Agenda No 7

AGENDA MANAGEMENT SHEET

Name of Committee	**Health Overview And Scrutiny Committee**
Date of Committee	**24 January 2007**
Report Title	**Arden Cancer Network**
Summary	Richard Hancox, Director of the Arden Cancer Network will attend to give a presentation to the Committee. Supporting papers attached.
For further information please contact:	Phil Maull Senior Committee Administrator Tel: 01926 412834 philmaull@warwickshire.gov.uk

Arden Cancer Network

PEER REVIEW FINDINGS

Presentation to Warwickshire Overview and Scrutiny Committee

Richard Hancox, Network Director

24th January 2007

Arden Cancer Network

Welcome

Presentation contents:

1. What is Arden Cancer Network?
2. Overview of Clinical Outcomes
3. Peer Review Findings, Action Planning and Progress to date
4. Commissioning Intentions 2007-8
5. Next Steps

Arden Cancer Network

1. What is the Network?

Arden Cancer Network

The Vision of the Arden Cancer Network is:

- *"To provide the highest quality, safe, equitable and locally accessible services, in line with the NHS Cancer Plan and NICE guidelines, to the people of Coventry, Warwickshire, Redditch and Bromsgrove".*

Arden Cancer Network

Network Key Aims:

- Develop a managed clinical network for cancer care, optimising patient experience throughout the cancer journey
- Implement the NHS Cancer Plan and NICE guidance to improve standards of cancer care, as well as reducing cancer waiting times
- Ensure a continued focus on health promotion, screening and disease prevention, working closely with primary care
- Work with our partners and service users to plan and deliver services that as well as being clinically safe and technically and diagnostically excellent, are also patient centred, taking a service improvement perspective
- Assess both good and poor performance, including through Peer Review processes, and support the improvement of service quality

Arden Cancer Network

Network Achievements

- Opening of Arden Cancer Centre
- Cancer Waiting Times (31 days 99% 62 days 95% Aug)
- Coventry & Rugby Bowel Cancer Screening Pilot
- Clear Network Strategy and Commissioning plans
- Early Introduction of Herceptin and improved Prescribing
- Strong Clinical Engagement and thriving User Group
- Successful Macmillan funding for Palliative Care Psychology posts
- Advanced Communication Skills training programme
- Overall successful Peer Review
- But - need to complete some WIP

Arden Cancer Network

2. Clinical Outcomes

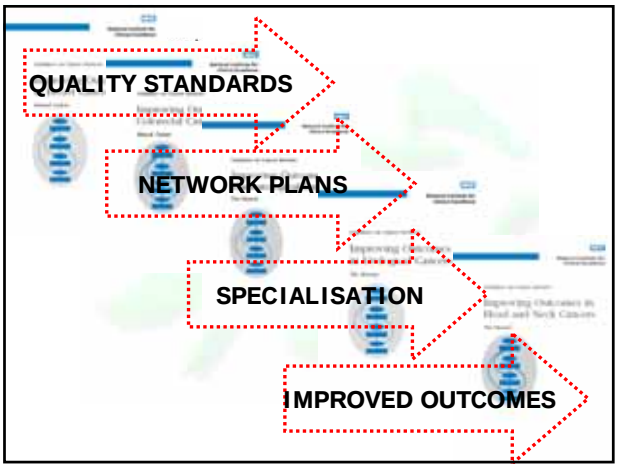
5 year survival %, 2000-02

males 4.2%, females 2.9% in Coventry

Females 31.9% in N Warks

Females 30.7% in Rugby

Tumour		West Midlands	Arden
breast		77.6	79.5
lung	m	6.9	5.4
	f	6.9	6.1
colon	m	45.6	45.1
	f	46.5	43.7
rectal	m	46.2	44.2
	f	49.9	50.3
ovarian		38.3	36.3
prostate		64.3	68.8
oesophago-gastric	m	11.7	11.8
	f	11.4	10.4



Arden Cancer Network

3. Peer Review Findings, Action Planning and Progress to date

- Urology
- Gynaecology
- Upper GI
- Haematology
- Chemotherapy
- Oncology

Arden Cancer Network

Urological cancers

- Agree date for Specialist MDT at Cancer Centre *- agreed to commence on 7th February 2007*
- All complex surgery for Coventry & Warks at Centre *- agreed to commence from January 2007*
- Agree guidelines / service model for Redditch & Bromsgrove patients *- model agreed with 3CCN / DH*
- Agree referral policy re testicular / penile cancers *- patients referred to Leicester. Guidelines being developed, supported by West Midlands Rarer Tumours Group*

Arden Cancer Network

Gynaecological cancers

- NSSG attendance from Trusts *- confirmed*
- Agree activity levels and plan transfer of work to Cancer Centre *- transfer now commenced from all sites (including WAHT)*
- Appointment of 2nd gynaecologist at UHCW *- out to advert / interviews to be held in early 2007*
- Agree date for SMDT *- date to be agreed at 31st January 2007 NSSG*

Arden Cancer Network

Upper GI cancers (HPB)

- UHCW service not complaint (expected catchment population 2-4M) for hepatobiliary and pancreatic (HPB) cancers *- West Midlands Rarer Tumours Group has recommended a service model (Dec 2006) which allows the HPB service at UHCW to grow within a two-year timeframe to help support needs of West Midlands population (5-6M). In addition, an audit framework is being developed by Supra Network HPB Group (Sub Group of West Midlands Rarer Tumours Group).*

Haematology

- Need to plan to develop 2 SMDTs - *agreed! (lymphoma and non-lymphoma).*

  But: need to press on with IOG implementation - subject to commissioner 2007 LDP approval (net cost of transfer of activity from Warwick to UHCW and quality enhancement = £1.1M).

Chemotherapy

- Strategy for development of Chemotherapy services to be developed - *Draft Strategy presented to Network Executive Group in November 2006.*

  Final Draft taking into account late comments to be circulated to Network Board members in January 2007. Strategy encompassed ambulatory care models at Warwick and UHCW

Oncology

- Need to undertake a capacity and demand analysis of oncology provision - *capacity and demand study at Warwick and WAHT underway - data from GEH and UHCW is still awaited.*

  Business case for two additional UHCW medical oncology posts to form part of 2007 LDP discussions

4. Commissioning Intentions

Commissioning intentions for 2007 LDP to include:

- Haematology
- Paediatric Oncology
- Head & Neck IOG
- Specialist Palliative Care - Coventry Myton
- Medical Oncology
- Ambulatory Care

5. Next Steps

- Input commissioning intentions (as above) into PCT 2007 LDP
- Plan for haematology transfer - Oct 2007
- Implement Warwick ambulatory care model via Project Board - April 2007
- Complete any outstanding Peer Review issues and embed good practice before follow-up Peer Review (2007-8)

Web address: www.arden.nhs.uk

Arden Cancer Network Paper for Executive Group meeting 22nd January 2007

PEER REVIEW IMPLEMENTATION ACTION PLAN – PROGRESS REPORT

UROLOGY
PEER REVIEW REPORT

The urology NSSG has agreed a plan for implementing IOG but this does not meet the requirements of the measures in a number of respects:

- The Worcestershire team is currently acting as a specialist MDT. Joint discussions with the 3 Counties Cancer Network and the Cancer Action Team are needed to agree:
  - Either: A specialist MDT based in Worcestershire, undertaking radical surgery locally and linked to two networks for oncology support, agreement of guidelines, data collection and audit. (NB: This would not meet the IOG population requirement).
  - Or: A local MDT for Worcestershire, cessation of radical surgery being undertaken in Worcestershire and referral of patients to specialist teams in both 3 Counties and Arden networks in accordance with network-agreed guidelines.
  - Or: a local MDT for Worcestershire, patients discussed at the specialist teams in the 3 Counties and Arden networks, with radical surgery undertaken in Worcestershire according to agreed clinical, referral and follow up guidelines.
  - Review of network-wide clinical, referral and follow up guidelines to ensure that these reflect the new arrangements.
- The action plan does not yet address the issues of surgeons at UHCW performing less than five cystectomies per year.
- The arrangements for care of patients with testicular cancer are not clear. The team at UHCW does not meet the requirements of a supra-network testicular team. The visiting team to UHCW made the following recommendations in relation to the care of patients with testicular cancer:
  - UHCW does not have the referral population to establish a supra-network testicular cancer MDT.
  - It is appropriate for the oncologists at UHCW to continue to provide simple chemotherapy locally, following discussion at a supra-network MDT and in accordance with clinical guidelines agreed by that MDT.
  - The UHCW oncologists need to be part of the discussion at the supra-network MDT – which could be achieved by video-conferencing.
  - If the cancer network continues with its decision to refer patients to the testicular MDT based at Leicester, it will need to ensure that this team is commissioned and developed to meet the measures for a testicular team, in particular:
- The team should have the composition expected by IOG. In particular, specialist nursing support should be available to patients throughout their 'journey'.
- Clinical and referral guidelines should be agreed.
- Arrangements for care of patients with kidney and penile cancers have not yet been agreed.

PEER REVIEW ACTION PLAN

Organisational action plan details. (cross referenced to Network Action Plans)	Director responsible for Action	Key Milestones	Date of Completion
Need to agree joint guidelines with 3CCN	NSSG Chair		December 2006
Need to agree service model re WHAT with 3 Counties Cancer Network and NSSG	Network Chair		September 2006
Agree date for SMDT	Trust cancer managers/ lead clinicians		October 2006
Need to consolidate cystectomy procedures within UHCW	Trust lead clinicians/SIL to facilitate change		October 2006
Need to agree referral policy re testicular cancer with LNR and identify infrastructure requirements	NSSG Chair/SIL		December 2006
Need to agree referral policy re Kidney and Penile cancer with LNR	NSSG Chair/SIL		December 2006

PEER REVIEW ACTION PLAN UPDATE

The transfer of surgical activity from the Units to the Cancer Centre has been agreed and Mr John Strachan will operate at UHCW one session every four weeks; Mr Krishna Prasad will cover the other session over the other three weeks. This is due to start week commencing 7th January 2007.

Mr John Strachan is working on the referral policies for testicular, kidney and penile cancers with LNR, which will be discussed and approved at the next NSSG on March 19th 2007. At the NSSG on 13th December 2006, it was agreed that the SMDT will run on Wednesday afternoons at UHCW, from 2 – 4 pm on a weekly basis. The agreed start date is 7th February 2007.

The service model at WAHT has been agreed with the Cancer Action Team and Three Counties Network. The Alexandra Hospital will continue as a local MDT with patients discussed at the Arden SMDT and treated locally.

GYNAECOLOGY
PEER REVIEW REPORT

This is not a functioning NSSG. There is no involvement by the lead clinicians from any of the three local MDTs although CNSs attend from these teams. Although compliance with some measures has been given as 'yes' – this should not be taken as reflecting achievement of these measures in the way intended in the Manual of Cancer Services. Improving Outcomes Guidance has not yet been implemented across the Network, patient pathways are not clear and patients are being operated on by local teams where the guidance recommends that they should be referred to the specialist team. The Network plan is for a second surgical gynaecological oncologist to be trained at UHCW with the assumption that appropriate patients will then be referred to the specialist team. Across the Network there are no surgical links between local teams and the specialist team. Most referrals to the specialist team come via oncologists who attend some of the local MDT meetings – and who link more closely with local teams than their surgical colleagues.

These difficulties in establishing effective patient pathways and NSSG working across the Network were evident at the last visit (2001). The situation has deteriorated since then, with less cooperation between South Warwickshire and UHCW. Given the difficulties in relationships between teams, it is very unlikely that implementation of IOG will be achieved without additional support. The Network Board needs to given a higher priority to achieving a functioning NSSG and to ensuring that this group addresses all aspects of implementation of IOG.

PEER REVIEW ACTION PLAN

Organisational action plan details. (cross referenced to Network Action Plans)	Director responsible for Action	Key Milestones	Date of Completion
Trust clinical leads to confirm Trust attendees for future NSSGs.	Trust clinical leads.		May 2006 NSSG
Need to identify current activity levels at local MDTs (including Alexandra) and plan transfer of work to cancer centre at UHCW to agree IOG milestones.	Trust Cancer Managers/SIL to facilitate change.	Transfer of work planned for October 2006 (as per 10G plan)	May 2006 NSSG
Appointment of further gynae-oncologist at UHCW.	Medical Director, UHW.		October 2006 – Jan 2007
Agree day and times for SMDT, including video.	NSSG Chair/SIL.		October 2006

PEER REVIEW ACTION PLAN UPDATE

The transfer of gynaecology surgical activity from the Units to the Cancer Centre has commenced, as agreed at the special meeting held at UHCW on 23rd July 2006 and as per the IOG Action plan.

The commencement date for Mr Sant Cassia to hold clinics at the Alexandra Hospital has been confirmed as 15th January 2007. Patients are already booked in at that clinic.

The timings for Specialist MDT have yet to be agreed, but it should be noted that video conferencing facilities are available at all Trusts. Final agreement should be reached at the NSSG meeting due to take place on 31st January 2007. (Unfortunately the schedule meting for 13th December 2006 was stood down).

A job description for the second gynae-oncologist has been approved by the UHCW Hospital Management Board.

UPPER GI
PEER REVIEW REPORT

The Improving Outcomes Guidance action plan does not meet the expected two to four million catchment population for hepato-biliary and pancreatic services.

PEER REVIEW ACTION PLAN

Organisational action plan details. (cross referenced to Network Action Plans)	Director responsible for Action	Key Milestones	Date of Completion
Trust to produce business case for development of HPB service to achieve IOG compliant catchment population, with clear milestones, for agreement of Network Board /Supra Network HPB Group.	NSSG Lead	Complete feasibility study – July 06. UHCW to produce a business case for agreement by the Network Board Sept 06.	Sept 2006 Network Board Meeting.

PEER REVIEW ACTION PLAN UPDATE

Following a round table discussion at UHCW - including the Chair of the Rarer Tumours Group, the Chair of the Supra Network HPB group, a representative from Pan Birmingham Cancer Network and the Arden Cancer Network Lead Clinician and Network Director - proposals were put forward to the Arden Cancer Network Board as well as to the Supra Network HPB Group and Rarer Tumours Group to establish a three centre model for pancreatic and biliary cancer services, and a two centre model for liver cancer services across the West Midlands. Under these proposals, the Cancer Centre within the Arden Cancer Network would be providing the full range of HPB services (ie both pancreato-biliary and liver cancer services).

The members of the Arden Cancer Network Board voted in favour of the continued development of HPB services at Coventry and for a request that the service be subject to external follow up Peer Review within a two-year timeframe (this is now planned for Spring 2008). The continued development of HPB services at UHCW was also supported by the West Midlands Rarer Tumours Group at its meeting held on 15th December 2006, and at present the audit requirements for this service are being defined through the HPB Supra Network Group.

HAEMATOLOGY
PEER REVIEW REPORT

The plan for implementation of Improving Outcomes Guidance for patients with haematological malignancies involves reducing to two MDTs within the Network. At present there are four MDTs in operation across the Network. Each of these MDTs has a population of less than the expected 500,000.

PEER REVIEW ACTION PLAN

Organisational action plan details. (cross referenced to Network Action Plans)	Director responsible for Action	Key Milestones	Date of Completion
The IOG plan is not to maintain 4 MDTs, but to create SMDTs for lymphoma and non-lymphoma network side. Awaiting financial agreement for transfer of service by commissioners.	Network Director / Network Commissioners / Trust Lead Clinicians		April 2007

PEER REVIEW ATION PLAN UPDATE

Further to the letter from the Network Chair to the Chief Executives of South Warwickshire PCT and Warwick Hospital in respect of the local implementation of the haematology IOG, dated 6th July 2006, a briefing note has been developed for the Warwick Hospital Trust Board by the Director of Strategy, circulated to the Cancer Network on 9th November, which confirms that progress has been made in terms of matching income to the current cost of this service at Warwick hospital (principally through the identification of funding for high cost drugs). Further to a series of finance meetings held during 2006 with representatives from Warwick Hospital, UHCW and also commissioners from Warwickshire and Coventry PCTs to agree the overall financial position in respect of the transfer of activity to the Cancer Centre, the revised position (subject to final confirmation) as at 19th December 2006 was a gap of £1.1Million in total: represented by £610k cost for "Phase 1" transfer of activity and £466k "Phase 2" improvements in quality standards.

Subject to commissioner support to the costs of meeting the IOG standards at the cancer centre, and to funding the residual income shortfall re the transferred activity from Warwick as an 2007-8 LDP "pre-commitment", discussions can commence in earnest re the arrangements for transfer of this activity including patient pathways. Assuming agreement to funding through the 2007-08 LDP round, a revised implementation timescale of October 2007 is felt to be more realistic.

CHEMOTHERAPY
PEER REVIEW REPORT

There is a mixed picture of chemotherapy services across the network and no clearly agreed strategy for tackling this. (Details are given in the individual Trust/locality reports.) The Network needs to develop and agree a strategy for the development of chemotherapy services across the Network. This strategy needs to take account of:

- Impact of new drugs and regimens
- Impact of appointing medical oncologists
- Potential for developing services at Warwick, George Eliot and Alexandra Hospitals
- Medical cover and organisation of chemotherapy services at Warwick, George Eliot and Alexandra Hospitals
- Capacity required at UHCW in the interim and when additional capacity is available at other hospitals
- Management of complications of chemotherapy

This strategy, when agreed, will need to be driven forward with determination on a network-wide basis.

PEER REVIEW ACTION PLAN

Organisational action plan details. (cross referenced to Network Action Plans)	Director responsible for Action	Key Milestones	Date of Completion
Strategy for development of chemotherapy services to be developed.	Network Lead Nurse / Drug an Therapeutic Group Chair		December 2006

PEER REVIEW ACTION PLAN UPDATE

The initial draft of the Arden Cancer Network Chemotherapy Strategy was evolved for wider comment following consultation and discussion with members of the Nursing and Pharmacists Chemotherapy Group. The main focus of the Network Chemotherapy Strategy is the development of ambulatory chemotherapy services at the Cancer Centre and the peripheral units which will resolve capacity deficits. Themes explored within the strategy include: quality of care, workforce development, service improvement and financial infrastructure. A number of recommendations have been made to ensure the development of an equitable, safe service.

A second draft of the strategy was circulated for wider comment following the Executive Group meeting held on 20th November 2006, and the document is currently in final draft stage, pending sign off by the Arden Cancer Network Board at its next meeting on 19th February 2006.

CONSULTANT ONCOLOGY SESSIONS
PEER REVIEW REPORT

The distribution of consultant oncologist sessions across the hospitals in the Network is uneven. At present, there are no medical oncologists in the Network – although this has been identified as a priority for development. South Warwickshire Hospital has only five oncologist sessions, George Eliot Hospital has eight sessions and the Alexandra Hospital, Redditch has seven sessions. (UHCW has 103 DCCs but it is not clear if this includes sessions in other hospitals.) The workload for some oncologists is excessive and several MDTs across the network have no oncologist – or there is no cover for absences. There does not appear to have been any capacity and demand work to identify the 'true' gap in service provision. This work needs to be done and a strategy for future services developed. This strategy should take into account the need for oncologist time to support the organisational and development of services in peripheral hospitals. As part of this work, it may be helpful also to look at the distribution of consultant haematologist sessions across the network – and the issues raised for further consideration in the haematology NSSG report.

PEER REVIEW ACTION PLAN

Organisational action plan details. (cross referenced to Network Action Plans)	Director responsible	Key Milestones	Date of Completion
Capacity and demand analysis to be undertaken across the Network to recommend appropriate future distribution of resources across Cancer Units and Centre. Resulting action plan to be submitted in next commissioning round 06/07.	Network Director / Network Commissioning Group Chair.		December 2006

PEER REVIEW ACTION PLAN UPDATE

The questionnaire and timetable to identify current activity was circulated to Trusts with a deadline for completion of the end of November 2006. It is intended that an analysis of the information will identify gaps in service and the resulting action plan will inform next commissioning round.

To date, however, only 2 questionnaires have been received - from Alexandra and Warwick Hospitals - and the analyses from UHCW and GEH remain outstanding. UHCW have, however, developed a business case for the introduction of two medical oncology posts to feed into the 2007-8 LDP planning process.

Commissioning Intentions for Cancer Services 2007-12

1. Implementation of NICE Improving Outcomes Guidance action plans

Haematology Improving Outcomes Guidance Implementation
The Arden Cancer Network plan to complete the centralisation process for haematological cancers involves the transfer of complex cases from Warwick Hospital to UHCW and improvements in nurse staffing levels to achieve JACIE accreditation for the Network's population. The plan also requires an additional consultant haematologist to provide 11 whole time equivalent posts across Coventry and Warwickshire: this will give flexible countywide cover, sub-specialised into two teams. Additional oncology, radiology and pathology time is also required for full countywide Multi-Disciplinary Team (MDT) working. The service aim is to deliver outpatient chemotherapy and other treatments locally – and for care standards to be enhanced.

Paediatric Oncology Improving Outcomes Guidance Implementation
UHCW provided a business case during the 2006-7 LDP round for the enhanced treatment services required to develop local paediatric oncology shared care, linking into Birmingham Children's Hospital. Whilst the West Midlands Specialist Commissioning Group is co-ordinating overall IOG implementation - and has helpfully defined the appropriate model of shared care to be commissioned locally -, PCTs are expected to commission local shared care services.

Head and Neck Improving Outcomes Guidance Implementation
In order to implement the Head & Neck IOG, MDTs from UHCW, Heart of England NHS Trust, Warwick Hospital and Walsall Hospitals NHS Trust have been merged into a single, weekly, joint meeting - using audio-visual links to minimise the impact on therapist and auxiliary support and the extended members of the team –; and inpatient care for people requiring complex head and neck surgery across Coventry and Warwickshire has been centralised at UHCW. A Specialist dental rehabilitation/restorative service will also require development, and it is anticipated there will be a further requirement for increased support from the cancer nurse specialist, speech and language therapist, dieticians and physiotherapists at UHCW as the case load and complexity of inpatient surgery increases following major head and neck surgery.

Specialist Palliative Care Improving Outcomes Guidance Implementation
Following a needs assessment of palliative care services undertaken by SCHARR in 2004, it was determined that Arden Cancer Network required an additional 20 hospice beds. An outline commitment was given by the Network's commissioners to provide financial support of £500k from the specialist palliative care allocation to support the development of additional capacity within the proposed new Coventry Myton Hospice. Discussions are

continuing between Coventry and Warwickshire PCTs and Myton Hospice in order to determine the final service model – as well as and patient and associated financial flows. It is hope that this new facility will be commissioned in 2008.

Implementation of Improving Outcomes Guidance for other tumour sites
Recent Implementation of NICE Improving Outcomes Guidance for Urology, Gynaecology and Upper GI cancers will need to be reflected in PCT commissioning plans for 2007-8 onwards. In addition, future iterations of the Commissioning Strategy will need to be updated to encompass new IOG implementation plans for skin, colorectal (revised IOG), bone and soft tissue, brain & central nervous system cancers etc.

2. Gaps in service provision identified through Peer Review processes.

Medical Oncology posts
The lack of medical oncology within the Arden Cancer Network was, as expected, picked up as a serious service deficit through Network Peer Review (2005). Implementation of medical oncology will also bring additional drug therapy costs associated with improved prescribing practice.

3. Local priorities within the Arden Cancer Network Strategy 2006

Ambulatory Care
Both Warwick Hospital NHS Trust and UHCW are developing business cases for the introduction of Ambulatory care, in line with the Arden Cancer Network Strategy 2006. Peer Review noted that Warwick Hospital was the only cancer unit in the West Midlands not providing solid tumour chemotherapy. Provision of local chemotherapy at Warwick will also unlock more physical capacity for chemotherapy (and potentially further trials activity) at UHCW. The aim of the ambulatory care is to provide as much specialist care and support to patients at their local hospital as possible, as well as providing specialist advice and support from the Cancer Centre and strengthening the professional links to more specialist Cancer Centre based services.

Bowel Cancer Screening
The success of the national pilot site for bowel cancer screening at Coventry and Rugby has led to the national roll-out of this programme across the Country. Following on from this early success, the Arden Cancer Network will bid to DH to establish of a screening service across Coventry and Warwickshire from April 2007.

Improved early detection and diagnosis of cancer
Finally, improved early detection and diagnosis of cancer will be facilitated locally trough the adoption and use of revised Network primary Care two week wait referral guidelines, including through Choose and Book.

DH Department of Health

Choosing Health
Making healthier choices easier

NHS

Health Profile for Warwickshire 2006

ASSOCIATION OF PUBLIC HEALTH OBSERVATORIES APH

Introduction

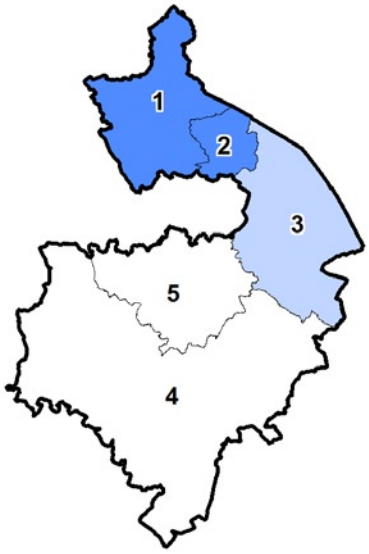
Local authority health profiles are designed to show the health of people in each local authority area, and include comparisons with other similar populations. They are produced by Public Health Observatories and will be updated annually. With other local information[1] these profiles demonstrate where action can be taken to improve people's health and reduce health inequalities.

[1]e.g. Community Plans, Director of Public Health Annual Reports, Local Area Agreements.

Key points

- Deprivation is low overall in all of the constituent areas. The rate of violent crime is significantly lower than average.
- Secondary school examination results are significantly higher than national results, with White and Asian children achieving significantly higher results when compared nationally.
- The rate of elderly supported to live independently at home is significantly lower than the national average.
- Health is generally good when compared with England; approximately 1 in 15 adults surveyed reported being in poor health.
- Estimates suggest that the percentage of adults who smoke or are obese are both lower than the national figures. The percentage of adults who binge drink is higher than the national average, however the rate of hospital admissions relating to alcohol is significantly lower.
- Both male and female life expectancy is significantly above the national average. The county has significantly lower than average rates of death from smoking related disease and heart disease and stroke and cancer. Deaths and serious injury on the county's roads are significantly lower than average.
- The teenage pregnancy rate is significantly lower than the national average.
- Dental decay in the under 5s and drug misuse are both significantly lower than the national figure.
- The significantly high prevalence of diabetes may be due to high quality reporting within GP practices.

Health inequalities – life expectancy



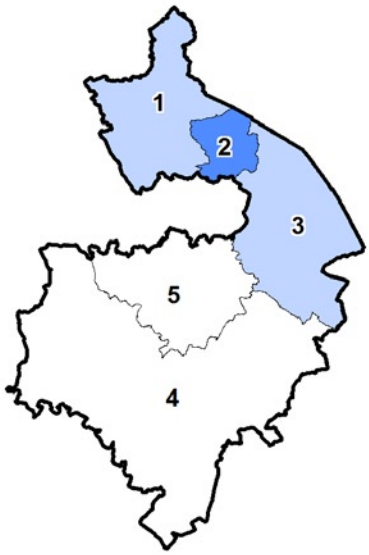
This map shows inequalities in life expectancy at birth for males only, by district. It is based on significance above and below the England average for males.

Comparison to England average for males (76.6 years) 2002-04

- Significantly lower
- Lower but not statistically significant
- Higher but not statistically significant
- Significantly higher

Life expectancy for all persons in the lowest fifth of wards in the county is 76.2 years compared with 82.7 years for the highest.

Health inequalities – deprivation



This map shows deprivation by district. The four categories are population- based, ie. 'most deprived 25%' refers to the most deprived districts accounting for 25% of England's population.

Index of Multiple Deprivation 2004 District averages

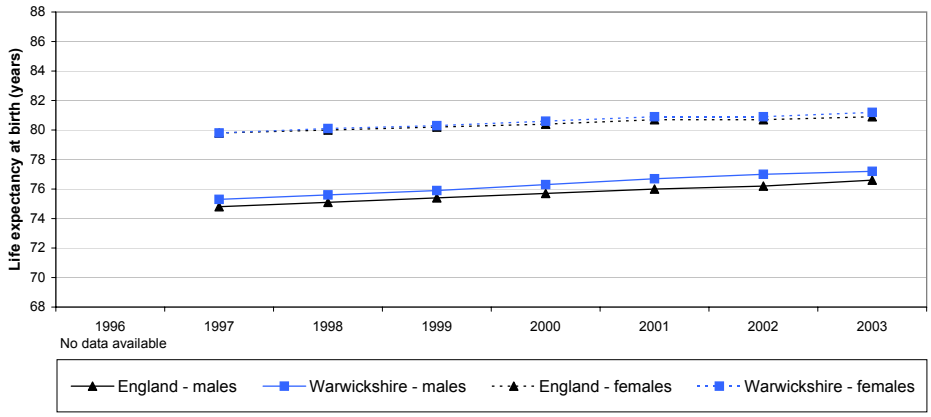
- Most deprived 25%
- Second most deprived 25%
- Second least deprived 25%
- Least deprived 25%

District legend

1 North Warwickshire
2 Nuneaton and Bedworth
3 Rugby
4 Stratford-on-Avon
5 Warwick

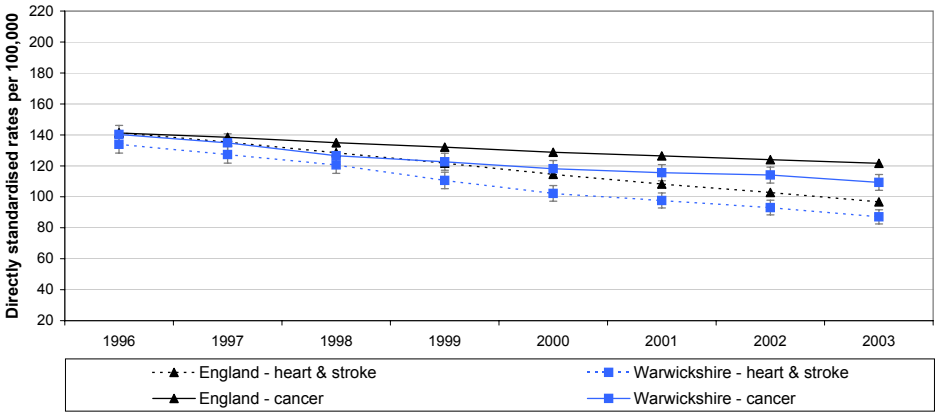
Health inequalities

Trend 1: Male and female life expectancy



This chart compares the trends in life expectancy at birth for men and women in this area with that for England.

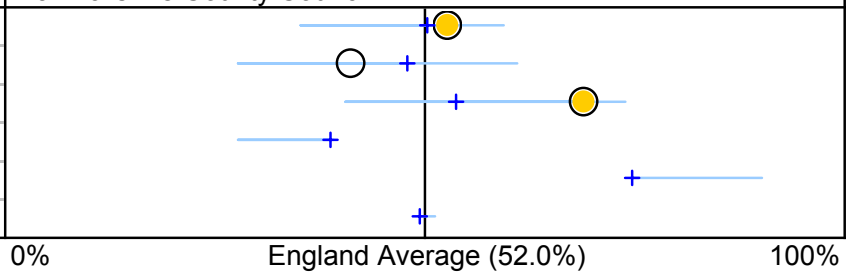
Trend 2: Deaths from heart disease/stroke and cancer



This chart compares the trends in deaths for all persons under 75 years due to heart disease/stroke and cancer in this area with that for England.

Health inequalities – GCSE achievement

Ethnic group	No.	%
Total White	2902	54.8
Total Mixed	41	42.7
Total Asian	155	70.8
Total Black	-	-
Chinese	-	-
Other ethnic group	-	-



Significantly better than England average
Significantly worse than England average
Not significantly different from England average
Ethnic Group National Average
Ethnic Group Regional Range

This chart compares GCSE achievement (no. and % achieving 5 A*-C grades in 2003/04) of children in different ethnic groups in this education authority's schools to the England average for all children. Completeness of ethnicity coding varies for different indicators - GCSE achievement is one of the most complete, at 96%. Where less than 30 children in a particular ethnic group took GCSE exams the % pass rate is not shown.

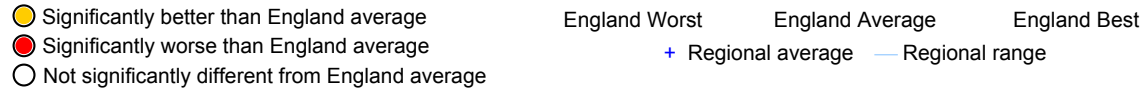
Further information

You may use this prototype for non-commercial purposes provided the source (APHO and Department of Health) is acknowledged. Produced by APHO with interpretation by your regional PHO. Thanks to all partner organisations. More information at www.communityhealthprofiles.info and your regional PHO www.apho.org.uk. Also see Audit Commission Area Profiles at www.audit-commission.gov.uk/areaprofiles. 'Health Profile of England' to be available at www.dh.gov.uk.

Health summary

How to interpret:
First look at the circle which shows how this local authority is doing, compared with the England average (central line), best (right side) and worst (left side). Look at the numbers, values and time periods in the columns. Some numbers shown are totalled over more than 1 year. Red is significantly worse and amber significantly better than the England average (95% confidence intervals used for the local data). Amber may still indicate a significant public health burden. A clear circle is not significantly different from the England average. Then, compare with the regional average (+ symbol), and the regional range (—).

Domain	Indicator	No.	Value		Warwickshire County Council	Period	Notes
Our communities	Deprivation	24,720	4.9	%		2001	1,2
	Air quality*					2001	2
	Poor quality housing*			%		01.04.05	3,10
	Children in poverty*	12,964	13.2	%		2001	2
	GCSE achievement (5 A*-C)*	3,471	57.2	%		2004/05	
	Violent crime	6,491	12.4	CR1		2004/05	
	Older people supported at home*	5,128	59.7	CR2		31.03.05	4
Giving children and young people a healthy start	Smoking in pregnancy						5
	Breast feeding						5
	Obese children*						5
	Physically active children*						5
	Teenage pregnancy (under 18)*	1,071	37.8	CR3		2001-03	
The way we live	People who smoke*		20.3	%		2000-02	6
	Binge drinking		20.0	%		2000-02	6
	Healthy eating		26.8	%		2001-02	6
	Physically active adults						5
	Obese adults		24.9	%		2000-02	6
How long we live and what we die of	Life expectancy - Male*		77.2	yrs		2002-04	
	Life expectancy - Female*		81.2	yrs		2002-04	
	Deaths - smoking	2,484	111.7	DSR1		2002-04	
	Early deaths - heart disease & stroke*	1,532	87.1	DSR2		2002-04	
	Early deaths - cancer*	1,875	109.3	DSR2		2002-04	
	Infant deaths (under 1 year)*	75	4.6	CR4		2002-04	
	Road injuries and deaths*	1,036	6.1	CR5		2003-04	7
Health and ill health in our community	Feeling “in poor health”	39,507	6.7	DSR3		2001	
	Mental health treatment	2,427	0.4	%		2005	8
	Alcohol related hospital stays	3,593	137.8	DSR4		1998-03	
	Drug misuse treatment*	983	467.0	CR6		2004/05	9
	People with diabetes	16,989	3.1	%		2005	9
	Children’s tooth decay		0.7	DMFT		2003/04	10,11
	Sexually transmitted infections						5



- Significantly better than England average
- Significantly worse than England average
- Not significantly different from England average

Notes

Full indicator information in metadata report, see www.communityhealthprofiles.info

Notes

1. No. and % of people in this area living in the 20% most deprived areas of England. **2.** No significance is calculated for this indicator. **3.** No data for authorities that have undertaken large scale voluntary transfer (LSVT). **4.** Data only available for County/Unitary Authorities/London Boroughs; data presented at District Authority level is County data. **5.** GAP indicator - no data currently available, but will be provided when it becomes available. **6.** Synthetic estimates derived from the Health Survey for England. **7.** New indicator - People killed or seriously injured per 100 million vehicle kilometres. **8.** High rates considered ‘better’ as reflects better service provision. **9.** High rates considered ‘worse’ as reflects high prevalence. **10.** Data incomplete or missing for some areas. **11.** DMFT: Average no. decayed, missing or filled teeth.

Key

* Supports PSA Targets 2005-2008.

DSR1 Directly age standardised rate / 100,000 population **DSR2** Directly age standardised rate / 100,000 population under 75; **DSR3** Directly age standardised percentage; **DSR4** Directly age standardised rate / 100,000 population; **CR1** Crude rate / 1,000 population; **CR2** Crude rate / 1,000 population aged 65 or over; **CR3** Crude rate / 1,000 female population aged 15-17; **CR4** Crude rate / 1,000 live births; **CR5** Crude rate/ 100 million vehicle kilometres; **CR6** Crude rate / 100,000 resident population aged 15-44; **CR7** Crude rate / 100,000 resident population.

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CANCER SURVIVAL IN WEST MIDLANDS STRATEGIC HEALTH AUTHORITIES

The Office for National Statistics has recently published cancer survival figures for each strategic health authority (SHA) in England[1]. Five year survival rates for patients diagnosed in the period 1995-1997 and followed up to 31 December 2002 have been estimated for eight common cancers: bladder, breast (women), cervix, colon, lung, oesophagus, prostate and stomach. This summary report examines how residents of West Midlands SHAs are surviving from these cancers.

Key Points

- Bladder cancer five year survival is significantly higher in men from West Midlands South SHA compared to men from England as a whole
- Cervical cancer five year survival is significantly higher in women from West Midlands South SHA compared to women from England as a whole
- Lung cancer five year survival is generally very poor but is (almost significantly) higher in men from Birmingham and The Black Country SHA compared to men from England as a whole
- Five year survival does not vary significantly for the remaining cancer site and sex combinations

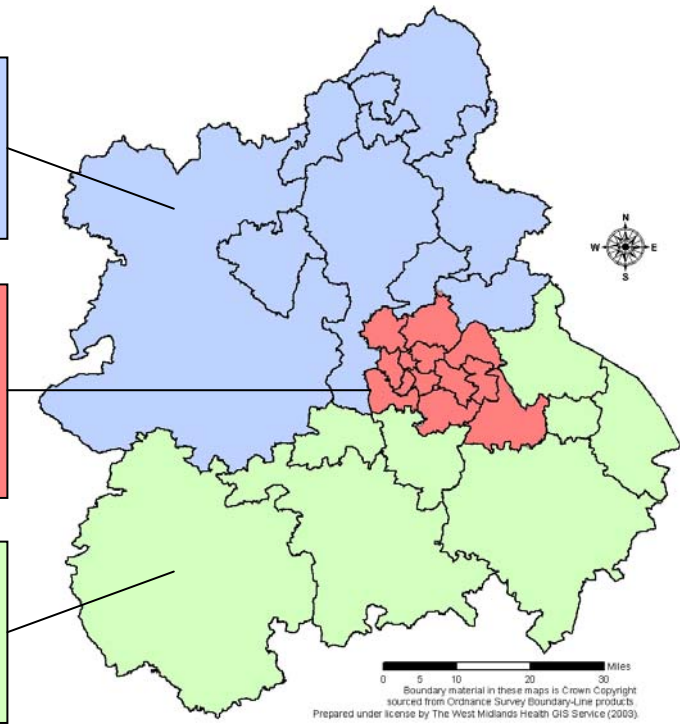
WEST MIDLANDS STRATEGIC HEALTH AUTHORITIES

The West Midlands is made up of three SHAs:

Shropshire and Staffordshire SHA (SS SHA)
SS SHA could be described as the most average SHA, with 5/10 PCTs occurring in the middle third PCT ranking for levels of deprivation in the West Midlands[2].

Birmingham and The Black Country SHA (BBC SHA)
BBC SHA could be described as the most deprived SHA, with 8/12 PCTs occurring in the top third PCT ranking for levels of deprivation in the West Midlands[2].

West Midlands South SHA (WMS SHA)
WMS SHA could be described as the least deprived SHA, with 4/8 PCTs occurring in the bottom third PCT ranking for levels of deprivation in the West Midlands[2].



Primary Care Trust (PCT) boundaries (as at April 2003)

[1] http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=11991
[2] West Midlands Public Health Observatory (2002). 'Patterns of deprivation in the West Midlands.'

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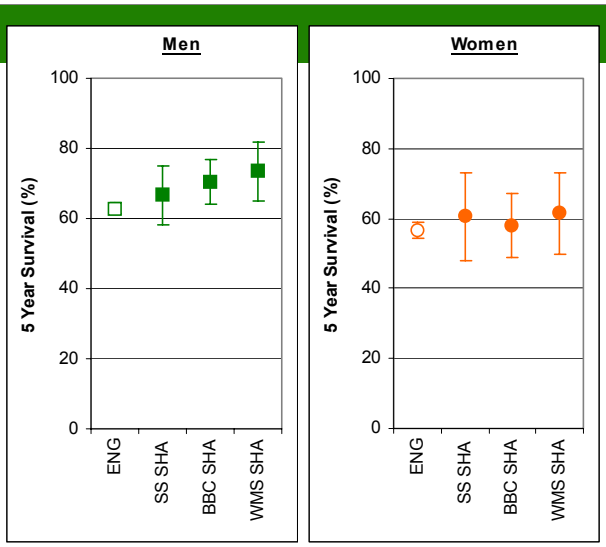
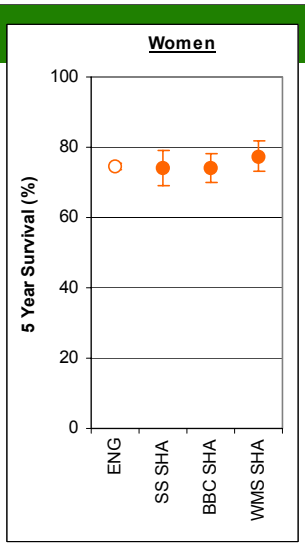
BLADDER CANCER

- Five year survival is slightly higher in men than in women.
- Five year survival is *significantly higher* in men from WMS SHA compared to men from England as a whole.
- Five year survival does not vary significantly in women.
- During the period studied, there were known differences in the classification and registration of non invasive bladder tumours, which were recorded as invasive by some cancer registries. This contributes to part of the variation in bladder cancer survival in England. These differences in coding are now being addressed by the UK Association of Cancer Registries.



BREAST CANCER

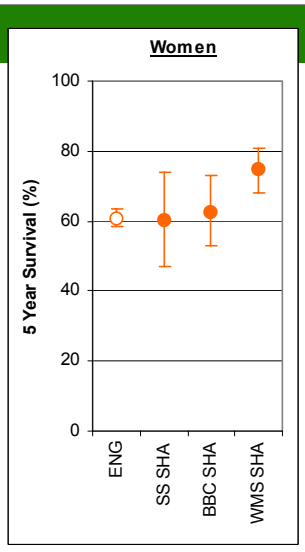
- Five year survival is good in women and is improving rapidly.
- Five year survival does not vary significantly, but it is slightly higher in women from WMS SHA compared to women from England as a whole.
- The high five year survival in women from WMS SHA could be explained in part by the relative affluence of the population, since previous studies have shown that affluent women have a survival advantage over more deprived women[3].
- Within the screening age group, five year survival varies significantly with screening status. Thus, five year survival in women with screen detected breast cancer diagnosed in 1992-1996 is 90%, whilst that in women who never attended screening is only 52%[4].



CERVICAL CANCER

- Five year survival is *significantly higher* in women from WMS SHA compared to women from England as a whole.
- The high five year survival in women from WMS SHA could be explained in part by the relative affluence of the population, since previous studies have shown that affluent women have a survival advantage over more deprived women[3].
- The incidence of cervical cancer is decreasing rapidly. Much of this decrease can be attributed to the introduction of the national call/recall system for the NHS Cervical Screening Programme in 1988[5] and of financial incentives for GPs in 1990.

N.B. Due to small numbers, the five year survival for WMS SHA has not been adjusted for age. This may also contribute to the higher survival rate.



[3] West Midlands Cancer Intelligence Unit (2002). 'Cancer and Deprivation Report.'
[4] Lawrence, G. and D. George (2002). 'NHSBSP Surgical QA Data for the Year of Screening 1 April 2000 to 31 March 2001.' http://www.cancerscreening.nhs.uk/breastscreen/publications/ba00-01.html
[5] Quinn, M.J., P.J. Babb, J. Jones and E. Allen (1999). 'The Effect of Screening on the Incidence and Mortality From Cancer of the Cervix in England: Evaluation Based on Routinely Collected Statistics.' *British Medical Journal*, **318**, 904-908.

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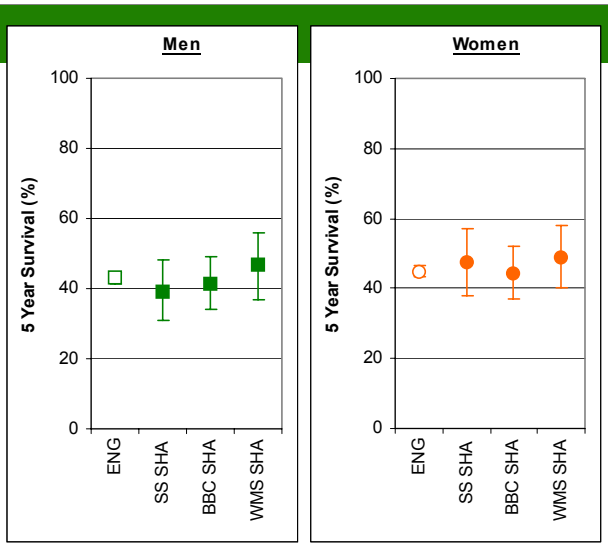
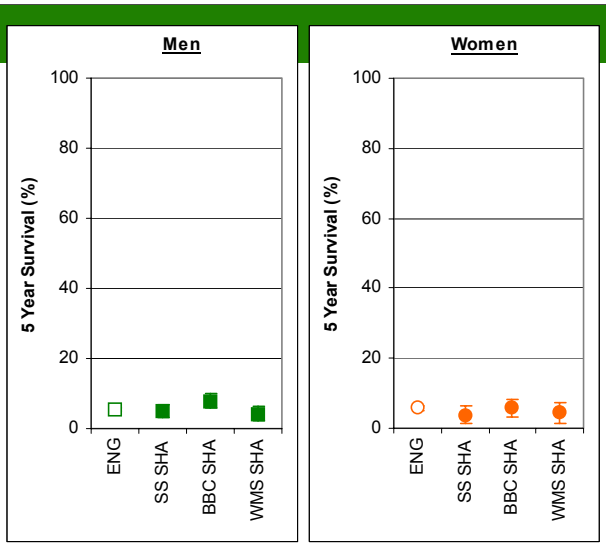
COLON CANCER



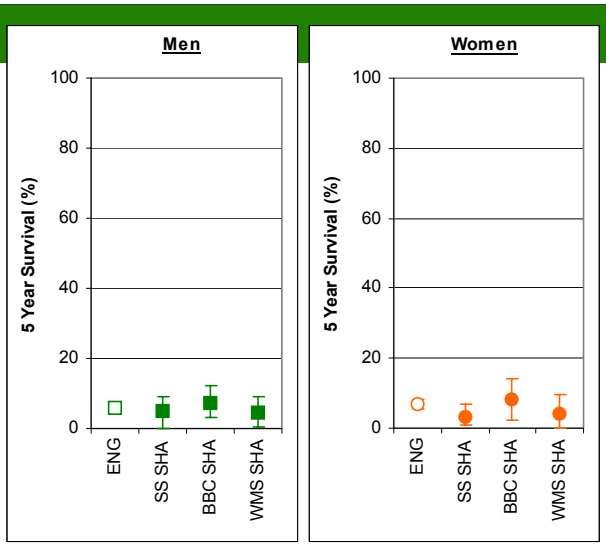
- Five year survival is similar in men and women.
- Five year survival does not vary significantly in men, but it is slightly lower in men from SS SHA and slightly higher in men from WMS SHA compared to men from England as a whole.
- Five year survival does not vary significantly in women, but it is slightly higher in women from SS SHA and WMS SHA compared to women from England as a whole.
- Colon cancer incidence is 1.4 times higher in men than in women and it is increasing more in the most affluent men and women[3].

LUNG CANCER



- Five year survival is very poor in men and women.
- Five year survival is (almost significantly) higher in men from BBC SHA compared to men from England as a whole.
- Five year survival does not vary significantly in women.
- The incidence of lung cancer is decreasing rapidly in men and remaining fairly stable in women.
- If the current trends continue, lung cancer incidence in men will be the same as that in women by approximately 2013.

OESOPHAGEAL CANCER



- Five year survival is very poor in men and women.
- Five year survival does not vary significantly in men.
- Five year survival does not vary significantly in women, but it is slightly lower in women from SS SHA and WMS SHA compared to women from England as a whole.
- The incidence of adenocarcinoma of the oesophagus is increasing in men and women. This has been correlated with an increased consumption of alcohol and tobacco[6].

N.B. Due to small numbers, the five year survival in women from SS SHA has not been adjusted for age.

[3] West Midlands Cancer Intelligence Unit (2002). 'Cancer and Deprivation Report.'
[6] Lawrence, G. (2004). 'Cancer at the Gastro-Oesophageal Junction.' Upper GI Surgery: Springer Verlag (London) Ltd., Chapter 3.

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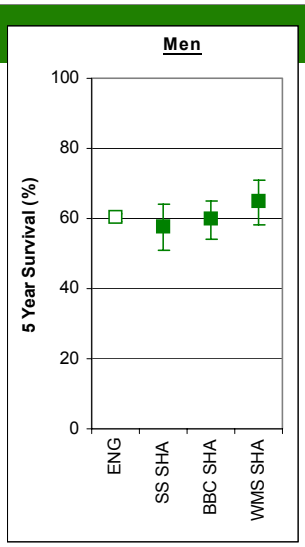
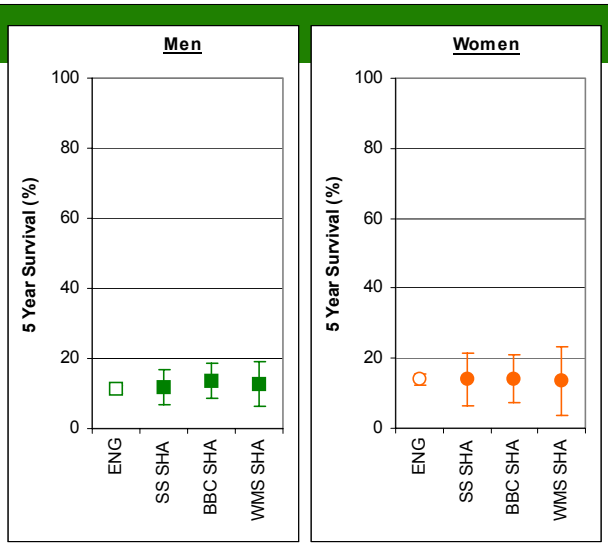
PROSTATE CANCER

- Five year survival does not vary significantly, but it is slightly higher in men from WMS SHA compared to men from England as a whole.
- The high five year survival in men from WMS SHA could be explained in part by the relative affluence of the population, since previous studies have shown that affluent men have a survival advantage over more deprived men[3].
- The incidence of prostate cancer is increasing rapidly. Much of this increase can be attributed to the introduction of prostate specific antigen (PSA) testing in the 1990s[7]. This increase is significantly greater in the most affluent men[3].
- Mortality from prostate cancer remains relatively unchanged despite the increase in incidence.



STOMACH CANCER

- Five year survival is very poor in men and women.
- Five year survival does not vary significantly in men or women.
- The incidence of stomach cancer is decreasing rapidly. This has been correlated with the introduction of refrigeration as a means of food preservation. The increased consumption of fresh fruits, raw vegetables and salads is also believed to have played an important role[6].
- The decrease in incidence is much higher in the most deprived men and women[3,6].



FURTHER INFORMATION

- If you would like further information on cancer survival in the West Midlands, please contact the West Midlands Cancer Intelligence Unit's Information Team:

  Telephone: (0121) 414 7711
  Email: ciuinfo@wmciu.nhs.uk

- Up-to-date cancer survival rates for PCTs in the West Midlands can also be obtained from the Cancer Information Service (CIS). The CIS is accessible over the NHSNet to authorised personnel in SHAs, PCTs, cancer networks and acute trusts.

For further information on the CIS and/or an application form, please contact the CIS help desk:

Telephone: (0121) 414 7716
Email: wmciu@wmciu.nhs.uk

KEY

- 5 year age standardised relative survival rate (%) in men
- 5 year age standardised relative survival rate (%) in women
- 95% confidence interval range

[3] West Midlands Cancer Intelligence Unit (2002). 'Cancer and Deprivation Report.'
[6] Lawrence, G. (2004). 'Cancer at the Gastro-Oesophageal Junction.' Upper GI Surgery: Springer Verlag (London) Ltd., Chapter 3.
[7] Brewster, D.H., L.A. Fraser, V. Harris and R.J. Black (2000). 'Rising Incidence of Prostate Cancer in Scotland: Increased Risk or Increased Detection?' *British Journal of Urology International*, **85**, 463-472.

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