



**Northamptonshire  
Health & Wellbeing Board**

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# **JSNA Summary 2013**

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## **Cancer**

**Delivering meaningful, healthier, longer lives for the people of Northamptonshire**

## Introduction

- Cancer is a group of 200 diseases which together impose a heavy burden of disease. Cancer is the third highest cost category in the NHS, after mental health and cardiovascular disease.
- Although there are many cancers, cancer of the breast, bowel, prostate and colon are the four most common and constitute 54% of the total. This needs assessment focuses on these four, along with cervical cancer, which we include because there is a national screening programme.

## Key Points

- Cancer is a key public health concern which should be tackled at a number of different levels. It mainly affects older people; although not all the strategy documents for Northamptonshire County Council, Nene CCG and Corby CCG specify that cancer is a priority, it is implicit in that they all have as one focus, frail and elderly people.
- Most significant as a cause of cancer is smoking. It causes 80% of lung cancer and a number of other cancers, as well as heart disease and stroke. Prevention and cessation of smoking are of paramount importance. Also implicated are alcohol, diet and obesity, significant in different cancers. It has been estimated that 40% of cancers are preventable, and individual risk factors should be modified.
- Cancer is associated with socioeconomic deprivation. Corby has a high level of deprivation and shows high rates of incidence and mortality especially of lung cancer and all cancers combined compared with Northamptonshire, East Midlands and England, and mortality from colorectal cancer in females compared with East Midlands and England. In Northamptonshire, prostate cancer is more common than in the East Midlands and England.
- Screening programmes are available for detection of early breast, bowel and cervical cancer. Amongst communities where there is deprivation, and in ethnic minority groups, nationally take-up is low.
- Early presentation by patients and symptom recognition by GPs is very important. Local awareness and early diagnosis programmes have helped to stimulate this. A GP usually sees fewer than ten patients with cancer each year, so symptom recognition is not straightforward. Of the patients referred via the two-week wait route to a consultant, only 10% to 20% are found to have cancer, in Northamptonshire and in England. Referral of patients without cancer is expensive and causes great anxiety to patients until they receive a diagnosis. GPs also have an option to request some tests directly for their patients, but it is unclear how well this works in Northamptonshire.
- Cancer patients are treated in a number of different hospitals, but the majority are admitted to Northampton General Hospital, which is also the Cancer Centre,
- Some important data are not available. These include staging (how early the cancer is diagnosed) and one- and five-year survival rates, both measures of how well cancer services work. These data will be available from the Oxford Cancer Registry which is currently unavailable as it is in the process of reorganisation.

- Early diagnosis of cancer tends to give better outcomes and is more cost effective. But sometimes, a cancer is diagnosed during an emergency admission. These cancers are usually more advanced, and outcomes are worse than after earlier diagnosis. Treatment is also more expensive.
- Nene CCG has undertaken some useful analysis of district of residence, diagnosis and number of episodes of cancers diagnosed after emergency admissions. Most of these admissions are for very short periods. The analysis does not seem to include whether the emergency presentation was for cancer diagnosis or management of symptoms after diagnosis. This work should be developed to add understanding to the current pathways of care.
- Northamptonshire is unusual in having two hospices funded by the NHS rather than from charitable sources. This is being reviewed and we recommend examining different models of provision. More than 50% of people want to die at home when the time comes, and as demand increases owing to an older population with more cancer and other end-of-life diseases, palliative care may need to take different forms. There is a current proposal for additional beds to be provided at Cransley Hospice in Kettering. If this model persists it is likely to be unable to meet future demand, and the current opportunity for review of the service should embrace new opportunities for provision of care with innovation with the potential for improved quality (meeting place of death requests) and lower costs.
- The Commissioning for Value framework suggests 50 lives each year in Nene CCG and 24 lives in Corby CCG to be saved and savings to be made from secondary care (£3.2m in Nene CCG and £578,000 in Corby CCG, including elective and day care and non-elective care, and from prescribing costs (£460,000 in Nene CCG and £33,000 in Corby CCG)). The information produced should be analysed for congruence with the understanding of local commissioners. The Insight Pack offers free training and this option should be taken up widely as a valuable source of additional data.
- Cancer services are constantly developing and we describe two new initiatives: the latest report on Outcomes in Cancer, and a new style of service – Acute Oncology.
- A national survey collects patients and service users and carers' views and these reports are presented for Nene Corby CCGs.

## Recommendations

- *Reducing the prevalence of smoking and obesity* are crucial both to health of individuals and to NHS and social care costs, and other sections of the JSNA cover these. We recommend that these must be the subject of evidence-based change programmes.
- *Screening in areas of high socioeconomic deprivation and amongst people of ethnic minorities should be encouraged.* This is important because those who miss screening are probably those most in need of it, and cases can be missed. We recommend that work should be done at GP surgery level and with local communities to encourage attendance and take-up of screening. This is an area where many initiatives have been tried. This section of the JSNA links to a number of proposals including from the [UK National Screening Committee](#) which offers advice for engaging with a number of different ethnic and minority groups, in the attempt to increase screening take up. This is

necessary for better outcomes through early diagnosis, and for the efficacy and cost effectiveness of the screening programmes.

- *We recommend support for local awareness and early diagnosis of cancer to enable much better outcomes and reduced treatment costs (see [Key Messages for Cancer Commissioners](#)).*
- *Where there is a suspicion of cancer, GPs should first consider excluding the possibility by using recommended tests, chest x-rays for lung cancer, colonoscopy and flexible sigmoidoscopy for bowel cancer, MRI/ CT for brain cancer and non-obstetric ultrasound for ovarian cancer. These should be available in a timely manner and reported for GPs to enable efficient decision making on referral. No information was available on this.*
- *Patients should be referred via the two-week wait pathway, but the proportion with cancer is low, as it is with East Midlands and England. Direct access to diagnostic tests was introduced to alleviate the two-week wait route; this was found to be inadequate for the number of patients referred elsewhere, though not in Northamptonshire. But the pickup rate is low and this may mean that people with cancer experience delay because of the 80% to 90% of patients referred who are found not to have the disease. Agreement should be reached with GPs and practices about appropriate referral, using the agreed criteria for direct access to diagnostics where appropriate and only referring by two-week wait where the suspicion of cancer is strong. Consultant medical staff should audit referrals to aid GP education where necessary.*
- *Commissioners should decide how to act on information from Commissioning for Value. This proposes lives to be saved and savings to be made from secondary care, elective and day care and non-elective care, and from prescribing costs. The information produced should be analysed for congruence with the understanding of local commissioners. The Insight Pack offers free training and this option should be taken up widely as a valuable source of additional data.*
- *Commissioners should consider the development of an acute oncology service. This includes pathways for management of cases with short inpatient stays, offers efficient review and diagnosis in the Accident and Emergency Department both for new patients and those with neutropenic sepsis and other acute oncological needs. The presence of an oncology-trained doctor at the “front end” of the hospital is recommended, but should be combined with early diagnosis because of the high numbers of emergency admissions and cases diagnosed as emergencies. This is particularly true for lung cancer patients for whom incidence and mortality is particularly high in Corby.*
- *The high rates of lung cancer in Corby should be urgently addressed [at each part of the pathway](#), prevention, early diagnosis, surgery, adjuvant therapies and palliative care. Lung cancer is particularly difficult to diagnose in primary care, but most presentation is late and with a relatively young and small population in Corby, early awareness initiatives in addition to those already used should be pursued.*
- *We recommend investigation of the high rates of mortality in Corby, and especially those from lung cancer. Costs appear to be high compared with spend on the much larger population of Nene CCG. Lung cancer is particularly difficult but most presentation is late and with a relatively young and smaller population in Corby, early awareness initiatives and smoking cessation (in addition to those already used) should be pursued.*
- *We recommend a review of the equity of access to cancer surgery for older patients. This should be part of an audit programme to ensure there is no age discrimination.*
- *Commissioners should consider a model of hospice provision with fewer beds and more provision at home. Hospice provision in Northamptonshire is unusual in being largely*

funded by the NHS. The service is currently under review with a proposal for additional beds. It is likely that more cost-effective care is available using community nurse specialists, hospice at home and Macmillan GPs (who provide a strategic rather than a clinical role) and nurses already in post. Lakelands Hospice is an under-utilised day hospice in Corby. Seven additional beds are planned for Cransley Hospice in Kettering to support the current model of care but as the population continues to age and expand, experiencing the need for end-of-life care, hospice provision may become untenable. Care at home, besides being the service of choice for more than half the population, has been shown to be more cost effective with better outcomes. The Northamptonshire Integrated Care Partnership has as one of its top outcomes an increase in the number of patients dying in their preferred place of death. This includes care homes where this is the normal place of residence. Additional community support could allow those patients to stay where they are and be cared for with better quality outcomes and at lower cost. Commissioners should support the review of hospice care in Northamptonshire with a clear remit to include all models of care and associated costs together with an end-of-life register to manage workflow. This would also indicate geographical distribution of cases to ascertain feasibility.

### Key early priorities are:

- Inspect and agree the brief for review of hospice services to ensure a variety of models will be included in the proposed specification, with a range of costs.
- Require GPs to refer early through direct access to diagnostics and then through two-week wait routes. Consultants should provide feedback for GP education on the quality of referrals.
- The analysis of emergency admissions should be developed and built on to analyse diagnosis on an emergency basis. This should be part of the specification for an acute oncology service.