

Newcastle JSNA: Cancer prevention, screening and treatment December 2008

Cancer is a major contributor to health inequalities. Approximately 21% of the gap between the national average life expectancy and that in the fifth of areas with lowest life expectancy (i.e. Spearhead areas) is attributable to cancer mortality.

What do we know?

Facts and Figures

Nationally:

- Every year around 230,000 people will be diagnosed with cancer and around 125,000 will die from the disease, making it the leading cause of mortality in people under the age of 75.
- Cancer mortality in people under 75 fell by over 17% between 1996 and 2005. This equates to approximately 60,000 lives saved over this period;
- In 1996, 71,000 people under 75 died from cancer - in 2006 this figure had dropped to 62,000;
- Over half of all cancers could be prevented by changes to lifestyle, e.g. smoking is the single largest preventable risk factor for cancer.

Males:

Cancer is by far the greatest contributor to excess mortality amongst men in Newcastle, accounting for one-third (32%) of the gap in male life expectancy. Premature deaths from lung Cancer account for 17.5% of the gap.

Females:

Cancer is the greatest contributor to excess mortality amongst women in Newcastle, accounting for 30% of the gap in female life expectancy. Premature deaths from lung cancer account for 24.7% of the gap.

Trends

Progress on the national health inequalities target for cancer

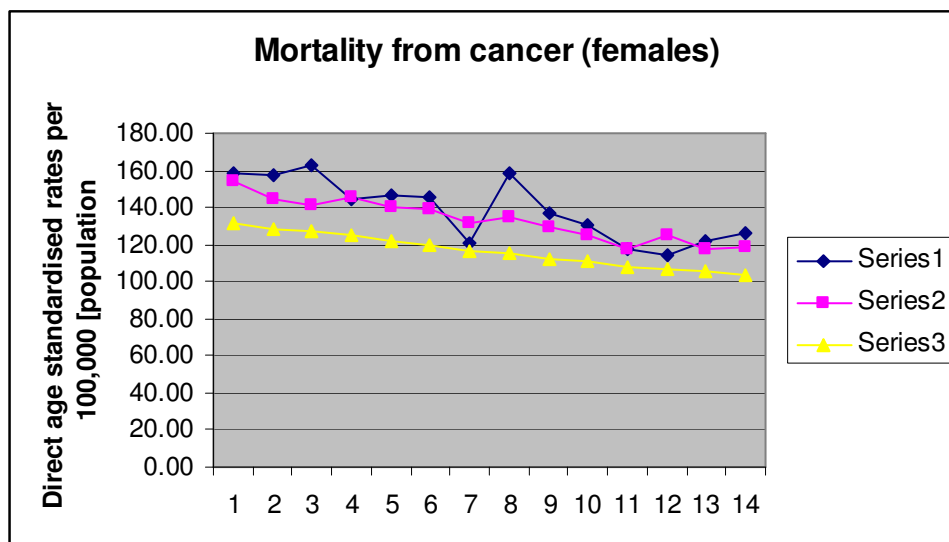
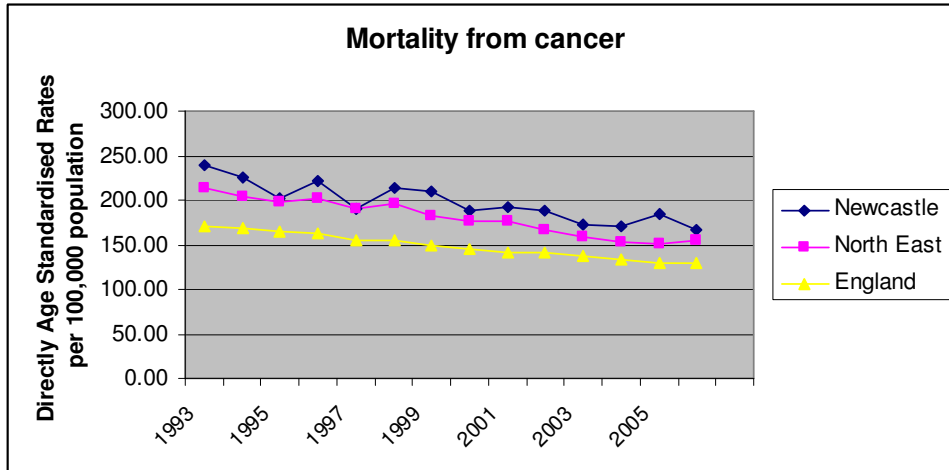
Nationally:

- Reduce mortality rates in England by 2010 (from 1995-97 baseline) from cancer by at least 20% in people under 75, with a reduction in the inequalities gap* of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole. (*The gap referred to is the absolute gap in mortality. This is the actual difference between the mortality rate in England and the mortality rate in Spearhead areas. It measures the impact of the unequal health experience in absolute terms, for example how many more deaths from cancer (per 100,000 population) there are in the Spearhead authority).

Locally:

- Mortality due to cancer has declined in Newcastle in the period between 1995-97 and 2004-06, but the percentage reduction has been less than the national average – 16.9% compared to 17.1% nationally.
- Over the same period the gap in the mortality rate between Newcastle and England has narrowed by 16.3%. – from 33.9 per 100,00 in 1995-97 to 28.4 per 100,000 in 2004-06.

Mortality from all cancers



Targets

Nationally:

- a minimum 20% reduction in cancer mortality by 2010 from the 1995/97 rate;

Locally:

- As part of the Annual Operational Plan (AOP), targets have been set for the period from 2009 to 2011. The target for Newcastle is the projected mortality rate based on current trends. Therefore, provided that these trends continue into the future Newcastle should meet or be very close to meeting its AOP target.

Performance

Locally:

- Newcastle does not have an LAA target in relation to inequalities within the city but monitoring trends in cancer mortality within the city has been part of the PCT's strategy for the past three years.
- Between 1995-97 and 2003-05 the death rate in the most deprived parts of the city fell by 23.8%, compared to 17.3% in Newcastle as a whole.
- The absolute gap between the most deprived areas and the Newcastle average narrowed from 91.2 to 58.0 per 100,000 population, a 36.3% reduction.

Earlier diagnosis - screening

Cervical Cancer Screening

The effectiveness of the cervical screening programme is judged by its *coverage*. Coverage is defined as *the percentage of women in a population eligible for screening who have been screened in the previous five years*.

Nationally:

- The target for five-year coverage is 80% but coverage has been falling slightly over the past five years, with much of this decline being in young women.

Locally:

- In Newcastle 5-year coverage has fallen 2.9% in the past 5 years, and is now below the England average
- coverage varies considerably by GP practice
 - 4 (11%) out of 37 practices achieve coverage of 85% or higher
 - 12 (32%) practices with coverage of between 80% and 85%
 - 21 practices (56.8%) have coverage levels below the national target of 80%
 - 5 of these have coverage levels below 68%, the lowest at 43.5%.

Breast cancer screening

There are two indicators used in the breast screening programme – Coverage and Uptake. Coverage is defined as *the proportion of eligible women area who have had a test with a recorded result at least once in the previous 3 years*. Currently coverage is best assessed using the 53-64 age group as women may be invited for screening at any time between their 50th and 53rd birthdays.

Locally:

- Coverage in Newcastle (73.5%) is below both the SHA (79.4%) and England (76%) average, with little change over the past three years.
- Coverage in the 65-70 age group is also monitored as part of the Healthcare Commission's Annual Health Check. Newcastle, at 69.6% is meeting the target of 65%.

Uptake is the proportion of women invited for screening, for whom a screening test result is recorded.

Nationally:

- Between 2000 and 2005 the number of new cancers diagnosed through breast screening increased by over 60%.

Locally:

- Uptake varies by GP practice from 41% to 83% across GP practices
 - 7 practices achieve 80% or greater uptake
 - 19 obtaining uptakes rates between 70% and 78%
 - 9 practices have uptake rates between 60% and 69%
 - 2 practices achieve less than 60% uptake

Bowel cancer screening

Nationally:

- The national Bowel Cancer Screening Programme (BCSP) was launched in 2006 and is the first screening programme to target both men and women
- Between April 2006 and October 2007, over 400 cancers have been detected, out of 305,000 returned kits;

Locally:

- Since February 2008 men and women aged 60-69 have been invited for screening and those aged over 70 will be screened on request

Earlier diagnosis – reduced waiting times

Nationally:

- The 31 day standard will be extended to cover all cancer treatments;
- In addition to patients referred urgently by their GP, all patients with suspected cancer detected through national screening programmes will in future enter the 62 day pathway;
- Hospital specialists will have the right to ensure that patients who were not referred urgently by their GP, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62 day pathway
- all patients referred to a specialist with breast symptoms, even if cancer is not suspected, should be seen within two weeks of referral.

Locally:

- 99.9% had a two-week maximum wait from urgent GP referral to first out patient appointment for all urgent suspected cancer referrals (target = 97%)
- 99.8% had a maximum waiting time of one month (31 days) from diagnosis to treatment for all cancers (target = 96%)
- 98.2% had a maximum waiting time of two months (62 days) from urgent referral to treatment for all cancers (target = 93%)
- The Northern Centre for Cancer Treatment is also achieving the maximum acceptable waiting times in relation to Radical and Palliative Radiotherapy

Treatment

Locally:

- The North of England Cancer Network (NECN) has been established to ensure consistency of standards in services for cancer across the North of England and address inequalities. The aim of the NECN is to improve local outcomes for cancer and commission clear pathways between primary, secondary and tertiary services
- The NECN Improving Outcomes Guidance plans have been implemented in 4 tumour areas through service reconfiguration in gynaecological, urological, haematology and upper gastrointestinal cancers
- work is progressing to meet the DH milestones for head and neck cancers by December 2008
- In NECN there is a robust process in place for the approval of new cancer drugs prior to NICE decisions. North East Cancer Drugs Approval Group has won national acclaim for its process and impact.

End of Life Care

Nationally:

- Survival rates for many cancers are improving greatly but around 125,000 people die from cancer every year.

Locally:

- The North East has a strong reputation for developing best practice in end of life care. Despite good progress, there remain significant issues to be addressed. The key problem is that, although there is much good practice, it is not universal and is too dependent upon which services an individual happens to be involved with. The commissioning of care is also perceived to be variable and according to the recently published North East strategy for health and healthcare services “commissioners also do not recognise the role they need to play in enabling individual end of life preferences to be met”

Local Views

Locally:

- There is an on-going programme of local engagement events and in June 2008 the focus was on the national cancer reform strategy and, in particular, on what can be done to encourage earlier presentation of symptoms of cancer
- Patient surveys that have been carried out to assess levels of satisfaction with cancer services generally report very high levels of satisfaction with many aspects of care
- Lower levels of satisfaction have been reported with the environment, standard of meals, the discharge process and being kept up-to-date with changes to treatment
- In a recent peer review of the quality of local services peer reviewers were impressed with patient and carer involvement at Network Board, Locality and MDT levels
- Health Trainers are involved in improving access to current services through empowering individuals and helping services to become more accessible (for example, buddying women for mammogram and other screening appointments).

- A report for the Healthy Communities Collaborative project to establish a baseline knowledge of breast, bowel and lung cancer in Byker, Walker and Elswick made the following recommendations:
 - More information was required on the signs and symptoms of the diseases.
 - Campaign to reduce embarrassment about bowel cancer issues
 - Information about what to expect from exploratory treatment
 - Evening appointments for evening and shift workers
 - Publicise useful websites for medical information
 - Campaigns to publicise the target ages for screening
 - Convenient locations for breast screening e.g. chemists

National and local strategies

Our Vision is taken primarily from the North East's Strategy for health and well-being – *Better Health, Fairer Health: A Strategy for 21st Century Health and Well-being in the North East of England* which was launched in February 2008. The vision statements which are most relevant in relation to cancer are:

- The North East will reduce its overall smoking prevalence to the lowest in the country and will narrow the gap in smoking prevalence between social groups
- The North East will have the best preventive services. These and treatment services will be distributed fairly and geared to reducing inequalities in health and well-being. Individuals will receive the information and help needed to recognise health problems and act as early as possible
- The North East will have the highest quality services to support individuals (along with their families and carers) in their choices as they approach death. By a good death we mean one which is free of pain, with family and friends nearby, with dignity and in the place of one's choosing.

Newcastle's Health Improvement Strategy, in relation to cancer, sets out a vision for Newcastle in 2017 where:

- Fewer people will die prematurely from the major killers: cancer, heart disease and stroke before the age of 75
- Few people will continue to smoke and most people will view smoking negatively

Current activity and services

Prevention remains the best form of tackling cancer, reducing the human suffering caused by the disease and improving outcomes. There is also a strong economic case for investing more in prevention, therefore reducing the pressure on services in the long term.

Reducing smoking prevalence

Smoking is the single largest preventable risk factor for cancer. See topic guide for smoking for further details of reducing smoking prevalence in Newcastle.

Healthier nutrition / Increasing physical activity

The evidence linking poor diet and obesity to cancer has become much stronger. Locally we have an obesity strategy and the action plan is in the process of being refreshed. The action plan links with the Healthy Schools Awards and the Personal Health and Social Education (PHSE) curriculum and includes:

- increasing the capacity of community workers in delivering healthier eating sessions
- supporting businesses to adopt healthy eating practices
- developing community food initiatives (like co-ops and community cafes)
- Health Trainers employed in disadvantaged communities to work specifically to tackle health inequalities, through offering personalised support to enable individuals to adopt healthier lifestyles.

Alcohol

Excessive alcohol consumption is strongly linked to an increased risk of several cancers. In Newcastle a draft strategy is currently undergoing public consultation and responses will be used to develop detailed action plans. The strategies aim to promote sensible drinking and to reduce the impact of alcohol misuse. See topic guide for alcohol for further details of reducing alcohol consumption in Newcastle.

Human Papilloma Virus (HPV) vaccination for cervical cancer

Vaccination now presents a further opportunity in cancer prevention, specifically for cervical cancer. The government has introduced a national vaccination programme for young girls against the human papillomavirus. This will protect against the strains of the virus which cause around seven out of ten cases of cervical cancer.

A specification is currently in development for the implementation of the HPV vaccination programme from Autumn 2008 in the North of Tyne area.

Increasing awareness and earlier presentation

Healthy Communities Collaborative Cancer project

A two-year community-based cancer initiative was launched in mid-2007. The Healthy Communities Collaborative aims to raise awareness and promote the earlier presentation of cancer symptoms. The project is focusing on three areas that have a high incidence of cancer, high death rates and poor survival rates - Walker, Byker and Elswick. The focus is on breast, bowel and lung cancer. The aims of the collaborative are to reduce health inequalities by working specifically with disadvantaged populations. The project is subject to on-going evaluation.

Social Marketing

THE North East's Strategy for Health and Wellbeing promises that a sustained social marketing campaign to promote cancer awareness in the North East will be undertaken.

Earlier diagnosis - Increasing the coverage/uptake of cancer screening

Cervical cancer screening

A key objective for the Newcastle Public Health team in reducing health inequalities is to improve cervical and breast screening uptake in Newcastle, focusing particularly on practices with low rates. Data has been analysed by Practice and is being used to design appropriate and culturally acceptable measures to improve screening coverage in targeted areas.

Screening rates will also be monitored over time with shared learning from a range of initiatives.

Breast Screening

The Cancer Reform Strategy will have major implications on the delivery of the service. The planned expansion of the programme and the move to digitalised mammography will have workforce and funding implications. The PCT's Plan has prioritised some additional investment for the Breast Screening Unit to increase its capacity. As described under the plans for increasing cervical screening coverage, similar initiatives will be undertaken in relation to breast screening. The Healthy Communities Collaborative is providing an additional opportunity to engage with communities, raise awareness of breast cancer and promote screening in targeted areas.

Bowel cancer

The progress of this new programme will be monitored by a BCSP steering group, which currently meets at two monthly intervals.

Improving treatment

Key actions for 2008/09 (from Annual Operational Plan)

- Develop and implement the Improving Outcome Guidance for skin, sarcoma, and children and young people.
- Improve radiotherapy services across the patch, incorporating recommendations from the National Radiotherapy Advisory Group (NRAG) document and the local oncology strategy group on Teesside.
- Address workforce issues which have been identified during the course of the year, particularly with regards to the development and introduction of new technologies.
- Ensure early implementation of NICE guidance and new technologies.

Improving End of Life Care

Specialist Palliative Care teams across North of Tyne have been leading developments in relation to improving standards of end of life care in the care home setting, with the key focus being on education and development of care home staff, building competencies and capabilities to deliver high quality end of life care across all long term conditions.

In relation to both End of Life Care and care for those who have survived cancer, work to implement the Cancer Reform Strategy will be taken forward by PCT commissioners in collaboration with Practice Based Commissioning (PBC) Groups.

Delivering Choice Programme

Tyneside has been selected as a site in the Marie Curie Delivering Choice Programme, a palliative care initiative that helps patients with terminal illnesses to make choices over their place of care and death. The three year project which begins in September 2008 will review all models of current service provision and make recommendations on alternative models of care / commissioning arrangements to bring care closer to home.

Improving the patient experience

Work to implement robust systems to ensure that patients experience good continuity of care and that psychological support services are available to cancer patients and their families has been ongoing in NECN over the past two years but further action is required to ensure that the needs of patients are met.

There are plans to carry out a patient satisfaction survey across the network.

Strengthening commissioning

Cancer services across the North of Tyne are planned through two structures:

1. the hospital trust locality groups; and
2. the North of England Cancer Network (NECN) commissioning group

There is a hospital trust locality group for Newcastle Hospitals and this acts as a multi-disciplinary forum bringing together the different professions involved in cancer as well as user and carer representation to inform service planning. In light of the Cancer Reform Strategy there is now a need to re-focus the work of the locality group so as to strengthen the role of Primary Care in commissioning. Discussions from the locality group is fed to the NECN commissioning group through the PCO commissioning representative. The Network commissioning group agrees priorities for investment, undertakes performance management and facilitates co-ordination between PCOs and the network.

Statement of resources and investment

Expenditure and Outcomes for Cancer

In mid-2007, an exercise was undertaken across the three North of Tyne PCOs, which compared health expenditure and outcomes across a range of programmes including cancer. National programme budgeting data for 2005-06 was analysed alongside QOF data and the data from the National Centre for Health Outcomes Development (NCHOD).

The outcome variables used in the analysis of Cancer programmes are listed below:

- Incidence of major cancers: Direct Standardised Rates – persons
- Mortality from all cancers: SYLL ages <75 - persons
- Mortality from colorectal cancer: Standardised Mortality Ratios - persons
- Mortality from lung cancer: Standardised Mortality Ratios – persons
- Mortality from breast cancer: Standardised Mortality Ratios - ages 50-64 – females
- Mortality from cervical cancer: Standardised Mortality Ratios - ages 15-64 females
- Percentage of deaths at home from all cancers: all ages – persons
- Breast screening programme coverage
- Cervical screening programme coverage

The results of the analysis for Newcastle were: **High Cost: Poor Outcomes**

It is important to attach a 'health warning' to the analysis undertaken and the conclusions reached, and to emphasise that this was only the first step in a process of investigation. The routinely available data identified *what appear to be* relatively high spending programme

areas, relatively low spending areas, relatively low performing areas, and relatively inefficient areas. However, there are several possible explanations for these findings including errors in the data and differences in the way different PCTs have calculated programme expenditure.

As Newcastle appears to be relatively high spending PCT with relatively poor outcomes cancer programmes have been identified as one of the top priorities for further in-depth investigation. This work, which will focus specifically on lung cancer, will be undertaken during 2008 and will influence service developments from 2009 onwards. This investigation will incorporate the views of key stakeholders including patients, service users, carers and the public. The conclusions and recommendations arising from this work will be a key component of our 3-5 year commissioning strategy.

Funding / Investment on prevention / early detection

Area of work	Funding/Investment
Awareness Raising / promoting earlier presentation	<ul style="list-style-type: none"> Improvement Foundation funding for the Healthy Communities Collaborative
Reducing Smoking prevalence	<ul style="list-style-type: none"> Choosing Health investments prioritised Stop Smoking services Investments in FRESH and the Stop Smoking services range of Neighbourhood Renewal investments in appropriate areas
Cancer Screening	<ul style="list-style-type: none"> Mainstream funding allocated to support all screening programmes Additional investment in 2008/09 for Breast Screening National investment for Bowel Screening

What is this telling us?

What are the key inequalities

- Smoking prevalence remains higher than the national average – reflecting our socio economic landscape. Whilst we are targeting resources at the most deprived areas, smoking prevalence is not reducing as quickly as we would like.
- There is a variability between GP practices in screening coverage
- There is a variability in access to services;
- We need to improve access to radiotherapy and reduce waiting times for radiotherapy treatments;

What are the key gaps in knowledge/services?

- Inadequate data and intelligence to inform commissioning, monitor inequalities, assess quality and promote choice
- The Cancer Reform Strategy will have major implications on the delivery of the service. The planned expansion of the programme and the move to digitalised mammography will have workforce and funding implications

- Lack of resources – staff/physical infrastructure/ finance - for the expansion of the breast screening programme;
- Improving access to radiotherapy and reducing waiting times for radiotherapy treatments;

What are the risks of not delivering our targets?

The primary target for cancer is a minimum 20% reduction in cancer mortality by 2010 from the 1995/97 rate and that fewer people will die prematurely from cancer, heart disease and stroke before the age of 75. Thus the risks of not delivering in other areas, such as smoking and physical activity and diet obesity, will have an impact on cancer outcomes. In particular,

- Smoking prevalence remains higher than the national average – reflecting our socio economic landscape. Whilst we are targeting resources at the most deprived areas, smoking prevalence is not reducing as quickly as we would like;
- Our culture impacts on late presentation of cancer. Innovative social marketing combined with community engagement approaches are required otherwise this will impact on early diagnosis;
- Further decline in screening coverage, particularly in relation to cervical screening and a further reduction in variability between GP practices in screening coverage. Also difficulty in achieving the 14-day turnaround for cervical screening results.
- Not reducing variability in access to services

What is coming on the horizon?

The potential impact of the Bowel screening programme on resources with the anticipated increase in colorectal cancers.

What should we be doing next?

1. Reducing variability between GP practices in screening coverage and access to services.
2. Improving outcomes (not just survival) regarding quality of life, palliative care, support for families, support to patients and carers;
3. Improving access to radiotherapy and reducing waiting times for radiotherapy treatments;
4. Improve data collection and analysis to inform commissioning, monitor inequalities
5. Our culture impacts on late presentation of cancer. Innovative social marketing combined with community engagement approaches are required to increase early screening.