men and women in Fylde yet in Wyre the percentage rates between men and women in relation to cancer, circulatory disease and respiratory disease are very similar.

4. Source: Public Health England: Segmenting Life Expectancy Gaps by Cause of Death

Part 1 Prevention, Early Detection and Diagnosis

Nationally more than 4 in 10 cases of cancer are caused by aspects of lifestyle that we have the ability to change. Tobacco remains the main risk factor, followed by obesity. We need to continue to raise awareness of the impact that risk factors have on health, especially in selected populations and support people to make changes. Efforts to tackle smoking rates should continue at pace, with the ultimate aim of reaching 5% in adults by 2035. Locally it should be decided through the Health and Wellbeing Boards which combination of initiatives across education, housing, planning and healthcare would deliver the most impact and which should be led through workplace health and wellbeing initiatives.

With increasing numbers of people surviving their primary cancer, there needs to be a stronger focus on preventing secondary cancers, with NHS providers ensuring that all patients treated for cancer are given advice, tailored to their individual circumstances on how to improve their lifestyle and should include healthy eating, weight control, physical activity levels, smoking cessation and alcohol consumption.

There is considerable variation in the uptake of screening programmes resulting in health inequalities. Screening uptake is often lower in BME communities and in communities of lower socio-economic status.

Prevention

Cancer Research UK has highlighted the role of lifestyles in cancer prevention and estimate that 4 in 10 UK cases of cancer could be prevented, largely through lifestyle changes of:



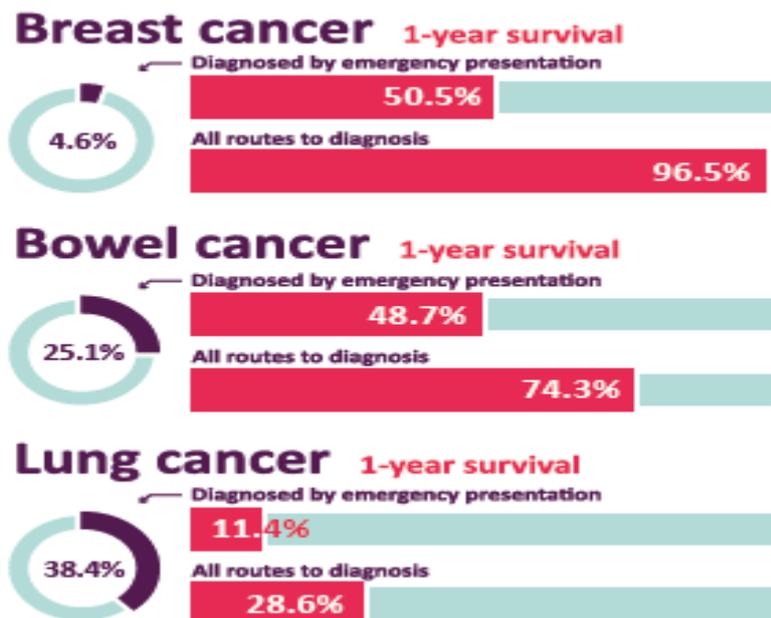
The people of Blackpool, Fylde & Wyre will be supported in making lifestyle changes, and making healthier choices will be promoted. This will be achieved through identifying and using as many opportunities as we can to promote healthier lifestyles and help people to make and sustain lifestyle changes, such as referral to stop smoking services, Health Care Professionals discussing lifestyle choices and risks with patients during NHS Health Checks, promoting physical activity and promoting healthy eating and other health campaigns.

Early Detection and Diagnosis

Diagnosing substantially more cancers earlier could be transformative in terms of improving survival, reducing mortality and improving quality of life. Earlier diagnosis makes it more likely that patients will receive treatments such as surgery, chemotherapy and radiotherapy which contribute to the majority of cases where cancer is cured.

Cancer Research UK has estimated that there would be a 0.5% increase in 10-year cancer survival for every 1% increase in the proportion of patients diagnosed at the earliest stages (1 or 2), for all cancers combined.

Cancer survival rates in England are worse than comparable countries and the gap in survival is not narrowing. There are many factors which influence a patient's chances of surviving cancer, not least the treatment they receive.



Even for those cancers where, overall, our stage distribution compares favourably internationally, there is still unacceptable variation within England and no doubt that diagnosis at an earlier stage is associated with better outcomes.

To improve our early detection rates, we need to ensure our population are aware of important symptoms which need urgent investigation to exclude cancer, are aware of national screening programmes to pick up asymptomatic disease, attend for screening, are able to get quick access to diagnostics and results, are referred on efficient pathways and have their cancer risks accurately assessed and are referred appropriately.

Increased Awareness

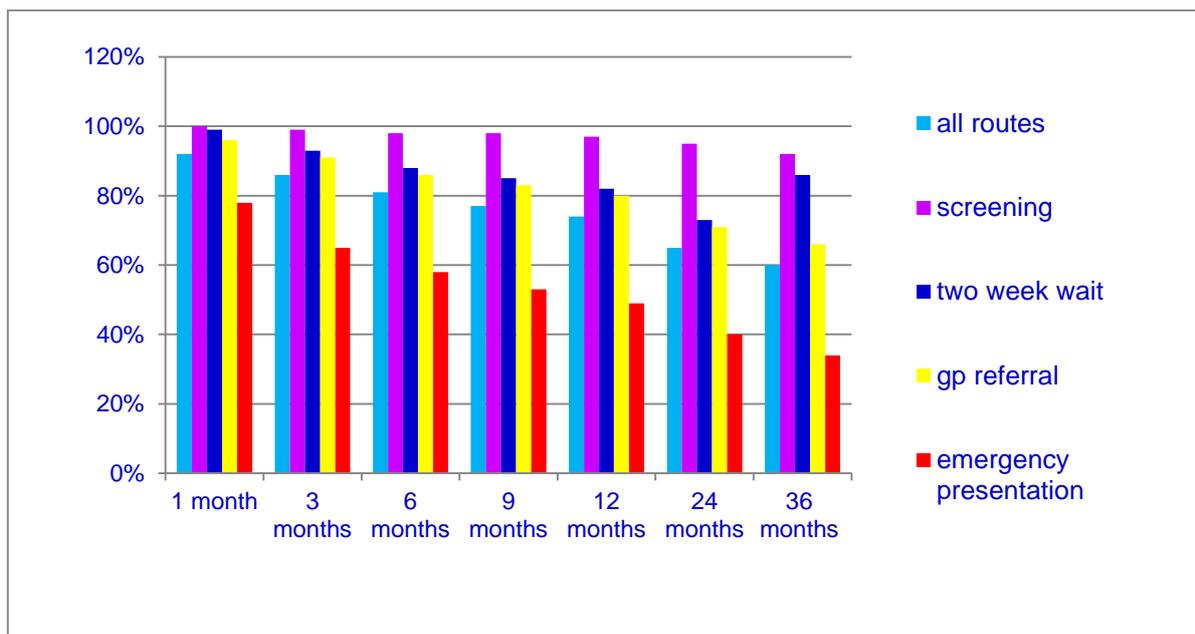
The National Awareness and Early Diagnosis Initiative - NAEDI - is a public sector/third sector partnership. It is led by Cancer Research UK, the Department of Health, NHS England and Public Health England. They work in partnership with other public and voluntary sector organisations to support and drive forward work on early diagnosis. Be Clear on Cancer campaigns aim to improve early diagnosis of cancer by raising public awareness of signs and/or symptoms of cancer, and to encourage people to see their GP without delay. National Cancer Awareness Campaigns will be supported locally through the use of local media, social media, TV screens in healthcare and other available resources. Local awareness campaigns based on local data, prevalence and needs can be used to raise awareness in the local population.

Tackling late diagnosis is a multifaceted challenge and requires action across the whole pathway from public awareness and encouraging people to see their doctor, to

supporting GPs and other services so that all patients have timely access to tests, specialist advice and treatment.

Screening

There are established National Screening programmes in place for cervical, breast and colorectal cancers. It is well documented that early detection, offers patients the best prognosis. Screening offers the opportunity for earlier detection for some cancers at an earlier stage when treatment can be more effective.



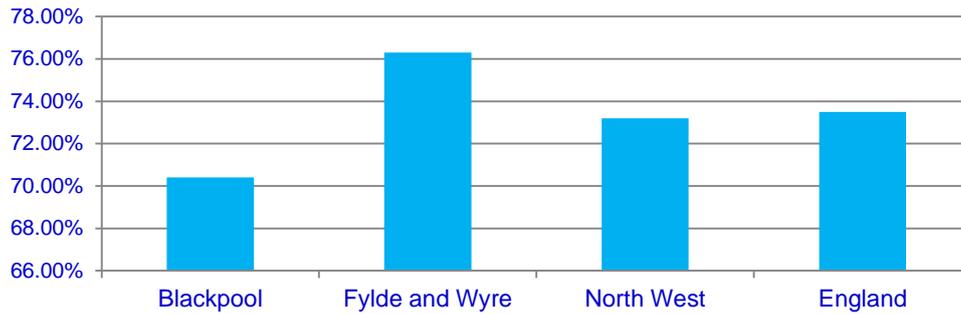
Relative survival estimates by presentation route and survival time for Colorectal Cancer 2006 -2013 Source NCIN/PHE

Improving screening uptake rates will require promoting screening programs through all communication channels available, ensuring attending local screening is convenient, identifying barriers to screening uptake and targeting harder to reach groups including people with learning disabilities. GP Practices play a key role in improving screening uptake, and they will be worked with to aid in the promotion of screening and to identify and target harder to reach groups and non-responders.

Cervical Screening

Experts estimate that cervical screening saves around 5,000 lives each year in the UK. The Fylde Coast has wide variations in uptake as can be seen below.

Females 25 - 64 attending cervical screening within target period (3.5 or 5.5 yr coverage %) 2014 -15

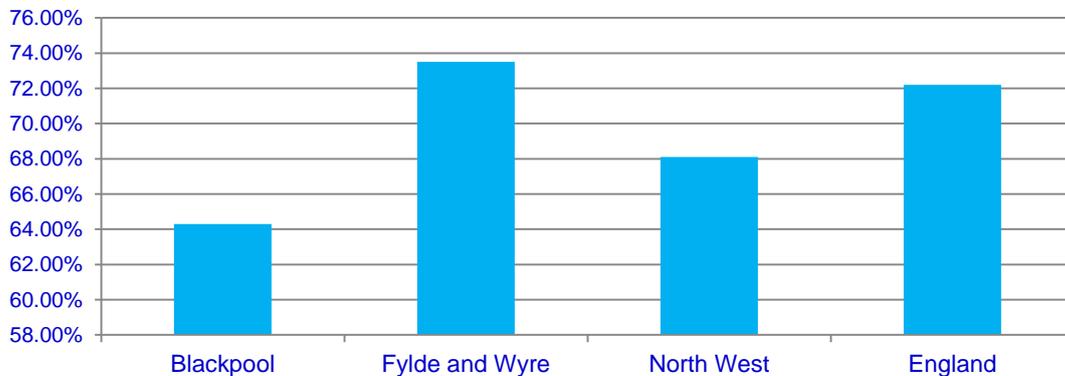


(Source: Data was extracted from the NHAIS via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme)

Breast Screening

The National breast screening programme invites women aged 50-65 for a mammogram every 3 years. Again the Fylde Coast health economy has a wide variation in uptake between practices with some managing as little as 30%, while other practices manage over 70% uptake. There is a close correlation between the deprivation rates and the uptake level of screening offered.

Females 50 -70 screened for breast cancer in last 36 mths (3 yr coverage %) 2014 - 15

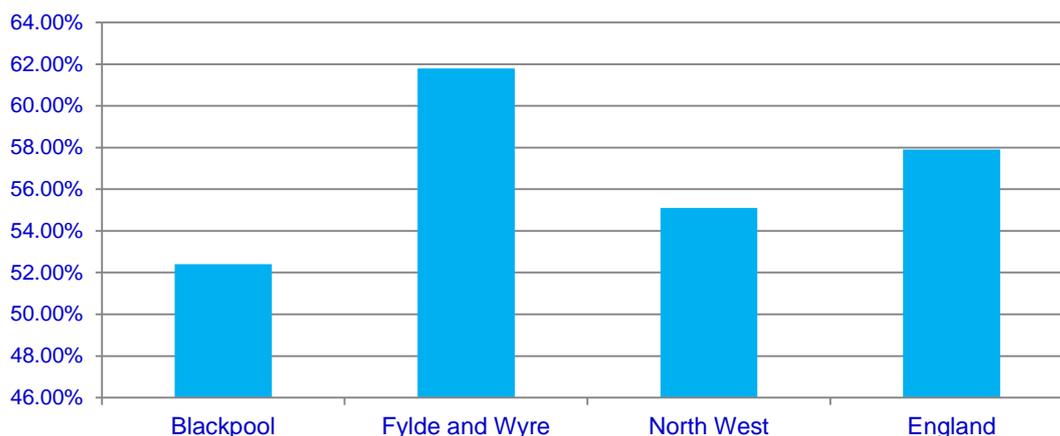


(Source -Data was extracted from the NHAIS via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme)

Bowel Screening

The NHS Bowel Cancer Screening Programme (BCSP) has been running since 2006. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16% in the population invited Research has shown that for every 190 people screened, bowel scope stops one person from getting bowel cancer, and for every 490 people screened, saves one life from bowel cancer.

Persons 60-69 screened for bowel cancer in last 30 months (2.5yr coverage %) 2014 - 15



Source: Data was extracted from the Bowel Cancer Screening System (BCSS) via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme

Whilst the aspirational target for the uptake of the bowel screening programme is 70% there is clearly much work to do to promote and increase awareness of the benefits of the programme both across the Fylde coast and nationally to achieve this goal.

Routes to Diagnosis and NICE Guidelines

GPs in England see fewer than eight new cancer cases per year on average, but many more patients present with symptoms which could be cancer. GPs are required to evaluate these symptoms and determine whether to refer for an investigative test which might then lead to a definitive diagnosis.

Recently the National Institute for Health and Care Excellence (NICE) reviewed and updated the '*NICE Suspected cancer: recognition and referral guidelines*' in June 2015 and included a number of changes aiming to give GPs more flexibility to refer patients in order to help diagnose cancers earlier;

Lowered symptom thresholds; any sign or symptom that has a three in 100 chance (or more) of being caused by cancer are now included;

For children and young adults, that threshold has been lowered even further;

Guidance organised by signs and symptoms is now available, a format that much better reflects how patients present to primary care;

GPs recommended to refer patients directly for tests, such as CT scans and endoscopies for a number of symptoms. This should support more comprehensive rollout of direct access nationally;

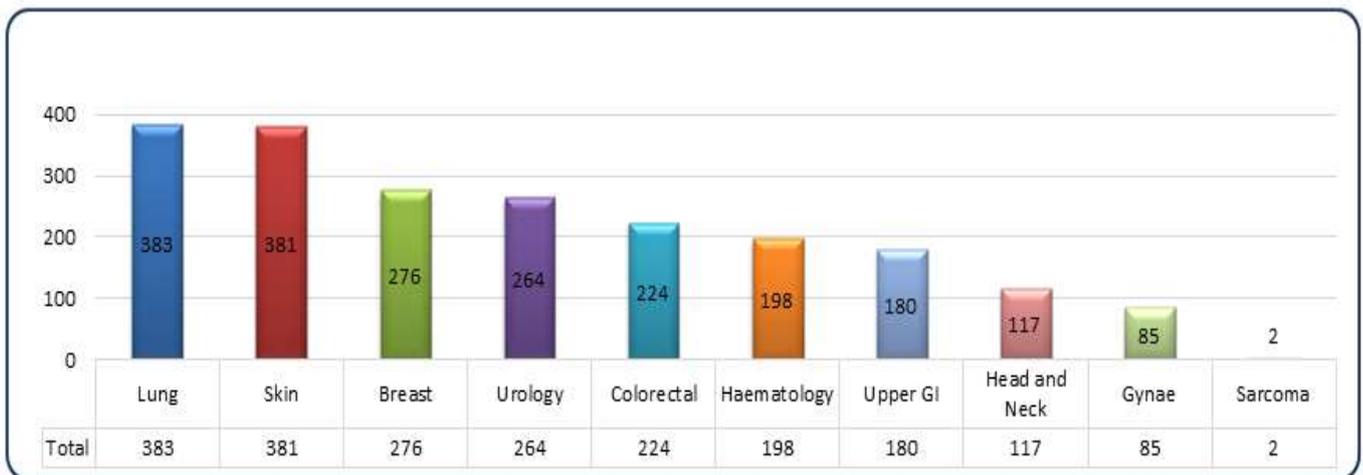
"Very urgent" referrals now recommended for some symptoms, where a patient should be seen within 48 hours;

Specific recommendations on ‘safety netting’ patients who are not displaying/or only vaguely displaying the level of symptoms which may indicate a cancer diagnosis are now given close follow up and monitoring of their symptoms.

The role of GPs in the early diagnosis of cancer is extremely challenging given there are more than 200 different types of cancer and many have vague symptoms. But it is also pivotal in making sure the patient gets on the right pathway at the earliest opportunity.

Blackpool Teaching Hospitals Cancer Patients Treated by Tumour Site

During 2014/15 approximately 2110 cancer patients were treated on the Fylde Coast. The highest tumour sites were both Lung (383) and Skin (381) Cancers closely followed by Breast (276), Urology (264) and Colorectal (224). The remaining tumour sites show Haematology (198), Upper GI (180), Head & Neck (117), Gynaecology (85) and Sarcoma (2).



Part 2 Support for Living with and Beyond Cancer

There are over 2 million people living with cancer in the UK and this is projected to rise to 4 million by 2030. The Fylde Coast had 9,788 people living with cancer in 2010.

There are currently 4,453 patients on the Cancer Disease Register (2013/14), who are registered with Fylde & Wyre CCG – This represents an increase of 4.3% against the previous years' figure of 4,284 persons. During 2013/14 there were 4,280 people on the cancer register living in Blackpool, this is a prevalence rate of 2.5% of the registered population, which is significantly higher than the national prevalence rate of 2.1%. Overall Blackpool has a slightly higher recorded prevalence of cancer compared with the national picture.

Over the last ten years (2003-2012) there have been a total of 12,898 new cancer diagnoses in the Fylde and Wyre districts, an average of 1,290 per year. In Blackpool, there were 694 new cancer diagnoses per 100,000 population in 2012. This is higher than the national average of 599.

It is estimated that the Fylde & Wyre male cancer incidence will increase by 55% between 2007 and 2030, whilst female incidence will increase by 35%. Based on this calculation, female incidence would go from 597 to 776, whilst male incidence would increase from 635 to 826. However, if we add this estimated increase to the 2012 figures, it suggests that in 2030 Fylde and Wyre will see 978 new female diagnoses and 937 new male diagnoses. In Blackpool, at the end of 2010, around 4,700 people in Blackpool were living with and beyond cancer. This could rise to an estimated 9,200 by 2030 (based on current 20 year prevalence and indicative future estimates).

The national Cancer Survivorship Initiative Vision Document (DoH: 2010), identified 5 key shifts to improve survivorship outcomes:-

1. A cultural shift in the approach to care and support for people affected by cancer – to a greater focus on recovery, health and wellbeing after cancer treatment.
2. A shift from a one-size-fits-all approach towards assessment, information provision and personalised care planning based on identification of individual risks, needs and preferences.
3. A shift towards support for self-management. This is a shift from a clinically led approach to follow-up care to supported self-management, based on individual needs and preferences and with the appropriate clinical assessment, support and treatment.

4. A shift from a single model of clinical follow-up to tailored support that enables early recognition of and preparation for the consequences of treatment, as well as early recognition of signs and symptoms of further disease.
5. A shift from an emphasis on measuring clinical activity to a new emphasis on measuring experience and outcomes for cancer survivors through routine use of Patient Recorded Outcome Measures (PROMs) in aftercare services.

Follow up should be risk stratified to individual patient clinical need and priority. Some patients, by the nature of site and complexity of surgery will require Consultant led follow up in the Acute Trust. However, a growing number of patients are prepared and supported to self-manage and these alternative methods of follow up have been widely researched; nurse led telephone follow up being the most popular and most researched method.



In order to unlock the financial and human resources, a dedicated programme of transformational work needs to be prioritised. Adoption of new models of care requires a reallocation of resources across the pathway and including between providers. Currently, in the majority of cases, the Acute Trust(s) maintain ownership of cancer patient follow up and this is typically for five years.

Routine follow up for cancer patients takes up a good deal of service capacity, time and resources and the care is often organised around the needs of the service rather than the patient's needs. Whilst there is a dedicated Macmillan Windmill Unit at Blackpool Teaching Hospitals, which is utilised for non-surgical oncology, haematology and palliative care and new and follow up consultations, there is no additional capacity to meet the increasing number of cancer survivors and thus a

change must be considered. Cancer patients at other points in their journey are frequently seen in often overstretched outpatient clinics and often experience long delays. For some patients, the experience of lengthy waits in busy outpatient clinics can be overwhelming and can actually cause increased anxiety.

The national cancer survivorship initiative (NCSI) have researched and tested new approaches to follow up and these have been tailored to the needs of individual patients using stratified pathways of care:-

1. Self-care with support and open access
2. Shared care between patient and clinician
3. Complex case management through the MDT

The aim of the service redesign is to change the way that patients experience follow up once they have completed curative treatment. The shift, for clinically eligible patients, is from a planned episodic outpatient approach to one where patients are suitably prepared to enter a pathway where they are supported to self-manage their follow up, and able to trigger their return for specialist advice, without recourse to going through their GP.

Key elements for this approach to aftercare in place are:-

Effective remote monitoring of surveillance tests, this is an IT solution which links to and is based within the organisation core IT systems; provides a range of surveillance schedules according to individual patient requirements; can alert to the need for test, and be auditable; can import test/diagnostic results; generates standard letters/treatment summary; is simple safe and secure.

Patient preparation, through: timely discussion with clinical professionals; tailored personalised information; and a self-management education event which enables confident self-monitoring for symptoms and recurrence, managing lifestyle change and goals for recovery and transition to 'normal'

Clear contact point for issues of concern. Can be through CNS or coordinator support role.

Rapid and easy access back to the appropriate person/service in the pathway without recourse to GP. A clear contract with response times provided.

The overall aim of the approach is to improve key patient outcomes by tailoring aftercare and the embedding of self-management, education and support.

Supported self-management:

An essential and key component of stratified pathways of care is to support patients to self-manage their condition where and when appropriate. Pilots undertaken by NCSI demonstrated that:-

- 70–77% of breast cancer patients can self-manage from two to three months after the end of treatment, or one year after diagnosis.

- 40–45% of colorectal patients can self-manage from four to six months after the end of treatment or stoma reversal.
- 28–44% of prostate cancer patients can self-manage, usually from two years after treatment.
- Some lung cancer patients will be able to self-manage for some periods, but, in general, are not suitable for this pathway
- 90% of testicular cancer patients can self-manage from two months after the end of treatment.

Patients who have previously been diagnosed and treated for cancer are more likely to develop a second cancer or to have a recurrence. It is therefore essential that GPs are particularly alert to symptoms in these patients, and to refer quickly if such symptoms occur. With increasing numbers of people surviving their primary cancer, we need a stronger focus on preventing secondary cancers.

Fylde Coast New Models of Care

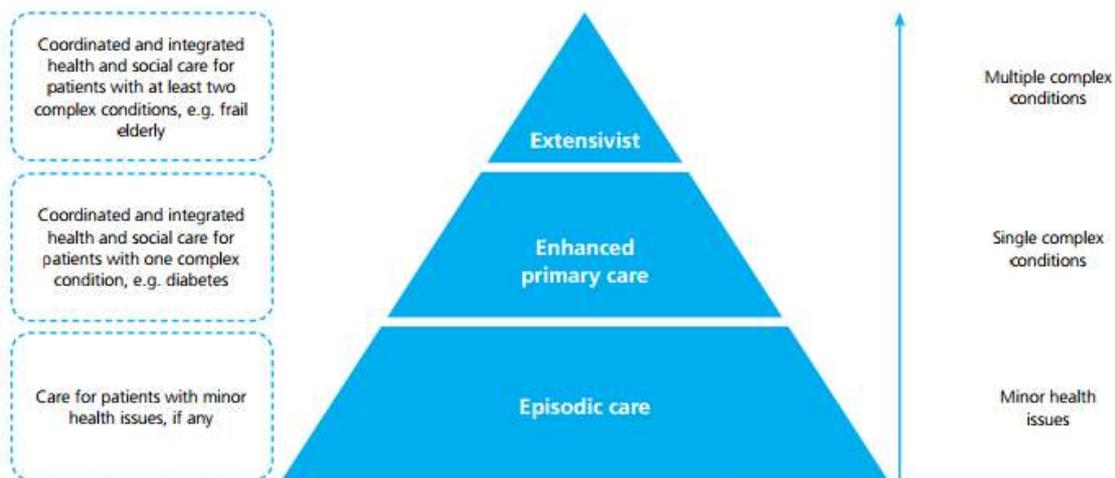
It is clear that fragmentation of care is a reality for patients across many health and social care pathways. Putting the patient at the heart of the re- design of services for cancer (and other long-term conditions) will require a will and determination that must be realised. This principle should be embedded in every aspect of the cancer journey, to ensure that services are responsive to patients' needs. It is estimated that 70% of cancer patients have at least one other long-term condition that needs managing and over a quarter have at least three other such conditions (ACHIEVING WORLD-CLASS CANCER OUTCOMES A STRATEGY FOR ENGLAND 2015-2020 Report).

In Blackpool, Fylde and Wyre cancer patients will benefit from the shift to new ways of working, benefiting from Enhanced Primary Care and Extensive Care services in the future. This will enable cancer patients to benefit from integrated care to meet their needs both in terms of the non-specialist elements of cancer care and a co-ordinated approach to manage co-existing long term conditions for the 70%.

Across the Fylde Coast, time has been spent understanding the challenges that are faced and identifying opportunities to improve the healthcare we commission. To make a difference to the lives of those with long-term conditions, care models have been assessed that exist across the world which focus on the provision of integrated and coordinated care for patients with the highest needs. There are two models – 'extensivist' and 'enhanced primary care' – which have been successful in improving quality, outcomes and patient experience with the use of fewer resources. Work is currently ongoing with local partners, with support from world experts, to design and pilot the models locally. Both models provide specialist, coordinated care and support to two distinct groups of patients:

1. those with multiple complex conditions – 'the sickest of the sick';
2. those with single chronic conditions.

In both models, the care team has holistic responsibility for an individual's care, acting as the coordinating point across the local health and social care system and holding other individuals and organisations to account with respect to their patients. Moreover, all care decisions are taken by the patient and their carers supported by the lead clinician and their team.



To reflect the feedback from our engagement exercise and our strong desire to work with NHS England to co-commission an improved model of primary care access, we are developing a third model called 'episodic care' to support patients with minor health issues. Self-care, community pharmacy, primary care nurses and other similar services will be maximised to free up GP time and expertise to focus on the provision of enhanced primary care, which we consider to be the GP role of the future.

Recovery Package

The recovery package is made up of the following key and integral elements:

- Holistic Needs Assessment (HNA)
- Treatment Summary
- Cancer Care Review
- Education and support event such as a Health & Wellbeing Clinic (HWBC)



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Assessment and care planning:-

Conducting Holistic Needs Assessments in partnership with the patient, using appropriate assessment tools, and preparing a subsequent care plan, focusing time and resources on areas where need is greatest.

Developing patient education and support events, such as the Health and Wellbeing Clinic.

Holistic Needs Assessments should take place at or near diagnosis, and at the end of treatment. Further assessments may be required if circumstances change. Holistic Needs Assessments and care planning were included as a Cancer Peer Review measure in April 2011 and are still include in these Quality Measures. Pilots have indicated that conducting a Holistic Needs Assessment (including relevant paperwork) takes about one hour of nursing time. The cost of this proactive care planning will be offset by reduced unplanned contact, as it ensures that patients have appropriate information and a clear management plan.

In summary, holistic needs assessment matters because it:-

- Identifies people who need help

- Provides an opportunity for the person to think through their needs and, together with their healthcare professional, make a plan about how to best meet these.
- Helps people to self-manage their condition
- Helps teams to target support and care efforts and work more efficiently by making appropriate recommendations

The Treatment Summary should include the READ codes that inform the GP IT systems that the patient had cancer, their treatment and whether they are at risk of developing other conditions, such as cardiac disease, osteoporosis and diabetes. The purpose is to inform primary care of actions to be taken, and who to contact with questions. The patient should also receive a copy to improve understanding and share with others if they choose. It is available in an electronic format on the main cancer information systems – Somerset Cancer Registry and Inflex CIMs Ltd.

The Macmillan Cancer Care Review templates enable GPs to code key areas of care consistently, and also act as an aide memoir for GPs to trigger discussions. There is now a requirement through the Quality Outcome Framework that all patients should have a cancer care review within six months of the GP practice being notified of a cancer diagnosis.

All key professionals and partners involved in the care for cancer patients should be working seamlessly to ensure that all elements of the recovery package are streamlined and used in combination to support patient recovery from cancer. The recovery package can also be used as an enabler to reduce emergency readmissions.

It is important to recognise that the interventions require a timely investment, at least initially. At present, clinicians will often conduct an assessment without discussing it with a patient, so moving to this more structured process will require an adjustment. Staff may need training in assessment and care planning.

Producing a Treatment Summary documenting the care provided, informing the GP and patient about prognosis and planned future care, and highlighting signs and symptoms of recurrence and consequences of treatment.

It will also inform the GP Cancer Care Review and enable the GP database to be kept up to date.

It is aimed at:-

- GPs and primary care professionals
- Patients
- Secondary care clinicians, particularly in A&E and for unplanned emergency admissions.
- Hospices, day centres and care homes.

Part 3 Reducing Inequalities

Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have an impact, because they result in certain people experiencing poorer health and shorter lives. The aim of the Strategy is to reduce the difference in mortality and morbidity across these groups to increase quality of life and a sense of wellbeing of the whole local community. A key part of this project, will be working with the local authority on key themes as outlined below.

An action plan has been developed which is rag rated against the national world class cancer outcomes strategy. The key actions are embedded within the strategic action plan which will be monitored through the Fylde Coast Cancer Steering Group.

Prevention

To reduce the incidence of cancers associated with lifestyle factors.

Awareness and Early Diagnosis

To reduce overall cancer mortality through earlier presentation to primary care services.

Screening

To reduce mortality from cancers for which there is an NHS population based screening programme.

Diagnostics/Therapeutic

- Review/audit variation in direct access to diagnostics across geographic areas
- Review patient experience surveys to identify issues around decision making and supporting the development of materials appropriate for different population groups
- Supporting the commissioning of streamlined assessment and treatment pathways across all patient groups

Survivorship

- Promotion of lifestyle messages through all channels, for example, secondary care clinicians, specialist nurses, social care, third sector organisations, smoking and alcohol services

- Develop appropriate patient information and key streams of dissemination through patient sub-groups
- Collaboration between patient sub-group and clinical services to review/audit equity issues across the Fylde Coast and to take the appropriate action

Engagement

Engagement will be undertaken via triangulation of engagement activities with stakeholder organisations:-

- Strategic Clinical Network
- Local authority
- Social Care
- Public Health
- Health and Wellbeing Board
- Primary Care Teams
- Third sector organisations
- Screening providers
- HealthWatch
- Smoking Cessation and Alcohol Services

Part 4 Improving the Cancer Patient Experience

Cancer Services on the Fylde Coast must be responsive to the needs and wishes of the public, many of whom will use its services at some point in their lives. The Health Economy will ensure that public, patient and carer voices are at the centre of cancer services, from planning to delivery. Every level of the strategy and services will be informed by insightful methods of listening to those who use and care about our services.

Patients have a right to have their views taken into account on all issues that affect them. Participation activities will take into account barriers associated with language, age, access to information, disability etc.

To realise this overall vision we have set a series of ambitious aims for cancer services. These aims cover the effectiveness of clinical services, the experience of patients being treated, and the health outcomes achieved. A key aim is to deliver improvements to patient services as a direct result of implementation of the strategy. Patient engagement and feedback is the cornerstone of improvement of existing services and development of new services. The Health Economy will work in partnership with patients in order to:-

- improve patient experience by identifying themes and issues within the national cancer patient survey and act upon these issues
- ensure equitable access to excellent clinical care through integrated pathways across primary, secondary, tertiary, community and third sectors
- provide and develop local services where possible and centralised services where necessary
- to increase the numbers of patients enrolled in clinical trials to improve cancer care for all in our community
- to provide good information, and improve year on year patient and carer experience and quality of life.

The Health Economy approach will focus on working in co-design with patients, families and carers and collaborating to improve outcomes.

In addition to the above, consultation and input from the Patient Participation Subgroup will be invited regarding elements of the 5 year strategy, prior to implementation. Patients will also be consulted and involved in the implementation of elements of the National Cancer NICE Guidance

The CCG will develop a patient engagement plan which will encompass the following principles:-

1. Understand what individual patient participation is already happening locally. What are patients saying about how they are involved in their care? How can individual participation better meet their needs and improve outcomes?
2. Identify the gaps and what more is needed locally to ensure that patients and carers are involved in decisions about their healthcare, for example informed discussions with clinicians and considering how information and support can be targeted to ensure it reaches appropriate audiences, for example support for those who lack capacity.
3. Identify local champions and resources, linking in with local patient groups, voluntary organisations and other partners
4. Use the tools and support guides available nationally and online
5. Monitor implementation, and measure the impact of patient participation, for example on service improvement
6. Seek feedback about what is working well and areas for improvement, through commissioner assurance and wider patient engagement.
7. Share learning through local, regional or national networks.
8. The patient's wishes as regard to both treatment and end of life care will be at the core of all cancer management. There will be strives towards strengthening links with end of life care. The Steering Group is accountable for the end to end cancer pathways from prevention, screening, diagnosis and treatment through to survivorship and linking to the Fylde Coast Strategic End of Life Group and Fylde Coast End of Life Strategy and action plan for end of life care. It will monitor progress across the whole of the Cancer Action Plan and all its individual work streams.
9. In addition to the above, the Health Economy will seek to develop new innovative methodologies and technologies for harnessing feedback from a broader range of patients and service users on a continual basis during the lifetime of the strategy

Part 5 Risks to Delivering Our Plans

Introduction

The Health Economy will develop a Cancer Strategy risk register that will identify, analyse, evaluate and control the risks that threaten the delivery of the Strategy. The risks will be reviewed, updated and monitored on an annual basis. Risks will be assessed in terms of proximity and how likely it is that they will occur.

The key risks which have been identified at the outset of the strategy are considered to both physical, in terms of staffing resource to implement the plan and financial, in terms of investment required to develop and implement new services.

Physical Risks

The delivery of the strategy is dependent on engagement and feedback of a wide range of stakeholders. There will need to be a commitment from all stakeholders to deploy the appropriate level of staffing resource to support the implementation of the strategy. However, it is recognised that this commitment may change over the life of the strategy as a result of competing demands and priorities in each of the stakeholder organisations.

Financial Risks

The Health Economy is working in a challenging financial climate and as a result of this, elements of the strategy which require significant investment may need to be deferred and could be dependent upon efficiencies being made elsewhere in the system. The financial plans of the Health Economy are reviewed and adjusted on an annual basis and therefore it is not possible to assess the longer term financial risk to the strategy. The Health Economy will also seek to secure external investment to develop services; again there is a risk that elements of the strategy will need to be deferred if funding is not secured.

Furthermore there may be financial risks at a national level which cannot be identified at the outset of the strategy as they are dependent and linked to Government National Policy.

It is not possible at the outset to identify and then fully implement actions that eliminate or minimise a risk. However, it is essential that the significance of the risk that remains is understood and the Health economy is aware of and accepts the level of risk.

Part 6 Governance & Delivery

Strategic Oversight

The Fylde Coast Cancer Steering Group is accountable for ensuring the delivery of the strategic cancer priorities across the Fylde Coast. These priorities are embedded in the Strategic Cancer Action Plan 2016-2021.

The purpose of the Steering Group is to ensure a collaborative, co-ordinated and consistent approach to cancer care delivery on the Fylde Coast. Its key role is the implementation of the action plan, which ensures that local cancer services are developed to provide optimal care to patients with, or affected by, cancer on the Fylde Coast. The Steering Group is accountable for the end to end cancer pathways from prevention, screening, diagnosis and treatment through to survivorship and linking to end of life care. It will monitor progress across the whole of the Cancer Action Plan and all its individual work streams.

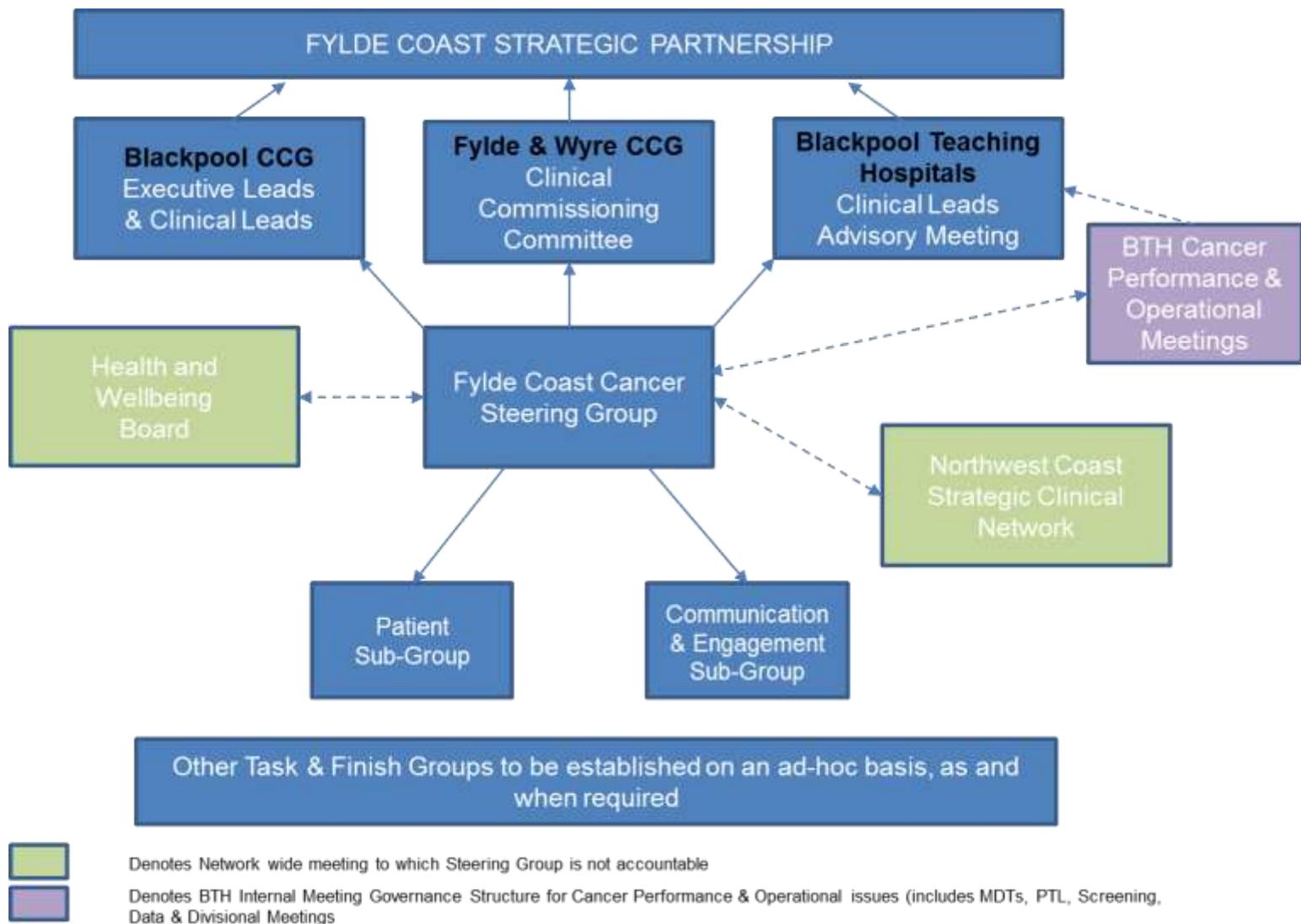
Implementation

The Steering Group is accountable for the delivery of all elements of the action plan through the formation of subgroups across the Fylde Coast to deliver different elements of the plan. The subgroups will have a clear remit, membership and reporting arrangements which will be set by the Steering Group.

These subgroups will report directly into the Steering Group where they will receive updates on the delivery on aspects of the strategy. The Steering Group will continually monitor progress against implementation of the strategy to ensure that the action plan is updated on a regular basis.

The Steering Group is also responsible for ensuring achievement of the national standards and to identify corrective actions/improvements should any performance decline.

FYLDE COAST CANCER GOVERNANCE FRAMEWORK



Clinical Commissioning Groups

NHS Fylde and Wyre Clinical Commissioning Group and Blackpool Clinical Commissioning Group are membership organisations with a combined total of 43 GP practices across the Fylde Coast. Clinical leadership is embedded into the working practice of the CCGs, with each GP Member of the Governing Body having lead responsibility for a particular area of care.

Blackpool Teaching Hospitals NHS FT

The Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust was established on 1st December 2007. The Trust then gained teaching hospital status and became Blackpool Teaching Hospitals NHS Foundation Trust in 2010. In April 2012 the Trust

merged with community health services from NHS Blackpool and NHS North Lancashire as part of the Transformation of Patient Pathways Programme.

The Trust now serves a population of approximately 440,000 residents across Blackpool, Fylde, Wyre, Lancashire and South Cumbria and the North of England.

The Trust comprises Blackpool Victoria Hospital which is a large busy acute hospital, two smaller community hospitals (Clifton Hospital and Fleetwood Hospital).

Voluntary Sector

HealthWatch ensures that the public and patients continue to be consulted and influence the development of plans, as referenced in the patient participation engagement of the Strategy.

Across the Fylde Coast, the local Council for Voluntary Services (CVS) hosts a network of 300+ Voluntary Community Faith Sector Organisations who regularly circulate updates, invites to events and questionnaires on behalf of both Blackpool and Fylde & Wyre Clinical Commissioning Groups.

Fylde Coast Governance

The Fylde Coast Cancer Steering Group recognises that in order to meet the scale of the challenges of the strategy, the vision, objectives and implementation must align with partner organisations across the Fylde Coast.

The Fylde Coast Cancer Steering Group is responsible for oversight and delivery of the Cancer Strategy. However, each of the major stakeholder organisations (the CCGs and the Acute Trust) are accountable to their own organisations for providing assurance regarding delivery of the strategy.

Lancashire Wide & Regional Governance

The Fylde Coast Cancer Steering Group has clear links to the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network and will seek advice and support, as appropriate. However the group is not accountable to the Network.

The CCG is not accountable to NHS England in terms of delivery of the Strategy but is assured by NHS England in respect of a number of Cancer outcomes and measures, aspects of which may also be included in the Cancer Strategy.

Health and Wellbeing Board

The Health and Well Being Board is central to the development and implementation of joined up health and social care strategies which will also align to our Cancer Strategy.

Clinical Developments

The development of regional, UK and international evidence base on early diagnosis and treatment of cancer should be integrated into and educate our local service provision. We need to understand the impact on cancer survival in relation to our patterns of treatment (taking into account age, co-morbidities and stage of disease) e.g. lung cancer resection rates and the use of adjuvant chemo and radiotherapy.

Ours services should provide the use of the best clinically appropriate evidence based treatments as indicated by NICE, the Royal Colleges, the national quality indicators for cancer and our NSSGs that are appropriate to our population. These require ongoing review of the best place of care for all tumour sites and use of confederated services when appropriate to our community.

Research & Development

Recognising the importance of Research & Development in cancer care and also the need for this to be multicentre we would encourage an increase in the number of our patients recruited into regional, national and international Research & Development projects.

Annual Self-declaration of Cancer Quality

We intend to optimise the cancer quality surveillance process by the continuation of a robust governance process involving primary, secondary and CCG colleagues in the annual self-declaration.

Equality Delivery System

We use the Equality Delivery System (EDS) to drive improvements, strengthen the accountability of services to those using them and bring about workplaces free from discrimination

Our objectives are to improve access to health care for vulnerable people e.g. ensuring the homeless are able to register with a GP or access the Urgent Care Centre or GP Led Centre. We have also plans to integrate care for improving access to care services with other providers; Council/ Lancashire Care Foundation Trust and social services

Aims of the E & I strategy:-

- Develop better health outcomes for all;
- Develop improved patient access and engagement;
- Develop empowered, engaged and well supported staff, and;
- Develop inclusive leadership at all levels.