

## **Programme 2: Cancers and Tumours**

**This is work in progress, your views and input are welcomed.**

### **What are the big health issues for North Yorkshire and the City of York in this programme?**

This programme covers all tumours – benign and malignant. It was the subject of a major review published in 2007 – the Cancer Reform Strategy – published by Professor Mike Richards. It adopts the same “patient pathway” steps that are a feature of each programme in this report.

### **Programme purpose:**

To reduce the avoidable burden of cancer in North Yorkshire and the City of York by a combination of prevention, early detection (including screening), rapid access to treatment, enhanced quality and length of life, and a well-managed terminal phase and death at the place of the patient’s choosing.

Specific aims:

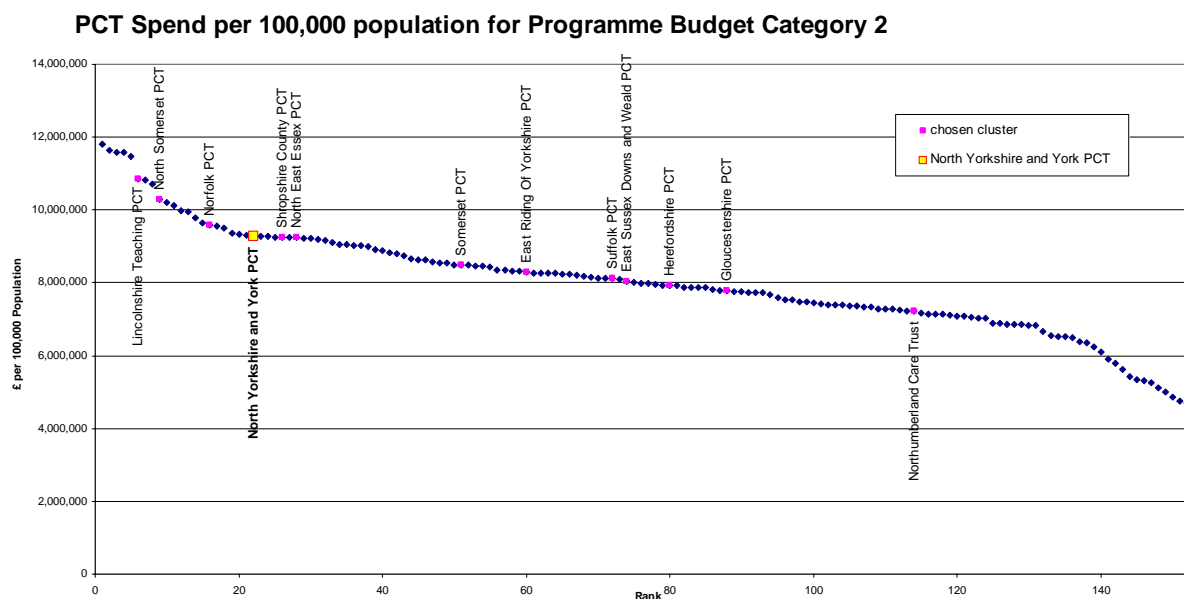
- Reduce the prevalence rates of smoking with a particular focus on pregnant mothers, and patients awaiting routine operations.
- Reduce the prevalence of obesity and excessive alcohol consumption (see programme 21: healthy individuals)
- Expand the Sun Smart campaign to include sun beds.
- Introduce the HPV (human papilloma virus) immunisation for eligible girls during 2008, to reduce cervical cancer risk.
- Maintain uniformly high uptake rates across all GP practices for cancer screening – breast and cervix (see below) – and prepare for the new bowel cancer screening programme.
- Achieve the 2-week waiting time to first appointment with a specialist for people with suspected cancer.
- Achieve rapid access to diagnostic tests – imaging, endoscopy and pathology
- Disseminate NICE guidance for cancer therapies for all eligible patients and monitor implementation in clinical practice.

- Support people living with cancer, and their carers, so as to “add life to years” as well as “years to life”.
- Reduce premature mortality rates (“dying before one’s time”) – currently arbitrarily set at 75 years, for each cancer.
- Achieving higher rates for patients dying at the place of their choosing, eg at home (see below).

**What was the NYYPCT estimated programme budget for cancers and tumours in 2006/07, as indicative expenditure per 100,000 unified weighted population, and how did that compare with our peers and with the English average?**

NYYPCT	£9,282,000
Cluster average	£8,778,000
Yorkshire and the Humber SHA average	£8,778,000
England average	£8,178,000

The chart below shows how the investment in NYYPCT compared with every other PCT in England and highlights those PCTs in the same cluster.



**How did that programme budget break down between our providers (total sums)?**

NHS Hospital Trusts	£45,548,000
YHFT	£16,318,000
HDFT	£5,507,000
STHT	£5,714,000
SNEYT	£5,620,000
General Practitioner medicines prescribing	£5,378,000
PCT provider services	£6,101,000
Non NHS Providers	£2,721,000
Other NHS providers	£1,820,000
Other	£1,894,000

This table emphasises that investment in treatment for cancer is concentrated in the hospital setting to a greater degree than other large programmes, such as mental health or circulation disorders.

**How did that estimate break down into sub-programmes, and what was the NYYPCT ranking against the other 152 PCTs in England?**

*(Source: new data return to DH, 2006/07)*

	£ per 100,000 weighted population	Rank out of 152 PCTs (1 is highest)
Total Cancers	9,353,571	20
<b>Head &amp; Neck</b>	<b>172,580</b>	<b>107</b>
<b>Upper Gastrointestinal</b>	<b>323,288</b>	<b>108</b>
<b>Lower Gastrointestinal</b>	<b>627,740</b>	<b>71</b>
Lung	359,340	86
Skin	215,059	42
Breast	607,694	98
Gynaecological	260,499	80
Urological	857,817	41
Haematological	612,411	120
Other	5,317,142	11

This breakdown is new, and much is allocated to “other” still.

## What are the age-related issues in this programme?

The national programme budget project does not as yet collect data by age in each programme (the difficulty being capturing GP prescribing data by age). The table below looks at the impact on hospital admissions for different age groups. Note that these age groups are in multiples of five years, but are not all the same size. They are the categories used to weight the allocation of resources to PCTs. Since we receive resources in these groupings it is appropriate to consider the health impacts at these ages, and plan ahead as the age structure of the population changes over the next ten years (see “the big picture” section).

Ages of admissions within this programme, NYYPCT residents, 2006/07

Programme	Age group (years)							Total
	0-4	5-14	15-44	45-64	65-74	75-84	85+	
Cancers & Tumours	194	295	2706	9465	6842	5594	1474	<b>26570</b>
<b>ALL</b>	<b>12306</b>	<b>6027</b>	<b>48029</b>	<b>44253</b>	<b>28075</b>	<b>26841</b>	<b>12087</b>	<b>177618</b>

Patients with cancer account for 15% of all hospital admissions. This is a larger than for any other programme. Hospital costs dominate this programme more than most others, reflecting the complexity of the disease and its treatment.

Another distinguishing characteristic of this programme is the relatively high proportion of 45-64 year olds, making up 34% of admissions in that age group. In the NYYPCT population we have a higher proportion of the population in this age band than is the case for England overall, and this excess is projected to remain in the 10-year forward projection.

Older age groups – 65-74 and 75-84 in particular are also heavily represented in the admissions figures. The numbers and proportion of these individuals is projected to rise even further in the next 10 years, so we should look to increasing the value of this programme budget accordingly.

Note the long list of NICE-approved treatments in the recent past and in the forward work programme (see below) which are generally paid for under hospital contracts as part of an admissions cost. The PCT needs to budget for this, but it also serves as a reminder to invest in prevention too.

The national lead for cancer services, Professor Mike Richards, has recently published a cancer reform strategy, taking each step in the patient journey in turn (see end of this chapter) and calling for a greater investment in prevention of hospital admissions.

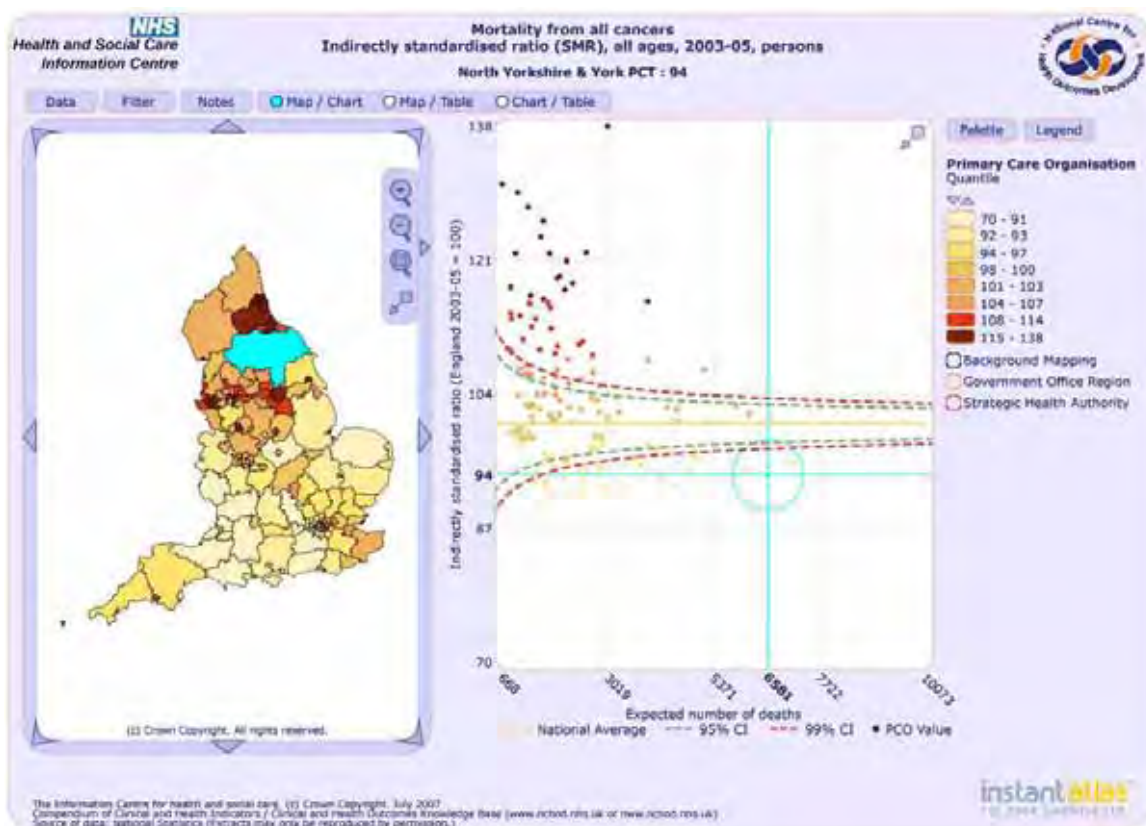
It would be informative to review the NYYPCT cancer programme during the coming year with patient groups, clinicians and managers to take stock of our relative priorities and investment. We need to keep pace with new treatments, but also to have a balanced portfolio of investment where quality of life and not just the prolongation of life is the focus of effort.

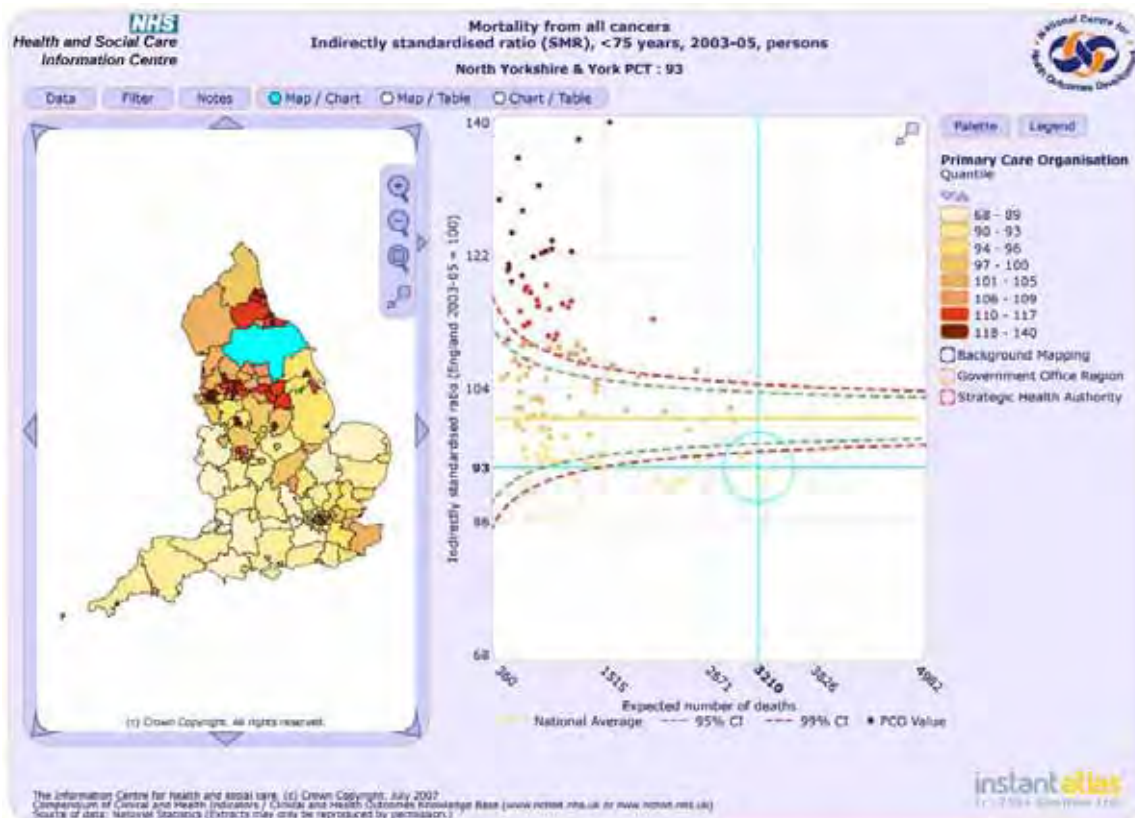
## How does the cancers and tumours programme outcome in North Yorkshire and the City of York compare with PCTs around England?

*Work in progress with DH/NCHOD ([www.nchod.nhs.uk](http://www.nchod.nhs.uk))*

The charts on the next page show the mortality from all cancers couched as indirectly standardised mortality ratios between 2003-05 in NYYPCT (highlighted in cyan on the map and in the crosshairs on the funnel plot) compared with every other PCT in England. The first chart is for all ages and the second, just for under 75s.

In both of the charts, North Yorkshire and York is an outlier with outcomes significantly better than the average for England.

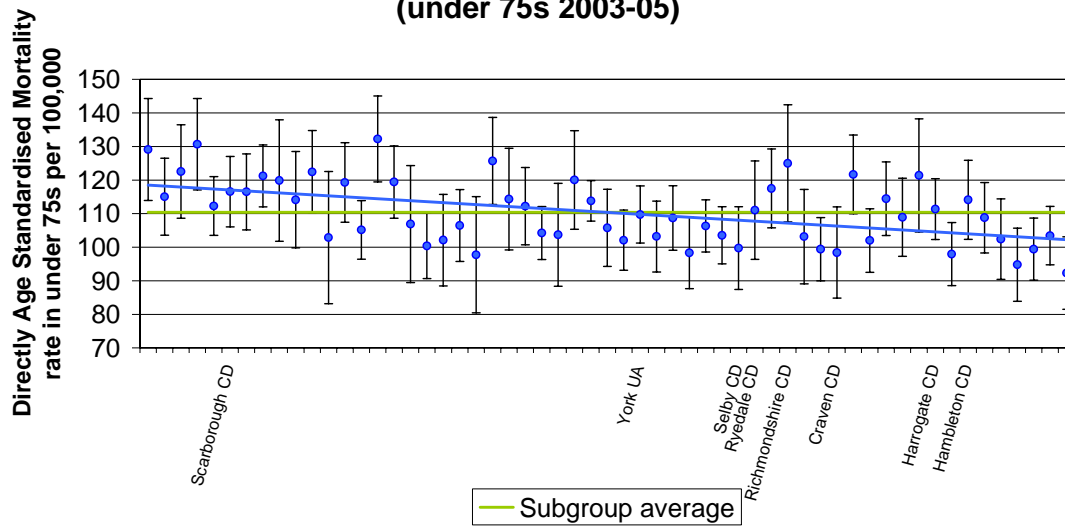




Do the rates of mortality and admission to hospital correlate with deprivation, at Local Authority district and electoral ward level, in North Yorkshire and the City of York?

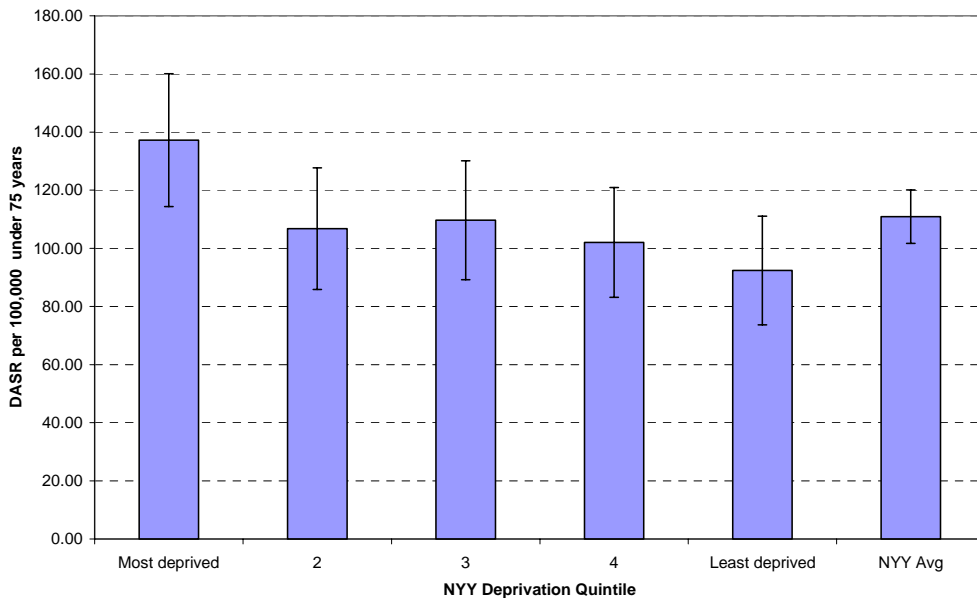
The following chart looks more closely at the Local Authority Districts that are served by the PCTs in the same ONS cluster as us to see if there are any geographical variations in mortality. The charts show Local authorities ranked from most deprived on the left to least deprived on the right according to deprivation as measured by the Indices of Deprivation 2004.

**Inequalities in premature mortality from cancer between  
Local Authority Districts served by the PCTs in the  
"Prospering Smaller Towns - B" ONS Subgroup  
(under 75s 2003-05)**



Source: The Information Centre for health and social care . © Crown Copyright.  
(NCHOD Workbench - July 2007)

**North Yorkshire and York PCT  
Premature mortality from all cancers (ICD10 C00-C97) by NYY deprivation quintile  
Directly age standardised rate (95% CIs) per 100,000 aged <75 years (2001-2005)**



Source: ONS; ODPM

## What guidance has NICE published of relevance to and recommended by way of investment in this programme?

### Published Guidance

Publication date	Type of guidance	Topic
<b>May-05</b>	Technology appraisal	Ovarian cancer (advanced) - topotecan, pegylated liposomal doxorubicin hydrochloride and paclitaxel for second-line or subsequent treatment
<b>May-05</b>	Technology appraisal	Ovarian cancer (advanced) - topotecan, pegylated liposomal doxorubicin hydrochloride and paclitaxel for second-line or subsequent treatment
<b>Jun-05</b>	Clinical guideline	Referral for suspected cancer
<b>Aug-05</b>	Technology appraisal	Colorectal cancer (advanced) - irinotecan, oxaliplatin and raltitrexed (review)
<b>Aug-05</b>	Cancer service guidance	Children and young people with cancer
<b>Feb-06</b>	Cancer service guidance	Skin tumours including melanoma
<b>Apr-06</b>	Technology appraisal	Colon cancer (adjuvant) - capecitabine & oxaliplatin
<b>Jun-06</b>	Technology appraisal	Prostate cancer (hormone-refractory) - docetaxel
<b>Jun-06</b>	Cancer service guidance	Brain tumours
<b>Aug-06</b>	Single Technology Appraisal	Breast cancer (early) - Trastuzumab
<b>Aug-06</b>	Technology appraisal	Colorectal cancer - laparoscopic surgery (review)

Publication date	Type of guidance	Topic
<b>Sep-06</b>	Single Technology Appraisal	Breast cancer (early) - Paclitaxel
<b>Sep-06</b>	Single Technology Appraisal	Breast cancer (early) - docetaxel
<b>Sep-06</b>	Single Technology Appraisal	Follicular lymphoma - rituximab
<b>Oct-06</b>	Clinical guideline	Familial breast cancer (Update)
<b>Nov-06</b>	Technology appraisal	Breast cancer (early) - hormonal treatments
<b>Jan-07</b>	Technology appraisal	Colorectal cancer (advanced) - bevacizumab and cetuximab
<b>Jan-07</b>	Single Technology Appraisal	Breast cancer - gemcitabine
<b>Feb-07</b>	Single Technology Appraisal	Leukaemia (lymphocytic) - fludarabine
<b>Jun-07</b>	Technology appraisal	Glioma (newly diagnosed and high grade) - carmustine implants and temozolomide
<b>Jul-07</b>	Short clinical guideline	Acutely ill patients in hospital
<b>Aug-07</b>	Single Technology Appraisal	Lung cancer (non-small cell) - pemetrexed

## In Progress Guidance

Publication date	Type of guidance	Topic
<b>Oct-07</b>	Single Technology Appraisal	Multiple myeloma - bortezomib
<b>Nov-07</b>	NPSA pilot	Systems based and IT based interventions in medicines reconciliation
<b>Dec-07</b>	Single Technology Appraisal	Follicular lymphoma - rituximab
<b>Jan-08</b>	Single Technology Appraisal	Glioma (recurrent) - carmustine implants
<b>Feb-08</b>	Clinical guideline	Prostate cancer
<b>Feb-08</b>	Technology appraisal	Anaemia (cancer-treatment induced) - erythropoetin (alpha and beta) and darbepoetin
<b>Feb-08</b>	Single Technology Appraisal	Breast cancer (advanced & metastatic) - lapatinib
<b>Apr-08</b>	Clinical guideline	Perioperative hypothermia (inadvertant)
<b>Nov-08</b>	Clinical guideline	Metastatic spinal cord compression
<b>Dec-08</b>	Clinical guideline	Medicines concordance
<b>Jan-09</b>	Clinical guideline	Breast cancer (Advanced)
<b>Jan-09</b>	Clinical guideline	Breast cancer (early)

Publication date	Type of guidance	Topic
<b>TBC</b>	Single Technology Appraisal	Head and neck cancer - cetuximab
<b>TBC</b>	Technology appraisal	Pancreatic cancer - gemcitabine
<b>TBC</b>	Technology appraisal	Colon cancer (advanced) - irinotecan
<b>TBC</b>	Single Technology Appraisal	Lung cancer (non small cell) - bevacizumab
<b>TBC</b>	Single Technology Appraisal	Lung cancer (non-small cell) - erlotinib
<b>TBC</b>	Technology appraisal	Lung cancer (non-small cell) - gefitinib
<b>TBC</b>	Technology appraisal	Mesothelioma - pemetrexed disodium
<b>TBC</b>	Single Technology Appraisal	Prostate cancer (hormone-refractory) - atrasentan
<b>TBC</b>	Technology appraisal	Glioma (recurrent) - temozolomide

## Summary of commissioning questions for cancers and tumours.

- In the light of our slightly higher than average investment in this programme compared with other PCTs, and the favourable outcomes that are being achieved, should we invest more or the same programme budget, bearing in mind the very long list of NICE appraisals in this programme?
- Have we got the balance of activity and investment right at each step from prevention to terminal care, and between the partners (marginal analysis)?
- What are the most important things to do this year?

### Prevention

- Smoking cessation
- 5-a-day
- Physical activity (obesity reduction)
- Alcohol reduction
- SunSmart (skin cancer reduction initiatives)
- Prepare for launch of HPV immunisation in girls during 2008 (to reduce risk of cervical cancer)

### Diagnosis and Assessment

- Maintain uniformly high screening uptake – breast, cervix and bowel (when available)
- Meet two week access target from referral.
- Direct access to diagnostic facilities

### Treatment

- Follow NICE guidance where issued (see above) This will be a major focus for investment and redeployment of resources for cancer in 2008 and beyond. Although our death rates are favourable for the UK, they are not falling fast enough, especially in the under-75s.
- New developments such as the Leeds Oncology wing should enhance quality of care but at a substantial opportunity cost to the local system, especially in start-up costs.

### Rehabilitation and Continuing Care

- Cancer is often a chronic condition, so minimise hospital admission in favour of community or domiciliary treatments wherever practicable.
- Enter into proper Service Level Agreements with carers and their support organisations, who can enhance the patient experience and reduce calls on NHS services.

### Terminal Care

- Frank and informed planning for terminal illness, respecting patient choice for place of death whenever possible.