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Leeds CITY COUNCIL

WEST YORKSHIRE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Monday, 23rd January, 2017 at 10.00 am

MEMBERSHIP

Councillors

Councillor M Gibbons	-	Bradford Council
Councillor V Greenwood	-	Bradford Council
Councillor M Greenwood	-	Calderdale Council
Councillor C Pearson	-	Calderdale Council
Councillor J Hughes	-	Kirklees Council
Councillor E Smaje	-	Kirklees Council
Councillor B Flynn	-	Leeds Council
Councillor P Gruen (Chair)	-	Leeds Council
Councillor Y Crewe	-	Wakefield Council
Councillor B Rhodes	-	Wakefield Council

Please note: Certain or all items on this agenda may be recorded

Agenda compiled by:
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Steven Courtney
Tel: (0113) 24 74707

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (*In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified on this agenda.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 18 NOVEMBER 2016** To confirm as a correct record, the minutes of the meeting held on 18 November 2016.	1 - 4
7			**CHAIR'S UPDATE** To receive an update from the Chair of the Joint Committee on any specific actions or activity since the previous meeting, which is not presented elsewhere on the agenda.	5 - 6
8			**WEST YORKSHIRE AND HARROGATE STP PRIORITY AREA - STROKE SERVICES** To receive a report from the Head of Governance and Scrutiny Support introducing information in relation to the Stroke Services priority area, within the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP).	7 - 12

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**WEST YORKSHIRE AND HARROGATE SUSTAINABILITY AND TRANSFORMATION PLAN PRIORITY AREA - CANCER** To receive a report from the Head of Governance and Scrutiny Support introducing information in relation to the Cancer priority area, within the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP).	13 - 84
10			**SCRUTINY OF ACCESS TO NHS DENTAL SERVICES - DRAFT TERMS OF REFERENCE** To receive a report from the Head of Governance and Scrutiny Support introducing draft terms of reference in relation to the scrutiny of 'Access to NHS Dental Services'	85 - 90
11			**WORK PROGRAMME** To receive and consider a report from the Head of Governance and Scrutiny Support on the development of the Joint Committee's future work programme.	91 - 92
12			**DATE AND TIME OF NEXT MEETING** To be confirmed.	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
			THIRD PARTY RECORDING Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

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WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 18TH NOVEMBER, 2016

PRESENT: Councillor P Gruen in the Chair

Councillors S Baines, Y Crewe, B Flynn, M Gibbons, M Greenwood, V Greenwood, J Hughes, B Rhodes and L Smaje

1 Late Items

The following late / supplementary information was submitted:

- In relation to Item 6: Minutes - Draft minutes from meeting held on 21 December 2015
- In relation to Item 7: West Yorkshire STP- Submission from Leeds Local Medical Committee (LMC).

2 Declaration of Disclosable Pecuniary Interests

There were no declarations of pecuniary interest and all members remained present for the meeting. However, for the purpose of openness and transparency, the following matters were brought to the attention of the Joint Committee:

- Councillor L Smaje: two close family members receiving treatment for cancer
- Councillor S Baines: Member of Calderdale and Huddersfield NHS Trust
- Councillor M Gibbons: Member of Bradford Care Trust Board.

3 Apologies for Absence and Notification of Substitutes

Apologies were received from Councillor C Pearson (Calderdale Council) with Councillor S Baines (Calderdale Council) attending as a substitute member.

4 Minutes - 21 December 2015

RESOLVED – That the minutes from the previous Joint Committee (21 December 2015) be agreed as an accurate record.

5 Draft West Yorkshire and Harrogate Sustainability and Transformation Plan

The Joint Committee considered a report from the Head of Governance Services (Leeds City Council) that introduced the draft West Yorkshire and Harrogate Sustainability and Transformation Plan (STP).

The following were in attendance for discussion of the item:

- Ian Holmes, Programme Director, West Yorkshire and Harrogate, STP
- Helen Hirst (Bradford Airedale and Craven CCGs)

The key areas of discussion were:

- The Joint Committee expressed significant concern regarding the development of the West Yorkshire STP and the lack of engagement with elected members and public throughout the process.
- It was suggested the West Yorkshire STP have in place two communication plans, one focusing on cross county services and the other for local areas.
- The need for clarification regarding the governance arrangements of the West Yorkshire STP and the six supporting plans.
- Concerns regarding decision-making processes for cross cutting West Yorkshire and Harrogate matters.
- The need for member representatives from Harrogate to be invited to attend future meetings of the Joint Committee.
- It was suggested that a more detailed timetable of proposed changes within the STP be used to develop and set out a draft programme of scrutiny involvement / activity on a West Yorkshire and Harrogate basis.
- The legal obligations and responsibilities around proposed variations/ development of local health services and the involvement of Health Overview and Scrutiny Committees.

RESOLVED – That a more detailed forward plan around key milestones within the STP be presented to the next meeting of the Joint Committee for discussion.

(Councillor Hughes (Kirklees Council) joined the meeting at 1:55pm during consideration of this item.)

6 Work Programme

In discussing the future work programme of the Joint Committee, the following actions were agreed:

- Officers to develop a draft forward plan for the Joint Committee, to be presented at the next meeting in late January/early February 2017.
- Cancer wait times and Autism to be included on the next agenda for the Joint Committee.
- In addition, Councillor Greenwood (Bradford Council) raised the issue of access to dentistry that had been identified by the Bradford Health Scrutiny Committee and suggested it as a matter of joint scrutiny, due to NHS England not operating on a local footprint any longer.

RESOLVED –

(a) That a draft forward plan be presented to the next meeting of the Joint Committee for discussion and agreement.
(b) That cancer wait times and Autism to be included on the next agenda for the Joint Committee.
(c) That access to dentistry across West Yorkshire be included in the forward plan of the Joint Committee.

7 Date and Time of Next Meeting

RESOLVED – That the next meeting of the Joint Committee be held in late January/early February 2017, with the exact date to be confirmed.

(The meeting concluded at 3:25pm)

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 23 January 2017

Subject: Chairs Update

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to provide an opportunity to formally outline any areas of work and activity of the Chair of the Joint Committee since the last meeting, and which are not covered elsewhere on the agenda.

2 Main issues

2.1 Invariably, scrutiny activity can often take place outside the formal Joint Committee meetings. Such activity may involve a variety of actions and can involve specific activity and actions of the Chair of the Joint Committee.

2.2 The purpose of this report is, therefore, to provide an opportunity to formally update the Joint Committee on the Chair's activity/ actions, including any specific outcomes, since the previous meeting in November 2016. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.3 The Chair and Principal Scrutiny Adviser will provide a verbal update at the meeting, as required.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and any additional details provided at the meeting.
b) Identify and agree any specific matters that may require further scrutiny input/ activity.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 23 January 2017

Subject: West Yorkshire and Harrogate STP Priority Area – Stroke Services

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The Draft West Yorkshire and Harrogate Sustainability and Transformation Plan (WY&H STP) was submitted to NHS England on 21 October 2016. The draft plan, alongside a public summary for consultation, was subsequently published on 10 November 2016.

2. The WY&H STP was subsequently considered at the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) at its meeting on 18 November 2016.

3. The WY&H STP highlighted that over recent months the leadership and staff of the West Yorkshire and Harrogate health and care organisations have been working together on how to respond to the significant health and care challenges faced across West Yorkshire and Harrogate.

4. The WY&H STP also highlighted that, while underpinned by the six locality plans (covering Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield), a range of work / activity was also being undertaken collectively, across the wider STP area. This work / activity being determined by one or more of the following:

    - Services cut across the area and beyond the six local places.
    - There is benefit from doing the work once and sharing, so we make the best use of the skill and expertise we have.
    - Working together can deliver a greater benefit than working separately.

5. On this basis, the following areas / priorities have been identified in the WY&H STP:

    - Prevention
    - Primary and community services
    - Mental health
    - Stroke
    - Cancer
    - Urgent and emergency care
    - Specialised services
    - Hospitals working together
    - Standardisation of commissioning policies.

6. The purpose of this report, is to introduce some specific and more detailed information in relation to the 'Cancer' priority. Appended to this report are the following documents:

    - Report on the Cancer work stream within the West Yorkshire and Harrogate STP.
    - Cancer in West Yorkshire – Summary Report (April 2016)
    - Cancer in West Yorkshire – Information Pack (January 2017)

7. Appropriate NHS representatives have been invited to the meeting to discuss the details of the draft STP in more detail and address questions from members of the Joint Committee.

Recommendations

8. That the Joint Committee considers the details presented and agrees any specific scrutiny actions and/or future activity.

Background documents[1]

9. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Joint Health Overview and Scrutiny Committee Briefing Paper

23 January 2017

West Yorkshire and Harrogate: Stroke Services

Introduction

Nationally and locally lots of work has taken place to improve outcomes for people who have had a stroke.

The numbers of people having a stroke are expected to increase in the coming years. However, the good news is that the number of deaths related to stroke continues to decline.

In 2015/16 there were 3,633 stroke admissions in West Yorkshire and Harrogate. The majority of people who had a stroke were in the 65+ age group with half aged over 75 years.

Progress in improving stroke care over the past 10 – 15 years has increased the demand for the provision of specialist hyper acute stroke services. This has led to some of our hyper acute stroke services experiencing difficulty in recruiting and retaining the skilled workforce needed to meet these demands. We want to make sure our services are fit for the future and that we make the most of new technology, the skills of our valuable workforce whilst maximising opportunities to improve outcomes for local people.

There are challenges for the health and social care system and most importantly for stroke survivors, their families and carers.

This alongside an ageing population, with complex health and social care needs, means we have to change if we want to continue to further improve people's quality of life with the resources we have available.

Summary

Health professionals across West Yorkshire and Harrogate have been considering how we can further improve our hyper acute stroke and acute stroke care services so they are fit for the future whilst maximising the opportunity to increase quality and outcomes for people.

Evidence from elsewhere suggests the outcomes following hyper-acute stroke are likely to be better if people are treated in a small number of specialised centres, even if this increases travelling time following the event. We know that most people with a suspected stroke arrive at hospital by ambulance. We work closely with our ambulance staff and they provide assessment and treatment as they convey people to the right hospital for their medical needs.

Ongoing rehabilitation should however be provided at more locations, closer to where people live, and they should be transferred to these as soon as possible after initial treatment.

We want to ensure care across the whole stroke pathway is working effectively to meet the current and future needs of our population. The work to date has been supported by Healthy Futures Programme and the Strategic Clinical Network which includes doctors, consultants and other health care professionals.

Staff, public and communities are being asked for their views on how best we can move forward.

This engagement will cover the whole stroke pathway with prevention, first 72 hrs of care, rehabilitation and community support. It will stress the importance of improving people's health, through better coordination of services and asks for people's views on the quality of care they received.

With the support of Healthwatch, the public engagement work will take place from 1st February for 6 weeks. This will include meeting with voluntary and community organisations who support people, including those who have had a stroke and their carers.

Once the engagement work has been evaluated we will consider the need for pre-consultation with a target group of people who have been affected by stroke. This feedback will further shape our consultation proposals.

The Clinical Senate, which is made up of specialist doctors and nurses, will be asked to review the proposals to inform the next steps. Further consultation with the wider public and communities will take place as appropriate.

It's important to note that no decision will be made until all the engagement and consultation work has concluded. Decisions will be made by the Clinical Commissioners who are responsible for commissioning stroke services on behalf of people living in West Yorkshire and Harrogate.

We are anticipating that all the engagement and appropriate consultation work will be completed in 2017/18 with any service implementation made during 2018/19.

Why change?

In 2016, we face the most significant challenges for a generation. We know that we must keep innovating and improving if we are to meet the needs of our population.

Demand for services is growing. Services in some places may not be designed to meet modern standards, and local people want things to be better, more joined up, and more aligned to their needs.

It's great news that people are living longer than previous generations, but the reality is that up to two thirds of people in the UK could spend their retirement years in ill-health.

An ageing population, people living longer with complex health and social care needs, means we have to change if we want to improve people's quality of life and meet the challenges we face together with the money we have available now and in the future.

Our workforce is also changing. We need to improve the way we do things if we are to meet these changing needs whilst improving the health and wellbeing of people and fully supporting our staff.

Stroke is a life changing event and evidence shows the care people receive in the first few hours can make a difference to how well they recover. This includes having specialist scans to assess the nature of the stroke and if appropriate receive clot-busting drugs (thrombolysis) delivered by specialist staff working in sustainable and resilient hyper acute stroke units.

Further improving hyper acute stroke services and making sure all stroke care services are fit for the future has been highlighted as a priority in the draft Sustainability and Transformation Plan (STP) for the area. This

outlines how we want to improve people's health and wellbeing, for example by reducing incidence of stroke, premature mortality and further improving care quality, such as increasing the number of patients scanned within 12 hours.

West Yorkshire and Harrogate has five hyper-acute stroke units (HASU), based in:

- Bradford Teaching Hospitals NHS Foundation Trust – Bradford Royal Infirmary
- Calderdale and Huddersfield NHS Foundation Trust – Calderdale Royal Hospital
- Harrogate and District NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust – Leeds General Infirmary; and
- Mid Yorkshire Hospitals NHS Trusts – Pinderfields Hospital

It is important that we now focus on developing proposals to further transform hyper acute and acute stroke services so that no matter where people live, and no matter what time of the day, they are able to receive the best possible quality of care and outcomes now and in the future.

It's important to note that no firm proposals are in place and there is an honest and genuine commitment to engage with staff and the public to find out how services could further improve for the better for people living across West Yorkshire and Harrogate.

Previous engagement work

It is useful to note that some engagement work has already taken place, for example in Airedale, Wharfedale and Craven (AWC) and Bradford in 2015.

The engagement exercise identified five key themes in relation to people's concerns and ideas for improvement. These are:

- Discharge and aftercare focused on both physical and mental health support.
- Travel and parking costs with people having to travel further distances to see their loved ones
- Treatment and outcomes for patients
- Staffing
- Communication

As a result a patient information leaflet for ambulance staff to give to family and friends was produced highlighting what would happen to their relative and where they would be taken along with maps and telephone numbers. Visiting times to hyper acute stroke units were flexed for people who travel across AWC; a community stroke rehabilitation service was commissioned in AWC (Bradford already had this) and providers established a joint focus group with patients and carers.

Other stroke and engagement and consultation work taking place

South Yorkshire and Bassetlaw and North Derbyshire are proposing to make changes to hyper acute stroke services to improve the experience of patients needing stroke care in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham and Sheffield. The consultation is open until the 14 February. You can view this here.

This may have an impact on people living on the boundary of West Yorkshire in regard to Pinderfields hospital admissions and we are working together with South Yorkshire , Bassetlaw and North Derbyshire commissioner to ensure any proposed changes (subject to the outcome of their consultation) inform our future proposals.

What next?

- Communications and conversations with staff from mid-January 2017
- Public and communities engagement 1 February 2017
- Pre-consultation work with targeted groups of people most affected (as appropriate) during Q4 2016/17;
- Consultation with options for service change (as appropriate); and
- Decision making Q4 2017/18.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 23 January 2017

Subject: West Yorkshire and Harrogate STP Priority Area – Cancer

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
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Recommendations

8. That the Joint Committee considers the details presented and agrees any specific scrutiny actions and/or future activity.

Background documents[1]

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Joint Health Overview and Scrutiny Committee

23 January 2017

West Yorkshire and Harrogate: Cancer

Background

Cancer is responsible for a considerable burden of mortality and morbidity in our population, therefore fully understanding the causes of cancer, major types of malignancies, early detection and treatment are essential.

Each week around 250 people in West Yorkshire and Harrogate (WY&H) are diagnosed with cancer and sadly around 115 people die from this disease. The number of people diagnosed and living with cancer each year will continue to grow rapidly, even with major improvements in prevention, primarily due to our ageing population and our success in increased survival. Briefly for West Yorkshire and Harrogate (WY&H) we have:

- a diverse population with 17% of people from BME communities;
- some of the highest levels of deprivation and lifestyle risks associated with the development of cancer;
- a higher incidence and mortality from cancer compared to the England average with lung cancer being the most common;
- significant variation in incidence and mortality with 9 / 11 CCGs with higher than England average mortality and 5 / 11 higher incidence of all cancers;
- although survival is improving we are still behind England's average one-year survival (69.5 versus 70.2);
- curative stage (1 and 2) at diagnosis is currently 39%. If we achieved the best CCG stage in England for lung and colorectal cancer alone, then an additional 156 people would survive one year since diagnosis; and
- screening uptake is poor overall with 9/11 CCGs and 4/11 CCGs with lower than national average uptake for breast and colorectal cancer.

Context

The report from the National Cancer *Taskforce* *'Achieving World Class Cancer Outcomes – A Strategy for England 2015-2020',* presents a compelling case for improvement in outcomes and experience for people affected by cancer. This has been accepted as the 'cancer roadmap' for delivery of the Five Year Forward View by all the National Arm's Length Bodies.

The Taskforce report includes a large number of recommendations grouped around five strategic priorities. Our West Yorkshire and Harrogate draft STP proposals for cancer, built around these five priorities have been considered and endorsed by the Healthy Futures Clinical Forum in August 2016.

1. **Spearhead a radical upgrade in prevention and Public Health** – over 40% of cancers are potentially preventable. If we truly wanted to reduce the burden of cancer on our population and health and social care, we would invest heavily in evidence based

preventative interventions and awareness-raising. However, timescales for return on investment are generally considered to be outside usual planning systems.

2. **Drive an ambition to achieve earlier diagnosis** – this will require a behavioural shift towards faster and less restrictive investigative testing, quickly responding to people who present with symptoms by confirming or ruling out cancer or other serious disease. This philosophy is perceived in many quarters as a high risk strategy which will inflate activity, and at odds with the gatekeeping/demand management role, often imposed at the very start of a person's contact with health services. The counter-argument underpinning the Taskforce recommendation is that this is false economy, due to risk of adverse impact on patient outcome and treatment costs through delayed diagnosis of cancer and any other serious condition responsive to earlier diagnosis. A more 'rapid solution focussed' service model for investigation may actually reduce multiple or speculative testing and therefore be more efficient use of resources. This is currently being evaluated with two national pilots running in the West Yorkshire and Harrogate area as part of the Accelerate, Coordinate and Evaluate (ACE) Programme.

3. **Establish patient experience on a par with clinical effectiveness and safety** – current commissioning and regulatory levers and incentives do not always prioritise patient experience yet it is frequently the enduring memory of care for people affected by cancer.

4. **Transform our approach to support people living with and beyond cancer** – in many cases our post treatment care of people affected by cancer is not designed for long term survivorship. There is a way to go to make supported self-management the norm wherever appropriate for a rapidly growing number of cancer survivors. The number of people living across the area beyond a diagnosis is expected to grow from 69,000 to 117,000 over the next 15 years. There will be an increasing need for local health and social care services to support cancer patients and survivors with complex comorbidities (both consequences of treatment and other conditions) in the community but with specialist support.

5. **Invest in modern, high quality services** – currently the majority of cancer treatment services are commissioned by NHS England Specialised Commissioning Team, which plans through a national rather than local place based lens. It could be said that this focuses on one part of the patient pathway rather than integrated whole system, person centred bundles of care.

Implementation in West Yorkshire and Harrogate

The national strategy for cancer, *'Achieving World Class Cancer Outcomes – A Strategy for England 2015-2020'*, was published in July 2015. It contained 96 recommendations that were endorsed by the national Arm's Length Bodies including NHS England, Public Health England and NHS Improvement. It recommended the creation of Cancer Alliances to deliver the recommendations in local health economies. In West Yorkshire and Harrogate (WY&H) the development of the delivery plan for its 2.8 million populations began in May 2016 as the West Yorkshire & Harrogate Integrated Cancer Services which was formally adopted as the cancer work stream within the WY&H STP in June 2016. The WY&H Cancer Alliance was

formally agreed with NHS England (and is co-terminus with the WY&H STP) in November 2016.

The formal accountability for the delivery of the cancer programme is both through the draft STP governance process as well as being accountable to the National Cancer Delivery team.

WY&H has a single cancer plan to deliver the recommendations from the national cancer strategy. The vision for the West Yorkshire and Harrogate Cancer Alliance is:

> *'The West Yorkshire and Harrogate cancer system pulling together as one, with common objectives, actively breaking down barriers and maximising resources, with the aim of being able to deliver the best possible, seamless, clinically led and patient driven health and social care so that every person affected by cancer is assured of the best possible outcomes.'*

On 1 November 2016, the commissioners and providers have collectively agreed that this single plan will be delivered through the six local placed-based planning foot prints (Bradford, Calderdale, Harrogate, Leeds, Kirklees, Wakefield). This is a relationship where the WY&H function and success on behalf of its patients is interdependent on local delivery.

As a single plan WY&H Cancer Alliance will have an agreed single set of ambitions and key metrics whereby we can judge our success and delivery of improved outcomes for patients. There are five work streams required to deliver this plan: Tobacco Control, Early Diagnosis, Living With and Beyond Cancer, High Quality Services and Patient Experience.

The governance and structure on delivery is more easily described visually (Annex A).

Progress to date

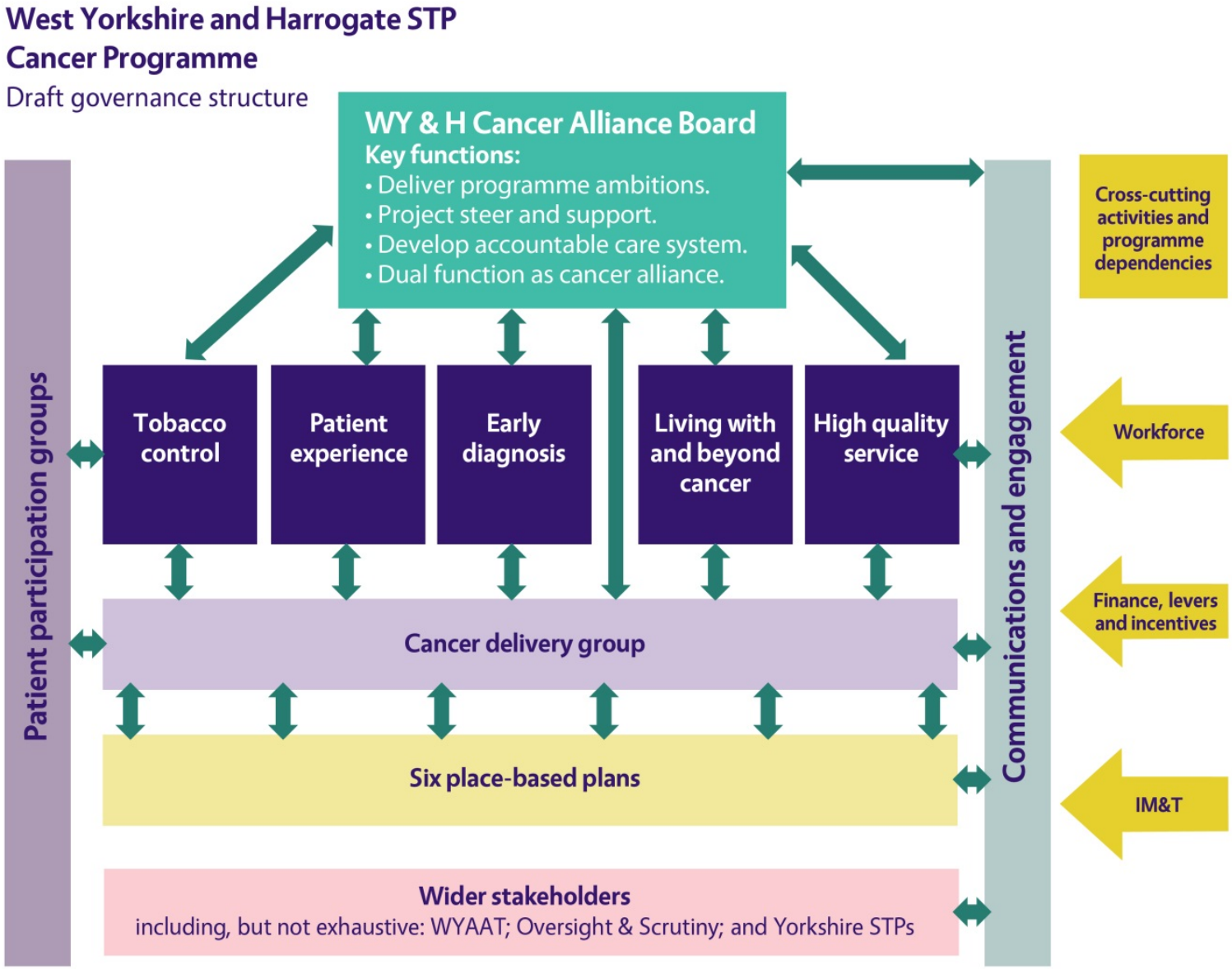
There is a Programme Management function for the Cancer Alliance, hosted by the STP Programme Management Office. It has a small but enlarging cancer PMO team that ultimately will be core funded by national Cancer Alliance funding. Having the right staff and resources is vital if we are to achieve our ambitions.

The Cancer Alliance Board is fully formed and functional. It has agreed terms of reference and five work programmes have been put in place. It has had its first meeting In November 2016 and is chaired by Professor Clive Kay.

Each of the five work streams has a draft TOR, PID documentation in place, agreed membership and chairs appointed. There have been informal meetings with an allocated Chair. Formal group meetings are all scheduled for January 2017. They will be responsible for the development and engagement around the emerging plans for the implementation of the cancer strategy recommendations.

Our high level delivery plan and funding requirement have been submitted to the National Cancer Team for sign-off.

Professor Sean Duffy
Strategic Clinical Lead, Leeds Cancer Centre
Programme Clinical Director and Alliance Lead,
West Yorkshire and Harrogate Cancer Alliance


West Yorkshire and Harrogate STP
Cancer Programme
Draft governance structure
WY & H Cancer Alliance Board
Key functions:
• Deliver programme ambitions.
• Project steer and support.
• Develop accountable care system.
• Dual function as cancer alliance.
Cross-cutting activities and programme dependencies
Patient participation groups
Tobacco control
Patient experience
Early diagnosis
Living with and beyond cancer
High quality service
Communications and engagement
Workforce
Finance, levers and incentives
IM&T
Cancer delivery group
Six place-based plans
Wider stakeholders
including, but not exhaustive: WYAAT; Oversight & Scrutiny; and Yorkshire STPs

Cancer in West Yorkshire

Summary Report

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For: West Yorkshire Integrated Cancer Services
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Contents

1. Summary

This report has been produced by Yorkshire Cancer Research to give an overview the cancer pathway in West Yorkshire. It focuses on prevention, screening, early diagnosis and follow up care, and summarises publically available data on the current and changing cancer landscape in the region.

Identifying and summarising key data will be a driver in becoming aware of local problems and commissioning services to make change happen and improve cancer outcomes.

The report is not intended to provide answers or solutions to the issues we see across the localities in West Yorkshire.

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2. Introduction

2.1. Introduction

This report, prepared by Yorkshire Cancer Research, presents data on cancer in West Yorkshire. It highlights key incidence and mortality cancer statistics for the West Yorkshire region, as well as taking a look at preventable risk factors for cancer, stage of diagnosis and the cost implications of late stage diagnosis.

Publically available information has been gathered from sources such as the Office for National Statistics (ONS), Public Health England (PHE), the Cancer Commissioning Toolkit (part of the National Cancer Intelligence Network or NCIN), CancerData, and NHS England. All relevant data

for Yorkshire has been extracted and where necessary our own calculations have been applied to give more detailed information. Unless otherwise stated, age-standardised rates have been calculated using the 2013 European Standard Population (ESP).

Where possible, the data is broken down by Clinical Commissioning Group (CCG), and all areas across the West Yorkshire region are taken into account. For the purposes of this report, the West Yorkshire region is considered to include the 10 West Yorkshire CCGs plus NHS Harrogate and Rural District CCG. Where data is included that refers to Yorkshire, the Charity considers the Yorkshire region to include all of North, South, East and West Yorkshire, together with South Tees to the north, but not including parts of Cumbria to the west, North and North East Lincolnshire to the east, or Bassetlaw to the south.

2.2. The West Yorkshire cancer landscape

There is variation in cancer epidemiology and outcomes across the West Yorkshire region and in Yorkshire cancer is the biggest cause of death from illness in every age group.

- Around 69,000 people in the West Yorkshire region are currently living with or beyond cancer[1].
- In 2013, around 13,000 people[2] in West Yorkshire were newly diagnosed with cancer – about 44% of all cases diagnosed in Yorkshire. This means around 250 people are receiving a new diagnosis of cancer each week. The total number of new cases diagnosed each year is expected to rise to around 17,500 by 2030.
- Many more people are referred with suspicion of cancer under the Two Week Wait pathway. In 2014/2015 the West Yorkshire region handled over 41,500 referrals for suspected breast, lower GI, lung and skin cancers alone[3].
- Over 6,000 people[4] died from cancer in West Yorkshire in 2013 (115 people each week).
- Most common cancers are lung, prostate, breast and bowel cancer – but they aren't always worse than the England averages[2]. These cancers are sometimes called "the big four" and this report focuses on these cancer types.
- Around 42% of cancers are due to preventable lifestyle and environmental factors such as tobacco, diet, alcohol, obesity and exposure to UV light[5,9] - particularly preventable cancers include lung, malignant melanoma, bowel, bladder, and kidney cancer.
- Early diagnosis saves lives but screening uptake for breast, cervical and bowel cancers is often low.

West Yorkshire is heterogeneous with a diverse population.

- Significant variation exists across the region in access to and uptake of screening, treatment, support, palliative care and clinical trials.
- When looking at ethnicity 17.36% of the West Yorkshire population is non-white[6], which equates to around 413,801 people. NHS Bradford City CCG has the highest percentage of non-white residents in England at 72.2%[7].
- There are some areas of West Yorkshire which have high levels of social deprivation[8] which may influence people's behaviour, their knowledge and symptom awareness, and their access to healthcare.

3. At a glance – cancer incidence and mortality in West Yorkshire

3.1. Introduction

The following section summarises incidence and mortality in England and across the 21 Yorkshire CCGs, with a focus on West Yorkshire for "all cancer (excluding non-melanoma skin cancer)", as well as the four most common cancers – lung, breast, colorectal and prostate[2,4]. It includes the number of cases or deaths and the age-standardised rate (ASR). The ASR gives the number of people per 100,000 of the population who were diagnosed or died in the stated year.

The numbers highlighted in green indicate that the ASR for incidence or mortality is lower than the England average while those numbers highlighted in red indicate that the ASR for incidence or mortality is higher than the England average [significance not calculated]. The data shows that many CCGs in West Yorkshire have ASRs higher than the England national average in both incidence and mortality. This means that given the population size for each CCG, a higher number of people than expected are either being diagnosed with, or dying from cancer compared to the national average. Only a couple of cancer types have lower than England national average rates for both incidence and mortality. Compared to England, overall West Yorkshire has:

- higher incidence and mortality rates for all cancers combined and lung cancer
- lower incidence and mortality rates for breast and prostate cancer
- for colorectal cancer, incidence rates are lower but mortality rates are higher than the equivalent rates for England.

The data tables are presented on the following pages. It is interesting to note that lung cancer is the most common cancer in West Yorkshire (also the case for Yorkshire), however data for England shows it to be the third most common behind breast and prostate cancer. Also of interest is that the gender profile of lung cancer is changing. In the last decade or so there has been a 14% decrease in the incidence rates of cancer in men, but a 26% increase in incidence in women[2] – however each year a higher number of men are still diagnosed with the disease. In 2013, 250 more women died from lung cancer in Yorkshire than from breast, ovarian, and uterine cancers combined[4]. A similar story is seen for men – in 2013, 920 more men died from lung cancer in Yorkshire than from prostate, penile and testicular cancers combined[4].

3.2. Incidence and mortality rates in West Yorkshire

3.2.1. Incidence and mortality rates – 2013

Table 1a: 2013 incidence and mortality data for all cancer sites and lung cancer for West Yorkshire CCGs[2,4]

	All cancers				Lung			
	Number of cases	Incidence per 100,000	Number of deaths	Mortality per 100,000	Number of cases	Incidence per 100,000	Number of deaths	Mortality per 100,000
England	**293,936**	**614.93**	**132,379**	**281.71**	**37,005**	**80.70**	**28,543**	**61.33**
Yorkshire	**29,872**	**631.15**	**13,789**	**298.23**	**4,438**	**96.13**	**3,430**	**73.58**
West Yorkshire	**13,023**	**625.01**	**6,028**	**296.56**	**1,939**	**96.13**	**1,506**	**72.91**
Airedale, Wharfedale & Craven	1,020	628.66	485	294.62	125	77.71	96	59.78
Bradford City	221	572.67	102	289.11	36	106.76	21	63.87
Bradford Districts	1,510	586.84	758	308.35	235	97.00	177	73.84
Calderdale	1,170	644.84	556	315.32	175	98.70	134	74.08
Greater Huddersfield	1,242	600.90	588	289.58	165	82.32	144	71.40
Harrogate & Rural District	1,005	611.64	414	253.20	120	71.35	68	41.58
Leeds North	1,126	594.50	523	275.25	150	81.62	115	61.48
Leeds South & East	1,217	674.33	558	320.46	211	121.26	172	97.94
Leeds West	1,609	685.52	728	320.29	263	114.63	215	95.77
North Kirklees	970	636.65	408	284.31	151	101.60	112	76.80
Wakefield	1,933	638.50	908	311.71	308	104.52	252	85.44

Table 1b: 2013 incidence and mortality data for breast, colorectal and prostate cancers for West Yorkshire CCGs[2,4]

	Breast				Colorectal				Prostate			
	Number of cases	Incidence per 100,000	Number of deaths	Mortality per 100,000	Number of cases	Incidence per 100,000	Number of deaths	Mortality per 100,000	Number of cases	Incidence per 100,000	Number of deaths	Mortality per 100,000
England	**42,930**	**165.54**	**9,545**	**35.43**	**33,851**	**71.63**	**12,999**	**27.55**	**40,467**	**185.71**	**9,187**	**45.58**
Yorkshire	**4,204**	**160.20**	**874**	**33.32**	**3,295**	**69.92**	**1,329**	**28.52**	**3,964**	**180.05**	**848**	**44.08**
West Yorkshire	**1,863**	**162.47**	**377**	**32.63**	**1,398**	**67.33**	**584**	**28.15**	**1,671**	**173.61**	**374**	**45.22**
Airedale, Wharfedale & Craven	154	173.88	38	39.17	104	62.17	48	29.35	143	191.36	33	47.43
Bradford City	35	156.35	7	36.97	15	43.86	6	18.98	18	111.27	1-5	-
Bradford Districts	201	134.78	44	29.50	163	66.10	70	28.10	168	145.54	43	42.03
Calderdale	186	180.17	34	32.27	139	78.97	51	29.14	157	190.20	35	48.27
Greater Huddersfield	161	136.91	35	29.60	143	72.12	57	28.85	180	190.14	33	39.03
Harrogate & Rural District	198	226.24	33	34.48	103	64.13	51	30.68	151	203.52	39	54.85
Leeds North	130	122.15	39	36.47	140	73.23	64	32.93	150	176.76	38	46.64
Leeds South & East	187	181.93	33	32.50	125	72.06	48	26.60	135	165.88	39	53.64
Leeds West	234	174.42	49	36.37	169	74.28	65	29.22	189	189.84	34	36.18
North Kirklees	128	151.03	23	26.59	102	67.51	35	24.84	113	159.83	23	38.02
Wakefield	249	149.28	42	25.05	195	66.28	89	30.98	267	185.33	57	46.10

The big four cancers account for a significant proportion of all cancer cases and cancer deaths that occur each year, both in West Yorkshire, Yorkshire and nationally. To summarise:

- Of the 293,936 cancers diagnosed in England in 2013, 154,253 of these were in the big four cancers = 52.5% (139,683 cases were in all other cancers)[2].
- Of the 29,872 cancers diagnosed in Yorkshire in 2013, 15,901 of these were in the big four cancers = 53.2% (13,971 cases were diagnosed in all other cancers)[2].
- Of the 13,023 cancers diagnosed in West Yorkshire in 2013, 6,871 of these were in the big four cancers = 52.8% (6,152 cases were diagnosed in all other cancers)[2].

- Of the 132,379 cancer deaths that occurred in England in 2013, 60,274 of these were in the big four cancers = 45.5% (72,105 deaths occurred in all other cancers)[4].
- Of the 13,789 cancer deaths that occurred in Yorkshire in 2013, 6,481 of these were in the big four cancers = 47.0% (7,308 deaths occurred in all other cancers)[4].
- Of the 6,028 cancer deaths that occurred in West Yorkshire in 2013, 2,841 of these were in the big four cancers = 47.1% (3,187 deaths occurred in all other cancers)[4].

This summary indicates that the big four cancers accounted for over half of all cancer cases diagnosed in 2013, and almost half of all cancer deaths. In West Yorkshire and in Yorkshire, slightly more cancer cases and cancer deaths are in the big four cancers compared to percentages for England and importantly, many of these cancers are considered to be preventable. The preventability of cancer is explored further in the following section.

4. How preventable is cancer?

4.1. Introduction

Around 42% of all cancers are considered preventable[5,9] however, the level of preventability varies greatly between different cancers. According to Parkin, Boyd and Walker (2011)[9] the following percentages of the big four cancers are considered to be due to lifestyle and environmental factors: lung - 89%, breast - 27%, and colorectal - 54%. Prostate cancer is not thought to be linked to any preventable risk factors.

This indicates that there is a potential to reduce the number of people diagnosed with cancers related to preventable risk factors (particularly in some of the most common cancers). However, as many of the risk factors are lifestyle related, this would require behaviour change at an individual level. This may be difficult to achieve in some instances, particularly when the recommended limit is zero – such as for tobacco and consumption of red and processed meats.

There are a number of caveats to consider regarding this information. First it is estimated that for the majority of risk factors, the latent period is about 10 years, meaning that cancer incidence rates for 2010 are based on risk factor rates and behaviours from 2000. Therefore, it follows that looking at the most recent data for levels of certain risk factors across West Yorkshire now, will not impact cancer incidence rates for at least another 10 years from the point of data collection. In

addition, the Parkin, Boyd and Walker (2011) supplement[9] concludes that simply reducing risk factors will not directly relate to a reduction in cancer. For example, around 54% of bowel cancers are attributable to lifestyle and environmental factors, but it has been estimated that only about half of this number is preventable in a reasonable (20 year) timescale. It should be stated, perhaps obviously, that we will not be able to change each individual's behaviour so they achieve optimal levels of each risk factor but these caveats should not be seen as a reason not to help people stop engaging in these behaviours. Interventions focused on young people may be particularly important in order to prevent them starting the behaviour in the first instance. It is apparent that reducing the general population's engagement with risk factors will have long-term health benefits and should therefore be considered as a potential priority area.

Some preventable lifestyle risk factors for cancer are more prevalent within the West Yorkshire region than expected given national averages. It is important that individuals are made aware of the risks associated with certain behaviours, and are encouraged and supported in their efforts to change them. For some risk factors there are relatively low levels of awareness of the links between them and cancer (for example alcohol) and therefore awareness needs to be raised among the general population, including younger people. This will require local collaborations which are targeted to address specific local problems.

Some of the main risk factors and their impact on cancer in West Yorkshire are discussed below. A full summary of lifestyle and environment related risk factors can be found in the Parkin, Boyd and Walker (2011) supplement[9].

4.2. Tobacco

Tobacco is the leading preventable cause of cancer, estimated to cause 19% of all cases each year[9] (including lung, larynx, oesophagus, bladder, and pancreatic cancer). In West Yorkshire, it is estimated to have caused over 2,300 cancers in 2010[2]. Smoking rates are above the national average (18%) in West Yorkshire at 20.1%[10] (21.6% if Harrogate is excluded), meaning there are around 379,836 smokers in the West Yorkshire region.

Not only does smoking have a significant impact on the development of cancer but it also impacts on many other debilitating diseases (two-thirds of long-term smokers will die as a result of smoking if they do not quit[11]). Each year in West Yorkshire it is estimated that smoking costs society approximately £646.1m[12].

Although national smoking rates are falling, the Cancer Taskforce strategy[13] recommends a standard of achieving smoking rates of 13% by 2020 and 5% by 2030 [Recommendation 2]. To achieve this, significant behaviour change is required among tobacco smokers.

Importantly, smoking is increasingly concentrated in disadvantaged and deprived populations, and therefore strategies to drive down smoking must target the groups most in need. Products available to aid quitting include nicotine patches, gum, or e-cigarettes, as well as pharmacotherapies such as Zyban and Champix. Evidence shows that a combination of treatment and support (such as that provided through the NHS stop smoking services) often has the most

positive outcome[14]. The number of people in Yorkshire and the Humber using NHS stop smoking services has more than halved in the last 5 years despite the region having reported the highest proportion of successful quitters in 2015[15].

4.3. Overweight and obesity

An estimated 5% of all cancers are linked to being overweight or obese[9] (including uterine, kidney, oesophagus, colorectal, pancreatic, and breast cancer). In West Yorkshire, being overweight or obese is estimated to have caused 668 cancers in 2010[2]. A higher percentage of adults in West Yorkshire are estimated to be overweight or obese (65.2% compared to the England average of 63.8% and a Yorkshire average of 65.9%[16]). This means there are nearly 1.3 million adults in West Yorkshire who are overweight or obese.

As with smoking, obesity is not only linked to cancer, but is also linked to other conditions such as diabetes and heart disease – it is the second most important preventable cause of ill health and death after smoking. Being obese may also mean that patients are limited in the treatment options they are offered, and therefore their cancer outcomes may be poorer. In 2015 the estimated cost to the NHS in Leeds of diseases related to overweight and obesity was £219.1 million[17]. National costs are predicted to reach £9.7 billion by 2050 and pose a large threat to the NHS[18]. The Cancer Taskforce strategy[13] recommends the development and delivery of a national action plan to address obesity which should focus on things like sugar reduction, food marketing, local weight management services and children [Recommendation 3].

4.4. Alcohol

An estimated 4% of all cancers are linked to excess alcohol consumption[9] (including oral cavity and pharynx, larynx, oesophagus, colorectal, liver and breast cancer). In West Yorkshire, excess alcohol consumption is estimated to have caused 486 cancers in 2010[2]. The estimated percentage of adults in West Yorkshire who binge drink is 22.7% (compared to an England average of 20.1% and a Yorkshire average of 24.3%[19]). This means there are around 455,000 adults in West Yorkshire who binge drink.

Again excess alcohol consumption may impact on many aspects of an individual's health, not just cancer. Awareness of alcohol consumption as a risk factor for cancer is relatively low and therefore there is an opportunity to educate people on some of the less well known risk factors of alcohol consumption. The Cancer Taskforce strategy[13] suggests the development of a national strategy to address alcohol consumption, which should include some marketing campaigns to raise awareness [Recommendation 4].

Currently, cancer incidence is increasing year on year - without significant intervention and advances in treatments and surgery it will continue to do so. The next section explores the current predictions for how cancer will look by 2030.

5. What might cancer rates look like by 2030?

Nationally, the number of new cases of cancer being diagnosed annually is growing by an average 2% each year[2]. By 2030 the annual number of new cancer cases is expected to reach over 360,000[13].

For Yorkshire, the average rate of increase year on year is slightly lower at 1.8%. This takes us from a figure of 29,872 cases diagnosed in 2013 to a predicted number of around 40,500 cases in 2030. For West Yorkshire, the rate of increase follows that of Yorkshire, and so the number of cases diagnosed annually is expected to rise from 13,023 in 2013 to over 17,600 in 2030. This means there will be an estimated 4500 additional patients going through cancer diagnosis, treatment and follow-up each year.

In terms of cancer prevalence, there are currently around 150,000 people living with and beyond cancer in Yorkshire, with around 69,000 living in West Yorkshire[1]. If prevalence in Yorkshire increases at the same predicted rate as national prevalence (2 million in 2015 to 3.4 million by 2030) then we could expect somewhere in the region of 255,000 people in Yorkshire, and 117,000 people in West Yorkshire to be living with and beyond cancer by 2030 (an additional 48,000 people in West Yorkshire alone). As discussed in Section 2 above, around half of these cancers will be in the big four, and the other half across all remaining cancer types.

Using the average percentage increase in the number of cancers diagnosed each year (from 2001 to 2013[2]), figures have been produced showing the estimated number of new cancers diagnosed each year in 2015, 2020 and 2030, for all cancers combined and the big four cancers (assuming the number of new cases continues to increase at the same rate as they have over the previous 13 years of available data). The data gives proxy figures that can be used to give a rough indication of how many cancers we may expect to see in the future.

Table 1 below shows that the greatest increase is in prostate cancer (likely due to increased PSA testing over recent years), whereas the increase in colorectal cancer is relatively small in comparison. It should be noted that as the average of the year on year percentage change in cancer cases diagnosed has been used (2001 to 2013), this does not take into account any decreases in cancer incidence (as was seen in the 2013 data for colorectal cancer[2]). If these predictions are directionally correct, it is likely that prostate cancer will become the most common cancer in England, Yorkshire and West Yorkshire. For Yorkshire only, lung cancer will maintain its position ahead of breast cancer.

Table 1: Predicted incidence rates for 2030, based on average annual increase in numbers of new cancers diagnosed between 2001 and 2013.

	Area	Annual average % increase	2013 incidence (actual)	2015 incidence (predicted)	2020 incidence (predicted)	2030 incidence (predicted)
All cancer	West Yorkshire	1.5%	13,023	13,417	14,454	16,774
	Yorkshire	1.8%	29,872	30,957	33,845	40,455
	England	2.0%	293,936	305,811	337,640	411,581
Lung	West Yorkshire	1.2%	1,939	1,986	2,108	2,375
	Yorkshire	1.5%	4,438	4,572	4,925	5,716
	England	1.4%	36,853	37,892	40,620	46,679
Breast	West Yorkshire	1.6%	1,863	1,923	2,082	2,440
	Yorkshire	1.8%	4,204	4,357	4,763	5,693
	England	2.0%	55,591	46,392	51,221	62,438
Colorectal	West Yorkshire	0.6%	1,398	1,415	1,458	1,548
	Yorkshire	0.9%	3,295	3,355	3,508	3,837
	England	1.6%	33,851	34,943	37,829	44,337
Prostate	West Yorkshire	3.2%	1,671	1,780	2,083	2,855
	Yorkshire	3.5%	3,964	4,246	5,043	7,114
	England	3.2%	40,467	43,098	50,450	69,128

The analysis above demonstrates the extent to which the number of people being diagnosed with cancer each year could increase over the next 15 or so years. As outlined in the Cancer Taskforce Report[13], these increases are likely to be due to many contributing factors such as an ageing and growing population, improvements in the healthcare system and advancements in treatments for other conditions (meaning that people are less likely to die from other conditions), along with lifestyle and environmental changes which expose people to risk factors for cancer. Both the increase in number of cancer diagnoses and the expected increase in people living with and beyond cancer, mean the healthcare system will be put under increasing pressure in future years. Diagnosing cancers as early as possible will help to alleviate some of this pressure, as treatment of early stage cancers often costs less and has less severe long-term impact on patients, meaning they can go on to live a healthy life after a cancer diagnosis. These topics are explored in the following sections.

6. Early diagnosis of cancer leads to better outcomes

6.1. Introduction

When cancer is diagnosed at an early stage, treatment options and chances of full recovery are greater. For example, it is estimated that around 95% of men diagnosed with bowel cancer at the earliest stage of disease survive at least 5 years compared with around 7% of those diagnosed with the most advanced stage of disease[20]. This disparity is huge and many variables will impact on the stage of diagnosis. It is important to think about factors that contribute to early diagnosis of cancer which may include (amongst others):

- raising awareness and knowledge of cancer signs and symptoms among the public and how this is translated into help-seeking behaviour
- increasing engagement with GPs and HCPs
- getting more people through screening
- tackling negative attitudes to cancer
- tackling barriers to seeing a GP or going for tests
- supporting primary care to manage and refer patients when necessary
- increasing access to diagnostic tests for primary care practitioners
- planning adequate diagnostic capacity and making the most effective use of the capacity we have across the region
- need to organise our diagnostic capacity to get a rapid yes/no answer for patients (diagnosis within 28 days as standard).

6.2. Staging data

We know that for some cancers early diagnosis at Stage 1 or 2 leads to better survival for patients, however many patients are not diagnosed until their cancer has reached Stage 3 or 4. Table 2 below shows the stage of diagnosis for all cancers combined, as well as for breast, colorectal, lung and prostate cancers for England, Yorkshire and West Yorkshire[21], and includes actual patient numbers and percentages for 2012.

This is the best data that is currently available, despite the seemingly large percentage of unknown stage of diagnosis data (labelled as "X" in the tables). This is likely to be skewed by a small number of CCGs across Yorkshire, as very few have higher than national average occurrences of unknown stage of diagnosis data.

Table 2: Stage of diagnosis for England, Yorkshire and West Yorkshire for all cancers combined, breast, colorectal, lung and prostate cancer[21].

	Stage of Diagnosis					
	1	2	3	4	X	Total
England: All Cancer	65932	43712	37161	54514	92425	293744
	22.45%	14.88%	12.65%	18.56%	31.46%	
Yorkshire: All Cancer	6939	4186	3817	5848	9065	29855
	23.24%	14.02%	12.79%	19.59%	30.36%	
West Yorkshire: All Cancer	3188	1892	1829	2623	3482	13014
	24.50%	14.54%	14.05%	20.16%	26.76%	
England: Breast	16645	15073	3707	2141	7119	44685
	37.25%	33.73%	8.30%	4.79%	15.93%	
Yorkshire: Breast	1650	1494	333	235	508	4220
	39.10%	35.40%	7.89%	5.57%	12.04%	
West Yorkshire: Breast	764	715	173	101	113	1866
	40.94%	38.32%	9.27%	5.41%	6.06%	
England: Colorectal	4945	7508	8036	7358	6004	33851
	14.61%	22.18%	23.74%	21.74%	17.74%	
Yorkshire: Colorectal	544	747	823	770	411	3295
	16.51%	22.67%	24.98%	23.37%	12.47%	
West Yorkshire: Colorectal	251	328	356	353	110	1398
	17.95%	23.46%	25.46%	25.25%	7.87%	
England: Lung	4846	2615	6867	17430	5070	36828
	13.16%	7.10%	18.65%	47.33%	13.77%	
Yorkshire: Lung	677	366	831	2142	422	4438
	15.25%	8.25%	18.72%	48.26%	9.51%	
West Yorkshire: Lung	367	159	328	953	132	1939
	18.93%	8.20%	16.92%	49.15%	6.81%	
England: Prostate	11804	7726	6814	6744	7379	40467
	29.17%	19.09%	16.84%	16.67%	18.23%	
Yorkshire: Prostate	1212	683	818	777	474	3964
	30.60%	17.24%	20.65%	19.62%	11.97%	
West Yorkshire: Prostate	491	261	433	354	132	1671
	29.38%	15.62%	25.91%	21.18%	7.90%	

6.3. Cost implications

In 2014, Incisive Health produced a report for Cancer Research UK analysing the financial implications of achieving earlier diagnosis of colorectal, lung and ovarian cancer[22]. Data from this report has been reviewed and re-analysed for Yorkshire. In order to allocate the un-staged patients categorised as "X" in the data presented in Table 2 above, a methodology used by the authors of the Incisive Health Report has been adopted. The methodology involves allocating un-staged patients to a stage in accordance with the proportions observed with staged patients. A summary of the methodology used by the Charity is presented in Appendix 1.

We consider that the data produced using this approach serves to give an estimation of staging allocation only – the data should not be interpreted as exact. Therefore costing are presented for staging data as we see it now (and as shown above in Table 2), and are also presented separately for the inclusion of the reallocated, previously un-staged patients. This applies to patients with colon, rectal and non-small cell lung cancers (NSCLC) only.

The Incisive Health Report estimates the cost of treatment for colon cancer, rectal cancer and NSCLC by stage to be the following (not including the cost of recurrence).

Table 3: Cost of treatment by stage[22]

	Colon cancer	Rectal cancer	Non-small cell lung cancer
Stage 1	£3,373	£4,449	£5,328
Stage 2	£7,809	£6,944	£10,217
Stage 3	£9,220	£8,302	£11,207
Stage 4	£12,519	£11,815	£15,081

Following the reallocation of the un-staged patients to one of stages 1 to 4 based on the proportions observed with staged patients, the estimated patient numbers for these three cancer types for Yorkshire and West Yorkshire are presented below in Table 4. The numbers are estimates as Yorkshire staging data was available for colorectal cancer and lung cancer only – not by the specific cancer type. The methods used to calculate these estimates are shown in Appendix 1.

Table 4: Estimated patient numbers in Yorkshire and West Yorkshire

	Estimated patient numbers – based on known staging data[20]			Estimated patient numbers – based on un-staged patients re-allocated to stage		
	Colon	**Rectal**	**NSCLC**	**Colon**	**Rectal**	**NSCLC**
Yorkshire						
Stage 1	271	273	594	307	308	733
Stage 2	559	188	321	644	218	396
Stage 3	572	251	729	661	290	912
Stage 4	528	242	1880	595	273	2346
West Yorkshire						
Stage 1	125	126	322	135	135	384
Stage 2	245	83	140	268	91	168
Stage 3	247	109	288	271	119	354
Stage 4	242	111	836	260	119	1017

The patient numbers (shown in Table 4) have been used to calculate the estimated cost of treatment for colon cancer, rectal cancer, and NSCLC in Yorkshire and West Yorkshire (using the costs in Table 3). These are presented in Table 5 below and clearly show that the costs of treating patients with early stage disease are lower than treatment costs for late stage disease.

Table 5: Estimated cost of treatment for colon, rectal and non-small cell lung cancer in Yorkshire and West Yorkshire.

	Estimated cost – based on known staging data[20]			Estimated cost – based on un-staged patients re-allocated to stage		
	Colon	**Rectal**	**NSCLC**	**Colon**	**Rectal**	**NSCLC**
Yorkshire						
Stage 1	£915,114	£1,213,217	£5,383,504	£1,036,576	£1,368,220	£5,824,840
Stage 2	£4,361,583	£1,308,716	£3,055,734	£5,032,141	£1,513,425	£3,302,864
Stage 3	£5,274,895	£2,082,852	£7,257,123	£6,092,156	£2,405,468	£7,967,989
Stage 4	£6,610,762	£2,858,541	£28,013,076	£7,443,025	£3,222,679	£30,674,449
Total	**£17,162,354**	**£7,463,326**	**£43,709,437**	**£19,603,899**	**£8,509,792**	**£47,770,143**
West Yorkshire						
Stage 1	£422,231	£559,775	£2,918,384	£454,679	£601,417	£3,056,749
Stage 2	£1,915,126	£574,644	£1,327,491	£2,094,264	£629,640	£1,404,970
Stage 3	£2,281,728	£900,966	£2,864,424	£2,500,058	£987,639	£3,087,290
Stage 4	£3,030,648	£1,310,474	£12,463,334	£3,252,986	£1,408,302	£13,297,710
Total	**£7,649,734**	**£3,345,859**	**£19,573,633**	**£8,301,987**	**£3,626,999**	**£20,846,719**

However, the costs of recurrence should also be taken into account. For lung cancer in particular, due to the high level of recurrence, increasing rates of early stage diagnosis would likely lead to a cost increase to the NHS, however many patients would benefit and increased delivery of early stage lung cancer diagnosis would be highly cost-effective, generating many additional years of life. As discussed in Section 4, a significant number of lung cancers are preventable and therefore by reducing incidence through better lifestyle choices, it follows that the impact of recurrence would be reduced, again highlighting the importance of effectively tackling lifestyle related risk factors for cancer.

The Incisive Health Report gives the following average cost per patient of treatment for recurrence of their cancer (taken from Tables 3, 27, 31 and 35 of the Incisive Health Report).

Table 6: Average cost per patient of recurrence, by stage and percentage of patients by stage expected to have a recurrence (shown in brackets)[22]

	Colon cancer	Rectal cancer	Non-small cell lung cancer
Stage 1	£376 (10%)	£354 (3%)	£8,457 (52%)
Stage 2	£2,003 (20%)	£1,890 (16%)	£10,346 (55%)
Stage 3	£4,757 (34%)	£4,490 (38%)	£12,251 (58%)
Stage 4	n/a	n/a	n/a

6.4. Matching the best in England

Continuing to treat patients that are diagnosed following the stage of diagnosis profile outlined above will continue to cost the NHS large amounts, particularly if the incidence of these cancers increases at rates similar to those predicted in Section 5 of this report. Table 7 below gives a summary of the local and national averages for the proportion of patients diagnosed with early stage cancer (Stage 1 and 2 combined), as well as the percentages for the best CCGs in England. Despite the average for early stage diagnosis in West Yorkshire being above the average rates for both England and Yorkshire, there are still around 12% fewer patients are being diagnosed with

early stage cancer when compared to the best performing CCG in England. This is summarised in terms of patient numbers and cost implications in Table 8.

Table 7: Percentage of patients diagnosed with early stage cancer (Stage 1 and 2) in 2013

	England average	Yorkshire average	West Yorkshire average	Best in England
Colorectal cancer	35.88%	39.77%	42.05%	54.39% (NHS Great Yarmouth & Waverley)
Lung cancer	20.79%	23.92%	27.21%	39.43% (NHS Dorset)

Table 8: Summary of patient impact and NHS cost implications of achieving the best in England

	Additional patients diagnosed with early stage cancer	Additional cost
Yorkshire		
Colorectal cancer	**482** • Estimated 325 colon cancers • Estimated 157 rectal cancers	**Colon** • -£1,732,004 **Rectal** • -£899,163
Lung cancer	**689** • Estimated 605 NSCLC	**NSCLC** • £1,129,095
West Yorkshire		
Colorectal cancer	**173** • Estimated 117 colon cancers • Estimated 56 rectal cancers	**Colon** • -£621,653 **Rectal** • -£322,729
Lung cancer	**236** • Estimated 207 NSCLC	**NSCLC** • £386,744

As in the Incisive Health Report, we have predicted the cost implications for if the rates of early diagnosis in Yorkshire and West Yorkshire were in line with the best CCG in England.
Creating a shift in stage of diagnosis towards more early stage diagnoses would benefit many patients across the region and for colon and rectal cancer lead to annual cost savings of around £2,631,167 in Yorkshire and £944,381 in West Yorkshire.

As there is a high level of recurrence in patients with NSCLC, matching the best CCG in England would lead to an increase in costs of £1,129,095 in Yorkshire and £386,744 in West Yorkshire. However, many patients would benefit and attaining an overall earlier stage of diagnosis for lung cancer would be cost saving as survival rates would improve and therefore additional life years gained.

The methodology for calculating these costs is included in Appendix 1. The calculations show that despite increased costs for increased early stage diagnosis for lung cancer, these would easily be

recuperated through cost savings for other cancers (colorectal being the example used here, however the Incisive Health Report also showed large savings for ovarian cancer).

6.5. Impact on survival

As well as looking at the cost implication, we can also estimate the impact earlier diagnosis has on survival. The figures for one year survival for patients diagnosed in 2012 by stage of diagnosis[23] and five year survival for patients diagnosed 2002-2006 for colorectal cancer[20] and 2003-2006 for lung cancer[24] are presented below.

Table 9: Survival by stage of diagnosis[23,24]

One year survival (persons)[23]		
	Colorectal cancer	**Lung cancer**
Stage 1	98.2%	86.8%
Stage 2	95.0%	73.4%
Stage 3	90.3%	48.0%
Stage 4	46.4%	19.3%
Unknown	64.4%	31.6%
Five year survival (persons)[20, 24]		
Stage 1	97.5%	35.0%
Stage 2	85.0%	21.0%
Stage 3	63.0%	6.0%
Stage 4	7.5%	n/a
Unknown	26.5%	6.0%

Yorkshire

Using the current number of patients diagnosed with each stage of colorectal cancer in Yorkshire, as shown in Table 2 above[21], and the survival by stage data shown in Table 9, of the 3,295 patients, 2,609 would be alive one year after diagnosis and 1,851 alive five years after diagnosis. If the staging profile for colorectal cancer matched the best CCG in England at around 54% then survival rates would improve with around 2,728 patients alive one year after diagnosis (an additional 119 patients) and 2,095 patients alive five years after diagnosis (an additional 244 patients).

Applying the same method to lung cancer patients, of the 4,438 patients, 1,802 would be alive one year after diagnosis and 389 alive five years after diagnosis. If the staging profile for lung cancer matched the best CCG in England at around 39% then survival rates would improve with around 2,132 patients alive one year after diagnosis (an additional 330 patients) and 561 patients alive five years after diagnosis (an additional 172 patients).

West Yorkshire

The same method was applied to the number of patients diagnosed with each stage of colorectal cancer in West Yorkshire, shown in Table 2 above[21], and the survival by stage data shown in Table 9. Of the 1,398 patients, 1,114 would be alive one year after diagnosis and 803 alive five years after diagnosis. If the staging profile for colorectal cancer matched the best CCG in England at around 54% then survival rates would improve with around 1,157 patients alive one year after

diagnosis (an additional 43 patients) and 889 patients alive five years after diagnosis (an additional 86 patients).
Applying the same method to lung cancer patients, of the 1,939 patients, 818 would be alive one year after diagnosis and 189 alive five years after diagnosis. If the staging profile for lung cancer matched the best CCG in England at around 39% then survival rates would improve with around 931 patients alive one year after diagnosis (an additional 113 patients) and 248 patients alive five years after diagnosis (an additional 59 patients).

7. Summary of National Screening Programmes

7.1. Introduction

There is a need to increase the number of people engaging with screening services, whilst ensuring they make an informed decision, and are educated about the purpose, outcomes, and potential risks of screening. In particular, people need to:

- attend screening appointments for breast screening
- make and attend screening appointments for cervical screening
- complete home screening kits for bowel screening.

In many areas of West Yorkshire, screening coverage rates (i.e. the number of eligible people who have recorded a screening result in the target time period) are in line with, or above, the national average. However, in the case of screening, the national average may be relatively low, and we should be aiming beyond this, trying to get as many people as possible into the national screening programmes. This would help patients receive an earlier diagnosis of cancer, or even avoid the need for a cancer diagnosis at all if abnormal cells are detected early enough and can therefore be treated.

Understanding why people do not attend, or take part in screening, both within and between communities in West Yorkshire, and ensuring people are aware of the different purposes of screening is extremely important. Understanding these factors may help service providers in targeting information to specific communities in a more persuasive and effective manner.
Current screening coverage rates are shown in Figures 1, 2 and 3 below – the data has been taken from the National General Practice Profiles – Cancer dataset[3] and covers the period 2014/2015.
The percentages refer to the proportion of the eligible population who have undergone screening within the target period for each screening programme. Work is already being carried out at a local level to address poor screening uptake, for example in Bradford City CCG which has some of the worst screening rates in the country.

7.2. Breast screening

Offered to women aged 50 to 70 every 3 years (after the age of 70 women can request screening appointments through their local screening centre). Breast screening aims to detect cancers when they are too small to see or feel i.e. before they might otherwise be detectable.

Breast screening rates are shown in Figure 1. Nine of the 11 CCGs in West Yorkshire have breast screening coverage rates lower than the national average for England – the lowest being Bradford City at 54.8%. Only Greater Huddersfield CCG and Harrogate and Rural District CCG have breast screening rates above the England average. Evidence from the literature tells us that South Asian women are less likely to attend breast screening services, and are more likely to be diagnosed at a later stage[25]. This indicates a key need to get women from this demographic into the national breast screening programme.

Figure 1 also shows the rate of deprivation in each CCG i.e. the average deprivation score according to the Indices of Multiple Deprivation (2015)[26] (IMD 2015) – the higher the number the greater the level of deprivation. A line of best fit is included and the data indicates that uptake of breast screening tends to be lower in areas of higher deprivation.

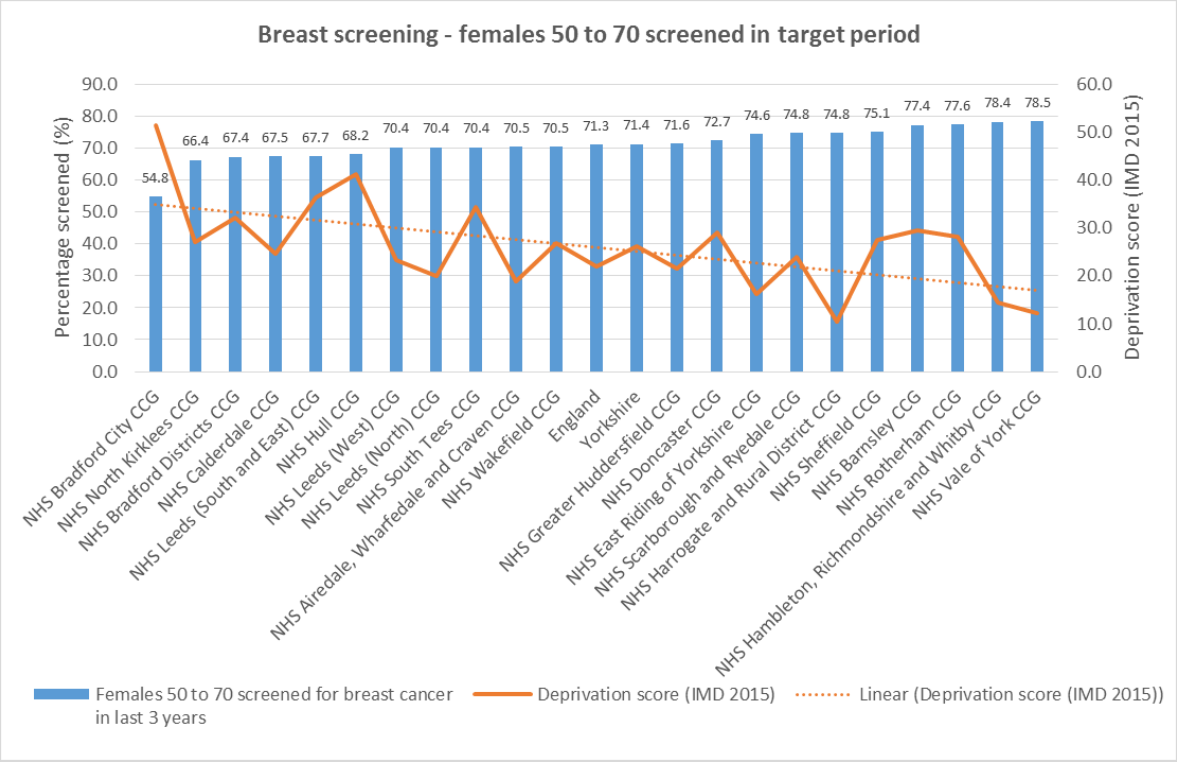

Figure 1: The percentage of women aged 50 to 70 who have attended breast screening services within the last 3 years[3], plotted alongside deprivation rates[26] in each CCG.

Overall around 29% of all breast cancers are detected through screening nationally, and in Yorkshire and West Yorkshire[27]. Of those screen detected the national staging breakdown is as follows: 62% stage 1, 23% stage 2, 4% stage 3, 1% stage 4 and 10% unknown[28].

7.3. Cervical screening

Cervical screening is offered to women aged 25 to 49 every 3 years and women aged 50 to 64 every 5 years. It involves testing apparently healthy women and looks for changes and abnormal cells in the cervix. These cells could lead to cancer if left untreated, but as a result of early detection through screening, the person can be treated and the cancer prevented from developing. Cervical screening rates are shown in Figure 2. Within West Yorkshire, only Bradford City CCG has an average cervical screening coverage rate below the national average at 62.5%. The data indicates that uptake of cervical screening tends to be lower in areas of higher deprivation.

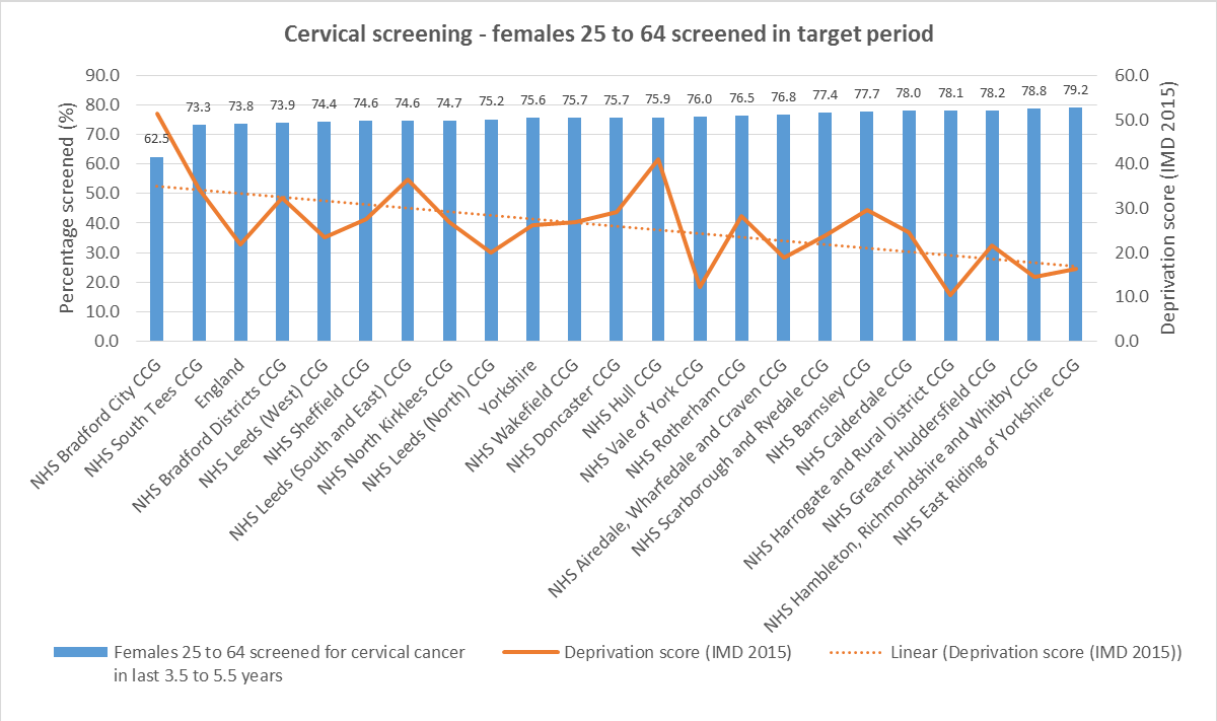

Figure 2: Percentage of females aged 25 to 64 who have attended cervical screening services within the target period (3.5 to 5.5 years)[3], plotted alongside deprivation rates[26] in each CCG.

Around 17% of all cervical cancers (including those in-situ) are diagnosed through screening nationally[29].

7.4. Bowel screening

FOBT (faecal occult blood testing) bowel screening is offered to men and women aged 60 to 74 every 2 years. The Faecal Immunochemical Test (or FIT) is currently being piloted in England and rolled out in Scotland. Screening with FIT involves only a single stool sample and therefore screening rates are expected to improve given the greater acceptability of the test to people. After the age of 75 you can still request a test.

Another type of test called a flexible sigmoidoscopy is also offered to men and women at the age of 55 in a few areas across the country. It involves a doctor or nurse using a thin flexible

instrument to look inside the lower part of the bowel and remove any small growths, called polyps, which could eventually turn into cancer.

The bowel screening rates presented in Figure 3 below relate to uptake of FOBT in 2014/2015. Figure 3 also shows the rate of deprivation in each CCG i.e. the average deprivation score according to IMD (2015). A line of best fit is included and the data indicates that uptake of bowel screening tends to be lower in areas of higher deprivation. However, although previous research in the field also shows the association between low levels of screening in BME populations, the association with socio-economic factors is less clear[30].

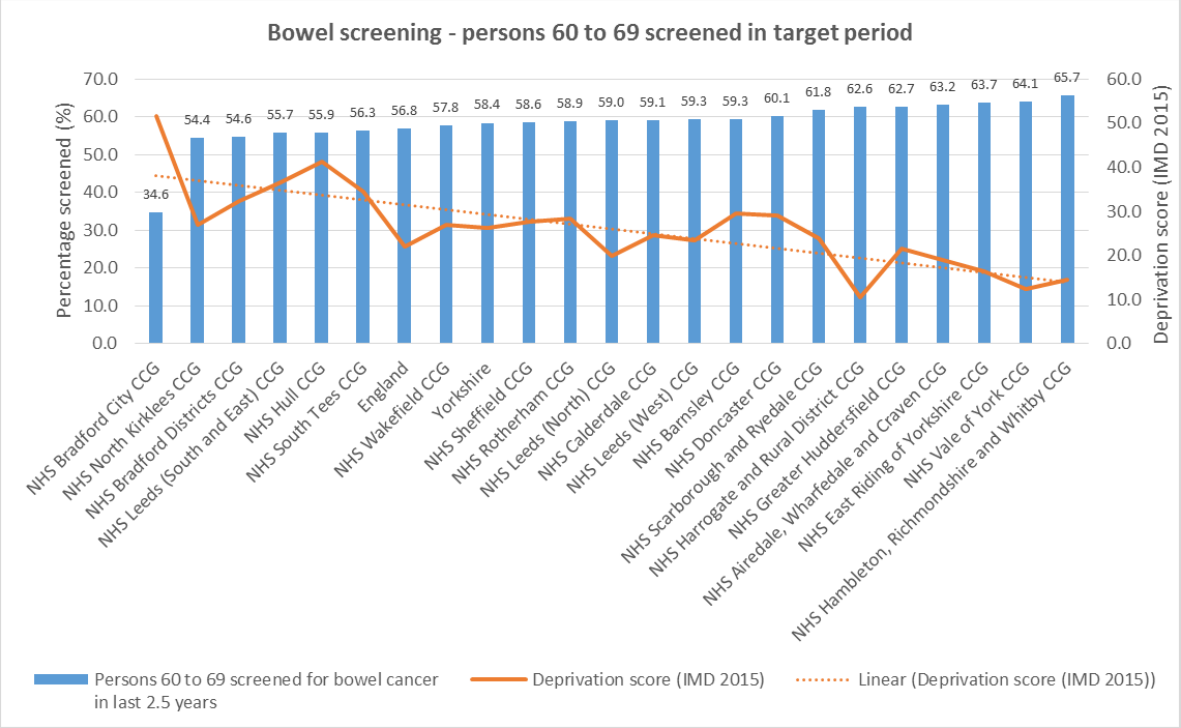

Figure 3: Percentage of persons aged 60 to 69 who have undergone bowel screening within the target period (2.5 years)[3], plotted alongside deprivation rates[26] in each CCG.

Four of the 11 CCGs in West Yorkshire have bowel screening coverage rates lower than the national average for England – the lowest being Bradford City at 34.6% - the lowest in England. The remaining 7 CCGs all have bowel cancer screening rates above the England average.

Overall around 7% of all colorectal cancers are detected through screening nationally, around 6.5% in Yorkshire and around 5.8% in West Yorkshire[27]. Of those screen detected the national staging breakdown is as follows: 34% stage 1, 25% stage 2, 28% stage 3, 8% stage 4 and 6% unknown[28].

7.5. Other diagnostic tools and methods

In addition to increasing uptake of the three national screening programmes across West Yorkshire, people must also be aware of and able to act upon potential cancer symptoms for other types of cancer.

Initiatives such as the national Be Clear on Cancer campaign highlight to people symptoms of common cancers and encourage them to seek medical help. Localised versions of these have been shown to be effective, for example the Leeds based "Got a cough? Get a check" campaign which signposts people to their GP or a walk-in x-ray service (and therefore the patient is able to bypass a referral from their GP).

A different type of innovative approach to referring from general practice to support early diagnosis of cancer is being run in Denmark and is centred on a three-legged strategy[31]. It acknowledges the need for diagnostic routes for what GPs recognise as alarm symptoms (the obvious cancer suspicion), the nonspecific symptoms (the difficult diagnosis) and the vague symptoms (the common symptoms):

- *Urgent referral pathway (obvious cancer suspicion)* – the risk of having cancer given a single alarm symptom is relatively low (often in the range of 3-8%), and only 40-45% of all cancer patients are primarily referred to specific pathways – this forms the platform for introducing further diagnostic possibilities.
- *Urgent referral for unspecific, serious symptoms and the diagnostic centres (the difficult diagnosis)* – implemented nationally in Denmark in 2012. Where cancer is one of several diagnostic possibilities, the patient can be referred to a diagnostic centre. This is a two-step approach with a filter conducted by the GP (blood and urine tests and diagnostic imaging with results within 4 days), then referral to the diagnostic centre if still relevant. When referred to the diagnostic centre the GP no longer has the diagnostic responsibility for the patient. A diagnostic centre is a medical unit with comprehensive facilities for medical investigation, including easy access to expertise in a wide range of relevant specialities. Around 15-20% of those referred to a diagnostic centre go on to receive a cancer diagnosis.
- *The NYC (the common symptoms)* - Services are conducted in hospitals or specialist clinics but the GP retains responsibility of diagnosis and they have direct access to fast investigations. The patient is not admitted to hospital to avoid repetition of tests, history taking, blood tests and other general admin.

Pathways such as these allow the patient to receive a much faster diagnosis and help to reduce the demand on resources within both primary and secondary care.

8. Time to treatment and patient experience

The Danish Model outlined in Section 7 above outlines one example of a well-designed pathway that results in earlier diagnosis for patients and ultimately faster access to treatment. Currently, Trusts across NHS England work to a 62 day target from the point of urgent referral from a GP to starting their treatment for cancer if cancer is confirmed.

8.1. Cancer waiting times

There are a number of standards relating to cancer waiting times[32]:

1. Maximum of two weeks from urgent GP referral for suspected cancer to first outpatient attendance (or to first hospital assessment for any patients with breast symptoms) [Operational Standard of 93%].
2. Maximum one month (31 days) from decision to treat to:
   - first definitive treatment [Operational Standard of 96%] or to
   - start of second or subsequent treatments for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is surgery [Operation Standard of 94%], drug treatment [Operational Standard of 98%], radiotherapy [Operation Standard of 94%].
3. Maximum two months (62 days) from:
   - **Urgent GP referral for suspected cancer to first treatment (62 day classic) [Operational Standard of 85%]**
   - Urgent referral from a NHS Cancer Screening Programme for suspected cancer to first treatment [Operational Standard of 90%]
   - Consultant upgrade of urgency of a referral to first treatment [currently no Operational Standard]
   - Maximum one month (31 days) from urgent GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers [monitored within 62 day classic Operational Standard].

The national cancer waiting times monitoring dataset guidance[32] states:

> *"It is not expected that all patients will be seen and treated within these time frames. Some patients will choose to wait longer and others will not be clinically fit to be seen/treated within these time frames. To take account of this, 'operational standards' have been set that allow for a proportion of patients to breach these standards due to medical reasons or choice. These operational standards are for all tumours taken together. Some tumour areas will exceed these standards; others (where there are complex diagnostic pathways and treatment decisions to make) are likely to be below these operational standards. However, when taking a typical provider's case mix as a whole, the operational standards should be achievable if providers have streamlined and efficient patient centred pathways in place."*

8.2. Breach Allocation Policy

The 62 day target is one of the most challenging targets relating to cancer waiting times. However, because cancer patients are often seen in a number of hospitals while having investigations, tests and treatment, if the patient does not start their treatment within 62 days it can often be difficult to determine where in the pathway the hold-up has been and therefore who needs to take responsibility for that patient not receiving treatment within the target timeframe (providing the patient has not chosen to delay their treatment). The Breach Reallocation Policy (effective as of 1 April 2016)[33] recommends day 38 as a maximum handover date from referring trust to treating trust.

The following summary is taken from the Breach Allocation Policy, April 2016.

Table 10: Summary of breach allocation scenarios from the April 2016 Breach Allocation Policy[33]

Scenario	Referral timeframe	Total timeframe	Allocation
1	> 38 days	< 62 days	100% of success allocated to the treating provider
2	< 38 days	< 62 days	50% of success allocated to the referring provider and 50% allocated to the treating provider
3	< 38 days	> 62 days	100% of breach allocated to the treating provider
4	> 38 days	> 62 days, but treating trust treats within 24 days	100% of breach allocated to the referring provider
5	> 38 days	> 62 days and treating trust treats in > 24 days	50% of breach allocated to the referring provider and 50% allocated to the treating provider

8.3. NHS Providers in West Yorkshire - achieving the 62 day target

Data is presented below for West Yorkshire NHS providers on the percentage of patients who are treated within the 62 day target. The data shows the average rate between June 2015 and February 2016, as taken from the HSCIC Cancer Waiting Times datasets[34] and refers to all cancers and all types of care. As stated above, the Operational Standard for the 62 day classic is 85% - we can see the majority of NHS providers meet this standard on average, despite monthly fluctuations (the detailed data set can be found in Appendix 2).

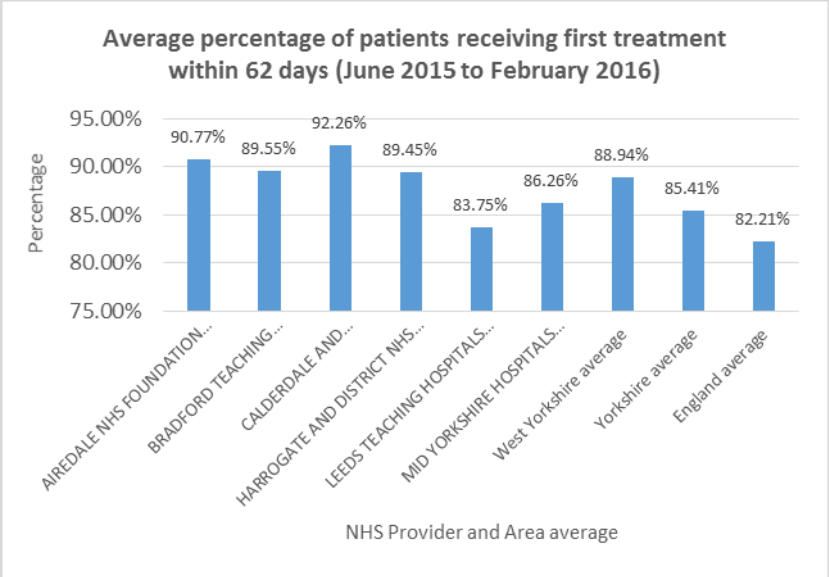

Figure 4: Average percentage of patients receiving first treatment within 62 days of urgent GP referral between June 2015 and February 2016, by NHS Provider[34].

From the chart above we can see that between June 2015 and February 2016, all West Yorkshire NHS Providers achieved rates better than the England average. However, Leeds Teaching Hospitals NHS Trust did not meet the Operational Standard of 85%. Looking at the larger dataset presented in Table 1, Appendix 2, it can be seen that of the nine data points recorded, the five most recent have been above 85%, indicating that Leeds may begin to see improvements in their achievement of the 62 day target with cancer patients.

These rates are only averages and the monthly variation within providers is large in some instances (See Table 1 in Appendix 2), as an example Airedale ranges from 83.75% to 98.44% within this timeframe.

If we compare data for West Yorkshire, Yorkshire and England, the monthly averages show similar trends (i.e. when national rates increase or decrease, local rates tend to follow this same pattern).

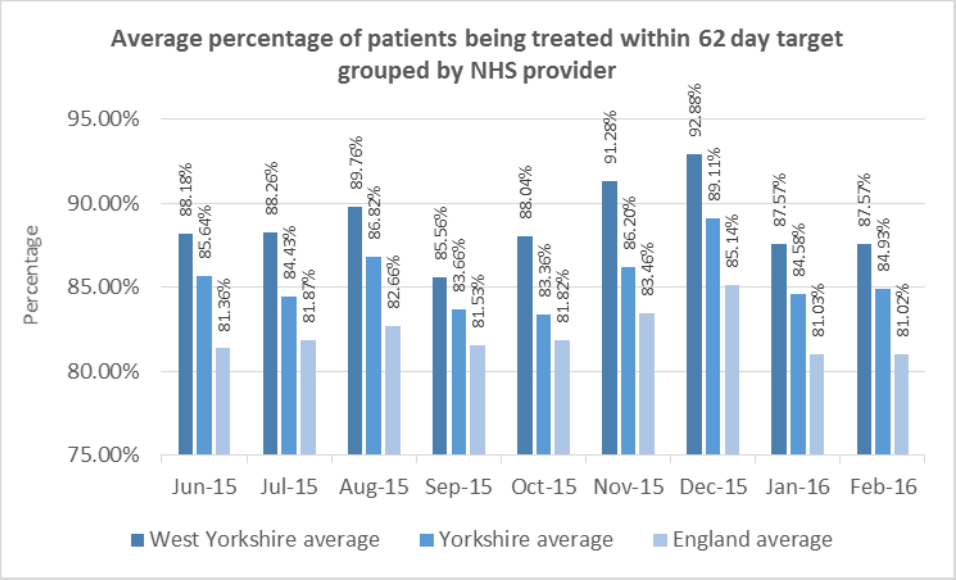

Figure 5: Average percentage of patients receiving first treatment within 62 days of urgent GP referral each month by area[34].

Overall, the data indicates that both Yorkshire and West Yorkshire are performing better than England, with a higher percentage of patients starting treatment within 62 days of an urgent GP referral, and both areas largely exceeding the 85% operational standard. From this it could be suggested that efforts on achieving an earlier diagnosis should be focused on primary care and getting patients referred sooner.

8.4. Patient experience

The National Cancer Patient Experience Survey[35] measures numerous variables by NHS provider. Of particular interest are:

- Question 1: Saw GP once/twice before being told had to go to hospital
- Question 21: Patient given the name of the CNS in charge of their care
- Question 30: Taking part in cancer research discussed with patient
- Question 70: Patient's rating of care 'excellent' / 'very good'

The latest data publically available was published in September 2014[35], however an update is expected in the near future. Data for each West Yorkshire NHS Provider is presented below for each question, along with the averages for West Yorkshire, Yorkshire, and England.

Table 11: Summary of West Yorkshire NHS Provider scores on Question 21 of the 2014 Cancer Patient Experience Survey.

Question 1: Saw GP once / twice before being told had to go to hospital								
	2014 Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored %in highest/lowest 20% of Trusts 2014
Airedale NHS Foundation Trust	74%	68%	80%	72%	79%	94%	193	
Bradford Teaching Hospitals NHS Foundation Trust	75%	69%	81%	72%	79%	94%	212	
Calderdale and Huddersfield NHS Foundation Trust	79%	74%	83%	72%	79%	94%	307	
Harrogate and District NHS Foundation Trust	82%	76%	87%	72%	79%	94%	200	
The Leeds Teaching Hospitals NHS Trust	75%	72%	77%	72%	79%	94%	1,055	
The Mid Yorkshire Hospitals NHS Trust	76%	72%	81%	72%	79%	94%	335	

The averages by area are:

- West Yorkshire = 77%
- Yorkshire = 77%
- England = 75%
- Best in England = 94%

Airedale performed the worst on this question at 74%, Bradford and Leeds were in line with the average for England at 75%. Harrogate performed the best with 82% of patients seeing their GP only once or twice before being told they needed to go to hospital (among the highest 20% of all

Trusts). Overall, the average for Yorkshire sits slightly higher than the average for England, however nearly a quarter of all patients are reporting they go and see their GP three or more times before being referred to hospital.

Table 12: Summary of West Yorkshire NHS Provider scores on Question 21 of the 2014 Cancer Patient Experience Survey.

Question 21: Patient given the name of the CNS in charge of their care								
	2014 Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored %in highest/lowest 20% of Trusts 2014
Airedale NHS Foundation Trust	90%	86%	94%	86%	92%	97%	238	
Bradford Teaching Hospitals NHS Foundation Trust	83%	78%	87%	86%	92%	97%	263	
Calderdale and Huddersfield NHS Foundation Trust	91%	88%	94%	86%	92%	97%	400	
Harrogate and District NHS Foundation Trust	95%	93%	98%	86%	92%	97%	251	
The Leeds Teaching Hospitals NHS Trust	88%	86%	90%	86%	92%	97%	1,325	
The Mid Yorkshire Hospitals NHS Trust	88%	84%	91%	86%	92%	97%	394	

The averages by area are:

- West Yorkshire = 89%
- Yorkshire = 90%
- England = 89%
- Best in England – 97%

Bradford performed the worst on this question at 83% (among the lowest 20% of all Trusts), while Leeds and Mid Yorkshire did not meet the average for England. Harrogate performed the best with 95% of patients being given the name of the CNS in charge of their care (among the highest 20% of all Trusts). Overall, the average for Yorkshire sits slightly higher than the average for England.

Table 13: Summary of West Yorkshire NHS Provider scores on Question 30 of the 2014 Cancer Patient Experience Survey.

Question 30: Taking part in cancer research discussed with patient								
	2014 Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored %in highest/lowest 20% of Trusts 2014
Airedale NHS Foundation Trust	32%	26%	38%	21%	35%	61%	237	
Bradford Teaching Hospitals NHS Foundation Trust	38%	32%	44%	21%	35%	61%	255	
Calderdale and Huddersfield NHS Foundation Trust	36%	32%	41%	21%	35%	61%	390	
Harrogate and District NHS Foundation Trust	30%	24%	36%	21%	35%	61%	236	
The Leeds Teaching Hospitals NHS Trust	48%	45%	50%	21%	35%	61%	1,261	
The Mid Yorkshire Hospitals NHS Trust	30%	26%	35%	21%	35%	61%	391	

The averages by area are:

- West Yorkshire = 36%
- Yorkshire = 30%
- England = 31%
- Best in England = 61%

Harrogate and Mid Yorkshire performed the worst on this question at 30%. Leeds performed the best with 48% of patients reporting having taking part in cancer research discussed with them, and along with Bradford was among the highest 20% of all Trusts. Overall, the average for Yorkshire sits slightly lower than the average for England.

Table 14: Summary of West Yorkshire NHS Provider scores on Question 70 of the 2014 Cancer Patient Experience Survey.

Question 70: Patient's rating of care 'excellent' or 'very good'								
	2014 Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored %in highest/lowest 20% of Trusts 2014
Airedale NHS Foundation Trust	89%	85%	93%	86%	92%	97%	241	
Bradford Teaching Hospitals NHS Foundation Trust	88%	84%	92%	86%	92%	97%	279	
Calderdale and Huddersfield NHS Foundation Trust	89%	86%	92%	86%	92%	97%	410	
Harrogate and District NHS Foundation Trust	94%	91%	97%	86%	92%	97%	249	
The Leeds Teaching Hospitals NHS Trust	87%	85%	89%	86%	92%	97%	1,343	
The Mid Yorkshire Hospitals NHS Trust	88%	85%	91%	86%	92%	97%	419	

The averages by area are:

- West Yorkshire = 89%
- Yorkshire = 90%
- England = 89%
- Best in England = 97%

Leeds performed the worst on this question at 87%, while Bradford and Mid Yorkshire did not meet the average for England. Harrogate performed the best with 94% of patients rating their care as either excellent or very good (among the highest 20% of all Trusts). Overall, the average for Yorkshire sits slightly higher than the average for England.

9. Improvements in treatment are leading to growth in long term survivors

Cancer survival rates are at an all-time high and are improving year on year. One year survival rates tend to be reflective of whether cancer was diagnosed early or not whereas five year survival rates are more reflective of the treatment the patient received along with whether the cancer was diagnosed early. In this next section we will look at one and five year survival rates for some of the most common cancers.

One year survival

One year survival rates are increasing, however survival rates in Yorkshire have not yet caught up with the average rates for England[36] (with the exception of one year lung cancer survival in West Yorkshire). The CCGs in Yorkshire with the highest survival rates (Lung = Bradford District 41.2%, Colorectal = South Tees 79.2% and Breast = Bradford District 97.7%) indicate that one year survival rates can be improved across the region, beyond the national averages for England.

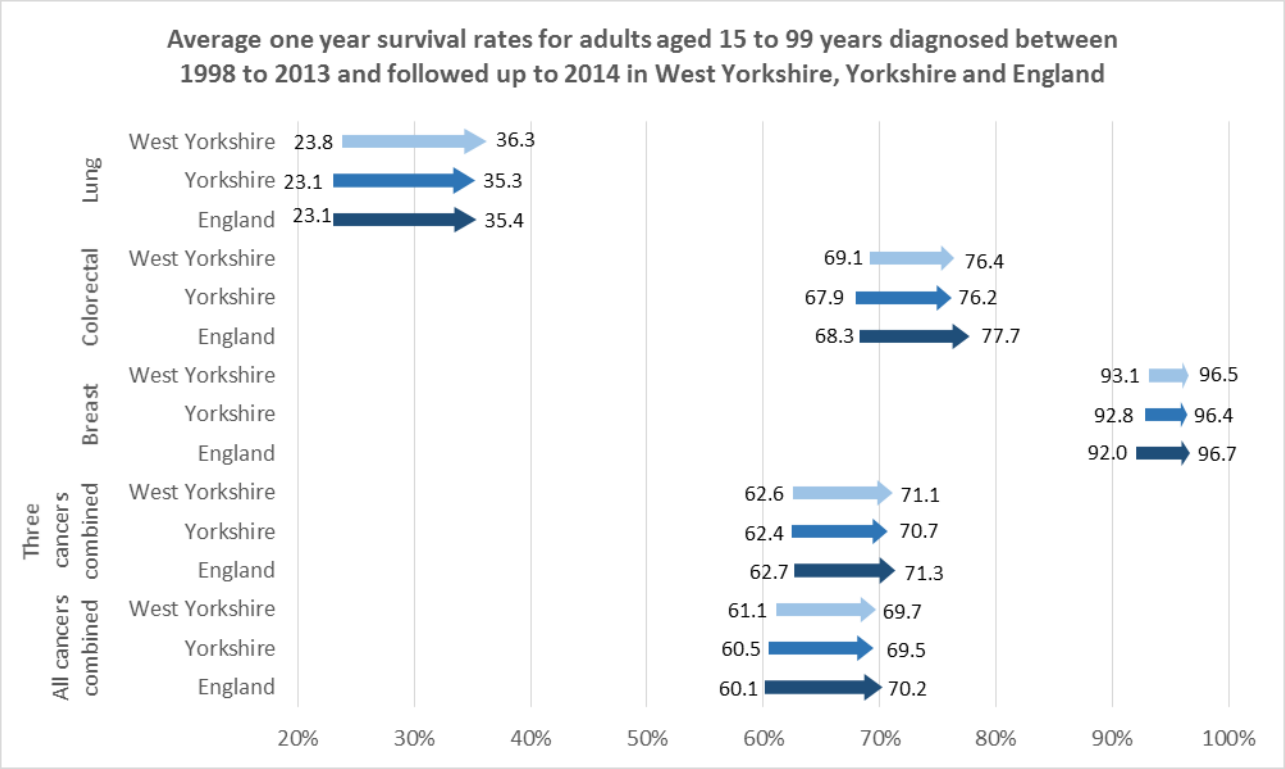

Figure 8: Average one year survival rates for adults aged 15 to 99 years diagnosed between 1998 to 2013 and followed up to 2014[36]. Data is presented for lung, colorectal and breast cancers separately, these three cancers combined, and all cancers.

Five year survival

As with one year survival rates, five year survival rates are also increasing[36]. Five year survival rates across all cancers, and those for breast, colorectal and lung cancers combined ("Three cancers combined") are shown in the figure below. The data shows that there has been around a 7% increase in five year cancer survival for patients diagnosed in 2009 and followed up to 2014, compared to those patients diagnosed in 1998.

To put this into perspective, in 2009 there were 4,921 people diagnosed with breast, colorectal and lung cancers in West Yorkshire. A one year survival rate of 67.2% for patients diagnosed in 2009 means that we would expect that 1,614 patients would have died within the first year. A five year survival rate of 50% of those 4,921 patients diagnosed in 2009, means that we would expect 2,460 patients to have died within five years of diagnosis, 846 of whom would have died after the first year post-diagnosis but within five years of diagnosis. If the five year survival of West Yorkshire (50%) matched the best region in England, Thames Valley at 51.8%, we would expect

that 88 fewer patients would have died from their cancer in West Yorkshire alone. However, had survival rates not improved and remained at the same rate as in 1998 (42.9%) then of the 4,921 patients diagnosed with a combination of breast, colorectal and lung cancer in 2009 a total of 2810 would have died within five years - 350 additional patients. This indicates the huge patient benefit that can be achieved even with small increases in survival rates.

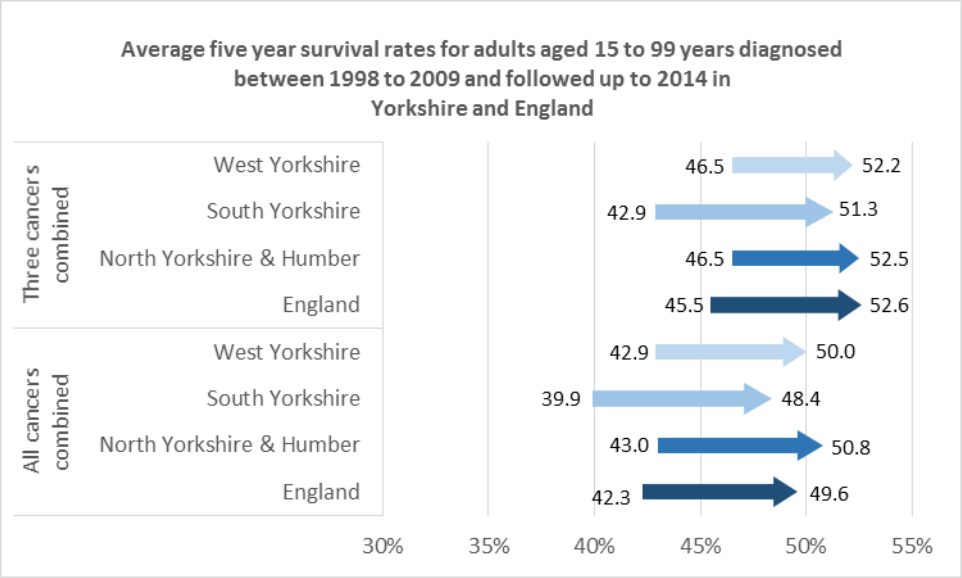

Figure 9: Average five year survival rates for adults aged 15 to 99 years diagnosed between 1998 to 2009 and followed up to 2014[36]. Data is presented for lung, colorectal and breast cancers separately, these three cancers combined, and all cancers.

For all cancers combine, West Yorkshire performs slightly better than England when we look at patients diagnosed in 2009, however the data shows that for the combined five year survival for breast, colorectal and lung cancer, survival in West Yorkshire is slightly lower than the rate in England. When we think about how this compares to other countries, the International Cancer Benchmarking Partnership (ICBP)[37], a global collaboration looking at variations in breast, colorectal, lung and ovarian cancer survival has shown that out of Sweden, Australia, Canada, Norway, Denmark and the UK, the UK has the lowest five year survival rates for breast, colorectal and lung cancer, and the second lowest for ovarian cancer. This indicates that survival rates for Yorkshire and West Yorkshire fall further behind the international comparators than the rates for England.

10. Continuing current models of follow up care for survivors is unsustainable

As the general population ages, there will continue to be more people being diagnosed with cancer. As described above survival rates are increasing, and providing patients receive an early diagnosis and the right treatment for them, we can expect both one year and five year survival to continue to improve. This will mean that more people will be living with and beyond cancer, many of whom may have multiple comorbidities. It is important that every patient has access to a

suitable recovery package and to prepare models of follow up care that are appropriate for patients. The current recommendation is that all patients should have access to the Recovery Package which includes:

- A holistic needs assessment
- A treatment summary
- A cancer care review
- A patient education and support event[38].

To determine how many CCGs were commissioning all four parts of the Recovery Package, in 2014 NHS England commissioned the Living with and beyond Cancer; Baseline Report. Variation between CCGs was found in Yorkshire and the Humber and so the Yorkshire and Humber Strategic Clinical Network for cancer repeated the survey in 2015[39]. Of the 17 CCGs that responded 14 had a cancer strategy that included living with and beyond cancer, however only three were commissioning the whole Recovery Package, while another eight were commissioning elements of the Recovery Package. The conclusions of the survey were as follows:

> *"It is encouraging that most CCGs have a cancer strategy which incorporates Living with and Beyond Cancer and that most CCGs commission the Recovery Package (in part or as a whole), although it is clear from the findings that were are a number of challenges when commissioning services for people Living with and Beyond Cancer, including prioritisation, capacity and system constraints.*
>
> *There are a number of things that can be done at a local, Yorkshire and Humber and national level to overcome some of the barriers to change that have been identified.*
>
> - *Including cancer in work on Long Term Conditions; some people who move beyond active treatment will require minimal long term follow up, while others will have complex health and social care needs. CCGs will increasingly need to consider how the needs of these patients are incorporated into the overall approach to long term conditions.*
> - *Working collaboratively to maximise capacity; CCGs already identified the benefits of working collaboratively and there is the opportunity to work more effectively by pursuing joint work with other CCGs either across Yorkshire and Humber or at a locality level."*

Risk stratified pathways may be one way to effectively reduce follow ups and improve capacity by removing those patients with minimal requirements from the standard follow up pathway. Taking breast cancer as an example, the current model of follow up care involves patients being invited for follow-up hospital appointments for five years after their cancer treatment, and patients may attend up to 15 times for those appointments. This model of care requires a lot of time (of both the patient and the health service), expert resource, may cause anxiety for the patient, and takes some of the responsibility of self-management away from the patient. Furthermore, only 10% of recurrences are identified in a follow-up clinic while 48% are identified by the patient themselves[40].

In order to make better use of its resources, Calderdale and Huddersfield Foundation Trust developed a follow-up education programme for patients at low to moderate risk, alongside Breast Cancer Care and the University of Huddersfield[41]. The programme (called "Moving Forward") consists of four three hour sessions held over consecutive weeks and women are invited as close to completing surgery and radiotherapy as possible. Its implementation means that clinical resources can be focused on patients most in need. After two years an audit of the service showed it reduced overall patient anxiety and the number of routine hospital appointments (the majority of respondents were "very happy" they had not been required to attend any hospital appointments a year after finishing the programme), maintained standards of care, and provided patients with an effective support network.

Initiatives such as these indicate the possibility of alternatives to current models of follow-up care that help alleviate pressure on specialist resources so they can be focused on high risk patients. It also demonstrated that patient safety and quality of care was not compromised and the benefits to women of an education programme that helps them to self-manage their care. The audit concluded that the programme could be transferred to other specialist areas, and rolling out this model of follow up care in breast cancer in other Trusts should be considered.

11. Conclusion

The report gives a brief outline of the many factors that can influence cancer outcomes and attempts to illustrate the potential impact of these factors at a local level across the West Yorkshire region.

It is clear that a holistic approach is needed, and that significant and sustainable improvements in outcomes require changes at all levels of the pathway. To summarise the topics included in this report:

1. **Prevention** – action needs to be taken to help reduce the burden of disease from preventable risk factors for cancer. This report focuses on smoking, alcohol and being overweight, however many other factors such as poor diet and lack of physical activity also contribute.
2. **Screening** – screening rates across the region vary, and even in CCGs where overall screening rates are high, local variation between GP practices still exists. There is a need to close the gap between the worst and the best performing areas.
3. **Early diagnosis** – we know that treatment options and patient survival rates are better when cancer is diagnosed at an early stage, however many patients still present with late stage cancer or through emergency routes. As well as educating people to recognise the signs and symptoms of cancer and transfer recognition into help-seeking behaviour we need to ensure that suitable pathways for diagnosis are in place. These should make the most of resources available across the region and be tailored to the needs of both the patient and healthcare provider.

4. **Follow-up care** – Survival rates will continue to increase as more cancers are diagnosed early and treatments improve. Therefore, more people will be living with and beyond a diagnosis of cancer within the community. Continuing to monitor patient experience will help to identify areas where local providers are not in line with other similar providers. Implementing risk stratified models of follow up care should be considered to help increase clinical resource for patients most in need, and those with multiple long-term conditions.

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13. Appendices

Appendix 1

Methodology for working out patient treatment costs

1. The total number of patients with colon and rectal cancer were calculated for each stage of diagnosis by adding together the figures in columns 1 and 2 of Table 4 in the Incisive Health Report[19].
2. The percentage of the total colon cancers and rectal cancers which were colon cancers was calculated for each stage of diagnosis. The overall percentage of the total number of colorectal cancers which were colon cancers and rectal cancers was also calculated.

Stage	Colon cancer	Rectal cancer	Total
1	2,931 (49.9%)	2,946 (50.1%)	5,877
2	7,237 (74.8%)	2,442 (25.3%)	9,679
3	7,450 (69.5%)	3,267(30.5%)	10,717
4	5,690 (68.6%)	2,607 (31.4%)	8,297
Total	23,308 (67.4%)	11,262 (32.6%)	34,570

3. Using the Yorkshire data from Table 2 in the main report above, the percentages calculated for each stage of diagnosis in step 2 was applied to the Yorkshire data to calculate the estimated number of colon cancers in Yorkshire diagnosed at Stages 1 to 4.

Stage	Total colorectal in Yorkshire	Percentage colon	Estimated number of colon cancers in Yorkshire
1	544	49.9%	271
2	747	74.8%	559
3	823	69.5%	572
4	770	68.6%	528
Total	2,884	67.4%	1,944

4. The proportion of cancers diagnosed at each stage was recorded as outlined in Table 1 in the Incisive Health Report.

Stage	Colon cancer	Rectal cancer
1	13%	26%
2	31%	22%
3	32%	29%
4	24%	23%

5. Using the overall percentage for the proportion of cancers that are colon (67.4%) an estimate for the number of unstaged patients with colon cancer in Yorkshire was calculated. The total number of unstaged colorectal cancer patients was 411, giving an estimated 277 unstaged patients with colon cancer.
6. The proportion of colon cancers diagnosed at each stage as outlined in Step 4 above was applied to the 277 unstaged patients. The total estimated number of patients with colon cancer was then calculated.

Stage	Colon cancer – proportion diagnosed at each stage	Estimation of staging of unstaged patients	Total estimated number of colon patients in Yorkshire
1	13%	36	307
2	31%	86	644
3	32%	89	661
4	24%	66	595
Total		277	2,221

7. Two sets of treatment costs were then calculated (see Table 5 in the main report above):
   - Set 1: using only the known staging data (not including the re-allocated unstaged patients)
   - Set 2: using the known staging data combined with the re-allocated unstaged patients to the proportionally relevant stage.

These steps were then adapted and repeated to calculate the estimated cost of treatment of rectal cancer and NSCLC in Yorkshire, as well as calculating treatment costs across the three cancer types for West Yorkshire.

Methodology for working out differences in patient treatment costs with a higher rate of early stage presentation

1. The additional number of patients with early stage colorectal cancer was calculated for Yorkshire if the region had the staging proportions of the best CCG in England. This gave an additional 482 patients.
2. Using the overall percentage of cancers which are expected to the colon cancers (67.4%) the estimated number of colon cancers was 325.
3. The staging proportions given in Table 1 of the Incisive Health Report were then used to assign the relative proportion given that all 325 cancers needed to be assigned to either stage 1 or stage 2. This was done by totalling the sum of the stage 1 (13%) and 2 (31%) proportions (44%) and then dividing the individual percentages by the total (13/44 and 31/44 respectively) to give relative proportions of 30% and 70%.
4. The estimated number of stage 1 colon cancers was defined as 30% of 325 and the estimated number of stage 2 colon cancers was defined as 70% of 325.
5. The costs of treatment by stage (including the cost of recurrence) were then used to calculate the cost of treating the 325 additional colon cancer patients.
6. The same methodology was then applied to find out how much the treatment costs for the patients would have been if those 325 cancers had been diagnosed at stage 3 or 4.
7. The difference in costs was calculated by subtracting the cost of treatment at stage 3 and 4, from the cost of treatment at stage 1 and 2 and is presented in Table 8 above.

Appendix 2

NHS Provider - Table 1

	NHS Provider						Area average		
Month	Airedale NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Calderdale and Huddersfield NHS Foundation Trust	Harrogate and District NHS Foundation Trust	Leeds Teaching Hospitals NHS Trust	Mid Yorkshire Hospitals NHS Trust	**West Yorkshire average**	**Yorkshire average**	**England average**
Jun-15	89.53%	88.59%	89.83%	89.80%	79.57%	91.75%	**88.18%**	**85.64%**	**81.36%**
Jul-15	91.86%	89.62%	89.42%	87.22%	81.66%	89.75%	**88.26%**	**84.43%**	**81.87%**
Aug-15	93.59%	85.82%	93.18%	92.66%	82.81%	90.48%	**89.76%**	**86.82%**	**82.66%**
Sep-15	88.57%	86.90%	90.07%	83.13%	80.16%	84.50%	**85.56%**	**83.66%**	**81.53%**
Oct-15	83.75%	90.57%	91.93%	91.89%	86.28%	83.82%	**88.04%**	**83.36%**	**81.82%**
Nov-15	94.00%	90.65%	95.54%	93.86%	85.14%	88.46%	**91.28%**	**86.20%**	**83.46%**
Dec-15	98.44%	93.01%	95.32%	94.57%	85.58%	87.36%	**92.88%**	**89.11%**	**85.14%**
Jan-16	89.69%	89.10%	90.41%	86.02%	86.43%	83.75%	**87.57%**	**84.58%**	**81.03%**
Feb-16	87.50%	91.67%	94.62%	85.86%	86.10%	76.44%	**87.57%**	**84.93%**	**81.02%**
Total average	**91.18%**	**89.28%**	**91.96%**	**89.89%**	**83.45%**	**87.48%**	**88.94%**	**85.48%**	**82.36%**

Clinical Commissioning Group – Table 2

	Clinical Commissioning Group											Area average		
Month	NHS Airedale, Wharfedale and Craven CCG	NHS Bradford City CCG	NHS Bradford Districts CCG	NHS Calderdale CCG	NHS Greater Huddersfield CCG	NHS Harrogate and Rural District CCG	NHS Leeds North CCG	NHS Leeds South and East CCG	NHS Leeds West CCG	NHS North Kirklees CCG	NHS Wakefield CCG	**West Yorkshire average**	**Yorkshire average**	**England average**
Jun-15	87.80%	100.00%	86.11%	85.71%	86.79%	91.11%	76.92%	87.23%	84.93%	86.05%	89.39%	**87.46%**	**85.52%**	**81.18%**
Jul-15	90.00%	90.91%	87.01%	82.69%	89.36%	82.46%	88.89%	87.50%	84.62%	86.84%	89.41%	**87.24%**	**85.07%**	**81.63%**
Aug-15	90.70%	75.00%	86.15%	90.63%	86.96%	94.44%	80.65%	91.30%	90.77%	92.59%	86.67%	**87.81%**	**85.63%**	**82.44%**
Sep-15	90.24%	100.00%	85.92%	80.56%	89.80%	80.00%	80.49%	88.89%	86.11%	67.86%	84.93%	**84.98%**	**83.37%**	**81.35%**
Oct-15	89.13%	71.43%	88.57%	93.18%	88.64%	89.36%	100.00%	86.00%	90.00%	75.00%	86.42%	**87.07%**	**83.25%**	**81.66%**
Nov-15	95.45%	95.71%	87.69%	100.00%	92.59%	90.70%	95.24%	80.39%	90.77%	88.89%	86.42%	**91.26%**	**86.76%**	**83.30%**
Dec-15	100.00%	89.89%	87.72%	100.00%	96.29%	92.98%	94.87%	85.71%	85.42%	88.00%	85.14%	**91.37%**	**88.97%**	**84.97%**
Jan-16	86.00%	69.23%	93.10%	87.80%	87.18%	86.36%	95.00%	88.46%	90.63%	83.33%	81.03%	**86.19%**	**84.66%**	**80.84%**
Feb-16	90.91%	90.91%	89.83%	94.44%	88.57%	82.22%	87.50%	91.11%	89.29%	59.09%	78.46%	**85.67%**	**84.18%**	**80.82%**
Total average	**91.17%**	**86.52%**	**87.78%**	**90.07%**	**89.70%**	**88.43%**	**89.01%**	**86.94%**	**87.91%**	**83.57%**	**86.18%**	**87.92%**	**85.40%**	**82.17%**

Cancer in West Yorkshire

Prepared by: Leah Simmons, Cancer Information Analyst

Date: 19 January 17

About Yorkshire Cancer Research

Our vision

Every single person in every community in and around Yorkshire has the very best chance of living a long and healthy life with, without and beyond cancer.

Our purpose

Helping people in and around Yorkshire to avoid, survive and cope with cancer.

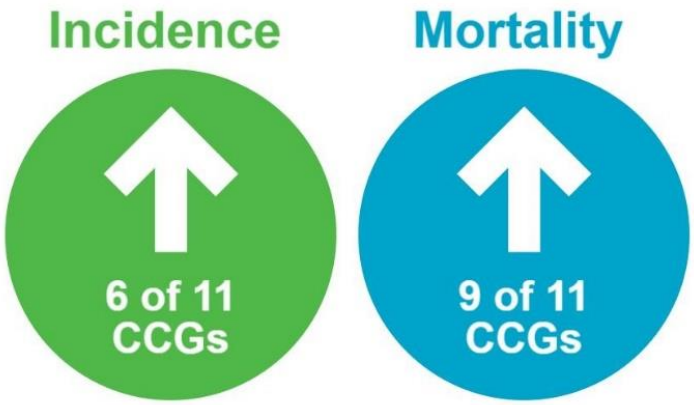
Our core theme is to improve cancer outcomes by:

- Closing the gap (between Yorkshire and the rest of England)
- Going beyond (making Yorkshire a beacon region for patient-centred research).

Incidence and mortality

In 2013 in West Yorkshire:

13,023 new cases of cancer were diagnosed



6,028 people in the region died from cancer

Incidence and mortality

yorkshire cancer research

Each week 250 people in West Yorkshire are diagnosed with cancer

Each week 115 people in West Yorkshire die from cancer

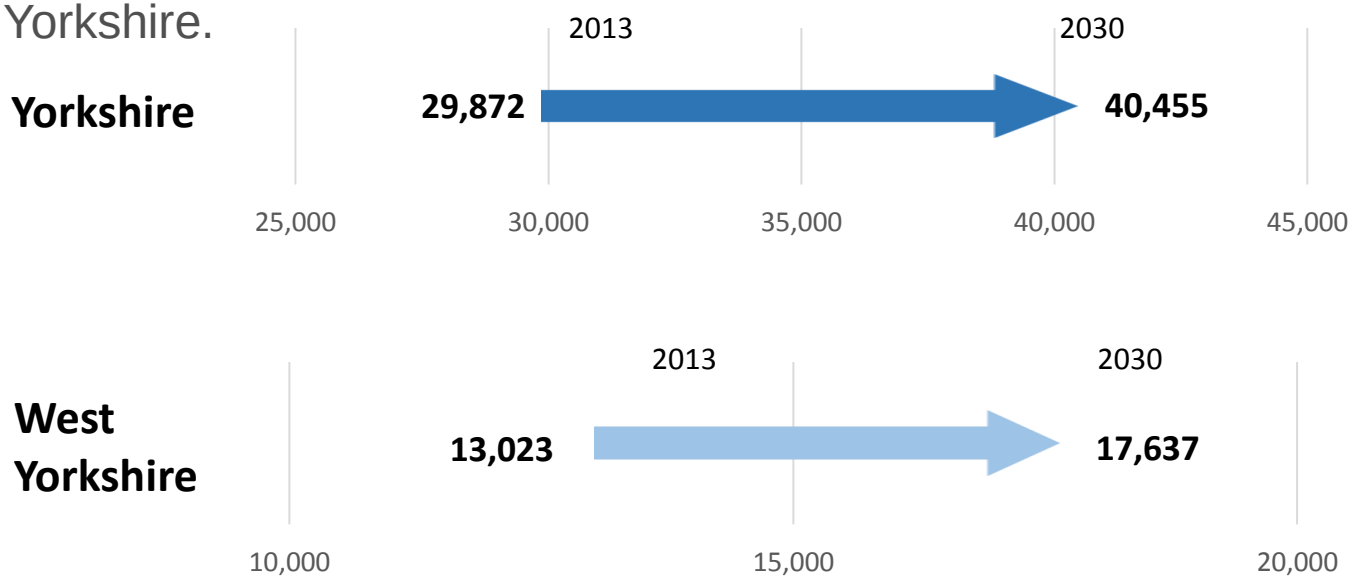
Lung cancer is West Yorkshire's most common cancer – it is the third most common in England.

Around **69,000 people** in the West Yorkshire region are currently living with or beyond cancer.

Cancer in 2030

The number of new cancer cases diagnosed each year is increasing year on year.

- By 2030, the annual number of new cases in England is expected to reach over 360,000 and a similar rate of increase is expected in Yorkshire.



Cancer in 2030

The prevalence of having or having had a diagnosis of cancer will also increase.

By 2030, it's estimated that an **additional 48,000 people** in West Yorkshire alone will be living with or beyond cancer:

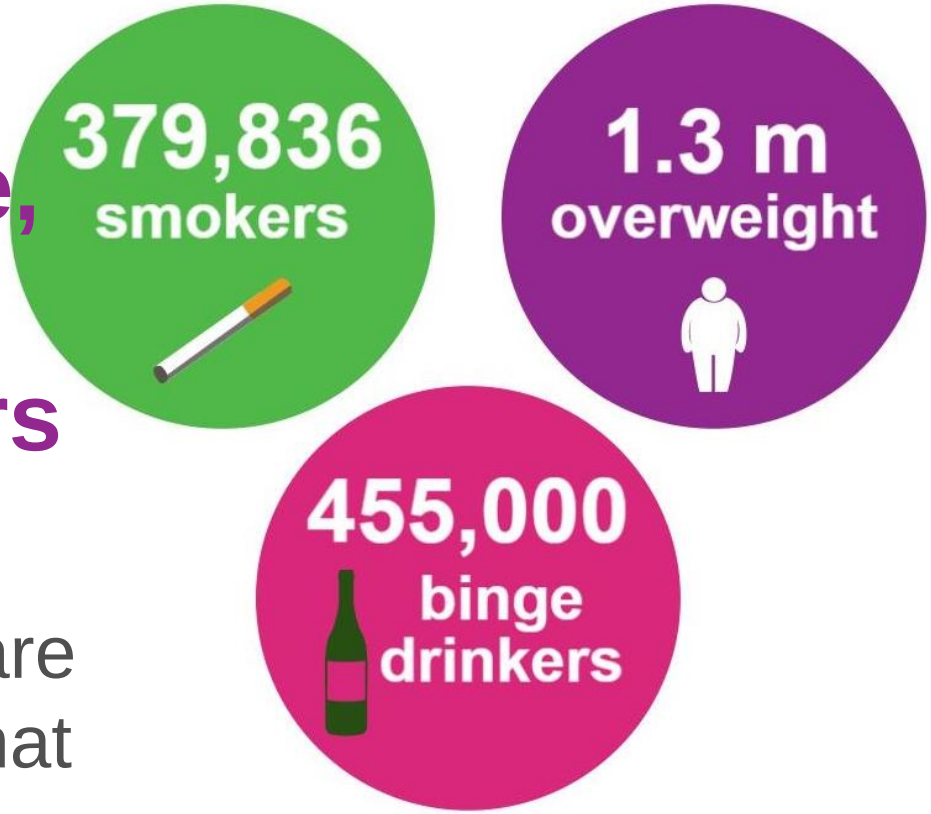
69,000 to 117,000 people

For Yorkshire this figure could rise from 150,000 to 255,000.

Preventable risk factors

42% of cancers are preventable:

12,500 Yorkshire, or 5,470 West Yorkshire cancers per year



Large number of people are engaging in behaviours that are preventable risk factors for cancer.

Preventable risk factors

Tobacco

- **20.1%** of population in West Yorkshire are smokers.
- Leading preventable cause of cancer - caused an estimated **2,300 cancers** in 2010 (19% of all cancers).
- Two-thirds of long-term smokers will die as a result of smoking if they do not quit.
- Costs society around **£646.1m** each year.
- Cancer Taskforce – achieve rates of 13% by 2020 and 5% by 2030.

Overweight and obesity

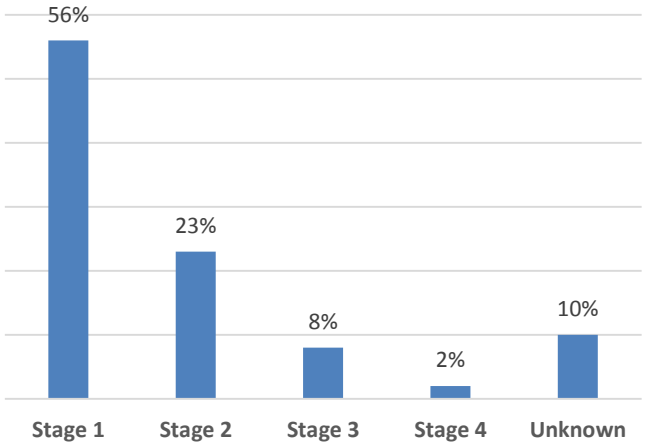
- **65.2%** of population in West Yorkshire is overweight or obese.
- Caused an estimated **668 cancers** in 2010 (5% of all cancers).
- Second most preventable cause of ill health and death after smoking.
- Cost the NHS in Leeds an estimated **£219.1m** in 2015.

Alcohol

- **22.7%** of population in West Yorkshire regularly binge drink.
- Caused an estimated **486 cancers** in 2010 (4% of all cancers).
- Awareness of link between alcohol and cancer is low.

Screening

- Significant variation in screening uptake across the West Yorkshire region.
- Bradford City has particularly poor uptake – links with deprivation and BME communities.
- Breast cancer screening rates are at a ten year low and are falling faster in Yorkshire than any other region in England.



65,787 women in Yorkshire have NEVER been screened for breast cancer

= 513 cancers

Early diagnosis – cost of treatment

Cost of treatment by stage of diagnosis

	Colon cancer	Rectal cancer	Non-small cell lung cancer (NSCLC)
Stage 1	£3,373	£4,449	£5,328
Stage 2	£7,809	£6,944	£10,217
Stage 3	£9,220	£8,302	£11,207
Stage 4	£12,519	£11,815	£15,081

Early diagnosis – cost of treatment

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Estimated costs of treatment by stage of diagnosis in Yorkshire and West Yorkshire

Estimated cost – based on un-staged patients re-allocated to stage			
	Colon	**Rectal**	**NSCLC**
Yorkshire			
Stage 1	£1,036,576	£1,368,220	£5,824,840
Stage 2	£5,032,141	£1,513,425	£3,302,864
Stage 3	£6,092,156	£2,405,468	£7,967,989
Stage 4	£7,443,025	£3,222,679	£30,674,449
Total	**£19,603,899**	**£8,509,792**	**£47,770,143**
West Yorkshire			
Stage 1	£454,679	£601,417	£3,056,749
Stage 2	£2,094,264	£629,640	£1,404,970
Stage 3	£2,500,058	£987,639	£3,087,290
Stage 4	£3,252,986	£1,408,302	£13,297,710
Total	**£8,301,987**	**£3,626,999**	**£20,846,719**

Early diagnosis – cost of treatment

Cost of treatment by matching the best in England stage of diagnosis profile

- If all CCGs in Yorkshire achieved the same rates of early stage diagnosis as the best CCG in England, the following differences in cost of treatment could be r

	West Yorkshire	Yorkshire
Colon cancer	- £621,653	- £1,732,004
Rectal cancer	- £322,729	- £899,163
NSCLC*	£386,744	£1,129,095
Total	**- £557,638**	**- £1,502,072**

* NSCLC – high level of recurrence leads to a cost increase, however shift to earlier diagnosis would be cost efficient – survival rates would improve leading to a gain in additional life years so many patients would benefit.

Other ways to achieve early diagnosis

- Raising awareness through campaigns such as Be Clear on Cancer.
- Increasing engagement with GPs and HCPs.
- Increasing access to diagnostic tests for primary care practitioners
- Planning diagnostic capacity and making effective use of resources across the region.
- Rapid yes/no answer for patients (decision to treat made within 28 days of GP referral).

Other ways to achieve early diagnosis

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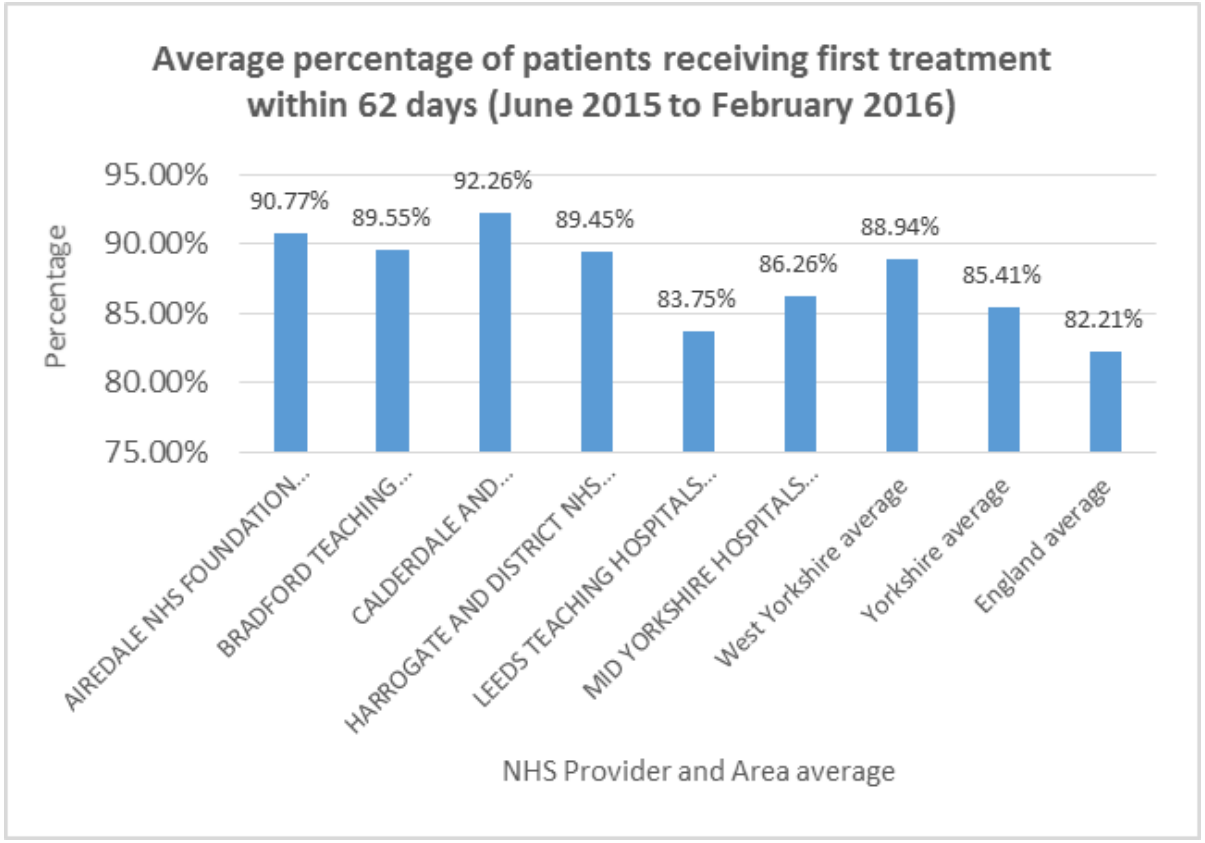
Danish Model – three-legged strategy

- **Urgent referral pathway** – when there is an obvious cancer suspicion the patient is referred to a specific pathway.
- **Urgent referral for unspecified serious symptoms** – when cancer is one of several possibilities patients can be referred to a diagnostic centre. The centre takes on diagnostic responsibility for the patient.
- **The NYC** – for common symptoms. The GP retains responsibility of diagnosis but they have fast and direct access to tests.

Cancer waiting times

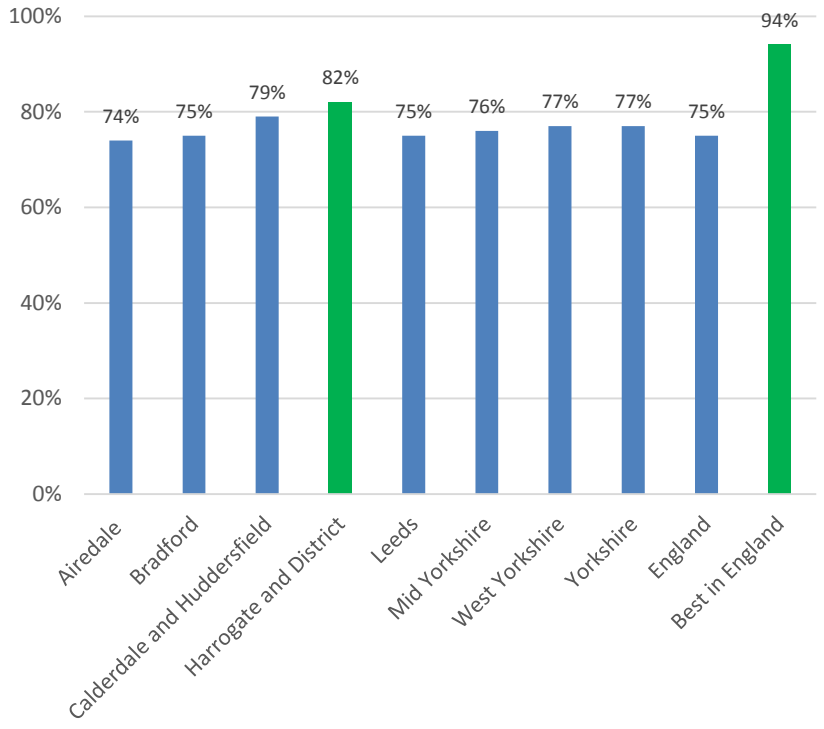
62 day wait

- Maximum of two months from an urgent GP referral for suspected cancer to first treatment.
- Operational standard of 85%.

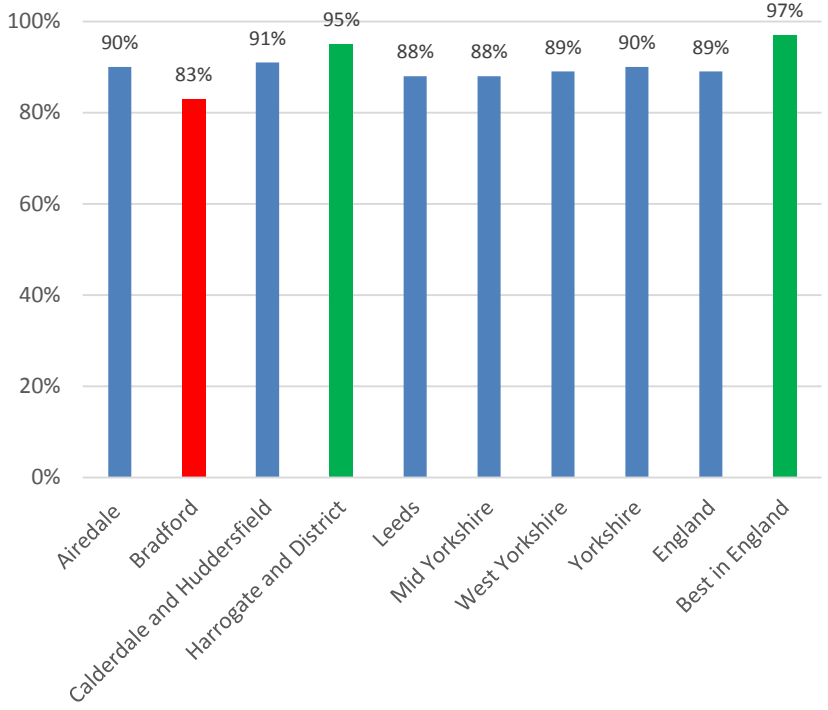


Patient experience

1. One or two GP visits before referral

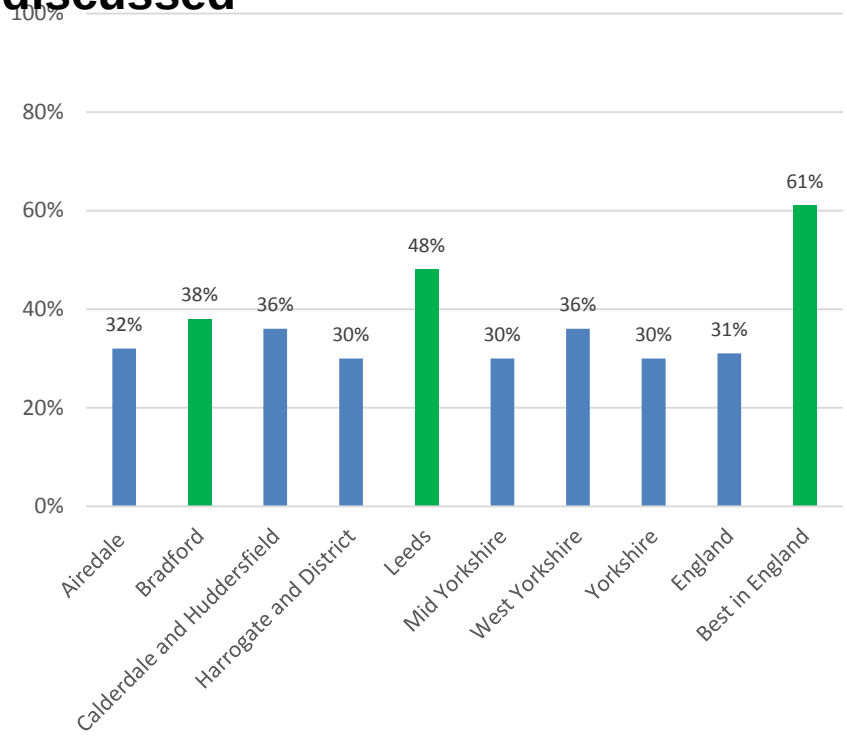


21. Patient given name of CNS

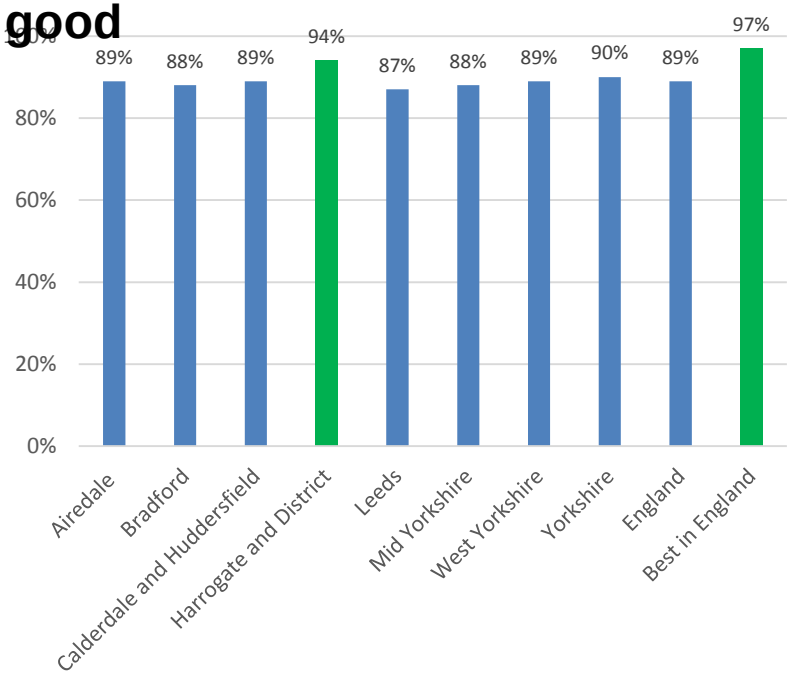


Patient experience

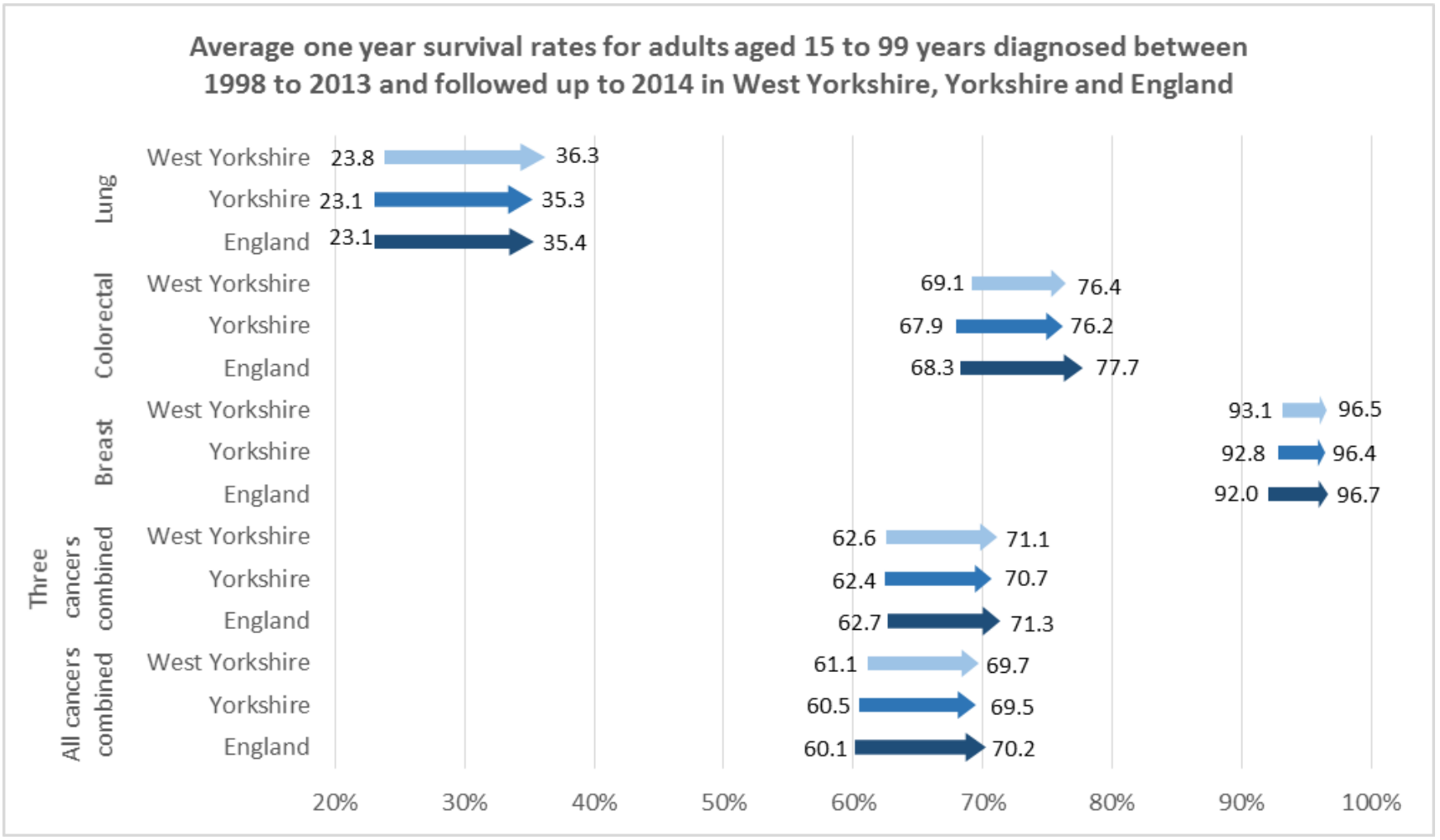
30. Taking part in cancer research discussed



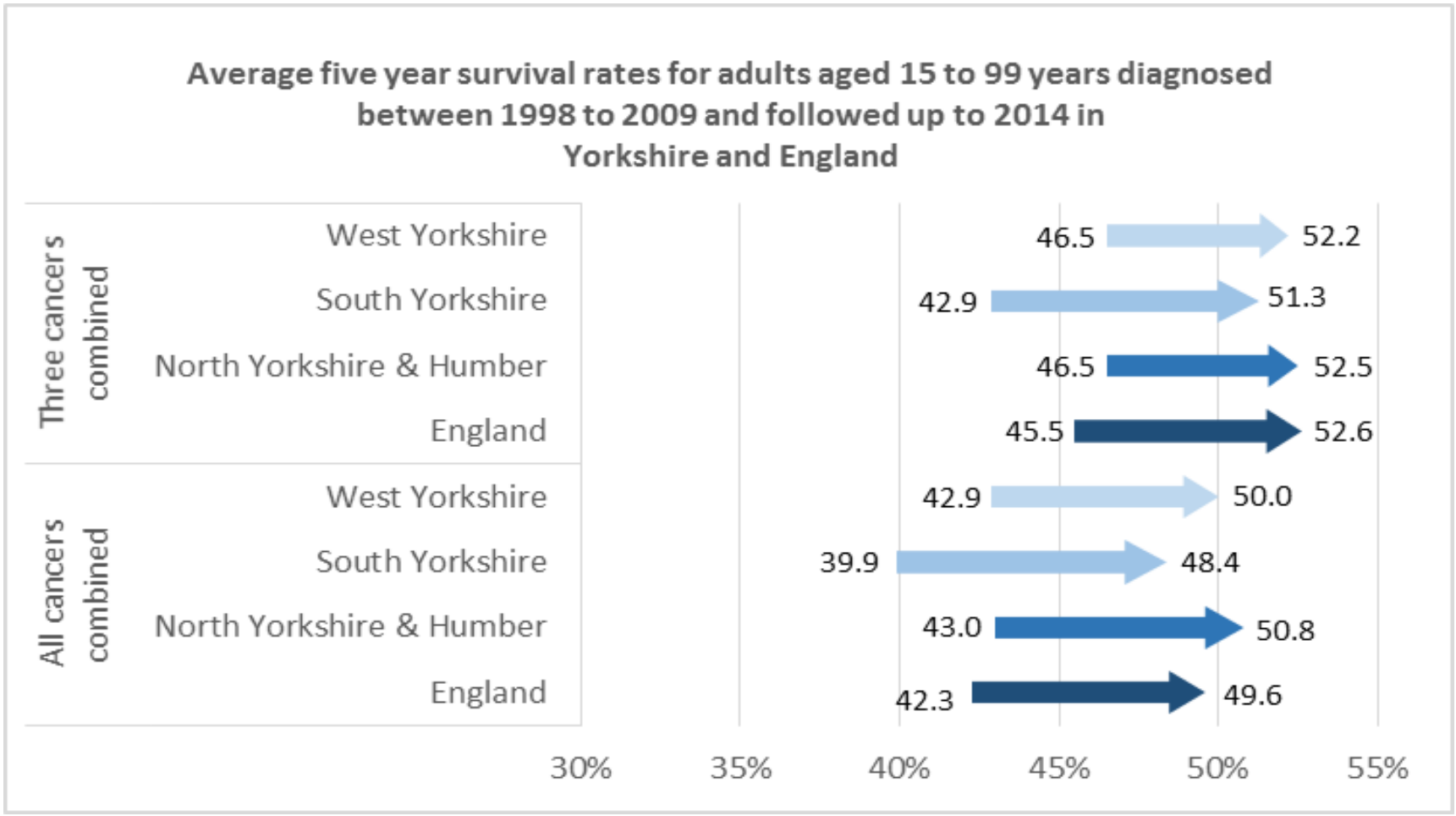
70. Care rated as excellent or very good



Survival – one year



Survival – five year



Living with and beyond cancer

Recovery Package

- Support CCGs to adopt a cancer strategy which incorporates living with and beyond cancer and deliver all elements of the Recovery Package.
- Risk stratified pathways could help to reduce follow ups and improve capacity for those patients that need it most.
- Follow-up education programme for low to moderate risk breast cancer patients implemented for patients at Calderdale and Huddersfield Foundation Trust

Summary

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Key points

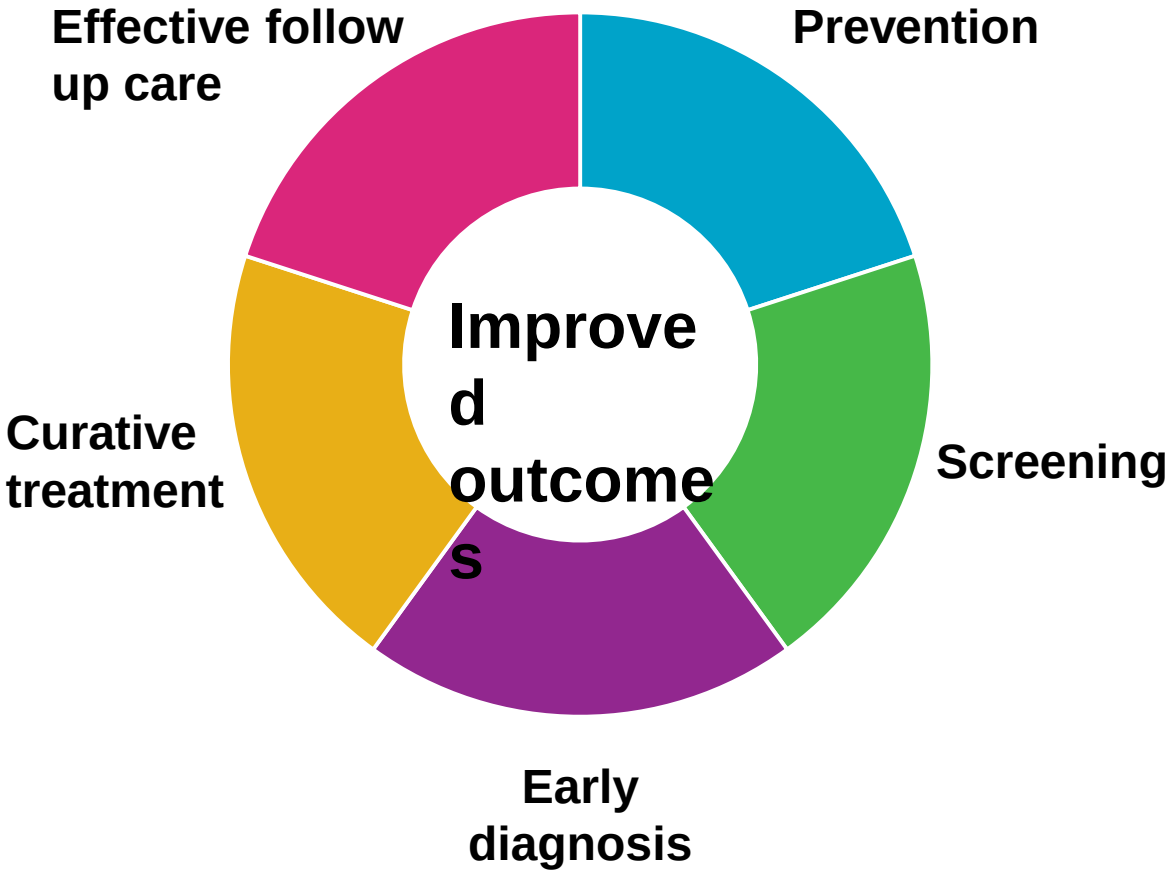
- Lung cancer incidence and mortality is significantly higher in West Yorkshire than England and disproportionately affects our most deprived groups.
- However, lung cancer survival in West Yorkshire is similar or better than average.
- Smoking rates in West Yorkshire remain significantly higher than England.
- West Yorkshire has a higher proportion of cancers diagnosed via the emergency route than average.
- Parts of West Yorkshire have some of the lowest cancer screening uptake in the country.

Summary

Address the issues that are impacting cancer outcomes from across the pathway

- Identify local requirements for tackling lifestyle related risk factors.
- Reduce the variation in screening uptake and for all areas to surpass national averages.
- Break down barriers to accessing the healthcare system and giving patients a fast cancer diagnosis.
- Implementing evidence based changes to improve capacity, resources and patient pathways in relation to diagnosis, treatment and follow up care.

Summary


Effective follow up care
Prevention
Improved outcomes
Curative treatment
Screening
Early diagnosis

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 23 January 2017

Subject: Scrutiny of Access to NHS Dental Services

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. Currently, accessing routine NHS dental services is difficult for some people in West Yorkshire, particularly in Bradford and north Kirklees areas. NHS England also report that demand for unscheduled dental care (UDC) in West Yorkshire is rising year on year, an indication that an increasing number of people have to access emergency dental services because they can't get registered with an NHS dentist. This has resulted in a UDC overspend of £1.5m across West Yorkshire (2014/15). UDC services are due to be re-contracted in 2017 [1].

2. At its previous meeting, the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC) agreed to include 'Access to NHS Dental Services' as part of its forward plan.

3. Draft Terms of Reference for this specific scrutiny activity are appended to this report for consideration and agreement.

Recommendations

4. That, subject to any identified amendments, the Joint Committee considers and agrees the draft Terms of Reference for in relation to Access to NHS Dental Services.

Background documents[2]

[1] Report of NHS England – North (Yorkshire and Humber) to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 06 October 2016: Dental Commissioning Update https://bradford.moderngov.co.uk/documents/s11059/Hlt6OctDocM.pdf

[2] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include

5. None.

West Yorkshire Joint
Health Overview and Scrutiny Committee

Scrutiny of Access to NHS Dental Services

1. Background

1.1 Currently, accessing routine NHS dental services is difficult for some people in West Yorkshire, particularly in Bradford and north Kirklees areas. NHS England also report that demand for unscheduled dental care (UDC) in West Yorkshire is rising year on year, an indication that an increasing number of people have to access emergency dental services because they can't get registered with an NHS dentist. This has resulted in a UDC overspend of £1.5m across West Yorkshire (2014/15). UDC services are due to be re-contracted in 2017 [1].

1.2 In response to concerns raised directly by patients, access issues have also been highlighted by both local and national Healthwatch organisations (see Key Documents section 4 below).

1.3 On 6 October 2016 NHS England reported to Bradford Council Health and Social Care Overview and Scrutiny Committee that it had established a task and finish group to look at how to improve access to NHS dental services and UDC across West Yorkshire. While the group had proposed a number of pilot projects to improve access in West Yorkshire, particularly for vulnerable groups and people in Bradford and north Kirklees, a decision had been made not to proceed due to resource constraints and to allow for work to take place comparing West Yorkshire to other areas of Yorkshire and Humber.

1.4 The Bradford Council Health and Social Care OSC resolved:

(*1) That the Committee expresses its disappointment that no action has been taken by NHS England to progress the pilot scheme in Bradford as put forward by the NHS England Task and Finish Group.*

(2) That the Committee's Members of the West Yorkshire Joint Health Overview and Scrutiny Committee (WYJHOSC) raise the issue of access to NHS Dentistry to be considered at a sub-regional level.

1.5 In line with resolution (2) above, a Committee Member raised the issue at the meeting of the WYJHOSC held on 18 November 2016. It was agreed that the issue be included in the forward plan for the Joint Committee.

[1] Report of NHS England – North (Yorkshire and Humber) to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 06 October 2016: Dental Commissioning Update https://bradford.moderngov.co.uk/documents/s11059/Hlt6OctDocM.pdf

2. Key Lines of Enquiry

The proposed key lines of enquiry are:

2.1 To receive an update on the work of the task and finish group, including any proposed pilot projects;

2.2 To receive information on demand for, and provision of, unscheduled dental care and proposals for the re-contracting of the service;

2.3 To examine the impact/pressures on other parts of the health and care system when people are unable to access routine NHS dental care;

2.4 To explore possible new models for delivering dental care in communities.

3. Indicative list of interested parties

- NHS England – North (Yorkshire and Humber)
- West Yorkshire Healthwatch organisations
- Local Dental Committees (dentists)
- Local Care Direct (111 service)
- Yorkshire Ambulance Service
- Clinical Commissioning Groups (primary care and accident and emergency leads)
- Sustainability and Transformation Plan leadership

4. Key Documents

- Report of NHS England – North (Yorkshire and Humber) to the meeting of the Bradford Council Health and Social Care Overview and Scrutiny Committee to be held on 06 October 2016: Dental Commissioning Update.

- Report of Healthwatch Bradford and District to the meeting of the Bradford Council Health and Social Care Overview & Scrutiny Committee to be held on 6th October 2016: Access to NHS Dentistry in Bradford District.

- 'Why can't I find an NHS dentist in Kirklees?' Healthwatch Kirklees (2014).

- 'Access to NHS Dental Services: What people told local Healthwatch' – Healthwatch England Evidence Review (November 2016).

5. Indicative arrangements and timescale

5.1 It is proposed to hold a special, single issue meeting of the WYJHOSC to be held in Bradford before the end of April 2017.

5.2 The Committee will receive reports and make any recommendations it considers appropriate.

5.3 The Committee will consider the most appropriate approach and timing for receiving responses to any agreed recommendations and subsequent progress monitoring. This may include monitoring progress via regular business meetings of the WYJHOSC.

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 23 January 2017

Subject: Work Programme

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The Draft West Yorkshire and Harrogate Sustainability and Transformation Plan (WY&H STP) was submitted to NHS England on 21 October 2016. The draft plan, alongside a public summary for consultation, was subsequently published on 10 November 2016.

2. The WY&H STP was subsequently considered at the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) at its meeting on 18 November 2016.

3. The WY&H STP highlighted that over recent months the leadership and staff of the West Yorkshire and Harrogate health and care organisations have been working together on how to respond to the significant health and care challenges faced across West Yorkshire and Harrogate.

4. The WY&H STP also highlighted that, while underpinned by the six locality plans (covering Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield), a range of work / activity was also being undertaken collectively, across the wider STP area. This work / activity being determined by one or more of the following:

    - Services cut across the area and beyond the six local places.
    - There is benefit from doing the work once and sharing, so we make the best use of the skill and expertise we have.
    - Working together can deliver a greater benefit than working separately.

5. On this basis, the following areas / priorities have been identified in the WY&H STP:

    - Prevention
    - Primary and community services
    - Mental health
    - Stroke
    - Cancer
    - Urgent and emergency care
    - Specialised services
    - Hospitals working together
    - Standardisation of commissioning policies.

6. It is proposed to base the majority of the Joint Committee's future work programme around the nine priority areas identified above, taking account of the key milestones within each project area. However, as plans within the priority areas are still under development, it remains difficult to identify key milestones at this time to inform the development of an outline work programme.

7. Nonetheless, in the absence of any outline project plans, the Joint Committee may wish to set out a provisional work programme, whereby 2 or 3 priority areas are considered on a rolling basis. The Joint Committee will also need to consider the frequency of future meetings and the resources available to support its work programme.

Other areas / issues

8. While it is proposed to develop a future work programme around the key milestones within each of the nine WY&H STP priority areas identified above, there remains an opportunity to incorporate other specific areas within the overall work programme.

9. For example, based on discussion at the meeting in November 2016, the Joint Committee previously identified the following areas / matters for the work programme:

    - Autism;
    - Access to NHS dental services; and,
    - The development of the WY&H STP governance arrangements

10. Prior to the development of the WY&H STP, the Joint Committee had also previously identified work around the Urgent and Emergency Care Vanguard and the West Yorkshire Association of Acute Trusts (WYAAT) for specific consideration. It should be recognised that these areas may form part of the nine priority areas with the STP.

Recommendations

11. That the Joint Committee considers the details presented in this report and determines how its future work programme should be developed.

Background documents[1]

12. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.