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1.0 Executive Summary

This is Cwm Taf University Health Boards third cancer annual report which sets out the progress over the last 12 months. At the time of writing this report our updated Local Delivery Plan for 2014/15 has been in place for 4 months so the report only partly reflects progress in relation to that Plan.

The report includes data on Cwm Taf’s incidence, mortality and survivorship rates as well as report on our lifestyle factors such as smoking obesity and alcohol intake levels. The report demonstrates the impact cancer has on the Cwm Taf community and how we as a health board are improving services so that we can best meet the needs of cancer patients and their families.

Overview of key achievements and progress over the past 12 months is as follows:

- **GP Facilitators** - Cwm Taf has two Macmillan funded GP Facilitators who have been encouraging use of universal Advance Care Planning (ACP) tools, starting with a pilot of new admissions to nursing homes. This has now been extended to existing nursing home residents. The GP Facilitators have made excellent progress over the last two years and during 2013/14 Macmillan approached us to extend the project by another year.
- **ACP Clinical Nurse Specialists** – two ACP Clinical Nurse Specialists have recently been appointed with the support of Macmillan funding. The ACP nurses will work alongside the GP Facilitators to develop and embed the processes for advance care planning in primary and community care.
- **ACP Speech & Language Therapist** – Macmillan funding has also enabled the appointment of a Speech & Language Therapist (S&LT) for advance care planning. The postholder is supporting the ACP nurses in the development and delivery of holistic, safe and dysphagia appropriate care plans for people at the end of life. The S&LT will also provide training for care home staff to help them manage patients with dysphagia competently and safely and help avoid hospital admissions that arise as a result or relating to dysphagia issues.
- **Speech & Language Therapy** – as well as the Advance Care Planning S&LT post, Macmillan has also funded another post for Oncology and Palliative Care. This post will evaluate the effectiveness of providing preventative head and neck treatments for those with swallowing/communication problems, as well as scoping the need and providing a role in the palliative care team for all cancers, giving advice and training to the team and supporting decision making in end of life care.
- **Access to palliative care medication** – ‘Just In Case’ boxes have been rolled out across Cwm Taf to ensure access to medication when needed for palliative care patients in the community.
- **End of Life Care Pathway** – the GP Facilitators have developed a primary care End of Life Care Pathway which guides GPs through all the steps in a patient’s journey. It brings together on one page for GPs and primary care teams all the appropriate steps and supporting documentation they need to ensure the provision of well co-ordinated, holistic end of life care.
• Acute Oncology Project – this was launched by holding a stakeholder workshop, following which a service model was developed and a successful bid submitted to Macmillan for a pilot project. A Project Group has now been established to set up the service.
• Improved our partnership working with Tenovus resulting in an increase in Welfare Benefits service particularly in our community hospitals.
• The Tenovus Man Van is now working in partnership with the Urology Multi Disciplinary Team (MDT) and visits Royal Glamorgan Hospital weekly where newly diagnosed patients are referred for same day service on the Man Van and are provided with a range of information and support.
• Big Bite Event - The Wellbeing Zone, run by Cwm Taf UHB featured again this year in the Big Bite event in Ynysangharad Park, Pontypridd. The event took place on Saturday 2nd August and Sunday 3rd August 2014 and attracted a footfall of approximately 7,000 people per day. The chosen theme this year was Cancer Awareness/Early Detection.
• We demonstrated full participation in the National Peer Review which has resulted in many areas of good practice as well as areas that need further development.
• CRUK Project - bid approved in March 2014 with Cancer Research UK and Cardiff University for a project around promoting awareness and early diagnosis of cancer in deprived communities. It is proposed to develop and evaluate the Tenovus Health Check in deprived communities of Cwm Taf as well as neighbouring health boards.
• Dr Rachel Parsons, Macmillan Consultant Psychologist commenced work in CTUHB in June 2014. The psychology service has been planned in partnership with the voluntary sector who offers counselling services for cancer patients and their families.
• Held our third annual stakeholder event to share and celebrate the progress made against the Cancer Plan during 2012/13 and to engage with stakeholders to determine priorities for the 2014/15. Within Cwm Taf we have embraced the partnership aspect of the Plan and feel this is noteworthy practice.
2.0 Introduction

We are pleased to present Cwm Taf’s UHB Annual Report for 2013/14, our third report which clearly demonstrates our commitment and ongoing progress to delivering against the Welsh Government’s Cancer Delivery Plan (June 2012) over the last 12 months.

Together for Health – Cancer Delivery Plan was published in June 2012 and provides a framework for action by Local Health Boards and NHS Trusts working together with their partners. It sets out the Welsh Government’s expectations of the NHS in Wales to tackle cancer in people of all ages, wherever they live in Wales and whatever their circumstances. The Plan is designed to enable the NHS to deliver on their responsibility to meet the needs of people at risk of cancer or affected by cancer. It sets out:

- The population outcomes we expect.
- The outcomes from NHS treatment we expect.
- How success will be measured and the level of performance we expect.
- Themes for action by the NHS, together with its partners.

The vision:

For our population we want:
- People of all ages to have a minimised risk of developing cancer and, where it does occur, an excellent chance of surviving, wherever they live in Wales.
- Wales to have cancer incidence, mortality and survival rates comparable with the best in Europe.

Our Cancer Delivery Plan for 2014/15 was launched at the end of April 2014. Here in Cwm Taf we pride ourselves on our partnership approach to delivering cancer services and setting our priorities. Cwm Taf has, for the third year, held a stakeholder event aimed at updating our partners on the progress made over the past 12 months and to task those present with the development of shared priorities to inform our Local Delivery Plan for 2014/15. At our workshop on 28th January 2014 there was good presentation across stakeholders including the voluntary sector, patient representation, the screening service, General Practitioners, Cancer leads, members of the Community Health Council and the major cancer charities to name a few totalling over 50 representatives. The event was an example of successful and meaningful engagement, which resulted in an agreed set of priorities for 2014/15.

We are pleased to report that we made significant progress during 2013/14 as described in this Annual Report. However we recognise that whilst a lot has been achieved over the last 12 months we still have challenges in meeting the requirements of the Welsh Government’s Cancer Delivery Plan. Cancer remains a top priority for the Welsh government as well as for Cwm Taf UHB. We are committed to responding to those challenges and have set ourselves an ambitious programme of work within our Delivery Plan for the coming year.
On a personal note I would like to express my gratitude to our Executive Cancer Lead, Mr K Asaad, and our Cancer Lead Clinician, Mr S Berry, our Cancer Site Leads and Multi Disciplinary Teams for their hard work and commitment. In particular I would like to thank Macmillan Cancer Support, Tenovus and other partner organisations for their support in making our plans for service improvement a reality.

Mrs Allison Williams
Chief Executive
3.0 Cancer Incidence, Mortality and Survival in Cwm Taf UHB

Overview

We are using three outcome indicators to measure and track how well cancer services are doing over time. These are:

- Cancer incidence rate
- Cancer mortality rate
- One and five year survival rate

Outcome One – Cancer incidence rate

This measures how many new cases of cancer are found each year and tells us how well we are doing at preventing cancer in Wales. If we are achieving our objectives, we would expect to see over time:

- A slower rise in the rate of increase compared with what might be expected to happen in line with past experience.
- A reduced gap between the most and least deprived areas of our region.
- Incidence rates comparable with the best in Europe\(^1\).

Cancer incidence (excluding non melanoma skin cancer) in Cwm Taf UHB has been higher than the all Wales average in 12 out of the last 18 years. In 2011 (Figure A), cancer incidence in Cwm Taf was equal to the Wales average. It has increased in 2012, whilst the Wales rate has gone down.

Figure A

Cancer Incidence in Wales and Cwm Taf 1995-2012 EASR per 100,000 population All Malignancies excluding non melanoma

Produced by Cwm Taf Public Health Team, using WCSIU data
In 2012, Cwm Taf had the highest European age standardised cancer incidence rate (excluding non melanoma skin cancer) in Wales at 431.9 per 100,000 population (Figure B). The rate was particularly high in men (475.3 per 100,000).

### Figure B showing age-standardised cancer incidence rate per 100,000 population 2012 in Wales (excluding non melanoma skin cancer)

<table>
<thead>
<tr>
<th></th>
<th>Cwm Taf</th>
<th>All Wales</th>
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</thead>
<tbody>
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<td>418</td>
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<tr>
<td>2012</td>
<td>432</td>
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</tr>
</tbody>
</table>

Source: Welsh Cancer Intelligence & Surveillance Unit June 2014

**Site-specific cancer incidence**

Compared to the Wales average, figures for 2010-12 show that Cwm Taf has statistically higher incidence rates of lung and cervical cancer in women. There is a statistically lower incidence of melanoma cancer in men and women combined. The rates for men and women combined can be seen in Figure C.
Outcome Two – Cancer mortality rate

Although higher than the Wales average, deaths from cancer in Cwm Taf are falling. It appears that, in the last three years the Wales average rate has reached a plateau at 111 deaths per 100,000 population under 75 (excluding non melanoma skin cancer). It is too early to assess, as shown in Figure D, whether this is also the case for the Cwm Taf population rate.
Figure D

Cancer Mortality in Wales and Cwm Taf 1995-2012 EASR per 100,000 population All Malignancies excluding non melanoma skin cancer

Produced by Cwm Taf Public Health Team, using WCSIU data

<table>
<thead>
<tr>
<th>Year</th>
<th>Cwm Taf</th>
<th>All Wales</th>
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<tbody>
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<td>1995</td>
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<tr>
<td>2012</td>
<td>117</td>
<td>111</td>
</tr>
</tbody>
</table>

Source: Welsh Cancer Intelligence & Surveillance Unit June 2014

Figure E shows the age-standardised cancer mortality rate for Cwm Taf compared to other health board areas. Cwm Taf has the highest rate at 184.8 per 100,000 population in 2012 (excluding non melanoma skin cancer). The difference is particularly pronounced in males.
Figure E showing European Age Standardised Mortality Rates from all malignancies (excluding non-melanoma skin cancer) per 100,000 for Cwm Taf 2012 compared to Welsh Health Boards.

<table>
<thead>
<tr>
<th>University</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betsi Cadwaladr University</td>
<td></td>
</tr>
<tr>
<td>Hywel Dda University</td>
<td></td>
</tr>
<tr>
<td>Abertawe Bro Morgannwg University</td>
<td></td>
</tr>
<tr>
<td>Cardiff &amp; Vale University</td>
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</tr>
<tr>
<td>Cwm Taf University</td>
<td></td>
</tr>
<tr>
<td>Aneurin Bevan University</td>
<td></td>
</tr>
<tr>
<td>Powys Teaching</td>
<td></td>
</tr>
</tbody>
</table>

Source: Welsh Cancer Intelligence & Surveillance Unit September 2014

Site-specific cancer mortality

For women the mortality rate was statistically higher for cancer of the cervix and for men and women combined, it was significantly higher for lung and stomach cancer in 2010-12. These differences are shown in Figure F.

Figure F showing European Age Standardised Mortality Rates per 100,000 for Cwm Taf 2010-12, by site.

Source: Welsh Cancer Intelligence & Surveillance Unit September 2014
Outcome Three – One and five year survival rate

The percentage of adults surviving one year is 67.6% in Cwm Taf compared to 69.9% across Wales as measured in the period 2007-11 (excluding non melanoma skin cancer). This is shown in Figure G. The difference between one year survival in Cwm Taf and the Wales average is decreasing. In 1991-1995 it was 5.8% and in 2007-11 it has reduced to 2.3%.

**Figure G**

One Year Relative Survival (%) in Wales and Cwm Taf 1991-2011
All Malignancies excluding non melanoma skin cancer (C00-C96 exc C44)

<table>
<thead>
<tr>
<th></th>
<th>Cwm Taf</th>
<th>All Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-95</td>
<td>50.9</td>
<td>56.7</td>
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<td>92-96</td>
<td>51.8</td>
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<td>93-97</td>
<td>52.4</td>
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</tr>
<tr>
<td>94-98</td>
<td>53.7</td>
<td>58.3</td>
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<td>95-99</td>
<td>54.9</td>
<td>59.5</td>
</tr>
<tr>
<td>96-00</td>
<td>56.9</td>
<td>60.5</td>
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<tr>
<td>97-01</td>
<td>58.3</td>
<td>61.5</td>
</tr>
<tr>
<td>98-02</td>
<td>60.1</td>
<td>62.6</td>
</tr>
<tr>
<td>99-03</td>
<td>62.2</td>
<td>63.9</td>
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<tr>
<td>00-04</td>
<td>63.0</td>
<td>64.8</td>
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<tr>
<td>03-07</td>
<td>63.8</td>
<td>67.2</td>
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<tr>
<td>04-08</td>
<td>64.4</td>
<td>67.9</td>
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<td>68.6</td>
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<td>06-10</td>
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<tr>
<td>07-11</td>
<td>67.6</td>
<td>69.9</td>
</tr>
</tbody>
</table>

Source: Welsh Cancer Intelligence & Surveillance Unit June 2014

The percentage surviving at one year is improving, in line with the Wales trend. The one year rate increased from 50.9% during 1991-95 to 67.6% in
The relative difference between the one and five year survival rates of health boards is illustrated in Figures H and J. Both Cwm Taf's 1 and 5 year rates are the lowest in Wales (excluding non melanoma skin cancer).

The one year survival rate is statistically significantly lower than the Wales average, along with Powys Teaching and Betsi Cadwaladr Health Boards.

Figure H One year Survival rates for cancer, by Health Board, 2007-2011, (excluding non melanoma skin cancer).

A breakdown of the one year survival rate by cancer site is shown in Figure I. Women have a particularly low survival rate at one year in Cwm Taf, at 68.5%.

Figure I showing 1 year cancer survival rate Cwm Taf 2007-11 by site, men and women combined.
The five year survival rate is statistically significantly lower than the Wales average, along with Cardiff and Vale University and Powys Teaching Health Boards.

**Figure J** Five year survival rates for cancer, by Health Board, 2003-07 (excluding non-melanoma skin cancer)

Source: Welsh Cancer Intelligence & Surveillance Unit September 2014

The gap between the Wales and Cwm Taf percentages are narrowing in this 5 year survival measure. In the period 1991-95 it was 6.2% and in 2003-07 it was 4.2%, as illustrated in Figure K.

**Figure K**

Five Year Relative Survival (%) in Wales and Cwm Taf 1991-2006 All Malignancies excluding non melanoma skin cancer (C00-C96 exc C44) Ages 15-99

Produced by Cwm Taf Public Health Team, using WCSIU data
<table>
<thead>
<tr>
<th>Site of Cancer</th>
<th>Cwm Taf (%)</th>
<th>All Wales (%)</th>
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</thead>
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<td>91-95</td>
<td>34.2</td>
<td>40.4</td>
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<td>94-98</td>
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<td>95-99</td>
<td>38.7</td>
<td>43.7</td>
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<tr>
<td>96-00</td>
<td>41.1</td>
<td>44.8</td>
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<td>98-02</td>
<td>44.1</td>
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</tr>
<tr>
<td>03-07</td>
<td>48.3</td>
<td>52.5</td>
</tr>
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</table>
Our Approach to Tackling Cancer

In October 2012, we published our Cancer Delivery Plan. In April 2014 we reviewed and refreshed this plan to ensure that our strategy and action plan are in line with the needs of our population.

The process for doing this included holding our annual stakeholder workshop event aimed at updating our partners on the progress made and to task those present with the development of shared priorities to inform our revised Local Delivery Plan. It was felt that there was good representation across all stakeholders including the voluntary sector, patient representation, the screening service, General Practitioners, cancer leads, members of the Community Health Council and the major cancer charities to name a few totally over 50 representatives.

During the discussion workshops at the stakeholder event held on 28th January 2014 suggested priorities were given to each group along with the rationale for the selection of each priority i.e a recommendation out of peer review, an action required for delivery of the cancer plan, in response to local need. There was a discussion group for every theme within the Cancer Plan.

Alun Tandy, Macmillan Cancer Care speaking at our Stakeholder Event 28th January 2014
Mr Kamal Asaad, Medical Director/Executive Lead for Cancer welcomes those present.

Professor P N Haray talks about his award winning Patient DVD.

Sara Thomas, Public Health Consultant highlights incidence, mortality and survivorship and its correlation to deprivation.
The Plan is designed to enable us to deliver on our responsibility to meet the needs of people at risk of cancer or affected by cancer. It sets out:

- The population outcomes expected
- The outcomes from NHS treatment expected
- How success will be measured and the level of performance expected.
- Themes for action by the health board, together with its partners.

A summary of our revised priorities for cancer care are:

- **Preventing cancer:**
  - To ensure the uptake across Cwm Taf for National Screening Programmes bowel, cervical and breast are within national targets
  - To analyse and address inequalities in cancer screening uptake in particular in relation to areas of deprivation

- **Detecting cancer quickly:**
  - To raise awareness of the early signs and symptoms of cancer in particular progressing with the Cancer Research UK funded project around promoting awareness and early diagnosis of cancer in deprived communities. It is proposed to develop and evaluate the Tenovus Health Check in deprived communities across Cwm Taf
  - To raise GP awareness of symptoms to promote prompt referrals in line with national guidance, local pathways and waiting times standards
  - Provide GPs with direct and prompt access to diagnostics and to diagnose cancer

- **Delivering fast, effective treatment and care:**
  - To develop acute oncology services to further support the needs of cancer patients admitted as emergencies
  - To participate in the Macmillan funded Metastatic Spinal Cord Compression Project and to implement the required service improvements.
  - To provide definitive treatment consistently in line with national waiting times targets across all cancer sites
  - Participate in local and national clinical audit and other quality improvement activities and reflect on action to be taken in local cancer delivery plans
  - Participate in peer review and reflect learning in local cancer delivery plans.
  - Act on the findings within the National Cancer Patient Experience Survey

- **Meeting People’s Needs:**
  - Review and improve patient information – clinical and non clinical e.g how to access financial or emotion support
  - Ensure every patient diagnosed is assigned a key Worker
- Ensure all cancer sites have a Clinical Nurse Specialist
- Establish a system for contribution to the Welsh Cancer Bank
- Ensuring care plans are in place and offering written care plans to patients

- **Caring at the End of Life:**
  - Continue to promote Advance Care Planning, focusing initially on the care homes involved in the pilot.
  - To continue to encourage meaningful use of GP Palliative Care Register to identify and plan care for patients of all ages with less than one year life expectancy
  - To implement and evaluate the revised LA for the Marie Curie nursing service to support the @home model
  - To continue to improve and evaluate out of hours access to palliative care medication
  - To progress plans for the reporvision of Y Bwthyn Services
  - To prioritise Carer and Patient Feedback

### 5.0 Preventing Cancer

At least one-third of all cancer cases are preventable. Prevention offers the most cost-effective long-term strategy for the control of cancer (WHO). Tobacco, obesity and alcohol are all modifiable cancer risk factors.

The Welsh Health Survey provides information about the health of people living in Wales, the way they use health services and their health-related lifestyle. It is based on a randomly selected sample of people living in private households in Wales and is designed to be representative of the general adult population in Wales. The survey runs all year round and is reported annually in October. The most recent data available (2012/13) is discussed below. [Welsh Health Survey 2012/13](#)

#### Tobacco

Tobacco use is the single greatest avoidable risk factor for cancer mortality. The downward trend in smoking prevalence continued in 2012/13, but levels of smoking in Cwm Taf in 2012/13 (24%) and its constituent local authority areas remains higher than the Wales average (22%). The proportion of adults smoking in Merthyr Tydfil dropped by 2% from the previous 2011/12 Welsh Health Survey, and Rhondda Cynon Taf (RCT) by 1% over the same period.
Obesity

There is a link between overweight and obesity to many types of cancer such as oesophagus, colorectum, breast, endometrium and kidney. Obesity in Cwm Taf has remained at 26% for the last three years. This is, however, the highest in Wales.

The proportion of the adult population classified as obese (BMI 30+) has risen consistently since 2005/7 and, at 26%, Cwm Taf is statistically significantly higher than the Wales average (23%) and is the highest among health boards in Wales. However, the latest WHS shows a 1% improvement in the obesity figure for Merthyr Tydfil. The figure for RCT has remained static at 25% since 2009/10.

Cwm Taf Health Board has the highest proportion of 4/5 year olds who are obese in Wales. However, these figures should be treated with caution until more information for future years becomes available.
Physical Activity

Current guidelines, introduced in 2011, recommend that an adult undertakes at least 30 minutes of physical activity, of moderate intensity, on five or more days each week. Previous guidelines were slightly less flexible and as such slightly harder to meet.

In the most recent survey (2011/12), a smaller percentage of Cwm Taf population reported meeting current physical activity guidelines (27%) than the Wales average (29%). This was higher in Merthyr Tydfil (32%) but significantly lower than the Wales average in Rhondda Cynon Taf (26%). There has been little change in the level of physical activity reported since 2003/5.
Alcohol

Alcohol use is a risk factor for many cancer types including cancer of the oral cavity, pharynx, larynx, oesophagus, liver, colorectum and breast. Risk of cancer increases with the amount of alcohol consumed.

The Welsh Health Survey questions on alcohol consumption changed in 2008. The current question asks all adults (drinkers and non-drinkers) about the most units drunk on any one day in the last seven days. Above guidelines means men drinking more than 4 units a day and women drinking more than 3 units. Binge means men drinking more than 8 units a day and women drinking more than 6 units.

In the most recent WHS (2012/13), 43% Cwm Taf population reported a consumption of alcohol above guidelines; Merthyr Tydfil (39%) and Rhondda Cynon Taf (44%).

The trend across Wales is flat. There has been a downward trend in Merthyr Tydfil since 2008-09 and this is now below the Wales average. RCT showed a 2% fall in 2012/13 compared with the previous 2011/12 report.
Figure 4: Trend in Alcohol consumption

**Adults who reported consuming alcohol above guidelines**  
(%, age-standardised) 2003/05 - 2012/13

Produced by Cwm Taf Public Health Team, using WHS (WG) data

In 2012/13, binge drinking in RCT (29%) had fallen by 2% from the previous 2011/12 survey, but was statistically significantly higher than the Wales average (26%). The figure for Merthyr Tydfil (27%) remained the same as the previous year.

**Adults reporting binge drinking of alcohol**  
(%, age-standardised) 2003/05 - 2012/13

Produced by Cwm Taf Public Health Team, using WHS (WG) data

**Uptake of HPV Vaccine**

Uptake of HPV vaccination among girls in Cwm Taf is consistently higher than the average uptake across Wales.
Uptake of all three doses of HPV vaccine, routinely scheduled in School Year 8 2008/9 to 2012/13.

<table>
<thead>
<tr>
<th>School Year</th>
<th>Cwm Taff</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-9</td>
<td>91.8%</td>
<td>85.3%</td>
</tr>
<tr>
<td>2009-10</td>
<td>87.9%</td>
<td>81.6%</td>
</tr>
<tr>
<td>2010-11</td>
<td>89.1%</td>
<td>85.5%</td>
</tr>
<tr>
<td>2011-12</td>
<td>92.1%</td>
<td>86.6%</td>
</tr>
<tr>
<td>2012-13</td>
<td>91.1%</td>
<td>85.4%</td>
</tr>
</tbody>
</table>

Local Action

We are working closely with local government, Public Health Wales NHS Trust, GPs, pharmacists, dentists, opticians, the Third Sector to tackle these root causes of poor health.

Over the past 12 months we have undertaken a range of measures to address cancer risks.

Raising awareness of the risks

A Tackling Cancer Inequalities group has been established comprising: health board, public health, third sector, and academic partners to take forward work addressing, awareness raising, prevention and early detection issues, particularly in our more deprived communities.

A cancer prevention workshop was held in September for Communities First clusters and Registered Social Landlords in Cwm Taf to share learning and raise awareness in our most deprived areas.

The Screening Services Division of Public Health Wales has developed the Screening for Life website containing information for professionals and the public on national screening programmes, including those for...

**Tobacco**

The Welsh Government has set a target to achieve a smoking prevalence rate of 16% by 2020, and has set a Tier 1 target to increase the number of smokers who make a quit attempt. Key priorities identified within the Tobacco Control Action Plan for Wales are included as actions within the Cwm Taf Smoke Free Strategic Action Plan, Health Board Environmental Tobacco Plan, the emerging Respiratory Action Plan, and other partner strategies and action plans.

Recognising that smoking cessation is a key treatment for all smokers, the health board has developed a policy statement requesting that all health professionals should take every opportunity to ‘Ask, Advise, Act’:

www.tinyurl.com/AskAdviseAct

Colleagues from the Public Health Team have worked with primary and secondary care colleagues to embed the Ask, Advise, Act approach and increase referrals to smoking cessation services. This has included:

1. Developing a dedicated intranet site to communicate the policy statement to all staff
2. Building clear understanding of the referral pathways
3. Staff training and support.

Community pharmacies play a key role, with 39 pharmacies currently offering smoking cessation services across Cwm Taf, with an increase in a further 20 planned for this year.
Targeting pharmacy services in our areas of greatest deprivation reaches our population where smoking prevalence is highest and addresses health inequalities.

**Obesity**

The causes of obesity are not simply due to individuals’ food and physical activity choices. They are more complex than this, and relate to a wide variety of societal, environmental and behavioural factors. Action to address obesity often requires multi agency partnership working.

- A weight management resource and support toolkit has been developed for use in communities. To date, 21 community weight management groups have been established in Cwm Taf. A good practice scheme is being developed to support the groups.
- A community based, Joint Care Programme (JCP) pilot was successfully completed as a partnership between Public Health, the Health Board and Local Authorities. The Health Board is currently considering the feasibility of implementing this programme on a permanent basis.
- Maximising the opportunities for walking and cycling has been identified as a Regional Collaboration Board priority. An Active Travel Steering Group has
been established to take forward the implementation of the Active Travel Act and Open Space Strategy through partnership working.

**Alcohol**

Alcohol Brief Intervention Training has been rolled out, led by Public Health Wales. In 2013/14, 29 training sessions were delivered across Cwm Taf with 290 individuals trained. The training has been promoted to a range of community partners, including those working with young people.

Established in 2010, the Cwm Taf Area Planning Board supports the planning, commissioning and performance management of substance misuse services.

A Drug and Alcohol Single Point of Access (DASPA) service assists people of all ages in seeking help for a drug and alcohol problem to ensure they get the support they need by the most appropriate agency. A range of services across the tiers are provided locally by the Community Drug and Alcohol team (CDAT), Drugaid and Teds with Tier 4 services commissioned via Brynawel House.

**Over 50s Health Checks**

The ‘Add to Your Life’ programme aims to make a positive contribution towards improving health and wellbeing for people aged over 50 in Wales by providing quality information and advice, helping people to get easy access to the right public health services.

Communities First clusters in Cwm Taf have worked with Public Health Wales and Age Cymru to encourage participation in this online health check.

https://addtoyourlife.wales.nhs.uk/

### 6.0 Detecting Cancer Quickly

Rapid diagnosis and treatment of cancer improves not only survival, but also the quality of life of survivors and lessens their longer term care needs.

#### 6.1 Screening

The national population based cancer screening programmes are evidence based interventions that aim to detect cancer early, when chances of treatment and survival are highest. There are three national cancer screening programmes in Wales: Breast Test Wales, Cervical Screening Wales and Bowel Screening Wales.
A report discussing screening in Cwm Taf was issued by Screening Division of Public Health Wales in April 2014.

Breast Screening

Breast Test Wales invites eligible women aged 50-70 for breast screening every three years. Women aged over 70 can self refer. The minimum uptake standard is 70% of invited women attending for screening, while the target is 80%.

<table>
<thead>
<tr>
<th>Population</th>
<th>Uptake of breast screen 2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Wales</td>
<td>71.5%</td>
</tr>
<tr>
<td>Cwm Taf UHB</td>
<td>72.8%</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>73.2%</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>72.2%</td>
</tr>
</tbody>
</table>

Overall the uptake for breast screening for the period April 2012 to March 2013 for the population of Cwm Taf Health Board was 72.8% which met the minimum uptake standard. The uptake was similar to this period in the previous year (72.3%) and that for all Wales in 2012-2013 (71.5%).

Both Local Authorities individually met the minimum uptake standard; Merthyr Tydfil had an uptake of 73.2% which compares to 68.5% the previous year while Rhondda Cynon Taf had an uptake of 72.2% which was similar to the previous year. However, it is important to remember that breast screening is on a 3 year round so a 1 year period will show some variation as only a proportion of women may be invited from a defined geographical area.

Breast Test Wales is the first fully digitised breast screening programme in the UK. Advantages of digital mammography include a lower radiation dose and having digital images that can be manipulated and stored more easily.

Recruitment and capacity have been key issues in South East Wales over the last 12 months. As the programme recovery plan starts to imbed, there have been reassuring improvements in key areas such as report turn-around times and overall activity. Recruitment for upcoming retirements will be a major factor in maintaining the current momentum towards achieving across all the required standards and targets.

Cervical Screening

Cervical Screening Wales invites women aged 25-50 years every three years and those aged 50-64 every five years. Previous to September 2013, women aged 20-64 year were invited every 3 years and the data presented covers this period. The change in age range and frequency was implemented following an announcement by the Health Minister in February 2013, based on recommendation from the UK National Screening Committee and the Wales Screening Committee. In future we will be presenting coverage for women aged 25-64.
Population | Coverage of cervical screening 2012-13
---|---
All Wales | 76.2%
Cwm Taf UHB | 76.9%
Merthyr Tydfil | 74.6%
Rhondda Cynon Taf | 77.5%

For the group aged 20-64 years the coverage was 76.9% for Cwm Taf Health Board in April 2012-March 2013, which did not reach the target. This is slightly similar to that for all Wales (76.2%) and the previous year (76.7%). For the group aged 25-64 years the coverage was 79.1% for Cwm Taf Health Board in April 2012-March 2013, which is similar to that for all Wales (79.3%).

There is increasing evidence that the use of the HPV test within an organised screening programme is more effective in preventing cervical cancer than cervical cytology alone. There are staged plans to implement HPV as part of the Cervical Screening Wales programme. The first stage will be to implement Test of Cure. Samples from women having early repeat smears following colposcopy for abnormal smears will be examined with cytology and HPV test six months later. They will be returned to normal recall if cytology and HPV test are both negative. HPV Test of Cure will allow us to distinguish much more quickly between the minority of women who need more colposcopy follow up and treatment, and the majority of women who can be returned to normal. This will be introduced in September 2014.

The provision of access to colposcopy under General Anaesthetic remains an area for concern across Wales.

**Bowel Screening**

Bowel Screening Wales invites eligible men and women aged between 60 and 74 to take part in bowel screening every two years. The uptake target is to have 60% of the eligible population who are invited, that go on to participate in screening.

<table>
<thead>
<tr>
<th>Population</th>
<th>Uptake of bowel screening 2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Wales</td>
<td>48.2%</td>
</tr>
<tr>
<td>Cwm Taf UHB</td>
<td>48.1%</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>44.8%</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>48.9%</td>
</tr>
</tbody>
</table>

The uptake for April 2012-March 2013 was lower than the target of 60% for Cwm Taf University Health Board and for all individual Unitary Authorities. The uptake has also decreased slightly from the previous year for all individual Local Authorities and Cwm Taf as a whole. This trend reflects that seen for Wales as a whole.
A project team has been established to develop, implement and evaluate strategies to improve uptake. Work is focused on three levels of activity:

- strategic work includes the development of a framework to address inequity;
- operational strategies include the development of key messages and an introductory letter and will need to be piloted and evaluated;
- routine programme activities include the development of the participant champion role and collaboration between Specialist Screening Practitioners and the Screening Engagement Team.

The uptake figures have recently shown an improvement, although they remain below standard.

There are considerable challenges relating to capacity in endoscopy units across Wales. A service improvement plan has been agreed by the Bowel Screening Wales Programme Board and is being implemented working closely with the health board.

**Uptake and Inequities in uptake of screening**

It has been demonstrated that there is inequity in screening uptake for the cancer screening programmes, with a lower uptake in more deprived groups. Reducing inequity is a priority for Public Health Wales and for screening division.

A strategic approach to identifying and addressing inequities is being implemented across Wales, working with partners.

Primary care play an important role in the delivery of cervical screening and in promoting and endorsing all the national screening programmes. As part of the uptake work, emphasis is being put on building relationships with GP practices and GP clusters, providing teaching and training and sharing information and resources.

All of the screening websites are being refreshed, and a renewed focus put on the use of digital communications and engaging via social media.

July was Screening for Life month, an annual national campaign run by Screening Division of Public Health Wales to raise awareness of the National Screening Programmes. This was supported by the Local Public Health Team and included work with Community Pharmacy Wales, the Farmers Union of Wales and other community partners.

**Conclusion**

Uptake by Cwm Taf residents of the nationally managed screening programmes in 2012/13 was on a par with all-Wales figures. Local cervical screening uptake is below target (by 3.1%). Bowel screening uptake is below target by 11.9% and down 3.8% compared to the previous year’s data.
There is inequity in screening uptake for the cancer screening programmes across Wales, with a lower uptake in more deprived areas. These are being addressed at a national level with input and joint working with local teams.

6.2 Early Diagnosis

Performance Measure 1 – The percentage of people whose cancer is diagnosed at each stage

The stage not recorded (NR) within Cwm Taf increased from 18.33% in 2012 to 26.35% in 2013. We are disappointed with this result as in previously years our staging data has been well above the Welsh average. The reason for this has been the increase in workload associated with Cancer Services Department supporting standards, peer review and cancer targets. We are planning to improve on this position over the coming year.

Raising public awareness – The Big Bite Event

Cwm Taf prides itself on how we are committed to working with our partners to delivery the Welsh Government’s Cancer Plan. The Big Bite Event is a prime example of partners coming together to achieve a shared goal i.e the prevention and early detection of cancer.

The Wellbeing Zone, run by Cwm Taf University Health featured again this year in the Big Bite event in Ynysangharad Park, Pontypridd. The event will took place on Saturday 2\textsuperscript{nd} August and Sunday 3\textsuperscript{rd} August 2014 and attracted a footfall of approximately 7,000 people per day. The chosen theme this year was Cancer Awareness/Early detection.
The Tenovus “Man Van” was present on Sunday 2nd August to share information with the public and to undertake the Tenovus Health Check.

People were then be signposted to over 50 stands in the Wellbeing Zone sharing information with the public on Health & Wellbeing. Stands include Smoking Cessation, Healthy Lifestyles, Energy, Mental Health and much more.

One of the stands was provided National Screening Service providing information on screening programmes:
Macmillan Cancer Support also attended providing a wide range of information for those present and signposted to the services they offer.

The Tenovus Choir also made a guest appearance:

*Tenovus Choir with members of Cwm Taf Partnership Team*
**Prompt Access to Diagnostics**

On 13th March 2014, new funding of more than £5m to reduce waiting times was announced by the Health Minister Mark Drakeford to go towards cutting waiting for diagnostic tests. Faster access to these tests is important as it means patients can start their treatment more quickly.

The Health Minister approved a number of capital funding projects including £780,000 for a new CT scanner and £300,000 for three new ultra sound machines in Cwm Taf which was great news for us!

**Cancer Research UK Funded Project – Development and pilot evaluation of the Tenovus health check: a targeted cancer awareness intervention for people from deprived communities**

Evidence suggests that delayed help-seeking and poorer cancer survival may be linked to low cancer awareness and attitudes reflecting fear, denial and fatalism in deprived populations. To date, interventions designed to increase cancer awareness and encourage help-seeking have not been targeted at communities with high levels of social deprivation.

The Tenovus Health Check is a touch screen questionnaire delivered by a trained lay advisor. The aim is to raise awareness of cancer risk factor and symptoms by answering 30 questions in 3 domains i.e your history, your lifestyle and your health. Individualised risk is determined and signposting is then undertaking.

The aim of this project is to develop the health check as a way of engaging people in deprived areas of Wales to become more aware of cancer and visit the GP early. The pilot project is being run across Cwm Taf and Aneurin Bevan Health Boards. Phase 1 of the project to commence in October 2014 will involve public, professional and community partners in developing the health check. Phase 2 will gain advice on the best ways of approaching /recruiting people for the pilot evaluation. The funding for this project was agreed during 2014.

**Developing an Acute Oncology Service within Cwm Taf**

The South Wales Cancer Network define Acute Oncology Service (AOS) as a service that brings together multi-disciplinary clinical expertise to facilitate the rapid identification and appropriate prompt management of patients that present acutely with complications following their cancer treatment, complications as a consequence of their cancer or who present acutely with previously undiagnosed cancer.

An AOS will provide rapid and appropriate specialist input (ensuring access to appropriate disease site specific advice) for any patient presenting acutely with problems relating to cancer. The essence of an AOS is to accelerate coordinate and signpost patients onto the correct pathway and ensure consistent access to oncology expertise, wherever the patient presents.
The management of unscheduled presentation of cancer outpatients is fundamental in avoiding inappropriate hospital admission and reducing lengths of stay where admissions are necessary.

In May 2014 Cwm Taf held a stakeholder workshop to launch its Acute Oncology Project. Colleagues from neighbouring health boards who have already established their service shared their learning and experiences and representatives from the Cancer Network, the Macmillan funded Chemotherapy Development Project and Metastatic Spinal Cord Compression Project also provided expertise and information during the event. A service model has since been written and a bid has been submitted to Macmillan, which was approved at the end of September 2014.

7.0 Delivering fast, effective treatment and care

7.1 Access and cancer waiting times

Our aim is to treat patients as efficiently and effectively as possible. In Wales we have two targets for waiting times. We aim to meet the waiting times on a consistent basis.

Performance Measure 2 – The percentage of patients starting their definite cancer treatment in line with the cancer waiting times target.

% of people starting treatment within 62 days
% of people starting treatment within 62 days
Patients newly diagnosed via the urgent suspected cancer route starting treatment – all Wales / Cwm Taf

<table>
<thead>
<tr>
<th>Quarter ending</th>
<th>% Starting treatment within 62 days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cwm Taf</td>
</tr>
<tr>
<td>Dec 09</td>
<td>78.5%</td>
</tr>
<tr>
<td>Mar 10</td>
<td>77.7%</td>
</tr>
<tr>
<td>Jun 10</td>
<td>84.4%</td>
</tr>
<tr>
<td>Sep 10</td>
<td>92.7%</td>
</tr>
<tr>
<td>Dec 10</td>
<td>90.2%</td>
</tr>
<tr>
<td>Mar 11</td>
<td>88.9%</td>
</tr>
<tr>
<td>Jun 11</td>
<td>85.6%</td>
</tr>
<tr>
<td>Sep 11</td>
<td>86.0%</td>
</tr>
<tr>
<td>Dec 11</td>
<td>89.7%</td>
</tr>
<tr>
<td>Mar 12</td>
<td>85.9%</td>
</tr>
<tr>
<td>Jun 12</td>
<td>83.6%</td>
</tr>
<tr>
<td>Sep-12</td>
<td>85.7%</td>
</tr>
<tr>
<td>Dec-12</td>
<td>86.5%</td>
</tr>
<tr>
<td>Mar-13</td>
<td>77.9%</td>
</tr>
<tr>
<td>Jun-13</td>
<td>78.2%</td>
</tr>
<tr>
<td>Sep-13</td>
<td>82.7%</td>
</tr>
<tr>
<td>Dec-13</td>
<td>87.7%</td>
</tr>
<tr>
<td>Mar-14</td>
<td>91.4%</td>
</tr>
</tbody>
</table>

Source: Welsh Government - Health Statistics and Analysis - June 2014

% of people diagnosed with cancer treated within 31 days
% of people starting treatment within 31 days
Patients newly diagnosed not via the urgent suspected cancer route starting treatment – all Wales / Cwm Taf by quarter

<table>
<thead>
<tr>
<th>Quarter ending</th>
<th>Cwm Taf</th>
<th>All Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 09</td>
<td>96.7%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Mar 10</td>
<td>98.2%</td>
<td>98.3%</td>
</tr>
<tr>
<td>Jun 10</td>
<td>97.8%</td>
<td>98.2%</td>
</tr>
<tr>
<td>Sep 10</td>
<td>98.5%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Dec 10</td>
<td>99.6%</td>
<td>99.1%</td>
</tr>
<tr>
<td>Mar 11</td>
<td>98.7%</td>
<td>98.7%</td>
</tr>
<tr>
<td>Jun 11</td>
<td>98.4%</td>
<td>97.7%</td>
</tr>
<tr>
<td>Sep 11</td>
<td>98.9%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Dec 11</td>
<td>98.1%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Mar 12</td>
<td>98.8%</td>
<td>98.8%</td>
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<tr>
<td>Jun 12</td>
<td>98.9%</td>
<td>98.2%</td>
</tr>
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<td>Sep-12</td>
<td>99.7%</td>
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</tr>
<tr>
<td>Dec-12</td>
<td>99.1%</td>
<td>98.1%</td>
</tr>
<tr>
<td>Mar-13</td>
<td>98.2%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Jun 13</td>
<td>97.8%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Sep-13</td>
<td>98.6%</td>
<td>98.3%</td>
</tr>
<tr>
<td>Dec-13</td>
<td>98.7%</td>
<td>98.7%</td>
</tr>
<tr>
<td>Mar-14</td>
<td>97.5%</td>
<td>97.8%</td>
</tr>
</tbody>
</table>

Source: - Welsh Government - Health Statistics and Analysis - June 2014

7.2 Mortality rates following surgery

Performance Measure 3 – 30 days post treatment mortality for surgery

Cwm Taf Consultant to lead Wales-wide work on mortality reviews!

In July, the Welsh government published an independent review into hospital mortality data. It concluded that the current risk adjusted mortality index (RAMI) measure is not an effective “smoke alarm” to warn about potential failings in care at a hospital. The Palmer review said the two-stage process of reviewing the medical notes of all patients who have died in hospital – a system pioneered in Wales – could provide a better, more robust way of assessing safety and quality of care.

The Health Minister on 16th September announced that Dr Jason Shannon, Assistant Medical Director/Consultant Pathologist from Cwm Taf UHB would look how variations in this process can be reduced so that a consistent approach is taken across the country. Dr Shannon will lead the further development of the Wales-wide approach to mortality reviews and extending them to deaths which occur in the community.
Dr Shannon said “In Cwm Taf we do not rely solely on mortality indices to tell us about patient safety, we are pioneering the process of examining in detail the clinical record and circumstances in which a patient dies in hospital – the case note mortality review. From April 2013, the hospital notes of every patient dying in either Prince Charles or Royal Glamorgan Hospital has been or is in the process of being reviewed by a team of senior clinical staff including GPs, hospital specialists and senior nursing staff. As of April 2014 we extended this process to other hospital sites across Cwm Taf”.

Our aim is not just to prevent avoidable death but to prevent any harm to patients, especially that which results in long-term suffering or disability. The process has already be valuable in highlighting areas where we thinking we could do better.

We have a comprehensive system to review all in-hospital deaths including patients admitted for surgery. The minority of cases determined at first stage review as requiring further consideration are subject to a thorough Stage 2 review which includes several questions about surgical treatment, fluid balance, sepsis etc.

**Deaths within 30 days of Chemotherapy for solid tumours**

Benefits to patients from systemic anti-cancer therapies (SACT) occur at a cost of significant toxicities that can be life threatening. In 2008 the National Confidential enquiry for patient Outcome and Death (NCEPOD) published their report of a study which examined the process of care of all patients who died within 30 days of SACT, looking for areas where their care might have been improved. It did not concentrate solely on those patients whose death may have been treatment-related.

The work was supported by the Joint Collegiate Council for Oncology (JCCO), a joint group between the Royal College of Radiologists and Royal College of Physicians; and the Joint Specialty Committee (JSC) for Medical Oncology at the Royal College of Physicians.

Originally it was proposed that the study would focus on those patients in which it was thought that the toxic effects of the patient’s therapy contributed to their death. Whilst this is an extremely important group of patients to study, it would only be possible to identify this cohort of patients following close examination of individual sets of case notes. As stated above, the study included all patients who died within 30 days of systemic anti-cancer therapy and therefore included many patients who died from progressive disease as well as those who suffered iatrogenic disease. Patient management should adhere to guidelines and standards, which aim to reduce risk. This expanded study enabled NCEPOD to obtain a large dataset on patient care from which to identify remedial factors and make meaningful recommendations.
To identify remediable factors in the care of patients who received SACT which may have contributed to their death, the NCEPOD Expert Group identified five main thematic areas that would address the overall aim of the study. These were:

- The appropriateness of the decision to treat with SACT;
- The process of prescribing the anti-cancer therapy and administration of the treatment;
- The safety of the care with regard to monitoring of toxicity and management of complications;
- Communication - patient information, care pathways, protocols, guidelines, and MDT meetings; and
- Regular clinical audit with regard to process of care and clinical outcomes.

At Velindre Cancer Centre data is obtained from Canisc on a monthly basis using the death analysis tool. The data QA’ed for accuracy and as much information as possible is reviewed from annotations and prescriptions. Information is sent on a monthly basis to individual consultants and prompt feedback requested on missing data items:

- performance status
- intent and regimen
- cycle number
- number of lines of previous SACT
- whether the death was unexpected
- whether the death was related to the SACT
- cause of death
- time to death following chemotherapy and the place of death
- if further investigation, for example through the SCIF group.

For the purposes of the study, the definition of chemotherapy treatment includes cytotoxic drugs and biological agents, such as interferon and monoclonal antibody therapies.

% deaths within 30 days is calculated using the formula:-

\[
\frac{\text{Total } N^0 \text{ deaths within 30 days of SACT cycle per quarter}}{\text{Total } N^0 \text{ patients starting SACT cycle per quarter}} \times 100
\]
For reporting purposes, the time period is 3 monthly (quarterly) as this is in line with the NCEPOD time span (2 months data) and enables us to benchmark against other cancer centres (Marsden, Christie). Data can then be recorded on run charts so we can observe changes over time.

The data for Cwm Taf UHB has been extracted from the existing data used for Velindre Cancer Centre analysis. The ‘LHB of residence’ data item has only recently been included in the data analysis tool for deaths so information available from January to July 2014.

**Results**

**All Cancers Cwm Taf UHB (7A5)**

It must be acknowledged that anomalies exist due to the different methods of calculation that can be used to determine % death rate within 30 days of SACT. The NCEPOD study reviewed patients who had chemotherapy over a two month period. As data at VCC is reviewed on a quarterly basis, the rate of death within 30 days has been calculated as a percentage of individual patients who had chemotherapy during that quarter (Figure 1)

**Percentage deaths by quarter Jan – June 2014 (N = 17)**

<table>
<thead>
<tr>
<th>Quarterly</th>
<th>SACT</th>
<th>Deaths</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Jan – March 2014</td>
<td>368</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Q2 April – June 2013</td>
<td>361</td>
<td>6</td>
<td>1.7</td>
</tr>
<tr>
<td>Q3 July – September 2014</td>
<td>Data not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4 October – December 2014</td>
<td>Data not available</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

![Graph showing quarterly % deaths within 30 days of SACT for Cwm Taf UHB patients](image)
### 7.3 National cancer standards

**SUMMARY OF IMPROVEMENT IN COMPLIANCE AGAINST CANCER STANDARDS (Using Welsh Government summary reporting tool)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal PCH</td>
<td>56%</td>
<td>67%</td>
<td>95%</td>
<td>97.5%</td>
<td>97.5%</td>
<td>97.5%</td>
<td>95%</td>
</tr>
<tr>
<td>Colorectal RGH</td>
<td>56%</td>
<td>69%</td>
<td>90%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>46%</td>
<td>67%</td>
<td>86%*</td>
<td>Network reporting</td>
<td>Network reporting</td>
<td>Network reporting</td>
<td>Network reporting</td>
</tr>
<tr>
<td>Breast</td>
<td>35%</td>
<td>69%</td>
<td>89%</td>
<td>89%</td>
<td>95%</td>
<td>97.5%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Lung PCH</td>
<td>45%</td>
<td>71%</td>
<td>93%</td>
<td>96.5%</td>
<td>96.5%</td>
<td>96.5%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Lung RGH</td>
<td>66%</td>
<td>58%</td>
<td>83%</td>
<td>95.1%</td>
<td>92.50%</td>
<td>90%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Gynae RGH</td>
<td>37.5%</td>
<td>65%</td>
<td>84%</td>
<td>87.2%</td>
<td>90.24%</td>
<td>92.6%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Gynae PCH</td>
<td>55%</td>
<td>57.5%</td>
<td>73%</td>
<td>PCH/RGH Teams now merged.</td>
<td>90.24%</td>
<td>92.6%</td>
<td>87.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper G.I</td>
<td>61.90%</td>
<td>54.76%</td>
<td>95%</td>
<td>95%</td>
<td>97.51%</td>
<td>97.51%</td>
<td>95.55%</td>
</tr>
<tr>
<td>Urology</td>
<td>58%</td>
<td>62%</td>
<td>88%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>93.18%</td>
</tr>
<tr>
<td>Palliative Care RGH</td>
<td>52%</td>
<td>60%</td>
<td>84%</td>
<td>90.4%</td>
<td>94.28%</td>
<td>94.28%</td>
<td>97.22%</td>
</tr>
<tr>
<td>Palliative Care PCH</td>
<td>56.91%</td>
<td>65.71%</td>
<td>72%</td>
<td>87.5%</td>
<td>88.57%</td>
<td>93.13%</td>
<td>88.23%</td>
</tr>
<tr>
<td>Skin</td>
<td>57%</td>
<td>57%</td>
<td>71%</td>
<td>71%</td>
<td>80.56%</td>
<td>80.56%</td>
<td>91.67%</td>
</tr>
<tr>
<td>Haematology RGH</td>
<td>32%</td>
<td>42%</td>
<td>66%</td>
<td>89.2% PCH/RGH Teams now merged.</td>
<td>94.44%</td>
<td>91.67%</td>
<td>96.79%</td>
</tr>
<tr>
<td>Haematology PCH</td>
<td>37%</td>
<td>38%</td>
<td>72%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic standards</td>
<td>85%</td>
<td>85%</td>
<td>100%</td>
<td>96.43%</td>
<td>100%</td>
<td>100%</td>
<td>95.65%</td>
</tr>
</tbody>
</table>

- This reflects the newly implemented Network Service which local responses fed into

**PCH =** Prince Charles Hospital  
**RGH =** Royal Glamorgan Hospital

A summary of non compliant areas that still remain are as follows:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current Position</th>
</tr>
</thead>
</table>
| Lung Team Royal Glamorgan Hospital | Lack of Thoracic surgeon input into main weekly multi disciplinary team meeting (a separate meeting is held). There is a problem with cover arrangements for thoracic surgeon in Prince Charles Hospital. Cover for oncologist is also an issue. This will be addressed via peer review action planning process.  
More than 60% of patients with small cell lung cancer and more than 10% of patients with non small cell lung cancer should receive chemotherapy. We achieved 30% and 12% respectively. |
<table>
<thead>
<tr>
<th><strong>Lung Teams Prince Charles and Royal Glamorgan Hospital</strong></th>
<th>Cover for CNS is an issue for both teams as standards state that patient should be seen by a CNS at the time of diagnosis. Full year audit would reveal non compliance due to annual leave/study leave.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lung Team Prince Charles Hospital</strong></td>
<td>Patients with small cell lung cancer requiring first line chemotherapy should start treatment in 2 weeks. 15 patients referred, 4 met this target. Average days 14.1 days, medium 17 days. Pathway review is taking place to try and improve performance.</td>
</tr>
</tbody>
</table>
| **Urology** | Patients with testicular cancer to have orchidectomy within 2 weeks of clinical diagnosis. Out of 3 patients diagnosed 2 received this treatment within 2 weeks (1 patient did not, 13 days over). This waiting time has been measure from the point of radiological investigation (rather than pathological report) to time of operation.  
  Audit of whether patients adequately fit referral criteria need to be repeated.  
  Policy not to downgrade USC referrals was removed during 2013. An audit now needs to be undertaken of whether a GP was advised of the downgrading to non urgent by a specialist. |
| **Breast** | Policy not to downgrade USC referrals was removed during 2013. An audit now needs to be undertaken of whether a GP was advised of the downgrading to non urgent by a specialist. |
| **Haematology** | No Clinical Nurse Specialist |
| **Gynaecology** | MDT lead does not have his appointment formally detailed in his job plan.  
  MDT does not have role and responsibilities detailed in his job plan  
  Audit of informing the GP of a diagnosis within 24 hours failed. Audit is currently in the process of being repeated.  
  No Clinical Nurse Specialist within the team, advised 3 times but appointment process has been unsuccessful.  
  No oncology input into the Multi Disciplinary Team. |
| **Palliative Care Ysbyty Cwm Cynon** | Specialist inpatient units should have sufficient core staff to provide 24 hour medical cover. There is no facility for a medical review of patients at Ysbyty Cwm Cynon between 21:00 – 9:00 unless the patients undergoes an ambulance transfer to Prince Charles Hospital. |
All Cancer patients referred to the SPCT should be discussed by the team at 1st available meeting - 92% complaint.

Patients referred to SPCT for urgent review of uncontrolled symptoms should be assessed within 2 days of referral. All new referrals were audits during 2013/14. 115 fulfilled this requirement. 79 did not comply.

Audit of % of patients where the relevant clinical notes were available at the time of 1st assessment was 75% so was non compliant.

### Palliative Care South
Specialist inpatient units should have sufficient core staff to provide 24 hour medical cover. Overnight medical cover for the inpatient unit was withdrawn in 2013/14. This should be resolved when the unit moves to its new hospital site.

### Haematology
No clinical nurse specialist

No Oncology input into weekly Multi Disciplinary team meetings.

### Skin
No Oncology input into Multi Disciplinary Team Meeting.

Policy not to downgrade USC referrals was removed during 2013. An audit now needs to be undertaken of whether a GP was advised of the downgrading to non urgent by a specialist. No record keep in medical records during 2014 to enable audit. This will be resolved in 2014.

### Upper GI
Policy not to downgrade USC referrals was removed during 2013. An audit now needs to be undertaken of whether a GP was advised of the downgrading to non urgent by a specialist. No record keep in medical records during 2014 to enable audit. This will be resolved in 2014.

The audit programme within the standards need completing.

### Generic
Audit relating to reports allowing assessment of the diagnostic radiology component of TNM status determination where appropriate.

### Colorectal PCH
Auditing relating the referrals fitting the referral criteria.

Audit relating to informing the GP within 24 hours of a diagnosis.

### 7.4 National Audits

Cwm Taf Health board has a dedicated and enthusiastic team of Cancer Coordinators responsible for recording information into Canisc providing a database of all cancer patients.
The completeness of the data is consistently high and feeds directly into many National Cancer Audits. The data in Canisc is also available to clinical colleagues in tertiary referral centres providing an electronic record for our cancer patients.

The National Audits that Cwm Taf Health Board participates in annually are:

- Wales Lung Cancer Audit
- National Lung Cancer Audit (UK)
- National bowel Cancer Audit (NOGCA) (E & W)
- National Head and Neck Cancer Audit (DAHNO) (E&W)
- Welsh Breast Cancer Audit
- National Oesophago-gastric Cancer Audit (NOGGA) (E&W)

The findings of these audits provide a benchmark for the quality of data capture and local service provision and practice. Generally we have good data completeness across audits. Each audit is formally reviewed by the relevant MDT, and from this review an action plan is developed in order to ensure local practice matches best national practice.

Each Cancer MDT is also required to organise regular management meetings and develop a local annual audit plan to constantly evaluate and develop its service.

### 7.5 Peer Review

The Peer Review process for cancer services, led by the Health Inspectorate Wales (HIW) working in partnership with the Cancer Networks in North and South Wales, was launched in 2012 and comprises three levels as follows:

1. Internally validated self-assessments - Undertaken by Health Boards.
2. Externally verified self-assessments - involving peer group and HIW.
3. Peer Review visits

The broad aims of Peer Review are to ensure the safe provision of services through improvements in the quality and effectiveness of cancer care and the trial stage of the programme focussed on the lung cancer multidisciplinary team

### Reviews Undertaken during 2012/13 – 2013/14

**Lung Cancer - Summary of Assessment**

The Lung Cancer Peer Review Process commenced during November 2012 with the deadline for completion of the self assessments modules and submission to HIW being 31st December 2012. Following external verification the peer review visits for both the Prince Charles and Royal Glamorgan Hospital Multi Disciplinary Teams (MDTs) was held in March 2013 following which teams were issued with a report on 9th August 2013.
A summary of the outcome report for lung cancer is detailed below:

**Good Practice/Significant Achievements:**

- The use of rapid access clinics.
- The early warning system in radiology.
- Good interpersonal communications.
- The delivery of a single pathway for pathology.
- Strong clinical and nursing leadership in the Prince Charles Hospital MDT.

**Concerns identified:**

- Thoracic surgeon attendance at both MDT meetings.
- Lack of cover at MDTs for disciplines including thoracic surgeon, oncology and CNS.
- Lack of clinical leadership and co-ordination at Royal Glamorgan Hospital which may be due to lack of dedicated time in job plans for lung cancer and for clinical leadership of the MDT.

**Serious concerns/Immediate Risks**

- The review did not identify any areas of serious concern.
- The review did not identify any areas of serious risk.

**Upper Gastro Intestinal - Summary of Assessment**

The Upper Gastro Intestinal MDT completed and submitted their self evaluation document by 28th June 2013 and the peer review visit was held on 19th September 2013.

**Good Practice/Significant Achievements:**

- A strong, functional MDT with excellent working relationships and effective communication between members and with the regional MDT. The team has self awareness of the issues it faces and a whole-team commitment to improving the service.
- Strong CNS input to the team and also good participation from Allied Health Professionals.
- Good performance against the Urgent Suspected Cancer (USC) 62 day target.
- Good interaction with primary care and with Public Health with evidence of efforts to engage with prevention, health promotion and early referral scheme.

**Concerns identified:**

- There is significant reliance on key individuals and relationships, with less emphasis on systems to support the clinical pathway. The lack of a systemised clinical pathway could make the service vulnerable in the absence of a key individual.
- There is no formal Acute Oncology Service on either site, and no formalised medical input and support from the oncology service.
- The EUS service provided by Cardiff & Vale UHB at UHW relies on outdated equipment, long past its expected working-life.
- The lack of a single dedicated Upper GI MDT meeting hampers the ability of the team to provide cross cover for core MDT posts

**Serious concerns/Immediate Risks:**

The team does not have its own Multidisciplinary meeting (MDM); the two existing MDT meetings are not dedicated to Upper GI Cancer, and are led by colorectal surgeons, and as such, do not provide a focus for the Upper GI service in Cwm Taf. The surgeons are unable to attend the Royal Glamorgan meeting on alternate weeks and this can lead to over-reliance on individuals to make sure that the process works. Since the review have already implemented change and the Upper GI MDT now operates completely independently from colorectal on both sites with a new Chair. A single MDT will be discussed in Business Meeting of MDT during April 2014.

Immediate Risks - none identified.

**Urological Cancer - Summary of Assessment**

The Urology MDT completed and submitted their self evaluation document by 13th December 2013 and the peer review visit was held on 30th January 2014. All Health Boards then had to respond with an Action Plan to address the findings by 21st February 2014.

**Good Practice/Significant Achievements:**

- Patient focused enthusiastic team
- Clinically led and delivered service
- MDT Leadership
- Radiology Service
- One stop clinic
- Nurse Led raised PSA clinics
- Business meeting
- Service improvement engagement

**Concerns identified:**

- Different referral pathways to Royal Glamorgan Hospital and Prince Charles Hospital – need to undertake further work to streamline the referral pathway
- MDT co-ordination and the use of Multi Disciplinary Module within the MDM setting
- Pathway capacity vulnerable due to staffing levels
- Mechanism to performance monitor cases referred for radical surgery
- Lack of Acute Oncology Service
- More engagement with Executive Board around areas of performance and service improvement
- Recruitment to Wales Cancer Bank

**Serious concerns/Immediate Risks:**
- The review did not identify any areas of serious concern.
- The review did not identify any areas of serious risk.

**Colorectal**

The Urology MDT completed and submitted their self evaluation document by 13th December 2013 and the peer review visit was held on 30th January 2014. All Health Boards then had to respond with an Action Plan to address the findings by 21st February 2014.

**Good Practice/Significant Achievements:**

**Health Board**
- Good attendance at the Peer Review visit
- A great effort in completing the documentation
- Strong corporate strategy, recognised the hard work and effort of the Deputy Head of Strategy
- Excellent Stakeholder Events
- Excellent advances with Acute Oncology Service

**Prince Charles Hospital**
- Excellent One Stop Clinic
- Pre-operative Assessment clinic same day as diagnosis given
- Development of Patient Information DVD’s
- Hard working CNS Team
- Exceptional laparoscopic service (90% is probably one, if not the highest in the UK).

**Royal Glamorgan Hospital**
- Very motivated team
- Annual Plan

*Immediate Risks - None*

*Serious concerns – None*
Concerns -
Health Board wide

- Low access to Clinical Trials
- Lack of formal links between the two MDT’s and variation in services across the Health Board.
- Lack of sufficient access to CT Colonography
- No standardised Follow up protocol
- No audit of Lymph Node Harvesting
- Issues with the CHIRP interface for Pathology Reporting
- No unified MDT for the Health Board
- Low attendance by Clinical Oncologists at MDT meetings and no agreed cover arrangements
- Lack of an Acute Oncology Service, although plans are now being developed

Prince Charles Hospital

- Single Handed Radiologist
- Limited access to Stenting
- Staging inaccuracies in the data submitted
- Disseminated audit

Royal Glamorgan Hospital

- 20% patients not staged due to co-morbidities
- Low rate of Laparoscopic surgery
- Salvage surgery for anal cancer being performed at Royal Glamorgan hospital and not at a specialist centre.

All Health Boards had to respond to their Peer Review Report with an Action Plan to address the findings. Updated Action Plans from all of the above peer reviews will be available on the Health Board’s internet site once a cancer specific page has been developed during 2014.

Regional peer reviews were also held during the year for Upper Gastro Intestinal and penile cancer which Cwm Taf participated in and are contributing to the implementation of those action plans.

Ongoing Peer Reviews:

The Head and Neck MDT are awaiting their peer review visit at the time of writing this report. The Gynaecology MDT are currently working towards the completion of their self evaluation documentation with a planned completion date of 24th October 2014.
7.6 High quality clinical research

Performance Measure 4 – The percentage of patients recruited into high quality clinical research

The number of people entering approved NISCHR research studies as a percentage of cancer incidence in Wales:

<table>
<thead>
<tr>
<th>Year</th>
<th>All Wales</th>
<th>South East</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>13.4%</td>
<td>15.2%</td>
</tr>
<tr>
<td>2009-10</td>
<td>13.8%</td>
<td>14.4%</td>
</tr>
<tr>
<td>2010-11</td>
<td>13.5%</td>
<td>16.8%</td>
</tr>
<tr>
<td>2011-12</td>
<td>13.9%</td>
<td>13.8%</td>
</tr>
<tr>
<td>2012-13</td>
<td>18.8%</td>
<td>22.6%</td>
</tr>
<tr>
<td>2013-14</td>
<td>14.4%</td>
<td>15.6%</td>
</tr>
</tbody>
</table>

Source: NISCHR April 2014

The Cwm Taf Research & Development Department (R&D) continues to deliver and manage a robust Research Governance process, in addition to providing support, guidance, advice and training to research active professionals across the Health Board and external researchers who wish to undertake collaborative research within the Health Board. R&D funding is allocated and prioritised in compliance with national, regional and local strategies & policies (primarily NISCHR Welsh Government) to enable the organisation to participate and support studies in priority disease areas such as cancer and cancer prevention (Public Health - Health Promotion/Protection & Prevention). During 2014 R&D has provided funding support for several high quality collaborative ‘Portfolio’ cancer studies aimed at improving patient outcomes:

ARISTOTLE: A phase III trail comparing standard versus novel chemoradiotherapy as pre-operative treatment for locally advance rectal cancer - This study is trying to find out if adding a second drug called irinotecan to the standard treatment of chemoradiotherapy (oral chemotherapy (capecitabine) and radiotherapy) will reduce the risk of cancer coming back.
PATCH: Prostate Adenocarcinoma: TransCutaneous Hormones - This study is trying to find out if oestrogen patches are a safe treatment for men with prostate cancer. The information from this study may help to treat future patients with prostate cancer better.

ELCID: Early Lung Cancer Identification & Diagnosis - This study is trying to find out whether referring more people for a chest X-ray will result in reducing the time to diagnosis for lung cancer.

ICBP MODULE 4: Root causes of diagnosis and treatment delay in cancer - There are important international differences in cancer survival and the explanation for these is not known. The International Cancer Benchmarking Partnership (ICBP) which is a international partnership of clinicians, academics and policymakers, seeks to determine how cancer survival varies between jurisdictions and to explore reasons that could explain any differences. This study is the 4th module of the ICBP and it aims to establish a cross country benchmark of the total interval from onset of initial symptoms to commencement of treatment in patients diagnosed with one of four cancers lung, breast, colorectal and ovary.

UKGPCS: UK Genetic Prostate Cancer Study: Epidermiology and Molecular Genetic Studies - Prostate cancer is the commonest cause of cancer mortality in men after lung cancer and resulted in 10, 160 deaths in 2003 in the UK. There is some epidemiological evidence to suggest that a family history of the disease confers an increased risk of development of the disease in relatives of affected cases. The purpose of the study is to find genes which predispose to developing prostate cancer and investigate whether such genetic changes affect the behaviour of the disease.

The aims are:
- to find genes which predispose to PrCa
- to determine if genes which predispose to PrCa are associated with disease and treatment parameters and tumour molecular changes
- to find biological markers associated with PrCa, genetic predisposition and disease behaviour
- to determine if genes which predispose to PrCa are associated with environmental factors
- to estimate the percentage of PrCa patients who have a positive family history of the disease
- to estimate the relative risk of developing PrCa in a currently unaffected member of a PrCa family
- to ascertain whether relatives of PrCa patients are at increased risk of developing cancers other than PrCa

LUNGAST; Smoking Status and Lung Cancer: Retrospective reports suggest continued smoking after receiving a diagnosis of lung cancer probably worsens survival and increases treatment complications. There are plausible biological reasons why this could happen but well designed studies proving a causal effect are lacking. The health gains from seeing a stop smoking specialist in people with such limited life expectancy are also debated. This 4 year project, aims to recruit around 2700 consecutive patients with newly diagnosed lung cancer over 2 years and follow outcomes at 1, 3, 6, 12 and 24 months.
Cwm Taf Health Board has also utilised some of its research support and portfolio development funding to support a collaborative ‘Pathway to Portfolio’ study, MAMMS: Smoking Cessation in pregnancy - This study is investigating whether the uptake of smoking cessation services by pregnant women will increase, if flexible models of support are delivered by a Maternity Support Worker sited within the Midwifery team.

The following cancer research studies are currently open in Cwm Taf Health Board:

NSCCG: National Study of Colorectal Cancer Genetics - This study is trying to find out if certain mutations or changes in genes (Genes are the information storage system of the body and dictate how we look and how our body functions) can be matched with the development of cancer and look at how these interact with environmental factors. This information may be beneficial in the future in understanding how the cancer arises.

ART DECO TRIAL: A trial examining the effectiveness of a type of radiotherapy treatment called Intensity Modulated Radiotherapy (IMRT), for patients with cancer of the larynx or hypopharynx - This study is trying to find out if increasing the dose of the radiotherapy will be effective in treating cancer of the larynx (voice box) or hypopharynx (lower part of the throat).

ARTemis: Avastin Randomised Trial with neo-adjuvant chemotherapy for patients with early breast cancer – This study is investigating whether combining the treatment of Avastin (Avastin is a monoclonal antibody which can stop some cancers from developing new blood vessels) with chemotherapy is more effective than chemotherapy alone in the treatment of breast cancer.

COSTAR: Cochlear Sparing Therapy and Conventional Radiation: A multicentre randomised study of Cochlear Sparing Intensity Modulated Radiotherapy versus Conventional Radiotherapy in patients with parotid tumours - This study is investigating if a different type of radiotherapy, called Intensity Modulated Radiotherapy (IMRT) can reduce the amount of hearing loss caused when compared to treatment with standard/ conventional radiotherapy. The idea is that the use of IMRT will reduce the dose of radiation received by the inner ear and so reduce the frequency of hearing loss.

Pet-Neck: A multicentre randomised phase III trial comparing PET-CT guided watch and wait policy versus planned neck dissection for the management of locally advanced (N2/N3) nodal metastases in patients with head and neck squamous cancer – This study is comparing two methods for managing head and neck cancers for patients with cancer which has spread into the neck glands. One is a watch and wait policy using PET/CT scanning after chemo radiotherapy compared with the standard method, which is surgical removal of neck glands following chemo radiotherapy.
Head & Neck 5000 – The overall aim of the programme is evaluate and disseminate the outcome of centralization in Head and Neck cancer (H&N). In order to accomplish this to create a clinical cohort of 5,000 people with H&N and follow up this cohort for two years.

TACT 2 – The aims of TACT2 are to see if we can reduce the short-term side effects of chemotherapy treatment and at the same time improve the long term outcome for patients with early breast cancer. We are looking at 2 possible ways to achieve this:

1. We would like to see if using a drug called capecitabine (Xeloda) in place of other commonly used drugs can reduce unwanted side-effects, yet still be just as effective.
2. Research in other countries shows that it might be better to speed up, or accelerate some chemotherapy treatment. TACT2 aims to find out if a drug called Epirubicin works better if you accelerate treatment (i.e. give it every two weeks instead of the usual three weeks). We also want to know if patients prefer it.

FRAGMATIC: A Randomised Phase III Clinical Trial Investigating the Effect of Fragmin Added to Standard Therapy in Patients with Lung Cancer – This is an open-label multi-centre phase III randomise controlled clinical trial in patients with lung cancer comparing a research arm of anticancer treatment according to local practice plus dalteparin against the control arm of anticancer treatment according to local practice alone. The primary aim is to determine whether the addition of dalteparin results in improved survival.

SORCE:A Phase III Randomised Double-blind Study Comparing Sorafenib With Placebo In Patients With Resected Primary Renal Cell Carcinoma at High or Intermediate Risk of Relapse - The SORCE trial is a multi-centre randomised phase III double-blind placebo-controlled study examining the efficacy and tolerability of sorafenib in patients whose affected kidney has been partly or totally removed, and who are objectively judged to be at high or medium risk of their disease returning. Patients will be randomly assigned to 3 years of placebo (Arm A), 1 year sorafenib followed by 2 years placebo (Arm B) or 3 years sorafenib (Arm C). Sorafenib will be given at 400 mg po (per oral) bd doses.

FOXTROT – is a research study testing two new types of treatment to see if these are better than standard treatment. The first is to give some of the chemotherapy before the operation (“preoperative chemotherapy”) with the aim of shrinking and controlling the cancer as soon as possible. The second treatment being tested is a new drug called “panitumumab”. FOxTROT whether giving panitumumab along with chemotherapy also helps people with less advanced disease whose cancer can be treated by surgery.

BETH – A Multicenter Phase III Randomized Trial of Adjuvant Therapy for Patients with HER2-Positive Node-Positive or High Risk Node-Negative Breast Cancer Comparing Chemotherapy Plus Trastuzumab with Chemotherapy Plus Trastuzumab Plus Bevacizumab. - The main purpose of this study is to learn if adding bevacizumab to chemotherapy and trastuzumab for HER2-positive breast cancer will prevent breast cancer from returning.
APHINITY - A randomized multicentre, double-blind placebo controlled comparison of chemotherapy plus Trastuzumab plus placebo versus chemotherapy plus Trastuzumab plus Pertuzumab as adjuvant therapy in patients with operable HER2 positive primary breast cancer. The purpose of this study is to find out if we can improve the benefits of chemotherapy by adding the new experimental medication called Pertuzumab in combination with Trastuzumab (Herceptin ®) in addition to the other treatment medications that would be commonly used to treat patients with this type of breast cancer. The study will help us to understand how well Pertuzumab works.

ST03: A Randomised Phase II/III Trial of Peri-operative Chemotherapy with or without Bevacizumab in Operable Adenocarcinoma of the Stomach and Gastro-Oesophageal Junction – This study is trying to assess the safety and efficacy of adding the monoclonal antibody Bevacizumab to ECX chemotherapy administered peri-operatively in patients with tumours of the stomach and gastro-oesophageal junction.

PERSEPHONE: Duration of Trastuzumab with Chemotherapy in Women with Early Breast Cancer: six months versus twelve - This study is investigating whether 6 months of Herceptin (a drug given to breast cancer patients for 12 months) is as clinically effective as 12 months treatment in women with early breast cancer.

REACT: A Trial of Celecoxib versus Placebo in Patients with Primary Breast Cancer - This study is investigating if celecoxib can be used after breast cancer treatment to reduce inflammation around any new potential tumour sites and as a result reduce the ability of new tumours to grow and survive.

The Phase I/II I-START trial: ISOToxic Accelerated RadioTherapy in locally advanced non-small cell lung cancer - The study is trying to establish the highest dose of potentially curative radiotherapy that can safely be used in locally advanced non small cell lung cancer (NSCLC). Increasing the dose of radiotherapy given to patients may improve both local control of the cancer and survival in some patients.

OPTIMA: Optimal Personalised Treatment of early breast cancer using multiparameter Analysis – It is normal clinical practice to offer several months of adjuvant chemotherapy to women with early breast cancer who have involved axillary lymph nodes. It has been argued that chemotherapy may have little effect on some subtypes of breast cancer. These patients already benefit substantially from hormone (or endocrine) therapies and the addition of chemotherapy may provide no significant additional survival benefit. The study is trying to find out if the development of personalised medicine in breast cancer by using multiparameter pathology tests will identify those women who are likely to benefit from chemotherapy, sparing those who are unlikely to benefit.

POUT: A phase III randomised trial of Peri-Operative chemotherapy versus surveillance in upper Tract urothelial cancer - POUT is a randomised controlled trial which aims to establish the optimum management strategy following surgery to treat locally advanced upper urinary tract transitional cell carcinoma (TCC).
This affects the cells which line the inside of the kidney (renal pelvis) and the ureter which connects the kidney to the bladder. This type of cancer is rare, with an estimated incidence of 24 cases per 100,000 individuals per year. Tumours frequently come back (recur) following surgery and survival rates are poor; for patients diagnosed in 2001-2003 five year survival was 50%.

Predictors of Malignancy in patients with Thyroid Nodules - In this study we aim to examine the medical records of patients who previously presented to our hospital department with neck lumps, in order to collect demographic and clinical data on risk factors for cancer and how these risk factors interact in predicting cancer in individual patients. The outcome of this study will be to produce a model which will guide clinicians in determining and stratifying the risk of thyroid cancer in individual cases.

FABIO: Functional Assessment in early Breast cancer in Older patients - Patients diagnosed with early surgical operable breast cancer, may then undergo surgery/chemotherapy/radiotherapy and further treatments like hormonal manipulation and Trastuzumab (Herceptin®). In order to benefit from intended treatment, the patient’s life expectancy irrespective of their cancer has to be sufficiently good to accept the side effects and risks of treatment. Age alone is a poor predictor of life expectancy and tolerance of treatment. Breast cancer specific mortality is not trivial in the older age, particularly when one considers that according to 2003 life expectancy tables, a woman without breast cancer who has reached 70 years is likely to live another 16 years. Therefore all active treatment options should be considered when older patients present with breast cancer, as there is a real possibility that the disease may be associated with significant risks of morbidity and mortality. However, assessment of a number of different factors may help predict these outcomes. These include assessments of functional status, comorbid medical conditions and nutritional status. A number of validated assessment tools have been devised to assess these parameters in various patient populations. However, the applicability and usefulness of these surveys in older breast cancer patients has not been fully investigated. Therefore we plan to characterise patients over the age of 70 with newly diagnosed early surgical operable breast cancer in terms of objective health assessments (Comprehensive Geriatric Assessment). This will assess to see if the tools we are planning in using may be able to implemented in clinical practice, as we tend to either undertreat or over treat this group of patients and as oncologists, just tend to assess fitness on performance status only which has many a bias.

Beliefs surrounding fertility and breast cancer - The study aims to examine the beliefs and concerns of patients and health professionals surrounding breast cancer and fertility and to investigate how the advice from health professionals impacts on patients’ fertility choices. With better treatments options available, breast cancer survival rates are improving and quality of life issues post cancer treatments are consequently becoming increasingly important. We previously conducted a small focus group study looking at the fertility issues and effects of services on the experiences of young women with breast cancer. We found that there were a number of issues that the participants were concerned about regarding their survival and how this is affected by fertility decisions.
This has led us to creating this study looking at these issues in more detail from both patient and health professional perspectives.

COMPARE study: COMparing treatment options for ProstAte cancer - Looking at what characteristics of treatment are important to men with early prostate cancer. This is important to know because there are now so many treatments for localized prostate cancer. Men with localized prostate cancer face a choice between surveillance and whole gland treatments such as surgery or radiotherapy and new minimally invasive treatments. This project involves a questionnaire which presents different treatment scenarios.

The EARLY project: Early Detection of Respiratory Disease using Expired Breath Analysis by Ion Mobility Spectrometry: This prospective observational study is designed to collect exhaled breath samples from patients with lung cancer and other lung complaints. The breath samples will be analysed by a commercial mobile ion spectrometer and the profile of volatile organic compounds recorded. The data from patients with confirmed lung cancer and other lung complaints will be compared to data collected from healthy subjects (collected in a separate study).

The cancer research studies currently open for patient recruitment at Cwm Taf Health Board are: Persephone, OPTIMA and NSCCG, ELCID, LUNGAST, LUNGSafe, Head and Neck 5000, COMPARE, UKGPCS, EALRY, Beliefs surrounding fertility and breast cancer, FABIO, ICBP MODULE 4 and UKGPCS. The R&D Department for the current reporting period have reviewed and approved the provision of support services for the following cancer research studies hosted by Velindre NHS Trust: GA101, ARADES, ASTEX, SAPROCAN, BRIM8, MetMAb, BELLE3, De-ESCALaTE HPV, GATSBY, Ion, 4EVERUK, PARAGON, BILCAP, MVA, INCYTE, PHEREXA, Pralatrexate, ARCHER, CUP-ONE, LUX Lung 7, PLUTO, TNT, GU86, FIESTA, HOPE, SKOPOS, MILLENNIUM, METFORMIN, MEDIX 73, ORCHARRD, Transgene, MERIDIAN, REALISTIC, NEOSCOPE, BELLE 3, GALAXY, OLAPARIB, FAKTION, PACMEL, ESPAC-4, OE05, IMPORT HIGH, G028053, SCOR, ICON8, ABRIRATON, VS-6063, COBRIM, NALA, PALOMA 3, KAITLIN, VINCAP, UKMCC-01, REACT, Tesaro Bravo, PAKT and SIEGE.

Several cancer studies open in Cwm Taf are supported by NISCHR-CRC research staff (research nurses and admin etc) where the level of support provided is dependent on the resource available and required. For example, some of the cancer studies supported by NISCHR CRC staff equate to 1-4 sessions per week/month depending on the research study.

R&D funding is also provided to the departments involved with supporting these research studies which include Pharmacy, Radiology and Pathology, with specific posts in Pharmacy and Pathology. Without this funding support, the Health Board would be unable to support and participate in clinical trials. The organisation will require additional funding investment from NISCHR/NISCHR AHSC and Cwm Taf University Health Board to develop and establish the appropriate infrastructure i.e. dedicated clinical staff resources if the organisation is to deliver and meet the performance targets set by NISCHR, Welsh Government and NISCHR AHSC.
The Health Board will be expected to deliver against the newly implemented performance targets which include increasing annually the number of patients recruited into clinical trials.

The R&D Department continually strives to increase the Health Boards R&D funding allocation which primarily can be achieved through the organisations increased participation in high quality collaborative research. Increasing the clinical research activity will be challenging but there are many dedicated staff members who are prepared to act as Chief or Principal Investigators and support such important studies.

Discussions are being undertaken with the Wales Cancer Bank to facilitate and increase involvement of Cwm Taf patients in the provision of samples of tumour from patients who are undergoing an operation to remove tissue where cancer is a possible diagnosis.

NISCHR CRC, South East Wales Research Network has confirmed that NHS organisations’ in the South East Wales region including Cwm Taf Health Board have collectively reported an annual recruitment figure of 15.6% of patients into cancer research clinical trials. This is above the 10% national recruitment target.

7.7 Tissue donations to the Wales Cancer Bank

Performance Measure 5 – The percentage of people diagnosed with cancer who consent to donate samples to the Wales Cancer Bank

<table>
<thead>
<tr>
<th>Year</th>
<th>Cwm Taf</th>
<th>All Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>1.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>2009</td>
<td>1.4%</td>
<td>4.9%</td>
</tr>
<tr>
<td>2010</td>
<td>1.8%</td>
<td>5.6%</td>
</tr>
<tr>
<td>2011</td>
<td>2.9%</td>
<td>7.2%</td>
</tr>
<tr>
<td>2012</td>
<td>8.0%</td>
<td>10.8%</td>
</tr>
<tr>
<td>2013*</td>
<td>14.0%</td>
<td>14.1%</td>
</tr>
</tbody>
</table>
WCB consenting figures by year
*Using 2013 WCB data against 2012 incidence data

Source: Wales Cancer Bank May 2014

Supporting information

Data is sourced from WCISU for the cancer incidence (minus 0-17 year olds and haematology patients) for the calendar years 2008, 2009, 2010, 2011 and 2012. There is no WCISU data for 2013, therefore the data attached used 2013 WCB data against 2012 incidence data

Unlike other Health Boards, Cwm Taf had never received central funding for nurses to obtain consent or laboratory staff to process specimens for donation to the Wales Cancer Bank (WCB). Cwm Taf patients however did have an opportunity to donate tissue whilst receiving treatment at tertiary referral centres.

We are pleased to report that during 2013/14, following discussion the WBC, they provided us with enough funding for laboratory costs so that the lung and head and neck teams could commence taking consent and donating to the WCB. Other cancer teams within Cwm Taf have also agreed and are keen to undertake this role however further developments are on hold until further funding is identified.

8.0 Meeting People’s Needs

We are committed to ensuring that all patients are cared for with dignity and respect and will ensure that services are planned and delivered around the patient and their individual needs. Below are the results for Cwm Taf from some of the questions asked as part of the Macmillan/Welsh Government National Cancer Survey (2013).

**Question:** Were you given the name of a Clinical Nurse Specialist who would be in charge of your care?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>84%</td>
<td>182 patients</td>
</tr>
<tr>
<td>No</td>
<td>16%</td>
<td>35 patients</td>
</tr>
<tr>
<td>Don’t know/not sure</td>
<td>1%</td>
<td>1 patient</td>
</tr>
</tbody>
</table>

**Performance Measure 6 – The percentage of people with a diagnosis of cancer who are assigned a key worker**

**Question:** Were you given the name and contact details of your Key Worker?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes and this was not a CNS</td>
<td>29%</td>
<td>79 patients</td>
</tr>
<tr>
<td>Yes and this was my CNS</td>
<td>23%</td>
<td>65 patients</td>
</tr>
<tr>
<td>No I did not have anyone who was named as Key Worker</td>
<td>36%</td>
<td>101 patients</td>
</tr>
<tr>
<td>Don’t know/Not sure</td>
<td>12%</td>
<td>32 patients</td>
</tr>
</tbody>
</table>
The result to this question is not consistent with question above relating to the Clinical Nurse Specialist whereby the 84% of patients are given the name of their CNS. As 36% of patients reported they did not have a named Key Worker this raises potential issues about terminology around the role.

**Performance Measure 7 – The percentage of people with a diagnosis of cancer who have a care plan**

**Question:** Were you offered the opportunity to discuss your needs and concerns in order to put together your care plan?

- Yes: 20% (45 patients)
- No: 80% (182 patients)
- Don’t know/can’t remember: 12% (33 patients)

**Question:** Have you been offered a written care plan?

- Yes: 20% (45 patients)
- No: 80% (182 patients)
- Don’t know/Can’t remember: 14% (37 patients)

**Source: National Patient Experience Survey 2013/14**

The above results highlight the need to make improvements both in terms of offering patients the opportunity to discuss the care plan and to be offered a written copy. This has been highlighted as a priority in our Local Cancer Delivery Plan which was revised in April 2014.

In summary the findings of the National Patient Survey at a health board level (not focusing here on specific tumour groups) were:

**Key Strengths:**

- 85% of patients said they were send by a hospital doctor as soon as they thought was necessary after referral.
- 86% of patients were told sensitively they had cancer.
- Most patients (83%) were given a choice of treatment, where this was possible.
- High proportion of patients were given the name of a Clinical Nurse Specialist (CNS) who would be in charge of their care (84%), said the CNS listened carefully to them (91%) and gave understandable answers to questions (92%). Most Key Workers, where they were notified to the patients, were also said to listen carefully (84%).
- High proportion of patients said they had complete explanations of what would be done in the operation they were having (86%).
- Some scores for doctors were high with 87% of patients having confidence and trust and 85% saying doctors did not talk in front of patients as if they were not there.
- 86% of patients said nurses did not talk in front of them as if they were not there.
• 87% of patients did not believe that information was being withheld from them and 82% said they did not receive conflicting information.
• High scores of over 80% were achieved for privacy.
• 87% of patients said that staff did everything they could to control their pain whilst they were in hospital.
• 84% said they were always treated with respect and dignity.
• 98% of patients said that doctors had the right notes and results with them when they were seen in outpatients.
• 91% of patients said their GP was given enough information about their condition and treatment they had at the hospital.
• Overall scores were high, with most patients saying that they were given the right amount of information (84%); that they were not treated as a set of cancer symptoms but were treated as a whole person (80%); and their care was excellent or very good (86%).

Key Weaknesses:

• The Royal Glamorgan Hospital had a number of scores lower than the all-Wales average.
• Lower proportions of patients were given written information about the type of cancer they had (59% compared to 62% in Wales as a whole).
• Information on potential long term side effects was given to only 53% of patients.
• Fewer patients (59%) were given details of their Key Worker compared to 84% being told about a CNS.
• Only 53% were offered the opportunity to discuss needs and concerns and only 20% of patients were offered a written care plan.
• 32% of patients were not given information about emotional support (e.g. through support groups) but would have liked some.
• Information was given to only a minority of patients on any financial help or benefits they might be entitled to (42%).
• Only 61% of patients said there were always enough nurses on the ward to care for patients.
• Only 54% of patients said they were asked what name they would prefer to be called by.
• 21% of patients said they did not have the opportunity to discuss any worries or fears they had whilst they were in hospital or only did so some of the time.
• Only 53% of patients said all the information on how to look after the patient on discharge was given to their family.
• Only 62% of patients said that they got enough support from health, social services post discharge.
• 10% of patients said that GPs, hospital staff etc did not always work well together to give the best possible care to them or only sometimes did.
The above findings as well as more detailed tumour site information will form the basis of an action plan to be implemented by Cancer Leads and the Macmillan Funded Patient Centred Care Manager post which is due to be advertised early April 2014.

The % of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Cwm Taf</th>
<th>Wales</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>93.1%</td>
<td>93.9%</td>
<td>93.9%</td>
</tr>
<tr>
<td>2012</td>
<td>94.0%</td>
<td>93.7%</td>
<td>93.6%</td>
</tr>
<tr>
<td>2013</td>
<td>93.9%</td>
<td>93.4%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

Source: QOF Database June 2014

Over the last 12 months we have made the following progress which will ensure improvements in meeting people’s needs:

A Macmillan Highly Specialist Speech and Language Therapist

Kate Paterson, the Health Board’s Macmillan Highly Specialist Speech and Language Therapist commenced her role at the beginning of March 2014.

Since coming into the role, Kate has set up a pathway which facilitates the transfer of patients who are discharged from hospital back to care homes, from her SLT colleagues working in hospital to herself working in the community. This ensures patients receive a timely follow-up visit from SLT in their own home, whilst freeing up therapists’ time in the hospital setting to see acutely unwell patients.
She is also developing a training package for staff in care homes. The training will include information on the causes, signs and symptoms of swallowing problems, and the impact these can have on a person’s health. Strategies around how to help people with swallowing difficulties will also be shared.

By giving staff in care homes increased knowledge and skills, it is hoped that they will be confident in identifying problems at an early stage and therefore make appropriate adjustments to help and, if appropriate, refer to SLT for specialist advice.

A key part of Kate’s role is to offer timely swallowing assessments and give advice around how to make eating and drinking as safe and enjoyable as possible. She is also contributing to a multi-disciplinary project around Advanced Care Planning. By offering advice before reaching a crisis, or before a person becomes very unwell, and by having discussions about the future in good time, it is hoped that ill health and unnecessary hospital admissions relating to swallowing difficulties will be avoided.

Kate has bases in Keir Hardie University Health Park and Ysbyty Cwm Rhondda and has approximately 45 nursing and care homes to cover in her role.

**Appointment of Dr Rachel Parsons, Macmillan Clinical Psychologist for Cancer Patients.**

This role will include working across cancer services with patients and also supporting staff.

Rachel will be working four days a week (Monday – Thursday) and clinics will be held in both the Royal Glamorgan and Prince Charles Hospitals.

Rachel’s role will include providing psychological interventions for patients and their families on both a 1-1 and group basis. She will also be providing staff in cancer services with consultation/supervision around specific cases and teaching and training around the psychological aspects of cancer and delivering psychological care.
Rachel will be drawing upon the following psychological interventions:

- Cognitive Behavioural Therapy
- Acceptance and Commitment Therapy
- Mindfulness
- Brief Solution Focussed Therapy

An introductory workshop was undertaken on 29th July for multi disciplinary teams to receive access to referral processes and pathways etc and to be informed of planned training sessions for them in relation to psychological support. This service has been established by working closely with the third sector that provide counselling services as well as a range of complementary therapies and patient transport service.

### 9.0 Caring at the end of life

We will ensure that access to health and social care, support and symptom control will be the same wherever a patient dies. We do this through the close coordination of services across primary, community, social and hospital care and between statutory and Third Sector organisations.

This third annual report sets out the progress we have made against each of our priorities and sets out a baseline for future years against which progress can be monitored.

In September 2013, we published our End of Life Care Delivery Plan. The Plan is designed to enable us to deliver on our responsibility in delivering high quality end of life care, regardless of diagnosis or circumstance. It sets out how we propose to address our priorities for end of life care, which are:

- Supporting living and dying well
- Detecting and identifying patients early
- Delivering fast, effective care
- Reducing the distress of terminal illness for the patient and their family

Our first End of Life Care Annual Report published in June 2014 provides a baseline for where CTUHB is; sets out the progress we have made against each of our priorities and sets out a baseline for future years against which progress can be monitored.

We are using a number of outcome indicators to measure and track how well end of life care services are doing over time. These include:
• **Outcome Indicator 1 - Residence at time of death**
  o Cwm Taf has a higher than average rate of death in hospital, correlating to a lower than average rate of death in care homes. The rate of death in the person’s own home is only slightly lower than the Wales average. We are therefore focussing our efforts on care homes, piloting an Advance Care Planning tool to support care homes in appropriately planning and managing end of life care for their residents.

• **Outcome Indicator 2 - The numbers of emergency admissions for palliative care patients amongst our population**
  o The overall rate of deaths within 3 days of emergency admission in Cwm Taf, at 1.04% of discharges, compares to the Wales average of 1.08%. The ACP programme in care homes should help to ensure that more patients have their end of life care appropriately managed within the care home thereby avoiding emergency hospital admission for their last days of life. To date this has already been achieved for some people as part of the ACP care home pilot.

• **Outcome Indicator 3 - The number of people recorded on primary care palliative care register prior to death**
  o Cwm Taf has a significantly lower percentage of patients on the GP Palliative Care Register than the Wales average, although this has increased from 11.3% 2012 to 16.9% in 2014. Our Macmillan GP Facilitators are helping to promote the use of the Register in primary care, as well as active management of care for people on the register.

• **Outcome Indicator 4 - The number of people receiving specialist palliative care**
  o In Cwm Taf, 26.5% of patients referred to the specialist palliative care team are recorded as having a completed assessment within 3 months, compared with the Wales average of 13.98%.

Our End of Life Care Annual Report also details progress made against each of our priorities:

**Supporting Living and Dying Well**

- **GP Facilitators** - Cwm Taf has two Macmillan funded GP Facilitators who have been encouraging use of universal Advance Care Planning (ACP) tools, starting with a pilot of new admissions to nursing homes. This has now been extended to existing nursing home residents. The initial report of the pilot has shown that 9 Advance Care Plans have been agreed, 7 of which helped to avoid a hospital admission, and 3 of which enabled the individuals to die in their care home as per their plan.

- **ACP Clinical Nurse Specialists** – two ACP Clinical Nurse Specialists have recently been appointed with the support of Macmillan funding. The ACP nurses will work alongside the GP Facilitators to develop and embed the processes for advance care planning in primary and community care.

- **ACP Speech & Language Therapist** – Macmillan funding has also enabled the appointment of a Speech & Language Therapist (S&LT) for advance care planning.
The postholder is supporting the ACP nurses in the development and delivery of holistic, safe and dysphagia appropriate care plans for people at the end of life. The S&LT will also provide training for care home staff to help them manage patients with dysphagia competently and safely and help avoid hospital admissions that arise as a result or relating to dysphagia issues.

- **RBID (Record of Best Interests Decisions)** – this is a complementary project implementing advance care planning for people without mental capacity.
- **Education** – The GP Facilitators and Lead Nurse for Palliative Care have held education sessions with GPs, District Nurses and Nursing Homes to introduce and ensure understanding of the End of Life Care Pathway and the various tools and processes involved. Ongoing training and education will be a key part of the ACP Nurses’ role and will feature as a priority in our updated Delivery Plan for 2014/15.
- **(w)IPADs** – the framework for advance care planning in Wales has been made available on [http://wales.pallcare.info/](http://wales.pallcare.info/)

**Detecting and Identifying Patients Early**

- **GP Register** – via a survey undertaken by our GP Facilitators in 2012/13, it was identified that although each GP Practice had a palliative care register, numbers of patients on these were lower than expected, with only a very small proportion having a non-cancer diagnosis. The GP Facilitators have therefore been working with practices to encourage active use of the register.
- **Prognostic Indicator Guide** – the GP Facilitators have adapted a Prognostic Indicator tool used by Hywel Dda Health Board to help health care professionals from primary and secondary care to identify suitable patients to be included on the palliative care register, including those with a non-cancer diagnosis. The tool asks “would it be a surprise if this patient died in the next 6 months?”.  
  - If the answer is unsure, the tool prompts the GP to look for 2 or more general clinical indicators, and 2 or more disease related indicators.
  - For those patients who are deemed likely to die in the next 6 months, the tool prompts the GP to assess needs, review treatment and medication priorities and consider advance care plan discussions with the patient and family.

**Delivering Fast, Effective Care**

- **Speech & Language Therapy** – as well as the Advance Care Planning S&LT post, Macmillan has also funded another post for Oncology and Palliative Care. This post will evaluate the effectiveness of providing preventative head and neck treatments for those with swallowing/communication problems, as well as scoping the need and providing a role in the palliative care team for all cancers, giving advice and training to the team and supporting decision making in end of life care.
- **Specialist Palliative Inpatient Care** – plans are progressing for the proposed relocation of specialist palliative care services from Y Bwthyn to the Royal Glamorgan Hospital.
Marie Curie Nursing service – the health board’s Service Level Agreement with Marie Curie has been revised to provide a service with unregistered nurses during the day, evenings and nights. This better complements our district nursing and continuing healthcare provision.

Access to palliative care medication – ‘Just In Case’ boxes have been rolled out across Cwm Taf to ensure access to medication when needed for palliative care patients in the community; to date, 7 boxes have been issued. A wider range of palliative care medications is now being held by 12 Community Pharmacies across the area. A controlled drugs safe has also been installed at the acute hospitals to ensure access to medication out of hours.

End of Life Care Pathway – the GP Facilitators have developed a primary care End of Life Care Pathway which guides GPs through all the steps in a patient’s journey. It brings together on one page for GPs and primary care teams all the appropriate steps and supporting documentation they need to ensure the provision of well co-ordinated, holistic end of life care. As well as helping GPs to identify patients for the Palliative Care Register and Advance Care Planning, it then prompts GPs to consider:

- DS1500 form – issuing the patient with a DS1500 form enabling them to claim benefits.
- DNACPR form – discussing with patients / their next of kin the appropriateness of undertaking CPR and whether to complete a Do Not Attempt CPR (DNACPR) form.
- Out of Hours Handover Form – completing an electronic Palliative Care Handover Form to ensure efficient communication with and handover to the Out of Hours service.
- Preferred place of death – asking about, and recording, the patient’s preferred place of death.
- Discussing the patient at regular MDT meetings
- Informing out-of-hours service of any changes to the patient’s care plan or preferences
- Referral when appropriate to the Specialist Palliative Care Team using the referral form provided.
- Anticipatory Prescribing
- Use of Just in Case Medication box

When Patient Identified as approaching Last Days of Life:

- the Pathway prompts GPs to review the patient’s preferred place of death, and to check their relatives’ / carers understanding of the situation. It provides links to:
  - Marie Cure End of Life Booklet providing information to the patient in the last stages of life, and their carers;
  - All Wales ICP for the Last Days of Life – to ensure that the care provided in the patient’s last days of life is guided by the ICP.

Reducing the distress of terminal illness for the patient and their family

- Preferred place of death – more patients are now being given the opportunity to discuss their preferred place of care at the end of life, including where they would prefer to die.
• **iWantGreatCare** – patients continue to be encouraged to provide feedback on their care through the iWantGreatCare survey. Cwm Taf continues to receive excellent scores indicating a high level of satisfaction with the care received. The average score for all 3 years between 2012 and 2014 was 9.75 out of 10, with a 16% questionnaire return rate.

• **Bereavement Survey** – the health board has obtained permission from the authors of the VOICES post-bereavement survey in England to adapt the questionnaire for use in Cwm Taf. Work is therefore ongoing involving the palliative care department, patient experience manager and chaplaincy service to develop a survey to obtain feedback from recently bereaved families.

• **Carers’ support** – links have now been made between the palliative care service and the local Carers’ projects to ensure carers are signposted to support services available.

• **Concerns / complaints** – in order to capture how many patient concerns are received in relation to end of life care, the concerns department now flags any that contain certain key words. This system is in its infancy and requires refinement, however in 2014 there were 4.7 complaints about end of life care per 1000 deaths.

### 10.0 Improving Information

People affected by cancer have significant information needs, not just in terms of their treatment but in terms of their financial and emotional needs. They consistently highlight the need to improve communications between themselves and all relevant agencies.

As can be seen from work described throughout this annual report Cwm Taf has embraced the partnership approach to the delivery of the Cancer Plan. We recognise that we can best meet the needs of our cancer patient by partners working together. Our work with the third sector is essential if we are to deliver on our plan and noteworthy partnership working is a theme running throughout this annual report from the setting of our priorities on an annual basis, reviewing the progress we have made and actually improving our service provision with newly funded specialist posts funded by Macmillan.

In terms of the provision of information Cwm Taf has Service Level Agreements with both Cancer Aid in Merthyr Tydfil and The Rowan Tree who work within Rhondda Cynon Taff which includes the provision of a patient transport service, counselling and patient information. During the last year our newly appointed Macmillan Psychologist has been establishing her service in partnership with the counselling services already provided by these third sector organisations. Once our Macmillan funded Patient Centred Care Manager is appointed during 2014 improving information will form part of their action plan in response to the National Patient Survey undertaken during 2013/14.
We have an excellent Macmillan Welfare Benefits service operating out of our Macmillan Cancer Unit as well as a Relate Counselling services. Tenovus have also been rolling out their Welfare Benefits service across Cwm Taf especially within our Community Hospital settings.

11.0 Conclusion and focus for the next 12 months and beyond

In summary from our Local Cancer Delivery Plan focus over the next 12 months will include:

- To focus on the defined priorities identified by the Cancer Implementation Group in August 2014 which are organisation of cancer support services; primary care oncology; development of a single urgent cancer pathway; patient experience and the national focus on lung cancer.
- Raising awareness of symptoms to promote prompt referrals in line with national guidance, local pathways and waiting times standards.
- Providing GPs with direct and prompt access to diagnostics to diagnose cancer.
- Continue to work in partnership with a range of stakeholders to improve the uptake of national screening programmes and to explore ways of raising awareness of signs and symptoms and to signpost to referral programmes to tackle obesity, smoking, alcohol and substance abuse.
- To develop acute oncology service to support the needs of people admitted as emergencies.
- To participate in the Macmillan funded Metastatic Spinal Cord Compression Project and to implement the required service improvements.
- To provide definitive treatment consistently in line with national waiting times targets across all cancer sites.
- To continue to act on the findings within the national Cancer Patient Experience Survey.
- To establish an internet page for cancer services.
- To review and improve patient information – clinical and non clinical needs such as accessing financial and emotional support.
- Assign a key worker to each period diagnosed with cancer to coordinate their ongoing care. Improve processes to record the allocation of the key worker. Implement the new Key Worker Principles and Guidance issued in September 2014.
- Ensure all cancer sites have a Clinical Nurse Specialist.

Caring at the End of Life

The priorities for the next 12 months are:

- **GP Palliative Care Registers** – we need to focus on increasing the number of patients with palliative care needs who are included on GP Palliative Care Registers, to ensure that their needs are recognised and are being met;
- **Advance Care Planning** – we will continue to promote and develop advance care planning in care homes, and to engage more GPs in undertaking and recording advance care planning;
• **Care at home** – we will continue to work in partnership with Marie Cure and Macmillan to support people to be cared for in their own homes if that is their wish;

• **Education** – we will further develop and roll out an education programme to promote awareness and competencies in end of life care provision in all care settings;

• **Y Bwthyn** – we will progress plans for the reprovision of Y Bwthyn Palliative Care services on the Royal Glamorgan Hospital site, in partnership with Macmillan;

• **Bereavement Survey** – we will develop and undertake a survey of people who have been recently bereaved to obtain their views on how services could be improved for people being cared for at the end of life and their families;

• **Carers Champion** – we will identify a Carers Champion for palliative care to promote support services available for people caring for a loved one at the end of their life;

• **Information** – we will review the information we provide to people with palliative care needs, and their families, to ensure appropriateness and effectiveness and identify areas for improvement.

**APPENDIX 1**

**WHSSC Cancer Annual Report**

**September 2014**

On behalf of the Health Boards in Wales, Welsh Health Specialised Services commission services for Welsh patients with rare cancers, and highly specialist treatments for patients with cancer. Services may be procured from Welsh or English providers. Details of the services and treatments which are commissioned by WHSSC are available in the referral directory which can be found at [http://www.wales.nhs.uk/sites3/page.cfm?orgid=898&pid=64292](http://www.wales.nhs.uk/sites3/page.cfm?orgid=898&pid=64292)

Due to the highly specialist nature of these services, WHSSC is usually involved around the ‘Delivering Fast, Effective Treatment and Care’ part of the patient pathway.

**National Cancer Standards**

• A Service Specification for Services for Children with Cancer is in development to ensure the National Standards for Children with Cancer are embedded in the commissioning of services.
**Mortality Rates following Surgery**

- The Service Specification for Hepatobiliary Cancer Surgery was published in March 2014. This specifies the outcome measures to be used for this service, and the monitoring arrangements.
- Agreement has also been reached with Cardiff and Vale UHB to enhance the regional hepatobiliary MDT by appointing a Consultant Hepatologist. The post is currently out for advertisement.
- The Service Specification for Blood and Marrow Transplantation has been published in September 2014. This mandates full compliance with the British Society of BMT outcome measurement requirements. Data from both Welsh services will be included in the BSBMT Annual Report which compares outcomes across the UK. This report is awaited in the Autumn of 2014.

**Access and Cancer Waiting Times**

- A revised Commissioning Policy for PET-CT has been published which increases the range of indications that are commissioned for this service. Commissioning agreements are in place to support the consequent increase in the number of Welsh patients who will now have access to this diagnostic technology.
- WHSSC has published a new Commissioning Policy for Stereotactic Ablative Body Radiotherapy for Non-small Cell Lung Cancer which lays out the arrangements for access for this treatment modality. Arrangements for the provision of the service in South Wales have been formalised with Velindre Cancer Centre and patients are now receiving this treatment.
- A new Commissioning Policy for Image-guided Brachytherapy for Gynaecological Malignancies has also been published. Arrangements for the provision of the service at Velindre Cancer Centre are in negotiation.