

**Warrington**

**Joint Strategic Needs Assessment (JSNA)**

**Cancer, 2015**

**August 2015**

## Version control

Version	Description of amendments	Date of amendment
1.0	Added in chapter sections, analysis to date, and details of further information to be added	20/02/2015
2.0	Analysis finalised and addition of information to each section	11/05/2015
3.0	Addition of local services and user views	19/05/2015
4.0	Amendments to chapter based on expert feedback; update to date of publication	01/06/2015
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Final Draft V3	Inclusion of new NICE guidelines	10/08/2015
Final Draft V4	Final amendments and proof reading	22/09/2015

The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities

## **EXECUTIVE SUMMARY**

### **Introduction**

The aim of this JSNA chapter is to describe what we know about cancer in Warrington. The chapter examines those who are most at risk of developing cancer; analyses numerous data sets relating to cancer; describes current services that are in place in Warrington; predicts future mortality trends and describes what service users had said about their experiences.

### **What is Cancer?**

Cancer is an everyday term which the majority of the population have heard of but most probably do not understand. Cancer can be described as a group of cells (cells are tiny building blocks that make up organs and tissues in our body) that can invade anywhere in the body. The cells grow and multiply uncontrollably, attacking and destroying healthy tissue and organs (NHS Choices, 2014; Macmillan Cancer Support, 2014).

Cancer is a complex condition because of the uncontrollable growth of cancerous cells and invasion into other parts of the body. What brings about the uncontrollable cell growth is not known, but there are known to be potential triggers which set it off. These include noxious chemicals (such as those found in tobacco smoke), genetics, viruses and radiation (Cancer Research UK, 2014a).

In a healthy immune system, the risk of cancer is low, as the immune system recognises and destroys cancerous cells. When uncontrollable cells continue to divide and spread because they have got through the immune system's safety net, this is when cancer starts to develop.

The cells that grow uncontrollably form a lump, which is also known as a tumour. Tumours can be described as being either benign (which is not cancerous) or malignant (tumours that are made from cancerous cells) (Macmillan Cancer Support, 2014). Left unchecked, malignant tumours continue to grow, spread, and invade other tissues and organs.

Treatment is not always successful, and depends on being provided early, hence the importance of cancer screening programmes designed to identify pre-cancerous or early cancerous changes before they have become fully established. Successful outcomes of treatment also depend on the type and aggressiveness of the tumour. Some tumours can be particularly aggressive and invasive, and can be difficult to control.

### **National Strategy**

In January 2011 the Department of Health published a national strategy for Cancer (Department of Health, 2011). The strategy sets out to improve outcomes for all cancer patients, with the specific aim to improve cancer survival rates, by 2014/15 the strategy aimed to save an additional 5,000 lives each year and narrow the inequalities gap (Department of Health, 2011).

The strategy stated four specific actions to achieve better outcomes for the population:

1. Reduce the incidence of cancers which are preventable, by lifestyle changes;

2. Improve access to screening for all groups and introduce new screening programmes where there is evidence they will save lives and are recommended by the UK National Screening Committee;
3. Achieve earlier diagnosis of cancer, to increase the scope for successful treatment – diagnosis of cancer at a later stage is generally agreed to be the single most important reason for the lower survival rates in England; and
4. Make sure that all patients have access to the best possible treatment.

Improved outcomes for the population are monitored through three national outcome frameworks: NHS Outcome Framework (NHSOF), Public Health Outcome Framework (PHOF) and Adult Social Care Outcome Framework (ASCOF).

Each of the frameworks includes a series of indicators that focus on their area of expertise in relation to the prevention, treatment and care for cancer patients. For example, the PHOF includes a series of indicators that monitors healthy lifestyle choices that can reduce the risk of an individual developing cancer; the participation of cancer screening initiatives and the uptake of vaccination programmes that are known to reduce the risks of developing certain types of cancer in later life. Whilst the focus of the NHSOF is about patients receiving timely and appropriate cancer treatment and the ASCOF measures those that are in need of care and support are receiving appropriate services. There are indicators that belong to more than one outcome framework, for example, early detection of cancer and premature mortality from cancer (deaths in those aged less than 75 years).

### **NHS Cancer Screening Programme**

Currently, in England, there are three cancer screening programmes; NHS Breast Screening Programme; NHS Cervical Screening Programme; NHS Bowel Cancer Screening Programme.

**NHS Breast Screening Programme** - The NHS Breast Screening Programme provides free breast screening every three years for all women aged 50 and over. Because the programme is a rolling one which invites women from GP practices in turn, not every woman receives an invitation as soon as she is 50. But she will receive her first invitation before her 53rd birthday. Breast screening is a method of detecting breast cancer at a very early stage. The mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor (NHS Cancer Screening Programmes, 2015a).

**NHS Cervical Screening Programme** - The programme aims to reduce the number of women who develop invasive cervical cancer (incidence) and the number of women who die from it (mortality). It does this by regularly screening all women at risk so that conditions which might otherwise develop into invasive cancer can be identified and treated. All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years. Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb) (NHS Cancer Screening Programmes, 2015b).

**NHS Bowel Cancer Screening Programme** - Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be

effective. Bowel cancer screening can also detect polyps. These are not cancers, but may develop into cancers over time. They can easily be removed, reducing the risk of bowel cancer developing. The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 74 (NHS Cancer Screening Programmes, 2015c).

### **Key Findings, Issues and Gaps**

- Warrington had a significantly higher rate of new cancers diagnosed (incidence rate) when compared to England and North West (new cases of cancer diagnosed between 2010 and 2012);
- Warrington had significantly higher incidence rates of Breast, Stomach and Lung Cancer when compared to England (between 2010 and 2012);
- New diagnosis of cancer is higher in more deprived areas of Warrington, this pattern is also seen nationally;
- Late stage diagnosis of cancer in men was significantly higher when compared to women during 2012;
- Cancer is the leading cause of death in Warrington; Warrington had a mortality rate that was significantly higher than England (all cancer deaths between 2011 and 2013);
- Uptake of cancer screening remains lower in the more deprived GP practices in Warrington, especially so for bowel screening;
- Late stage diagnosis was highest for lung and bowel cancer during 2012;
- Staging data<sup>1</sup> completeness reduced for those aged 75 years and above;
- Premature mortality from cancer is increasing in the 20% most deprived areas of Warrington;
- The target for patients to start cancer treatment within 62 days of referral was missed during 2014/15. With the introduction of new NICE guidelines in late June which will increase the number patients being referred for diagnostics and most likely result in more people requiring cancer treatment, there is the potential for more patients to miss the two month referral to treatment target.

### **Recommendations for Commissioning**

- The promotion of cancer screening messages should be further reinforced with external partners, especially organisations that work with deprived communities where uptake is low. There is the need to ensure that bowel screening messages are communicated effectively with deprived communities;
- Work with Primary Care practitioners to ensure that understanding of cancer signs and symptoms, clinical pathways and achieving a good rate of screening (national standards) is a priority;

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<sup>1</sup> Cancer staging is the process where a cancer is graded based on the size and/or extent of the original tumour and whether or not cancer has spread in the body.

- Ensure that GP Practices receive a quarterly update in regards to their cancer screening uptake;
- The strong association between smoking prevalence and lung cancer incidence emphasises the need for smoking cessation services to engage and target the most deprived areas of Warrington;
- There is a continued need to target men with messages about early detection of cancer and seeking timely referrals;
- Continued promotion of early symptoms of lung and bowel cancer is required in Warrington for both the public and clinical staff;
- Ensure that health professionals consistently provide staging data for all newly diagnosed cancer patients;
- Audit the 62 day pathway urgent referral to treatment pathway to ensure that blockages for patients receiving a diagnosis and starting cancer treatment are minimised.

### **1) Who is at risk and why?**

**Age:** One of the biggest risk factors of developing cancer is increasing age. This is because the changes that make a cell become cancerous in the first place take a long time to develop (Cancer Research UK, 2014c). 63% of people who get cancer (more than 3 out of 5) are over the age of 65 and more than a third are over 75 years (Macmillan Cancer Support, 2012a).

**Healthy Lifestyle Choices:** Up to 40% of cancers in the UK could be prevented by making healthy lifestyle changes; not smoking, eating a healthy diet and keeping physically active (Macmillan Cancer Support, 2012a).

**Stop Smoking** – smoking is the single biggest avoidable cause of cancer. Approximately 1 in 5 cancers and 1 in 4 cancer deaths are caused by smoking. Approximately 9 out of 10 people who develop lung cancer are smokers. Smoking also increases the risk of developing cancers of the mouth, throat, lung, bladder, kidney, pancreas, bowel, stomach and cervix (Macmillan Cancer Support, 2012a).

**Keep to a Healthy Weight** - Being overweight increases the risk of several cancers including cancers of the pancreas, bowel, womb (uterus), and kidney as well as breast cancer after the menopause (Macmillan Cancer Support, 2012a).

**Eat a Healthy Diet** - A healthy diet can reduce cancer risk, particularly the risk of developing bowel cancer (Macmillan Cancer Support, 2012a).

**Limit Alcohol Consumption** - About 4 in 100 cancers in the UK (4%) are linked to alcohol. Alcohol especially increases the risk of cancers of the mouth, throat and gullet (oesophagus). It is also linked to cancers of the bowel, liver and breast. In general the more you drink the more your risk increases (Macmillan Cancer Support, 2012a).

**Keep Physically Active** - Many studies have found that regular physical activity can reduce the risk of cancer. Lack of physical activity increases the risk of bowel cancer, womb cancer

and post-menopausal breast cancer. It may also increase the risk of other cancers, such as lung cancer and prostate cancer (Macmillan Cancer Support, 2012a).

**Genetics:** between 5 and 10% of cancer cases are associated with a strong family history of cancer (Macmillan Cancer Support, 2012a).

**Occupational and Environmental Factors:** Contact with certain harmful substances in the natural environment or workplace can cause cancer. Substances that are known to cause cancer are called carcinogens (Macmillan Cancer Support, 2012b).

**Radon Gas** is considered by Cancer Research UK to be the second leading cause of lung cancer after tobacco (Cancer Research UK, 2014b). Radon is usually a naturally occurring radioactive gas that is created when uranium in the earth's crust decays. Radon has been known to seep up from the ground into buildings. Radon is a known human carcinogen (NHS Choices, 2015).

**Industrial or Occupational Risk Factors:** Exposure to certain chemicals and substances that are used in a number of occupations and industries has been linked to a slightly increased risk of developing cancer (Macmillan Cancer Support, 2012b).

**Low Immunity:** People with poor immunity are more likely to develop lymphomas and certain types of skin cancer (particularly non-melanomas). They are also more at risk of cancers that are influenced by a virus or bacteria, such as cancers of cervix, some anal and genital cancers, and some cancers of the stomach and liver. People with lower immunity may have: had an organ transplant and are taking medication to lower their immune system to prevent the organ being rejected by their body; reduced immunity due to HIV (human immunodeficiency virus); medical conditions that reduce immunity (Macmillan Cancer Support, 2012c).

**Viruses:** One of the most common viruses that can affect cancer risk is HPV (human papilloma virus). This increases the risk of developing cancer of the cervix, head and neck cancers and cancers of the anal or genital area (Macmillan Cancer Support, 2012d).

## **2) The Level of Need in the Local Population**

### **2.1 Cancer Screening**

#### **2.1.1 Breast Cancer Screening (data presented on PHOF)**

Since 2012, the percentage of eligible women who were screened for breast cancer has reduced very slightly year on year in England. 2014 saw the lowest uptake of screening for a number of years, 75.9% of eligible women were screened; whilst in 2011 the screening rate was 77.1%. A reduction in the percentage of women screened during 2014 was also seen in the North West (73.4%) and locally in Warrington (77.9%). Positively, the percentage of women from Warrington who were screened was significantly higher than England for the last three years.

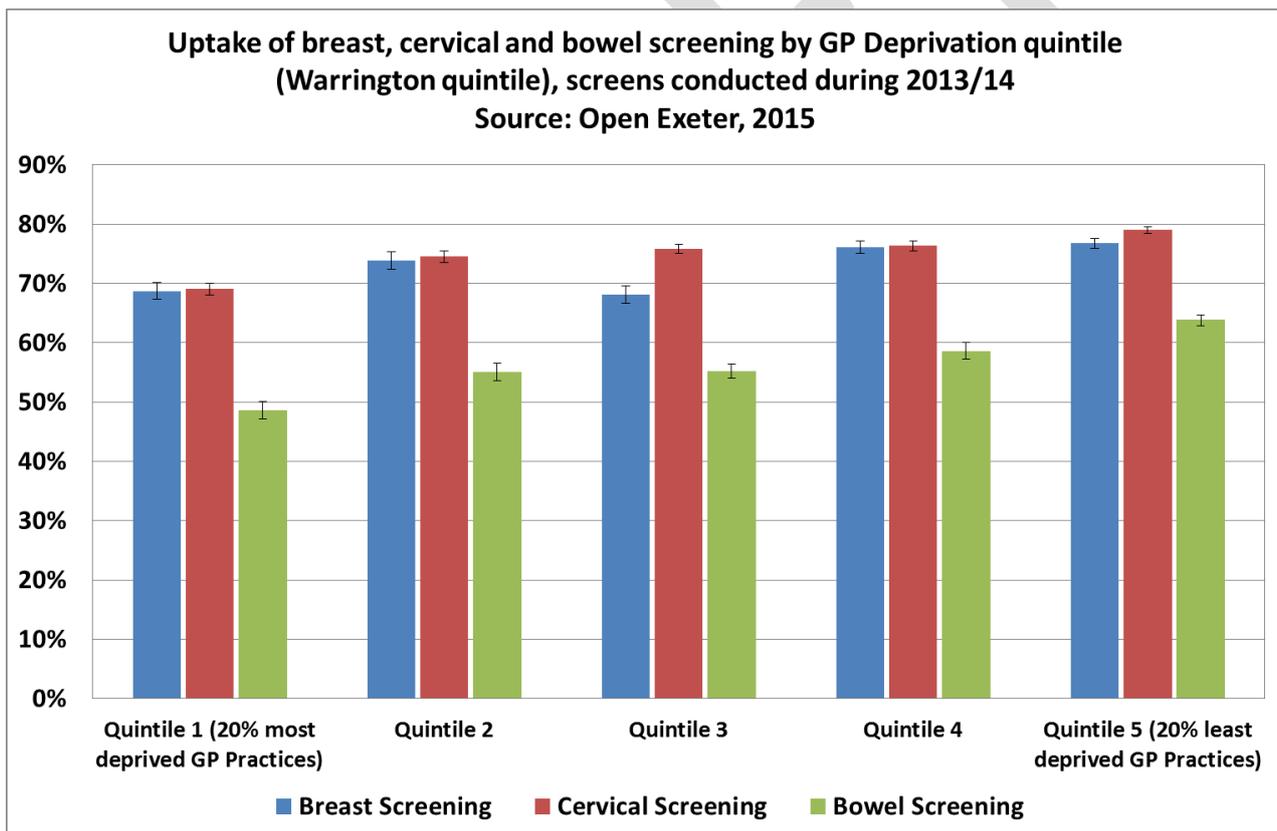
#### **2.1.2 Cervical Cancer Screening (data presented on PHOF)**

Nationally, the trend in the percentage of eligible women receiving a cervical screen has remained fairly stable (slight fluctuations in the uptake have been seen each year). During 2014 the uptake for England was 74.2%. However, there have been slight reductions in the uptake of screening at regional and local levels since 2012. During 2014, the screening uptake in Warrington was 75.4%, whilst in the North West the uptake was 73%. Positively, the percentage of women from Warrington who were screened was significantly higher than England for the last four years.

### 2.1.3 Screening uptake within Warrington

During the three years leading up to March 2014, there were over 78,000 cancer screens (breast, cervical, bowel) carried out in Warrington. Analysis of screening uptake by GP deprivation quintile<sup>2</sup> has shown that generally, uptake of screening is highest at GP Practices that are considered to be less deprived, whilst uptake was lowest in the most deprived GP Practices. The effect of deprivation and uptake appears to be greater for the bowel screening programme, when compared to the remaining two screening programmes.

**Chart 1: Uptake of cancer screening programmes by GP Practice deprivation quintile, 2013/14**



## 2.2 Cancer Waiting times

<sup>2</sup> GP Deprivation quintiles have been created by grouping GP Practice deprivation scores and splitting into five equal groups. GP Practice deprivation scores have been developed by assigning the LSOA IMD 2010 score to each patient registered at the GP Practice based on the patient postcode. All scores were summed and divided by the total population to create an overall population weighted deprivation score for each GP Practice.

The Government have set waiting time targets in England and Wales for treating cancer patients.

- No more than 62 days wait between the date the hospital receives an urgent GP referral for suspected cancer and starting treatment.
- Starting treatment no more than 31 days after the meeting at which the patient and doctor agree the treatment plan (Cancer Research UK, 2015b).

During 2013/14, 86% of patients in England had started to receive cancer treatment within 62 days (the time between the hospital receiving the urgent GP referral documentation to when the patient starts to receive treatment for their cancer). The percentage of patients seen within this specific timeframe was slightly higher in Warrington (88%) and exceeded the locally set target of 85% (NHS England). Performance during 2014/15 for Warrington has shown that the target of 85% has been narrowly missed as 84.5% of patients were seen within the specified timeframe of 62 days.

In England during 2013/14, 98% of patients who went onto be diagnosed with cancer received treatment within 31 days of agreeing a course of action with the doctor; the percentage was slightly higher in Warrington at 99% and exceeded the locally set target of 96%. Performance during 2014/15 has shown that performance in Warrington has been maintained at 98.9%.

## **2.3 Cancer Incidence**

### **2.3.1 Warrington and national cancer incidence rates compared**

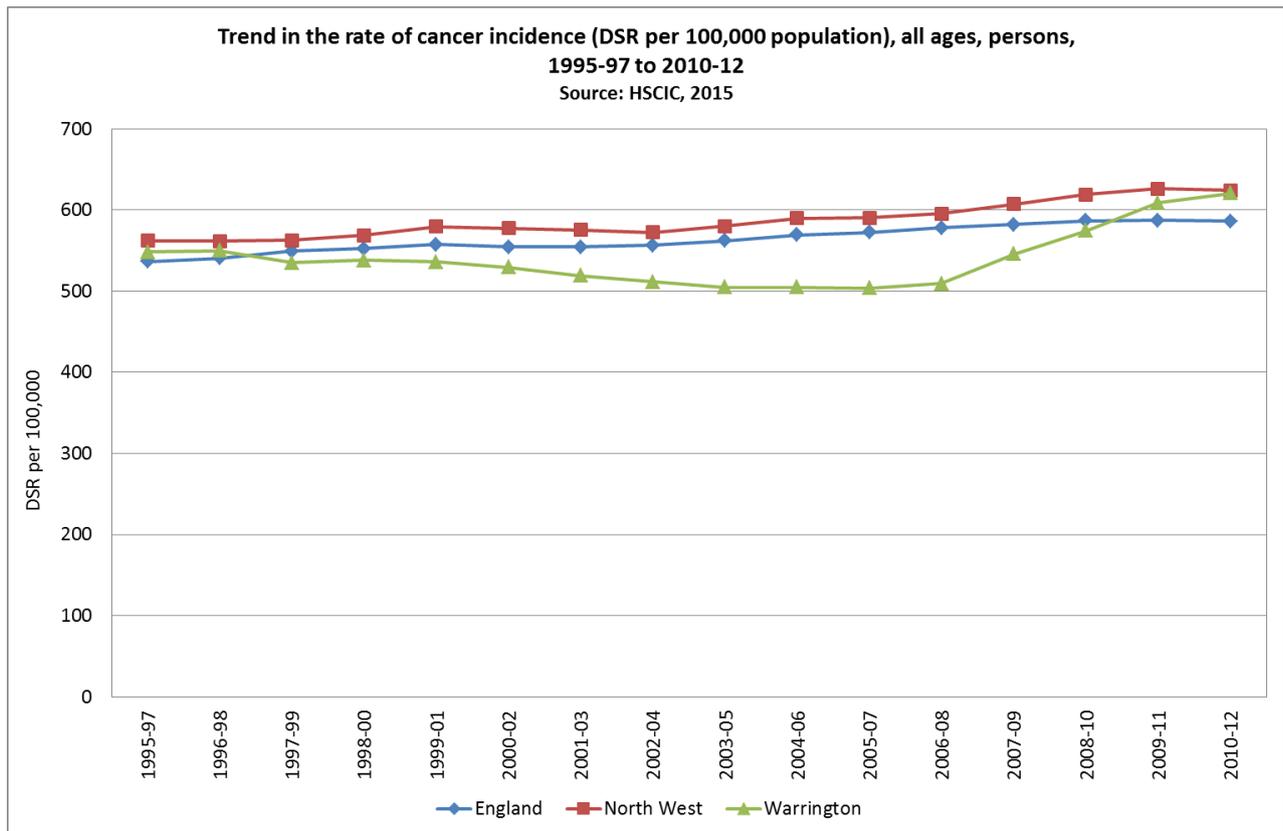
Between 2010 and 2012, a total of **3,321** new cancers were diagnosed in Warrington residents. The incidence<sup>3</sup> rate in Warrington was significantly higher than England between 2010 and 2012 (for women and persons). There appears to be a year on year rise in the rate of cancer incidence after a period of reduction between 2000-02 and 2006-08. The increase observed from 2007-2009 onwards requires further investigation to establish the cause of this dramatic increase. Although anecdotal evidence suggests that the increase may be due to improved data flows between Warrington and Halton Hospitals Foundation Trust and the Cancer Registry.

The incidence rate for those aged less than 75 was also significantly higher in Warrington when compared to England. The incidence rate for women was also significantly higher than England for both all ages and ages less than 75 years.

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<sup>3</sup> Cancer incidence includes all cancers diagnosed (ICD10 C00 to C97) with the exception of skin cancers other than malignant melanoma (ICD10 C44). This type of cancer has been excluded from national and local cancer incidence analysis as it is believed that this type of cancer is greatly under reported. The registration of this type of cancer varies widely between regional cancer registries, therefore by following ONS practice, the figures presented by the Health and Social Care Information Centre (HSCIC) and local analysis conducted by the North West Cancer Intelligence Service (NWCIS) has excluded any figures relating to skin cancers other than malignant melanoma.

**Chart 2: Trend in the cancer incidence rate**



Analysis by cancer type has shown that Warrington has significantly higher incidence rates when compared to England for three different types of cancer. These cancers are:

- Stomach Cancer
- Lung Cancer
- Breast Cancer

**Stomach Cancer** – there were 86 new cases of stomach cancer diagnosed in Warrington between 2010 and 2012. The incidence rate for women and persons (persons include data for both men and women) was significantly higher than England; this was also the case for persons aged less than 75 years. When examining the trend in the rate of incidence of stomach cancer, both nationally and regionally the incidence rate has been decreasing steadily for both men and women. However, in Warrington the trend differs slightly between the genders, after a period of reduction in the incidence rate for men, there was a slight increase during 2010 to 2012. Whilst for women there was a steady increase in the incidence rate between 2006 to 2008 and 2008 to 2010, then a slight reduction during the two latest time periods.

**Lung Cancer** – lung cancer incidence in Warrington was significantly higher than England for both men and women of all ages. In total there were 489 new cases diagnosed in Warrington between 2010 and 2012. The incidence rate was also significantly higher in Warrington for women and persons aged less than 75 years. The trend in the incidence of lung cancer differs by gender nationally; the rate for males has reduced whilst for females there has been an increase. The

increase in female lung cancer is reflected locally. However for males, after a period of steady decrease, the rate of cancer incidence has been increasing between the time periods 2009 to 2011 and 2010 to 2012.

Breast Cancer – Warrington had the 6<sup>th</sup> highest cancer incidence rate nationally (out of 326 Local Authorities) during 2010 to 2012; in total there were 575 new cases diagnosed. This resulted in an incidence rate that was significantly higher than both England and the North West. The trend in the rate of incidence has shown year on year increases since 2007 to 2009. When looking at women aged less than 75 years, Warrington had the 17<sup>th</sup> highest incidence rate nationally. Again, Warrington women had an incidence rate that was significantly higher than England and the North West.

There were two types of cancer where Warrington had significantly lower incidence rates when compared to England, these were:

- Malignant Melanoma
- Skin Cancers other than Malignant Melanoma

Malignant Melanoma – Warrington males (of all ages) had a significantly lower incidence rate than both England and the North West during 2010 to 2012.

Skin Cancers other than Malignant Melanoma – the incidence rate from this type of cancer was significantly lower than England for both men and women (all ages and ages less than 75 years) during 2010 to 2012.

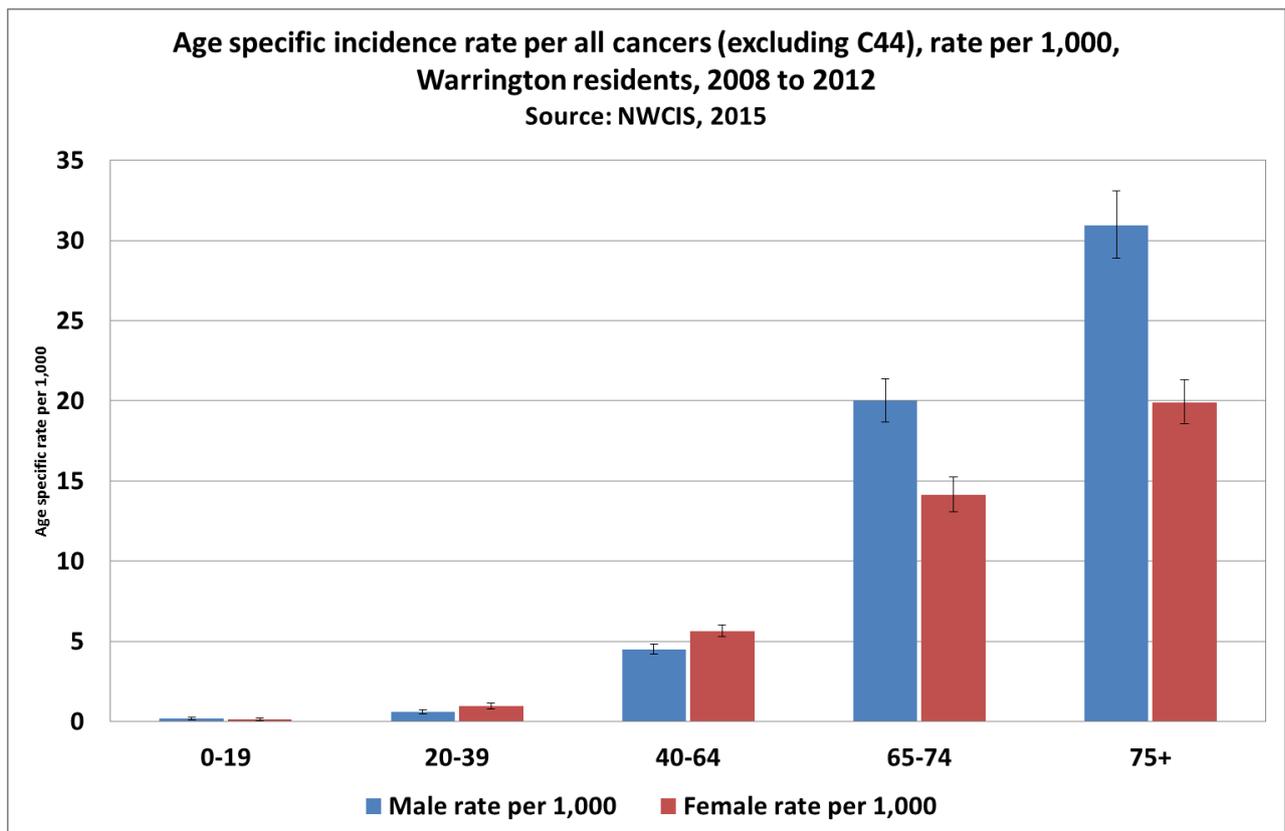
Although Warrington had significantly lower incidence rates of Skin Cancers other than Malignant Melanoma, this was the most common type of cancer diagnosed between 2010 and 2012 with 799 cases identified.

### **2.3.2 Warrington cancer incidence (analysis provided by North West Cancer Intelligence Service (NWCIS))**

The NWCIS conducted sub-Warrington analysis on cases of new cancer diagnosed between the years 2008 and 2012. During this five year period there were over 5,200 new cases of cancer (excluding skin cancers other than malignant melanoma), a slightly higher percentage of women (50.2%) were diagnosed when compared to men (49.8%).

The incidence rate by age band and gender found that the incidence rate increased as age increased. For both men and women, those aged 75 and above had the highest incidence rate. Analysis by age band also shows that older men had a higher incidence rate when compared to older women (aged 65 to 74 and 75+), whilst for the younger age groups females had a slightly higher incidence rate when compared to males (0 to 19 and 20 to 39 years).

**Chart 3: Age specific incidence rate of all cancers**



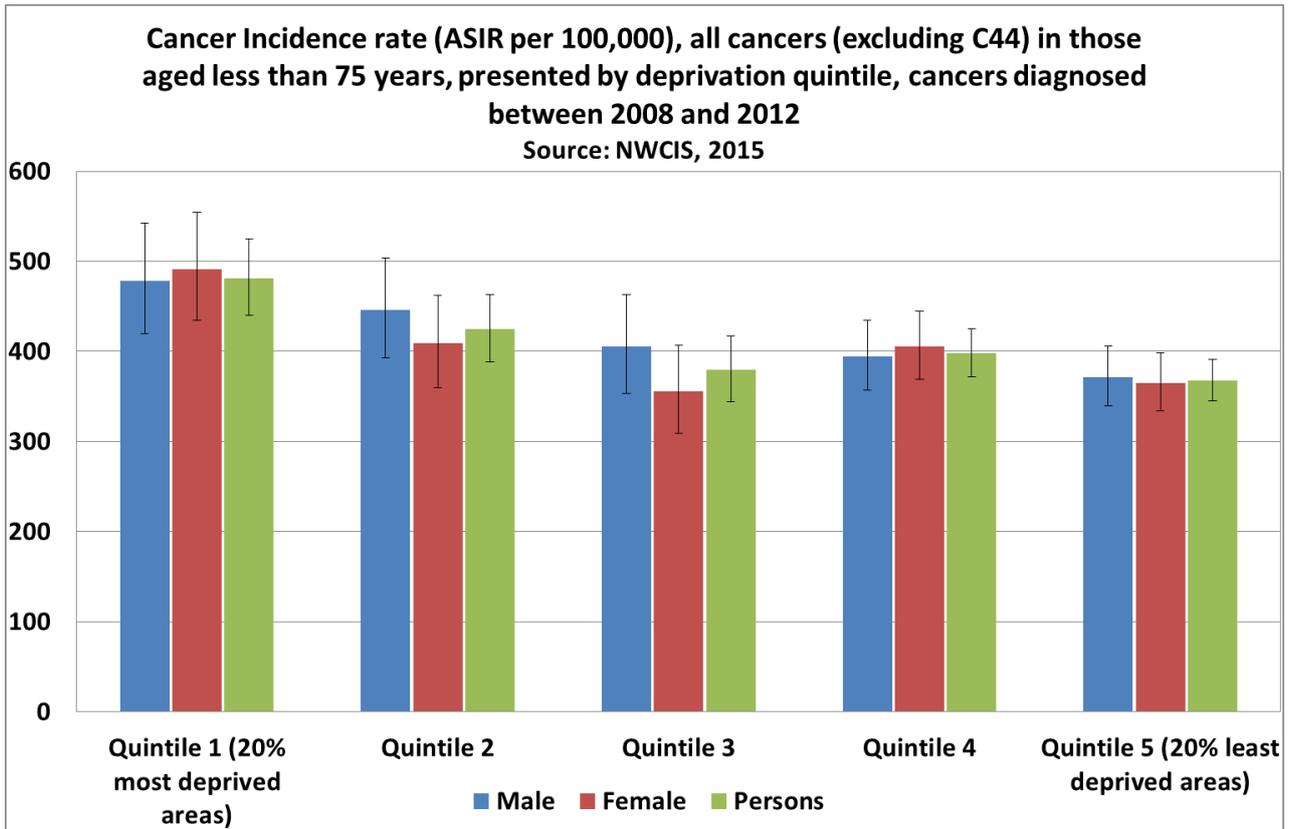
There appears to be a relationship between the rate of cancer incidence (for all cancers) and the level of deprivation<sup>4</sup> in Warrington. As deprivation decreases, the rate of cancer incidence also decreases; this relationship was seen for incidence rates of all ages and a statistically significant relationship was observed for people aged less than 75 years<sup>5</sup>. This pattern has also been observed at a national level through research conducted by the National Cancer Intelligence Network (NCIN) and Cancer Research UK (Public Health England, 2014), the analysis showed that for cancers that were diagnosed between 2006 and 2010 the incidence rate was significantly higher in the most deprived quintile, when compared to the least deprived quintile (Public Health England, 2014a).

The following chart presents the under 75 incidence rate by deprivation quintile in Warrington, the chart shows that cancer incidence rates (for males and females) were significantly higher in the 20% most deprived areas of Warrington, when compared to quintile 5 (20% least deprived areas). The deprivation quintile 1 incidence rate for persons was significantly higher than deprivation quintiles 3, 4 and 5.

<sup>4</sup> Cancer incidence rates have been calculated for deprivation quintiles in Warrington. Local areas in Warrington (LSOAs) have been grouped according to how they rank on a national deprivation scale (Indices of Multiple Deprivation 2010). Quintile 1 is those areas within Warrington which are ranked within the most deprived 20% of areas nationally. Quintile 5; those Warrington areas which rank within the least deprived 20% of all areas nationally.

<sup>5</sup> Statistical significance 0.05; Pearson Correlation Coefficient was used to determine if there was a correlation between deprivation and cancer incidence. The R value produced from this statistical test was used to calculate the P value and verify if the P value was significant.

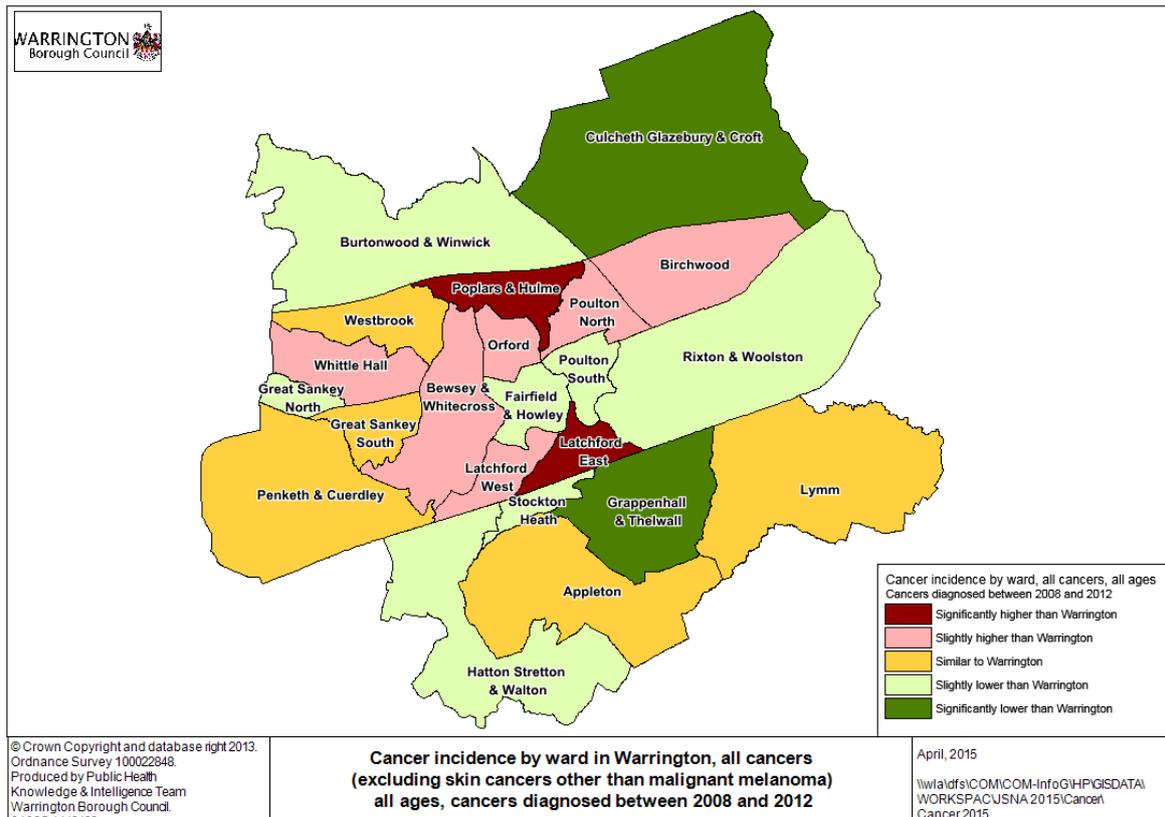
**Chart 4: Cancer incidence rate by deprivation quintile for all cancers (excluding C44), ages <75 years**



At ward level, cancer incidence rates were significantly higher than the overall Warrington rate in Latchford East and Poplars and Hulme; whilst Culcheth, Glazebury and Croft and Grappenhall and Thelwall had significantly lower cancer incidence rates, as presented in the following map. Incidence rates by gender showed a slightly different pattern as men had significantly high incidence rates in Orford and Poulton North, whilst for women it was Poplars and Hulme.

For those aged less than 75 years, cancer incidence was significantly high in Poplars and Hulme, for men the rate was significantly high in Orford, whilst for women the incidence rate in each ward was similar to the overall Warrington rate.

**Map 1: Cancer incidence rate by ward, all cancers (excluding skin cancers other than malignant melanoma), all ages**



As mentioned in section 2.3.1, during 2010 to 2012 Warrington had significantly higher rates of cancer incidence for lung cancer and breast cancer when compared to England. The following sub-Warrington analysis describes the incidence rate of these specific cancers by deprivation quintile.

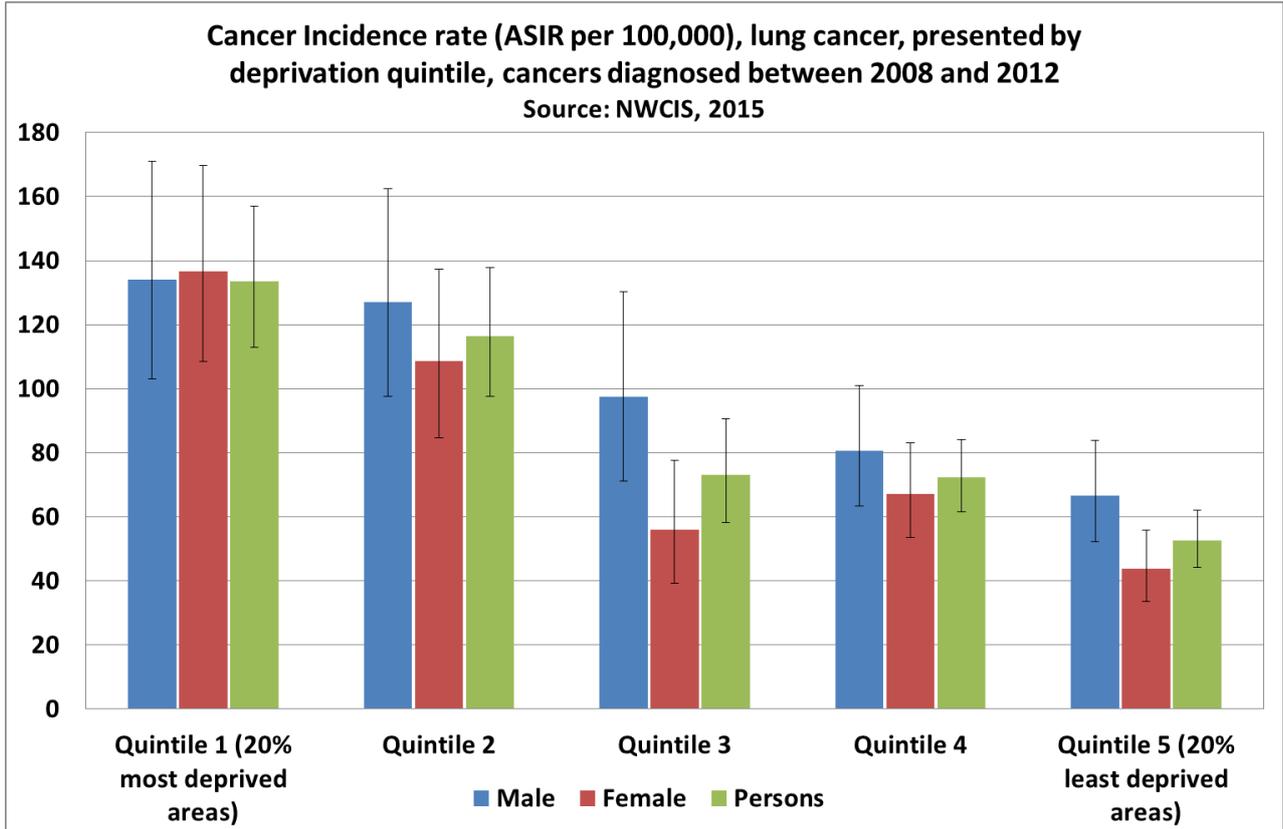
There was a very strong relationship between lung cancer incidence and deprivation. This finding was also observed at a national level using incidence data from 2006 to 2010 (Public Health England, 2014). As the level of deprivation increases, the lung cancer incidence rate also increases, as presented in the following chart. Further analysis found that males had a slightly stronger relationship between the level of deprivation and lung cancer incidence, when compared to females<sup>6</sup>.

The lung cancer incidence rate (for persons) was highest in deprivation quintiles 1 and 2 (the 40% most deprived areas in Warrington); the incidence was significantly higher in these quintiles when compared to the remaining areas of Warrington.

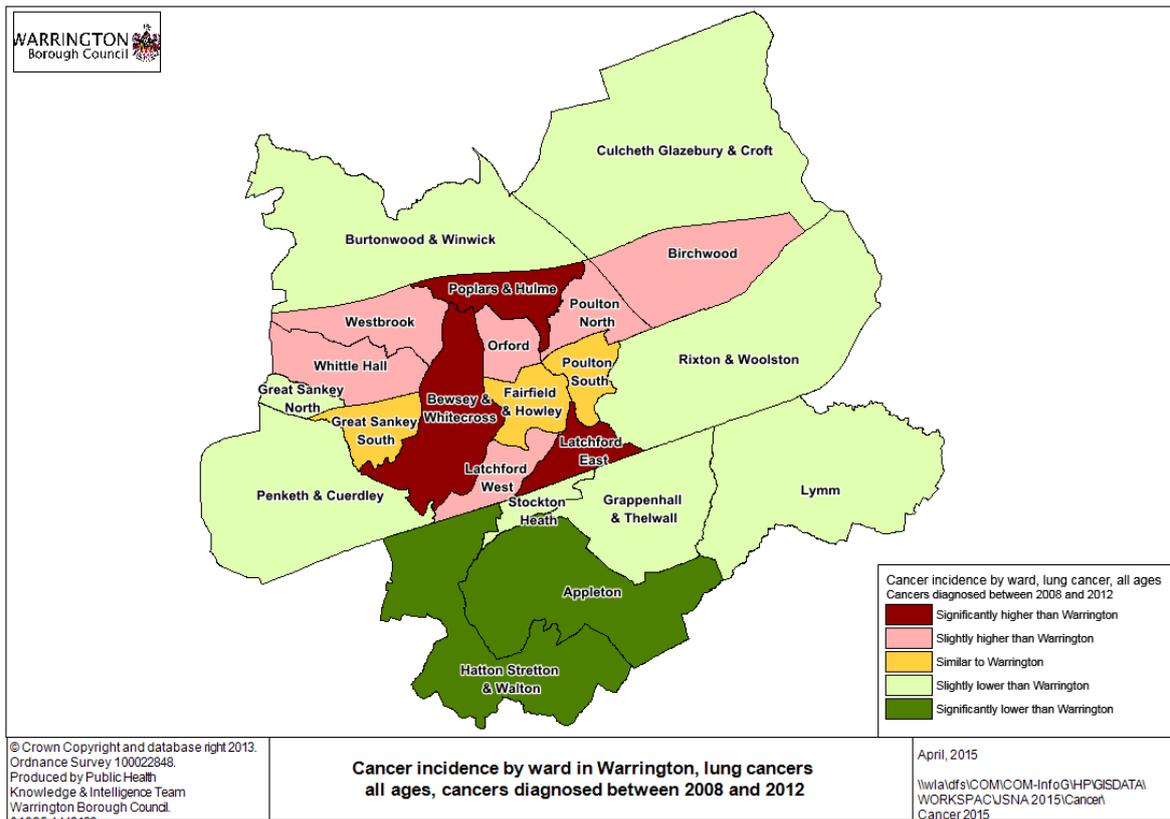
At ward level, the highest lung cancer incidence rates were found in the central wards of Bewsey and Whitecross, Latchford East and Poplars and Hulme; whilst the lowest rates were located in the southern wards of Appleton and Hatton, Stretton and Walton (as presented in the following map).

<sup>6</sup> The R value for males was -0.99; whilst for females it was slightly lower at -0.92.

**Chart 5: Lung Cancer incidence (all ages) presented by deprivation quintile**

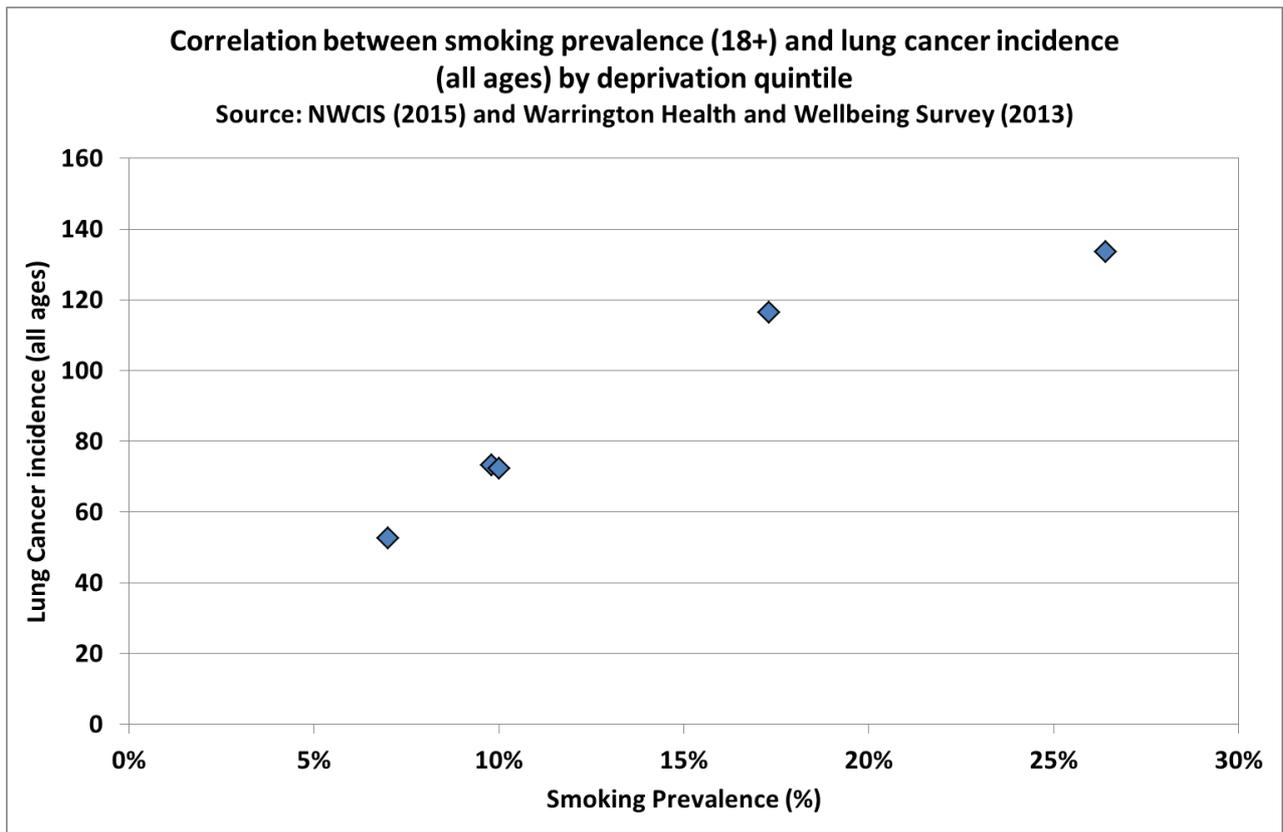


**Map 2: Lung cancer incidence (all ages) by ward in Warrington**



This pattern of lung cancer incidence is most likely related to high smoking prevalence levels in the more deprived communities of Warrington. The following chart shows the relationship between smoking prevalence<sup>7</sup> and lung cancer incidence (all ages) by deprivation quintile. The chart shows a very strong relationship between these two variables; as smoking prevalence increases, the rate of lung cancer incidence also increases.

**Chart 6: Relationship between smoking prevalence and lung cancer incidence by deprivation quintile in Warrington**



There appears to be no relationship between breast cancer incidence (for all ages and ages less than 75) and deprivation in Warrington. The following chart shows the incidence rate by deprivation quintile, but there were no significant differences in rates. This local finding differs to what has been seen at a national level. Based on cancers diagnosed between 2006 and 2010 in England, the breast cancer incidence rate was significantly higher in the least deprived quintile when compared to the most deprived quintile. A suggested cause for the higher incidence rate in the least deprived quintile was due to higher uptake of screening in least deprived areas (Public Health England, 2014).

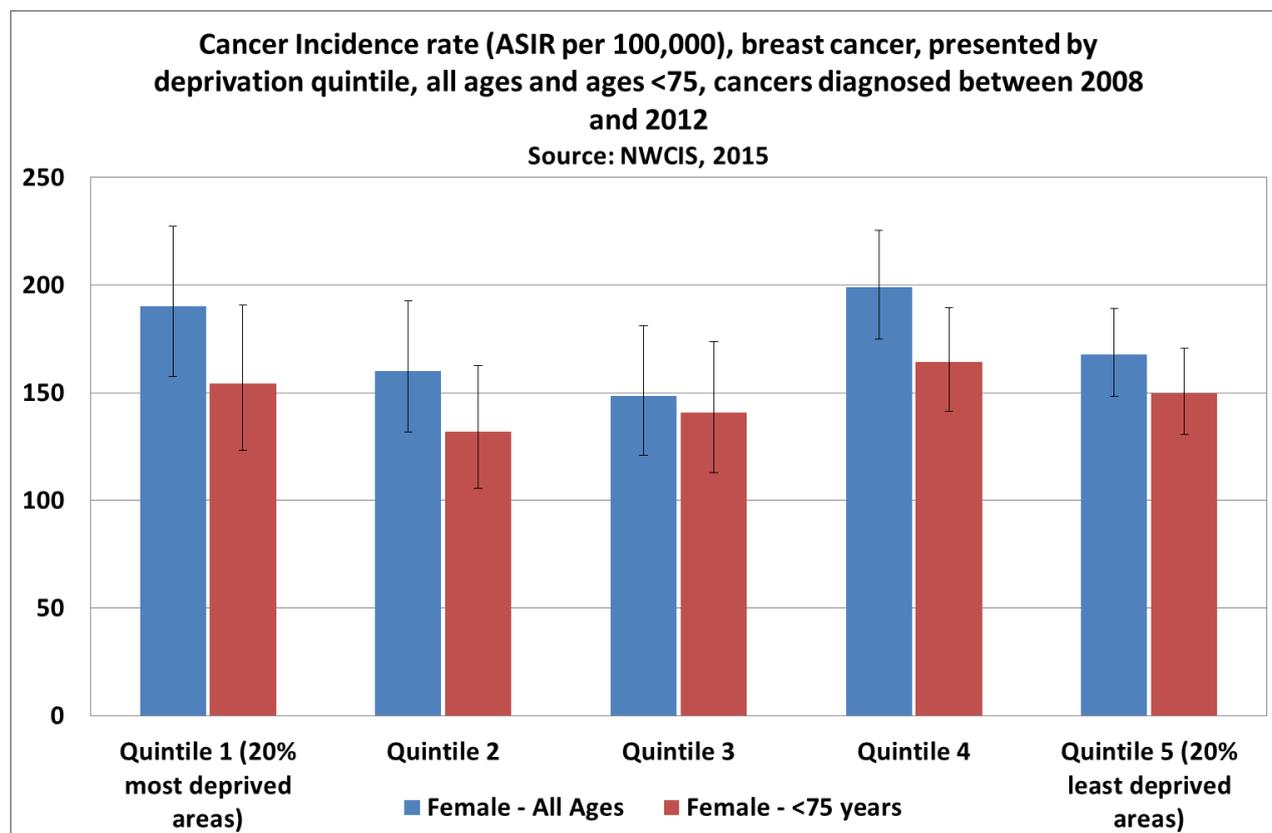
Analysis by ward showed that all areas within Warrington had an incidence rate that was similar to the overall Warrington rate; there were no statistical differences between wards in Warrington.

Both obesity and drinking alcohol to excess are both known to increase the chance of developing breast cancer. Results from the Warrington Health and Wellbeing Survey showed no relationship

<sup>7</sup> Smoking prevalence is sourced from the Warrington Health and Wellbeing Survey that was conducted during 2013. The survey was completed by just under 6,700 Warrington residents aged 18 years and above.

between the percentage of women who were obese, or the percentage of women who consumed alcohol to unsafe levels and breast cancer incidence.

**Chart 7: Breast cancer incidence rate by deprivation quintile (all ages and ages less than 75)**



## 2.4 Cancer Staging

### 2.4.1 Warrington and National cancer staging data compared

Nationally during recent years, there has been a drive to increase the recording of the stage of cancer in all newly diagnosed cancers (Department of Health, 2011). During 2012, Warrington had a valid stage recorded for 69.1% of all new cases of cancer diagnosed<sup>8</sup>. This percentage was significantly higher than what was seen nationally (59.4%) (Public Health England's National Cancer Intelligence Network, 2014).

Of those cases where staging information was available, 44% of cases were diagnosed at an early stage<sup>9</sup> in Warrington; this percentage was slightly higher than what was seen nationally (41.6%), but slightly lower than the North West average (46.1%) (National Cancer Registry, 2015).

<sup>8</sup> All Cancers (ICD10 C00 to C97)

<sup>9</sup> Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin

## 2.4.2 Warrington cancer staging (analysis provided by North West Cancer Intelligence Service (NWCIS))

Analysis supplied by the NWCIS is based on the following specific cancer sites: breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas and melanomas of the skin, with a valid stage at diagnosis.

During 2012, 79.4% of cancers diagnosed had a valid stage recorded. The percentage of cancers diagnosed with a valid stage was slightly higher for females (82.2%) when compared to males (76.3%). However, the proportion of cancers that were diagnosed at a late stage<sup>10</sup> for males (41.8%) was significantly higher than females (30%); this indicates the need to promote awareness of early detection of cancer to men.

Analysis by cancer site has shown that the percentage of cancers with a valid stage recorded ranges from 18.4% for Non-Hodgkin Lymphomas through to 95% for skin cancers. The percentage of new cases that were diagnosed at a late stage was highest for Lung (68.2%) and Bowel (57.4%), whilst late stage diagnosis was lowest for Breast (14.3%) and Uterus (14.3%).

This finding illustrates the continued need to promote messages of early symptoms of cancer, especially Lung and Bowel to the Warrington population, but also ensuring that health professionals are also aware of early cancer symptoms to allow for appropriate and timely referrals.

The recording of a valid stage varies by the age of the patient at diagnosis. During 2012, there were no valid stages recorded for patients aged 0 to 19 years. It is unknown as to why staging has not been recorded for this specific age group, and this may require further investigation. However, it is very likely that there were very few patients in this age group receiving a diagnosis of cancer.

The percentage of cancers with a valid stage recorded was relatively high in the remaining age bands, with the exception of those aged 75 years and above. The following table presents the percentage of cancers with a valid stage recorded during 2012 in Warrington. As the table shows, valid staging was present in the majority of cancers recorded for those aged 20 to 74 years. However, the percentage drops substantially for those who were aged 75 years and above (60.5%); this percentage was significantly lower than for those aged 40 to 64 and 65 to 74 years. This highlights the need for health professionals to consistently provide all required data sets to the Cancer Registry, regardless of the age of the patient.

**Table 1: Percentage of cancer diagnoses with a valid cancer stage recorded by broad age band, 2012**

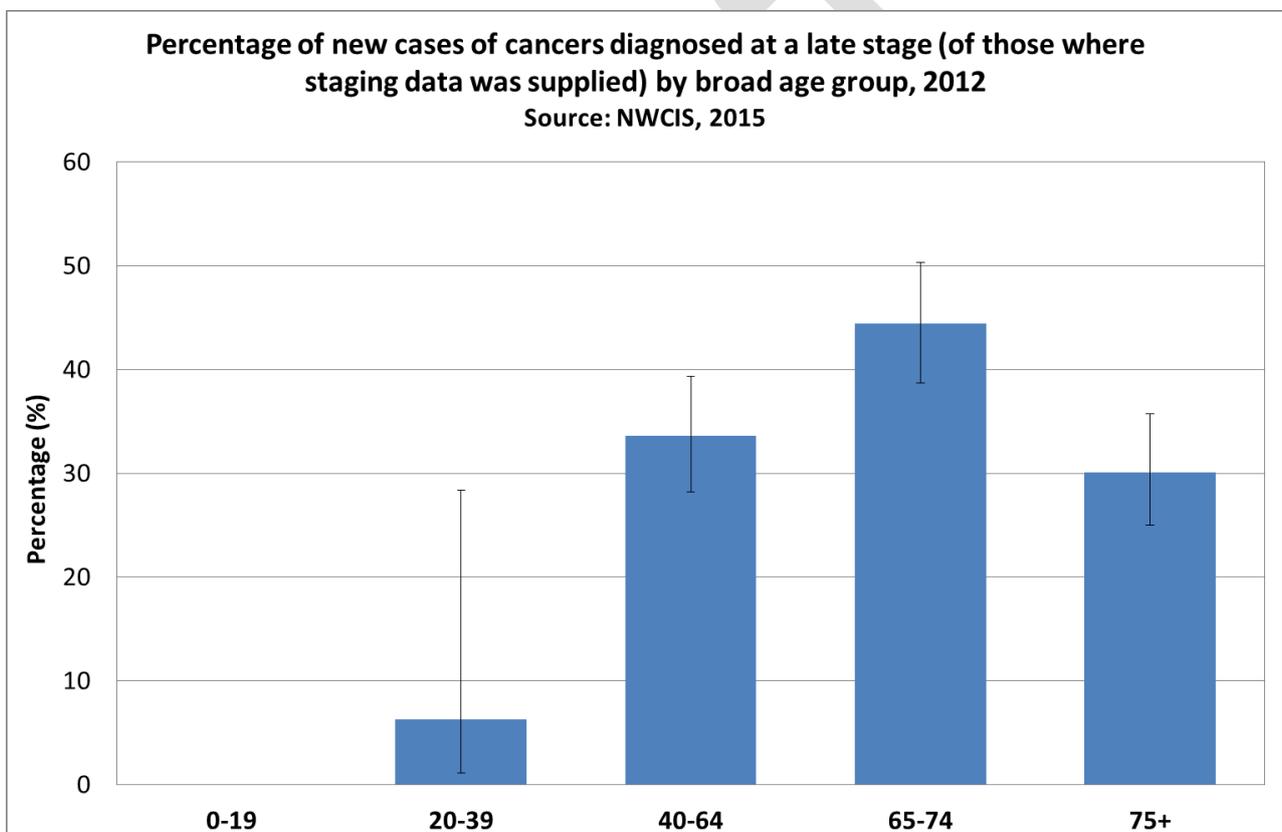
	95% Confidence Intervals (CI)		
	Value	Lower CI	Upper CI
0 to 19	0.0	0.0	0.0
20 to 39	81.3	57.0	93.4
40 to 64	90.9	86.9	93.7
65 to 74	87.1	82.7	90.5
75+	60.5	54.6	66.1

<sup>10</sup> Diagnosis at stage 3 or 4 is defined as late stage.

The percentage of new cases that were diagnosed at a late stage also varied by age group. Excluding those aged 0 to 19 years (as no valid staging was reported); those aged 20 to 39 years had the lowest percentage of cancer being diagnosed at a late stage (6.3%). Although this low percentage will mostly likely be partially attributed to the types of cancers being diagnosed in this age group, this highlights the impact of increased awareness of early cancer symptoms and attending routine screening services aimed at this age group.

As the following chart illustrates, over a third of the cancers with a valid stage recorded were a late stage diagnosis for those aged 40 to 64 and 65 to 74 years, whilst 30% of cancers were diagnosed at a late stage in those aged 75 and above. This highlights the need to continue to promote early cancer symptom awareness to these populations and to also ensure that health professionals are also aware of early symptoms and fully understand diagnosis pathways currently in place.

**Chart 8: Percentage of new cases of cancers diagnosed at a late stage, 2012**



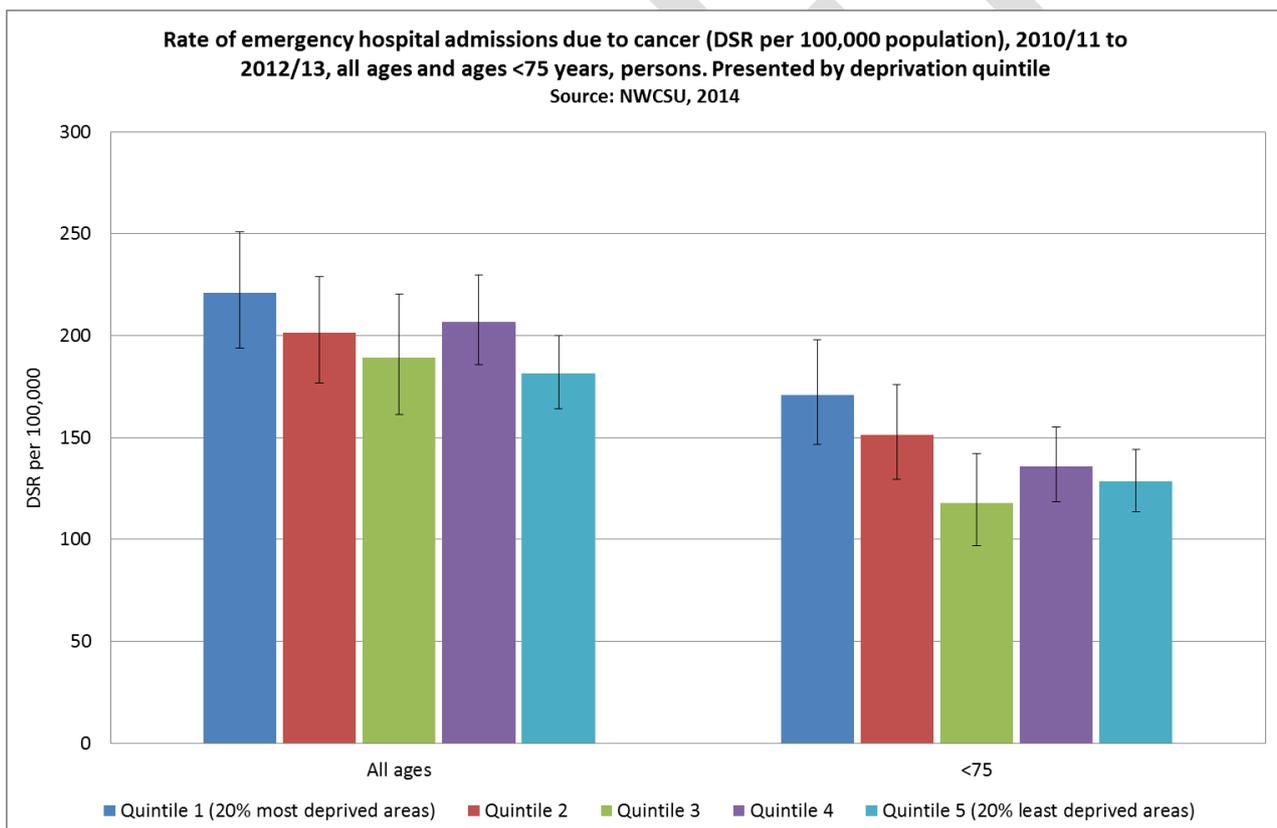
## 2.5 Hospital admissions

### 2.5.1 Emergency (non-elective) admissions

Between 2010/11 and 2012/13 there were **1,423** emergency hospital admissions in Warrington where the primary cause of admission was due to cancer. The type of cancer that had the largest number of admissions was 'Malignant neoplasms of ill-defined, secondary and unspecified sites' (this coding has been used where it is known that the patient has cancer, however the location/type of cancer was not known), of which there were 359 admissions. Following on from this, the second most common cause of admission was bronchus and lung cancer (146 admissions).

Admission rates were highest in deprivation quintile 1 (20% most deprived areas), and reduced steadily in each quintile, with deprivation quintile 5 (20% least deprived areas) having the lowest emergency admission rate, with the exception of quintile 4 which had a higher rate than quintiles 2 and 3. However, there were no statistical differences in the rate of admission between each of the deprivation quintiles.

**Chart 9: Rate of emergency hospital admissions due to cancer, 2010/11 to 2012/13**



However, when examining emergency admission rates for those aged less than 75 years, the rate of admission in deprivation quintile 1 (20% most deprived areas) was significantly higher than quintiles 3 and 5 (20% least deprived areas).

Emergency admission rates were significantly higher for men when compared to admission rates for women (for all ages and ages less than 75 years).

### **2.5.2 Elective (planned) admissions**

There were **11,370** elective admissions to hospital due to cancer between 2010/11 and 2013/14; the majority of these admissions (70%) were for less than one day. The very short admission was most likely due to the patient receiving treatment for their cancer as a day case admission. The most common cause of admission was due to other skin cancers (1,382 admissions). It is very difficult to conduct further analysis looking at the elective admission rates to hospital as the level of treatment required (and therefore hospital admissions) differ widely depending on the type and severity of the cancer that has been diagnosed.

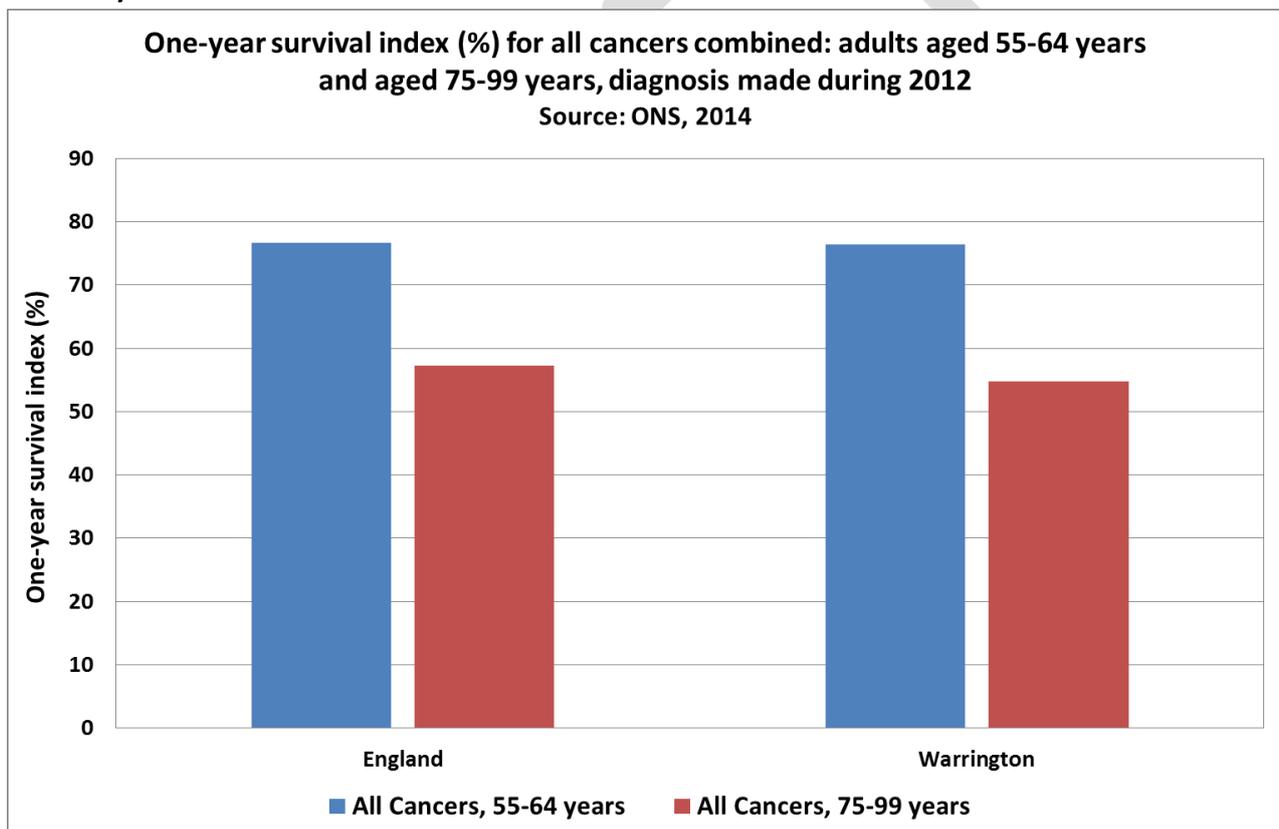
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## 2.6 Cancer Survival

The one-year survival index<sup>11</sup> for England has increased steadily from 59.7% for adults diagnosed in 1997 to 69.3% in 2012. The one-year survival index for Warrington was slightly lower than England during 2012 at 68.2%, and the rate of improvement between 1997 and 2012 was marginally slower than England (the Warrington one-year survival index during 1997 was 59.3%) (Office for National Statistics, 2014).

As age increases, the one-year survival index decreases dramatically, as illustrated in the following chart. The one-year survival index for adults aged 55 to 64 years was very similar in Warrington when compared to England; the index for England was 76.7% and 76.4% in Warrington. However, the one-year survival index reduced substantially for those aged 75 to 99 years for both England (57.2%) and Warrington (54.8%). The rate of decrease between these two age groups was greater in Warrington when compared to England.

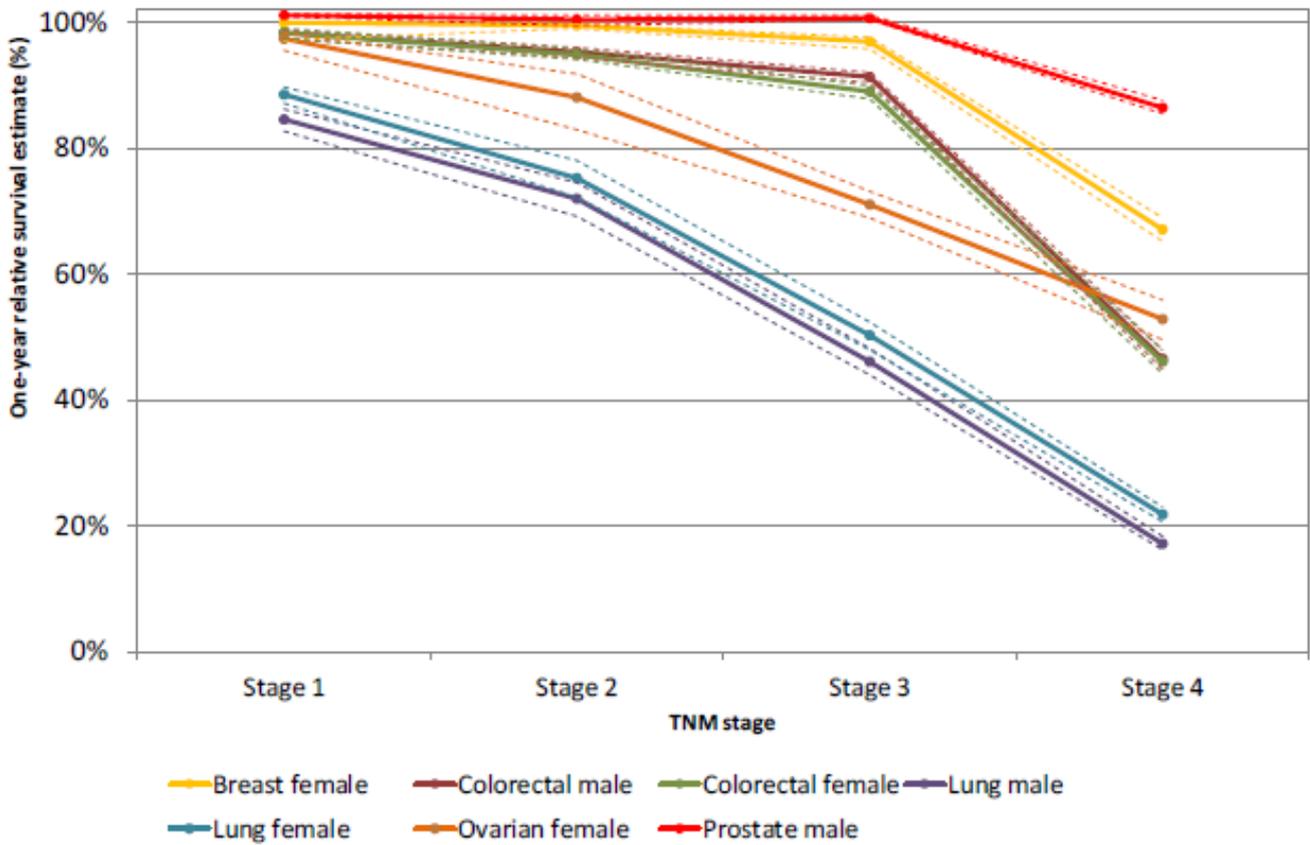
**Chart 10: One-year survival index (%) for all cancers combined: adults aged 55-64 years and aged 75-99 years**



<sup>11</sup> The index of survival is based for all cancers combined, at one year after diagnosis, for adults who were diagnosed during 1997 to 2012 and followed up to 31<sup>st</sup> December 2013. The index has been produced for patients living in the territories assigned to each of the 211 CCGs in England.

The following chart produced by Public Health England (2014b) illustrates the importance of early diagnosis in relation to one year survival by type of cancer. The earlier the cancer is diagnosed, the higher the percentage of people surviving at one year. However, the percentage of people surviving at one year drops substantially when a very late diagnosis (stage 4) is made.

**Chart 11: Age-standardised one-year relative survival estimates by stage at diagnosis, cancer site, sex, England, 2012**

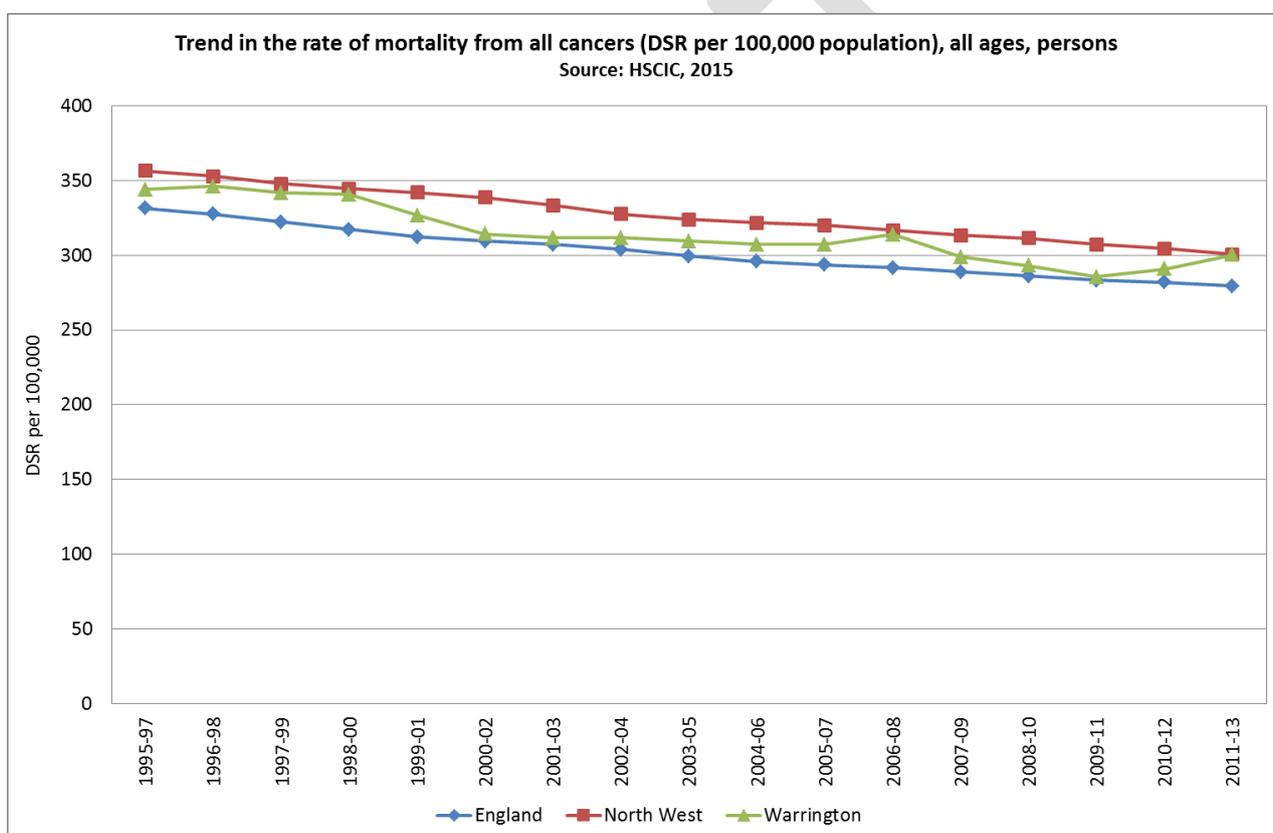


## 2.7 Mortality from Cancer

Cancer is the leading cause of death in Warrington, between the years 2011 and 2013 there were 1,575 deaths due to cancer and a further 33 deaths from non-malignant neoplasms. This is the first time period where deaths from cancer is the leading cause of mortality in Warrington, in previous years deaths from circulatory diseases was the leading cause of death.

The trend in the rate of mortality has on the whole shown a reduction in Warrington. However, the rate of mortality for the three year periods of 2010 to 2012 and 2011 to 2013 have shown an increase in the rate of mortality as presented in the following chart. During 2011 to 2013, Warrington had a significantly higher rate of mortality from cancer when compared to England. both males and females in Warrington saw an increase in the mortality rate during 2011 to 2013.

**Chart 12: Trend in the rate of mortality from all cancers**

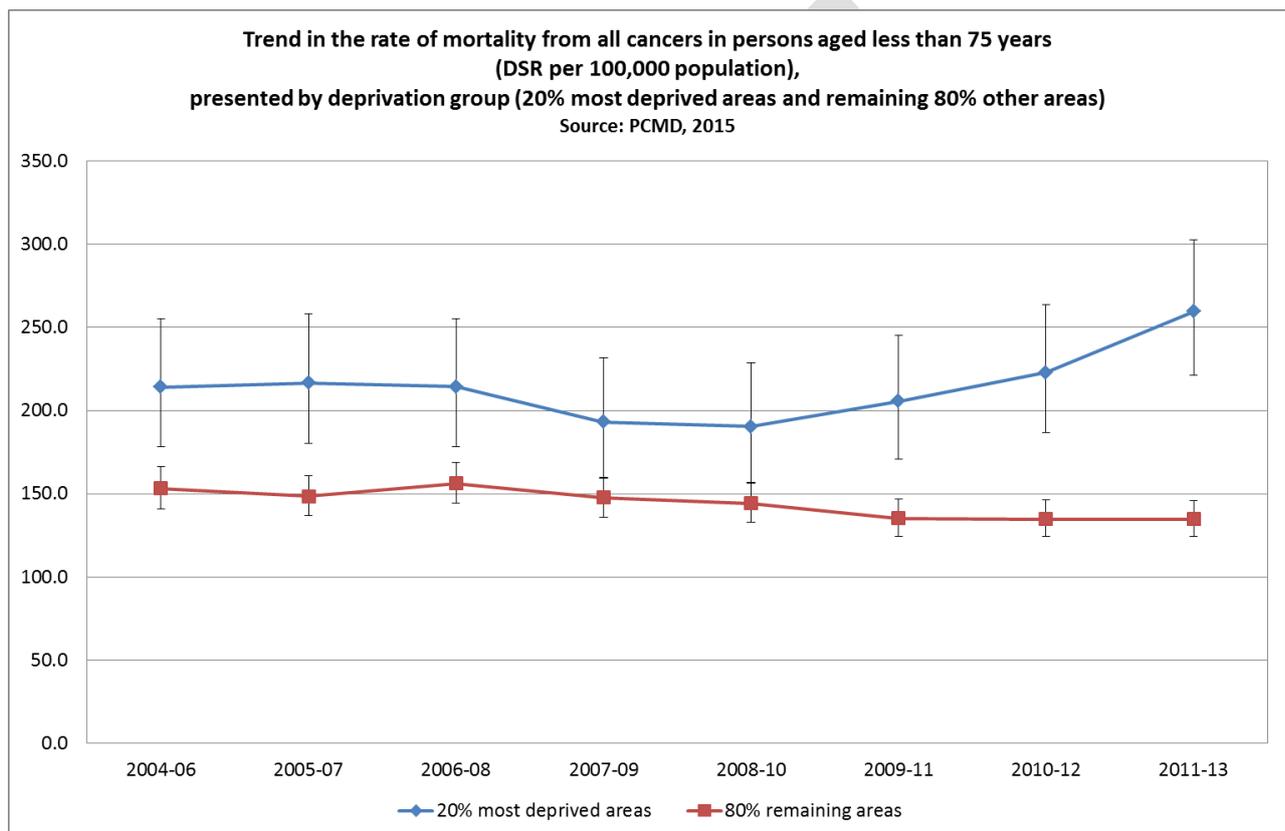


A similar pattern of mortality has been observed in premature deaths from cancer (deaths where the person was aged less than 75 years). After a period of reduction in the mortality rate, an increase has been observed from 2010 to 2012 onwards. However, the rate of mortality in Warrington remains at a similar level to what is observed nationally.

Analysis at a national level has shown that mortality rates from cancer (deaths between 2007 and 2011) showed strong links with deprivation, as the level of deprivation increased, the rate of mortality increased significantly (Public Health England, 2014).

Analysis of premature mortality at a sub-Warrington level has shown that rates are significantly high in the most deprived areas of the town, and it appears that the gap in the rate of mortality is widening. The following chart illustrates the trend in the rate of mortality for the 20% most deprived areas of Warrington, compared to the remaining areas. The chart illustrates that the 20% most deprived areas have consistently had higher mortality rates than the remaining areas of Warrington. With the exception of 2007 to 2009 and 2008 to 2010, the 20% most deprived areas had a mortality rate that was significantly higher than the remaining areas of Warrington.

**Chart 13: Trend in the rate of mortality from all cancers in persons aged less than 75 years, presented by deprivation group**



Further analysis of the increase in the mortality rate in the 20% most deprived areas of Warrington has shown a slight increase in the number of deaths from cancer. However, the dramatic increase in the mortality rate can be attributed to an increasing proportion of cancer deaths occurring at a younger age in the most deprived areas of the borough. Between 2011 and 2013, the age specific death rate in the 20% most deprived areas of Warrington was in excess of being twice as high as the remaining areas of Warrington for the following age bands: 25 to 29 years; 30 to 34 years; 45 to 49 years; 50 to 54 years; 55 to 59 years and 65 to 69 years.

The main types of cancer that were stated as the underlying cause of death between 2011 and 2013 were:

- Lung cancer – 414 deaths
- Colorectal cancer – 145 deaths
- Breast cancer – 124 deaths

- Prostate cancer – 99 deaths

Analysis by type of cancer has shown that there are a small number of cancers where Warrington have significantly higher rates of mortality when compared to England, these are:

- Bladder Cancer
- Lung Cancer

Bladder Cancer – the mortality rate in Warrington (for all ages) from bladder cancer was significantly higher than both England and the North West for men and persons. In total over the three year period of 2011 to 2013, there were 73 deaths from bladder cancer. It appears that there was a steep increase in the rate of male mortality during 2011 to 2013 when compared to the previous time period. However, this upward trend in the rate of mortality was not seen regionally or nationally where there has been a slight reduction in the rate of mortality.

Lung Cancer – Lung cancer mortality was significantly higher in Warrington for both men and women (and persons) when compared to England for all ages. For ages less than 75, women and persons from Warrington had a significantly higher mortality rate than England. As with incidence, there are differences in the trend of mortality from lung cancer regionally and nationally between the genders; the rate of mortality from lung cancer has been decreasing for males, whilst increasing for females. A similar pattern for females has been seen in Warrington, however after a period of steady reduction in the rate of mortality for males in Warrington, the rate has increased for the most recent three time periods monitored (2009 to 2011, 2010 to 2012 and 2011 to 2013).

There were two types of cancer where Warrington had significantly lower mortality rates than England, there were:

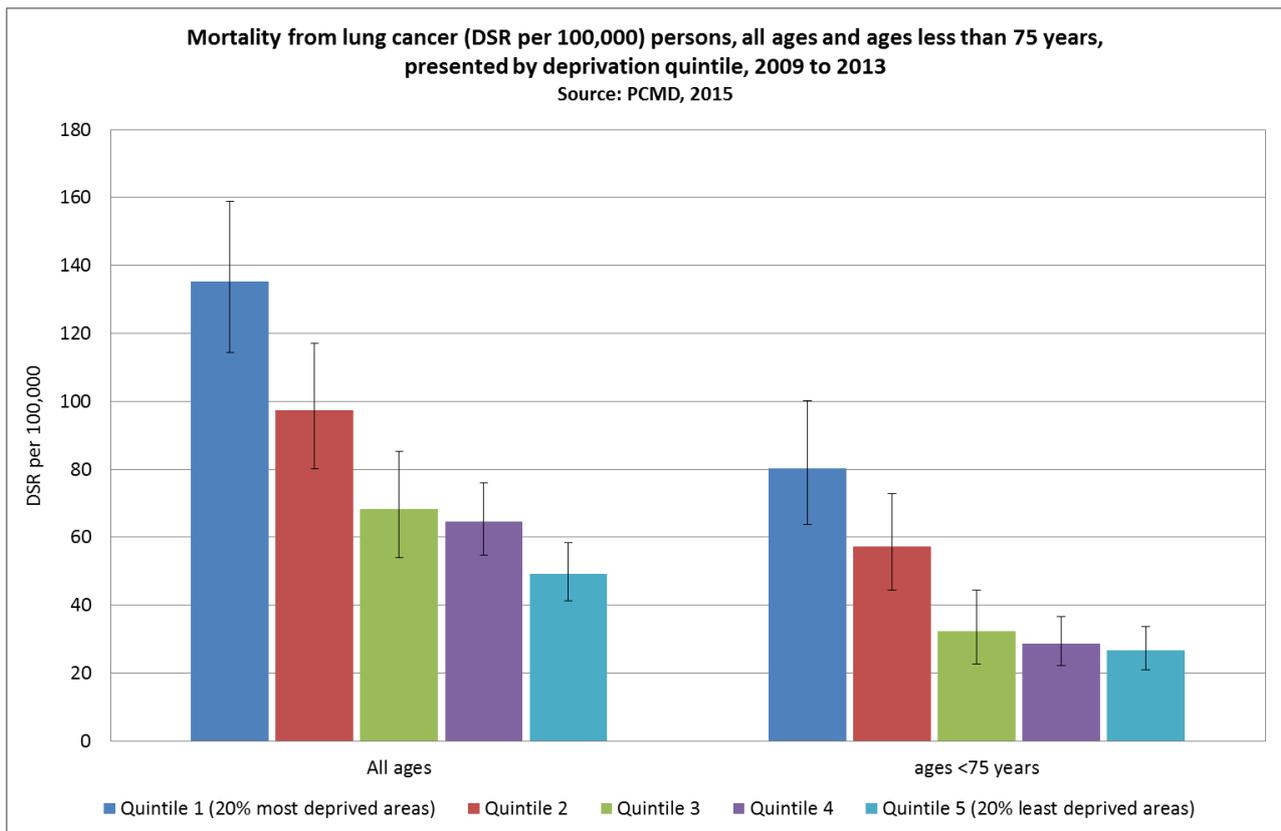
- Colorectal Cancer
- Malignant Melanoma

Colorectal cancer – women from Warrington had a significantly lower mortality rate (all ages) when compared to England and the North West.

Malignant Melanoma – men from Warrington had a significantly lower mortality rate (all ages) when compared to both England and the North West. The mortality rate for persons was significantly lower than England.

As identified above, lung cancer was the most common type of cancer death in Warrington and the mortality rate locally is significantly higher than England. The following sub-Warrington analysis illustrates that mortality in the most deprived areas of Warrington is significantly higher than the least deprived areas. This pattern was seen for both all ages and ages less than 75 years.

**Chart 14: Premature mortality from lung cancer presented by deprivation quintile**



Further analysis at ward level has shown that the following wards all had mortality rates that were significantly higher than the overall Warrington mortality rate (for all age deaths): Bewsey and Whitecross; Poplars and Hulme; Poulton North. A slightly different pattern was observed for premature death from lung cancer (aged less than 75 years). Mortality rates were significantly higher in the following wards: Bewsey and Whitecross; Orford; Birchwood.

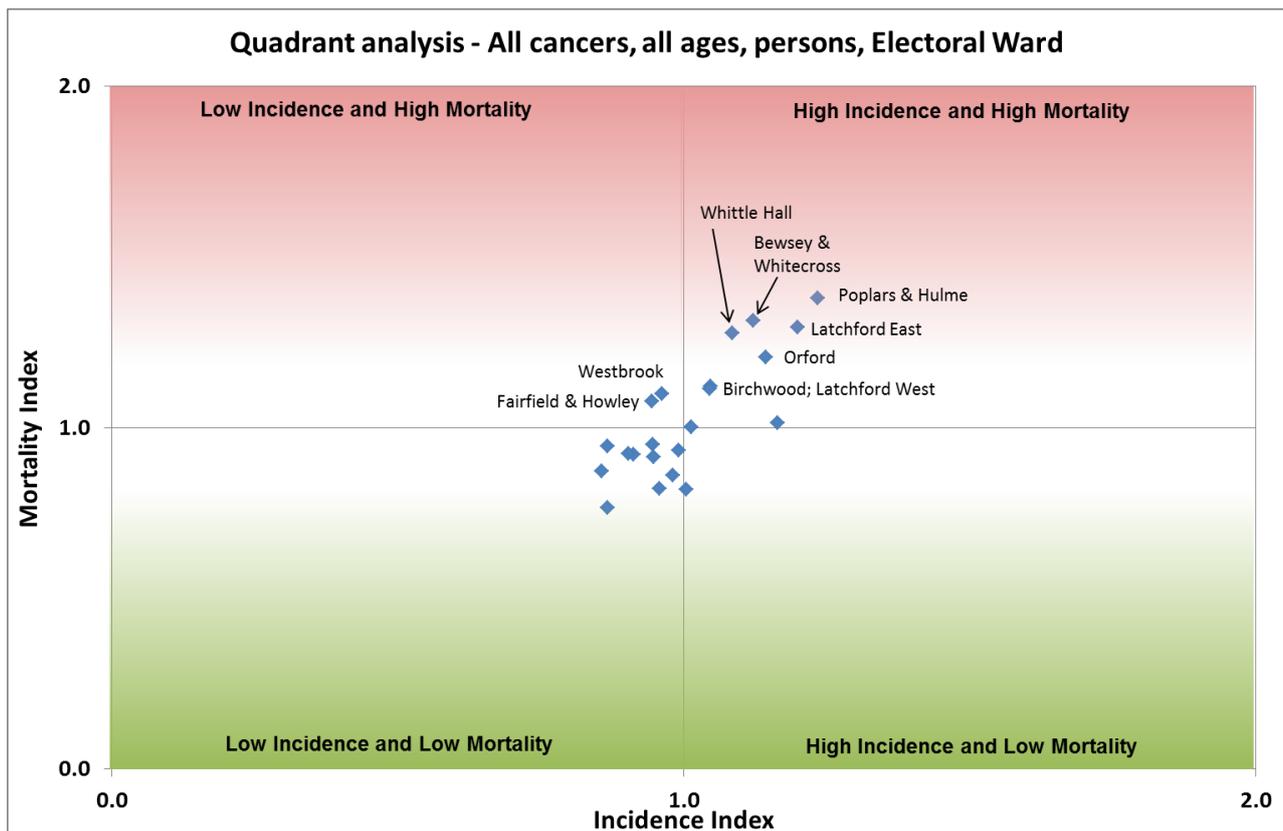
## 2.8 Cancer incidence and mortality compared

The following set of analysis presents ward level incidence and mortality data for all cancers and broad age groups. The chart places a ward in one of four rectangles:

- Low Incidence and Low Mortality
- High Incidence and Low Mortality
- Low Incidence and High Mortality
- High Incidence and High Mortality

Wards located in Low Incidence, High Mortality and High Incidence, High Mortality have been labelled as these rectangles are considered to be of greater concern than the remaining two rectangles.

Chart 15: Quadrant analysis – All cancers, all ages



Caution should be applied to the interpretation of this data as some wards within Warrington had very small numbers of people diagnosed/died from cancer during this five year period. However, it has been found that the following wards had incidence and mortality rates significantly higher than the Warrington value: Latchford East and Poplars and Hulme.

This indicates that cancer awareness messages (reduced risk through leading healthy lifestyles; symptom awareness; and highlighting the importance of early diagnosis) should be targeted in these areas of Warrington.

### **3) Current Service in Relation to Need**

#### **3.1 Prevention**

##### **3.1.1 NHS Health Checks**

Warrington Council commissioned the NHS Health Check programme from all General Practices across Warrington. The programme aimed at 40 – 74 years (with no pre-existing conditions) is a comprehensive cardio vascular (CVD) health check to determine the 10 year CVD risk of having an acute episode (e.g. heart attack, diabetes or a stroke). This programme identifies risks early and is able to give both brief intervention advice, referral to Lifestyle Services or if needed care and management through the general practice. This programme promotes healthy lifestyles and if

residents listen and take up the offer it will have an impact on cancer rates as well as vascular episodes.

### **3.1.2 Wellbeing Services**

Running alongside NHS Health Checks is the Wellbeing Service who offer one to one support to become happier and healthier. Any resident who would like to make changes to their lifestyle and need that little bit extra support can be seen by the service<sup>12</sup>.

### **3.1.3 Lifestyle Services**

Promoting healthy lifestyles and preventing ill health is core public health business. Warrington Council commission a range of lifestyle services from Livewire Community Interest Company (CIC)<sup>13</sup>:

1. Stop Smoking Service;
2. Weight Management Services (including Fit to Tackle a combination of healthy eating and exercise);
3. Reach For Health (exercise programme);

## **3.2 Screening**

### **3.2.1 Cancer Screening Promotion**

Public Health promotes the importance of cancer screening through a campaign that is run during February and March each year. The campaign is aimed at all eligible people who can be screened for the three cancers (breast, cervical, bowel), with an emphasis on promotion at the more deprived GP Practices in Warrington. This work is conducted in conjunction with the Health Inequalities Team who is a part of the Neighbourhood's Team and Public Health Warrington and work specifically with those most deprived communities.

### **3.2.2 Breast Screening**

In Warrington, breast screening is co-ordinated by the Breast Screening Service, which is part of the NHS Breast Screening Programme. This service provides breast screening for women from the age of 50, to women registered at GP Practices in Warrington, Halton, St Helens and Knowsley. In Warrington breast screening takes place at Warrington Hospital and Bath Street Health and Wellbeing Centre (Warrington, Halton, St Helens and Knowsley Breast Screening Service, 2015).

### **3.2.3 Cervical Screening**

Postal reminders are sent to eligible women asking them to make an appointment for their cervical screening. In Warrington, women can arrange for their smear test to take place at their GP surgery or at Warrington Centre for Sexual Health (Warrington Borough Council, 2015a).

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<sup>12</sup> [http://www.warrington.gov.uk/info/200724/stronger\\_together/1198/wellbeing\\_service](http://www.warrington.gov.uk/info/200724/stronger_together/1198/wellbeing_service)

<sup>13</sup> <http://www.livewirewarrington.co.uk/>

### **3.2.4 Bowel Cancer Screening**

People who are aged 60-69 and registered with a GP will automatically be sent a screening kit. A test kit for bowel screening is sent through the post so the samples can be taken at home. Three separate samples from three different bowel movements are needed to complete the test kit (Warrington Borough Council, 2015b).

## **3.3 Cancer Awareness Promotion in hard to reach areas**

### **3.3.1 Health Promotion messages**

Public health raises awareness of cancer signs and symptoms and encourages early detection through:

- Annual promotion of cancer screening and the benefits;
- Sun safety awareness raising;
- 'Hey Mr/Mrs Warrington' campaigns; these campaigns are focussed on the top three most common types cancer diagnosed in Warrington;
- Localised promotion of any 'Be Clear On Cancer' national campaigns.

### **3.3.2 iVan**

iVan Cancer Awareness, Information and Support Van is a 27 foot long bright yellow mobile service that tours Merseyside and Cheshire. iVan is a walk on/no appointment necessary information and support service with a small private consultation area to speak to the nurse who specialises in cancer, and at the front of the vehicle is a comprehensive information library of leaflets about spotting the signs and symptoms of cancer, early detection and prevention (Action on Cancer, 2015). Warrington Public Health commissions the iVan to work alongside the public health and health inequalities / neighbourhood teams to deliver targeted campaigns and messages. Understanding that local knowledge and relationships with people and the community will make the interventions much more effective. The iVan is commissioned for 28 days during 2015/16; the iVan is primarily located in areas of high deprivation however the van will also be based in locations depending on level of need according to intelligence from the JSNA.

### **3.3.3 Cheshire, Warrington and Wirral Local Area Team (LAT)**

The Cheshire, Warrington and Wirral LAT have developed a Health Inequalities CQUIN (Commissioning for Quality and Innovation) scheme which has focused their activities on understanding the current uptake of cancer screening in population groups known to be vulnerable or deprived (this took place during 2014/15). For example, populations living in the 10% most deprived areas, people with learning difficulties and people with physical disabilities. The second part of the scheme (2015/16) is to promote cancer screening to the identified vulnerable or deprived at risk group.

### **3.4 Cancer Rehab Programme**

The Cancer Rehab programme is titled 'We're Positive' and includes two six week programmes that aim to offer physical and psychological support to people throughout various stages of their treatment: Positive Pre and Through Treatment Programme and Positive Supportive Care Programme. This pilot programme has been funded and developed by Warrington CCG in partnership with LiveWire and St Rocco's Hospice.

The programmes include a range of tailored exercise sessions, relaxation techniques, occupational therapy, benefits advice, healthy eating advice and help with regulating emotions. The programme has been developed as research has shown that taking part in light exercise can help minimise some of the side effects of treatment such as fatigue, breathlessness, lymphoedema, anxiety, loss of muscle strength and poor appetite (Warrington CCG, 2015).

### **3.5 Charitable Organisations**

#### **3.5.1 Macmillan Cancer Support**

##### **3.5.1.1 Community Macmillan Information Support Centre**

A Macmillan cancer information and support manager was appointed in early 2015. The Macmillan Cancer Information and Support Service (MCISS) Information Hub will be based at Orford Jubilee Park (a multi-functional health and leisure centre located in an area of high deprivation). The MCISS Service will be managed by the Macmillan Information and Support Manager, and will be supported by a newly appointed Macmillan specialist welfare benefits advice worker. This service has been developed by Warrington CCG, Warrington Citizens Advice Bureau (CAB) working in partnership with MacMillan.

From early summer 2015, a further six Macmillan cancer information points will be strategically located at various sites across Warrington (locations will be confirmed). The information points will contain information about cancer awareness/early symptoms, where to go if you are worried about symptoms, information about specific types of cancer, information about support that is available in Warrington.

##### **3.5.1.2 Macmillan Cancer Support, St Rocco's Hospice**

The Macmillan team offers support and advice to patients with cancer and their families. This includes symptom control, emotional and psychological support and information about their illness and treatments. The Macmillan team is based at St Rocco's hospice in Warrington but also see patients in their own home.

##### **3.5.1.3 Cancer Nurse Champion course**

Macmillan will be funding a six month education programme for Warrington practice nurses to help improve their knowledge and expertise on cancer. The aim is to educate practice nurses on the early symptoms of cancer, treatments, side effects and communication skills. The course will be delivered by Warrington CCG Clinical Lead for Cancer and Warrington CCG Lead Nurse for Quality in Primary Care with assistance from appropriate primary and secondary care colleagues.

### **3.5.2 Cancer Research UK (CRUK)**

Warrington Clinical Commissioning Group (CCG) and Cancer Research UK are working collaboratively to improve patient outcomes. This work stream includes support from a CRUK Health Professional Engagement Facilitator to support the CCG with regards to the cancer audit, non-clinical awareness raising sessions, practice visits to discuss key cancer statistics and providing support to practices around early diagnosis of cancer.

#### **3.5.2.1 CCG Practice Cancer Audit**

During 2014/15 a cancer audit was conducted across 19 GP practices in Warrington and involved a review of 308 cancers. The aim of the audit is to use the RCGP (Royal College of General Practitioners) audit tool and Significant Event Audits to collect a comprehensive dataset and case study examples on new cancer diagnoses in Warrington. This audit builds on the existing evidence base to inform and evidence the CCG Cancer Strategy.

### **3.6 Hospital Services**

Most patients who have received a diagnosis of cancer have the option to choose where their outpatient appointments will be located (either at Warrington Hospital or Halton Hospital) and in some cases where they will receive their treatment. For a small group of patients with complicated cases (less common types of cancer or confounding health conditions), it is more appropriate for these patients to be treated in a specialist setting<sup>14</sup>.

The Clatterbridge Cancer Centre offers chemotherapy at the CANtreat chemotherapy centre located at Halton Hospital, this service has been in place since September 2009. Patients who require radiotherapy will be required to travel to the Clatterbridge Cancer Centre located on the Wirral. Where possible patients will receive local follow-up care.

When surgery is required as part of the agreed treatment pathway, this can take place at both Warrington and Halton Hospital sites. However, lower risk surgery, for example breast surgery will most likely take place at Halton Hospital. Whilst more complicated surgery will take place at Warrington Hospital as there are specialist facilities to support the recovery of the patient.

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<sup>14</sup> For example, patients diagnosed with head and neck cancer will most likely be treated at Aintree Hospital (Liverpool); patients with tumours and cancer within the brain will be treated by the Walton Centre (Aintree Hospital site, Liverpool); gynaecological cancers will be treated at the Women's Hospital (Liverpool); upper gastro intestinal (GI) cancer will be treated at Liverpool Heart and Chest Hospital (Liverpool); Complex urology at will be treated at Wirral Hospital; Advanced colorectal cancers are treated at Aintree Hospital (Liverpool); Liver cancers are treated at Aintree Hospital (Liverpool); Hepatobiliary and Pancreatic Cancer are treated at the Royal Liverpool Hospital; Haematological cancers are treated at both Whiston Hospital (Knowsley) & Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT); Lung Cancers are treated at Liverpool Heart & Chest Hospital (Liverpool); Paediatric Cancers are treated at Alder Hey Children's Hospital (Liverpool); Teenage & Young Adults - The designated Principal Treatment Centre for Teenagers and Young Adults (TYA) is the Clatterbridge Cancer Centre NHS Foundation Trust. There are also close links with Alder Hey Children's NHS Foundation Trust (children's PTC) which provides solid tumour and haematological oncology services for patients up to their 20th birthday.

Cancer patients are supported by a team of cancer nurse specialists acting as the patient's key worker. Patients can access a range of support services including benefits advice, complementary therapies & counselling.

Each of the Multi-disciplinary teams are proactive in recruiting patients to available clinical trials from the national portfolio.

### **3.6.1 Peer Review**

The National Peer Review Programme is a quality assurance programme, which assesses NHS cancer services, provided by acute hospitals trust and community services since 2001. The key objectives of the National Peer Review Programme focus on improving care for people with cancer and their families by:

- Ensuring cancer services are as safe as possible;
- Improving the quality and effectiveness of care for cancer patients;
- Improving the patient and carer experience;
- Providing development and learning for all involved;
- Identifying local examples of good practice and encouraging their use nationally, so everyone can have access to the same quality of treatment (National Peer Review Programme, 2013).

As at July 2015, 4 peer reviews had been conducted at Warrington and Halton Hospital sites, the reviews covered the following services:

- Oncology;
- Breast
- Urology
- Cancer of unknown primary
- General acute oncology team;

At the time of assessment, no serious concern or immediate risk was identified for any of the services listed above with all teams reporting high levels of compliance.

## **4) Projected Service Use and Outcomes in 3 to 5 Years and 5 to 10 years**

New research has now found that one in two people born after 1960 in the UK will be diagnosed with some form of cancer in their lifetime (Cancer Research UK, 2015). More people will be diagnosed with cancer as people are living longer. However, it is very difficult to predict future incidence rates in Warrington due to previous issues with data flow between Warrington and Halton Hospital and the Cancer Registry. Therefore, it would not be appropriate to conduct this analysis. Although it is not possible to produce approximate number of people who will have cancer in future years, it can be assumed that there will be an increase in demand for cancer services in the borough.

## **5) Evidence of What Works**

### **5.1 Lifestyle Factors**

To reduce the risk of developing cancer in the future, changes in lifestyle need to be implemented, especially as 4 in 10 cancers diagnosed each year can be prevented by lifestyle changes (Macmillan Cancer Support, 2012a). NICE (National Institute for Health and Care Excellence) have developed a range of public health guidance to encourage people to start making health lifestyle changes:

- Reducing the amount of alcohol consumed (PH24, June 2010)
- Maintaining a healthy weight and preventing excess weight gain (PH47, October 2013; PH53, May 2014)
- Becoming more physically active (NG7, March 2015)
- Stopping and reducing tobacco use (PH45, June 2013)

## 5.2 Cancer Screening

The earlier cancer is diagnosed, the more likely that treatment will be successful. Increasing the uptake of NHS cancer screening programmes can help to identify people with cancer at an earlier stage. Although cancer screening uptake is high in Warrington when compared to national data, there is still the opportunity to increase the number of people screened especially in our more deprived wards where take up of screening is much lower.

**5.2.1 Breast Screening:** Researchers at the University of Kent found that the uptake of breast screening increased if the women invited for screening wrote down a plan as to how they will attend their appointment, this was especially successful for women who had to contend with obstacles, for example, arranging time off work to attend their appointment (Rutter et al, 2007).

**5.2.2 Cervical Screening:** A review of evidence (Everett et al, 2011) assessed the effectiveness of various methods to increase uptake of cervical screening. Methods evaluated were invitations, reminders, education, message framing, counselling, risk factor assessment, procedures and economic interventions. The evidence supports the use of invitations to increase the uptake of cervical screening. There was limited evidence to support educational interventions, but it is unclear as to which format was most effective (Everett et al, 2011).

**5.2.3 Bowel Cancer Screening:** Researchers in Scotland found that uptake of the bowel cancer screening programme increased significantly if participants were sent a pre-notification letter two weeks before receiving their screening test kit. The increase in uptake was seen for both males and females, in all age groups eligible for screening and all deprivation categories (Libby et al, 2011).

**5.2.4 Early Symptom awareness and Diagnosis:** In Warrington, a higher proportion of men were diagnosed with cancer at a late stage when compared to women. Research on the effectiveness of the Be Clear on Cancer national campaign found that awareness of early symptoms of Lung Cancer ('persistent cough' or 'hoarseness') and Bowel Cancer ('change in bowel/bladder habits') increased significantly when analysing responses to a questionnaire that was completed before and after the campaign (which ran during 2012). However, barriers to visit the GP, ('the doctor would be difficult to talk to' and 'being worried about wasting the doctor's time') which was also targeted in the campaign, remained in place (Power and Wardle, 2015).

NICE have recently updated their guidelines to help GPs ensure they are making prompt and accurate diagnoses (NICE NG12, June 2015). The guidelines include an increase in the number of red

flag symptoms for some specific types of cancer as well as promoting the investigation of more general symptoms, such as weight loss appetite loss and anaemia. People whose symptoms have a three in 100 chance of being cancer can now be urgently referred to a specialist by their GP.

## **6) (Target) Population/Service User Views**

### **6.1 Cancer Patient and Carer Feedback**

To help inform the development of the Cancer Rehab Programme, Warrington CCG gathered feedback from cancer patients and their carers who attended the John Holt Cancer Foundation, Halton Cantreat Centre and St Rocco's Hospice. In total, 24 patients and carers provided feedback to the CCG. The feedback showed that the patients felt that they would have benefitted from receiving extra support from a wide range of professionals, extra to the care they were receiving from their oncology team. All agreed that they would have benefitted having support from a clinical nurse specialist, psychologist or an occupational therapist; whilst most felt they would have benefitted from support from a dietician, physiotherapist, MacMillan Nurse or benefits advice.

### **6.2 Healthwatch Warrington**

During February 2015 a 'Coffee and Consult' event was held by Healthwatch Warrington to discuss issues faced by cancer patients and their carers', in total 10 people attended the event. Discussion highlighted the positive and negatives aspects of care patients and their carers' have received.

It was felt that communication methods were inadequate in some cases between medical staff and patients. Some examples provided were; medical staff not providing patient records when asked; patients not provided with enough information about treatment and side effects; patients not being communicated with in a reassuring way; patients felt that they were not being listened to and patients left feeling isolated as there was no follow up care/support from their GP.

However, discussion took place about what makes a good experience of cancer care. Praise was given to various nursing care teams, especially when nursing time was given to patients who were able to discuss their problems/fears. A number of examples about excellent ongoing GP support were provided; these included home visits, prioritised appointments and extended support to carers.

### **6.3 Cancer Patient Experience Survey (CPES)**

The CPES is a national survey which is designed to monitor national progress on cancer care and the latest published survey (2014) is in its fourth year. During 2014, 153 acute hospital NHS trusts that provide cancer services took part in the survey; this is every Trust that provides adult cancer care in England. Patients were selected to take part in the survey if they had been admitted to hospital as an inpatient or a day case, where the primary cause of admission was due to cancer. There were 352 eligible patients from Warrington and Halton Hospital Foundation (WHHFT) Trust of which 228 questionnaires were completed (69% response rate).

The response to the survey highlighted that WHHFT performed poorly (when compared to national responses) for the following questions:

- Q6. Staff gave complete explanation of purpose of test(s) – 77% (185 responded to question);
- Q7. Staff explained completely what would be done during test – 84% (195 responded to question);
- Q17. Possible side effects explained in an understandable way – 72% (199 responded to question);
- Q28. Hospital staff told patient they could get free prescriptions – 63% (82 responded to question);
- Q30. Taking part in cancer research discussed with patient – 17% (206 responded to question);
- Q31. Patient has taken part in cancer research – 53% (32 responded to question);
- Q33. Staff gave complete explanation of what would be done – 85% (132 responded to question);
- Q55. Family definitely given all information needed to help care at home – 53% (116 responded to question).

WHHFT have developed an action plan to help address the issues raised by patients. Actions include: Holistic Needs Assessments<sup>15</sup> will be offered to all patients with a diagnosis of cancer; development of patient posters and leaflets which provide details of clinical trials, free prescriptions and requesting copy of letters; development of a webpage within the WHHFT website; Macmillan cancer information point will be located at Warrington Hospital; cancer patient forum will be established in Autumn 2015.

## **7) Unmet Needs and Service Gaps**

- Uptake of cancer screening remains lower in the more deprived GP practices in Warrington, especially so for bowel screening;
- Late stage diagnosis of cancer in men was significantly higher when compared to women during 2012;
- Late stage diagnosis was highest for lung and bowel cancer during 2012;
- Staging data completeness reduced for those aged 75 years and above;
- Premature mortality from cancer is increasing in the 20% most deprived areas of Warrington;
- The target for patients to start cancer treatment within two months of referral was missed during 2014/15. There are concerns that in future this target will consistently be missed due to imminent changes in NICE guideline thresholds for GP diagnostic referrals, especially if the current service delivery model is not adjusted to take into account the potential increase in the number of patients on the two month pathway.

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<sup>15</sup> A Holistic Needs Assessment includes: background information and assessment preferences; physical needs; social and occupational needs; psychological wellbeing; spiritual wellbeing; information needs and carers needs.

## **8) Recommendations for Commissioning**

- The promotion of cancer screening messages should be further reinforced with external partners, especially organisations that work with deprived communities where uptake is low. There is the need to ensure that bowel screening messages are communicated effectively with deprived communities;
- Work with Primary Care practitioners to ensure that understanding of cancer signs and symptoms, clinical pathways and achieving a good rate of screening (national standards) is a priority;
- Ensure that GP Practices receive a quarterly update in regards to their cancer screening uptake;
- The strong association between smoking prevalence and lung cancer incidence emphasises the need for smoking cessation services to engage and target the most deprived areas of Warrington;
- There is a continued need to target men with messages about early detection of cancer and seeking timely referrals;
- Continued promotion of early symptoms of lung and bowel cancer is required in Warrington for both the public and clinical staff;
- Ensure that health professionals consistently provide staging data for all newly diagnosed cancer patients;
- Audit the 62 day pathway urgent referral to treatment pathway to ensure that blockages for patients receiving a diagnosis and starting cancer treatment are minimised.

## **9) Recommendations for Needs Assessment work**

It is recommended that premature mortality rates from cancer continue to be monitored on an annual basis. If the gap in the mortality rate continues to widen, further analysis should be conducted to fully understand the cause(s) of the widening gap.

The pattern of breast cancer incidence is not as expected, coupled with the very high incidence rate, it is recommended that further analysis is conducted to understand the profile of women diagnosed with breast cancer.

The findings from the CCG Practice Cancer Audit should be communicated with individual GP Practices and GP Federations and recommendations should be actioned.

## **10) Key Contacts**

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