NETWORK DELIVERY OF CRS COMMITMENT ON CANCER AWARENESS AND EARLY DIAGNOSIS (AN OVERVIEW)

Nationally the number of people getting cancer is predicted to rise by 33% and early discussions with our local cancer registry (NYCRIS) suggests that the number of people getting cancer in the Yorks and Humber region is predicted to rise by 40%. Levels of deprivation in parts of our network are high and there is evidence that people in these areas know less about their health, have more advanced cancer when they are first diagnosed and, therefore, less chance of successful treatment. The network Board were informed of the National Awareness and Early Diagnosis Initiative (NAEDI) at its meeting in March 2009 and the network Local Awareness and Early Diagnosis Initiative was launched at an event in June 2009. Discussions were also taking place at that time with regard to the Cancer Awareness Measure and GP Audit following their launch nationally in June 2009. Following the NAEDI launch networks were challenged to:

- Assess their own one year survival rates
- Identify target groups/cancers
- Invest in pilots to increase awareness and promote early presentation (and evaluate)
- Consider investing in Locally Enhanced Services to promote better referral by GPs).

To address this, the network had already started to look at the incidence, mortality and survival rates based on information produced by the National Cancer Intelligence Network and NYCRIS from the Cancer E-Atlas. A cancer landscape paper was taken to the HYCCN Board in June 2009 which identified lung, upper GI, colorectal and skin cancer as being the top 4 tumour sites that required focused attention. The Board also made a commitment to commission the same outcomes as the best in the UK. A strategic plan to deliver this aspiration was outlined in the network’s Service Development Strategy; Delivering the Best: Making it Happen approved by the Board in September 2009. This strategy outlined 6 strategic goals:

Goal 1 Minimise number of people developing cancer and improve survival rates. (CRS chapters 1/2/3)
Goal 2 Provide safe and timely, cost effective treatment. (CRS chapter 4/7)
Goal 3 Support patients living with and beyond cancer. (CRS chapter 5)
Humber and Yorkshire Coast Cancer Network

Goal 4 Organise services so that patients have the same high quality of care regardless of the cancer they have, where they live or who treats them. (CRS chapters 6/8)

Goal 5 Listen to and involve patient, public and carers to improve the patient experience of cancer services and design services to meet their needs. (CRS chapters 2-8)

Goal 6 Strengthening collaborative partnerships to develop effective and sustainable services. (CRS chapters 8/9/10/11)

The above strategy and strategic goals are now embedded in the network Board Assurance Framework, Network Work Plan, Commissioning priorities, NSSG and Locality Board work plans and the LAEDI and Survivorship Programme Board priorities.

Following presentation of the Cancer landscape paper to the Board and Commissioning Group, tumour site specific landscapes were produced for discussion at NSSGs (lung, breast, colorectal, urology) to gain the clinical expertise and insight into the information. As a result of this a number of audits have been undertaken and projects included in NSSG work programmes.

In addition to this, the network had also funded a number of local projects. For example, support to NE Lincolnshire Cancer Collaborative to develop a radio campaign aimed at encouraging younger women to take up their cervical screening appointment and NHS North Lincolnshire to develop a lung awareness and early diagnosis campaign using materials developed for the Doncaster campaign. Also at this time, NHS Hull/NHS East Riding and Hull and East Yorkshire Hospitals NHS Trust had been selected as a national pilot site for cervical turnaround times and the network had secured national funding to support three local projects within NHS Hull/NHS East Riding and Hull and East Yorkshire Hospitals NHS Trust in developing their lung awareness and early diagnosis project, network commissioning of a Head and Neck Pathway and a joint project with Anglia Cancer Network and HYCCN/NHS East Riding to develop a men over 50 skin campaign using the materials and learning from the Merseyside and Cheshire Cancer Network and Cancer Research UK.

To co-ordinate this work and further develop the LAEDI programme the HYCCN Board agreed to the establishment of a Local Awareness and Early Diagnosis Programme Board in July 2009. The remit of this Board is to provide a network forum, which includes primary care and public health colleagues to:

- progress the development of a HYCCN evidence based LAEDI strategy
- provide advice to the HYCCN Board and Commissioners
- support local baseline work to assess one year survival rates
- discuss local use and implementation of the CAM/GP audit
- Co-ordinate local projects
- Support local baseline work
- Develop links with commissioning bodies and other programmes ie healthy lifestyles, smoking cessation
- Develop opportunities for research.

This programme encompasses strategic goals 1, 4, 5 and 6.
The LAEDI Programme Board is chaired by the Director of Public Health for Hull and members include the NE Lincs Cancer Collaborative, commissioners, public health and GP colleagues from across the network. It is proposed that dedicated GP/public health sessions are purchased to support this programme. The first meeting was held in March 2010 and work is progressing on developing the LAEDI baseline in conjunction with national guidance. The CAM has been undertaken throughout the network and the results discussed and shared at the LAEDI Board, with local PCTs/HYCCN Board, Commissioning Group, Locality Boards and NSSG Chairs. National funding has been secured to support the GP audit and discussions are ongoing locally to implement this.
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CASE STUDIES OF NATIONAL/LOCAL PROJECTS

Early identification of people at risk of lung cancer – early awareness of signs and symptoms

Background

Information was taken from the NCIN and Cancer E-Atlas and presented to the HYCCN Board, Commissioners and the NSSG. Below are extracts from the lung cancer landscape. In contrast to our expectations, in Lung Cancer the HYCCN as a whole, is only a significant outlier in regards to mortality. However, the Hull locality, if looked at alone has one of the highest incidences in England whilst lung cancer incidence in North Lincolnshire is rising.
The below chart indicates the success rates of the NHS Stop Smoking Services across the PCTs within the HYCCN. The success rates are calculated on the basis of the number of client of the stop smoking services who have successfully stopped smoking at their 4 week follow-up appointment.
The above information supported the decision to focus resource and effort within lung cancer and two projects were approved for further development by the Board and Commissioners. Both projects focused on raising awareness and early diagnosis. The project in Hull/East Riding was supported by national funding and tested the Manchester Versus Cancer Alliance and the Christie Hospital, Cancer Chancer materials, whilst the project in N Lincs (Scunthorpe) tested the Doncaster campaign materials.
Humber and Yorkshire Coast Cancer Network

(LOCAL AWARENESS AND EARLY DIAGNOSIS
HULL AND EAST RIDING LUNG SOCIAL MARKETING PROJECT)

Key stakeholders  NHS Hull; NHS East Riding; Hull and East Yorkshire Hospitals NHS Trust

Project Leads:  Dr Gavin Anderson, Consultant Physician
               Dr Tim Allison, Director of Public Health, NHS East Riding
               Ruth Hudson, Network Service Development Manager

Project Status:  Project ongoing

Project Category:  Commissioning; Governance, Strategy and Outcomes;
                   Public Awareness Raising

Cancer Tumour Groups:  Lung

Project Summary:
A social marketing project to tackle delays in presentation of lung cancer was devised. The approach is initially to focus on raising awareness of the signs and symptoms of lung cancer in four areas of Hull and East Riding, which have high incidence of smoking, lung cancer and deprivation, particularly acute in some of our communities.

Research was first carried out by an external company which conducted focus groups with the target population. The focus groups provided insight into the behavioural and psychographic characteristics of the target groups and their relationship with cancer. A communications and marketing agency was then commissioned via the COI procurement framework. This company tested the Manchester Versus Cancer Alliance and the Christie Hospital ‘Cancer Chancer’ materials with further focus groups and combined this with the research insights to develop four posters that addressed local perceptions of cancer and barriers to going to the GP. Prior to the launch of the campaign education and training sessions were provided to healthcare professionals in primary care to advance expertise in symptom recognition and, consequently, increase early use of chest x-rays.

Research pointed to particular social and cultural issues causing people to delay going to their GPs. This is causing concern that many patients are not getting a diagnosis early enough to get curative or effective treatment.
Gender- and age-specific (broad age groups) lung cancer mortality rates per 100,000, deaths registered 2004-2008

<table>
<thead>
<tr>
<th>Location</th>
<th>Males &lt; 65</th>
<th>Males 65-74</th>
<th>Males 75+</th>
<th>Females &lt; 65</th>
<th>Females 65-74</th>
<th>Females 75+</th>
</tr>
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<tbody>
<tr>
<td>Bransholme</td>
<td>29.9</td>
<td>597</td>
<td>1,087</td>
<td>16.6</td>
<td>267</td>
<td>664</td>
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<tr>
<td>Orchard Park and Greenwood</td>
<td>35.7</td>
<td>481</td>
<td>622</td>
<td>9.5</td>
<td>417</td>
<td>560</td>
</tr>
<tr>
<td>Rest of Hull</td>
<td>22.8</td>
<td>456</td>
<td>800</td>
<td>19.8</td>
<td>257</td>
<td>352</td>
</tr>
<tr>
<td>Goole</td>
<td>34.9</td>
<td>579</td>
<td>876</td>
<td>9.7</td>
<td>149</td>
<td>212</td>
</tr>
<tr>
<td>South East Holderness</td>
<td>30.4</td>
<td>236</td>
<td>546</td>
<td>38.5</td>
<td>132</td>
<td>334</td>
</tr>
<tr>
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<td>16.8</td>
<td>199</td>
<td>459</td>
<td>14.7</td>
<td>130</td>
<td>215</td>
</tr>
</tbody>
</table>

Figure 1: Smoking prevalence 2007 (line), lung cancer mortality 2005-07 (bars) and deprivation (local quintiles of IMD 2007) in Hull
Project Purpose:

To reduce delays in presentation of lung cancer by:
- Raising awareness of the signs and symptoms of lung cancer with the general public through a social marketing approach
- Focus on areas of high incidence and in areas of greatest deprivation
- Provide education events for all healthcare professionals to increase expertise in recognition and the early use of chest x-rays
- To raise the profile of lung cancer through changing the perception of the disease.

Project Objectives:
- Work with PCTs to raise awareness with primary care colleagues using NICE Clinical Guidance 24 as evidence based to encourage GPs to promote early diagnosis through awareness raising and referral of patients earlier for chest x-ray and access to the relevant care pathway.
- Link with smoking cessations services to identify clients and recommend GP attendance in those who are showing signs of respiratory problems who have not attended the GP. It is also hoped this will have an impact on women and encourage them to stop smoking in pregnancy which is initiative 1, healthy lifestyles part of local WCC strategy.
- Work across primary and secondary care to improve access (especially deprived areas) to chest x-ray and reporting.
- Project team to oversee work.
- Triage referrals into GP discharge; GP 4-6 week follow up, CT scan or out-patient appointment. Work with smoking cessation programmes and local ‘smokeonjoke’ project to ensure consistent key messages are being delivered.
- To have eligible people who are better informed, presenting earlier to GPs who survive lung cancer. It is expected that this project will also benefit care of other patients with chronic lung problems and impact on other health promoting behaviours such as the number of people stopping smoking. It will also reduce health inequalities by focusing on areas of highest deprivation we will be targeting those areas with the highest lung cancer rates, therefore, narrowing the health inequalities gap.
- Utilise healthy communities and existing health promotion programmes to develop community led key messages and support.
- Reduce health inequalities by focusing on areas of highest deprivation by targeting those areas with the highest lung cancer rates, therefore, narrowing the health inequalities gap. The project will ensure that specifically focused materials are made available to BME groups.

Outcomes:

Expected Key Outcomes:

Short term
- Increased referral via 2ww + clinical view on referrals
- Increase in number of CXR requested (Patients being referred at earlier stage in pathway)
Humber and Yorkshire Coast Cancer Network

- Increase in resection rates (Reduction in emergency admissions)

Long Term
- Decrease in mortality/incidence
- Increase in survival

Evaluation
The evaluation and social return on investment are expected to report to the Project Steering Group and LAEDI Programme Board in January 2011. The results will then be taken to the Commissioning Group, Hull Locality Board and NSSG for action.

(LOCAL AWARENESS AND EARLY DIAGNOSIS
NHS NORTH LINCOLNSHIRE LUNG PROJECT)

Key stakeholders
NHS North Lincolnshire and North Lincolnshire and Goole Hospitals NHS Foundation Trust

Project Leads:
Dr Steven Reynolds, Consultant Physician
Dr Frances Cunning, Director of Public Health, NHS East Riding
Dr Priya Reddy, Project Clinical Lead
Marie Hancock, Project Manager

Project Status: Project ongoing

Project Category: Commissioning; Governance, Strategy and Outcomes; Public Awareness Raising

Cancer Tumour Groups: Lung

The aims and objectives of the network funded project were the same as the national pilot. However, this project had a slightly different approach and the team used the learning and materials from the Doncaster ‘cough, cough’ campaign. The campaign had two launches one for health professionals and one for the local community. A further part of this project was to undertake a small research project involving 12 lung cancer patients completing a questionnaire and face to face interview. The results of this research are awaited.

An audit undertaken by the Clinical Lead at the start of the project showed that there are is an average of 110 lung cancer deaths a year in North Lincolnshire and more than 60% of these were aged under 75
years at time of death. Male premature death rates from lung cancer are above the national average in North Lincs and the premature death rate for women is rising. The audit also found that the numbers and rates vary by GP practice and there are strong links with deprivation.
Insight work was commissioned prior to the launch of the campaign and education and training sessions were provided to healthcare professionals in primary care using the Sheffield Hallam University brief intervention training pack. A local care pathway was developed with local GPs/LMC/PBC/GPSI and respiratory physicians. This was disseminated to all GPs in the target areas. The project manager attended numerous community groups and health trainer volunteers had stands in local shops/supermarkets to promote the campaign.

Expected outcomes are:

**Short term**
- Increased referral via 2ww
- Increase in number of CXR requested (Patients being referred at earlier stage in pathway)
- Reduction in number of emergency admissions (currently 34% v 14% nationally)/increased resection rates

**Long Term**
- Decrease in mortality/incidence
- Increase in survival

Evaluation of the project is expected in Oct-December 2010.
Humber and Yorkshire Coast Cancer Network

COMMISSIONING A NETWORK PATHWAY FOR HEAD AND NECK CANCER PATIENTS

SHA data published by Cancer Research UK, highlighted that the Yorkshire and Humber Region has high incidence of head and neck cancers when compared to other SHAs and, following implementation of Improving Outcomes Guidance, the service is centralised in Hull. The Cancer Centre receives a lot of referrals from GPs and District Nurses and many of these could be managed in the patient’s home post treatment, if the expertise was available in the community. Head and neck cancer is smoking and alcohol related and the service has a lot of patients who present from socio-economically deprived areas so getting to the Centre can sometimes be problematic. The geographical spread of the network can also make attendance at the Cancer Centre challenging for some of our population. In addition, there have been advances in head and neck cancer treatments but there is a feeling that the OPCS clinical codes do not recognise the complexity of the treatment or other interventions. Having discussed the findings of the SHA data with the Network Site Specific Group (NSSG), a commitment was made to look at the whole pathway from prevention through to survivorship.

Objectives:

The aim of this project is to support the provision of an enhanced quality of service with care delivered closer to the patient’s home, where clinically appropriate. To achieve this, the project was split into three areas of work, Early Diagnosis, In-patients and Survivorship. This project encompasses the six strategic goal areas set out in the Humber and Yorkshire Coast Cancer Network (HYCCN) Service Development Strategy.

In order to achieve this, the key deliverables across the goal areas were to:

Early Diagnosis:

- Commission an epidemiology study to profile the network population
- Collect staging data to assess stage at presentation by post code

Treatment (In-patients)

- In patient audit to assess length of stay/barriers to discharge
- Use of the NHS Institute for Innovation and Improvement’s Return on Investment calculator to identify staff costs, use of adverse drugs (infections) and assess the costs of higher length of stay or excess bed days.

Survivorship

- Assess current levels of service available in the community
- Redesign post treatment pathway working with Allied Health Professionals and primary care colleagues to develop services closer to home.
- Work with Cancer Nurse Specialist team to develop personalised care plans.
Patient and Public Involvement
- Undertake experienced based design interviews to capture patient and carer experience of their cancer journey.

Inequalities
- Identify gaps in current network service provision in both primary and secondary care.

Commissioning
- Provide high level costing using HRG4 and scenario generator to test out scenarios where services are moved between secondary and primary care and the costs of changes in service provision.
- Use of Return on Investment calculator to assess quality benefits of any changes such as reduction in length of stay, less intense treatment and improving patient outcomes.

Monitoring
Support for the project was obtained through Cancer Network Board, Cancer Commissioning Group, Hull Locality Board, Survivorship and Local Awareness and Early Diagnosis (LAEDI) Programme Boards.

Epidemiology/Cancer Awareness Measure
Head and neck cancer data covering ten years from 1998 to 2007 was obtained from the Northern and Yorkshire Cancer Registry Information Service (NYCRIS) and a partner identified to analyse the data. However, there were gaps in the data, crucially in relation to information about sub site of cancer and staging, so our lead clinician looked at 550 sets of case notes for patients treated between November 2004 and November 2009 and information of sub site, stage and postcodes of their residence was collected. Epidemiological analysis was performed looking for geographical distribution with respect to sub site and stage (early v late) of tumours over individual primary care trust boundaries as well as individual electoral wards in the network. Results of the analysis have enabled the team to match the sub sites of high prevalence to areas of deprivation. It was found that patients generally presented with advanced disease at initial consultation. Eleven electoral wards in the network were identified as the areas of highest prevalence of head and neck cancers. The study also identified that two of the ‘ACORN’ classified groups, ‘Hard pressed’ and ‘Prudent Pensioners’ were traditionally late presenters to primary care with symptoms of head and neck cancer. Another interesting result from this study was the relatively higher incidence of oropharyngeal cancers in young people from North and North East Lincs which could be linked to human papilloma virus and has obvious implications in management of these cancers.

During the life of the project the network undertook the Cancer Awareness Measure and this has highlighted the low recognition, particularly amongst respondents aged 65+ of the signs and symptoms of head and neck cancer. This has now enabled us to identify our target audience and areas within the network on which to focus resources to raise awareness and encourage early presentation.
NORTH EAST LINCOLNSHIRE CANCER COLLABORATIVE

Evidence from the Cancer Awareness Measure and one year survival rates would seem to indicate that a lot of patients present to primary care in the later stages of disease. Therefore, one of the main objectives of the HYCCN LAEDI programme is to change people’s behaviour and help to get key messages across to the local population, patients and carers in different ways so that they can understand and act on the information they have been given. The North East Lincolnshire Care Trust Plus had established a Cancer Collaborative 3 years ago working with community volunteers to develop key messages and has been collecting information to demonstrate outcomes over the past 3 years. These include volunteer contacts with the public (giving messages about early signs and symptoms of cancer; and discussing when to use NHS services); changes in public knowledge levels; and impact on 2 week wait referrals.

The project was conceived as having the joint aims of narrowing the gap in cancer survival rates in the most deprived areas of North East Lincolnshire and strengthening those communities. Funding for the first year came from the Neighbourhood Renewal Fund, and a Liverpool based social enterprise was brought in to get the project going. This created an opportunity to bring together community engagement, health inequalities and social marketing.

Each team started by surveying their communities to uncover attitudes, levels of awareness and barriers to people going to the doctor and began to plan social marketing campaigns to reach their target audiences.

The three teams produced resources ranging from wallet-sized information cards to a fashion show; used their connections to gain entry to supermarkets, bingo clubs and football queues; and applied their knowledge of family and friends to make sure the messages would really hit home.

The baseline assessment and other new information such as the Cancer Awareness Measure is being used to demonstrate outcomes.

Products:
The North East Lincolnshire Cancer Collaborative has produced a wide range of resources and reports of their work, including

- an annual report that puts the work within a world class commissioning framework
- demonstrates outcomes for commissioners
- public awareness materials, including involvement of partners and for use by volunteers

Early planning reports, including insight research (public and NHS staff) and local public health/cancer profiles, are available. Plans are to produce an evaluation report, plus full details of resources, data and project delivery.

Discussions are taking place with the Network about the best way to capture and share the process they have used to build local ownership and investment.
The exemplar work in North East Lincs has provided learning on:

- community-led social marketing initiative, including sustaining volunteer capacity and enthusiasm; plus embedding services in medium term trust contracts (reports available, including alignment with World Class Commissioning).
- Outcome measures have demonstrated impact.

The Cancer Collaborative has developed campaigns for prostate, cervical, breast, bowel cancer and bowel screening.

Results from the Cancer Awareness Measure in this PCT demonstrated that awareness of signs and symptoms of cancer was higher in North East Lincs CTP and residents in this area were more likely to take action within one week in comparison to other PCTs in the network. Residents also demonstrated more awareness of cancer incidence and screening programmes.

**SKIN CANCER – MEN OVER 50 CAMPAIGN**

*(Joint Project with Anglia Cancer Network and Humber and Yorkshire Coast Cancer Network)*

**Summary**

This project looked at making use of the “More men than women” materials developed in the Merseyside and Cheshire Cancer Network (MCCN), in conjunction with Cancer Research UK, in a rural area. The key purpose of this campaign was to increase awareness of the signs and symptoms of skin cancer in men aged over 50 and to encourage early presentation. It was also hoped that the programme would help raise awareness on how to reduce the risks of developing skin cancer. There were 3 phases to the project:

1. Evaluate the suitability of the materials for use in a rural setting (This was done in collaboration with the Anglia Cancer Network (ACN)).
2. To run a social marketing campaign in the Bridlington area using the materials, adapted for the outcome of phase 1.
3. To evaluate the effectiveness of the Bridlington campaign.

**Phase 1**

The initial evaluation took place during May 2010. This looked at both the content of the materials and also established a baseline of current knowledge of risks, signs and symptoms of skin cancer, in the target group, to use in evaluating the campaign. The feedback was positive about the content of the materials but put a greater emphasis on certain items. It identified the best method of getting the
message across in a rural setting and also highlighted the need to use partners as a key influencer of behaviour in the target group.

**Phase 2**

The campaign ran for 5 weeks from late July to the end of August. It included a number of media events, use of an ad-trailer, and targeted social engagement in areas identified during phase 1. This includes retail areas, allotments, recreation (golf and bowls) amongst others. Materials were been packaged in a kit, which it was hoped would assist in developing the habit of checking moles etc.

**Phase 3**

Evaluation of the success of the campaign looked at changes in knowledge of the risks, signs and symptoms, uptake of behaviours, such as avoiding risks, regular checking, etc, together with information on changes in presentation and referrals of skin lesions.

**Involvement of Key Stakeholders**

Throughout the process we involved Dermatology services, GPs, Public Health, PCTs and members of the Public. Local dermatologists and GPs were involved in planning the campaign. The Skin NSSG have been involved and updated on progress of the campaign, as has the Local Awareness and Early Diagnosis (LAEDI) Board. A workshop was held for all General and Practices within the target area, which included an explanation of the campaign and proposed materials. This was accompanied by an education session from a Consultant Dermatologist on the identification of skin lesions and appropriate treatments, including 2 week wait criteria. Additional dermatology sessions were arranged during the campaign to cope with any increase in demand. NHS East Riding of Yorkshire were involved throughout the planning process with their Director of Public Health and other staff being core members of the steering group.

**Sharing of Learning**

This project was based on taking materials from Merseyside and Cheshire Cancer Network, which were developed for an urban area, and applied in a rural setting. We worked with Anglia Cancer Network in testing the materials and shared information on the local campaign and evaluation. We involved Cancer Research UK throughout the process, as owners of the materials, so that they could build our experience into the continued development of the SunSmart programme. Learning from the project was also shared through the LAEDI Programme Board, both for use of the campaign in other areas of the network and to learn lessons from this campaign which will benefit other campaigns.
Lessons Learnt
Early discussions with commissioners and clinicians reinforced the importance of evidence and alignment to other policy drivers, for example health inequalities in a Spearhead PCT.

It has been a challenge for the team to demonstrate the emerging strategic ownership and quality.

Projects provided learning on
- the use of a range of data - public health and cancer needs assessment; geo-demographic profiles; and insight research on public and professionals (early report available)
- involvement of primary care and general practice in a social marketing initiative
- identification and agreement on outcome measures - patients/target groups; primary care; secondary care, plus application of a social return on investment (SROI) model
- capturing and sharing learning from existing initiatives - the local exemplar; Doncaster Lung Initiative; Cancer Chancer.
- Early learning reviews of the project highlighted the importance of involving key stakeholders to assist in maintaining and increasing engagement. The network team has prioritised this from the early days of their work on awareness and early diagnosis, so it will be important for this network team to describe their engagement work, and learning to share with others.
- they have committed to completing a full learning assessment as part of the project completion.

Sustainability:
A priority of the Network as they have developed their programme on awareness and early diagnosis has been to build engagement and ownership. This has been with the public through volunteers and partnerships; NHS organisations - both commissioners and providers; and clinicians - public health, GP and secondary care clinicians. Their aim has been to enable decision makers to understand and make decisions about the priority that will be given to awareness and early diagnosis. Also to embed investment and provider contributions, and thereby, achieving sustainability. The network has used projects, information and policy drivers to engage key stakeholders. Events, new governance arrangements, projects and partnerships have all provided opportunities to build ownership and focus. This has resulted in a widening group of NHS staff, partners and volunteers contributing to the network programme. The Network Director has also brought in or gone to other project/ programme expertise using the learning to sharpen the local decision making and practice. The network Deputy Medical Director provides clinical leadership for this programme and is helping to engage other clinical colleagues.

For example, the evaluation findings and outcomes will be fed into the Cancer Commissioning Group and The Local Awareness and Early Diagnosis Programme Board (LAEDI Board). Recommendations made by these groups will be discussed and finalised by the Cancer Network Board. Actions determined regarding project continuation and roll out will be implemented via the Locality Boards and contracting. It is important to note, that despite intensive efforts to build ownership, early reviews of learning on the projects showed that they needed to do even more. To make these interventions sustainable and a powerful mechanism for behaviour change with local communities there is a need to establish local
ownership with community leaders by empowering them to “sell” the intervention. PCTs and local cancer commissioners have a role to develop or mobilise current strategies to establish such mechanisms aligned with cancer.

The local and national work on this programme within the network and the need to engage with key stakeholders in both primary and secondary care has enabled collaborative partnerships and testing to be undertaken embedding this programme into mainstream business of the network.