Although a formal committee of the city council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults as well as Healthwatch. Papers come from a variety of sources. The format for Health & Wellbeing Board papers is consequently different from papers submitted to the city council for exclusive city council business.

1. Brighton and Hove Cancer Strategy 2017-2020

1.1. The Health and Wellbeing Board is asked to approve this Strategy.

1.2 This paper is for the Health & Wellbeing Board meeting on the 12th September 2017

1.3 Authors of the Paper and contact details;

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2. Summary

2.1 The joint Cancer Strategy (2017-2020) has been developed by Brighton and Hove's Cancer Action Group whose membership includes the CCG commissioners, service providers, Macmillan, patient representatives, data analysists, Cancer Research UK and the Council's public health specialists. (Full membership list is at Appendix 1 of the Cancer Strategy) . The strategy's vision is to improve outcomes for cancer patients in Brighton and Hove and improve the experience of those affected by cancer. The Strategy outlines actions to achieve high quality services based on individual needs and which have a clear focus on prevention, early diagnosis, high quality treatment, and support for those living with and beyond cancer.

2.2 It aims to be a living document, where the action table is further developed in light of local needs and priorities. Actions will be monitored and developed through the Brighton and Hove Cancer Action Group.

2.3 This strategy has been informed by the National Cancer Strategy[1], our local Joint Strategic Needs Assessment, local operating plans and strategies and recently published data.

2.4 The strategy is separated into six sections which are aligned to the six priority areas outlined in National Cancer Strategy, these are:

- Prevention
- Early Diagnosis
- Patient Experience
- Living with and Beyond Cancer
- Modernising Cancer Services
- Commissioning accountability and provision.

3. Decisions, recommendations and any options

3.1 That the Board is asked to approve the Cancer Strategy.

3.2 That the Board agrees to receive an update including an estimate of the strategy's predicted impact on clinical and financial outcomes, including a sensitivity analysis, at the March 2018 meeting.

[1] Independent Cancer Taskforce Review; Achieving World Class Cancer Outcomes, A strategy for England 2015-2020
http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

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4. Relevant information

4.1 The BHCC and CCG joint local strategy is informed by 'Achieving World Class Cancer Outcomes, A strategy for England 2015-2020 National Cancer Strategy' which provides a transformational framework for the prevention, diagnosis, treatment and care for people affected by cancer. The NHS Operational Planning and Contracting Guidance[2], the Five Year Forward View and Next Steps of the Five Year Forward View[3] all of which contain relevant recommendations, actions and targets.

4.2 The Cancer Action Group oversees the Strategy and its delivery. It has a membership drawn from a range of organisations and partners with terms of reference, a clear reporting line to the Brighton and Hove Planned Care and Cancer Board and through to the Health and Wellbeing Board. (see page 49).

4.3 The incidence and deaths from cancer is increasing nationally and locally as the population lives for longer. Cancer Research UK states that one in two people will develop cancer at some point in their lives.

4.4 Cancer is the most common cause of death in England, accounting for 27% of all deaths. It is also the most common cause of premature death, accounting for 42% of deaths in those aged under 75 years.[4]

4.5 The picture is similar in Brighton & Hove with cancer accounting for 28% of all deaths and 40% of deaths in those aged under 75. [5]

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[2] The 2017-2019 NHS Operational Planning and Contracting Guidance https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

[3] Five Year Forward View (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf and The Forward View into Action (2015) https://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf and Next Steps of the Five Year Forward View (2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

[4] ONS Vital Statistics (2015 data) [Accessed 13.6.17] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthreferencetables]

[5] Primary Care Mortality Database, NHS Digital (2015 data). http://content.digital.nhs.uk/pcmdatabase

4.6 Despite improvements in cancer survival and mortality in recent decades, outcomes in the UK are poor compared with the best in Europe. A report in the Lancet in 2015[6] analysing common cancer 5-year survival rates showed that the UK was lagging behind with rates in 2005-2009 similar to what other Western European countries had achieved ten years earlier.

4.7 In Brighton and Hove City, with a population of approximately 287,000 around 1150 people in the city are diagnosed with cancer each year; of these, over half are for the four most common cancers (210 female breast, 150 lung, 140 colorectal and 135 prostate). These cancers are also responsible for about half the premature deaths in the City (75 from lung cancer, 26 from breast cancer, 23 from colorectal cancer and 6 from prostate cancer).

4.8 Incidence and mortality from cancer is considerably higher amongst the more deprived groups, largely due to late presentation, resulting in later diagnosis and access to health services. The mortality gap between the poorest groups and the most affluent appears to be widening.

4.9 Tobacco smoking remains the most important avoidable cause of cancer in the UK, followed by diet, excess body weight; due to diet and inactivity, and alcohol consumption. Cancer Research UK estimate that 42% of cancers in the UK are preventable through lifestyle choices[7]. Exposure and conditions at work, sunlight and sunbeds, infections, radiation, not breastfeeding and hormone replacement therapy are also key risk factors. The importance of lifestyle choices can be seen when it is borne in mind that less than 5% of cancer is genetically linked.[8]

4.10 In terms of cancer screening the national screening programmes aim to detect cancer early when treatment is more likely to be effective. Cancer Research UK estimates that cervical screening saves 5,000 lives in England each year, while breast screening saves 1,300. Regular bowel cancer screening reduces the risk of dying from bowel cancer by 16%. In Brighton & Hove screening rates for all of the three national screening

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[6] Allemani C, Weir HK, Carreira H *et al* and the CONCORD Working Group. Global surveillance of cancer survival 1995–2009: analysis of individual data for 25,676,887 patients from 279 population-based registries in 67 countries (CONCORD-2). *Lancet* 2015; 385: 977–1010. http://dx.doi.org/10.1016/S0140-6736(14)62038-9

[7] Cancer Research UK. 2017 http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers

[8] Cancer Research UK. Are all Cancer Hereditary? [Accessed on 16.8.13] Available from http://cancerhelp.cancerresearchuk.org/about-cancer/cancer-questions/are-all-cancers-hereditary

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programmes; breast, bowel & cervical cancer, are lower compared to the rates for both the South East and England.[9]

4.11 NHS England published new ratings in October 2016 providing a snapshot of how well different areas of the country were diagnosing and treating cancer and supporting patients. Table 1 shows the indicator ratings for Brighton and Hove CCG.

Table 1: Brighton and Hove CCG Indicator Rating[10]

Rating	Brighton and Hove CCG - Indicator Rating			
	New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed	Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral	Of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis.	"Overall, how would you rate your care?" (with a score from 0 to 10, where 10 is the best.)
Brighton and Hove Overall rating (Requires Improvement)	47.3%	82.1%	68.9%	8.5
Best performing CCG	61.0%	94.9%	74.5%	9.0
Worst performing CCG	**37.5%**	**55.8%**	**64.7%**	**8.3**

9 PHE Screening update October 2015
https://cpdscreening.phe.org.uk/getdata.php?id=14456

The Independent UK Panel on Breast Cancer Screening. The Benefits and Harms of Breast Cancer Screening: An Independent Review. A report jointly commissioned by Cancer Research UK and the Department of Health (England). October 2012.
Cochrane Database of Systematic Reviews, 2006. Screening for colorectal cancer using the faecal occult blood test: an update.
Public Health England: Fingertips Cancer Services Profile [Accessed 5.7.17]
https://fingertips.phe.org.uk/profile/cancerservices
8 https://www.nhs.uk/service-search/scorecard/results/1173

Eastbourne, Hailsham and Seaford rating (Inadequate)	**44.2%**	**75.3%**	**68.8%**	**8.8**
High Weald and Lewes Havens (Requires Improvement)	**51.1%**	**77.5%**	**69.9%**	**8.7**
Coastal West Sussex (Requires Improvement)	**51.7%**	**85.2%**	**69.7%**	**8.6**
Crawley (Requires Improvement	**55%**	**82.6%**	**66.7%**	**8.7**
Horsham and Mid Sussex (Good)	**49.4%**	**80.6%**	**71.5%**	**8.7**

4.12 Brighton and Sussex University Hospital (BSUH) continued to be challenged in meeting the 62 day urgent GP referral to treatment standard in 2016/17. This has in part been due to increase in activity and pressures within the system in diagnostics and bed pressures. There has been a focus locally and nationally on achieving the 62 day standard and work in sustaining cancer performance. Estimated increases in activity are set out on page 14 of the Strategy in response to implementing NG12 Guidance. NHS England are working with Cancer Alliances to drive clinical leadership and change in local areas, supported by transformational funding, targeted investment in addition to local funding arrangements.

4.13 The experience of cancer patients in England is generally very positive. Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.7. On nearly half of the questions in the survey, over 80% of respondents gave positive responses. Brighton, Sussex and University Hospital (BSUH) had an average rating of 8.6. 86% of people rate their overall care as excellent or very good. The England average is 89%. 68% reported that hospital and community staff always worked well together (compared with the England average of 63.5%).

Brighton and Hove can make improvements in two areas;

- 77% said that they found it easy to contact their Clinical Nurse Specialist (CNS) (compared to 87% nationally)
- 36% said that they were given understandable information about whether radiotherapy was working (compared to 60% nationally).

4.14 This Strategy aims to address the various opportunities to improve patient outcomes;

- Prevention, by improving health and wellbeing, addressing risk factors and improving screening uptake.

- Early diagnosis, by shifting from detection due to symptoms, to detection as a result of screening using tools such as practice profiles, the cancer decision toolkit, communication and engagement with the public and utilising NHS Health Checks and faster investigation and increased diagnostic capacity.

- Prompt high quality treatment, by addressing patient and system initiated delays. Delivering integrated end to end seamless 62 day pathways; improved patient outcomes and experience using a very efficient model of care.

- Survivorship, - with improvements in early detection and rapid advances in treatment, we should expect even larger numbers of people living with and beyond cancer, and greater numbers of people acting as carers for people with cancer. This requires a shift away from the medical model of care to one that sees the patient and the public being empowered to take up ownership of their care.

4.15 Around 1,100 people are diagnosed with cancer each year in Brighton and Hove. The nature of the tumour and the stage at which it is diagnosed will directly impact on life expectancy. Treatment for cancers at an earlier stage generally have better outcomes for the patient and are less costly to the health care system.

4.15 Financial impacts will need to be considered in the light of different commissioning responsibilities:[11]

- Prevention: Approximately 50% Public Health England, 25% Local Authority Public Health and 25% CCGs
- Screening: Public Health England
- Diagnostics: Approximately 90% CCGs and 10% NHSE - Specialised Commissioning.
- Treatment: (Radiotherapy, Chemotherapy, Specialist Surgery, and Non-Specialist Surgery): NHSE– Specialised Commissioning have 100% of the responsibility for Radiotherapy, Chemotherapy and Specialist Surgery. CCGs hold 100% of the responsibility for Non-Specialist Surgery.
- Follow up/Surveillance: Approximately 95% CCGs and 5% NHSE
- Rehabilitation & Survivorship, and Palliative Care/End of life Care – approximately 80% CCGs and 20% Local Authorities

4.16 The National Cancer Strategy[12] highlights that the cost of cancer in the NHS is likely to grow rapidly due to increasing incidence, healthcare inflation and new technology Through investing in early diagnosis, cost efficiencies and cost savings can be made. Cost increases have already been taken into consideration in the Five Year Forward View baseline assumptions, which for cancer, are predicted to grow by around 9% per annum over the next five years, in the absence of any efficiency savings.

- In 2017/18 following NICE guidance (NG12)[13] Brighton and Hove CCG has invested an additional 1.4% in consultant led first outpatient appointments (n=1066) and 1.6% in consultant led follow up outpatient appointments (n=1,132) on top of a 3.8% growth increase in in acute contract.

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[11] https://www.macmillan.org.uk/about-us/working-with-us/health-social-care-commissioners/strategic-commissioning/england.html#253898
https://www.macmillan.org.uk/about-us/images-long-descriptions/commissioning-pathways-infographic.htm

[12] Achieving Word Class Outcomes for Cancer 2015-2020 A Strategy for England; Independent Cancer Taskforce Review (2015)
http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf
[13] https://www.nice.org.uk/guidance/ng12

- Efficiencies and cost savings have been identified throughout the cancer pathway within the National Cancer Strategy which includes stratified pathways and the introduction of direct access tests. The National Strategy recognised that further work is required to finalise the estimated costs and savings.

- Monies will be available through the Surrey and Sussex Cancer Alliance to transform cancer care including early diagnosis, treatment and living with and beyond cancer. £2.9 million has been made available to the south region to support 62 day recovery plans.

4.17 To illustrate the potential outcomes from investing in prevention and earlier detection examples of national clinical and financial impacts are given below.

- Four out of ten cancers could be prevented by individuals adopting healthier lifestyles. The most important of which is smoking which leads to one in six of all the deaths of people over 35 years of age including over a quarter of deaths caused by a range of cancers. Lung cancer risk is around 26 times higher in men who smoke 15-24 cigarettes per day, compared with never-smokers. The estimated incidence rate of lung cancer in England is 77 cases per 100,000 population of which over 80% are caused by smoking.

- The estimated return on investment of smoking cessation services is £1.77 for every £1 spent. [14]

- Jo's Cervical Cancer Trust [15] has calculated that increasing cervical screening coverage from current [16] England levels of 72.8% to 84% could save the NHS £10 million a year. The average cost to the NHS per person diagnosed with stage 2 or later cervical cancer is £19,261, whilst for those at stage 1a, the cost to the NHS is around £1,379 per person.

[14] Masters et al J Epidemiology Community Health 2017; 71:827-834
[15] https://www.jostrust.org.uk/get-involved/behind-the-screen
[16] 2015/16 figures updated from Jo's Trust report

4.18 A report by Cancer Research UK *Saving lives, averting costs, An analysis of the financial implications of achieving earlier diagnosis of colorectal, lung and ovarian cancer.* published in September 2014, provides an example of modelling of cost and stage for 4 cancers that are equal to 21% of all cancers nationally; [17]

4.19 As table 2 from the report shows the estimated cost of treating cancer at an early stage (stages 1 and 2) is generally less expensive than treatment for more advanced disease:

Table 2: Cost associated with cancer stage

Stage	Colon cancer	Rectal cancer	Lung cancer	Ovarian cancer
1	£3,747.63	£4,803.52	£16,409.07	£6,831.21
2	£9,810.70	£8,834.25	£18,694.95	£18,840.35
3	£13,974.87	£12,792.04	£20,984.13	£23,482.19
4	£12,518.58	£11,815.28	£13,077.65	£15,080.66
Local incidence[18] per100,000	colorectal 67.98 (England 70.43);		lung 82.22 (England 77.6)	ovarian 26.6 (England 24.0)

4.20 Table 3 shows the estimated number of additional patients diagnosed with early stage cancer and the resulting additional savings and costs that would be achieved if the overall performance of all CCGs were equivalent to the best performing CCG's diagnostic profile for the four cancers considered. In total over 11,000 people would have their cancer diagnosed at an earlier stage which result in savings of over £44 million pounds.

[17] Costings based on NICE guidelines, NHS reference costs and Healthcare Resource Group (HRG)
[18] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-1=NHS Brighton & Hove CCG&location-1=09D

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Table 3: summary of patient impact and NHS cost implications of achieving the best in England

Cancer Type	Additional patients diagnosed with early stage cancer	Additional costs
Colon cancer	4,516	-£24,435,267
Rectal cancer	1,707	-£9,624,907
Non-small cell lung cancer	3,468	£6,477,471
Ovarian cancer	1,406	-£16,673,157
Total	**11,097**	**-£44,255,861**

4.21 To put these savings into context, the overall savings for the four cancers amount to 5 % of the overall treatment budget for colon, rectal, non-small cell lung and ovarian cancer. This is a significant saving given the pressures facing health services. Without action to reduce late diagnosis, treatment costs for these four cancers were predicted to rise by approximately £165 million. Yet, if the number of cancers diagnosed at a late stage were halved, then this cost increase would reduce to £111 million, benefiting over 27,000 patients.

4.22 Cancer Research UK outlined that if the findings for these four cancers were replicated for all cancers, then savings in treatment costs of approximately £210 million would be realised, resulting in over 50,000 people being diagnosed with earlier stage cancer.

5. Important considerations and implications

Legal:

5.1 There are no legal implications arising from this report.

Lawyer consulted: Elizabeth Culbert Date: 21/08/17

Finance:

5.2 The Public Health funded contract to 'Increase uptake of cancer screening programme' within Brighton and Hove Cancer Strategy is funded equally by the main Public Health Grant and the Brighton and Hove CCG as part of awareness and prevention activity. The total value of the contract is £0.270m over the 3 years (£0.1m for 17-18 and 18-19 with a reduction to £0.071m in 19-20 due to part year effect of the CCG 3 year funding). The contract outlined in this report is within the allocated budget.

Finance Officer consulted: Sophie Warburton Date: 31/08/2017

Equalities:

5.3 Age: Incidence increases with age for most cancers, yet older people in Brighton and Hove are not aware of their increased risk and have lower awareness of cancer symptoms than younger groups. There is evidence that older people's cancers are investigated and treated less intensively. [19]

5.4 Gender: Cancer incidence and mortality is higher in men than women but, more women than men are living with or beyond a diagnosis of cancer. Men have a lower awareness of the signs and symptoms of cancer.

5.5 Socio-economic deprivation: Incidence and mortality from cancer is considerably higher in the more deprived groups, largely due to lifestyle factors, especially higher smoking rates.

5.6 Brighton & Hove is a local authority with particularly high levels of smoking: 20.9% of the adult population smoke, compared to the England average of 16.9%. Amongst routine and manual workers, this rises to 34.2% of the adult population compared to the England average of 26.5%.[20]

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[19] The Age Old Excuse: The under treatment of older cancer patients; Macmillan Cancer Support Report. [Accessed 13.6.17]
http://www.macmillan.org.uk/documents/getinvolved/campaigns/ageoldexcuse/ageoldexcusereport-macmillancancersupport.pdf

[20] Public Health England: Fingertips Cancer Services Profile [Accessed 5.7.17]
https://fingertips.phe.org.uk/profile/cancerservices

5.7 There is evidence of poorer uptake of bowel and cervical cancer screening in GP practices with more deprived populations. This link with deprivation is not seen in breast screening. Screening uptake rates tend to be highest in the West locality which has fewer practices with more deprived populations.[21]

5.8 Ethnicity: Women from BME groups (including White Other) are more likely to present with more advanced breast cancers and have poorer survival than White British women. Locally non-white residents were more likely to perceive barriers to help-seeking. [22]

5.9 Sexuality: Differences in health-related behaviours among lesbian, gay, bisexual and transgender (LGBT) people may lead to differences in cancer incidence. Perceptions of risk and healthcare seeking behaviour may also vary. In 2012, a survey of 152 people from the LGBT community was carried out to investigate health and inclusion. In terms of cancer screening, a high percentage of LBQ women were not having smears at regular intervals although this can be said to be true of the Brighton & Hove screening population generally. Some individuals had been wrongly informed that they were not at risk because of their sexuality. [23]

5.10 Disability: There is limited national information on variations in cancer incidence, treatment and outcomes for people with a disability. People with learning disabilities appear to have a similar age standardised incidence rate for all cancers combined but incidence by tumour site may be different. There is some evidence for increased cancer incidence associated with some mental illnesses, which is associated with increased cancer mortality.35 A recent report found that eligible females without learning disabilities were more likely to receive breast cancer screening than eligible patients with learning disabilities.[24]

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[21] National Cancer Intelligence Network. Evidence to March 2010 on cancer inequalities in England. June 2010. [Accessed 30.08.13] Available from http://www.ncin.org.uk/view?rid=169
[22] Cancer Inequalities in the South East Region: The Burden of Cancer http://www.sepho.org.uk/Download/Public/10398/1/cancerIneq1_051006_FINAL.pdf

Lake Market Research. Cancer Awareness and Early Diagnosis Initiative CAM Final Results. NHS Brighton and Hove: April 2010.
[23] LGBT Health and Inclusion Project: Lesbian, Bisexual and Queer Women's Health Survey – Report (2012).
[24] Public Health England: Learning Disabilities Health and Care: The New Information Source, presented at the South East Public Health Information Group, June 2017

Sustainability:

5.11 The demand on services will increase as the population ages. Prevention screening and service provision needs to be considered the STP.
Reducing smoking will have an impact on environmental pollution .

5.12 Health, social care, children's services and public health:

There are and will need to be appropriate commissioning of services to prevent, screen, diagnose, treat and support people living beyond cancer across the age range and to address specific inequalities.

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6. Supporting documents and information

Appendix 1 The Cancer Strategy
Appendix 2 Updated JSNA on cancer and cancer screening.