



LEICESTERSHIRE

JOINT STRATEGIC NEEDS ASSESSMENT

March 2012

Cancer

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1. INTRODUCTION

About one person in three in England develops cancer sometime in their life and more than one in four die from cancer, making it the second most common cause of death after circulatory diseases.

Cancer is the most common reason for people in our population to die prematurely, with two fifths of all premature deaths due to cancer (40%)¹. Reducing premature deaths from cancer will increase life expectancy and help to reduce health inequalities.

Information from the International Cancer Benchmarking Project shows that England has poorer survival rates for colorectal, lung, breast and ovarian cancer compared with other (non-UK) countries in the study². Australia, Canada and Sweden had the best survival. Much of the difference in 5-year survival for each cancer can be attributed to poor one-year survival in England. Although the survival gap has narrowed for breast and ovarian cancer, it has remained broadly similar for colorectal and lung cancer.

Although cancer services have improved for everyone, the progress made in achieving better cancer outcomes has been uneven. We know that inequalities between different groups of people persist: in incidence, access to services and treatment, patient experience and outcomes.

2. KEY ISSUES AND GAPS

There are five key areas to consider in order to reduce the rate at which people die from cancer and to help those sections of population with most need improve fastest:

2.1 Intelligence

Commissioners need the detail to be able understand which cancers are killing local people disproportionately, how well people with cancer are being treated and whether the local situation is different from that in similar areas. There are often significant gaps in cancer data collection e.g. measures of differences in survival rates among different social groups³

Data is key if commissioners are to describe the problem, understand the reasons underlying the problem, act, monitor and evaluate in response to those problems:

Quantitative data: needs to be timely and differentiated by:

- Cancer type (including rare tumours)
- Stage
- Cancer survival
- Age (under 75/over 75 years of age)
- Gender
- Ethnic minority
- Disability
- Social deprivation

- Sexuality
- Geographical area (including rurality, local authority, PCT cluster, super output areas, GP practice)

One-year survival rates are the fundamental to understanding the issues and local needs⁴. Much of the difference in five-year survival for each cancer can be attributed to poor one-year survival in England compared to the rest of Europe, and benchmarking highlights the need for local action.

Qualitative data: is important in understanding patient behaviour in relation to risks for cancer and uptake of cancer screening and other health services. Patient feedback is also essential to help monitor quality of current provision of cancer services.

2.2 Prevention and early diagnosis

Prevention

It is estimated that half of all cancers could be prevented by positive lifestyle choices. These measures include⁵:

- Not smoking (this reduces the risk of lung cancer, mouth cancer, bladder cancer and cervical cancer in particular). Smoking is one of the biggest preventable risk factors for many cancers. (See JSNA Staying Healthy chapter).
- Reducing alcohol intake (this reduces the risk of liver cancer, oesophageal cancer and bowel cancer) (See JSNA Staying Healthy chapter)
- Maintaining a healthy body weight (this reduces the risk of breast cancer in women after the menopause and bowel cancer) (See JSNA Staying Healthy chapter)
- Eating a healthy and balanced diet high in fruit and vegetables (this reduces the risk of colorectal cancer, stomach cancer and breast cancer)
- Keeping active (this reduces the risk of breast cancer and bowel cancer)
- Safe sun exposure (this reduces the risk of skin cancer such as malignant melanoma)

Secondary prevention⁶: There is also increasing evidence that lifestyle changes can reduce the risk of recurrence for cancer survivors, the impact of side effects of treatment and the burden of cancer survivors on the NHS and the benefits system. The clearest evidence for the impact on survival of lifestyle interventions following cancer diagnosis is for physical activity for survivors of breast cancer, colorectal cancer and prostate cancer.

Prevention-screening: It is vital that commissioners work to enhance the delivery of National Cancer Screening Programmes in Leicestershire. In particular commissioners must endeavour to improve access to and uptake of screening for cancers such as breast cancer, cervical cancer and colorectal cancer.

Early Diagnosis

Evidence⁴ indicates that the high rate of avoidable deaths from cancer in England is due to people being diagnosed with cancer when their tumour is at a stage when life-saving (usually surgical) treatment will not contain its impact and spread. The delay can happen at a number of points and for a number of reasons.

Cancer mortality and survival rates will be improved by increasing symptom awareness, ensuring access to screening programmes and ensuring prompt and appropriate referral for people identified as potentially having cancer. Commissioners will want to work with patients and primary care providers particularly to improve early awareness and diagnosis of cancer:

There is a need to:

- raise awareness of several cancer warning signs and risk factors, especially in more deprived and in certain ethnic groups in the UK, to facilitate improvements in early presentation and cancer prevention behaviours
- address barriers to seeking help, such as fear and lack of confidence to discuss symptoms with GPs*
- ensure that primary care is responsive when patients present with signs and symptoms suggestive of possible cancer
- increase awareness of and uptake of National Cancer Screening Programmes

* Cancer is generally still regarded by a significant part of the population as a death sentence, and relatively few people are aware of the chances of survival with good quality of life, and even 'cure', particularly when detection is early, and treatment prompt⁴. Cancer Research UK has undertaken research into this area with the 'Fear survey' and found that lower socio-economic groups are more afraid of cancer than higher socio-economic groups and more likely to think that whether or not you get cancer is down to fate. An important step in tackling fear is presenting positive images of people's experience of surviving cancer.

2.3 Better Treatment

Commissioners will want to ensure that patients have timely access to high quality, clinically effective and cost effective treatments and care for all cancers, at every stage of the cancer journey, including delivery of waiting time standards, expansion in capacity and the effectiveness of radiotherapy services through to end of life (including End of Life Care-see 'End of Life' JSNA chapter).

Examples of possible quality measures in secondary cancer services include:

- Range of cancer services provided by each Trust
- How many patients by equality characteristic were diagnosed/treated in the previous year
- Staging data
- Major resection rates
- Mortality rates within 30 days of treatment/survival data
- Whether each team has core members from all the relevant disciplines e.g. including a clinical nurse specialist;

- Compliance with waiting time standards;
- Compliance with peer review measures;

2.4 Quality of Life and Patient Experience

Commissioners should aim to improve broader outcomes and experiences for people living with and beyond cancer. This will be achieved by ensuring clinicians have the necessary skills to communicate effectively with patients, ensure access to national information prescriptions for patients, review findings of national patient experience survey, and consider the opportunities for increased access to clinical nurse specialists.

Although there have been significant improvements in support for people living with and beyond cancer, more needs to be done so that cancer survivors have the care and support they need to live as healthy a life as possible, for as long as possible⁶.

Improvements in the outcomes which are particularly relevant for people living with and beyond cancer should involve:

- reducing ill health associated with cancer treatment;
- reducing risks of recurrent cancer;
- reducing the proportion of people who report unmet physical or psychological support needs following cancer treatment;
- increasing the proportion of cancer survivors of working age who are able to work who are in work;
- increasing the proportion of children or young people survivors who are in education or employment; and
- increasing the proportion of cancer survivors who are able to live independently

2.5 Health Inequalities

There is a range of inequalities in the outcomes and experience of cancer patients⁶. These can occur at every stage of the patient pathway, including in awareness, incidence, access to treatment and care, patient experience, survival and mortality. They can also affect many groups in society, including socio-economically disadvantaged groups and areas, black and minority ethnic groups, older or younger people, men or women, people with disabilities, people from particular religions or with particular beliefs and the lesbian, gay, bisexual and transgender (LGBT) community^{***}.

^{***}There is now a range of evidence about the nature and extent of inequalities which occur in cancer⁷, including:

- Lifestyle factors (such as smoking, obesity, alcohol consumption and physical inactivity) almost certainly account for most of the variance in cancer incidence between the most and least deprived
- Levels of public awareness of cancer signs and symptoms are generally low, but even lower in some groups, such as deprived communities, some BME

groups and men. This may contribute to lower uptake of screening and later presentation when symptoms arise.

- Cancer incidence and mortality are generally higher in:
 - deprived groups compared with affluent groups (conversely, breast cancer has higher incidence in more affluent groups, but mortality is actually higher in less affluent women).
 - older compared with younger people
 - men compared with women
 - The picture for ethnic minority groups varies according to cancer type and ethnic group. In general, incidence is lower amongst ethnic minority groups, although there are some important exceptions (incidence of prostate cancer is greater amongst Black African men)

Poorer experience of care is reported by black and minority ethnic groups, men with prostate cancer, and people living in London. Part of the variance in mortality rates can be attributed to delayed diagnosis amongst deprived groups, older people (at least for breast cancer) and certain BME groups (at least for breast cancer).

The contribution of delayed diagnosis to poorer survival rates and higher mortality amongst men than women is still uncertain; and improvements in mortality have been slower in older people than in younger people. Older people with cancer receive less intensive treatment than younger people. In many cases this may be clinically appropriate. However, there is increasing evidence that under-treatment of older people may occur.

Commissioners need to collect more data on equality issues to inform activity to tackle inequalities and to measure progress.

3. RECOMMENDATIONS FOR COMMISSIONING

Commissioners should consolidate collaborative working with the local Cancer Network as the Network plays a pivotal role in supporting commissioning of cancer care locally and also works directly with local providers on the delivery of quality cancer services

Commissioners need to consider five key areas if they are to reduce the rate at which people die from cancer and to help those sections of population with most need improve fastest:

3.1 Intelligence:

Commissioners need the detail to be able understand which cancers are killing local people disproportionately, how well people with cancer are being treated and whether the local situation is different from that in similar areas. Therefore commissioners need to explicitly stipulate their data requirements from providers e.g. local hospital trusts, cancer intelligence agencies and incorporate these requirements into contractual arrangements. This should include quantitative and qualitative data. Data should be timely and should contain information on type,

stage, survival and demographics and cover equality issues in order to inform activity to tackle inequalities and to measure progress.

3.2 Prevention

Commissioners need to:

- target preventive measure as almost half of all cancers are preventable through developing positive lifestyle choices and
- increase awareness of and uptake of National Cancer Screening Programmes
- target secondary prevention e.g. lifestyle changes to can reduce the risk of recurrence for cancer survivors, the impact of side effects of treatment and the burden of cancer survivors on the NHS and the benefits system.

3.3 Early diagnosis

Commissioners should work with patients and primary care providers particularly to improve early awareness and diagnosis of cancer and to:

- raise awareness of several cancer warning signs and risk factors, especially in more deprived and in certain ethnic groups in the UK, to facilitate improvements in early presentation and cancer prevention behaviours
- address barriers to seeking help, such as fear and lack of confidence to discuss symptoms with GPs*
- ensure that primary care is responsive when patients present with signs and symptoms suggestive of possible cancer
- increase awareness of and uptake of National Cancer Screening Programmes

3.4 Better Treatment

Commissioners will want to ensure that patients have timely access to high quality, clinically effective and cost effective treatments and care for all cancers, at every stage of the cancer journey, including delivery of waiting time standards, expansion in capacity and the effectiveness of radiotherapy services through to end of life (including End of Life Care-see 'End of Life' JSNA chapter). Commissioners should also aim to improve broader outcomes and experiences for people living with and beyond cancer.

3.5 Health Inequalities

Commissioners must ensure that cancer services from prevention through to end of life are delivered equitably and commissioning plans target existing inequalities in the outcomes and experience of cancer patients which can occur at every stage of the patient pathway, including in awareness, incidence, access to treatment and care, patient experience, survival and mortality.

4. WHO'S AT RISK AND WHY

- In 2009 in England there were 128,600 deaths from cancer. ¹
- 61,900 of these deaths occurred to people aged under 75 years (48%). This is 41% of all deaths in people aged under 75 years.
- Almost three quarters of deaths from cancer can be attributed to six different cancer types⁸
 - Digestive organs – 28%
 - Lung cancer – 21%
 - Breast and prostate cancers – 7% each
 - Pancreas – 5%
 - Colorectal cancers – 4%
- Between 2006 and 2008 742,000 people in England were newly diagnosed with cancer (incidence), over 247,000 people per year. ¹
- In March 2011 there were over 876,000 people on GP registers with a diagnosis of cancer.⁹ This is a population prevalence rate of 1.6% of the population.
- More people are surviving and for longer with cancer. For cancers diagnosed between 2004 and 2008, nearly 30% of people with lung cancer, 96% of people with breast cancer and 74% of people with colorectal cancer were alive at 1 year after diagnosis. Survival at 5 years is lower, and this showed 8% of people with lung cancer, 84% of people with breast cancer and 53% of people with colorectal cancer were still alive at 5 years.

5. THE LEVEL OF NEED IN THE POPULATION

- In 2009 in Leicestershire County and Rutland there were 1,700 deaths from cancer
- 800 of these deaths occurred prematurely, i.e. before the person reached 75 years of age. This is over 42% of all premature deaths.
- In March 2011 in Leicestershire County and Rutland there were almost 10,600 people on GP disease registers with a diagnosis of cancer. This is a population prevalence rate of 1.7% of the population. This is significantly higher than the England average (1.6%).
- Between 2006 and 2008 over 9,900 people in LCR were newly diagnosed with cancer (incidence), over 3,300 people per year. ¹ This gives an incidence rate of 361 per 100,000 European Standard Population – a rate that is significantly lower than the England average (374 per 100,000).
- Between 1993-95 and 2007-09 under 75 mortality rates from cancer have fallen in LCR from a rate of 132 per 100,000 to 99 per 100,000.

- Mortality rates from cancer for all ages and for people aged under 75 years are significantly lower in Leicestershire County and Rutland than the England average (2007-09 data).¹
- Cancer survival rates for lung, breast and colorectal cancers at one and five years are not significantly different to the England averages.

6. CURRENT SERVICES IN RELATION TO NEED

There are many different types of cancer and the services and treatment people need are determined by their cancer type.

Cancer services start with prevention. A recent study by Cancer Research UK¹⁰ found that approximately half cancers are caused by lifestyle factors including smoking, unhealthy eating, alcohol consumption and being overweight. It is therefore possible to reduce the risk of cancer by stopping smoking, keeping fit, drinking alcohol within guidelines and eating healthily. Avoidance of excess sun exposure also reduces the risk of skin cancer.

7. SCREENING

Cancer screening services provide people with the opportunity to be tested for pre-symptomatic cancer and increase their chances of survival through early detection. There are three national screening services:

The NHS Breast Screening Programme - All women aged 50 to 70 are invited to attend mammograms every three years at a hospital or mobile screening unit. After the age of 70, women are able to make their own appointments for screening every three years.

- In 2009/10 in NHS Leicestershire County and Rutland, 85% of 53-70 year olds were screened for breast cancer compared with 77% nationally.
- In 2009/10 NHS LCR had the highest percentage of women screened of any PCT in the country.

The NHS Cervical Screening Programme screens more than 3 million women each year. Cancer Research UK scientists estimate that the programme saves more than 4,500 lives in England every year. Screening is used to detect abnormal cells on the cervix. Cervical cancer is one of the few preventable cancers, because screening picks up pre-cancerous changes. The test prevents up to 75% of cervical cancers.

Women aged 25 to 49 are invited for screening every three years. Women aged 50 to 64 are invited every five years.

- In 2009/10 79.9% of women aged 26-64 in LCR were screened within 3.5 years of the last adequate test and 83.6% within 5 years. This is higher than both the England and East Midlands average for both definitions.

The NHS Bowel Cancer Screening Programme aims to detect bowel cancer at an early stage, when treatment is more likely to be effective. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.

Men and women aged 60 to 69 are automatically invited for screening every two years. Most people who are diagnosed with colon cancer are over 60. People aged 70 and over can request screening every two years, but aren't automatically invited.

- In 2009/10 52% of men and women in LCR aged 60-69 who were eligible for bowel screening were screened.

8. WAITING TIMES FOR TREATMENT

Currently, all patients referred with suspected cancer by their GP have a maximum two-weeks wait to see a specialist.

Cancer patients should wait no more than 31 days from decision to treat to the start of their first treatment.

In Leicestershire County and Rutland 94.7% of suspected cancer patients saw a specialist within the 2 week wait target. This is significantly lower than the England average (95.7%).

9. PROJECTED SERVICE USE AND OUTCOMES IN 3-5 YEARS AND 5-10 YEARS

The numbers of people that develop cancer every year are increasing (incidence) and, once diagnosed, people are surviving for longer with cancer (prevalence). The PCT has targets to continually reduce the premature mortality rates from cancer. Since the 1995-97 baseline there has been a 22% reduction in the mortality rates from cancer. This is a real achievement but more needs to be done to see the reduction in rates continue.

Increasing incidence and prevalence of cancer will require greater efforts to address prevention, improve early detection and enhance treatment of cancer in the future

10. EVIDENCE OF WHAT WORKS

Briefing paper on practical action to reduce health inequalities in cancer (National Cancer Action Team and National Cancer Equality Initiative), 2011,
<http://ncat.nhs.uk/sites/default/files/inequalities.pdf>

How to REDUCE EXCESS MORTALITY FROM CANCER IN AREAS WITH THE WORST HEALTH AND HIGHEST LEVELS OF DEPRIVATION, (UK National Support Team, Cancer Action Team, 2011
<http://ncat.nhs.uk/sites/default/files/HINST%20NCAT%20How%20to%20Cancer%20final%20%2009032011.pdf>

Reducing cancer inequality: evidence, progress and making it happen, A report by the National Cancer Equality Initiative, 2010

<http://ncat.nhs.uk/sites/default/files/NCEI%20Report%20March%202010%20for%20website.pdf>

WE CAN, Reducing Inequalities In Commissioning Cancer Services, NATIONAL CANCER EQUALITY INITIATIVE (NCEI), National Cancer Action Team, 2010,

Improving Outcomes: A Strategy for Cancer, DH 2011,
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123394.pdf

National Institute for Clinical Excellence (NICE)-various guidance

Cancer Reform Strategy, DH, 2007,
<http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Cancer/ReformStrategy/index.htm>

11. USER VIEWS

Equality results of the Cancer Patient Experience Survey 2010 show variability in patient experience¹¹:

- White cancer patients report a more positive experience than other ethnic groups. Particular differences were noted on questions around receiving understandable answers, being given enough care after discharge, and staff working well together.
- Younger people are the least positive about their experience, particularly around understanding completely what was wrong with them.
- Older people are less likely to have access to a clinical nurse specialist.
- Men are generally more positive about their care than women, particularly around staff and staff working together.
- People with a disability or long term condition reported a less positive experience than other patients across a wide range of issues measured in the survey. This was particularly marked for patients with a mental health condition or a learning disability.
- Non-heterosexual patients reported less positive experience, especially in relation to communication and (broadly) being treated with respect and dignity.
- Despite what might be expected, there is no statistically significant link between deprivation and patient experience, taking all quintiles of deprivation together.
- People with rarer forms of cancer in general reported a poorer experience of their treatment and care than people with more common forms cancer.

11.1 Relevant local engagement activities in 2010/11¹²:

Quality Innovation, Productivity and Prevention: Strategic Operating Plan –
NHS Leicester City and NHS Leicestershire and Rutland have taken several

opportunities during 2010-11 to engage with the public on QIPP. Our aim was for the public to understand the current financial climate and challenges facing the NHS. The first QIPP event in September 2010 was a joint event with two PCTs, University Hospitals of Leicester NHS Trust (UHL) and Leicester Partnership Trust (LPT). A major theme in the discussion and feedback was the importance of prevention, including screening, e.g. for different cancers

Bowel cancer and bowel cancer screening awareness, LCR, 2009/10 - More than 2,000 people completed questionnaires. Six focus group sessions took place and all feedback was collated. The feedback showed that more interventions were needed to improve awareness of symptoms and to encourage people to realise the importance of bowel screening. It also showed that people were more likely to take part in the screening process if their GP contacted them about it.

Membership consultation - In March 2009 NHS Leicestershire County and Rutland started a membership scheme called 'Be Healthy, Be Heard'. The aim of the membership scheme was to help the public of Leicestershire and Rutland become as healthy as possible, and to provide a mechanism for people to feed back their views into the organisation on policies and service development by taking part in consultations. A number of talks were given throughout the county called "community medicine for members". Members attending these talks received up-to-date information and key health messages from health experts on a variety of topics, such as prostate cancer, women's cancers, dental health, diabetes and staying healthy for older people

Pacesetters Bowel Cancer Screening Awareness Project (2000/10) - The NHS Pacesetters Bowel Cancer project was established to increase awareness of bowel cancer and the NHS bowel cancer screening programme amongst the South East Asian community in North West Leicestershire and Charnwood.

Knowledge and awareness of bowel cancer screening is known to be a barrier to screening uptake and information needs to be provided to communities in a format that is easily accessible and understood. The local focus groups indicated quite strongly that the General Practitioner should be involved in this process of raising awareness of the bowel cancer screening programme, promoting it to eligible patients and encouraging participation.

The report from the Pacesetters project will be used to inform the Countywide project working with General Practice to improve cancer awareness and promote screening to support early diagnosis.

Women's Cancer Event –The aim of the event was to raise awareness of women's cancers. Members of the "Be Healthy Be Heard" PCT membership scheme were invited to attend along with members from University Hospitals of Leicester NHS Trust; NHS Leicestershire Partnership Trust and NHS Leicester City. Speakers presented on ovarian and cervical cancer, cervical screening, background to cancer research, current research trials for women's cancers and genetics. Following each presentation women were encouraged to ask questions and the health specialists answered. This was a successful engagement event which informed women about women's cancers and emphasises the importance of early intervention.

Teenage and Young Adults Cancer (TYA) – This was an engagement activity undertaken by East Midlands Specialised Commissioning Group, to ensure that the East Midlands service meets the needs of teenagers and young adults, the EMSCG involved patients in developing and improving the service.

We sought patients' views and suggestions on:

- Current service provision
- How the service can change to incorporate both the medical model and psychosocial model of care
- Improvements for physical facilities (to ensure the hospital surroundings stimulate and motivate teenage/young adult cancer patients).

This was achieved in a variety of ways including:

- Informal discussions at youth groups in order to build trust enabling patients to share their experience of the diagnosis, treatment and hospital care
- A user experience questionnaire which provided a confidential method for capturing experiences of patients and assisted in understanding things from a patient perspective.
- A media campaign, newsletters, direct mail and business card distribution, providing a comments book for thoughts, posters, and work with clinical teams to encourage them to seek feedback on patient views.

Some of the key issues identified were the need for:

- A quicker referral from GP to the acute sector and the early identification of TYA patients
- Improvements in communication i.e. in the explanation and understanding of diagnosis, treatment and consent to treatment
- Psychosocial support services that meet specific age group needs, such as alone time, access to peer support, support relating to feelings of isolation, fear and motivation
- Information on health care needs - body image, puberty, diet, health promotion, pathway journey
- Good facilities with choice, a contact person and a care plan
- Access to outreach support, moving on back in the community.

East Midlands Parent Experience (parents of children with cancer) Report, 2011 made a series of recommendations including the need to develop:

- better home support in early days after discharge from hospital
- improved provision of community nursing support to avoid e.g. need to return to - hospital for blood tests
- shorter wait times to receive medication prior to discharge
- more systematic psychological support
- review of the criteria and decision making processes in relation to the choice of central lines used to ensure that the choice offers optimum benefit
- better support to facilitate school attendance after treatment

11.2 Relevant local engagement activities in 2009/10¹³:

People were asked in January and February 2010 to complete an online survey, rating in order of importance what the local health priorities should be for the trust. In

total 136 people took part, giving their views on what they considered to be their most important healthcare needs. The aim of the survey was to find out what priorities were the most important to people, which will help the trust to make decisions on which services it starts to develop or commissions (buys) in the coming year, and where it should invest less. The second most popular response was improving cancer care (11%).

The results of the survey helped NHS Leicestershire County and Rutland to put together its Local Operating Plan, which was approved at the public board meeting in April 2010.

12. EQUALITY IMPACT ASSESSMENTS

The information in this section is taken from the “Cancer Reform Strategy Equality Impact Assessment”, published in 2007.¹⁴

12.1 Socioeconomic deprivation

The risk of cancer and lifestyle factors is affected by socioeconomic deprivation in the following ways:

- Deprivation has a marked adverse impact on cancer outcomes. Cancer mortality is 15.2% higher in people aged under 75 than in ‘spearhead’ i.e. most deprived PCTs (137 deaths per 100,000) than the national average (118.9 deaths per 100,000).¹ This is in part due to the high incidence of some cancers (such as lung) with a poor prognosis;
- Survival rates are also lower amongst cancer patients from spearhead PCTs. five-year relative survival for women with breast cancer is 2.4% less, for colon cancer in men 3% less and women 2.7% less, for lung cancer in men 0.6% less and women 0.5% less and for prostate cancer in men is 3.8% less;
- Lung cancer incidence is significantly higher in deprived than in more affluent groups, reflecting patterns of smoking. Smoking in manual groups is at 29% and in non-manual groups at 19%. In contrast breast cancer incidence is higher in affluent groups reflecting other lifestyle factors, although outcomes are worse in more deprived groups;
- The median rate of cervical cancer in the most deprived fifth of local authority areas is double the rate in the most affluent;
- Survival rates are worse for deprived groups across a wide range of cancer types. For example, for breast cancer there is a 7.6% difference in five year survival between the most affluent and the most deprived groups. Equivalent figures for other cancers are as follows: tongue 16.3%, larynx 9.3%, melanoma 8.1%, bladder 7%, kidney 4.3% and colon 4.3%.

12.2 Race

The risk of cancer and lifestyle factors is affected by race in the following ways:

- The number of cancer deaths is generally lower among BME groups than among white British people. This may partly be explained by the younger age profile of BME groups. In addition some older people from BME groups may return to their country of origin to die. In the 2001/02 national census 16% of

the White population was over 65, compared to 9% Black Caribbean, 6% Indian, 4% Pakistani, 3% Bangladeshi and 2% Black African;

- The incidence of specific cancers varies between ethnic groups. For example:
 - Prostate cancer incidence is high in men of African origin;
 - Mouth cancer is high amongst South Asians;
 - Liver cancer is high amongst Bangladeshis;
 - Liver cancer and naso-pharyngeal cancer is high amongst Chinese;19 and
 - Breast cancer incidence is generally lower amongst BME groups than amongst white British women.
- The lower than average socioeconomic position of BME groups is the main reason behind their worse health outcomes. Most BME groups have higher rates of poverty (lower income, less benefits, more unemployment, fewer necessities and more deprivation).

12.3 Age

The risk of cancer and lifestyle factors is affected by age in the following ways:

- For most cancers the risk of cancer increases with age (such as breast, colorectal, lung, prostate etc.)
- Using 2004 figures 11% of cancer is diagnosed under age 50, 15% over 50, 24% over 60, 29% over 70 and 22% over 80;
- Certain cancers, however, go against this trend, having an early peak of incidence in teenage and young adult life. Primary bone tumours, testicular cancers and Hodgkin's disease are examples;
- Some cancers occur almost exclusively in childhood (such as retinoblastoma, neuroblastoma, hepatoblastoma, neuroblastoma);
- In line with incidence figures, most deaths from cancer occur in older people. Of just over 126,000 cancer deaths in England in 2005 76% occurred at ages 65 or over;
- Survival rates are generally better for children with cancer than for adults;

12.4 Gender

The risk of cancer and lifestyle factors is affected by gender in the following ways:

- Some cancers are gender specific (such as prostate, testicular, ovary, cervix, endometrium);
- Other cancers affect one gender more than the other. This may be because of hormonal factors (such as breast cancer), lifestyle factors (such as melanoma) or occupational risk factors (such as bladder cancer);
- Two thirds of men are overweight and just over half of women. The weight men put on is more likely to be around the abdomen which results in increased cancer risk;
- For most cancers which affect both men and women, age standardised (adjusting for age structure of population) survival rates are somewhat higher in women. The reasons for this are not entirely clear
- Death rates for the ten commonest cancers which affect both men and women are in each case higher in men; and
- Overall each year 28% of male deaths (80,000) and 23% of female deaths (73,000) are from cancer.

12.5 Disability

The risk of cancer and lifestyle factors is affected by disability in the following ways:

- People with learning disabilities (LD) appear to have:
 - a lower risk of lung, prostate, urological, breast and cervical cancers; and
 - a higher risk of leukaemia, oesophageal and stomach cancers.
- These differences are likely to relate to both genetic factors (e.g. Down's syndrome and leukaemia) and lifestyle factors; and
- 70% of psychiatric patients in hospital are smokers.

12.6 Religion or belief

In general there is little available evidence on the links between specific religions or beliefs and cancer beyond that relating to race (see separate section).

12.7 Sexual orientation and gender identity

The risk of cancer is affected by sexual orientation in the following ways:

- Gay men have a higher incidence of anal cancer (HPV related) and HIV / Aids related cancers (e.g. Kaposi sarcoma and lymphomas); and
- Lesbians, as a group, may be at higher risk of breast cancer because studies have shown they may be less likely than heterosexual women, to have children. Heterosexual women without children may also be at increased risk.

13. UNMET NEED AND SERVICE GAPS

The most robust dataset for reviewing cancer outcomes is the cancer mortality dataset. The data factsheet contains a graph that illustrates that the people of Leicestershire who live in the poorest areas are more likely to die prematurely from cancer than the people who live in the most affluent areas. Those people living in the poorest areas of LCR have a significantly higher premature mortality rate from cancer than the people living in the most affluent areas.

It is clear that a variety of factors from lifestyle through to access to services, service provision and uptake explain this premature and there is a need to target resources towards our most vulnerable populations to address these factors.

14. CONCLUSIONS

Cancer is the most common reason for people in LCR dying prematurely. Reducing premature deaths from cancer will increase life expectancy and help to reduce health inequalities.

Cancer mortality and survival rates will be improved by increasing symptom awareness, ensuring access to screening programmes and ensuring prompt and appropriate referral for people identified as potentially having cancer. Commissioners will want to work with patients and primary care providers particularly to improve early awareness and diagnosis of cancer:

Commissioners also need accurate data to provide the detail to be able understand which cancers are killing local people disproportionately, how well people with

cancer are being treated and whether the local situation is different from that in similar areas

15. RECOMMENDATIONS FOR NEEDS ASSESSMENT WORK

- Conduct a health equity audit of existing cancer services
- Conduct an assessment of population growth by Tumour type, type of treatment needed and analysis of incidence, mortality, survival for LCR to identify target groups, cancers and inform strategic planning in order to improve ability to target service developments to areas of greatest need

16. CONSULTATION

This chapter is being discussed at the LNR Cancer Operational Group on 20th March, 2012

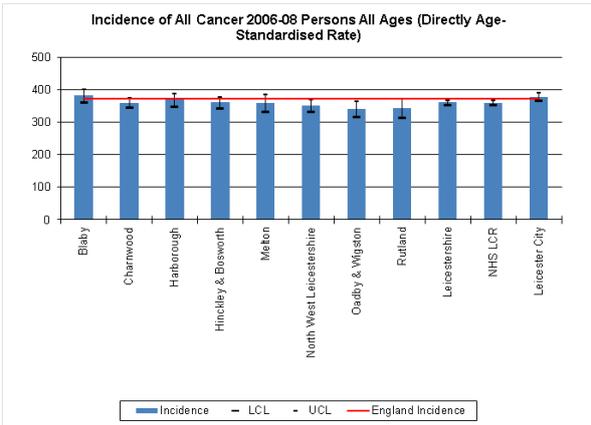
17. KEY CONTACTS

Dr Mike McHugh, Consultant in Public Health,

18. DATA FACTSHEETS

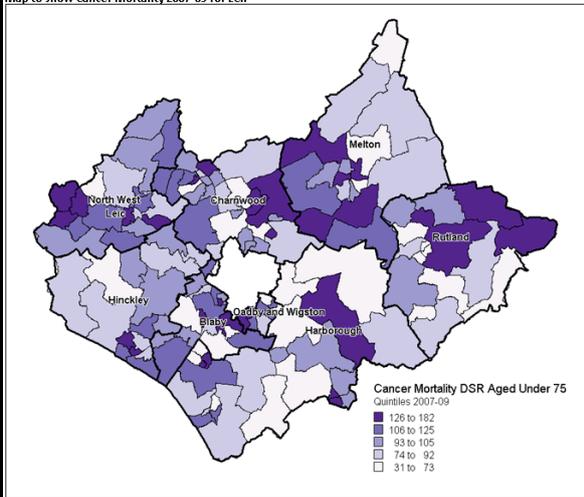
Cancer factsheet:

- Incidence of all cancers 2006-08 (Directly age standardised registration rate)
- GP registered counts of cancer (QOF) 2010/11
- Mortality from all cancers (ICD10 C00-C99 exc C44) aged under 75, 2007-09 (pooled)
- Directly age standardised mortality rates from all cancers 2007-09 by district
- All cancer mortality by PCT quintiles 2007-09
- Breast screening coverage (%) for women aged 53 to 64 (2005/06-2009/10)
- Breast screening coverage (%) for women aged 53 to 70 (2005/06-2009/10)
- 5 year relative survival (%) for 2000-04
- Cervical screening programme: Target age group (25-64) results of tests by primary care organisation 2009/10
- Cervical screening coverage less than 3.5 years since last adequate test (%) women screened aged 25-64 (2005/06-2009/10)
- Cervical screening coverage less than 5 years since last adequate test (%) women screened aged 25-64 (2005/06-2009/10)

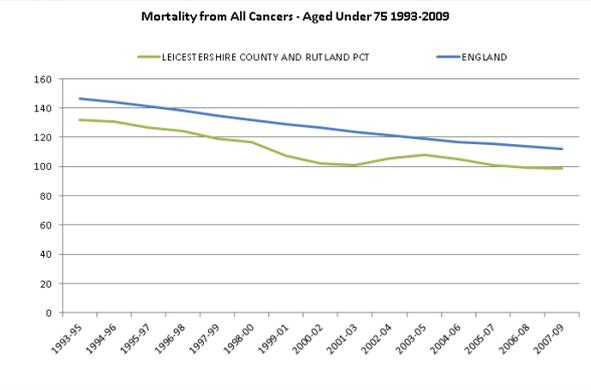


Source: NHS IC Indicator Portal (www.indicator.ic.nhs.uk or mww.indicator.ic.nhs.uk)

Map to show Cancer Mortality 2007-09 for LCR



Directly Age Standardised Mortality Rates for All Cancers 1993-2009 Persons aged Under 75



Source: NHS IC Indicator Portal (www.indicator.ic.nhs.uk or mww.indicator.ic.nhs.uk)

NOTE: DSR is Directly standardised rate per 100,000 European standard population

Incidence of All Cancer 2006-08 (Directly Age-Standardised Registration Rate)

	Persons			
	Observed	DSR	Lower Confidence Level	Upper Confidence Level
England	742,320	373.97	375.65	377.37
Leicestershire County and Rutland	9,943	360.64	353.30	367.97
Leicestershire	9,390	362.01	354.44	369.58
Rutland	553	343.91	312.91	374.92

Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk) or mww.nchod.nhs.uk)

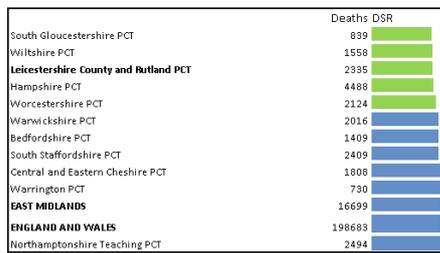
GP Registered counts of Cancer (QOF), 2010/11

	Recorded Prevalence		
	List Size (16+)	Disease Register Cancer	Recorded Prevalence (16+)
England	45,005,438	876,485	1.9%
Leicestershire County and Rutland	559,278	11,381	2.0%
Leicestershire	530,643	10,584	2.0%
Rutland	28,635	797	2.8%

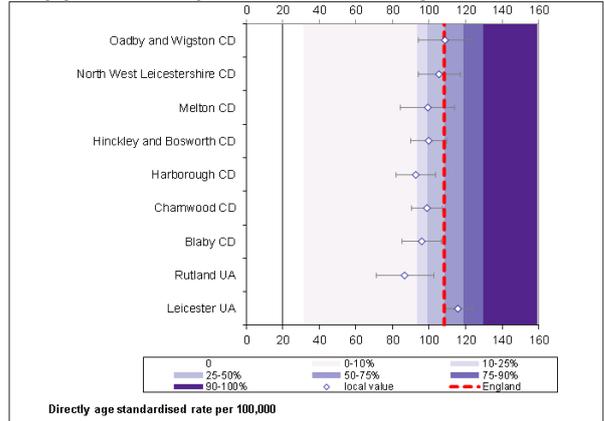
Source: QOF 2010/11

Mortality from All Cancers (ICD10 C00-C99 exc C44): Directly age-standardised rates (DSR) Aged Under 75, 2007-09 (Pooled)

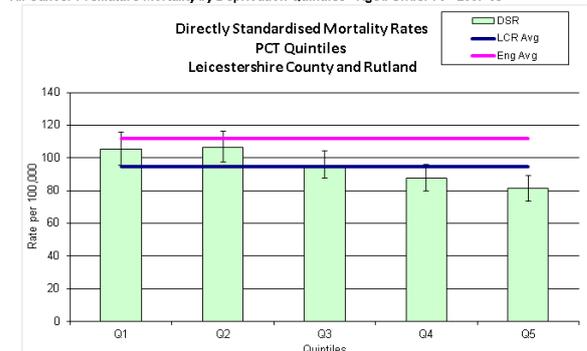
Significance compared to England
 Significantly higher
 Not significant
 Significantly lower



Directly Age Standardised Mortality Rates for All Cancers 2007-09 Persons aged <75



All Cancer Premature Mortality by Deprivation Quintiles - Aged Under 75 - 2007-09

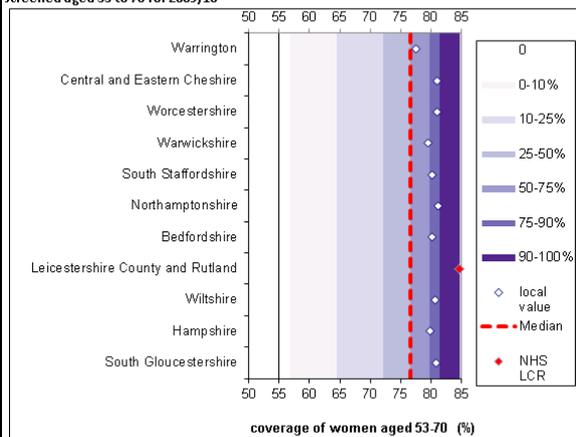


Source: NHS LCR - Public Health Baseline Data

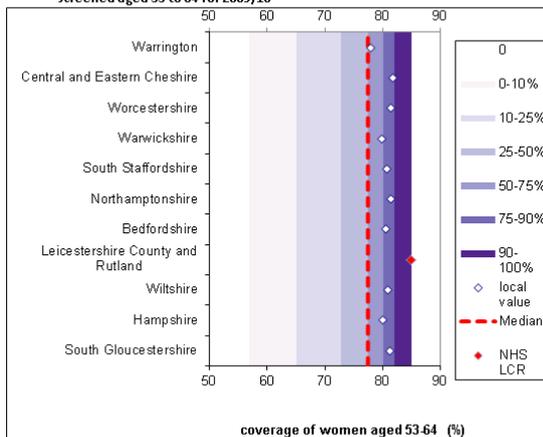
Q1 = most deprived 20% of population
 Q5 = least deprived 20% of population

JSNA Refresh 2012 - Long term conditions - Cancer Screening

Breast Screening Coverage (%) of women screened aged 53 to 70 for 2009/10



Breast Screening Coverage (%) of women screened aged 53 to 64 for 2009/10



Source: <http://www.ic.nhs.uk/statistics-to-and-data-to-collections/screening/breast-to-s-screening>

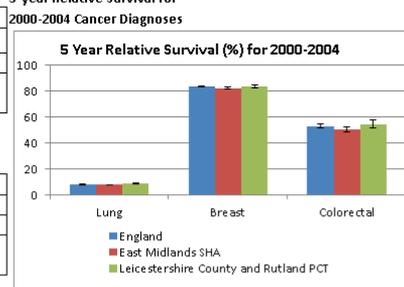
Source: <http://www.ic.nhs.uk/statistics-to-and-data-to-collections/screening/breast-to-s-screening>

Breast Screening Coverage (%) for women aged 53 to 64 (2005/06-2009/10)

	2005/06	2006/07	2007/08	2008/09	2009/10
England	75.9	76.0	76.7	77.0	77.2
East Midlands	81.5	80.9	80.9	81.7	82.1
Leicestershire County & Rutland PCT	84.8	84.5	84.6	84.8	85.0

Source: <http://www.ic.nhs.uk/statistics-to-and-data-to-collections/screening/breast-to-s-screening>

5-year Relative Survival for 2000-2004 Cancer Diagnoses

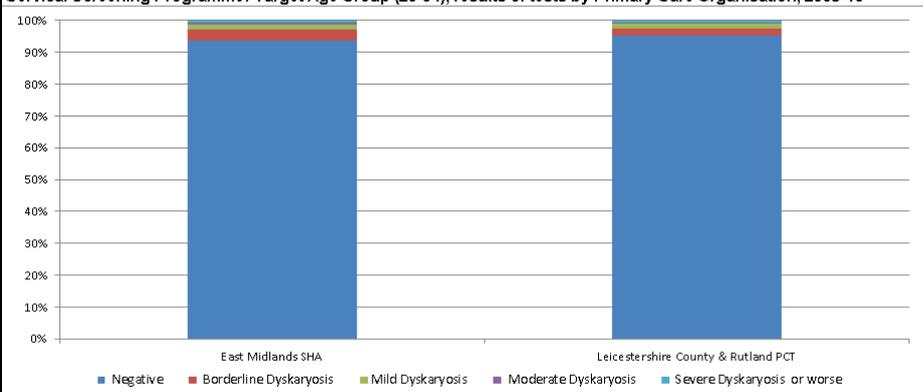


Breast Screening Coverage (%) for women aged 53 to 70 (2005/06-2009/10)

	2005/06	2006/07	2007/08	2008/09	2009/10
England	na	73.8	75.9	76.5	77.0
East Midlands	na	78.6	79.9	81.2	81.7
Leicestershire County & Rutland PCT	na	80.4	83.5	84.3	84.7

Source: <http://www.ic.nhs.uk/statistics-to-and-data-to-collections/screening/breast-to-s-screening>

Cervical Screening Programme: Target Age Group (25-64), results of tests by Primary Care Organisation, 2009-10



Source: Trent Cancer Registry

Source: <http://www.ic.nhs.uk/statistics-and-data-collections/screening/cervical-s-screening>

Cervical Screening Coverage less than 3.5 years since last adequate test (%) women screened aged 25-64 (2005/06-2009/10)

	2005/06	2006/07	2007/08	2008/09	2009/10
England	69.8	69.4	69	72.5	74
East Midlands	75.4	75.2	74.3	76.7	77.6
Leicestershire County & Rutland PCT	74.1	73.9	73.3	78.9	79.9

Source: <http://www.ic.nhs.uk/statistics-and-data-collections/screening/cervical-s-screening>

Cervical Screening Coverage less than 5 years since last adequate test (%) women screened aged 25-64 (2005/06-2009/10)

	2005/06	2006/07	2007/08	2008/09	2009/10
England	79.5	79.2	78.6	78.9	78.9
East Midlands	83.1	82.9	82.4	82.4	82.1
Leicestershire County & Rutland PCT	84.4	84.4	83.9	83.9	83.6

Source: <http://www.ic.nhs.uk/statistics-and-data-collections/screening/cervical-s-screening>

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- ⁹ The NHS Information Centre. The Quality and Outcomes Framework 2010/11 data tables.
<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework/the-quality-and-outcomes-framework-2010-11>
- ¹⁰ Cancer Research UK: British Journal of Cancer (2011) 105, S2 – S5
- ¹¹ Department of Health: National Cancer Patient Experience Survey Programme - 2010: national survey report: 10 December 2010: © Crown Copyright
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_122516
- ¹² Real Accountability Annual Report 2010 – 2011; NHS Leicester City, NHS Leicestershire County and Rutland
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