Public Health England Progress Report on the Independent Cancer Taskforce Recommendations

Independent Cancer Taskforce Recommendations	Public Health England Targets/ Objectives	Transformation Board Timelines	Organisation Lead(s)	Working with	Milestones	Current position for March 2018	PHE contribution progress
1. NHSE working with the other ALBs, should develop a cancer dashboard of metrics at the CCG and provider level, to be reported and reviewed regularly by Cancer Alliances.	**Phase 1 of CCG and Provider dashboard to be launched on 1st April.**	Phase 1 April 2016	Jem Rashbass	NHSE, Dashboard Steering Group Members	Prototype for 08/12/15 Live by March 2016	Phase 1 of the dashboard was completed and live as of May 2016. The further development of the dashboard will now be considered by NHS Digital. NCRAS remains involved through the Cancer Alliance Data, Evidence and Analysis Service and in conjunction with the Data and Analytics Advisory Group NCRAS is also undertaking additional internal work including the development of Cancer Stats 2 and 'Getting Data Out' projects.	Completed - no further reporting
2. Government should work with PHE and NHSE to publish a new tobacco control plan within the next 12 months.	**Work with DH to develop plan and stakeholder engagement** **Publish plan in summer 2016** **Once published initiate programme of implementation support**	Summer 2016/ongoing	Rosanna O'Connor	NHSE, Government		The Tobacco Control Plan was published in July 2017. A 100 days event took place on 3rd November with a video address from the Minister. Other speakers were from DH, NHS England and academic experts and the event was attended by around 120 delegates, mostly from local authority settings. PHE are working with DH on the development of an Implementation Plan, setting out key activities and milestones to achieve commitments in the Tobacco Control Plan. Engagement with key tobacco control stakeholders is being facilitated via the PHE Tobacco Implementation Board; the Minister attended the last meeting in December to discuss the plan. Key NHS facing work being undertaken via promotion of and support to the (Alcohol &) Tobacco CQUIN	Recommendation requirements met - further work continuing
3. PHE should work with Government, DPH and a wide range of other stakeholders to develop and deliver approaches to address obesity.	**Initiate whole systems obesity programme with 4 LA pilot sites across England and publish the new Eatwell Guide and refresh of the 5 a day campaign . Working with DH and Government, publish the childhood obesity strategy . Take forward actions and implementation plan following publication of the strategy**	August 2016 / Ongoing	Alison Tedstone	Government and wide range of external stakeholders		In November 2017 PHE held meetings to discuss the metrics which will be included in the report on progress towards the 5% first year sugar reduction with key stakeholders. As outlined in the COP, PHE is now moving forward with work to set guidelines for juice and milk based drinks that are outside the scope of the SDIL. Building on the previous stakeholder engagement, two final category specific meetings for drinks excluded from the SDIL are planned in early February with the plan to publish the guidelines alongside the main sugar progress report. On 5th March 2018 PHE published the ambition for calorie reduction. Specific guidelines for foods to be included in programme will be developed over the next 18 months. Phase 2 engagement with out of home businesses will be underway by mid-2018. Through stakeholder engagement PHE will provide information / advice to businesses and continue to drive clarity on clear objectives and requirements to deliver the objectives of the sugar reduction and wider reformulation programme. PHE will also begin to consider baby and infant foods in the wider reduction and reformulation programme, and plan to start engagement with industry later in 2018 on potential approaches.	Recommendation requirements met - further work continuing
4. PHE will publish an Alcohol Evidence Review of levels of harm and alcohol control policies	**Undertake a time limited evidence review and take forward an implementation plan following publication**	Q4 2016	Rosanna O'Connor	NHSE/ Government		Alcohol Evidence Review published in 2016. PHE continue to provide advice and support to DH and HO on the evidence base. At a local level PHE are supporting implementation of evidence based interventions including dedicated resource to support effective delivery of the alcohol and tobacco CQUIN in community and mental health trusts and secondary care. PHE's alcohol team has adapted the successful tobacco CLeaR model for alcohol and have a programme with Centres to roll this out over 18/19	Recommendation requirements met - further work continuing
5. By December 2016, PHE should determine the level at which HPV vaccination for boys would be cost-effective. JCVI should make a final decision by 2017. Assuming a cost-effective price can be achieved, national roll-out should take place by 2020.	**Determine cost effectiveness for HPV vaccination for boys**	Dec-17	Mary Ramsey/ Michael Edelstein	JCVI	JCVI Interim Statement on Extending HPV Vaccination to Adolescent Boys on July 19th https://www.gov.uk/government/publications/jcvi-statement-extending-the-hpv-vaccination-programme	The JCVI issued an interim statement for consultation in July 2017 which set out the key evidence, and the considerations on vaccinating boys for HPV. JCVI's interim advice was that an extension of the current HPV girls' programme to boys was highly unlikely to be cost effective, according to the National Institute for Health and Care Excellence health technology assessment methodology, and taking the evidence as a whole, it was unable to recommend extension of the national HPV programme to adolescent boys. The evidence JCVI considered indicated that the high HPV vaccine coverage in girls in the UK, currently around 85%, would lead to a substantial reduction in HPV related disease, not just in the female population, but also indirectly in the male population. At that time the findings of the cost-effectiveness analyses provided specifically to the committee predicted that extending the HPV programme to adolescent boys would not be a cost-effective use of health service resources in the UK setting. Whilst it is acknowledged that vaccinating both boys and girls could afford the highest level of protection the additional benefits gained from extending the programme to adolescent boys would be small, relative to the impact of the girls programme when coverage is high. The Committee did recognise, however, arguments made by stakeholders, including HPV Action, on the issue of equality of access and noted that these require consideration. A consultation on this interim advice closed at the end of August, and the JCVI considered the responses at their meeting in October together with updated results on the impact and cost effectiveness of vaccinating boys. The Committee concluded that they were not yet in a position to finalise their advice on HPV vaccination for boys because a number of outstanding issues remain. The JCVI will continue to review the position in 2018 and will make a decision once it has considered all the necessary evidence. The MSM HPV vaccination pilot programme started in 42 specialist sexual health services clinics from June 2016. The pilot concluded that an opportunistic HPV-MSM programme delivered in GUM and HIV clinics was feasible. The programme is commissioned by NHS England, whose first priority is to ensure the service continues in the pilot clinics. A phased nationwide rollout will go ahead in other clinics from April 2018, to protect men who have sex with men from some cancers caused by HPV as well as genital warts.	In train
	National roll out (if supported)	2020				This aspect of the recommendation is dependant on the decision from the JCVI	
10. Assuming a positive recommendation by the NSC, PHE and NHSE should roll out FIT into the BCSP, replacing gFOBT as soon as possible. NHS E should incentivise GPs to take responsibility for driving increased uptake of FIT and bowel scope in their populations, with an ambition of achieving 75% uptake of FIT in all CCGs by 2020.	**Incentivise GPs to drive uptake of FIT and bowel scope**	ASAP	Anne Mackie	NHSE/ NSC		The implementation of the Faecal Immunochemical Test (FIT) in the English NHS Bowel Cancer Screening Programme was highlighted in both the Cancer Strategy for England and in the 'one year on' report. FIT will be introduced during 2018 and NHS England is proposing that the starting sensitivity threshold is 120ug/g – this is a decision that needs to be approved by the Department of Health who fund the Bowel Cancer Screening Programme through the Section 7A agreement. Three months after switch over from gFOBt to FIT, NHS England propose to review the programme to assess the impact of the sensitivity level on NHS capacity and to see if further improvements can be made. In the period prior to the switch over to FIT, NHS England and Public Health England will continue to work with screening centres, screening hubs and other partners to develop plans for ensuring that the managed service contract for kits, analysers and IT support is operational and that there is sufficient capacity in place to deliver services to meet the requirements of the proposed FIT120 starting sensitivity threshold.	In train
	75% uptake of FIT in all CCGs by 2020	2020				The measurement of this aspect of the recommendation will come into affect when the rollout of FIT has commenced	
11. Assuming a positive recommendation by the NSC, PHE and NHSE should drive rapid roll-out of primary HPV testing into the cervical screening programme, with an aim of commencing roll-out by 2016 and full national coverage by 2020. The NSC should also regularly review whether the upper age limit for cervical screening remains appropriate.	**Rapid roll out of primary HPV testing into cervical screening programme**	2016				The falling capacity for cytology based screening due to the plans to implement HPV is causing delays to the 14 day turnaround time (TAT) for cervical screening results. Decisions on the options appraisal for the commissioning and laboratory footprint in relation to the implementation of HPV as the primary screening test are awaited from NHS England. Mitigations to address the 14 day TAT including releasing capacity from the primary pilot sites to assist laboratories who have a backlog are being considered along with other options. There is some uncertainty about funding for the mitigation options which is being discussed with NHSE.	In train

	Full national coverage by 2020	2020				Reporting to commence after the rollout of primary HPV testing into cervical screening programme	
12. A new cancer screening team under the Director of Screening within PHE should include a lead for all current and future cancer screening programmes. This should be matched with designated screening leadership in NHSE, with the responsibility of ensuring accountability and quality- and driving improvements and implementation of new services	**Revision of cancer screening in PHE**	ASAP				As part of the Securing Our Future Programme within PHE the Cancer Screening Team has been restructured and now includes new cancer programme specific posts at significantly higher grades than the current roles.	Completed - no further reporting
13. The NSC should examine the evidence for lung and ovarian cancer screening. PHE should be ready to pilot lung or ovarian screening within 12 months of a significant positive mortality outcome and cost-effectiveness evidence from studies currently under way, together with a plan for subsequent national roll-out.	**PHE to be ready to pilot following NCS approval**	Ovarian - No update expected in 2017				Ovarian - The ovarian trial published in December 2015 with the finding that there was no significant reduction in mortality from screening. The triallists intend to follow up the mortality outcomes over the next few years to see if the difference becomes significant. The UKNSC viewed the outcomes of the model at its June meeting and concluded that there not yet evidence of benefit. The committee recommended that it return to the issue when longer term outcomes on mortality are published and available. This is unlikely to be until 2020. Lung - The UKNSC is working with the HTA on a summary of lung cancer screening programme costs and benefits using data from European and US trials. It is likely that the European trial data will be available later than had originally been expected, perhaps into 2018. The UKNSC Secretariat is in contact with the triallists to ensure swift action on the data once it is available. In the meantime lung cancer research and evaluations are underway under the ACE programme and UKNSC officers are aware of the work and receiving regular updates.	In train
	National roll out of appropriate	TBC				This aspect of the recommendation is dependant on the outcome of the evidence review	
15. Public Health England should continue to invest in "Be Clear on Cancer" campaigns to raise awareness of possible symptoms of cancer and encourage earlier presentation to health services. Campaigns should include lung, breast over 70s, and other cancer types where pilots prove effective. PHE should also explore the use of this brand to improve uptake of screening programmes, particularly amongst disadvantaged groups. NHS England, Public Health England and the Department of Health should jointly plan campaigns to ensure an integrated roll-out across the service, with a minimum of two national campaigns each year.	**Range of campaigns including lung, breast, over 70's and others where pilots prove effective**	Ongoing	Sheila Mitchell	NHSE/CR-UK/ Macmillan and other Third Sector members		The Breast Cancer in Women over 70 national campaign will launch on 22 February and run until 31 March. The campaign will include TV, print and social media advertising. There will be a specific strand of activity targeting BAME women. Planning for 2018/19 is underway, subject to agreement with the BCOC steering group and approval from Cabinet Office. Proposed activity includes developing a new campaign to increase uptake of cervical screening, with the aim of launching national activity in February 2019. There will be one other national repeat campaign, subject TBC. PHE is continuing to work NHS England on timings and location of the second pilot phase of the abdominal symptoms campaign. This will allow NHS England to incorporate the benefits of work over the winter to enhance diagnostic capacity and implement new models of service provision. It will also allow PHE to share initial clinical evaluation results from the first phase of the pilot.	In train
	Explore how brand can be used to improve uptake in screening programmes	Ongoing					
	Minimum of 2 campaigns each year	Ongoing					
20. NHS England should commission an enhanced Diagnostic Imaging Dataset on a permanent basis.	**PHE has a representative on the Diagnostic Imaging Dataset Governance Group.**	Ongoing	Lucy Elliss - Brookes	PHE/NHSE		The group, run by NHS England, is considering enhancements to the dataset to flag cancer-related imaging; NCRAS representatives continue to advise as appropriate.	In train
21. NHS England should pilot, in up to 5 vanguard sites and in conjunction with Wave 2 of the ACE programme, multi-disciplinary diagnostic centres for vague or unclear symptoms. These should have the capability to carry out several tests on the same day.	**ACE-funded analyst embedded within NCRAS as part of the PHE-CRUK partnership, to enable analysis of the ACE pathways**	Ongoing	Lucy Elliss- Brookes	PHE/CRUK		ACE Pathway work presented at CRUK Early Diagnosis conference in February 2017 and the PHE Cancer Outcomes Conference in June2017.The lung pathway report was published August 2017. Further work on diagnostic pathway length by stage and Route was approved in November 2017.	In train
26. CRGs should regularly evaluate emerging evidence to determine whether service configuration for surgery merits further centralisation and advise NHS England accordingly. Any reconfiguration should be undertaken with regard to broader commissioning and patient experience factors.	**Support process to define key quality metrics for each cancer sub-specialty**		See Recommendation 28	RCS,CRUK, NHSE		The work on this recommendation has been merged with the work on surgery metrics and will be managed by the same working group. See Recommendation 28	In train
27. NCRAS should undertake an up-to-date evaluation of the impact on cancer outcomes of patients living different distances from a cancer Centre. Historical data suggested that longer distance from a Centre results in lower probability of curative treatment. We need to understand if this is still the case.	**New evaluation of impact of cancer outcomes**	Publications due Q1 2018	Luke Hounsome	PHE Geographical Information Strategy Group		NCRAS has worked with external academic partners to create a postcode-level dataset that includes travel times. Work has also been undertaken as part of the PHE-CRUK partnership, and a project looking as travel times for radiotherapy treatment is currently under development. Specification fora short report on survival outcomes by travel times has been drafted. Consultation with PHE Public Health Data Science team is taking place, to determine accuracy of the dataset, based on some queries they had.	In train
28. The Royal College of Surgeons of England and Royal College of Surgeons Edinburgh, working with Clinical Reference Groups, NCRAS, Care Quality Commission (CQC) and Cancer Research UK, should lead a process to define, by mid 2016, key quality metrics for each cancer surgery sub-speciality. Any new data collection should start in 2016 and then be incorporated in service specifications.	**Support process to define key quality metrics for each cancer sub-specialty New data collection begun and incorporated in service specifications**	Ongoing	Lucy Elliss-Brookes	RCS,CRUK, NHSE		Work on the centralisation of surgery (recommendation 26) is also considered as part of this recommendation and this working group. Terms of Reference for working group agreed, several meetings have taken place. A list of proposed metrics has been agreed, feasibility testing of the metrics is underway, with a progress meeting held in November 2017. Data quality issues have been identified which are now being investigated in partnership with representatives from NHS England Specialised Commissioning.	In train
29. From autumn 2015, NHS England should commence a rolling programme of replacements for LINACs as they reach 10-year life, as well as technology upgrades to all LINACs in their 5th year. All LINACs that are already ten years old should be replaced by the end of 2016 at the latest. This should be driven through a national capital fund, overseen in the first 2-3 years by a small implementation team, who will also need to ensure that equipment is geographically distributed to serve local populations optimally.	**Provide elements for dataset**	From Autumn 2015	NCRAS	NHSE/PHE		NHSE announced on the 6th December 2015 the 15 hospitals which will receive new LINACs. The Radiotherapy Dataset (RTDS) team based in NCRAS have received historical equipment data audits from NatCanSat(2013 data as a baseline and an extract of data from 2016). The RTDS team is now working with the Radiotherapy Information Strategy Group to agree data elements for inclusion in an equipment dataset for forward collation of these data items. New proposed dataset developed in collaboration with the Heads of Radiotherapy Physics community	In train
37. NHS England should transform access to molecular diagnostics to guide treatment for cancer: NHS England should nationally commission access to molecular diagnostic tests to guide treatment, starting with the following cancer types in 2016: melanoma, lung, colorectal, breast and all paediatric cancers. This would be in addition to haematological cancers, with a further broadening out to all cancer types where treatments are already subject to a molecular diagnostic test by 2020. Use of molecular diagnostic tests by providers should be added to the COSD data set. NHS England should undertake a year by year review of molecular diagnostics capacity given	**PHE to add molecular testing to COSD and mandate the collection of this data.**	Starting in 2016 for melanoma, lung& colorectal.	Andrew Murphy	NHSE/PHE		COSD is currently meeting requirements of this recommendation There is now a new section within COSD v7.0 for Somatic Molecular Testing: Somatic testing for targeted therapy and personalised medicine. This section covers the top 18 molecular diagnostic tests with the ability to record others not on the list and meets recommendation 37 requirements. PHE are defining a new molecular pathology dataset, which once complete will be pilot tested and then taken through SCCI, to mandate the structured collection of molecular pathology data. Once COSDv8 is implemented there will be no further changes until 2020	Recommendation requirements met - further work continuing
48. NHS England should ask NIHR and research charities to explore the needs of people with serious mental illnesses or learning difficulties when they have cancer.	**To ensure equal access to cancer screening and treatment for people with Severe Mental Illness or Learning Disability.** (Overview - PHE provides expertise on supporting those with mental health problems who are diagnosed with cancer and working with other ALBs and charities etc. to make better use of the resources that already exist.)	By Q1 2016/17 a scoping exercise has been completed to determine specific action required to address this area.	Lily Makurah	Macmillan, NHSE, CR-UK, Academia	Embedding of equalising access to screening and treatment in principles and operational delivery of cancer screening and treatment programmes.	Building on work by NHS digital the mental health intelligence network and public mental health teams are creating new interpretive resources on excess mortality for people affecting people with a mental illness. This will be a further step in providing better quality intelligence on cancer and moving towards more routine data capture and routine monitoring. These continue to focus on a. providing better quality intelligence on cancer, making data capture and monitoring more routine b. placing an additional emphasis on smoking cessation and reducing the persistently high rates of smoking amongst this group A shortlist of options to ensure the mental health needs of people with cancer have been identified and include further work with NHSE, Macmillan and others to establish standards/criteria for assessment of need or for interventions.	In train
	To ensure patients with cancer are asked about their mental health and have access to appropriate intervention when needed.	By Q1 2016/17 a scoping exercise has been completed to determine specific action required to address this area.	Lily Makurah	Macmillan, NHSE, CR-UK, Academia	Embedding the mental health needs of patients with cancer in principles and operational delivery of cancer treatment services.		
54. NHS England should continue to commission CPES annually. It should also take steps to increase BME representation in CPES for a minimum of 1 to 2 years to understand drivers of poorer experience within these groups better. It should consider how CPES data can be linked with other datasets to understand experience across the pathway. It should also develop a	**Provide information on data linkage**	Annual process to link each survey dataset as it becomes available.	Lucy Elliss - Brookes	NHSE/PHE		NCRAS delivered and published information on the data linkage and continue to link CPES data to cancer registrations as data sets become available	In train
64. NHS England and Public Health England should work with charities, patients and carers to develop a national metric on quality of life by 2017 which would enable better evaluation of long-term quality of life after treatment. PROMs should be rolled out across breast, colorectal and prostate cancer by 2020, with evaluation informing further rollout across other cancer types.	**Support development of quality of life metric**	2017	Lucy Elliss-Brookes	NHSE/PHE		The Living With and Beyond cancer oversight group has approved the approach to the metric and the survey pilots. Pilot sites have been selected and intend to begin collecting data in December 2017. Data will flow to PHE. The PROMs work as part of the National Prostate Cancer Audit is currently in a survey phase.	In train

	Roll out PROMs across breast, colorectal and prostate	2020				The Life After Prostate Cancer Diagnosis survey has re-surveyed men who returned the first round of questionnaires, and data passed to PHE and University of Leeds. A survey of a new cohort in England is currently under way. Reporting of results to public and hospital trusts is being developed for release in early 2018.	
78. NHS England should set expectations for and establish a new model for integrated Cancer Alliances at sub-regional level as owners of local metrics and the main vehicles for local service improvement and accountability in cancer. We advise that Cancer Alliances should be co-terminus with the boundaries of Academic Health Science Networks (AHSNs), although in some large AHSN geographies there may be a need for two Alliances. Alliances should be properly resourced and should draw together CCGs and encourage bimonthly dialogue with providers to oversee key metrics, address variation and ensure effective integration and optimisation of treatment and care pathways. Cancer Alliances should include local patients and carers, nurses and Allied Health Professionals.	**Analytical support for the Cancer Alliances**	Awaiting NHSE timelines, recruitment to begin mid 2017.	Lucy Elliss - Brookes / Sophie Newbound	NHSE/PHE		PHE is continuing to work with NHSE to establish the new Cancer Alliance Data, Evidence and Analysis Service (CADEAS) which will work to support the data needs of the Cancer Alliances. This work is being supported by the newly established Cancer Data and Analytics Advisory Group. A lead for CADEAS has been recruited and in post since October 2017 and further recruitment started in autumn 2017. 4 Analytical leads were appointed to start in early 2018. WebEx calls have been held with Alliances to help define their needs -it is thought these will take place from autumn 2017 onwards.	In train
82. NHS England should commission a rolling programme of national clinical audits for critical cancer services, e.g. annually for lung cancer, and oversee an annual audit of cancer diagnosis.	**PHE to continue to provide COSD data.**	ASAP	Andrew Murphy	NHSE/PHE		Clinical audits are already in place between NCLA and NCRS. In addition the Prostate Audit uses more than 50% of COSD data within their audit and reported through the Cancer Stats portal Discussions have been held with both the Breast Cancer Audit for Older People and the National Ovarian Cancer Audit, and there will not be additional data to collect or burden on Trusts, as all the data required can be collected from either COSD, SACT or RTDS. This work is ongoing.	In train
90. Public Health England, working closely with partners in a newly constituted PHE Cancer Board, should improve the provision of cancer data and intelligence via the National Cancer Intelligence Network and the National Cancer Registration Service:	**Creation of PHE Cancer Board**	ASAP	Jem Rashbass			Board established and Chaired by our Chief Executive. Representative from all senior PHE leaders for cancer-related activities, with external representation from CR-UK and Macmillan	Completed - no further reporting
Greater focus should be achieved by ensuring adequate resources are applied to collect comprehensive cancer data, link it across the whole cancer pathway and analyse it through a centralised data system.		ASAP				The registration and analysis functions have been restructured creating the National Cancer Registration and Analysis Service (NCRAS) as of February 2016. The focus is now to align our work plan with the taskforce recommendations and distribute staff and resources accordingly to deliver.	Completed - no further reporting
• **PHE should work with charities and researchers to clear the existing backlog of data requests from commissioners and researchers by the end of 2015. Thereafter, PHE, through NCRAS and NCRS, should work to establish further linkages of datasets, including RTDS, CPRD, SACT, and DID to help drive further service improvement.**	**Work with charities and researchers to clear the existing backlog of data requests from commissioners and researchers by the end of 2015.**	01/12/2015 /ongoing		CR-UK, Macmillan, NCRI, Academia	Recruit to new posts and establish linkages of datasets in CAS	During the current accounting year, the ODR has handled over 450 requests to access PHE data. In responding to these requests, the ODR provides expert advice and individualised support to PHE stakeholders to inform prospective data users of, and ensure requests to access PHE data comply with, the requirements of Data Protection Act, Caldicott Principles and ICO best practice for processing personal data –so that data can be disclosed where it is fair, lawful and legitimate to do so. In light of GDPR being transposed into UK law and the implementation of the National Data Opt-Out Programme, the ODR are continuing to update processes to ensure an uninterrupted service to stakeholders whilst maintaining the confidence and trust of those who provide us with their data. Through 2017-18, the ODR has launched bespoke training for PHE customers and has commence work on digitising the ODR application process. The NCRAS data dictionary has also been updated and published to share with prospective applicants and the public the type(s) of data that can be routinely request through the ODR. Analytical partnerships, clinical and patient liaison groups continue to help define priorities and support the timely processing of data requests Data is routinely linked a patient level across all datasets within the cancer analysis system (CAS) and there is a wider programme of work underway to progress tumour and event level data. Significant progress has been made in the delivery of AVpathway.	In train
Public Health England and NHS England should establish robust surveillance systems and, if possible, mandate the collection of data on recurrent and secondary cancer occurrences for all cancers and make this available for analysis and research.		01/04/2018 /ongoing		Macmillan, ONS, Academia	In order to drive up data completeness for the submissions to the NCRS, monthly reports on data quality and completeness of the Cancer Outcomes and Services Dataset are made available to all acute providers. Data quality reporting specifically targeting recurrence data will be included in these over the next year	Working in partnership, PHE is continuing to develop a robust programme of work to analytically identify recurrent cancer patients at a population level using a combination of datasets e.g. SACT, RTDS etc. This work was presented at the PHE Cancer Data and Outcomes Conference in June 2017 and is continuing to build. A summer intern programme also examined new methods of identifying recurrence in routine data. Recurrence data was mandated through COSD as of 2016. The COSD programme reports on the number of recurrences that are submitted by each trust on a monthly basis which can be found in the Level 2 COSD reports. Data quality reporting specifically targeting recurrence data will be included in these over the next year. In addition an updated annual summary of hospital-reported recurrence was published in November 2017.The work to ensure consistent definitions of registration processes for the recording of recurrence and new dataset items which will be mandated from April 2018, is also continuing. Similarly improved training and documentation is now available to Trusts and registration teams and data Liaison teams are undertaking 6 pilots in Manchester to inform data collection practice, with a view to improving data completeness once results have been assessed	In train
95. NHS England and Public Health England should work with Monitor and other bodies to consider how to develop better health economic evaluation of new service models and interventions.	**Collaboration with other ALBs to develop health economics evaluation of new service models and interventions**	Ongoing	Brian Ferguson	NHSE, DH, NHS Improvement (formerly Monitor), McKinsey, CRUK, Macmillan	Colorectal Cancer ROI project completed	The CRC ROI tool developed by the PHE Health Economics team was published in late 2016 and is available on www.gov.uk. The PHE Health Economics Team works with the local K&I service and PHE centres to train people in the use of such tools and we rely on feedback through this Health Economics 'virtual team' on how they are being used. We have received very positive feedback from CCGs and Cancer Alliances about the colorectal ROI tool (e.g. from a recent NoEevent) with people saying they need similar tools for other cancer sites.	In train