West Yorkshire and Harrogate Cancer Alliance

NHS West Yorkshire Integrated Care Board

Meeting: West Yorkshire Joint Health Overview and Scrutiny Committee.

Date and Time: Wednesday 30th April 2025, 10am to 12noon.

Report Title: Cancer and Early Diagnosis (Update).

Report Author: Jason Pawluk, ICB Associate Director for Cancer and Managing Director, West Yorkshire and Harrogate Cancer Alliance.

Recommendation: The Joint Health Overview and Scrutiny Committee is asked to **RECEIVE** the update and consider the suggestions made in section 4.

Executive Summary:

NHS West Yorkshire Integrated Care Board (WY ICB) has identified ten key population health priorities, referred to as big ambitions. Big ambition number 2 is to increase early diagnosis rates for cancer.

WY ICB committed to 1,000 more people having the opportunity for curative cancer treatment by 2024 then was the case in 2018/19. Progress against this goal was reported in the Joint Forward Plan and its annual refresh, which is published in the public domain and is available from the ICB website.

Using the Rapid Cancer Registration Dataset (RCRD), our analysis showed that 1,382 more people in West Yorkshire have been diagnosed at early cancer stages one and two, which make curative treatment more possible.

This meant that the WY ICB Joint Forward Plan now looks to go further, showing how we can progress towards three in four people being diagnosed with cancer at an early stage, as described in the NHS Long Term Plan, with an initial goal of 62%. Current rates of early diagnosis are 56%. This figure was used by reviewing the total number of diagnoses at cancer stages one and two at the end of each year with a cumulative figure created. Rates of early diagnosis decreased during the Covid-19 pandemic but recovered to this number.

The paper describes progress on existing initiatives which have supported improvements in early diagnosis rates and the appendix gives details of operational strategies being developed to support additional improvement. These include the fields of screening; population awareness raising activities; innovation; living with and beyond cancer; and improvement in pathways, so that the best treatment is

provided sooner. These efforts will continue to be supported by West Yorkshire and Harrogate Cancer Alliance, working with all its partners.

1.0 Introduction

NHS West Yorkshire Integrated Care Board (WY ICB) has identified ten key population health priorities, referred to as big ambitions. Big ambition number 2 is to increase early diagnosis rates for cancer.

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1.1 How are the efforts of the ICB to improve early diagnosis for cancer overseen?

The West Yorkshire and Harrogate Cancer Alliance is a hosted, non-statutory body which sets system-level strategy and oversees transformation work in this area towards achieving this vision, reflecting both national priorities and responding to local need.

As a body, its purpose is to bring partners together to transform outcomes, with specific areas of work focussing on improving patient and carer experience of cancer care improving patient and carer experience; reducing health inequalities; harnessing networks for better treatment outcomes; adopting innovation and new models of care; and developing our people.

1.2 Why continuing to focus on early diagnosis is important in West Yorkshire?

Cancer continues to be a major population health priority for the ICB because 1 in 2 people are expected to have cancer at some stage of their lifetimes, with outcomes continuing to be worse than international comparisons and strongly affected by health inequalities. Almost every family locally will have been touched by this condition.

For an increasing number of people affected by cancer, the disease will become a chronic condition, which will significantly affect the type, range, and duration of support they will need to care for them as individuals. It is vital that our focus as an

ICB reflects the ongoing needs of people affected by cancer as new, innovative, and more personalised, forms of care and treatment increasingly become available.

1.3 What are we aiming to achieve?

As described in the Joint Forward Plan and via our website, our vision for cancer care in West Yorkshire is that we transform services so that cancer care, treatment and support is wrapped around each individual patient throughout their entire care journey – from awaiting diagnosis, to treatment options, to discharge where appropriate, end of life care where needed, including living with and beyond cancer. We listen to our patients as part of this, a good example recently being through our non-surgical oncology work.

By the end of the 2027/28 financial year (year 5) and the end point of the Joint Forward Plan, the Cancer Alliance will have:

- Supported the West Yorkshire Integrated Care Board, and its constituent members and partners, to have achieved improvements for people affected by cancer in West Yorkshire both in terms of them being diagnosed earlier.
- Having a better experience of cancer pathways when they need them.
- Worked with partners to increase early diagnosis rates further.

2.0 Headline progress on early diagnosis of cancer - 2019-24

In 2019, the West Yorkshire early-stage cancer diagnosis rate, expressed as a twelve-month moving average, was 52%. By 2024, this same figure was 56%, with a range of 53.7-57.4%. An improving trend rate was demonstrated across four of the five Places in West Yorkshire, with Bradford and Leeds both seeing a 3.6% uplift; Kirklees and Wakefield a 6.3 and 6.4% uplift respectively; and Calderdale a balanced position. The Calderdale data partly impacted by completeness but with shows a high point of 58.3% being achieved in 2023.

Trend rates of early cancer diagnosis have overall increased at a faster rate in West Yorkshire than the underlying England average (3.5% uplift locally, versus 3.1% nationally) across the review period. These improvements have helped to support both the initial delivery of the ambition for cancer for the ICB and have kept the system on track to deliver the goal set out in the Joint Forward Plan, whilst recognising that more work needs to be done.

2.1 Interpreting early diagnosis data

Some additional contexts may be helpful to interpret and understand small deviations in these data.

- Cancers are staged at the point of diagnosis at four grades - one, two, three and four. The higher the stage the more advanced is the disease present in the patient and the greater its spread into other organs or body systems (metastasis).

- **Cancers staged at one and two are considered "early" whereas cancers which have either locally metastasised (three) or developed into wider organs or body systems (four) are referred to as "late."** Late-stage cancers are more challenging to treat and are typically associated with worsened prognosis and treatment outcome.
- Therefore, **cancers stages at one and two are generally accepted as a measure of better prognosis and treatment outcomes**, including treatment given with curative intent. Cancers detected via elective routes of presentation, such as GP referrals and screening detected cases also typically have better outcomes than cases detected via emergency admission as the initial route of presentation.

- **Data completeness refers to the staging completeness rate**. When a cancer is diagnosed, via any route of presentation, then there is an opportunity to determine the stage via discussion and agreement at a multidisciplinary team meeting including the clinicians responsible for the care of the patient.

- Within the period **January to March 2021 to April to June 2024,** the staging completeness rate increased across West Yorkshire from **61.4% to 72.6%** and improvements have been seen in all Places. This rate of improvement reflected national trends, where similar improvements were seen across England, based on concerted and continuing efforts to improve data quality.

- However, on some occasions, it is not possible to stage a cancer until either further surgical intervention, imaging, or pathology, is available which is then able to fully determine the extent and location/s of the tumour. On other occasions, staging of tumours is subject to retrospective review, and is also required to be assessed if there is a recurrence of a cancer in a previously treated patient. This also includes scenarios whereby post-intervention testing on the tumour is required to determine if it is either a malignant (harmful) or benign tumour or lesion.

- These clinical situations impact on the **overall cancer staging rate.** The overall cancer staging rate is a comparison between the total number of cancers recorded and the proportion of those which are staged, taking in to account the above clinical scenarios.

- Stage reported outcome metrics derived can also be influenced by the **case-mix** of cancers which are staged via these processes, particularly where differences are small. For example, the early-stage distribution rate for some common cancers tends to be both higher and associated with higher staging completeness than for some rarer tumours, or haematological (blood cancer) malignancies.

A rapid cancer registration dataset offers a reliable interpretation of tumours staged around six months following the cancers treated and is accepted for reporting purposes and a moving average is used to help reflect trends arising. The higher the underlying staging completeness rate, the more reliable are analyses from the data arising. Cancer registries, also retrospectively analyse and interpret all national data, report around two to three years in arrears.

It follows that whilst we can say that movement in cancer stage is statistically significant, caution should be applied to statements which rank Places based on relatively small variations in early-stage rates.

3.0 Ongoing work and activity to further improve early diagnosis of cancer

For clarity, each of the following priorities in this update section have been adopted into the five West Yorkshire Place based strategies for cancer and the Joint Forward Plan. We are continuing to seek to deliver initiatives which encourage patients to both be diagnosed earlier with cancer (through new services and innovation); support their awareness of cancer symptoms and participation in proactive measures (such as lifestyle adjustments and cancer screening programmes); and have better experiences of cancer pathways when they need them.

The implementation timeline for each goal, in each Place, commenced in either year 1 (2023/24) or year 2 (2024/25) of the plan – details of which are covered in the Delivery Plan for the Cancer Alliance. For signposting purposes, this is shown further in the paper headings below. Additionally, the Cancer Alliance is also developing a more comprehensive early diagnosis strategy, focussing on other elements, which will be published in the Summer. More details of this are provided in the Appendix and depict new or continuing actions from year three (2025/26) onwards.

3.1 Improving rates of cancer screening participation - progress:

3.11 Lung

All residents in West Yorkshire and Harrogate who have either ever smoked, or smoke currently, will have been invited to undertake a lung health check if aged between 55 and 74. For clarity, this will be achieved by 2028/29. Existing schemes preceded year 1 of the Joint Forward Plan commitment, a new scheme (Bradford District and Craven, Phase 2) commenced year 2.

Linked to the above, the Yorkshire Lung Screening Trial (YLST) has completed in Leeds and the system will re-invite the “aged-in” and “control group,” populations from later in 2025, subject to the finalisation of procurement processes. Bradford District and Craven (Phase 1) has been completed, with eligible patients undergoing surveillance and monitoring, and Bradford District and Craven (Phase 2) commenced in January 2025. North Kirklees has been completed with the same surveillance and monitoring processes as in Bradford District and Craven (Phase 1), building on a smaller pilot in Wakefield prior to the national lung cancer screening programme.

3.12 Lung (new schemes and next steps)

Evidence from each of these programmes show statistically significant increases in early diagnosis rates from cancer, with disproportionate benefit to lower socio-economic demographic populations. For clarity, our recorded coverage rates include all these populations and are based on the eligible population, as per the start of the lung cancer screening programme. However, via subsequent national agreement, we have also secured this programme incorporating those groups who have either "aged in" to eligibility or have moved into the West Yorkshire area since the start of the programme. This increases the eligible denominator population significantly, and the potential benefit, as does the decision to re-invite parts of the City of Leeds based on the initial success achieved by YLST. In this context, coverage and programme mobilisation rates are on track with the trajectories set by the Cancer Alliance, agreed with the ICB, and advised to NHS England respectively.

Additionally, procurement processes to develop the services in Wakefield, Calderdale, and Harrogate are also on track to commence invitation and community engagement activity prior to the end of the 2025/26 financial year (year three). This should mean that a lung cancer screening programme has commenced in all West Yorkshire districts by 2026/27 (year four). The Cancer Alliance and ICB are successfully managing reductions in 2025/26 lung cancer screening funding provided by NHS England (and lack of inflation-indexing) to ensure that eligible populations receive access to screening services in accordance with the national objectives set out.

Local management processes and the phasing of programme activity and population coverage has supported the system to manage the impact on thoracic surgery and other primary and secondary care support services, along with ensuring that the overall envelope of funding can support the wider range of activities which support earlier diagnosis of cancer cases. It is anticipated that linked to the advice of the National Screening Committee that there will be a transition to a national screening programme for lung cancer thereafter, in the same way as one exists for breast, bowel, and cervical cancers.

3.2 Bowel, Breast, Cervical, and Liver screening

Work continues to support increases in participation rates in the national cancer screening programmes (breast, bowel and cervical) and we have commissioned research, promotional, and awareness raising activity particularly amongst seldom heard, marginalised, and vulnerable population groups.

Age eligibility for faecal immunochemical testing (FIT, year one) has been extended for the bowel cancer screening programme and is progressing towards coverage from age 50 (continuing from year one in phases), based on evidence around age-based incidence of the condition.

West Yorkshire is also supporting initiatives to reduce positivity thresholds for FIT from 120ug/ml to 80 ug/ml by working with endoscopy hubs to generate the

additional capacity and workforce needed to expand asymptomatic surveillance amongst these cohorts (year three to four).

Nationally, tens of thousands have accessed NHS advice on attending mammograms since the launch of the first-ever NHS breast cancer screening campaign in February (year two). There were 32,432 visits to NHS breast screening advice pages last week from 17 February to 24 February – an increase of 145% in just a week. Locally, the "Don't let it be you" campaign in Kirklees has delivered success in supporting people to come forward (year two).

Notable success has been achieved with award-winning campaigns seeking to reduce barriers to access to cervical screening amongst the transgender population, which is now being extended to include men who have sex with men (years one and two, continuing to three).

The operational delivery network for hepatitis C has also achieved significant success in terms of signposting persons at elevated risk of liver cancer on to ultrasound and screening assessment services, using health awareness and treatment busses in community-locations (years one and two, continuing).

3.3 Smoking cessation - progress:

We aim to achieve and sustain the position adult smoking rate in West Yorkshire and Harrogate will be 13% or less. We continue to specifically support this goal through incorporating this focus into lung cancer screening and secondary influencing opportunities; supporting all tobacco control boards locally; encouraging local teams to invest in this area via Core20Plus5 recurrent funding and other commissioning opportunities; and by undertaking specific promotional campaigns highlighting the benefits of smoking cessation (all continuing from year one).

We work closely as a system with Improving Population Health colleagues in this regard. This includes via the lung cancer screening programme discussed.

Rates of cigarette smoking amongst adults has seen a percentage decline of 42% from 2011 to 2023 and across Yorkshire and Humber, prevalence was 12.7% in 2023. Prevalence is lower amongst younger populations who will also affected by legislative control measures.

3.4 Earlier presentation - progress:

We will continue to ensure that more patients to have access to curative treatment; improve population awareness of cancer signs and symptoms; and continue to close the health inequalities gaps in our system. This is reflected across the portfolio of work delivered by the Cancer Alliance, working with all of our partners (continuing).

3.41 Earlier presentation – supporting faster diagnosis

We continue to pursue our goal that at least 4 in 5 people receiving either a diagnosis of cancer, or an exclusion of cancer, within one month of being referred with cancer symptoms. Currently, across West Yorkshire and Harrogate, 82.5% of patients either received a diagnosis of cancer, or were excluded from the cancer pathway within one month of referral in February 2025 (year two), which is the most recent data available. The rolling quarterly performance was 80.5%. The headline national ambition was that 77% of patients would be managed in this way by the end of the 2024/25 financial year. In January 2025, faster diagnosis rates were the highest in West Yorkshire and Harrogate than in any of the other nineteen Cancer Alliances in England.

3.42 Earlier presentation – supporting best treatment, sooner

We also continue to pursue our goal that at least 95% of people receive cancer treatment within one month of a decision to treat being made. Currently, across West Yorkshire and Harrogate, 91.7% of patients received treatment within one month of a decision to treat being made in February 2025 (year two), which is the most recent data available. The rolling quarterly performance was 90.6%. The NHS Constitution measure is that 96% of patients receive treatment within this timeframe, but no specific improvement goal has been set nationally. This standard is met in five of the six hospital Trusts in West Yorkshire and Harrogate, the exception being Leeds Cancer Centre.

The standard is met for most enabling treatments and chemotherapy but is not currently met for radiotherapy provision and some specialist surgery, where an improvement plan is in place and performance is improving. Delivery rates compare favourably between West Yorkshire and Harrogate and other Cancer Alliances on a regional and national level, although more work is needed in this area linked to the Joint Forward Plan goals.

Nationally, the entire pathway length (of 62 days) is reviewed from the point of initial referral or escalation on to an urgent suspected cancer pathway through to the point of a first definitive treatment being delivered. Rates of referral on this pathway have doubled over the last ten years.

New diagnoses and new treatment courses have increased also significantly, but at a lower underlying rate in most scenarios. Currently, across West Yorkshire and Harrogate, 73.1% of patients received treatment within one month of a decision to treat being made in February 2025 (year two), which is the most recent data available. The rolling quarterly performance was 73%. The NHS Constitution measure is that 85% of patients receive treatment within this timeframe. The specific improvement goal has been set nationally for delivery by the end of 2024/25 (year two) is that 70% shall be achieved. Five providers have rolling quarterly performance more than this figure, the exception being Leeds Cancer Centre, where

adjustments for case-mix and complexity need to be made to render a fair comparison. Three providers (Calderdale, Harrogate, and Airedale) deliver significantly greater performance than national expectations and the system exceeds regional and national benchmarks for performance.

3.5 Personalised care – supporting best treatment, sooner

We continue to make progress towards a fully embedded system for genomics testing in West Yorkshire and Harrogate, reflecting national strategy aims. We are also supporting initiative to ensure all suitable patients have a personalised care support plan (PCSP) and benefit fully from the living with and beyond cancer programme, linked to a community model of support (year one onwards). Good work in this area has occurred with BRCA gene mutation testing for hereditary breast and ovarian cancer risk (year one onward); incorporation of local studies for EUROPAC (familial link of pancreatic cancer) (year two onwards); the Cancer Vaccine Launch Pad (year two onwards); and testing for lynch syndrome (year one) which has been effectively incorporated in to local cancer pathways.

3.6 Innovation – supporting best treatment sooner:

Alongside an enabling innovation pipeline, we continue to support transformation of cancer diagnostic management by introducing asymptomatic and symptomatic blood test screening for the local population, based on service evaluation and clinical trial evidence. We have also supported other innovations via the Small Business Research Initiative Route (SBRI), as part of a pipeline of around 45 projects currently in progress and being supported (year one onwards).

Linked to all the above, we continue to bring patient experience to the heart of what we do by developing and extending our partnership working. We continue to expand our reach and connection across the Health and Care Partnership, further expanding opportunities to work with primary care, research and the VCSE sectors as priorities. A good example of this work is our collaboration with Yorkshire Cancer Community and their highly successful Cancer SMART programme, linked to our Patient VIEW panel (year one onwards).

4.0 Conclusions and next steps

Overall, whilst recognising that more and accelerated efforts are needed to challenge health inequalities and how they interact with early stage of diagnosis rates for cancer, good progress is being made across the West Yorkshire system. Rates of early diagnosis have increased faster locally, than is the case nationally, pointing to the strong culture of collaboration and integrated working across the Health and Care Partnership. The Cancer Alliance will continue to support annual refreshes of the Joint Forward Plan and will pursue the areas shown the Appendix as new and continuing priorities respectively.

The Joint Health Overview and Scrutiny Committee is asked to receive the paper and indicate how it would prefer to retain information and updates about the progress being achieved by the health system in this area.

At a working partnership level, the Cancer Alliance was pleased to work with the Committee in relation to its work on improving non-surgical oncology services. Building on this, the Cancer Alliance would also be pleased to share details of its public awareness and campaign work with the Committee for early diagnosis of cancer, so that Members may be able to consider distributing information via their own networks to develop greater awareness and traction to the activities described for the benefits of people affected by cancer in West Yorkshire and Harrogate.

Additionally, we would also welcome the opportunity for further discussion, including developing the lung cancer screening programme into a national scheme at the end of population rollout.

Appendix:

West Yorkshire and Harrogate Cancer Alliance early diagnosis strategy – extract (year three onwards).

Introduction:

To comply with NHS England planning guidance directions, the strategy intents are reviewed annually and approved centrally, however we would envisage these steps to be multi-year focusses, aligning with the period both before and following the new 10-year NHS plan and refresh of the 10-year cancer plan in England. Funding and resource profiling is provided from a subset of the service development funding provided to Cancer Alliances annually, which is reserved for use on the improvement of cancer services.

Governance operates both via ICB approval mechanisms described in the Joint Forward Plan and via the Board of the Cancer Alliance. The Cancer Alliance continues to work with partner agencies across the Health and Care Partnership and others to maximise the activity it can undertake in this area. Operational delivery of programme areas is achieved through alignment to the strategic objectives of the Cancer Alliance and our programme management office functions. The plan both considers those areas where scale of impact warrants an approach of delivery once in West Yorkshire versus others whereby local intelligence and delivery will optimise population benefit.

Improving rates of early diagnosis of cancer

At a system level, we recognise that the causes of later stage presentation and diagnosis are highly complex. In some respects, and as is widely acknowledged in the literature, causes of later stage presentation may be outside of both the direct agency of Cancer Alliances, and in some respects, the population health systems which they reside within. This is particularly true in so far as causative factors relate to social inequality and spend distribution patterns; measures of social deprivation; and the associated measures of inequity which stem from poverty driven factors. Some of this can be seen within international benchmarking efforts, including the International Cancer Benchmarking Partnership. This is considered in the strategy and approach, whilst acknowledging that local health systems have significant opportunities to make a positive difference for the people they serve.

In forming priorities, we have also sought to consider both variations within the Cancer Alliance geography itself and how our performance compares with peer group health economies. By peer group health economies, we have selected the North East and Yorkshire Region and its four constituent areas of South Yorkshire

and Bassetlaw, Humber and North Yorkshire and the Northern Cancer Alliances. This is because we recognise that underlying social deprivation factors significantly influence stage of presentation. The evidence used to develop this plan was as follows:

- Consideration of research outcomes from Cancer Research UK and conference material in 2024 around early diagnosis pipeline initiatives.
- Review of outcomes and logic models from existing developments in the National Cancer Programme.
- Discussions with Cancer Alliance research partners, such as Yorkshire Cancer Research, with whom we are aiming to develop a wider Yorkshire Cancer Early Diagnosis strategy.
- Internal strategy engagement; discussions with clinical leads; interdependent ICB functions and Board-level dialogue.
- Review of Primary Care Network, Place and Alliance-level data from Cancer Stats and more granular database representations of referral, early diagnosis, and survival rates split by determining population characteristics such as age, gender, social deprivation quintiles, and ethnicity.

Annualised Target

In 25/26, West Yorkshire and Harrogate Cancer Alliance is aiming to improve stage one and stage two cancer diagnosis on the rapid cancer registration data calculations to 58.5% working with NHS West Yorkshire ICB principally, which represents a rate of improvement more than the underlying trend growth and improvement rate. This rate of achievement is targeted by March 2026. It also supports progress towards 62% as described in the Joint Forward Plan.

This aligns with the strategic goals and delivery trajectory in the ICB Joint Forward Plan; the wider achievement of the “top 10” ambitions for population health improvement in the local system; and data-driven approaches. The ICB Joint Forward Plan and associated “top 10” ambitions set an initial delivery trajectory of 2028 and this is the overall lifecycle of the Cancer Alliance strategy. Initiatives referred to in this submission will continue to mature and have impact across the remaining interval of the strategy (2028).

Stage baseline and completeness

Across West Yorkshire, staged cancers (1-4) in the RDRD represent 67.8% of the total Rapid Cancer Registration Dataset volumes. There has been a 6% increase in the percentage of staged cancers since 2019 and all remarks in the strategy and actions referred to staged volumes only.

A 12-month trend line of 8,874 cancers has been established with an equitably distributed trend line across all five Places in West Yorkshire; Leeds, Bradford, Calderdale, Kirklees, and Wakefield. Prostate, lung, colorectal and breast cancers accounted for 72.5% of all staged cancers in 2023, reflecting a distribution pattern as the most common cancers of incidence across all five Places, with some variation in order of prevalence by Place.

Our data shows that 4,976 of the 8,874 stageable cancers (56.1%) diagnosed in 2023 were identified at an early stage – an improvement of 2.7 percentage points on pre-pandemic levels, with a rising trend line across all Places. The start point value for 25/26 focus is 56.4% and a Place-Based range of 53-57% respectively.

Early detection rates by tumour

Early-stage detection rates for common cancers were 86.7% breast cancer; 51.3% prostate cancer; 50.3% colorectal cancer; and 34.4% lung cancer. Variation in early-stage diagnosis rates with comparator benchmarks is exhibited in prostate, lung, colorectal, and oesophageal cancers.

There are a high proportion of stage three diagnoses for prostate and colorectal cancer, and to a lesser extent in lung and oesophageal cancers, providing a high-volume opportunity for a stage-shift to stage two. 75.3% of the late-stage cancer diagnoses are found in prostate, lung, colorectal and oesophageal. Lung cancer accounts for 27.4% of all late-stage cancers (n=1067).

Over 50% of all staged cancers were diagnosed via an urgent suspected cancer (USC) route, ~15% were diagnosed via an emergency presentation (EP). In terms of late-stage diagnoses, 44.6% were from an urgent suspected cancer route, and 23.9% via emergency presentation. Late-stage cancers are over-represented when the route to diagnosis is either via emergency presentation or other non-elective routes.

The table below shows influenceable volumes on pathways affected by weaker performance in the Cancer Alliance boundaries. +10% ES volume goals align with the interval objectives set out in the ICB Joint Forward Plan for West Yorkshire.

Figure 1

Tumour Site	**Current Early Stage %**	**+2.5% ES (Volume)**	**+5% ES (Volume)**	**+7.5% ES (Volume)**	**+10% ES (Volume)**
Lung	34.4%	36.9% (41)	39.4% (81)	41.9% (122)	44.4% (163)
Prostate	51.3%	53.8% (48)	56.3% (97)	58.8% (145)	61.3% (194)
Colorectal	50.3%	52.8% (32)	55.3% (65)	57.8% (97)	60.3% (130)
OG	27.5%	30.0% (10)	32.5% (19)	35.0% (29)	37.5% (39)
All Cancer	56.1%	57.6% (131)	59.0% (263)	60.5% (394)	62.0% (525)

Approach to improving early-stage cancer detection

The Cancer Alliance early diagnosis strategy can be summarised as follows:

- Primary Consideration: Volume and performance gap

We will focus efforts on tumour groups where there is both a sizeable denominator of stage three diagnosed cancers, as we consider these to be most susceptible to stage-shift activity, whilst also recognising that the quality imperative for latest stage cancers (4) must also be a driver of our wider work and activity, considering the impact that late diagnosis has on all patients and their families.

- Secondary Consideration: Excess emergency presentation and below benchmark screen detection rates

Within this volume and performance adjusted profile, we will initially focus on non-clinical variation in emergency presentation routes at comparator PCN level, towards other elective routes of diagnosis.

We will maintain a specific focus on trying to support screen detected cancers closer to recognised international benchmarks where these possibilities happen to exist from our consideration of volume and performance gap.

- Tertiary Consideration – Stimulating innovation:

We will support stage-shift opportunities where there are "gaps in the field," in existing national programmes, avoiding duplication with Core20Plus5 where added value is achieved through intentional action led by the Alliance with its partners. This will include supporting research opportunity where possible, and channelling focus into health inclusion groups. Health inclusion groups will include socio-economic deprivation profiling, but will also include relevant other considerations, to achieve harmonisation of approach with local population health and inequalities strategies. Primary, secondary, and tertiary considerations operate together, but are prioritised accordingly.

Priorities by tumour group

- **Priority 1: Lung cancer**

The lung cancer early diagnosis rate is 34%, which is significantly below the national average. However, this has recovered to this figure from a nadir of 29% during the pandemic. The national average is 39.6%. The 75-89 age group has the highest number and proportion of diagnoses (45%). There is a disproportionate bias towards most deprived quintile 1 having the highest proportion of diagnoses (37%) whilst quintile 5 (least deprived) having the lowest (9%). 1627 cancers were diagnosed with this ICD10 classification in 2023, resulting in an influenceable denominator.

Emergency presentation routes have the highest proportion of diagnoses (30.7%), which also disproportionately affect lower decile groups and the 75-89 age group, with an equal distribution profile between male and female. 22.7% of cancers are at stage three, representing 370 patients in the Cancer Alliance in 2023, with higher proportion presenting as emergencies affecting Bradford, Kirklees, Wakefield, and

Leeds in particular. Delivery of a 10% (n=163) uplift in lung cancer earlier stage rates, along with the same uplift in prostate, colorectal and oesophago-gastric cancers, would contribute to a system position of 62%. Implemented over multiple years, this would provide a substantial contribution to the goals set out in the Joint Forward Plan.

Our approach for this priority is to:

- **Lung cancer screening**:

  Focus on scaling of the lung cancer screening scheme, achieving observational assessment in the upper age threshold for eligibility (up to 74) and in lower decile groups, which should translate to improved surveillance and risk assessment once these populations move into the highest risk-adjusted age bracket (75-89). This will also include re-invitation processes and enhanced surveillance of populations diagnosed with pre-cancerous nodules.

- **Symptom awareness campaigns**:

  Develop wider symptom awareness and call to action activity focussing on populations with low reading age, who are less digitally enabled, focussing on geographies targeted for rollout of lung cancer screening for aligned effort. This will include non-responders. We also plan to examine existing activity via pharmacy-based referral routes, including chest X-Ray access. We will also explore successful concepts around surveillance vans from neighbouring Alliances but will not be able to make a financial commitment or plan due to funding constraint, however other financing routes may be explored.

- **Referral optimisation**

  There are ten PCNs which are in the higher risk profile, based on significant numerators of lung cancer diagnoses, matched with later stage diagnosis rates of greater than 65%. Where these are not captured in lung cancer screening efforts then targeted awareness raising campaigns will be a focus.

- **Priority 2: Colorectal cancers**

The colorectal cancer early diagnosis rate is 50.3%, which is 1.2% above the national average, but 5.8% below the all cancer average in West Yorkshire. By age, the 75-89 age group has the highest number of diagnoses at stage three (n=136), followed by the 50-64 (n=134) and 65-74 (n=108) age groups. As a proportion, this distribution is split evenly by ethnicity, although White ethnicity males are typically over-represented in terms of volume. 1,297 cancers were diagnosed with this ICD10 classification in 2023, resulting in an influenceable denominator. 32.3% of cancers are at stage three, representing 418 patients in the Cancer Alliance in 2023,

Emergency presentation routes have the highest proportion of late-stage diagnoses for colorectal cancer compared to all other routes to diagnosis. More than 60% of

colorectal cancers are diagnosed at a late stage via this method of presentation in Wakefield, Kirklees and Leeds. A lower numerator but worsened position exists in Calderdale. There is disproportionate association between lower decile groups and emergency presentations. More than 120 cases of colorectal cancer are diagnosed via an emergency presentation per annum across the Alliance geography.

More widely, stage at diagnosis is disproportionately biased towards stages three and four in all socio-economic decile groups except for least deprived 5. Twelve PCNs have high volumes of late staged colorectal cancers, beyond the median, including one PCN with more than 70 cases last year. Delivery of a 10% (n=130) uplift in colorectal cancer earlier stage rates, along with the same uplift in prostate, lung and oesophago-gastric cancers, would contribute to a system position of 62%. Implemented over multiple years, this would provide a substantial contribution to the goals set out in the Joint Forward Plan.

Our approach for this priority is to:

- **Bowel cancer screening**:

  Focus on improving bowel cancer screening rates and accommodating the FIT threshold reduction to 80 ug/ml as a first step is a key part of the Cancer Alliance strategy, working with partners - and enabled by Public Health commissioner funding. Endoscopy units have planned for the proposed 30% increase in surveillance directed colonoscopies. Addressing barriers to participation in bowel cancer screening will be delivered via normalising educational resources focussed on groups with a low reading age and undertaking focus group/engagement activities on barriers to screening amongst the targeted demographics (PCN, age, gender, and deprivation quintile).

- **Symptom awareness campaigns**:

  Develop wider symptom awareness and call to action activity focussing on populations with low reading age, who are less digitally enabled, focussing on geographies targeted for bowel cancer symptom awareness raising programmes for aligned effort. This will include non-responders and issues. We also plan to examine existing activity via pharmacy-based referral routes. We will also explore successful concepts around surveillance vans from neighbouring Alliances but will not be able to make a financial commitment or plan due to funding constraint, however other financing routes may be explored.

- **Referral optimisation**

  There are twelve PCNs which are in the higher risk profile, based on significant numerators of colorectal cancer diagnoses, matched with later stage diagnosis rates of greater than 60%. Existing service structures for frailty assessment will also be considered in these settings.

- **Priority 3: Prostate cancers**

The prostate cancer early diagnosis rate is 51.3%, which is below the national average (53.9%). More than 75% of emergency detection cases were at stages three and four, which represents a similar position to the national average. On stage distribution, 30% of all prostate cancer diagnoses were at stage three (n=582), with 1,938 cases detected in total, the largest tumour group in the Alliance.

Emergency detection cases were disproportionate biased towards Leeds Health and Care Partnership within the NHS West Yorkshire ICB boundaries. According to area profile and census data, within Leeds, 26% of the population (an estimated 226,000 people) live within the 10% most deprived areas nationally (or IMD1). 63% of Black (denominator 43,576, 5.6% total population, 48% male), 40% of Mixed and 36% of Asian background people living in Leeds live within IMD1 areas. This makes IMD1 more ethnically diverse than the Leeds average and English is either not a first, or confidently spoken language for 10% of the population. There has been an increase of 15.7% in people aged 65 years and over in Leeds, with all age demographics above the age of 50 seeing a rise between 2011 and 2021. This leads to an operating context of an ageing, more ethnically diverse population where prevailing risk factors from prostate cancer are higher.

Prostate cancer is the most common cancer in men in the UK. Although it affects all men, Black men are two to three times more likely to develop this cancer than their white counterparts, including additional risk factors such as familial history. The mortality rate is twice as high, although early staged prostate cancers have one of the highest five-year survival rates of all cancers. Furthermore, Black men are more likely to develop prostate cancer at a younger age. It is established national policy that every Black man over the age of 45 years is eligible to have the blood test, called PSA (prostate specific antigen) from their GP. Our approach aims to build on successful campaign work in Kirklees working within the principles of the NHS Prostate Cancer Risk Reduction programme.

Ten PCNs have high volumes of late staged prostate cancers, beyond the median, including two PCNs with more than 80 cases last year. Several of the PCNs are in Leeds ICB boundaries. Delivery of a 10% (n=194) uplift in prostate cancer earlier stage rates, along with the same uplift in colorectal, lung and oesophago-gastric cancers, would contribute to a system position of 62%. Implemented over multiple years, this would provide a substantial contribution to the goals set out in the Joint Forward Plan.

<u>Our approach for this priority is to</u>:

- **PSA testing – promote access**:

PSA testing is known to have significant false-positive and less regular but still observable false-negative readings, so advances in multi-cancer blood testing amongst asymptomatic groups are likely to be a better intervention in time. GPs have access to the Prostate Cancer Risk Management Programme, which says that men, even with no urinary symptoms, can have a PSA on request.

Deprivation distribution data shows that more Black men live in higher socio-economically deprived groups than the population. However, specific data on PSA uptake and participation amongst this sub-group is challenging to identify. The intervention will focus on data collection, community advocacy, and local initiatives to expand knowledge and awareness of PSA testing amongst this group, learning from the pilot in Kirklees – seeking to mature in priority PCNs. The principles of the Prostate Cancer Risk Reduction programme are incorporated in to this work and effort. Workstreams are also in an earlier stage of development for achieving earlier stage of diagnosis for bladder cancer, including the prospective use of AI as a diagnostic aid and tool. A similar logic model exists in terms of population selection criteria and approach.

- **Symptom awareness campaigns**:

Develop wider symptom awareness and call to action activity focussing on populations with low reading age, who are less digitally enabled, focussing on geographies targeted for prostate cancer symptom awareness raising programmes for aligned effort. This will include bladder cancer. We will also explore successful concepts around surveillance vans from neighbouring Alliances but will not be able to make a financial commitment or plan due to funding constraint, however other financing routes may be explored.

- **Referral optimisation**

Ten PCNs have high volumes of late staged prostate cancers, beyond the median, including two PCNs with more than 80 cases last year. Several of the PCNs are in Leeds ICB boundaries. Existing service structures for frailty assessment will also be considered in these settings due to age profile distributions of later staged cancers.

- **Priority 4: Oesophageal (OG) cancers**

The OG cancer early diagnosis rate is 27%, which is below the national average (31.2%). 389 ICD10 classified OG cancers were detected overall with area distribution profiles for OG cancer detections are balanced on population size. Male detections of OG cancer were significantly higher than female detections. 132 male stage four and 57 male stage three detected cancers in 2023. 88 cancers overall were detected at stage three, representing an influenceable denominator.

Age range distribution of OG cancers was over-represented in 50-64, 65-74, and 75-89 age groups; in White ethnicity groups; across socio-economic deciles 1-4 (IMD1= 60/28 stage 4/3; IMD2 = 33/15 stage 4/3; IMD3 = 45/21 stage 4/3; IMD4 = 37/14 stage 4/3); and into non-elective and emergency presentation routes. Compared to the national average, when broken down by patient factors, our position is typically worse, and agnostic to place-based variation in this tumour site.

Nine PCNs have high volume late-stage cancers, significantly more than the median and worse than 75% overall. Delivery of a 10% uplift in prostate cancer earlier

stage rates would contribute to a system position of 62% delivery over multiple years which achieves the initial goals set out in the Joint Forward Plan (n=27).

Our approach for this priority is to:

- **Capsule sponge**

Support existing services to make use of capsule sponge as a diagnostic investigation and ensure that business as usual service evaluations are shared amongst the optimal pathway group to sustain services on the grounds of quality, addressing health inequality, and contributing to stage shift.

- **Symptom awareness campaigns**

Develop wider symptom awareness and call to action activity focussing on populations with low reading age, who are less digitally enabled, focussing on geographies targeted for OG cancer symptom awareness raising programmes for aligned effort, with any relevant national or regional programme. We will also explore successful concepts around surveillance vans from neighbouring Alliances but will not be able to make a financial commitment or plan due to funding constraint, however other financing routes may be explored.

- **Referral optimisation**

Nine PCNs have high volumes of late staged OG cancers, beyond the median, including two PCNs with more than 15 cases last year. Existing service structures for frailty assessment and diagnostic window availability will also be considered in these settings due to age profile distributions of later staged cancers.

- **Priority 5: Targeted action for health inclusion groups**

Kidney cancer

Kidney cancers account for 2-3% of all adult malignancies in the UK. Men are mostly affected by renal cancer with an average age at diagnosis of 64 years. Renal (or clear) cell carcinoma (RCC) accounts for 90% of kidney cancers. Early diagnosis improves survival with five-year survival rates for renal cancer of 70-94% for localised tumours in the UK. No national screening programme for kidney cancer exists, however results from the Yorkshire Kidney Screening Trial in Leeds were promising. WY&H will therefore support TACTICAL to work towards RCT by supporting this Yorkshire Cancer Research study by using the LCS eligibility cohort and inclusion criteria in either Bradford or Wakefield (depending on funding for LCS). However, no specific stage shift opportunity is profiled.

Liver cancer

Around 6,100 people are diagnosed with liver cancer each year. However, instances of liver cancer have increased by 50% over the past decade and are expected to continue to rise. Incidence of liver cancer in West Yorkshire is higher than the

national average. Existing evidence suggests only a third to a half of liver cancers are currently diagnosed at an early stage, either stage one or two.

The Community Liver Health Check aim to support early detection and diagnosis of liver cancer by identifying and referring those at high risk onto liver surveillance pathways, operated via the HPB Operational Delivery Network. People diagnosed with significant fibrosis or scarring of the liver are referred directly to liver cancer surveillance pathways, which aims to detect the commonest form of primary liver cancer (hepatocellular cancer) at a curable or treatable stage. Support work will continue, however, no specific stage shift opportunity is profiled.

Deprivation and Minority Group access to established national cancer screening programmes:

The Cancer Alliance has had considerable success in targeted screening awareness raising and accessibility campaigns focussing on minority populations such as people affected by a learning disability; people affected by a severe mental illness (SMI); transgender communities; men who have sex with men; and traveller populations.

These programmes will continue, as will research and interventions focussing on barriers amongst other known low-uptake groups, such as women from the South Asian community (all programmes) and younger women with respect to the cervical screening programme. Locally developed, co-produced assets with campaign groups and representatives from these communities, alongside the Cancer SMART initiative have proven to be more effective than more generalised campaign collateral, due to specific asset generation and evaluation-led call to action. These have been well received, working in partnership with NHSE Regional Public Health and Screening teams.

Routes to diagnosis data shows that UK screening diagnoses range between 1 in 16 and 1 in 14 of all cancers diagnosed. From Darzi, one can see that an achievable range is closer to 1 in 12 (reference Denmark). Danish early diagnosis and survival data is significantly better than the UK (and West Yorkshire) in each of the coverage areas. The intention is to expand and continue to these programmes by also reviewing barriers to access from a pan-geographic deprivation lens (quintile distribution); use of easy read materials; delivering targeted social media campaigns; and following community-based advocacy and influencing routes. Interventions will be targeted by a review of PCN data where a combination of routes to diagnosis, early-stage diagnosis and screening participation rates compare in an adverse manner with peer group average over a five-year period.

Along with priorities 1-4, this assessment will occur via dedicated GP clinical leadership in the Cancer Alliance, critically examining the range of contributory factors which could be contributing to a correlation – such as access to diagnostics; NG12 knowledge and education processes; workforce strengths and access barriers in primary care or lack of community engagement and activation.