Northumberland County Council

NHS Northumberland Clinical Commissioning Group

Northumberland Cancer Strategy

2018 - 2023

Northumbria Healthcare NHS Foundation Trust

Version	Changes	Author	Date
2	Minor changes following feedback and updates (e.g. waiting times)	Jim Brown	4 December 2017

Contents

Executive summary

Over 2000 people living in Northumberland are diagnosed with and treated for cancer each year, and more than 13,000 people are living with cancer. Whilst the number of people diagnosed with cancer each year in Northumberland is high, due in part to an older population, it is a notable achievement that the number as a proportion of the population (the 'incidence rate'), after adjusting for age, is not increasing. This is in contrast to the rest of England. However, lung cancer incidence is significantly higher than in England, particularly in the less affluent south east corner of the county. And, whilst survival from cancer is improving locally and nationally, Northumberland lags behind England in terms of lung cancer survival.

Our vision for Northumberland is:

- Fewer people getting preventable cancers;
- More people surviving for longer after a diagnosis;
- Reduced inequalities in survival from cancer in Northumberland;
- More people having a positive experience of care and support; and
- More people having a better long-term quality of life.

To achieve this vision, this strategy sets out a number of priorities that will be delivered by partners through the Northumberland Strategic Cancer Locality Group using the associated action plan:

Priority 1: Spearhead a radical upgrade in prevention and public health

- Optimise tobacco control and stop smoking pathways.
- Continuing to resource and support Fresh, the regional tobacco control programme, and Balance, the regional alcohol prevention programme.
- Develop whole-system approaches to tobacco control, promoting healthy weight, healthy diet and physical activity, and reducing harm from alcohol.
- Continue to promote 'making every contact count' (MECC) and embed into all clinical pathways including for people found not to have cancer following Two Week Wait referral.

Priority 2: Drive a national ambition to achieve earlier diagnosis

- Identify target communities, wards, localities and GP practice populations for risk reduction.
- Develop a coordinated approach to cancer awareness and screening media campaigns.
- Support general practices in Northumberland to reduce variation in early diagnosis.
- Explore opportunities to include early diagnosis of lung cancer in the continuing professional development of primary healthcare professionals.

- Support or develop interventions to improve access and uptake of cervical screening.
- Develop systems, job roles and specific interventions to decrease inequalities in screening uptake.

Priority 3: Establish patient experience as being on a par with clinical effectiveness and safety

- Ensure that patients are consistently offered information about entitlement to benefits and free prescriptions, and how to access them.
- Work with the North East & Cumbria Learning Disabilities Network, Northern Cancer Alliance and the Northumberland Community Learning Disabilities Team to understand experiences of cancer care for people with learning disabilities (or difficulties), develop a specific action plan to address any issues and explore how to assess access to and experience of services for people with learning disabilities.
- Develop and promote a directory of local services to facilitate local cancer support groups and health and social care professionals to provide peer and signposting support to cancer patients.
- Ensure appropriate integrated services for palliative and end of life care, in line with NICE quality standards, the Choice Review, the Ambitions for End of Life Care Framework and the Gold Standards Framework.

Priority 4: Transform our approach to support people living with and beyond cancer

- Continue to implement the Recovery Package for low-risk patients who have had breast cancer and continue to develop similar appropriate programmes for other cancers (including colorectal and urological cancers).
- Redesign pathways for, and improve management of, patients with lymphoedema.

Priority 5: Modern high quality services

- Implement a standardised lung cancer pathway aimed at optimising diagnostic, referral and treatment pathways, incorporating recommendations from the 2016 National Lung Cancer Audit and the National Lung Cancer Strategy, and the Accelerate, Coordinate, Evaluate (ACE) programme (when the evaluation is published).
- Ensure that there is regular liaison between Northumbria Healthcare NHS Foundation Trust (NHCFT) and Northumberland CCG to monitor Cancer Waiting Times (CWTs), including breaches, and to develop and monitor implementation of action plans for breaches.
- For Two Week Wait suspected cancer referrals, agree a patient choice offer of a minimum of one appointment in the first week and two appointments in the second week.

1 Introduction

1.1 Successes, challenges and opportunities

The number of people diagnosed with cancer in England is increasing by around 2% each year.[1] This increase is due to a growing and ageing population: people are less likely to die from other causes and cancer risk increases with age. It is also explained in part by changes in lifestyles including excess weight and alcohol consumption.[2] An estimated 42% of cancers in the UK are preventable, linked to a combination of 14 major lifestyle and other risk factors.[3]

The good news is that survival from cancer is improving, owing to earlier detection and improved treatment. Improved survival together with some improvements in lifestyle – notably fewer people smoking – has led to a decreasing mortality rate from cancer.[1]

Improved survival together with increasing numbers of people being diagnosed means that the number of people living with or who have experienced cancer is increasing. We need to maximise the quality of life of those people.

Despite improvements, survival from cancer in England remains less than in many other developed countries. This is thought to be due to later detection and sub-optimal treatment. There is also marked variation in survival from cancer within England with some CCGs having 10% or better survival than other CCGs.[1] Much of this is due to socioeconomic deprivation: there would be around 15,300 fewer cases and 19,200 fewer deaths per year across all cancers combined if socio-economically deprived groups had the same incidence rates as the least deprived.[1] However, not all of the difference is explained by socioeconomic factors, suggesting that there are additional opportunities for decreasing such variation.

1.2 National and regional context

The national cancer strategy, *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020*, was published in May 2016.[1] This strategy set out several strategic priorities:

- Spearhead a radical upgrade in prevention and public health.
- Drive a national ambition to achieve earlier diagnosis.

[1] Independent Cancer Task Force. *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020*. Available at: https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf
[2] http://scienceblog.cancerresearchuk.org/2015/02/04/why-are-cancer-rates-increasing/
[3] http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading-Zero

- Establish patient experience as being on a par with clinical effectiveness and safety.
- Transform our approach to support people living with and beyond cancer.
- Make the necessary investments required to deliver a modern high quality service.
- Overhaul processes for commissioning, accountability and provision.

The strategy had four aims:

- Fewer people getting preventable cancers;
- More people surviving for longer after a diagnosis, with 57% of patients surviving ten years or more;
- More people having a positive experience of care and support; and,
- More people having a better long-term quality of life.

The strategy identified the importance of delivery through regional Cancer Alliances:

> *"Working together in Cancer Alliances, and in partnership with patients, commissioners, providers and local authorities, clinical leaders from across different health and care settings in a local community will look at whole pathway data and information – including survival, prevention, early diagnosis rates, treatment outcomes, patient experience and quality of life – and use it to pinpoint areas for improvement through pathway redesign and changing clinical behaviours."*

The Northern Cancer Alliance (NCA) has a key action to *"Ensure all cancer locality groups have a delivery plan in line with the NCA and [Sustainability Transformation Plan] STP plans to achieve the cancer taskforce outcomes."* In Northumberland, there is a thriving Strategic Cancer Locality Group that oversees multiple activities to prevent cancer and improve the quality of care and outcomes for people who develop cancer.

This Northumberland Cancer Strategy provides an overarching framework for agreeing and delivering actions over the next 5 years, setting out the governance and priorities of partners across the system. Delivery will be monitored against the associated Northumberland Cancer Action Plan.

1.3 Our vision

Our vision for Northumberland is:

- Fewer people getting preventable cancers;
- More people surviving for longer after a diagnosis;
- Reduced inequalities in survival from cancer in Northumberland;
- More people having a positive experience of care and support; and
- More people having a better long-term quality of life.

1.4 How this strategy is structured

This strategy has been divided into five priorities:

- Spearhead a radical upgrade in prevention and public health.
- Drive a national ambition to achieve earlier diagnosis.
- Establish patient experience on a par with clinical effectiveness and safety.
- Transform our approach to support people living with and beyond cancer.
- Modern high quality service.

Each priority includes:

- Relevant data, current activities and possible gaps and opportunities (‘*Where are we now?*).
- Our vision and ambitions (‘*Where do we want to get to?*’).
- What we will do to achieve the vision and ambitions (‘*How will we get there?*’).

An action plan has been developed to meet each of the recommendations and include how we will monitor achievement (‘*How will we know we have arrived?*’).

1.5 Governance

The development of this strategy has been overseen and agreed by the Northumberland Cancer Strategic Locality Group, whose membership includes:

- Dr Stephen Doherty, Cancer Lead GP (Chair)
- Su Boyd, MacMillan Project Lead and Group Admin)
- Tina Thompson, Partnership Manager, MacMillan Cancer Support
- Fiona McQuiston, Health Professional Engagement Facilitator, Cancer Research UK
- Chris Walker, Chair, Northumbria Cancer Patient & Carer Group
- Jean Gardner, Deputy Chair, Northumbria Cancer Patient & Carer Group
- Andrew Colvin, Lead Health Trainer / Health Improvement Practitioner, Northumbria Healthcare NHS Foundation Trust (NHCFT)
- Amanda Walshe, Lead Cancer Nurse, NHCFT
- Judith Woodruff, Voluntary Sector Rep, Coping with Cancer North East
- Kirsty McLanders, Screening and Immunisation Team, NHS England
- Dr Jim Brown, Consultant in Public Health, Northumberland County Council
- Sheron Robson, Northern Cancer Alliance, NHS England
- Dr Katie Elliott, GP Clinical Lead Northern Cancer Alliance, NHS England

There is also a Northumberland CCG Cancer Group that provides additional oversight. The strategy and action plan will be presented to the Northumberland Health and Wellbeing Board and the Northumberland CCG Governing Body for approval and support for implementation.

The implementation of the strategy and its associated action plan will be overseen by the strategic locality group, which seeks to submit an annual report to the Health and Wellbeing Board to update on progress against the action plan.

1.6 Cancer in Northumberland

A brief summary of cancer incidence, prevalence, survival and mortality is presented here. Further brief information is also included within each section. A more detailed profile of cancer in Northumberland is available.

1.6.1 Incidence

The rate of new cancer cases (incidence rate) is similar in Northumberland to the England average: 636.8 new cases compared to 608.3 per 100,000 population.[4] Whilst there has been an upward trend in the incidence rate of cancer (after adjusting for age) in England by 0.8% per year since 2001, it is notable that there has been no such increase in Northumberland. A total of 2052 people living in Northumberland CCG area were treated for cancer in 2016/17.[5]

After adjusting for age, the incidence rates for lung cancer and breast cancer are significantly *higher* in Northumberland than England. Lung cancer incidence since 2001 has remained static, and incidence of breast cancer is increasing.

Many of the most deprived wards in Northumberland have some of the highest incidence rates of cancer - in particular in parts of south east Northumberland (see Figure 1). However, there are areas with lower deprivation but high incidence of cancer, for example in Norham and Islandshire, Bamburgh, and Amble West with Warkworth.

There is also variation by CCG locality. Cancer incidence, and lung cancer incidence in particular, are significantly higher in Blyth Valley and Central localities than the England average after adjusting for age (see Figure 2). Both North and West localities have significantly higher incidence of colorectal cancer compared to the England average.

1.6.2 Prevalence

In 2015/16, there were 13,067 people with a diagnosis of cancer (excluding non-melanoma skin cancer), or 4.1% of the population registered with GPs in Northumberland.

[4] https://www.cancerdata.nhs.uk/dashboard#?tab=Trends&ccg=00L
[5] NHS England. Cancer waiting times. Commissioner Time Series by CCG. Q1 2013-14 to Q4 2016-17

Figure 1. Index of multiple deprivation (IMD) in 2015 and incidence of all cancers (standardised incidence ratio, SIR) in 2010-14 by electoral ward in Northumberland

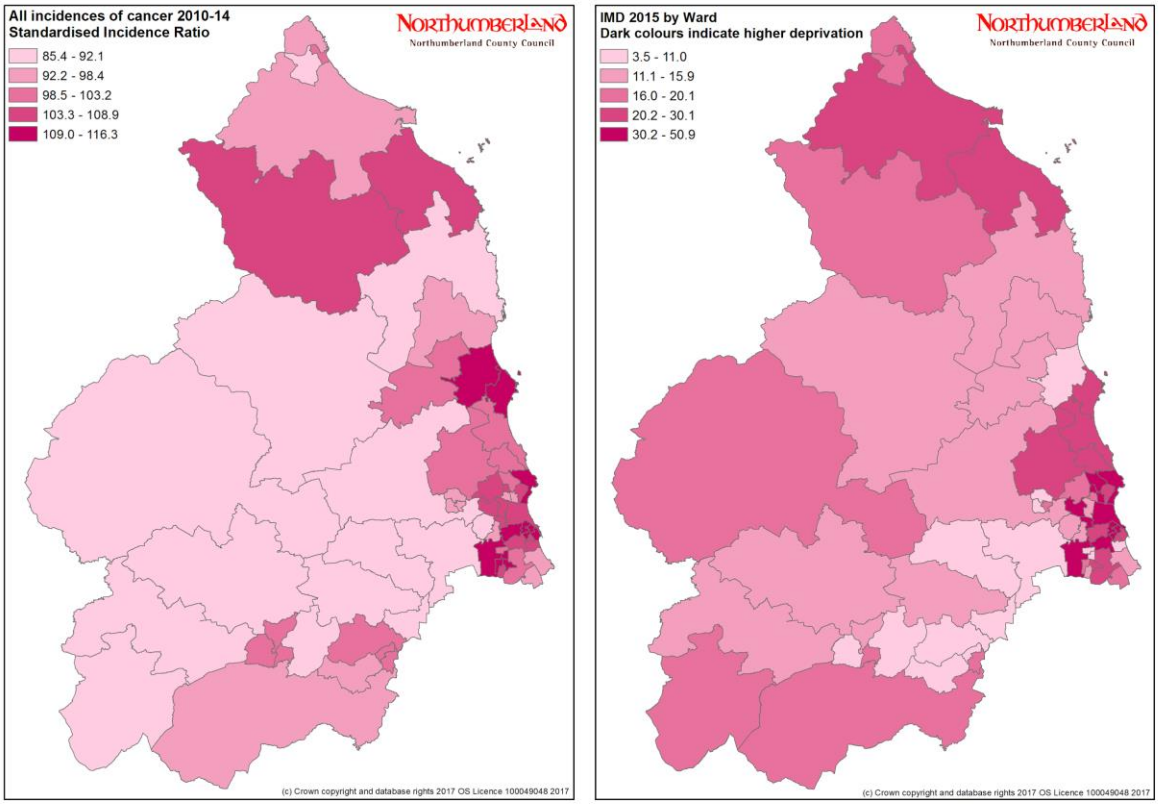
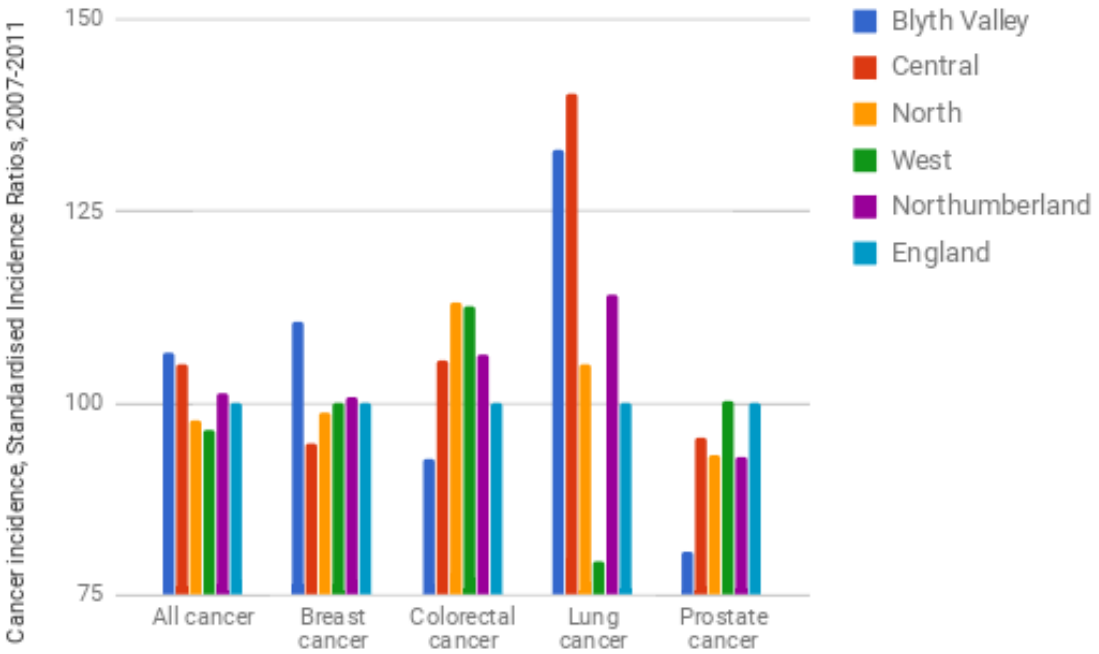


Figure 2. Cancer incidence by cancer site and CCG locality



1.6.3 Survival

In England and Wales, 50% of people diagnosed with cancer live for 10 years or longer. (No data on five-year and ten-year survival are available at the local level.) In 2014, one-year survival from all cancer except non-melanotic skin cancer and prostate cancer in Northumberland was similar to the England average: 69.8% compared to 70.4%. However, since 1999, one-year survival has gone from being significantly better than the England average to similar.

One-year survival for breast and colorectal cancer in Northumberland CCG is similar or better than the England average. However, it is significantly worse for lung cancer (see Table 1), and has been at least since 2010.

Table 1. Comparisons of one year survival by cancer type

Cancer type	**One-year survival (diagnosed in 2014 followed up to 2015)**	
	Northumberland	**England**
Breast	97.8%	96.5%
Colorectal	78.1%	77.2%
Lung	31.7%**	36.8%
All*	69.8%	70.4%

*Excluding non-melanotic skin cancer and prostate cancer
**Significantly worse than England average
Source: https://www.cancerdata.nhs.uk/dashboard#?tab=Trends&ccg=00L

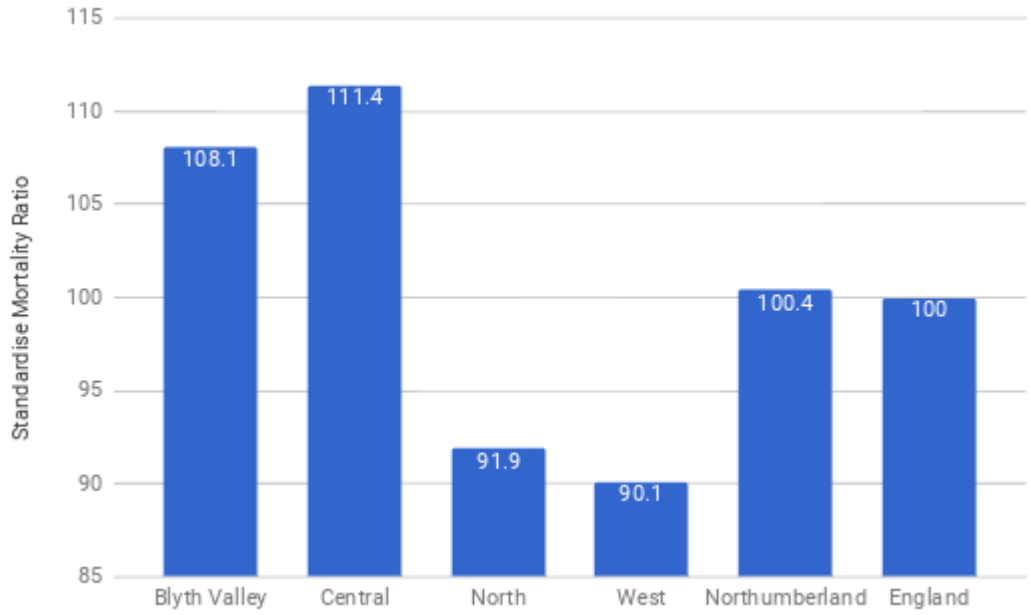
1.6.4 Mortality

Mortality in Northumberland from all cancers is similar to the England average, and the lowest in the North East.[6] Age-standardised premature mortality from cancer (under 75 years) in Northumberland was 141.2 deaths per 100,000 population; this is similar to the England rate (138.8 per 100,000 population) but significantly *lower* than the rate for the North East (162.7 per 100,000 population). Premature mortality from cancer has been decreasing over time.

In 2008 to 2012, all-ages mortality from cancer and premature mortality from cancer under 75 years of age (see Figure 3) were both significantly higher in Blyth Valley and Central localities, and significantly lower in West locality, than the England average.

[6] Public Health England. Cancer in the North East.

Figure 3. Comparisons of premature mortality from all cancers (aged under 75 years) between CCG localities and England - Standardise Mortality Ratios, 2008-2012



2 Spearhead a radical upgrade in prevention and public health

An estimated 42% of cancer cases each year in the UK are preventable, linked to a combination of 14 major lifestyle and other risk factors. The proportion is higher in men (45%) than women (40%), mainly due to the sex difference in smoking.

2.1 Tobacco

Smoking is the biggest preventable cause of cancer and accounts for more than a quarter of cancer deaths and 19% of all cancer cases.[7] The proportion of adults who smoke in Northumberland has decreased over recent years and is the lowest in the North East, but slightly higher than the England average: 16.9% compared to 15.5% in 2016. However, 30% of adults in routine and manual occupations and 37.1% of adults with serious mental illness in Northumberland are current smokers (compared to 25.5% and 40.5% respectively in England).

The Integrated Wellbeing Service undertakes local coordination on tobacco control and delivers a Stop Smoking Service. The Stop Smoking Service sees a higher proportion of people who live in the most deprived than the least deprived areas, thus contributing to decreasing health inequalities. Both Northumberland Tyne and

[7] http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading-Zero

Wear NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust have or are implementing smoking-free policies and interventions. Northumberland County Council is one of 11 local authorities that fund Fresh, a regional office for tobacco.

Fresh and the Making Smoking History in the North East Partnership set a vision that we could and should get smoking down to 5% (or fewer) people smoking by 2025, which is reiterated in the Northern Cancer Alliance (NCA) delivery plan. The Alliance also has an ambition of 13% of all adults, 21% of routine and manual workers, and 32% of adults with serious mental illness being smokers by 2020. Our aim in Northumberland is to meet the NCA target, and strive to meet the more ambitious aim set by the Making Smoking History in the North East Partnership.

The actions below are in line with *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020*,[1] the Northern Cancer Alliance Delivery Plan, and *Towards a smoke-free generation: a tobacco control plan for England*.[8]

We will optimise tobacco control in Northumberland and stop smoking pathways for Northumberland residents by:

- **Developing a whole-system approach to tobacco control.**
- **Reviewing and maximising the effectiveness, equity and efficiency of current services (in terms of numbers accessing, quit rates, impact on health inequalities, and capacity building/training of frontline staff).**
- **Increasing opportunities for healthcare professionals to offer support to people who smoke to stop smoking, including access to structured support, smoking cessation medication and follow up, targeting areas with highest smoking prevalence.**
- **Continuing to implement smoke-free NHS policies within both local NHS trusts.**
- **Continuing to resource and support Fresh, the regional tobacco control programme.**

2.2 Other risk factors

It is estimated that 4% of cancer cases in the UK each year are due to alcohol consumption.[9] Alcohol increases the risk of cancers of the breast, bowel, oesophagus, mouth, larynx, and liver. As in England as a whole, the incidence rate of alcohol-related cancer has seen a small rise in Northumberland from 35.7 to 38.4 per 100,000 between 2004-6 and 2013-15.[10] Adults (in particular, middle-age adults) in the North East (and North West) have the highest levels of binge drinking and

[8] https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

[9] Parkin DM. Cancers attributable to consumption of alcohol in the UK in 2010(link is external). Br J Cancer 2011;105 (S2):S14-S18

[10] https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938132984/pat/6/par/E12000001/ati/102/are/E06000057

alcohol consumption. That said, there is an overall downward trend in the amount of alcohol consumed in the UK driven by an increase in the numbers of tee-totallers and a reduction in young people drinking alcohol.[11]

An estimated 5% of cancer cases in the UK are due to excess bodyweight.[9] More than two-thirds (69.8%) of adults living in Northumberland are overweight or obese (2013-15).[12] This figure is 64.8% for England as a whole. In 2015/16, a third of children in year 6 (10-11 years of age) were overweight or obese. This proportion has remained static since 2006/7. In 2015, more than half (56.6%) of adults surveyed in Northumberland said that they consumed 5 or more portions of fruit or vegetables on a usual day (53.3% in England).[13]

Physical inactivity accounts for 1% of cancer case in the UK.[9] In 2015, just over half (55%) of adults surveyed in Northumberland stated that they achieved at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer (CMO) recommended guidelines on physical activity (57%). A quarter (24.3%) of adults in Northumberland are inactive, compared to 22.3% in England.[14]

Over 70% of cervical cancers are caused by two high-risk human papilloma virus (HPV) types – 16 and 18 – that are covered by a vaccine available to all 12-13 year-old girls as part of a national programme. In 2015/16, Northumberland outperformed England and the North East averages for girls 13-14 years of age who had received the recommended two doses.[15]

Current health improvement services in Northumberland include: an integrated substance misuse treatment and recovery service provided by the Northumbria Recovery Partnership; the Northumbria Healthcare NHS Foundation Trust (NHCFT) Alcohol Care Team, an alcohol liaison team that also provides alcohol identification and brief advice in secondary care settings; and the Integrated Wellbeing Service, which includes a health trainer service and specialist health improvement. There are also Healthy Weight and Drug and Alcohol Strategy groups, partnerships to promote physical activity, including the Northumberland Sports Partnership and Active Cramlington, and the embedding of 'making every contact count' into clinical pathways (a key objective of both the Accountable Care Organisation Clinical

[11] Report to the Health and Wellbeing Board. The Impact of Alcohol consumption in Northumberland. 8th October 2015.
[12] http://www.phoutcomes.info/public-health-outcomes-framework#page/1/gid/1000042/pat/6/par/E12000001/ati/102/are/E06000057/iid/90277/age/164/sex/4
[13] http://www.phoutcomes.info/public-health-outcomes-framework#page/1/gid/1000042/pat/6/par/E12000001/ati/102/are/E06000057/iid/90277/age/164/sex/4
[14] http://www.phoutcomes.info/public-health-outcomes-framework#page/1/gid/1000042/pat/6/par/E12000001/ati/102/are/E06000057/iid/90277/age/164/sex/4
[15] http://fingertips.phe.org.uk/search/HPV#page/1/gid/1/pat/6/par/E12000001/ati/102/are/E06000057/iid/92319/age/206/sex/2

Strategy and the Northern Cancer Alliance Delivery Plan).[16] Northumberland County Council also funds Balance, the regional alcohol prevention programme.

Our aims are to:

- Reduce the proportion of children aged 4/5 years who are overweight or obese from 23% in 2015/16 to 21% in 2023.
- Reduce the proportion of children aged 10/11 years who are overweight or obese from 33% in 2015/16 to 31% in 2023.
- Reduce the proportion of adults who are overweight or obese from 69.8% in 2013-15 to 65% in 2021-23.
- Reduce the proportion of adults who are physically inactive from 24.3% in 2015/16 to 20% by 2022/23.
- Reduce the incidence rate of alcohol-related cancer from 38.35 per 100,000 population in 2013-15 to 35 per 100,000 in 2021-23.

We will:

- **Develop whole-system approaches to promoting healthy weight, healthy diet, physical activity and reducing harm from alcohol.**
- **Continue to promote 'making every contact count' (MECC) and embed into all clinical pathways, including for people found not to have cancer following Two Week Wait referral.**
- **Continue to resource and support Balance, the regional alcohol prevention programme.**

3 Drive a national ambition to achieve earlier diagnosis

Diagnosis at an early stage of a cancer's development leads to significantly improved survival outcomes.[17] Tackling late diagnosis of cancer is a national priority.[18]

The percentage of people whose cancer was staged was significantly higher in Northumberland than the England average in 2013 (74.1% compared to 70.8%) having been significantly worse the year before (2012).[19] As a proportion of all those diagnosed with cancer at any stage or unknown stage, in Northumberland 55.4% had cancer diagnosed at an early stage (stage 1 or 2) in 2014 (quarter 4), compared to 50.7% in England.[19]

[16] http://www.makingeverycontactcount.co.uk/
[17] http://www.nature.com/bjc/journal/v112/n1s/pdf/bjc201549a.pdf
[18] http://www.cancerresearchuk.org/sites/default/files/achieving_worldclass_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf
[19] https://www.cancerdata.nhs.uk/dashboard#?tab=Overview&ccg=00L

There are currently national screening programmes for breast cancer, colorectal cancer, and cervical cancer.[20] Although cancer screening uptake is high in Northumberland relative to England and to other areas in the North East,[21] there remain several challenges:

- Between 26% and 32% of the eligible population of each cancer screening programme are not screened.[21]
- Bowel screening uptake is well below the target of 75%.[21]
- People from general practices in the most deprived areas are significantly less likely to take up screening than those from practices in the least deprived areas.[22] [23]
- There is some evidence that people with learning disabilities may be less likely to undergo breast or bowel screening.[24]
- Cervical screening uptake has been decreasing across the United Kingdom for at least 10 years, particularly by younger women. The reason for the decrease is not fully understood. In Northumberland, although the decrease is less marked, uptake has decreased from 81.4% in 2009/10 to 78.5% in 2015/16.[25]

Survival rates for people diagnosed via emergency routes are considerably lower than for people diagnosed via other routes. The proportion of cancer admissions diagnosed for the first time via emergency presentation has been consistently slightly *lower* in Northumberland (18% in quarter 4 2015) than in England (20.3%).[26] However, the proportion is high (33.1%) for upper gastrointestinal cancer.

Crude (that is, unadjusted for confounders such as age or sex) rates of emergency admissions, emergency presentations and other presentations for cancer are all higher in Northumberland than England, most likely due to higher age-standardised incidence rates and an older age profile in Northumberland.[27]

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[20] https://www.gov.uk/topic/population-screening-programmes

[21] http://fingertips.phe.org.uk/search/cancer%20screening#page/4/gid/1/pat/46/par/E39000027/ati/19/are/E38000130/iid/91339/age/265/sex/2

[22] PHE. Cancer in the North East.

[23] http://fingertips.phe.org.uk/profile/general-practice/data#mod,4,pyr,2016,pat,153,par,E38000130,are,-,sid1,2000005,ind1,91872-4,sid2,1938132829,ind2,91342-4

[24] https://app.powerbi.com/view?r=eyJrIjoiYTY2ZGM0ZGQtZGY0My00ZmFiLTljNTctYmNhMzA2OGJlYjczIiwidCI6IjgwN2YyZjMwLWNhOGMtNDE5Zi1hMTc5LTVjNGZjN2E0YmY2YiIsImMiOjN9&pageName=ReportSection

[25] http://fingertips.phe.org.uk/search/cancer%20screening#page/4/gid/1/pat/46/par/E39000027/ati/19/are/E38000130/iid/91339/age/265/sex/2

[26] https://www.cancerdata.nhs.uk/dashboard#?tab=Trends&ccg=00L

[27] https://fingertips.phe.org.uk/profile/cancerservices/data#page/1/gid/1938132830/pat/46/par/E39000027/ati/19/are/E38000130/iid/91355/age/1/sex/4

Figure 4. Screening uptake in Northumberland

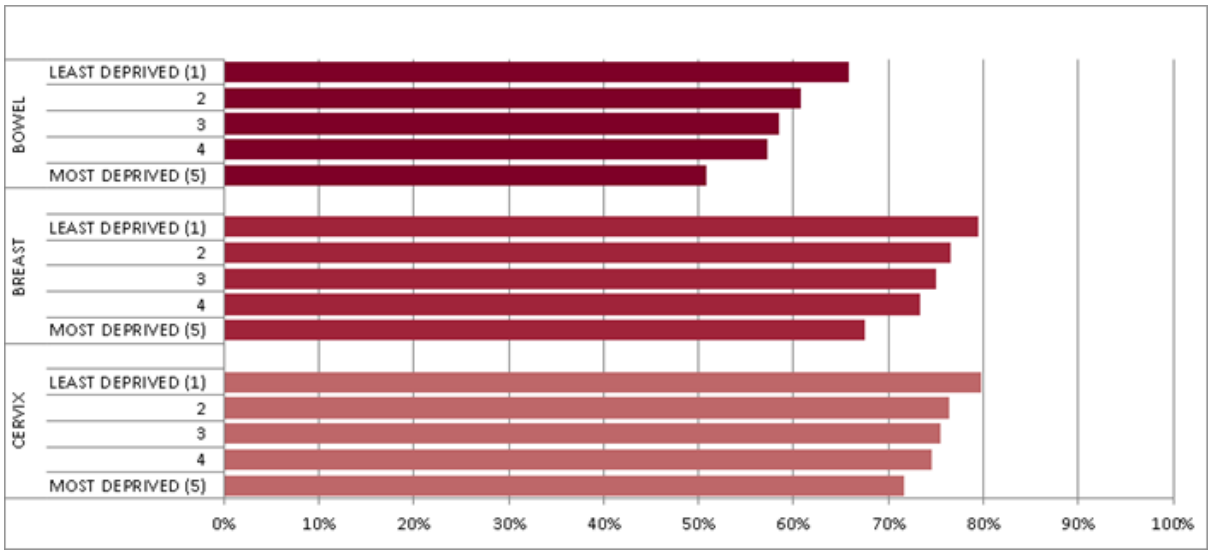
Compared with benchmark: Better, Similar, Worse, Not Compared

Benchmark Value: Worst/Lowest, 25th Percentile, 75th Percentile, Best/Highest

Indicator	Period	Northumberland			Sub-region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	2015/16	↑	39,921	78.3%	75.3%*	72.5%	49.2%		80.7%
Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	2015/16	↓	10,392	78.9%	76.0%*	73.5%	47.3%		83.2%
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	2015/16	↓	60,714	78.5%	75.6%*	72.8%	55.8%		82.7%
Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2015/16	↓	15,066	62.0%	57.5%*	55.6%	33.5%		65.2%
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2015/16	↑	29,760	63.7%	59.7%*	57.8%	35.4%		66.6%
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2015/16	↑	41,867	65.0%	60.9%*	58.5%	36.2%		67.4%
Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2015/16	↑	21,362	62.7%	58.6%*	56.4%	34.8%		66.0%

Source: PHE Cancer Profiles[25]

Figure 5. Screening uptake by deprivation quintile of practice, North East, 2014/15



Source: PHE. Cancer in the North East.

Four other factors are associated with earlier diagnosis of cancer, for which there is considerable variation between practices: [28] [29] [30] [31]

[28] https://www.ncbi.nlm.nih.gov/pubmed/22947579/

[29] https://www.ncbi.nlm.nih.gov/pubmed/26141458

[30] https://fingertips.phe.org.uk/profile/cancerservices/data#page/1/gid/1938132830/pat/46/par/E39000027/ati/19/are/E38000130/iid/91355/age/1/sex/4

[31] https://gp-patient.co.uk/SurveysAndReports

- Higher conversion rate (proportion of people referred by Two Week Wait who were diagnosed with and treated for cancer): *similar* in Northumberland to England.
- Higher detection rate (proportion of people treated for cancer who were diagnosed via Two Week Wait referral): significantly *lower* in Northumberland than England.
- For female breast cancer and lung cancer only (but not necessarily for other cancers), higher Two Week Wait referral rate: significantly *higher* in Northumberland for all cancer.
- Being at a practice where people perceive it is easier to book at appointment: significantly *better* in Northumberland.

Most people (92%) who are referred via Two Week Wait do not have cancer. At this time, they will be focused on their health, and many will be more receptive to messaging around lifestyle risk factors and symptom awareness, thus presenting a 'teachable moment'.[1] Advice could be given by the GP, the diagnostic clinician, or another health care professional.

The Integrated Wellbeing Service undertakes a number activities to increase cancer awareness in Northumberland, including campaigns, training of frontline staff, cancer awareness information provided by health trainers and stop smoking advisors, and developing 'health champions' in communities, who promote cancer awareness.

The Macmillan Cervical Screening ('Pink Letter') Project is supporting general practices in Northumberland to send pink letters to women that do not attend for their cervical screening and then follow up with telephone call from the practice nurse. This project was due to finish in Oct 2017, but is expected to continue until all engaged practices have submitted data for 2 years. Public Health England, in association with Jo's Trust, have recently proposed actions to improve uptake.[32]

Following an audit of lung cancer emergency presentation, the lung cancer specialist nurses at Northumbria are gathering 'soft data' from patients newly diagnosed with lung cancer via emergency admission, to determine the reasons why they did not present to primary care in the run up to their diagnosis. This will inform future interventions to promote earlier diagnosis. (See also the sections on Lung cancer and Cancer waiting times.)

In Doncaster, a public awareness campaign in conjunction with brief intervention training in general practices resulted in increased likelihood of presentation to a GP and requesting a chest x-ray following a prolonged cough (3 weeks or longer).[33]

[32] https://www.gov.uk/government/publications/cervical-screening-coverage-and-data/cervical-screening-ideas-for-improving-access-and-uptake
[33] http://thorax.bmj.com/content/thoraxjnl/early/2011/11/02/thoraxjnl-2011-200714.full.pdf

Following the Be Clear on Cancer national lung cancer awareness campaign, there was a small but significant increase by 3% in the proportion of non-small cell lung cancers diagnosed at stage 1 and a 2% increase in resections for patients seen during the national campaign, with evidence that these proportions did not change during the control period.[34]

Our aims are to:

- Increase the proportion of all those diagnosed with cancer at any stage or unknown stage in Northumberland who had their cancer diagnosed at an early stage (stage 1 or 2) from 55.42% in 2014 (quarter 4) to 60% in 2023.
- Increase the one-year survival for people with lung cancer from 31.7% if diagnosed in 2014 to 40% for those diagnosed in 2022. (No data are available for Northumberland on the more important statistic of 5-year survival from lung cancer. However, there is some evidence to suggest a correlation between one-year and five-year survival.[35])
- Increase uptake of cervical screening to the national target (currently 80%).
- Reduce socioeconomic and other inequalities in cancer screening uptake

Our proposed actions are in line with the national cancer strategy.[1]

We will:

- **Identify target communities, wards, localities and GP practice populations for risk reduction.**
- **Develop a coordinated approach to cancer awareness and screening media campaigns.**
- **Support general practices in Northumberland to reduce variation in early diagnosis.**
- **Develop further opportunities to include early diagnosis of lung cancer in the continuing professional development of primary healthcare professionals.**
- **Support or develop interventions to improve access and uptake of cervical screening.**
- **Develop systems, job roles and specific interventions to decrease inequalities in screening uptake, including working with the Cancer in the Community group, Macmillan, CRUK, the regional Learning Disabilities network and the Northern Cancer Alliance, and including an explicit function in job descriptions for roles funded by NHS England Cancer Transformation programme.**

[34] http://www.nature.com/bjc/journal/v112/n1/full/bjc2014596a.html?foxtrotcallback=true
[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3018568/

4 Establish patient experience on a par with clinical effectiveness and safety

In the National Cancer Patient Experience Survey 2015, respondents registered with a Northumberland CCG practice rated their overall experience of care (very good) as 89%, which compares favourably with the national average of 87% and is the highest for any CCG in the Cumbria and North East region. [36] [37] Similar positive survey results were found for Northumbria Health Care NHS Foundation Trust[38] and Newcastle upon Tyne Hospitals NHS Foundation Trust.[39]

For almost all questions, Northumberland was better or similar to the national average. The only two questions where Northumberland patients scored at the lower end of the expected range or significantly lower *were 'Q22 Hospital staff gave information on getting financial help'* and *'Q23 Hospital staff told patient they could get free prescriptions'*, respectively.

Place of death and hospital use in the last 100 days or year of life are proxy measures of the quality of end-of-life care. Home is the preferred place of care and death for the majority of people – including patients, caregivers and the public – and most do not change this preference.[40] Around two thirds of people with a serious illness such as cancer and less than a year to live would choose home as their preference.[41] That said, a substantial minority (20%) change their preference over time.[42]

In 2015, 45.3% of deaths with an underlying cause of cancer occurred in the person's usual place of residence; this was similar to the percentage for England (44.4%) and for 10 most similar CCGs, and slightly lower than that for Cumbria and the North East (47.9%).[43] In common with England as a whole, the percentage has been increasing since 2004 (see Figure 6). The highest percentage for an area was 65.4%.

[36] http://www.ncpes.co.uk/index.php/reports/local-reports/ccg/2855-00l-nhs-northumberland-ccg-2015-ncpes-report/file
[37] https://www.cancerdata.nhs.uk/dashboard#?tab=Overview&ccg=00L
[38] http://www.ncpes.co.uk/index.php/reports/local-reports/trusts/3171-rtf-northumbria-healthcare-nhs-foundation-trust-2015-ncpes-report/file
[39] http://www.ncpes.co.uk/index.php/reports/local-reports/trusts/3169-rtd-the-newcastle-upon-tyne-hospitals-nhs-foundation-trust-2015-ncpes-report/file
[40] Gomes et al. Heterogeneity and changes in preferences for dying at home: a systematic review, BMC Palliative Care 2013; 12(1):7
[41] Gomes B et al on behalf of PRISMA. Preferences for place of death if faced with advanced cancer: A population survey in England, Flanders, Italy, Germany, the Netherlands, Portugal and Spain. Annals of Oncology 2012; 23(8):2006-15.
[42] www.endoflifecare-intelligence.org.uk/view?rid=771
[43] https://fingertips.phe.org.uk/profile/end-of-life/data#page/1/gid/1938132902/pat/46/par/E39000027/ati/19/are/E38000130/iid/92449/age/1/sex/4

Out of a total of 1710 people who died in hospital in 2016-17, 585 (34.2%) spent 25 days or more in hospital out of their last 100 days.[44] The average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died during 2013-2015 was 20.8 days (compared to 18.8 for England).[45]

As well as the last national strategy published in 2008,[46] there are several sources of guidance and support for end-of-life care, including:

- NICE quality standards on End of life care for adults and Care of dying adults in the last days of life.
- The Department of Health Choice in End of Life Care review ('Choice Review').
- NHS England and National Palliative and End of Life Care Partnership Ambitions for palliative and end of life care framework.
- The Gold Standards Framework.

In Northumberland, the Care for the Dying document is used to support care planning for patients dying at home. Anticipatory medications are in place in patients' homes when required. Communication between primary care, North East Ambulance Service (NEAS) and GP out of hours services are vital in providing care for patients in their home environment.

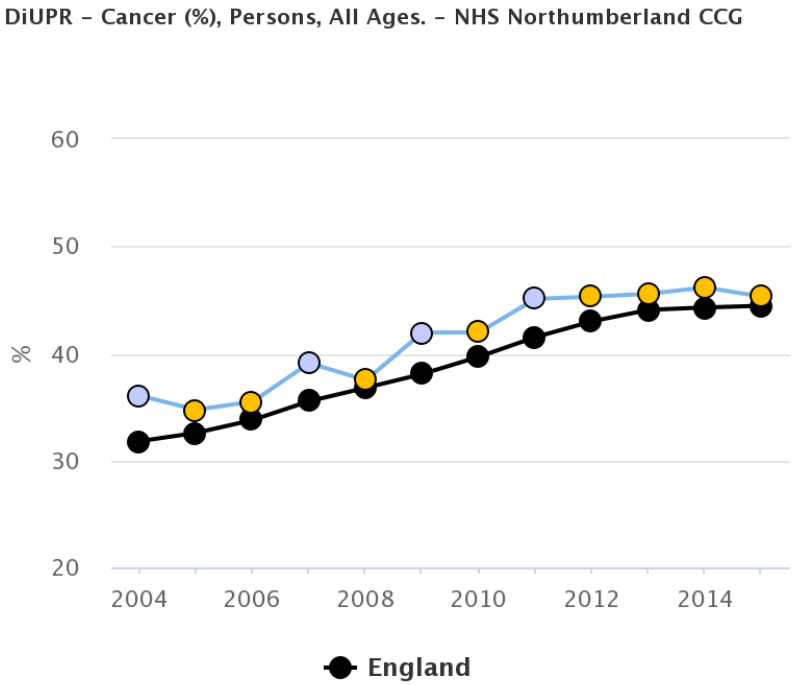
No information was found on carer experience in Northumberland that is specific to carers looking after people with cancer.

There is evidence that people with learning disabilities, or learning difficulties, have additional care needs and barriers to cancer care, which span prevention, early diagnosis, and experience.[47] End of life care is a specific area in which several studies have identified issues.[48]

A pilot is currently been undertaken with Macmillan Cancer Support to offer electronic health needs assessment (HNA), which is offered to all new diagnosed urological cancer patients. It is planned to roll out HNA to all newly diagnosed breast patients.

[44] Northumberland CCCG. Northumberland Vanguard Primary and Acute Care System and ACO Programme Metrics Report. July 2017
[45] NHS Right Care and Public health England. Commissioning for Value Focus Pack. Cancer and tumours. NHS Northumberland CCG. April 2017
[46] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf
[47] Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020; https://www.2gether.nhs.uk/files/serviceforcancerpatients.pdf
[48] http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2006.00350.x/full

Figure 6. Comparison of the proportion of people with an underlying cause of cause who died in their usual place of residence between Northumberland and England (2004-2015)



Our aims are to:

- Maintain the current high levels of overall experience of cancer care.
- Increase the proportion of deaths with an underlying cause of cancer that occur in the person's usual place of residence from 45.3% in 2015 to 50% by 2022.
- Improve the experience of people with learning disabilities, or learning difficulties, who are diagnosed with cancer.

These actions are based on recommendations in *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020*.[1]

We will:

- **Ensure that patients with cancer are consistently offered information about entitlement to and how to access benefits and free prescriptions.**
- **Work with the North East & Cumbria Learning Disabilities Network, Northern Cancer Alliance and the Northumberland Community Learning Disabilities Team to: understand experiences of cancer care for people with learning disabilities (or difficulties); develop a specific action plan to address any issues; and explore how to assess access to and experience of services for people with learning disabilities.**
- **Develop and promote a directory of local services to facilitate local cancer support groups and health and social care professionals to provide peer and signposting support to cancer patients.**
- **Ensure appropriate integrated services for palliative and end of life care, in line with NICE quality standards, the Choice Review, the Ambitions for End of Life Care Framework and the Gold Standards Framework.**

5 Transform our approach to support people living with and beyond cancer

Of the 2052 people from Northumberland treated for cancer in 2016/17, at least half can expect to live for 10 years or longer. However, living longer does not always mean living well: one in four people who have been treated for cancer live with ill health or disability as a consequence of their treatment.[49]

The National Cancer Survivorship Initiative (NCSI) developed the Recovery Package, a combination of interventions to assist people living with a diagnosis of cancer to prepare for the future, identify their individual needs and support them to live well after treatment.[49]

In Northumberland, there is an established Recovery Package ('survivorship' programme) for patients who have recovered from breast cancer. Stratified follow up for low risk patients has been implemented from 1st April 2017. Similar programmes are being developed for patients who have had colorectal and urology cancers. The recovery package consists of health needs assessments, treatment summaries and wellbeing events. It is planned that the first wellbeing event will take place in November 2017 and sessions will be rotated throughout the area and incorporate generic and site-specific sessions.

There is also an ongoing project to redesign the chronic oedema pathways with Tissue Viability and St Oswald's Hospice. It is anticipated that this will involve training and education of primary and community care staff and hub working.

A major depressive disorder is thought to occur in around 10% of people with cancer, and there are concerns that many do not receive adequate treatment.[49] Although there is emerging evidence on effective interventions, further research and piloting is needed on the most appropriate pathway for cancer patients.[50]

NHCFT provide a leaflet for patients ('*Your feelings and* cancer') containing useful links to sources of support. These include self-help resources (for example, on mindfulness) and professional sources, including Macmillan Support, specialist cancer nurses, the Cancer Psychology Service, the person's GP, and Talking Therapies.

Our aim is to improve the quality of life of people living with or beyond cancer.

[49] https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf
[50] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2361139/

We will:

- **Continue to implement the Recovery Package for low-risk patients who have had breast cancer and continue to develop similar appropriate programmes for other cancers (including colorectal and urological cancers).**[1]
- **Redesign pathways for, and improve management of, patients with lymphoedema.**

6 Modern high quality services

6.1 Lung cancer

Lung cancer detection, early diagnosis and treatment are a priority for Northumberland. Despite similar levels of overall socioeconomic deprivation, lung cancer incidence, survival and mortality in Northumberland compare unfavourably with the England average.

In England, lung cancer kills more people than any other cancer: 28,000 people in 2011. Only one in 10 people with lung cancer live for 5 years or longer after diagnosis.[51] The main cause of lung cancer is tobacco smoking, which accounts for 80-90% of lung cancers. Adult smoking prevalence in Great Britain decreased from 46% in 1974 (51% in men, 41% in women) to 19% in 2013 (22% in men, 17% in women).[52] Consequently, between 1990 and 2011, the age-standardised incidence rate of lung cancer in England decreased in men; however it *increased* in women.[53] This increase in women is thought to be due to a slower decline in smoking prevalence in women. In the USA, where a similar increase in lung cancer incidence among women has occurred, there was a steep increase in the 1990s in smoking rates among teenage girls with less than high school education.[54]

6.1.1 Incidence of lung cancer

In Northumberland, the incidence rate of lung cancer is significantly higher than in England, in common with many other CCGs in Cumbria and the North East, and has plateaued since 2001.[60] The age-standardised incidence rate of lung cancer in 2014 was 92.9 per 100,000 population in Northumberland, compared to 78.3 per 100,000 in England. Blyth Valley and Central localities have significantly higher incidence of lung cancer than England, whereas West locality has significantly lower incidence of lung cancer (see Figure 2).

[51] https://www.cancerdata.nhs.uk/dashboard#?tab=Trends&ccg=00L

[52] https://digital.nhs.uk/media/26786/Statistics-on-Smoking-England-2015-Tables/Any/stat-smok-eng-2015-tab

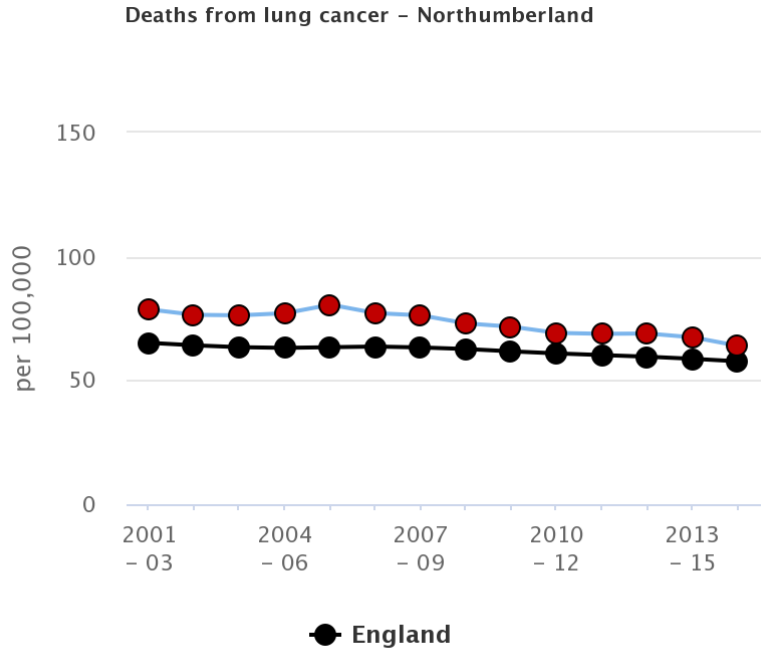
[53] http://ncin.org.uk/publications/data_briefings/recent_trends_in_lung_cancer_incidence_mortality_and_survival

[54] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2846780/

6.1.2 Survival and mortality from lung cancer

One-year survival from lung cancer (diagnosed in 2014 followed up to 2015) in Northumberland is 31.7%; this is significantly lower than the England average of 36.8%.[51] One-year survival from lung cancer has improved at a slower rate than England: in 1998, one-year survival in Northumberland was 24.9%, compared to 24.3% in England. Age-standardised *premature* mortality from lung cancer (under 75 years) was 37 per 100,000 population in Northumberland, compared to 32.1 per 100,000 in England. The age-standardised mortality rate from lung cancer (all ages) remains higher in Northumberland than England, but the gap is narrowing (see Figure 7).

Figure 7. Age-standardised mortality rate from lung cancer per 100,000 population



6.1.3 Diagnosis of lung cancer

A large national study reported an average delay of 33 days between symptom onset and presenting to a primary care professional in people who were subsequently diagnosed with lung cancer, and a further average delay of 33 days between this first presentation and specialist referral. [55] The authors recommended: “continuing efforts to support the diagnostic process after presentation to a general practitioner are needed, including the use of decision-support/risk assessment tools, clinical audit/root cause analysis reviews and widening of access to specialist diagnostics”. Decision support tools are also recommended in an evaluation of such tools as part of the Accelerate, Coordinate, Evaluate programme as a support to clinical judgment

[55] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4385974/

and a way to heighten GP awareness of cancer symptoms.[56] A local audit suggests that low awareness by patients of symptoms suggestive of lung cancer is a factor.[57]

6.1.4 Healthcare utilisation and costs from lung cancer

Northumberland CCG has a relatively high spend on non-elective (unplanned) admissions and similar spend on elective (planned) admissions for lung cancer to the England average:[58]

- Total spend on non-elective admissions for lung cancer per 1,000 age-sex weighted population in 2015/16 was £1,529 in Northumberland, compared to £963 in England.
- Total spend on non-elective admissions for lung cancer per 1,000 age-sex weighted population in 2015/16 was £1079 compared to £1130 for England.

6.1.5 Treatment

The National Lung Cancer Audit 2016 (patients diagnosed in 2015) reported that:[59]

- Anti-cancer treatment was given to 60% of patients overall, meeting the previous target of 60%.
- The proportion of patients undergoing surgery has risen, reaching 16.8% in patients with non-small-cell lung cancer (NSCLC).
- There has been a significant rise to 64% in the proportion of patients with NSCLC (advanced stage and performance status 0–1) who receive chemotherapy.
- There remains wide and unacceptable variation in standards of care between organisations.

Percentages of patients accessing specific lung cancer treatments are not statistically different between NHCFT and all providers in England, although the percentage receiving surgery remains lower for NHCFT patients:[60]

- Seen by a clinical nurse specialist: 87.4% in NHCFT compared to 83.9% in England
- Receiving surgery: 12.3% in NHCFT compared to 15.4% in England.
- Having chemotherapy for small cell lung cancer: 61.5% in NHCFT compared to 57.5% in England.
- Having chemotherapy for non-small cell lung cancer: 71% in NHCFT compared to 68.6% in England.

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56 https://www.cancerresearchuk.org/sites/default/files/ace_cancer_decision_support_tools_final_report_v1.1_080517.pdf

57 Doherty S. Northumberland CCG Lung Cancer emergency presentation report March-May 2017. 22nd June 2017.

58 NHS Right Care and Public health England. Commissioning for Value Focus Pack. Cancer and tumours. NHS Northumberland CCG. April 2017

59 https://www.rcplondon.ac.uk/projects/outputs/nlca-annual-report-2016

60 https://www.cancerdata.nhs.uk/dashboard/lung.html#?tab=Overview&provider=RTF

6.1.6 Where do we want to get to and how will we get there?

Our aim is to improve lung cancer survival in Northumberland from 31.7% if diagnosed in 2014 to 40% for those diagnosed in 2022.

The Accelerate, Coordinate, Evaluate (ACE) programme is testing innovative approaches to achieving rapid diagnosis of cancer, in particular lung cancer, including referral and diagnostic pathways.[61] The programme evaluation and recommendations will be published in 2018. The National Lung Cancer Strategy recommends using the recommendations of the ACE programme to optimise the referral, diagnostic and treatment pathway for lung cancer. [62]

The strategy also identified geographical variation access to a lung cancer specialist nurse and structures and processes of multi-disciplinary team (MDT) discussions for patients with lung cancer.

As well as actions described in Spearhead a radical upgrade in prevention and public health and Drive a national ambition to achieve earlier diagnosis, in order to achieve this aim, **we will:**

- **Implement a standardised lung cancer pathway aimed at optimising diagnostic, referral and treatment pathways, incorporating recommendations from the 2016 National Lung Cancer Audit and the National Lung Cancer Strategy, and the Accelerate, Coordinate, Evaluate (ACE) programme (when the evaluation is published).**

6.2 Cancer waiting times

Achievement of the national Cancer Waiting Times (CWT) standards is an indicator of the quality of cancer diagnosis, treatment and care that NHS organisations deliver, and a key objective in the Northern Cancer Alliance delivery plan. The standards include:

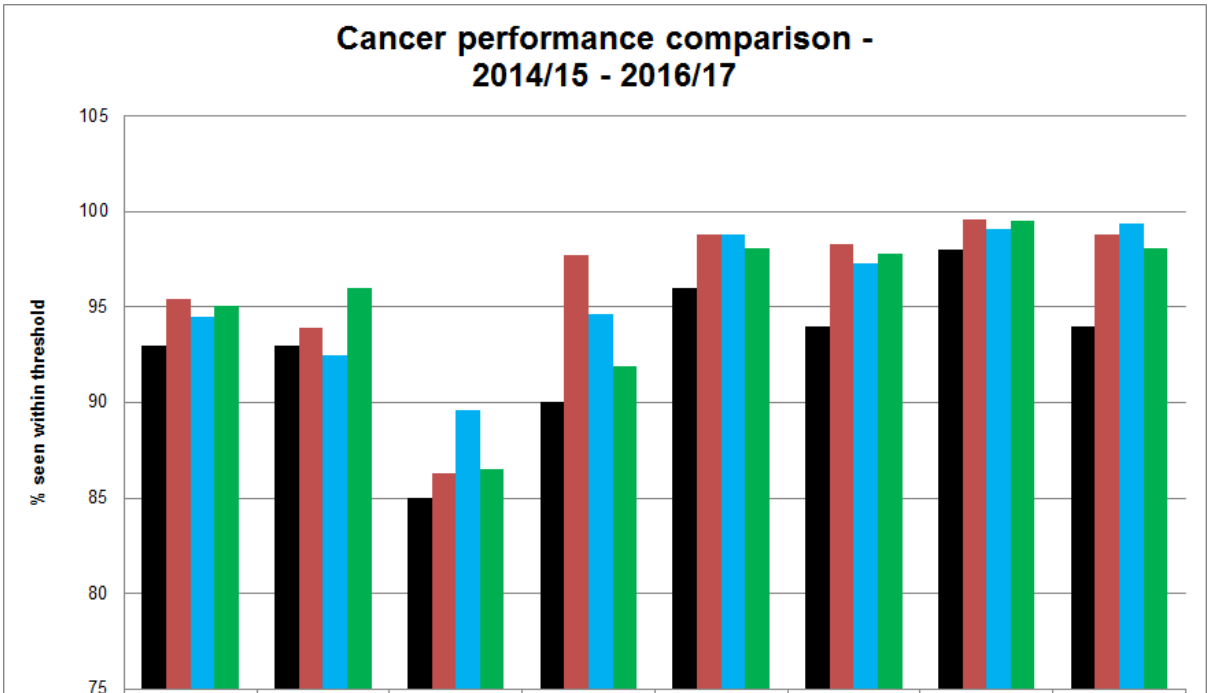
- The percentage of people who attended outpatient appointments within two weeks of an urgent referral by their GP for suspected cancer.
- The percentage of patients whose first definitive treatment (for all cancers) took place within one month (31 days) of the date of decision to treat.
- The percentage of patients whose first definitive treatment (for all cancers) took place within two months (62 days) of the date of an urgent referral by a GP for suspected cancer.

Performance in Northumberland has been above target for each of the CWT standards in each of the three years from 2014/15 to 2016/17, apart from a single year in 2015/16 when the two-week urgent referral target was not met for breast

[61] http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/ace-programme/ace-findings-and-resources
[62] http://www.uklcc.org.uk/files/UKLCC-%2025%20by%2025%20FINAL.pdf

symptoms (see Figure 8). Northumberland performance has also been better than the averages for both England and the North East and Cumbria for each year, and for most months, over that time.[63]

Figure 8. Cancer Waiting Time performance for Northumberland CCG - 2014/15 to 2016/17



	Seen within 2 weeks of GP referral	Seen within 2 weeks - breast symptoms	Treated within 62 days of a GP referral	Treated within 62 days of referral from screening service	Treated within 31 days of diagnosis	Treated within 31 days - surgery	Treated within 31 days - drugs	Treated within 31 days - radiotherapy
Target	93	93	85	90	96	94	98	94
2014/15	95.4	93.9	86.3	97.7	98.8	98.3	99.6	98.8
2015/16	94.5	92.5	89.6	94.6	98.8	97.3	99.1	99.4
2016/17	95.1	96	86.5	91.9	98.1	97.8	99.5	98.1

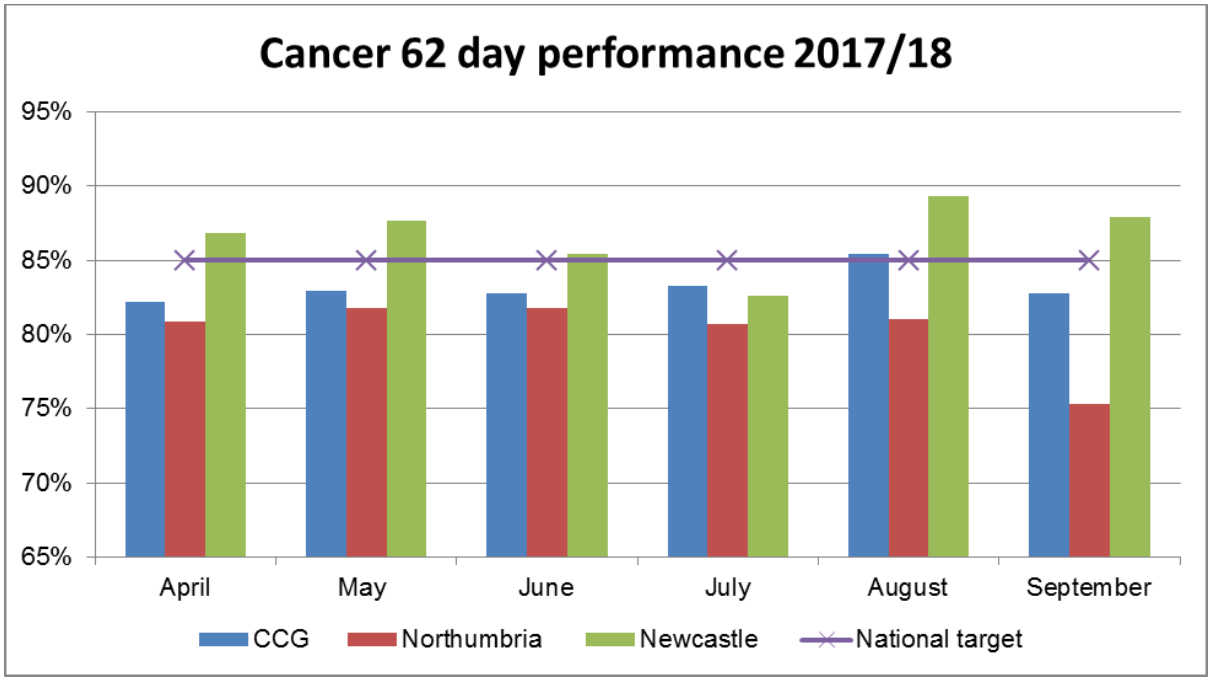
However, the target of 85% of patients being treated within 62 days of GP referral has not been met during five out of the first six months of 2017/18 (see Figure 9); this is due to breaches occurring for patients with colorectal cancer, lung cancer and urological cancers. There is some evidence from Safeguard Incident and Risk Management System (SIRMS) that two-week bookable appointment slots are not always available for people being referred with suspected cancer.[64]

The national strategy also stated that patients referred for testing by a GP, because of symptoms or clinical judgement, should either be definitively diagnosed with cancer or cancer excluded and this result should be communicated to the patient within four weeks (28 days). The ambition should be that CCGs achieve this target

[63] https://www.cancerdata.nhs.uk/dashboard#?tab=Trends&ccg=00L
[64] Northern Cancer Alliance. SIRMS Cancer report for Northern England Cancer Alliance. July 2017. Incidents from January to June 2017

for 95% of patients by 2020, with 50% definitively diagnosed or cancer excluded within 2 weeks.[65]

Figure 9. Percentage of patients whose first definitive treatment (for all cancers) took place within 62 days of the date of an urgent referral by a GP for suspected cancer (April to September 2017)



2017/18	April	May	June	Q1	July	August	September	Q2	YTD
CCG	82.2%	82.9%	82.8%	82.7%	83.3%	85.4%	82.8%	83.5%	83.3%
Northumbria	80.9%	81.8%	81.8%	81.5%	80.7%	81.0%	75.3%	78.7%	80.2%
Newcastle	86.8%	87.7%	85.4%	86.6%	82.6%	89.3%	87.9%	86.7%	86.7%

Our aim is to consistently achieve Cancer Waiting Time targets, in particular the 62-day target where there are emerging issues. Specific action plans have been developed for each tumour site.

We will:

- **Ensure that there is regular liaison between NHCFT and Northumberland CCG to monitor Cancer Waiting Times (CWTs), including breaches, and to develop and monitor implementation of action plans for breaches.**
- **For Two Week Wait suspected cancer referrals, agree a patient choice offer of a minimum of one appointment in the first week and two appointments in the second week.**

[65] Independent Cancer Task Force. Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020. Available at: https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf