HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 23 February 2016.

PRESENT: Councillors E Dryden (Chair), S Biswas, J G Cole, C Hobson and T Lawton and J McGee

ALSO IN ATTENDANCE: Kate Birkenhead - Public Health Commissioning Manager NHS England;
Fergus Neilson - Screening and Immunisations Manager, Cumbria and the North East; and
Carol Taylor - Macmillan Programme Manager, Macmillan Cancer Support / South Tees Hospitals NHS Foundation Trust.

OFFICERS: E Pout and C Lunn

APOLOGIES FOR ABSENCE Councillors S Dean, A Hellaoui and B A Hubbard.

DECLARATIONS OF INTERESTS

There were no Declarations of Interest made at this stage of the meeting.

15/40 **MINUTES - HEALTH SCRUTINY PANEL - 3 FEBRUARY 2016.**

The Minutes of the Health Scrutiny Panel held on 3 February 2016 were submitted and approved as a correct record.

AGREED

15/41 **HEALTH INEQUALITIES - CANCER SCREENING AND REDUCING CANCER RELATED DEATHS.**

The Scrutiny Support Officer recapped to the Panel that during the last evidence gathering on this topic in January 2016, the Panel had heard about the work of the Tackling Cancer Together Group that was being undertaken within Middlesbrough.

The Panel had also received details about public awareness campaigns in respect of four different types of cancer, and the work that was being undertaken to reduce health inequalities in deprived areas, including targeted campaign work around residents showing early symptoms of lung cancer.

The Panel had heard about the excellent work that had been carried out by the Macmillan Integration of Cancer Care Programme.

Following on from this, it was felt that it would be useful to invite appropriate representatives of South Tees Hospitals NHS Trust and NHS England to provide information in respect of screening processes around three different types of cancer - bowel, breast and cervical cancer.

Kate Birkenhead, Public Health Commissioning Manager for NHS England, Fergus Neilson, Screening and Immunisations Manager for Cumbria and the North East, and Carol Taylor, Macmillan Programme Manager for the Macmillan Integration of Cancer Care Programme, were in attendance at the meeting.

It was explained to the Panel that, for context, NHS England had a responsibility for the commissioning of screening programmes, rather than Clinical Commissioning Groups and Local Authorities.

In response to an enquiry regarding commissioning of services over and above what was

currently offered, it was explained that national screening programmes, e.g. breast and bowel programmes, were commissioned at around the same rate nationally. Programmes were commissioned locally to suit the environment, although they did have the same techniques and standards as national programmes. The money applicable to each programme was the same, however, reference was made to projects such as the Middlesbrough Cervical Screening Project, where it was hoped that cervical screening figures amongst the local population would be increased. It was explained that joint working between authorities on projects such as this meant that budgets were pooled, and therefore sometimes additional funding may have been available for areas where screening uptake figures were particularly poor. Cervical screening figures in Middlesbrough were amongst the lowest in the country. It was highlighted that this project had been a previous recommendation of the Health Scrutiny Panel.

In terms of programme participation rates, it was explained that NHS England provided this data. Discussion between Local Authorities, Clinical Commissioning Groups and NHS England could then be undertaken to determine what could be taken to improve low uptake figures.

A presentation pertaining to the following areas was made to the Panel:

- Cancer screening (breast, cervical and bowel);
- The screening processes;
- Frequency of screens / invites;
- How the programmes were run;
- How people were invited;
- Follow-up of DNAs;
- Access issues;
- Coverage / uptake rates against targets and comparisons; and
- Discussion.

<u>Breast Cancer Screening Programme</u>

Members heard that breast cancer was one of the most common cancers and had a high death rate. In terms of statistics, it was highlighted that for every 200 women screened, it was expected that one life would be saved. Although a large number of women needed to be screened in order to gain the benefit from the breast screening programme, the Health Economics continued to reiterate that screening was worthwhile.

It was acknowledged that there were downsides to the breast cancer screening programme. It was explained to Members that over-diagnosis had occurred in the past, which meant that there may have been some breast cancers detected that may never have lead to further harm, i.e. spreading outside of the breast. This point was communicated to patients when women were making their choice as to whether they participated in the programme or not.

The standard age range for screening was 50-70 years-old; however, nearly all of the country was involved in a national randomised trial to determine whether it would be worthwhile extending this downwards to 47 and upwards to 73.

A query was raised in relation to changes in Radiology services at James Cook University Hospital, and the consequential referral of patients between South Tees and North Tees Hospitals. In response, it was acknowledged that this had emerged from a shortage of Radiologists, and was a needs-must issue. Members felt that this presented a potential barrier to people attending for screening, particularly in respect of the distance that needed to be travelled.

Of the statistics provided in the presentation, a query was raised regarding the following:

- 4/100 screened called back for triple assessment; and
- 1/100 screened diagnosed with cancer.

It was clarified that the 1/100 formed a part of the 4/100, which essentially meant that a

diagnosis of breast cancer did not necessarily mean that it would ultimately lead to death.

Regarding survival rates, although a five year survival rate was frequently quoted, many women survived significantly longer than that. It was highlighted that, like other cancers, the earlier it was captured the greater the chances of survivorship. It was felt that the breast screening programmes worked exceptionally well and breast cancer was one of the more easily detectable cancers in that women were more likely to present to their GP if a lump was discovered.

There was a very small number of women who could be placed in a high risk category, for example: a genetic mutation increased their chances of getting breast cancer. Also, a small group of women who had received radiotherapy were also at increased risk of breast cancer, and were therefore targeted differently - e.g. MRI examinations rather than a traditional x-ray scan.

Regarding the screening process, it was explained that women were invited once every three years. Hard copy film was no longer used in the screening process; all mammography was now conducted digitally. This had posed a significant change to Middlesbrough's programme within the last 2-3 years. Most women would be invited to a static site close to their home address. 4/100 would proceed to triple assessment, which consisted of further x-rays, ultrasound and biopsies, and for this they would need to attend North Tees Hospital. If cancer was detected at this stage, further treatment would be undertaken, which may have included radiotherapy or chemotherapy.

In terms of screening and comparative coverage, i.e. analysing how many women in a defined locality have attended for screening within a three-year cycle, as at March 2014, in Middlesbrough this was 71.1%, in the North East 77.9%, and in England was 70.7%. Although Middlesbrough was higher than England as a whole, which was positive, it was acknowledged that this figure needed to be increased. Reference was made to other areas within the North East, such as Northumberland, where attainment rates were over 80%.

In response to an enquiry, Middlesbrough was at the bottom of the data in terms of the North East. Comparison was made to Gateshead, which although having a similar population make-up to Middlesbrough, had attained rates in the region of 76%. It was anticipated that more up to date data would be published by the Health and Social Care Information Centre within the next couple of months, although it was expected that the statistics would have remained about the same.

A map showing national coverage by area was presented to the Panel. A short discussion ensued in respect of performance in the various regions. It was commented that the rates in London were quite low, which may have related to transience in the population, or women not being registered with a GP. It was indicated that the latter was a prerequisite to being invited for screening. Interestingly, Cumbria was one of the highest performers, despite difficulties with transport links. The rates had declined nationally over time, which highlighted that there was more to be done in terms of the screening programmes. Despite this decline, however, the rate of detection had been increasing. It was felt that this demonstrated that the skills and techniques being utilised by the programmes were getting better (e.g. the introduction of digital screening). It was felt that capitalisation of this would help to raise the figures. Reference was made to publicity campaigns, the age at diagnosis and the number of women being diagnosed.

A query was raised regarding detection and invasive and non-invasive measurements. It was explained that the smaller the measurement, in millimetres, the better this was. Anything between 15mm-20mm was considered to be at the pre-symptomatic stage and therefore unlikely to be felt. Essentially, this formed the basis of the breast screening programme in that the smallest breast cancers, like the more larger breast cancers, could be detected.

In response to an enquiry raised regarding Middlesbrough's 71.7% rating and work being undertaken to improve this, it was explained that there were fewer activities taking place in respect of breast screening than in other areas such as cervical and bowel. The Panel's input was requested in terms of what additional projects could be undertaken.

The breast screening programme organised itself in such a way that presented mobile screening units to women, and made the information as accessible as possible to them. It was explained that the mobile screening units were parked in prominent areas, such as supermarket and shopping centre car parks. All women residing in the locality who were between the respective age ranges and registered to a GP, would receive an invitation to attend for a timed appointment. It was explained that walk-in appointments could not be offered as the identification of the person needed to be verified so that medical records could be updated with screening dates. However, information and advice would be offered to any person who wished to drop in. Despite these arrangements, it was felt that promotional activity in terms of when the mobile screening units would be in certain areas was lacking. It was suggested that targeted promotional work in collaboration with GP practices in the local area would be a positive move forward. Members felt that a good recommendation from the Panel would be for Councillors to assist with this promotional activity in the future.

Women who had missed an appointment or who were over the age of 70 could request a screening appointment; however, due to x-ray emissions, anyone who had received a screening within the last three years could not have another. In addition, it was noted that appointments were flexible and could be changed if not convenient.

In response to an enquiry, it was explained that the technique for screening was x-ray. Other methods such as ultrasound were not particularly effective in terms of locating smaller cancers.

Members queried whether the Council, as a large scale employer, could potentially promote this programme to female members of staff. In response, it was felt that any promotional activity that the Council could undertake to promote the service, encourage self-referral for those that may have missed appointments, and to not make it difficult for staff to attend appointments during work hours would be very helpful. It was felt that creation of a policy would take this forward in terms of facilitating time off work for screening appointments; extending this to other cancers would also be useful. From a Public Health perspective, it was felt that the resources and skills were available to assist in the publicising of this. Reference was made to a cervical screening project that South Tees Hospital was currently undertaking, where it had been agreed that female employees would be permitted to attend screening appointments during work time.

In terms of demographics and attendance at screening programmes, those most least likely to attend were those in the lower socio-economic groups, from BME communities, women with learning disabilities and mental health issues. Reference was made to the Authority's responsibilities and targets for ensuring that people with learning disabilities had regular health checks. It was explained that there was responsibility for GP practices to ensure that patients with learning disabilities had a health check once every year. The Scrutiny Support Officer would research what screenings the Local Authority had put in place for these groups of people.

A Member made reference to communication methods used by Councillors, including newsletters and social media, and commented on the potential benefits that this activity could offer if Councillors were advised as to when mobile screening units would be in their area, so that they could help promote the screening programme. This was highly welcomed by the representatives in attendance and it was suggested that regular communication between the programme providers and the Scrutiny Panel be undertaken to facilitate this.

<u>Cervical Screening Programme</u>

It was explained that this was not about looking for cervical cancers, but was about looking for changes in the cells in the cervix, which may have led to cervical cancer.

Cervical cancer was associated with the Human Papilloma Virus (HPV), which was a sexually transmitted virus and found in 99% of cervical cancers. It was the eleventh most common cancer in the UK; one of the reasons for this was because a cervical screening programme had been in place for many years and had therefore done very well at preventing cancers. It

was the most common cancer in women under the age of 35.

The target population for screening was 25-64 years old. Reference was made to previous age ranges; the programme had previously screened from 20 years old. It was indicated that the reason for increasing the age was that it was felt to be causing undue harm to young women in instances where cell changes that would not have turned cancerous had otherwise been acted upon.

In order to catch cervical cancer in its early stages, it was explained that invitations were sent out to women at age 24 1/2. If women presented themselves to their GP and were shown to have symptoms, the patient would have been referred to the Colposcopy unit immediately. It was explained to Members that self-referral after the age of 64 would not be possible.

Details pertaining to the testing procedures were outlined to the Panel.

In terms of screening and comparative coverage, data from March 2015 was provided to the Panel.

Reference was made to the Middlesbrough Project, a joint project carried out by Public Health within the Council, NHS England and other partners, which had commenced one year ago in order to raise cervical cancer screening rates within Middlesbrough. Women from BME communities, aged between 25-35 years, and those living in areas of higher deprivation were targeted primarily, as uptake was lower in women from those groups. A variety of work had been undertaken to date, which included:

- Insight work with those communities to facilitate planning of a campaign.
- Promotional campaign - incorporating radio, posters and a website to encourage women to attend for screening.
- Targeted GPs - the lowest 10% of GPs in respect of uptake rates were approached and a significant amount of work was carried out with them - e.g. re-training staff and encouraging practices to contact non-attendees by letter and by phone. It was highlighted that an increase had been seen in all of the practices involved. These were referred to as 'No Fear' practices; messages were sent out to advise that women would be taking samples, etc., in order to encourage their attendance.
- A new contract for sexual health services had been established. It had been stipulated within the contract that providers had to offer opportunistic cervical screening for women, e.g. women attending sexual health services for other reasons would be offered a test. It was indicated that, for the first time, targets had been put in place for this and it was expected that a specific number of women would be screened.

In response to an enquiry, it was explained that Virgin had won the contract for operation of this service, which would be commencing in September 2016. In terms of performance monitoring, the company would be required to report back on a quarterly basis.

- South Tees Hospital - the had hospital contacted all female employees to determine whether or not they all had up to date cervical screenings; 20% of the work force had not. Those women whose screenings were out of date could then have screenings completed during work time, at their place of work. This activity was still ongoing, however to date, 50 women had been screened, 6% of which had moved on to further treatment. It was highlighted that contract staff working within the hospital, and not just those employed directly by the Hospital Trust, had also been involved.
- Work had also been undertaken around Gynaecology outpatients; women attending outpatients would be offered an immediate appointment on site.
- Additional training with health visiting staff had been undertaken in order to encourage women with families and young children to attend.

The Middlesbrough Project was a joint arrangement that operated within a pooled budget. A steering group had been established. An initial project report of the work carried out had been prepared and a meeting to discuss the next steps would be undertaken in the near future.

It was felt that promotional work to raise awareness; obtaining assistance from health care workers to flag up screening delays; ensuring that literature was clear and understandable; and ensuring transparency around all aspects of screening were all imperative to raising the attendance statistics. Reference was made to media campaigns and debate in the short discussion that followed.

Consideration was given to the screening programme and the potential for replication of testing in varying workplace environments.

A Member queried whether a patient presenting to their GP would have their records checked to determine if their screenings were up to date. In response, it was felt the addition of flags on medical records would help to ensure that this could occur. It was felt that this could be extended to other matters such as missed vaccinations, etc. It was indicated that the low uptake practices that had been worked with in Middlesbrough had started to do this sort of thing.

In response to an enquiry, Members were advised that every GP practice within Middlesbrough carried out cervical screening. Reference was made to extended opening hours which a number of practices had introduced for this purpose.

The Chair made reference to the South Tees Health Scrutiny Joint Committee and the work currently being undertaken. It was suggested that the Health Scrutiny Panel refer the matter of (ensuring that GP practices throughout the South Tees be commissioned to open to cover the set days). The Panel agreed to this.

With regard to the Council's support to this work, the invited representatives made the following suggestions:

- To continue to support the work of the Public Health team and build upon work just completed into the next phase. The recommendations of this work were present in the submitted report.
- To ensure that employees (both directly employed by the Council and potentially wider - e.g. contractors) have the opportunity to attend for screenings during work hours - put this in contract or create a Council policy.
- With regards to screening for learning difficulties, ensure that those accessing services are up to date, as appropriate.

<u>Bowel Cancer Screening Programme</u>

An image of the screening kit forwarded to people in the post after age 60 was shown to the Panel. It was explained to the Panel that the testing age was based on the prevalence in the population. Receipt of a screening kit was on the basis of being registered with a GP; people initially received an invitation to take part in the screening programme, those selecting yes received a kit.

Details regarding the testing procedures were outlined to the Panel. It was indicated that the screening lab was based in Gateshead, which served both the North East and Yorkshire and the Humber areas.

In response to an enquiry, it was indicated that requests for screening kits could not be made by people under the age of 60, but could be by people over the age of the screening programme, which was 74. Reference was made to health economics in respect of the screening programme and the determinants for the age range involved.

Bowel cancer was the third most common cancer in the UK; 4/5 people were diagnosed after the age of 60.
It was felt that this was a very effective programme, and it was expected that the programme would reduce bowel cancer deaths by 16%. The frequency of the programme was every two years. Reference was made to the referral / treatment pathway involved in those instances where cancer or non-cancerous polyps were found.
With regards to coverage, the national target for the bowel screening programme was 60%,

which if achieved would make it economically viable. Reference was made to the South Tees statistics, which currently sat at 57.9% coverage. It was explained that 58% of those invited in that eligible population actually completed and returned the test. It was indicated that uptake in this programme, since its introduction in 2008/2009, had increased over time. One reason for this was that, over time, familiarity with the programme and discussions between friends and families had assisted in increasing the uptake.

A short discussion ensued regarding participation in the programme. It was clarified that patients do not automatically receive screening kits; they firstly receive a letter asking if they want to take part in the programme. It is then the responsibility of the patient to respond to this in order to receive the screening kit. This process is repeated every two years. It was felt that postal research response was generally problematic, and that relying upon people responding to letters could result in non-participation. It was felt that consignment of the pack initially, rather than sending letters, would not only save on administration costs and resources, but may potentially increase uptake. Members suggested that it may be useful to approach the CCG with the recommendation that a pilot exercise be undertaken whereby kits are automatically sent to pilot group, to determine if response is increased by sending the testing kit over the letter initially. The representatives indicated that this would provide a useful discussion point.

In response to an enquiry regarding the availability of packs in GP Surgeries for patients to call in and request one, it was explained that the packs were barcoded with individuals' information and were therefore personally traceable to individuals.

Reference was made to the work being undertaken by the Public Health Team in targeting specific populations where participation in the programme was low.

A short discussion ensued with regards to statistical gender differences in respect of participation in the programme. Both men and women were invited equally to the programme. It was explained that if you were to break down the 58% South Tees number, there would be a difference in gender. There tended to a 2-4% difference in participation rates, with women attending more.

With regards to activities taking place in terms of trying to improve the coverage within the bowel screening programme, Cancer Research UK had been carrying out campaigns right across the country; however, specific targeting of Middlesbrough had been undertaken because the uptake figures were low. It ran a media campaigns last summer and repeated in January/February 2016. It was hoped that an increase in the participation figures would be seen in light of this. In addition to this initiative, an additional letter of encouragement from participants' personal GPs would be included in the screening kit to try and improve participation. In addition to this, each of the screening practitioners in the colonoscopy service, as part of their job description and role, would be required to promote the programme - go out to various venues in order to talk about and promote the programme. It was felt that there would be opportunities for the Council to support this, for example: promoting the programme through own workforce (e.g. screening) and Councillors (e.g. promotional work). If the Council were able to assist the colonoscopy practitioners in locating other potential places for giving talks that would be helpful. Reference was made to the various media platforms that the Council could utilise to assist in the promotion of the screen, Love Middlesbrough Magazine, Social Media, etc. Regarding Love Middlesbrough, it was felt that a standard item for Public Health issues be included. A short discussion ensued with regards to potential messages and links that could be covered in future editions in order to promote health messages.

Reference was made to mapping the areas of low uptake. This tended to be areas with deprivation and a high proportion of people in BME communities. If you were to think about targeting work, those are the kinds of areas that you may wish to specifically target. Consideration was given to the potential reasons as to why people don't take part - e.g. yuk factor, attitudes, etc.

Consideration was given to Community Hubs and other buildings, such as leisure centres, that could potentially be utilised by having a public health presence in these settings. It was felt that there was a need for this. It was suggested that a recommendation be made regarding

this, particularly in respect of what work public health would undertake and how they planned to implement. Members agreed to this.

Reference was made to age distribution in respect of the cervical screening programme. It was explained that younger women were much less likely to come than older women, although the oldest women also weren't that likely to come. The women most concerned about where between the ages of 25-35, and then at the end of their screening lifetime between the ages of 55-64. Therefore, it was felt that anything targeting these two age ranges was welcomed.

The Macmillan Programme Manager was asked if her attendance at the next meeting of the Health Scrutiny Panel would be possible. This was agreed, however, the representative extended an invitation to the Members of the Panel to visit South Tees in order to look at the facilities being offered to patients on site. The Members welcomed this. It was suggested that the next meeting of the Panel be held at South Tees following the site visit. This was agreed by the Panel.

The Chair queried the possibility of liaising with Macmillan representatives in preparing recommendations and drafting its final report. This was welcomed by the Macmillan Manager.

Consideration was given to the recommendations that the Panel will make. It was queried with the representatives as to what they feel should be included in terms of what the Council could address. In response, it was indicated that these could potentially include: Extended opening times for practices for women attending cervical screening; Flagging for each of the three screening programmes as reminders on the GP systems; in terms of the CCG contributions - to support us in undertaking further work to target practices with low uptake, for example: offering additional resources for sampling purposes.

Reference was made to the 2016/2017 Public Health budget and the query made as to how this could potentially be used to support the programmes. It was felt that this would be to respond further to work being completed, for example: targeted campaign work in areas of higher deprivation and looking at the reasons as to why individuals did not present earlier with symptoms. A short discussion ensued regarding this, with reference being made to a potential 'Middlesbrough effect'.

Representatives indicated that there was quite a lot of work going on in respect of both cervical and bowel, there was less in terms of breast and it was just as much in need of improvement in terms of its coverage rates. If the Council were to also deliberately focus on breast screening, this would be useful. Reference was made to other neighbouring authorities and the potential for joint working for the benefit of the breast screening programme would be a good thing, particularly as there was only one programme covering a wide area. The Chair referenced the Tees Valley Joint Scrutiny Panel, which Middlesbrough would be administering from May 2016, and felt that active Scrutiny would play a prominent role in this. Members agreed that a letter from the Health Scrutiny Panel to the Tees Valley Joint Scrutiny Panel would help validate this point.

Regarding the NHS Health Check and the promotion of the screening programmes within this initiative, it was commented that a list of drop-in sessions would be a helpful addition to it.

A short discussion ensued with regards to the different tests undertaken across the health service and the application of these in terms of identifying an underlying condition.

The Chair thanked the representatives for their contributions to the meeting.

15/42 **OVERVIEW AND SCRUTINY BOARD UPDATE - 5 JANUARY AND 2 FEBRUARY 2016.**

The Panel noted the contents of the submitted report.

NOTED

15/43 **ANY OTHER BUSINESS.**

RECONFIGURATION OF HOSPITAL SERVICES

Reference was made to the impending reconfiguration of Radiology services in relation to personnel resources and equipment availability and ownership.

NOTED