

# Wirral JSNA: Cancer

## Summary

- 1 in every 3 people will develop some form of cancer in their lifetime
- Cancer caused 1 in 4 deaths annually in Wirral (up to 2012)
- There were 274,000 new cancers diagnosed in England (excl. C44\*), a 30% increase since 1993. In Wirral this is a 25% increase with 2,018 cancers diagnosed in 2011 compared with 1,620 in 1993.
- The full economic cost of cancer has been estimated at £15.8bn for the UK which based on the ratio of cancer incidence (Wirral has 0.592% of UK cancer cases) would equate to around £93.5million per annum for Wirral.
- In Wirral breast, lung, bowel and prostate cancer account for half, of all new cancers diagnosed
- The two most commonly diagnosed cancers in Wirral are prostate and lung (in men) and breast and lung (in women)
- Breast cancer incidence has increased by 40% since 1993. New cases of lung cancer in woman are continuing to rise with rates 30% higher than the national average
- Rates of Lung cancer in men are showing signs of improvement with a 25% reduction in new cases since 1993. However cases diagnosed via emergency presentation are a third higher than the national average
- An ecological study using historical information on deaths from cancer for the EU region (1970 to 2009) has predicted the numbers of deaths in women from lung cancer will continue to increase and it may become the most common cancer amongst women by 2040 (Madden, 2012)
- There has been little change in the rate of new cases colorectal cancer in both males and females
- Prostate cancer incidence was almost a fifth (18%) higher than the national average in 2011
- Deaths in those aged under 75 years (classed as premature mortality) have reduced by more than a third (36%) since 1993 (up to 2012)
- Deaths from breast cancer accounted for 14% of the total cancer deaths in 2012
- Lung cancer continues to be the most common cause of death in both males and females with death rates in males 20% higher than the national average and in females 30% higher. Smoking remains the main risk factor for lung cancer.
- Deaths from colorectal cancer in males under 75 years is lower than the national average, however for females it is almost 20% higher
- More than two-thirds of people diagnosed with cancer survive beyond the first year after diagnosis
- Almost half (46%) of all people diagnosed with cancer now survive for at least 5 years and 92% rated their cancer care as either excellent or very good
- Wirral's breast screening coverage is slightly higher than the national average at 77.2% in 12/13
- Bowel screening uptake is 52.65% within the Merseyside & North Cheshire Screening Centre (M&NCSC) area (2012/13). The national target is 60%
- Cervical screening coverage in the 25-49 age group has reduced in 2012/13 in current 2014 figures this continues to be the trend compared with previous years and coverage in the 50-64 age group has almost remained the same in since 2010/11 which appears to be a greater uptake than 25-49 year olds

\*C44/46 - "Other and unspecified malignant neoplasm of skin" ([full list here](#))

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## What do we know?

### Overview

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Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. Cancerous cells can invade and destroy surrounding healthy tissue, including organs. There are over 200 different types of cancer, with breast, lung, colorectal, and prostate cancer accounting for over half of all new cases. The risk of being diagnosed with cancer increases with age, with three out of four cases diagnosed in people aged 60 and over. More than one in three of all cases are in people aged 75 and over. Although cancer occurs predominantly in older people, it is also the most common cause of death in people under the age of 60. For risk factors which may lead to developing cancer see [Equity Audits](#) on the Wirral JSNA website. Survival varies by type of cancer and, for each cancer, by a number of factors including age, sex, treatment received and stage of disease at diagnosis. In Wirral Clinical Commissioning Group (CCG) it is estimated that approximately 9,600 are living with and beyond cancer up to 20 years after diagnosis (Macmillan, 2014; Maddam 2012). This chapter covers some of the most common types of cancers in Wirral, highlights some trends and indicates where there have been signs of improvement.

### Cancer Spend

In 2012/13 the then Wirral Primary Care Trust (PCT) spent £42.8m on cancer based on programme budgeting returns, which was 6.4% of the total spend of £672.8m (data for Wirral CCG for 2013/14 should be available in Spring 2015). This is only the direct NHS healthcare

spend for cancer and does not include all prevention costs, payments made direct to hospitals, or the cost of hospice care or private social care (hospices raise money as well as receiving money from the NHS). The full economic cost of cancer has been estimated at £15.8bn for the UK which based on the ratio of cancer incidence (Wirral has 0.592% of UK cancer cases) would equate to around £93.5million per annum for Wirral.

Since April 2013, cancer spending has moved to specialised commissioning which is controlled at a regional level, so the amount spent by Wirral CCG fell to £18.5m in 2013/14. It is difficult to disaggregate this regional data. Wirral has a regional cancer centre at Clatterbridge, which is building a new cancer centre on the site of the new Royal Liverpool University Hospital.

## Facts, Figures & Trends

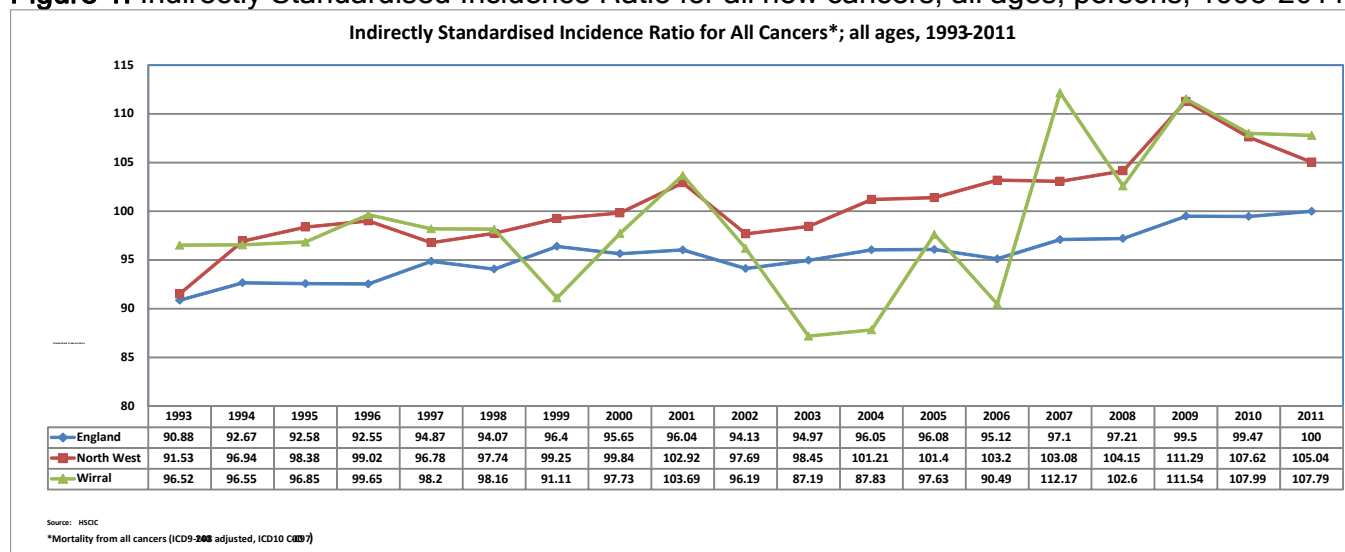
### Please Note:

Since producing this local Wirral story for Cancer three publications have provided additional annual data. They are the [Local Cancer Toolkit](#), [National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#). This information adds to the overall knowledge contained in this document and as such should be viewed as a package. In particular the figures and tables below are generally using standardised mortality ratios (SMR) and standardised registration rates (SRR) and over a period of time that compare areas to an England average in that year. The [Cancer Toolkit](#), [e-atlas](#) and [CRUK](#) content tend to reflect one year age standardised incidence or mortality rates which provide an annual perspective.

### Incidence

Over the last 20 years the number of new cases of cancers has increased by a quarter (25%) with 2,018 cases diagnosed in 2011 compared with 1,620 cases diagnosed in 1993 (Figure 1). In 2009-11 cancer incidence for Wirral was slightly higher than the England average with a Directly Standardised Rate (DSR) of 627 per 100,000 population compared with 588 per 100,000 population in England overall. The four types of cancers, breast, lung, colorectal and prostate continue to account for more than half (56%) of newly diagnosed cases in Wirral each year. This is also true nationally. The most common cancers in men are prostate (27%), lung (16%) and colorectal (13%). In women it is breast (28%), lung (14%) and colorectal (12%).

**Figure 1:** Indirectly Standardised Incidence Ratio for all new cancers, all ages, persons, 1993-2011



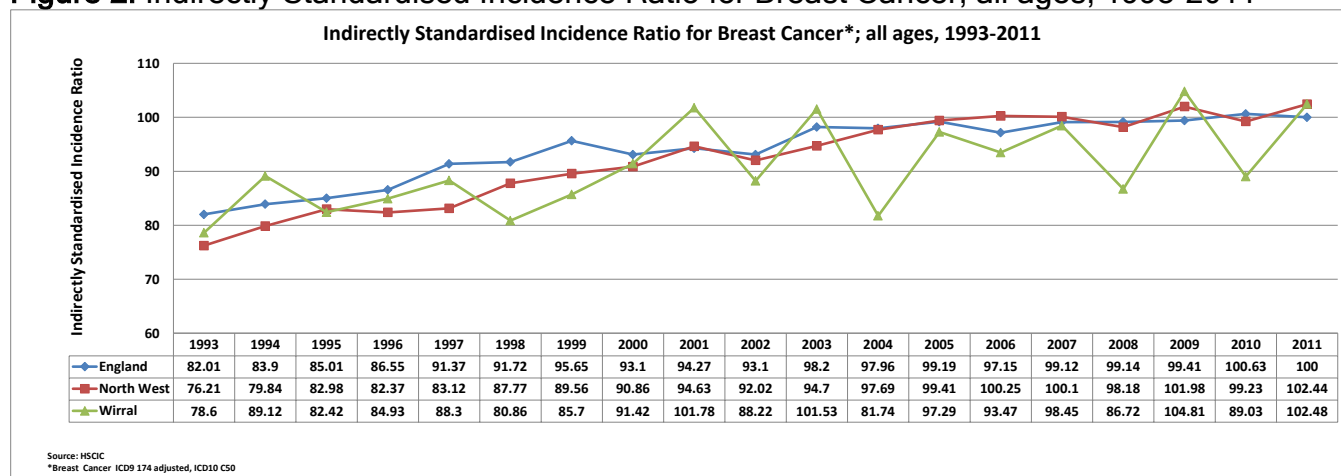
Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit](#) [National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

## Breast Cancer

Breast cancer incidence has increased by almost 38% since 1993. This may be due to improved detection and/or the introduction of the NHS Breast Screening Programme in 1988. Figure 2 below shows trends of all new cases of breast cancer in Wirral, rates have generally remained lower than the national average (albeit with some variation).

**Figure 2: Indirectly Standardised Incidence Ratio for Breast Cancer, all ages, 1993-2011**



Source: [Source: HSCIC Portal, 2014](#)

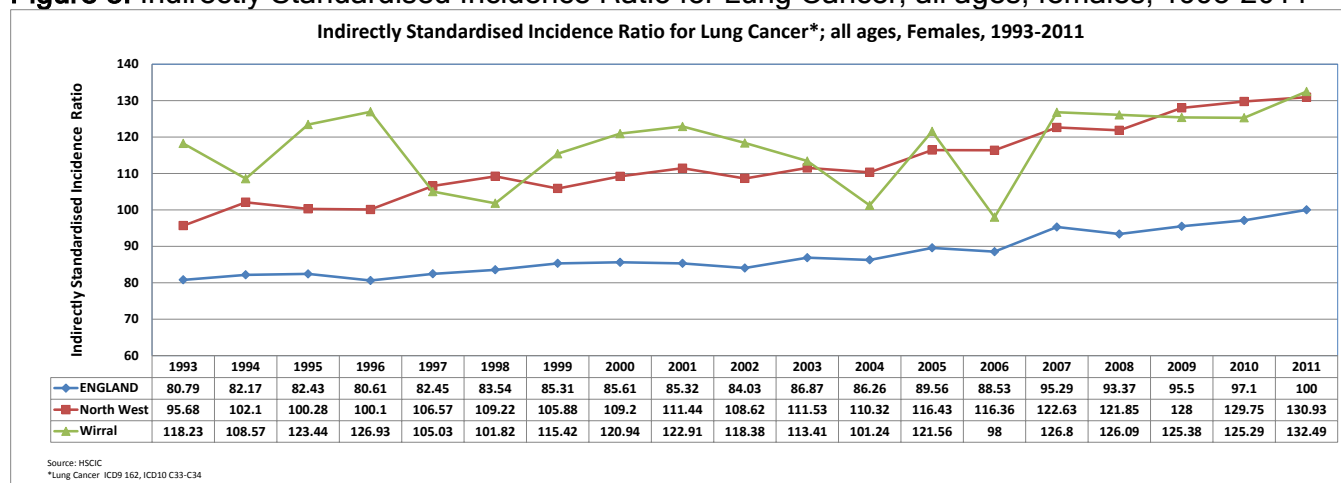
Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

## Lung Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

New cases of lung cancer in females has gradually increased in recent years (with some variation). Rates are 30% higher in Wirral compared to England, but similar to the North West with a Standardised Registration Ratio (SRR) of 132 in 2011 (see Figure 3).

**Figure 3: Indirectly Standardised Incidence Ratio for Lung Cancer, all ages, females, 1993-2011**

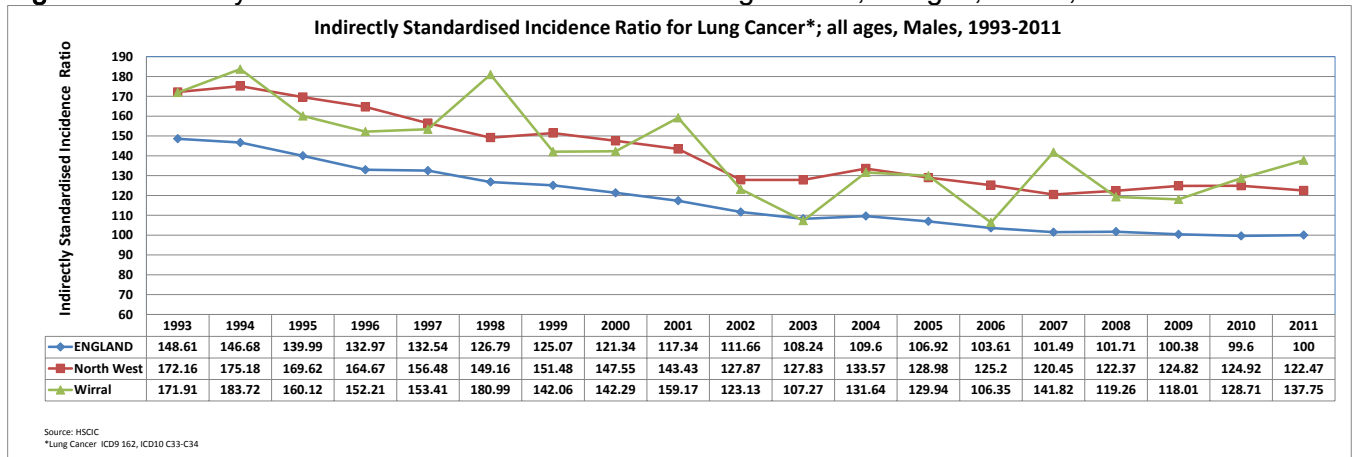


Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

In males, lung cancer rates have reduced by 25% since 1993, with a SRR of 138 in 2011 compared with 172 in 1993 (see Figure 4).

**Figure 4: Indirectly Standardised Incidence Ratio for Lung Cancer, all ages, males, 1993-2011**



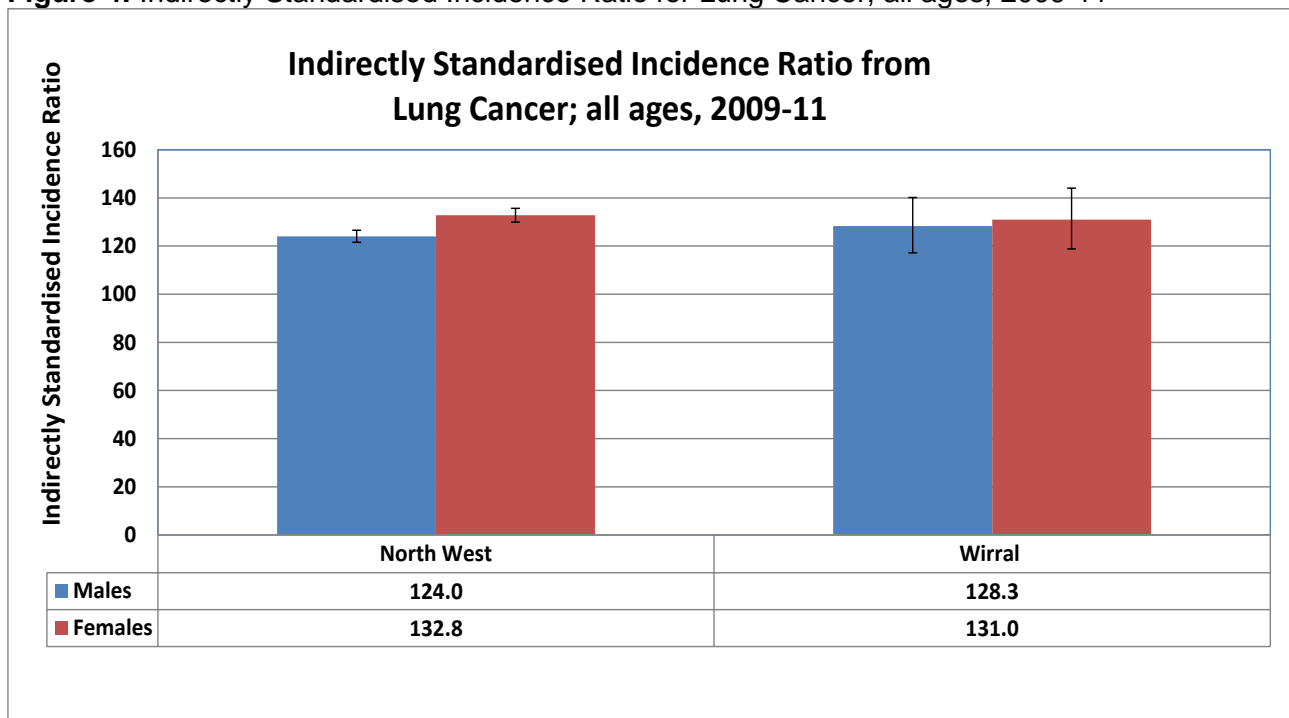
Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Information Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

The pooled data for 2009-11 shows lung cancer rates were almost a third higher than the England and North West average with a SRR of 128 for males and 131 for females (Figure 4).

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

**Figure 4: Indirectly Standardised Incidence Ratio for Lung Cancer, all ages, 2009-11**



Source: [Source: HSCIC Portal, 2014](#)

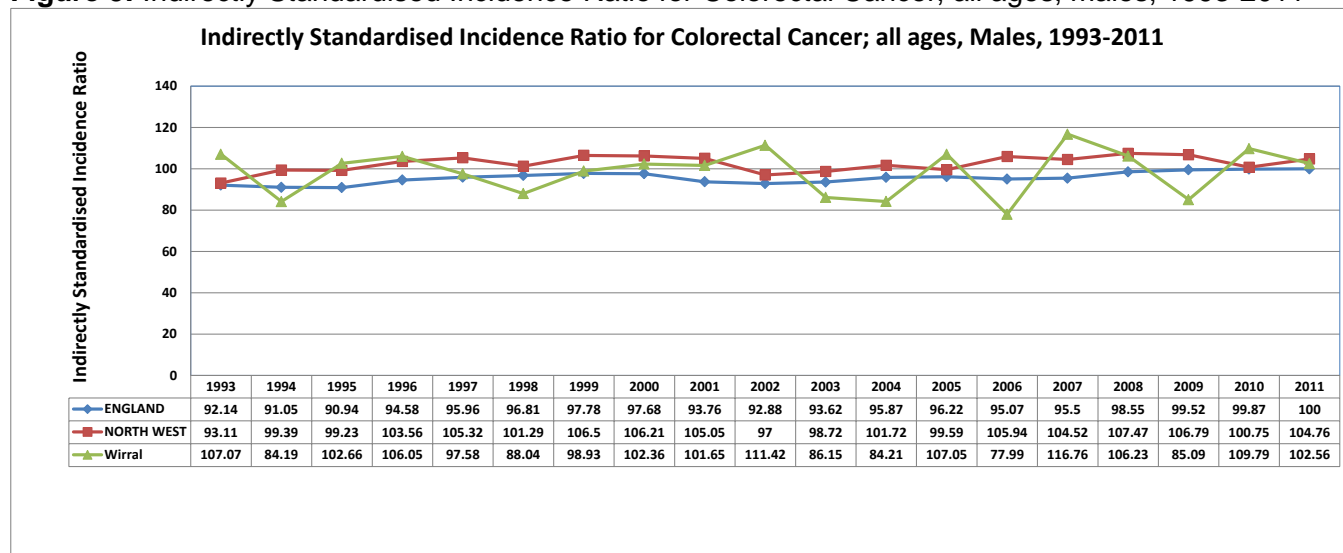
Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

## Colorectal Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

There has been some variation in the rates of colorectal cancer in males in recent years (Figure 5). However, Wirral has observed a small reduction (3%) in the rate of new cases with a SRR of 102 in 2011 compared with 107 in 1993.

**Figure 5:** Indirectly Standardised Incidence Ratio for Colorectal Cancer, all ages, males, 1993-2011

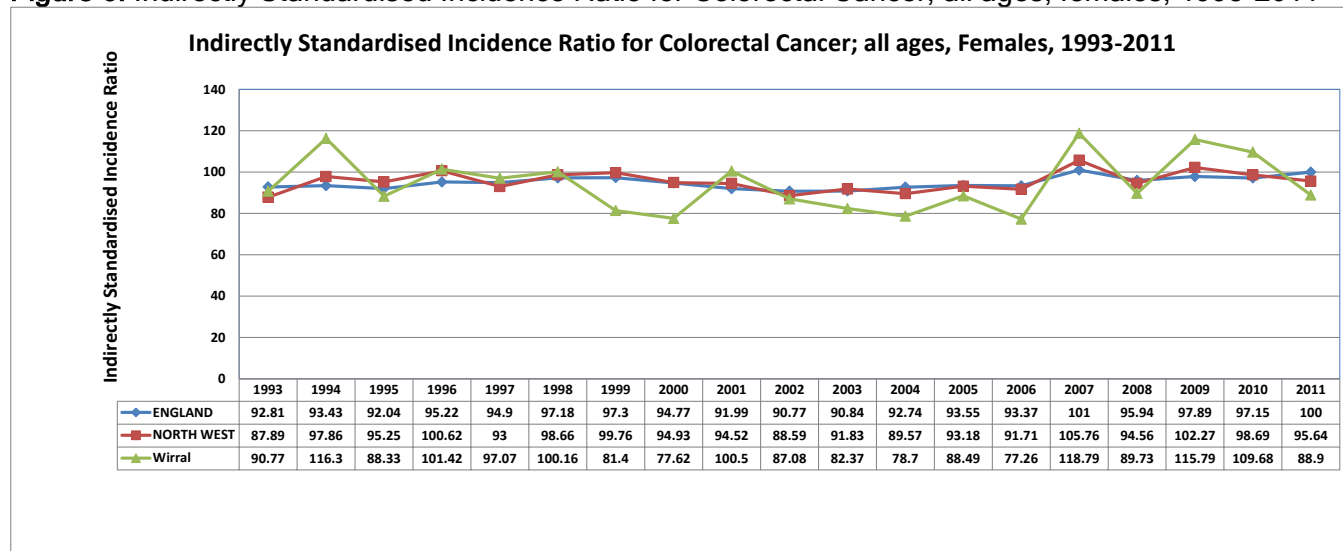


Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

In Wirral females, there is some variation with peaks in the rate of new cases seen in 1994, 2007 and 2009 (although this is to be expected due to smaller numbers than England overall). Overall, Wirral has seen a minimal reduction (2%) in the rate of new cases of colorectal cancer with a SRR of 89 in 2011 compared with a SRR of 90.7 in 1993 and is lower than the England average of 100 (Figure 6).

**Figure 6:** Indirectly Standardised Incidence Ratio for Colorectal Cancer, all ages, females, 1993-2011

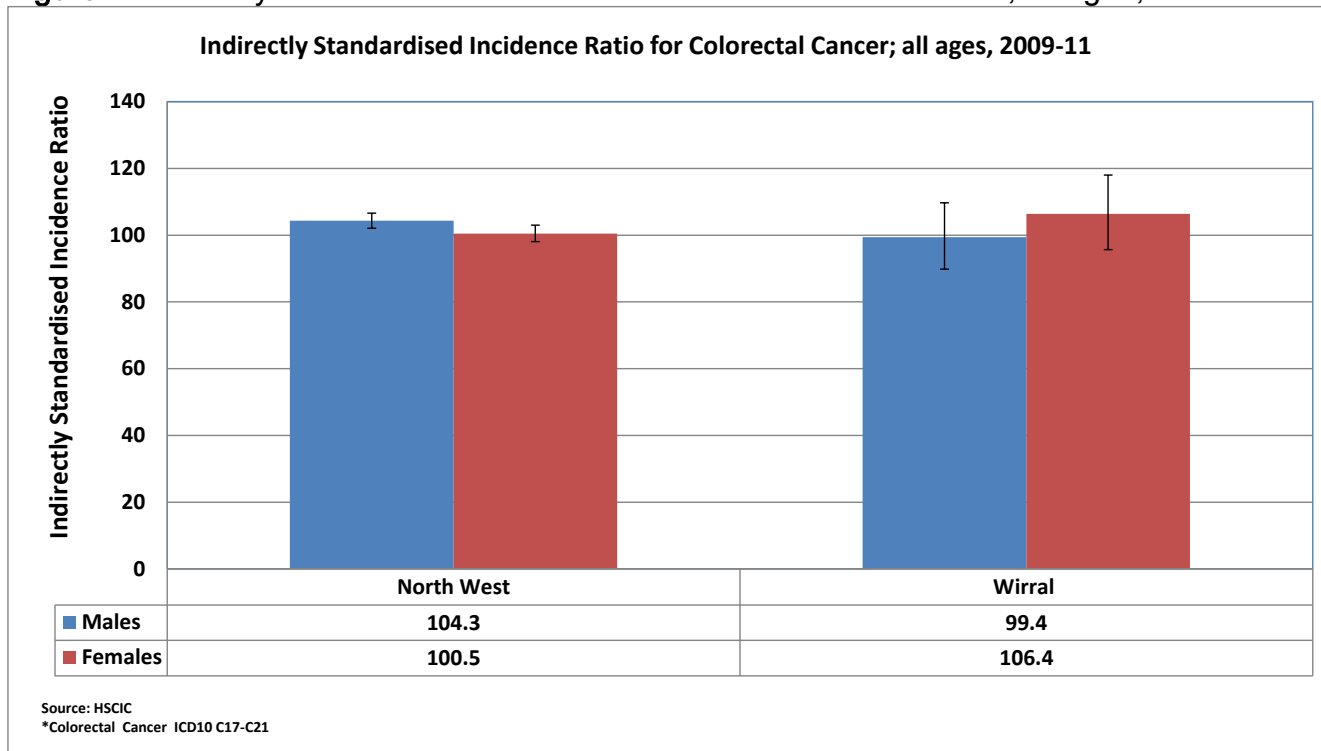


Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

In Figure 7 below, 3 years pooled data for 2009-11 showed the rate of new cases of colorectal cancer in men were slightly lower than the North West figure and England average with a SRR of 99.4. In females, rates were higher than both the North West figure and England average with a SRR of 106.4.

**Figure 7: Indirectly Standardised Incidence Ratio for Colorectal Cancer, all ages, 2009-11**



Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Information Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

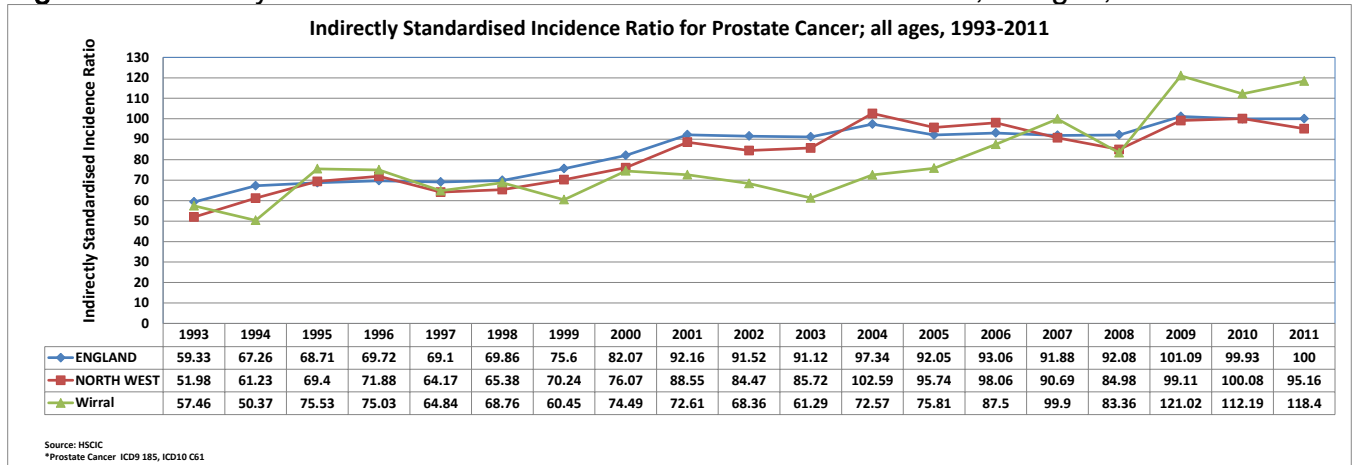
See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

### Prostate Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

Prostate cancer is the most commonly diagnosed cancer in men. Wirral observed a two-fold increase in the rate of new cases between 1993 and 2011 (SRR of 118 in 2011 compared with a SRR of 57 in 1993). Anecdotal evidence suggests this may have been due to the recently introduced, Prostate Specific Antigen Test (see Figure 8).

**Figure 8: Indirectly Standardised Incidence Ratio for Prostate cancer, all ages, 1993-2011**

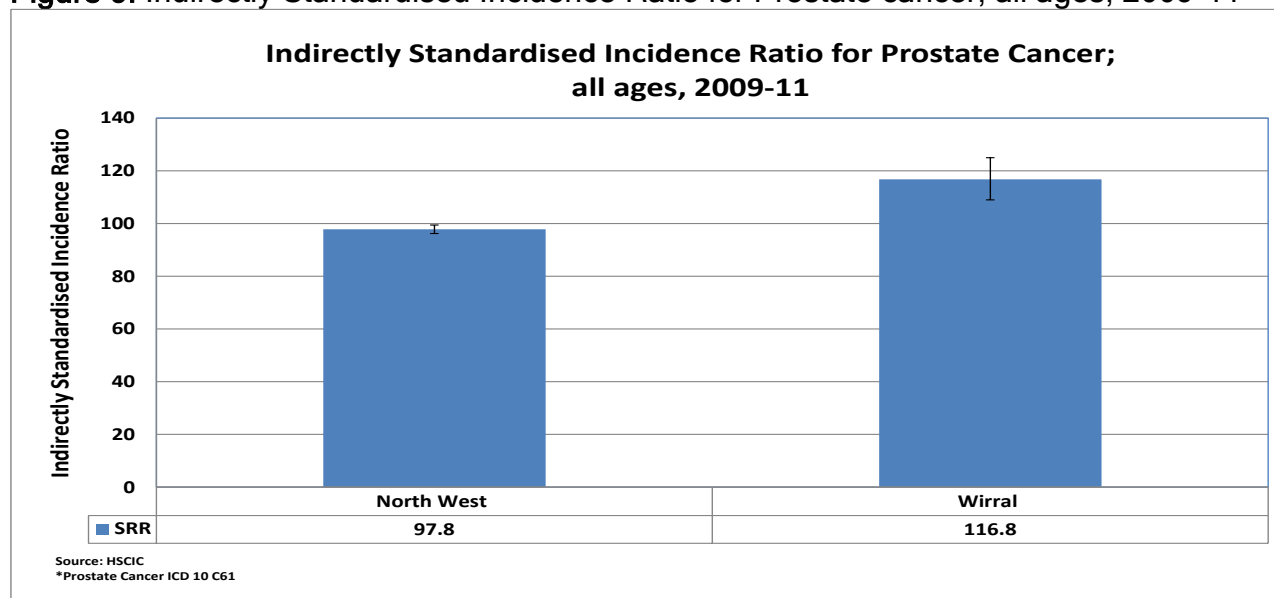


Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

The 2009-11 (3 years pooled) figures show a prostate cancer incidence was 16% higher than England, with a SRR of 116 (see Figure 9). Incidence has increased every year since the 1990s, partly due to better awareness, better diagnostic tests and the ageing of the population.

**Figure 9:** Indirectly Standardised Incidence Ratio for Prostate cancer, all ages, 2009-11



Source: [Source: HSCIC Portal, 2014](#)

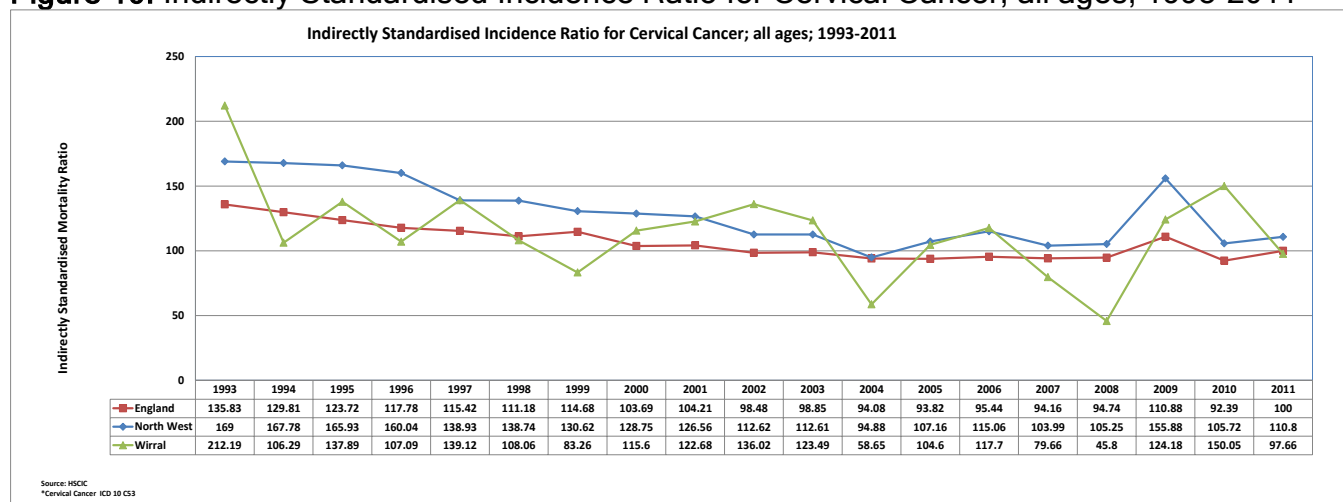
Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

## Cervical Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

Rates in new cases of cervical cancer have shown considerable variation in recent years with peaks observed in 1997, 2002, and 2010. Anecdotal evidence suggests the rise in cervical cancers detected after 2008 maybe due to the 'Jade Goody effect', (Figure 10).

**Figure 10:** Indirectly Standardised Incidence Ratio for Cervical Cancer, all ages, 1993-2011



Source: [Source: HSCIC Portal, 2014](#)

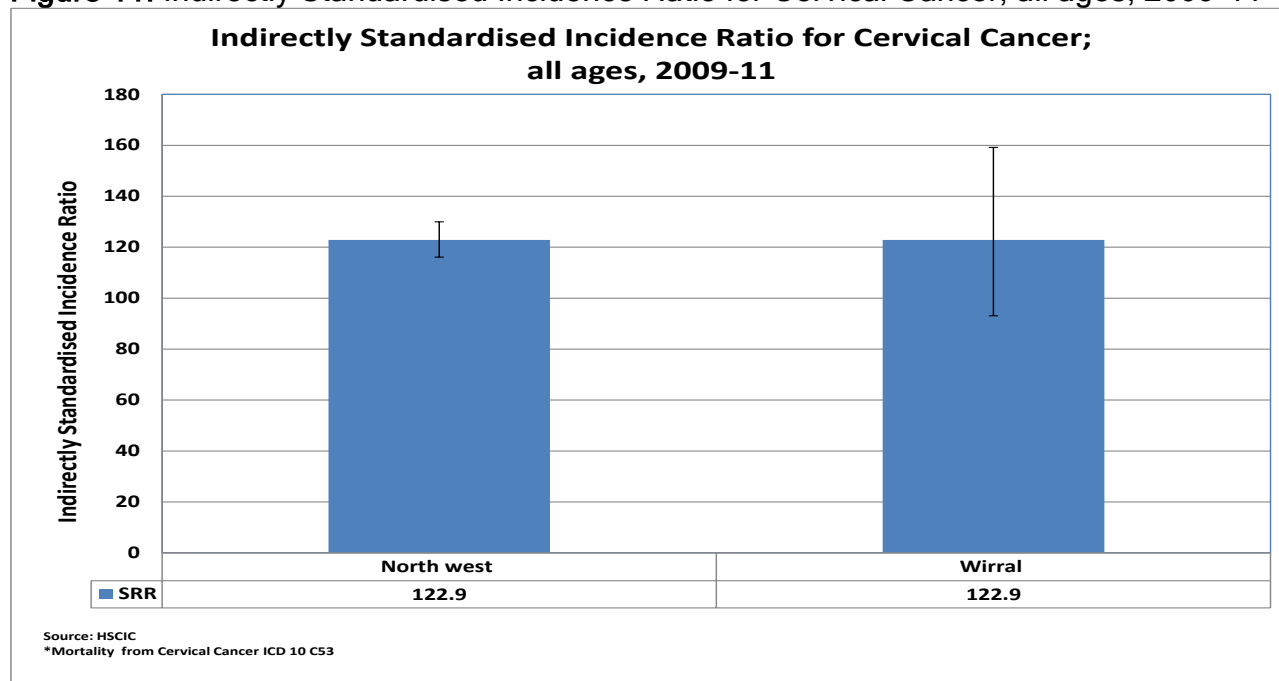
Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

The 2009-11 (3 years pooled) data shows that Wirral was a fifth higher than the England average for cervical cancer with a SRR of 122. It's important to note small numbers can significantly affect the incidence rate of cervical cancer, e.g. in this time period, there were 57 cervical cancers diagnosed in Wirral, which is statistically speaking, a small number.



It is anticipated that the HPV vaccine will reduce uptake of cervical screening, because young women will think it is no longer necessary. Health promotion activity will therefore need to concentrate on informing young women that it is still important to attend for cervical screening when they are called. The current programme of 3 yearly screening (up to age 50) and then 5 yearly screening (without abnormalities) will continue. The first cohort of young women (who were eligible for the HPV vaccine as part of the 'catch up' which aimed to vaccinate older girls) are due to enter the cervical screening programme in 2015. This group may not be a true reflection of the full impact of true HPV immunisation however, as they may have already been at risk of the HPV by being already sexually active and/or they may not have received the required 3 doses of the vaccine. The first Year 8 (ages 12-13) HPV cohort is due to commence cervical screening in 2025.

**Figure 11: Indirectly Standardised Incidence Ratio for Cervical Cancer, all ages, 2009-11**



Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

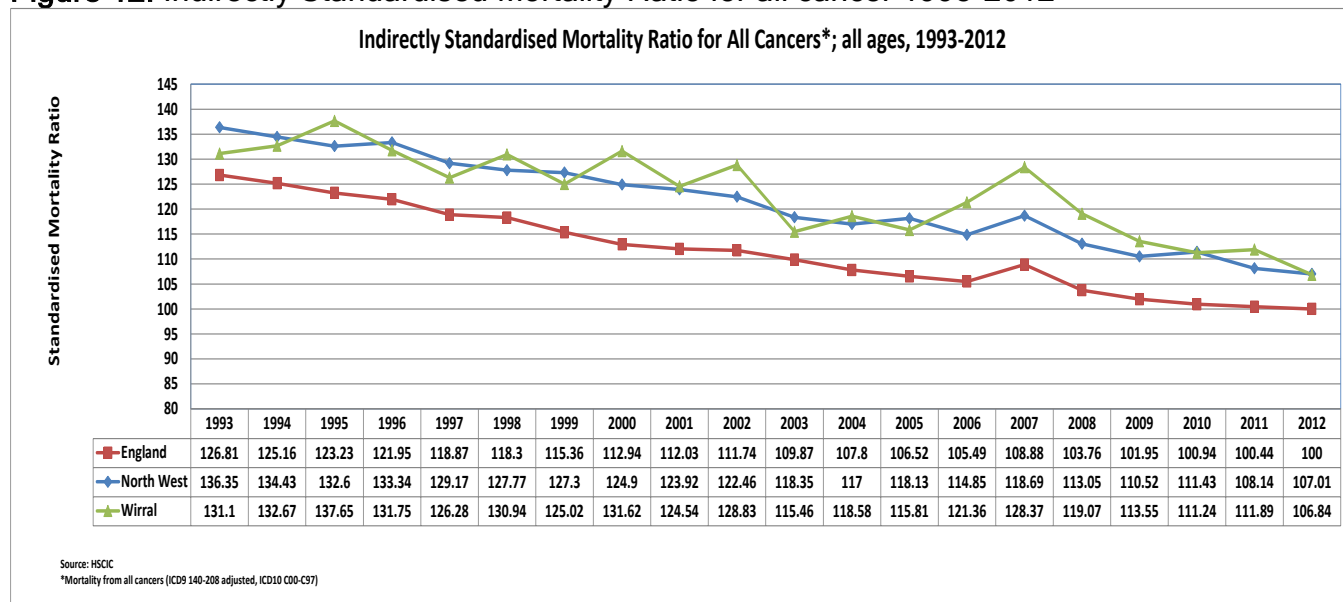
See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

## Mortality

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

Death rates from cancer in Wirral have been gradually decreasing. Figure 12 shows the trend in deaths from cancer for all ages. There is still however, significant variation between the most deprived areas (higher mortality) compared to the least deprived areas (lower mortality). This is also true for premature mortality (classed as deaths in those aged under 75). In Wirral, lung cancer makes up a large proportion of cancer deaths, the death rate is 30% higher than the England average and it is recognised as one of the priorities for the Wirral Cancer Strategy.

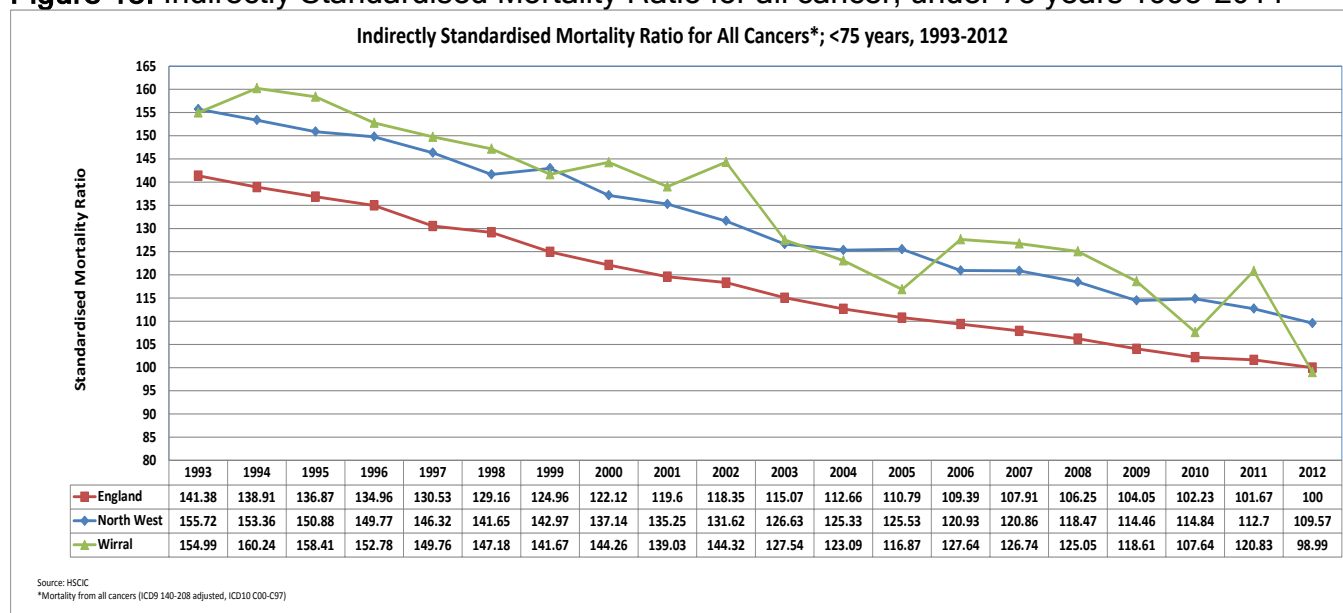
**Figure 12: Indirectly Standardised Mortality Ratio for all cancer 1993-2012**



Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

**Figure 13: Indirectly Standardised Mortality Ratio for all cancer, under 75 years 1993-2011**



Source: [Source: HSCIC Portal, 2014](#)

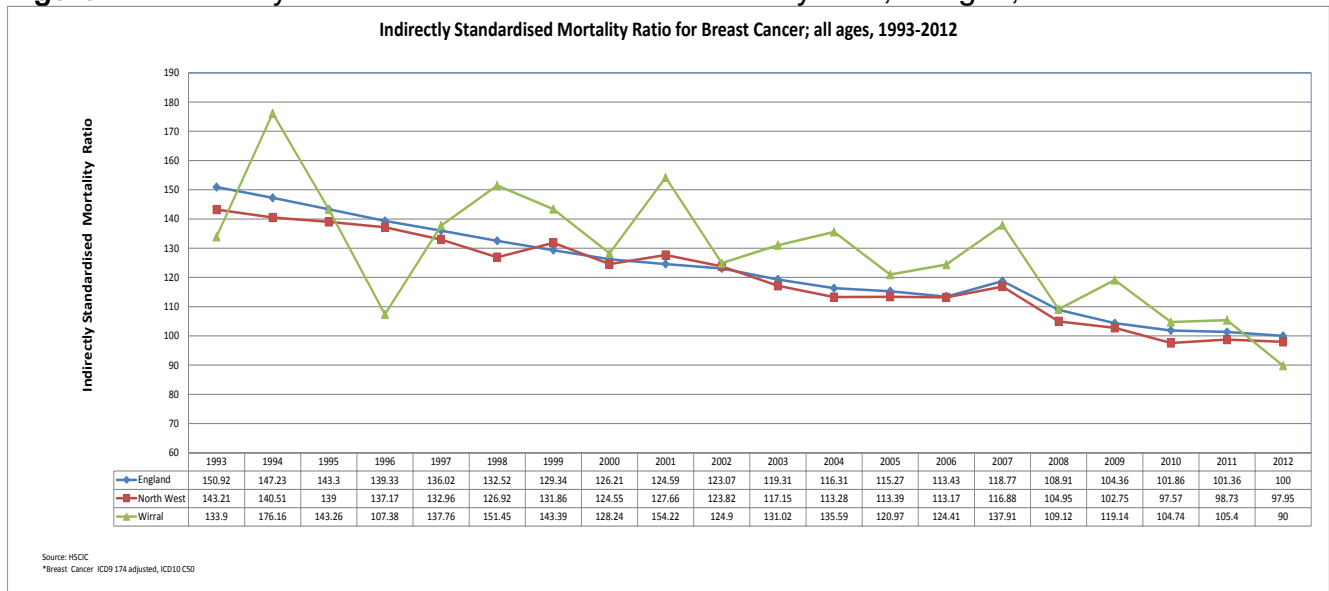
Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

## Breast Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

Breast cancer is the second most common death in women with 202 deaths reported in Wirral over the three years (2010-12) although deaths from breast cancer account for only 14% of the total cancer deaths during the same time period. Breast cancer deaths have reduced by a third (33%) since 1993 with a SMR of 90 in 2012. (Figure 14)

**Figure 14: Indirectly standardised breast cancer mortality ratio, all ages, 1993-2012**



Source: [Source: HSCIC Portal, 2014](#)

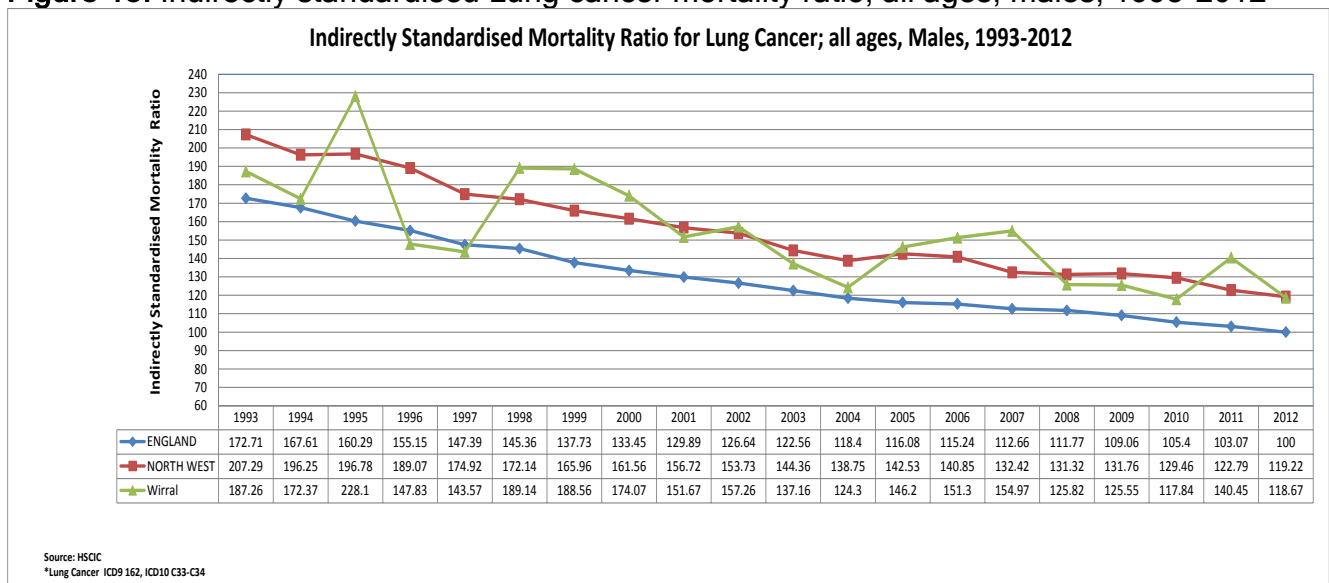
Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

## Lung Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

Lung cancer continues to be the most common cause of death in males and females both nationally and in Wirral. Deaths from lung cancer in males have been reducing in recent years, whilst deaths in females continue to increase. Both figures 15 and 16 shows the trend in lung cancer rates in males and females since 1993. Deaths in males in 2012 were almost 20% higher than the England average of 100 (SMR of 118), whilst deaths in females were 30% higher than the England average of 100 (SMR of 130).

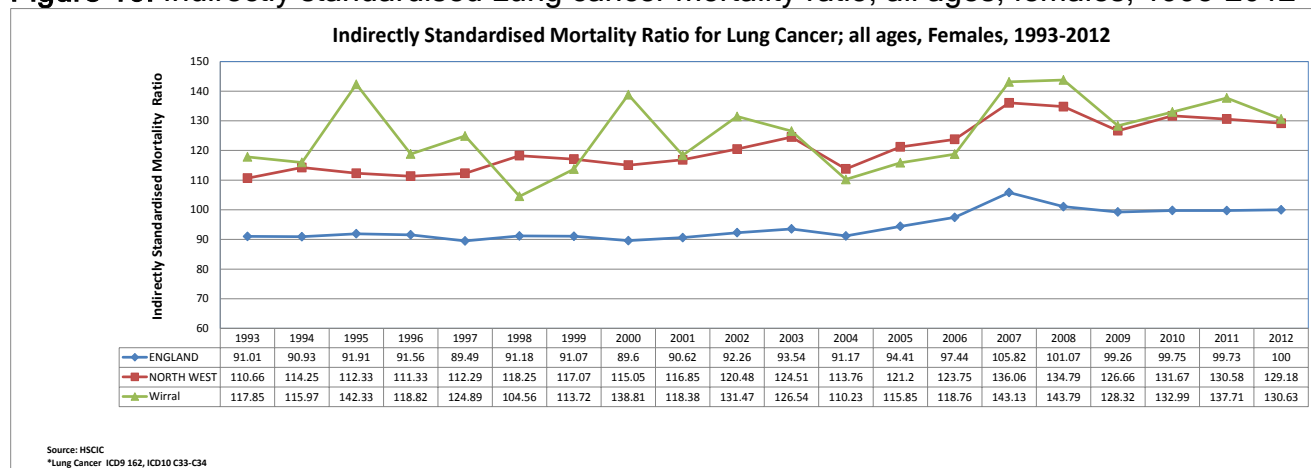
**Figure 15: Indirectly standardised Lung cancer mortality ratio, all ages, males, 1993-2012**



Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

**Figure 16: Indirectly standardised Lung cancer mortality ratio, all ages, females, 1993-2012**



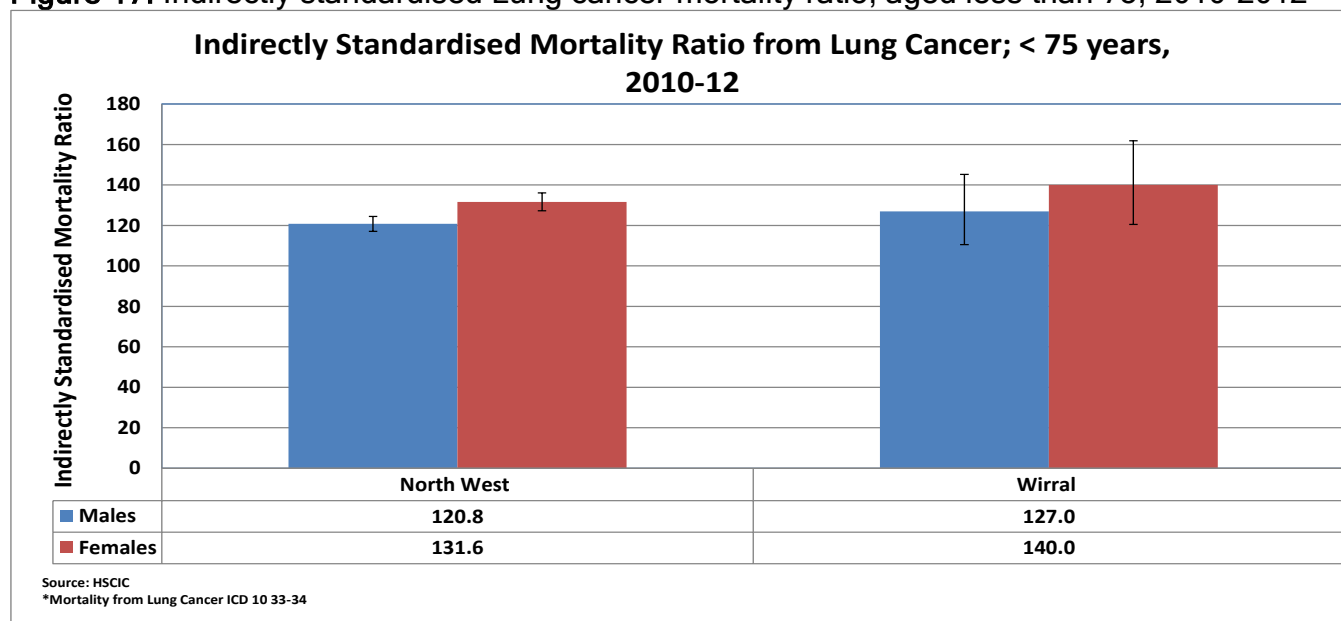
Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

Premature mortality (deaths in those aged under 75) were significantly higher in Wirral compared to both the North West and the England averages in 2010-12 (SMR for males was 127, for females it was 140 - see Figure 17).

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

**Figure 17: Indirectly standardised Lung cancer mortality ratio, aged less than 75, 2010-2012**



Source: [Source: HSCIC Portal, 2014](#)

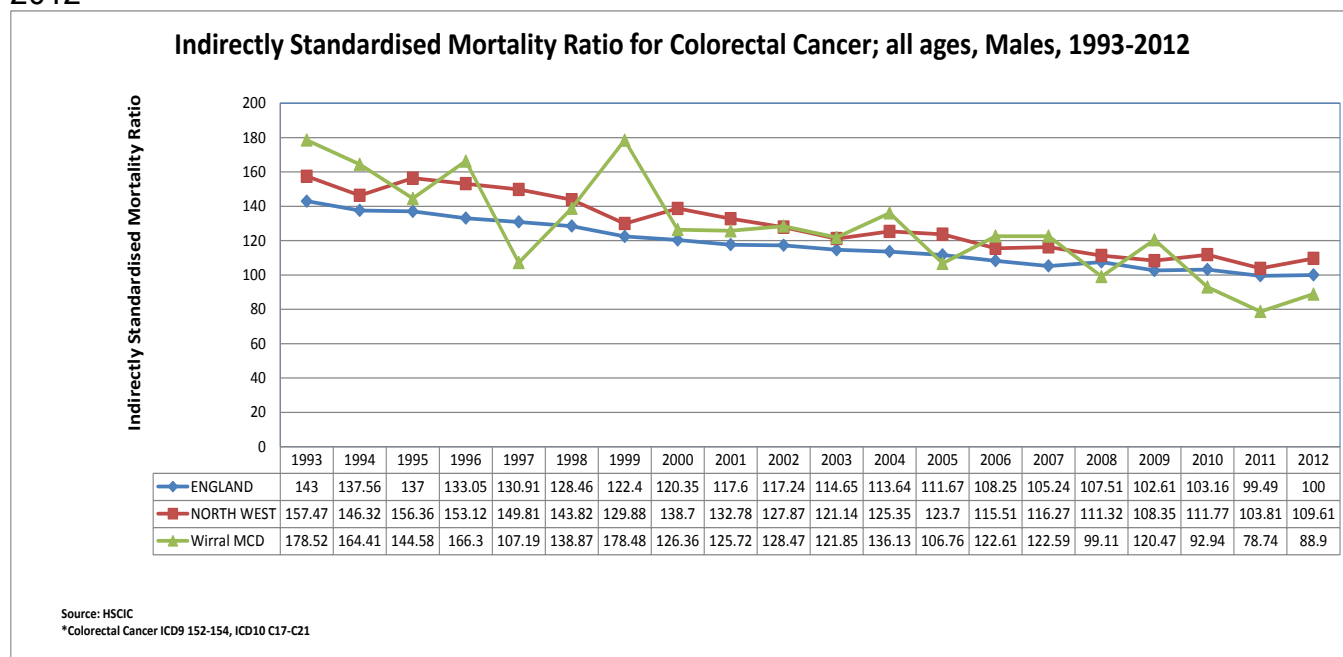
Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

## Colorectal Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

Colorectal cancer is the second most common cause of death in all persons in Wirral. The current death rate in males in 2012 was 11% lower than the England average (SMR of 89), whilst in females, deaths from colorectal cancer were 5% higher than the England average (SMR of 105). See Figures 18 and 19.

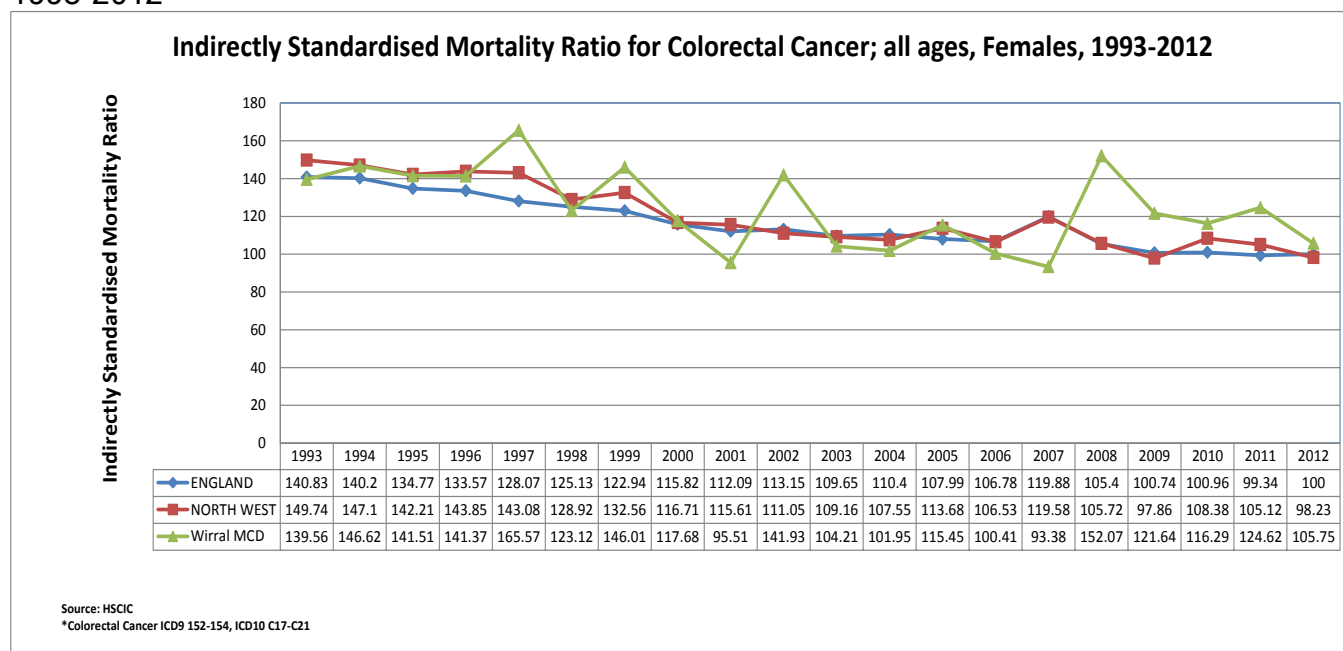
**Figure 18:** Indirectly Standardised Mortality Ratio for Colorectal Cancer, all ages, males, 1993-2012



Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

**Figure 19:** Indirectly Standardised Mortality ratio for Colorectal Cancer, all ages, females, 1993-2012

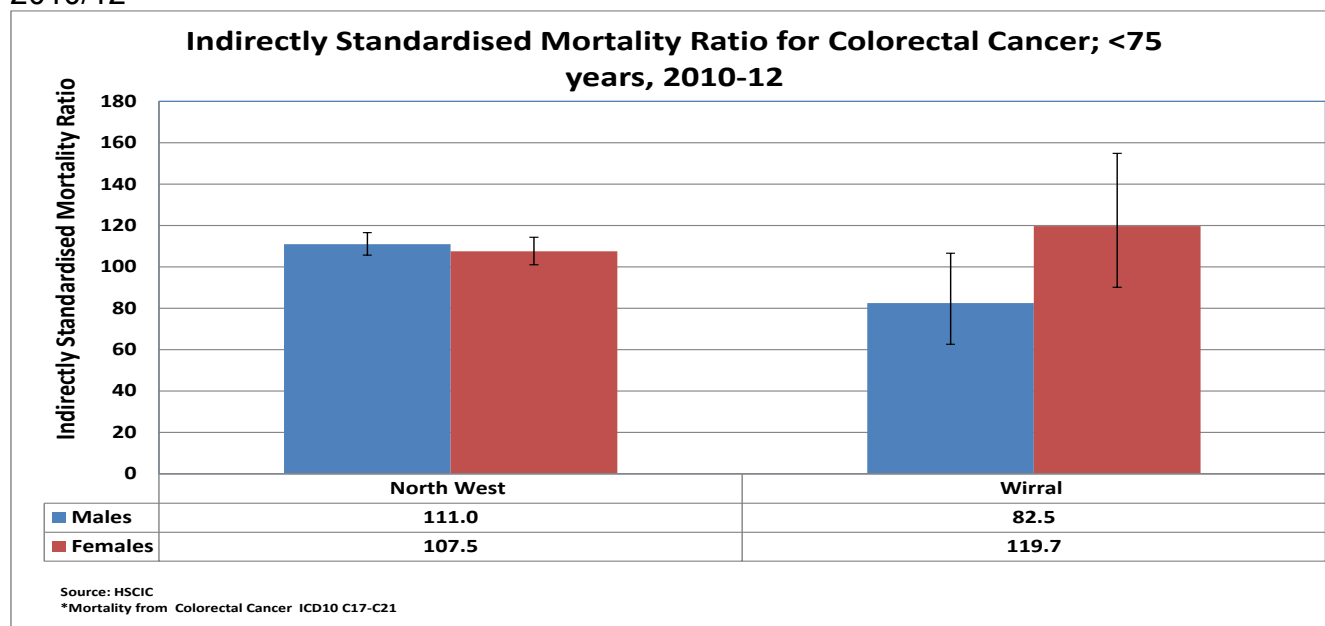


Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

Deaths in those aged 75 years and under (premature mortality), was higher among females with a SMR of 119 observed in 2010-12. This was 20% higher than the England average of 100 over the same time period. In males, death rates were lower than the England and North West average, with a SMR of 82 in 2010-12 (Figure 20).

**Figure 20:** Indirectly Standardised Mortality Ratio for Colorectal Cancer, under 75 years, 2010/12



Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

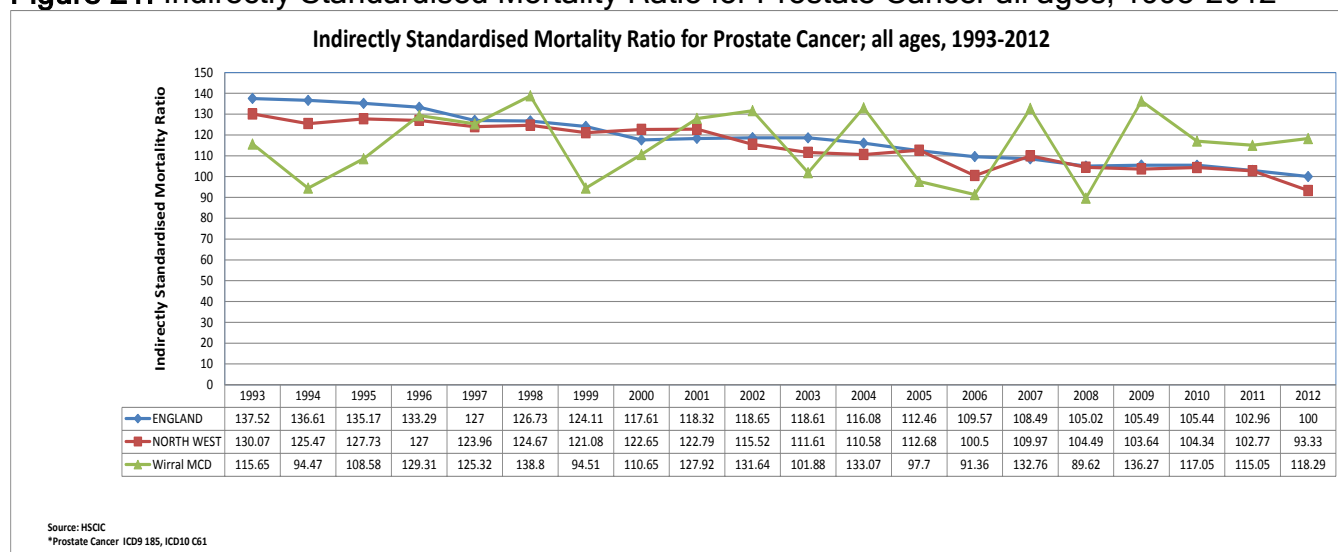
See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

## Prostate Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

Prostate cancer is the second most common cause of cancer death amongst men in Wirral with 213 deaths (7%) reported in 2010-12. The death rate in 2012 was almost a fifth (18%) higher than the England average with a SMR of 118, compared to 100 in England (Figure 21).

**Figure 21:** Indirectly Standardised Mortality Ratio for Prostate Cancer all ages, 1993-2012

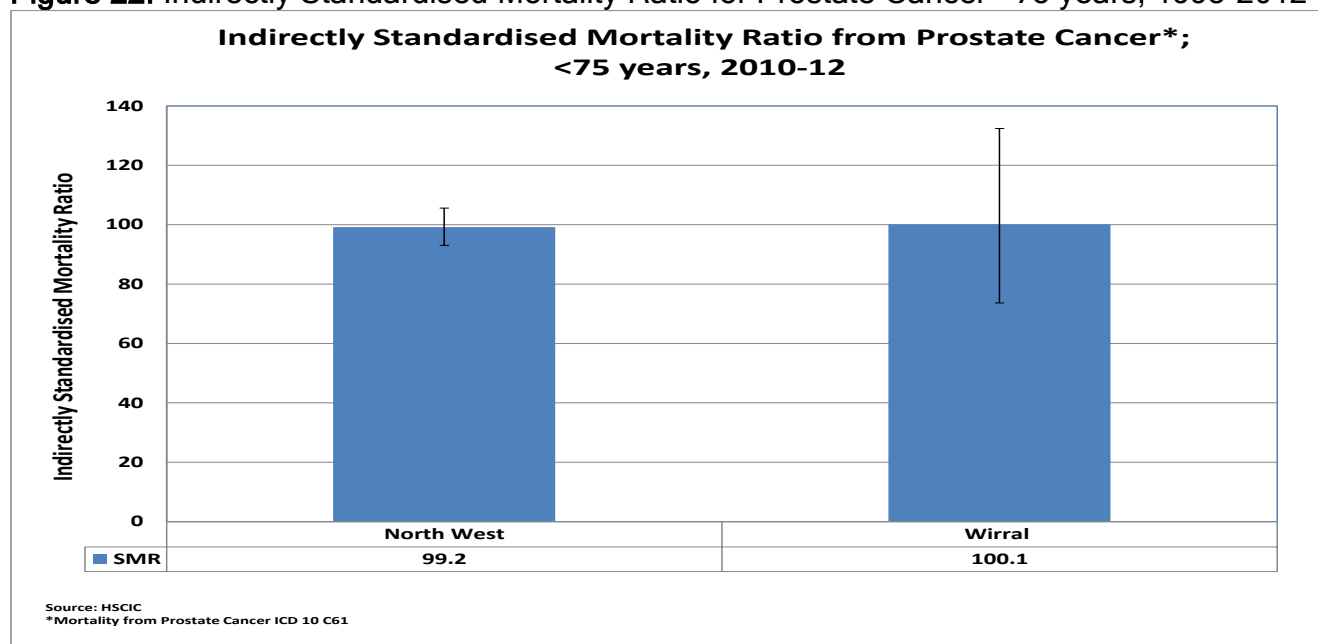


Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

Deaths in men aged under 75 years were the same as the England average with a SMR of 100 in 2010-12 in Wirral (Figure 22).

**Figure 22: Indirectly Standardised Mortality Ratio for Prostate Cancer <75 years, 1993-2012**



Source: [Source: HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

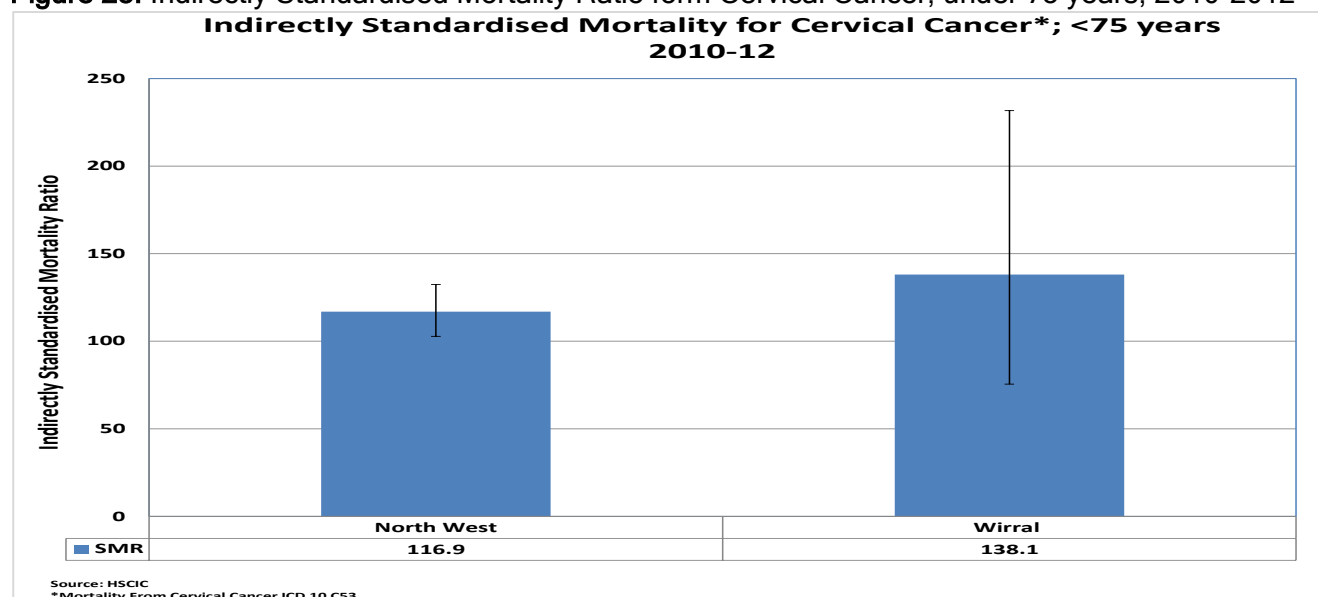
See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for more information

## Cervical Cancer

See [Local Cancer Toolkit](#), [Cancer Research UK](#) and [NCIN e-atlas](#) for later and supporting information

Deaths rates in Wirral for women under 75 years from cervical cancer are almost two-fifths higher than the England average with a SMR of 138 during 2010-12 this equates to 14 deaths (Figure 23). It is important to note deaths from cervical cancer include small numbers and the rate can fluctuate disproportionately year on year.

**Figure 23: Indirectly Standardised Mortality Ratio form Cervical Cancer, under 75 years, 2010-2012**



Source: [HSCIC Portal, 2014](#)

Notes: View this document in conjunction with these other sources for fullest picture [Local Cancer Toolkit National Cancer Intelligence Network e-atlas](#) and [Cancer Research UK: Local Cancer Statistics](#)

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## Targets

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The [Cancer Reform Strategy 2007](#) highlighted 10 priority areas of action to improve outcomes and drive delivery, these include;

1. **Actions to improve outcomes prevention** through encouraging lifestyle changes such as quitting smoking.
2. **Earlier diagnosis and treatment** through screening, improving public awareness and reductions in waiting times.
3. **Access to cost-effective treatments**, improved surgical techniques and increased radiotherapy capacity.
4. **Improving patients' experience** through better information and face-to-face communication with health professionals, and better coordination of care.
5. **Reducing cancer inequalities** for different groups in society.
6. Delivering care in the most appropriate setting by implementing new service models
7. **Better information** focused on improved collection and publication of data on outcomes and public awareness.
8. **Stronger commissioning** of cancer services reflecting local needs. Appropriate funding to build world class cancer services alongside effective commissioning to ensure
9. Better use of resources.
10. **Building for the future** through cancer research and the development of the cancer workforce.

The strategy '[Improving Outcomes](#): sets out how - in cancer care - the change needed in health and care services to improve results for all cancer patients and achieve the specific aim of improving cancer survival rates. (See Performance section)

More specifically, the [Public Health Outcomes Framework Guidance 2013-16](#) has identified several indicators to measure the success of improved cancer outcomes these are;

- Cancers diagnosed at stage 1 and 2 PHOF 2.19
- Cancer screening coverage PHOF 2.20 (breast and cervical only)
- Mortality from cancer PHOF 4.5

[NHS Constitution Handbook](#) provides the standards for waiting times:

- Cancer waits - two weeks
- Cancer waits - 31 days
- Cancer waits - 62 days

Wirral Clinical Commissioning Group (CCG) reports on the performance against cancer waits in Figure 24. The figures report that Wirral University Teaching Hospital (WUTH) is meeting all targets and is in line with national standards.



**Figure 24: Wirral University Teaching Hospital (WUTH) Cancer Waits 2013/2014 & 2014/2015, year to date (YTD)**

Period	01/04/2013 - 31/03/2014						
Target	Indicator	Threshold	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
Two Week Wait	GP Referral for Suspected Cancer to First Appointment	93.00%	96.64%	96.67%	97.25%	95.69%	96.56%
Two Week Wait	Symptomatic Breast Referral to First Appointment	93.00%	96.36%	98.00%	98.69%	98.40%	97.86%
31 Day Wait	Decision to Treat to First Definitive Treatment	96.00%	97.50%	97.40%	97.40%	98.50%	97.70%
31 Day Wait	Decision for Subsequent Treatment to Treatment (Surgery)	94.00%	96.97%	98.44%	98.08%	96.05%	97.39%
31 Day Wait	Decision for Subsequent Treatment to Treatment (Drug)	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day Wait	GP Urgent Referral to First Definitive Treatment	85.00%	86.60%	85.80%	85.40%	86.10%	85.98%
62 Day Wait	NHS Screening Referral to First Definitive Treatment	90.00%	100.00%	94.70%	95.50%	100.00%	97.55%
62 Day Wait	Consultant Upgrade to First Definitive Treatment	N/A	N/A	N/A	N/A	N/A	N/A
Period	01/04/2014 - 31/03/2015						
Target	Indicator	Threshold	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
Two Week Wait	GP Referral for Suspected Cancer to First Appointment	93.00%	96.82%	96.09%	94.10%	N/A	95.67%
Two Week Wait	Symptomatic Breast Referral to First Appointment	93.00%	95.06%	96.05%	95.56%	N/A	95.56%
31 Day Wait	Decision to Treat to First Definitive Treatment	96.00%	97.00%	97.80%	97.07%	N/A	97.29%
31 Day Wait	Decision for Subsequent Treatment to Treatment (Surgery)	94.00%	97.10%	94.81%	94.12%	N/A	95.34%
31 Day Wait	Decision for Subsequent Treatment to Treatment (Drug)	98.00%	100.00%	100.00%	100.00%	N/A	100.00%
62 Day Wait	GP Urgent Referral to First Definitive Treatment	85.00%	86.40%	85.40%	85.32%	N/A	85.71%
62 Day Wait	NHS Screening Referral to First Definitive Treatment	90.00%	93.80%	95.90%	97.89%	N/A	95.86%
62 Day Wait	Consultant Upgrade to First Definitive Treatment	85.00%	N/A	85.49%	86.32%	N/A	85.91%
*62 day wait consultant upgrade to first definitive treatment target came into effect quarter 2 14/15							
*Quarter 4 performance is not available yet as the final validation date is 08/05/15							

Source: Wirral Clinical Commissioning Group, 2015

## Performance

### Patient Experience

Patient experience encompasses most aspects of care outside of the impact of treatment. It includes things like whether patients were treated with dignity and respect, given good information, involved in decisions, and their views and preferences listened to and taken into account

The experience of care is measured by the [National Cancer Patient Experience Survey](#) (CPES) of people who have been a hospital inpatient or day case. The 2013 data have been collated to represent people with all cancers resident in the Clinical Commissioning Group (CCG). Overall in Wirral, 92% of people rated their care as either excellent or very good, compared with 88% for the England average.

### Patient information

**Routes to and from Diagnosis** - For further detail on routes to diagnosis please see [briefing](#)

Improving cancer survival is a key challenge identified in [Improving Outcomes](#): The survival difference in the first 12 months after diagnosis has been partly attributed to later stage at diagnosis. Understanding the routes taken by patients to their cancer diagnoses and the impact of different routes on patient survival will inform targeted implementation of awareness and early diagnosis initiatives and enable assessment of their success. The way that patients enter into secondary care on their way to being diagnosed with cancer has been analysed and each cancer diagnosis has been assigned a Route to Diagnosis.

Tumours assigned as diagnosed through an emergency route (Emergency Presentations) have the worst outcomes of all Routes. Routes to Diagnosis uses routinely collected data sources to work backwards through patient pathways to examine the sequence of events that led to a cancer diagnosis. The table below shows results for Breast, Lung, Colorectal and Prostate Cancer (Table 24).

**Table 24:** Directly Age Standardised Rate per 100,000 population by Route of Diagnosis, 2006-2010

<b>Tumour</b>	<b>Area</b>	<b>Screen Detected</b>	<b>Managed</b>	<b>Emergency Presentation</b>	<b>Other</b>
Breast	England	38.4	71.2	3.9	6
	Wirral CCG	<b>34.4</b>	<b>72.4</b>	<b>4.4</b>	<b>3.4</b>
Lung	England		27.5	16.6	1.6
	Wirral CCG		<b>33.2</b>	<b>22.1</b>	<b>1.6</b>
Colorectal	England	2.5	29.3	10.2	1.9
	Wirral CCG	<b>3.8</b>	<b>29.3</b>	<b>11.6</b>	<b>1.4</b>
Prostate	England		88.7	8.9	5.7
	Wirral CCG		<b>86.7</b>	<b>14.1</b>	<b>2.7</b>

[Source: Cancer Commissioning Toolkit, 2014](#)

### Screening

Cancer screening aims to detect cancer at an earlier stage to ensure the best possible outcomes and treatment for each individual. There are currently three national screening programmes: Breast, Cervical and Bowel (colorectal). Each screening programme has its own performance measure and target population which it aims to ensure screening coverage is reached to the most at risk groups.

[Cheshire, Wirral and Warrington Cancer Screening Annual report](#) provides a summary of all the key performance indicators for the national cancer screening programmes for Cheshire, Warrington and Wirral for 2013/14. It describes the work that has been taken by the screening and immunisation team together with the wider public health commissioning team in NHS England and describes key features of the work plan for 2014/15.

### Breast Screening

The breast screening programme was introduced in 1988. When a woman reaches her 50th birthday she will be automatically invited to take part in the breast screening programme and subsequently every three years thereafter. In 2010 age extension was rolled out nationally and now the age range that women are invited for screening is between 47 and 73 years. It's anticipated that the full roll-out will be completed by 2016. The minimum standard target coverage for breast screening is 70%. PHE Screening team use 80% as a stretch target for surgeries to aspire too. Table 25 shows breast screening coverage for the last 5 years, Wirral consistently exceeds the 70% target and is higher than the North West and England average.

**Table 25: Breast Screening Coverage women aged 53-70 years, 2008/09-2012/13**

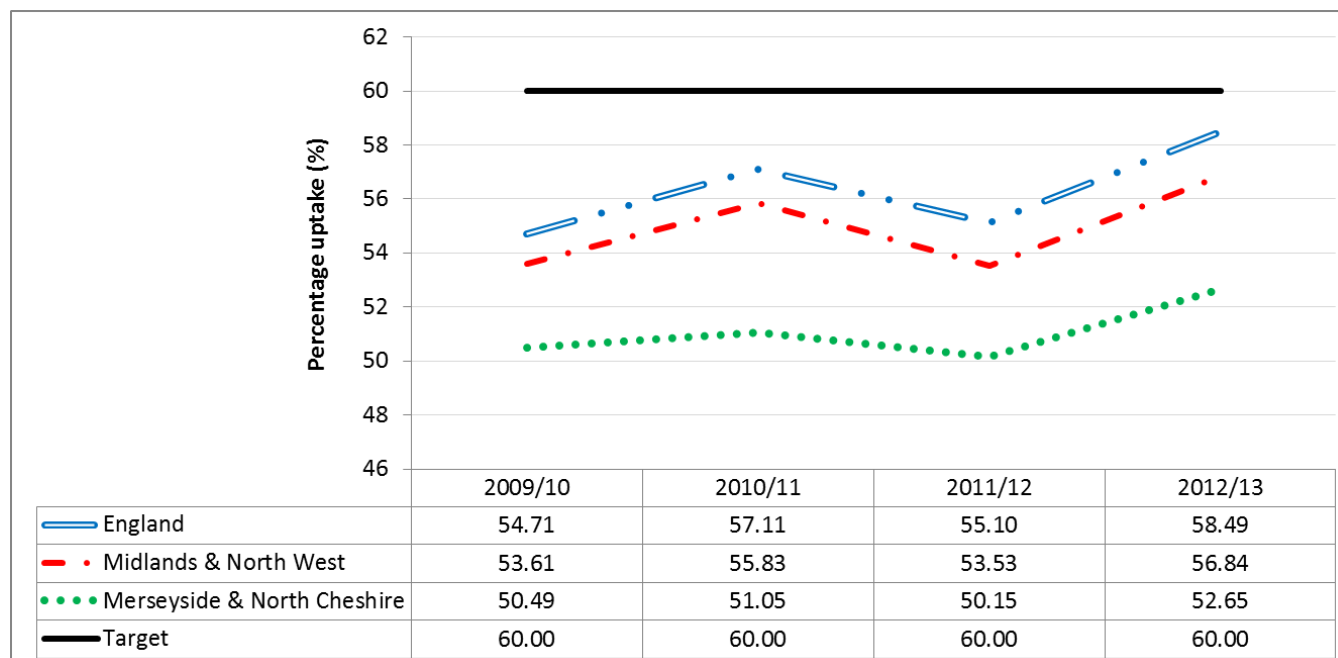
Area of Residence	Coverage Rate %				
	2008/09	2009/10	2010/11	2011/12	2012/13
Wirral CCG	78.7	78.4	78.4	77.7	77.2
<b>North West</b>	<b>75.8</b>	<b>75.7</b>	<b>75</b>	<b>74.7</b>	<b>74.1</b>
<b>England</b>	<b>76.5</b>	<b>76.9</b>	<b>77.2</b>	<b>77</b>	<b>76.4</b>

Source: [HSCIC Portal, 2014](#)

### Bowel Screening

The national Bowel Cancer Screening Programme was introduced in 2006 with Wirral participating from April 2007 onwards. The initial programme began by inviting men and women aged 60-69 years every two years. The Cancer Reform Strategy announced that the age range for bowel cancer screening would be extended up to 75 years from 2010. The target uptake for bowel screening is 60% and currently neither England, the Midlands & North-West Regional Programme Hub or the Merseyside & North Cheshire Screening Centre (M&NCSC) area (Wirral falls within this Centre) have not achieved the target (52.65%) since its introduction (nor have all areas of England, only reaching 58.49% in 2012/13 Performance against the target did improve between 2011/12 and 2012/13 however, as Table 26 shows.

**Table 26: Number of people who were eligible and participated in the bowel cancer screening programme in England, Midlands & NW regional programme hub and M&NCSC, 2009/10 to 2012/13**



Source: [Hansard \(House of Commons record\), 2014](#)

### Cervical Screening

The national Cervical Screening Programme was introduced in 1988 for all women aged 25-64 years. Women will be invited automatically for cervical smear either every 3 or 5 years depending on their age. The target coverage for cervical screening is 80%.

Table 27 shows cervical screening coverage from 2008/09 to 2012/13. In the 25-49 age group coverage has remained stable, however in 2012/13 coverage has reduced to 70.6 % this is also true for the national picture with coverage of 71.5%. In the 50-64 age group, coverage has remained stable in recent years and in 2012/13 coverage was 74.4% which is slightly below the England average of 77.5%.

**Table 27: Cervical Screening Coverage, women aged 25-64 years, 2008/09 - 2012/13**

Area of Residence	Coverage Rate %									
	2008/09		2009/10		2010/11		2011/12		2012/13	
	25-49	50-64	25-49	50-64	25-49	50-64	25-49	50-64	25-49	50-64
Wirral CCG	73.6	75.2	73.6	75.2	73.5	74.6	73.4	74.3	70.6	74.4
<b>North West</b>	<b>73.7</b>	<b>77.1</b>	<b>73.7</b>	<b>77.1</b>	<b>73.4</b>	<b>76.1</b>	<b>73.4</b>	<b>76.1</b>	<b>71.1</b>	<b>76.1</b>
<b>England</b>	<b>74.0</b>	<b>78.9</b>	<b>74.0</b>	<b>78.9</b>	<b>73.7</b>	<b>78.0</b>	<b>73.5</b>	<b>77.8</b>	<b>71.5</b>	<b>77.5</b>

Source: [HSCIC Portal, 2014](#)

## Survival

Survival rates give an indication on how effective service provisions are within an area. Variations in survival rates particularly higher rates may indicate areas of good practice but may also indicate areas that may require further improvement. Almost two-thirds (65%) of patients have survived beyond 1-year of a cancer diagnosis (these are patients diagnosed during 2011); this is slightly lower than the England average of 68%. For 5-year survival, almost half (46%) of all patients survive beyond 5-years of a cancer diagnosis, slightly lower when compared with the England average of 48% (these are patients diagnosed during 2007). Unfortunately data is not available by CCG group; therefore data represents all residents (patients) of Cheshire, Warrington and Wirral area team.

The Office for National Statistics has released the following reports that provide additional year of data demonstrating survival rates:

- Data by NHS England Area Team for one and five year age-standardised net survival can be found at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-384459>
- Index of survival for all cancers combined, at one year after diagnosis for CCG groups: <http://www.ons.gov.uk/ons/rel/cancer-unit/a-cancer-survival-index-for-clinical-commissioning-groups/adults-diagnosed-1997-2012-and-followed-up-to-2013/index-of-cancer-survival-for-clinical-commissioning-groups.html> or [http://www.ons.gov.uk/ons/dcp171778\\_389105.pdf](http://www.ons.gov.uk/ons/dcp171778_389105.pdf)

Whilst the overall message and trends in these outputs remain as previously reported, there are a few significant improvements in 2013 that are worth noting:

### Cheshire, Warrington and Wirral

- Large increase in 1year survival for men and women in cancer of Oesophagus. Figures now in line with the England average
- Increase in 1year survival for men and women in colon cancer. Survival for women is now significantly higher than England

An event led by Macmillan in April 2015 *Living with and Beyond Cancer* provided a catalyst for Cheshire and Wirral to work together to support this agenda. Presentations from this event which included examples of survivorship programmes across the UK can be accessed [here](#)

## What is this telling us?

### Local views

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In June 2013 the Wirral Cancer QIPP Group identified that a review of the cancer survivorship agenda was a priority for Wirral.

The aim of the review [Cancer Survivorship - Living with and beyond cancer](#) was to achieve the following objectives:-

1. Review national and local best practice and guidance
2. Review existing services on the Wirral
3. Speak to providers about what needs to be developed for Wirral patients
4. Collate qualitative feedback from patients via focus group with patients and carers

The findings from the review highlighted a need to ensure that consistent use of care plans and treatment summaries are provided to patients and carers. There is a need for more support in the form of events but also more clinical time given to patients in a form of communication that is understandable and offered at the right times. Carers needs urgently need to be incorporated in to the journey from the beginning and throughout offering them individual support.

The following improvement areas were recommended:

- To implement an action plan to ensure 100% of care plans are given to patients and carers at every stage of the patient pathway and for this to be monitored regularly.
- Explore ways for all providers to offer increased carer support throughout the whole pathway especially at the tertiary stage of treatment and after treatment
- To implement an action plan to ensure 100% of Treatment Summaries are given to patients and carers at every stage of the patient pathway and for this to be monitored regularly
- Increase the number of support events and patient education
- Explore ways in which information and communication can be improved through the patient journey taking into account when/in what format/ information to carer/ checking patients understanding.
- Implement individual support mechanisms for Carers and include them in the cancer journey offering them information and support through and offering it early on.

### National and local strategies

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#### National Strategy

In order to put patients, service users and members of the public at the heart of decisions about their care, the National Outcomes Strategy [Improving Outcomes](#):

- sets out the actions to tackle the preventable causes of cancer, by providing better information to people about risk factors and how individuals and communities might work to minimise them, as well as the steps we will continue to take to improve the experience of cancer patients and support the increasing number of cancer survivors;
- describes the ways in which choice for patients in their cancer care will be extended and implemented throughout the health and social care systems, informing both the decisions taken by NHS organisations now and the methods through which the mandate for the NHS Commissioning Board may be discharged; and
- identifies the gaps in information on health outcomes which are crucial to ensuring patients are empowered - in consultation and with the support of their clinicians - to exercise real choice over the care they receive, including through the extension of

national clinical audit and through the strengthened patient voice delivered by Healthwatch

[NICE Guidance suspected cancer: recognition and referral](#) to support GPs refer patients with potential cancer symptoms, which now incorporates the latest evidence on exactly the symptoms to look out for. This has been possible due to increasing evidence on what symptoms are linked to cancer. The guidelines provide GPs with more freedom to send patients to specialists, helping cut delays faced by some patients. Referring patients quickly has significant benefit. It can help reduce the number of GP appointments patients have before they see a specialist, which in turn frees up GPs time for others. But ultimately, it could also help more patients to be diagnosed at an early stage, which will boost their chances of long-term survival.

NICE now recommends GPs refer patients with any symptom - or collection of symptoms - that evidence suggests has at least a three in 100 chance of being cancer. There are also some instances where this figure - known as the 'threshold' - is even lower, for example when [children and young adults have certain symptoms](#).

### Local Strategy

A Cancer Summit was held on January 29<sup>th</sup> 2014 jointly hosted by Wirral Clinical Commissioning Group (CCG) and West Cheshire CCG. The learning and themes identified from the workshops sessions formed the recommendations for the future [Cancer Strategy for Wirral](#) as part of a 5 year plan. Wirral's priority tumour groups are:

- Lung
- Prostate
- Ovarian
- Colorectal

Wirral's Cancer Quality, Innovation, Productivity and Prevention (QIPP) group meet quarterly and are tasked with taking the strategy actions forward. The group is chaired by Dr Maria Earl, Wirral GP and Wirral CCG GP Lead for Cancer. The key components from the Strategy support the early intervention, prevention and diagnosis of cancer. An integrated approach across health and social care partners is indicated in each section of the action plan.

### **Current activity and services**

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#### Bowel TWW (Two Week Wait) pathway

Wirral's TWW pathway will be evaluated by the [ACE](#) programme. The pathway involves vetting of referrals to ensure patients get the most appropriate diagnostic test prior to their initial outpatient appointment.

#### Breast Cancer Survivorship

The pilot has developed out of the [National Cancer Survivorship Initiative \(NCSI\)](#) that recognised that current Cancer services do not always meet patient need. There has now been [an evaluation and subsequent report on its approach, work and progress](#). Feedback from the pilot has been positive, and the next steps will be to review whether the programme can be rolled out in the long term. The final report is published [here](#).

#### Living with Prostate Cancer Course

A new and recent initiative developed Prostate Cancer UK in collaboration with Maggie's centres around the country. <http://prostatecanceruk.org/about-us/news-and-views/2014/12/teaming-up-with-maggies-to-get-support-to-men-who-need-it> The 6 week course was originally piloted in Fife in Scotland and following its success it is being gradually rolled out at all Maggie's centres around the country. Maggie's Merseyside have formed a

partnership with the NHS Community Trust Livewell Team to provide a [locally tailored course](#)

The course was evaluated positively and feedback from the participants can be found [here](#)

The new Wirral Prostate Cancer Nurse Service is funded by Prostate Cancer UK for 18 months and aims to offer a Holistic Needs Assessment to every gentleman with a Prostate cancer diagnosis, especially those that have been discharged from secondary care on the Locally Enhanced Service. Support, advice, signposting and access to the Prostate Cancer Survivorship course is available for these patients and a treatment summary is copied to their GP following the assessment. GPs, secondary care, practice nurses and district nurses can refer to the service and patient can self-refer also. The service aims to respond to a referral within 24 hours and conduct the assessment within 2 weeks. Contact details for the prostate nurses can be found [here](#)

## **Key Inequalities**

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Many factors impact on the likelihood of developing cancer these include being a non-smoker, consuming less alcohol, being of a healthy weight, and eating healthily to name a few.

These factors are hard to measure at a population level, but are known to vary with socio-economic deprivation. A report published in 2014 by the [National Cancer Intelligence Network](#) (NCIN) highlights the variation observed in incidence and mortality figures with socio-economic deprivation, age, and gender.

It concluded that if the more deprived groups had the same rates as the least deprived, there would have been around 15,300 fewer cases and 19,200 fewer deaths per year across all cancers combined in the most recent 5-year periods. A local report published in 2010 analysed excess cancer deaths and indicated that if Wirral had the same cancer death rates as England, we would have had 350 less deaths between 2006-08. The full report can be found [here](#).

In addition, there are local equity audits produced by specific tumour groups which highlight some of the inequalities identified in Wirral. These can be found [here](#)

## **Key gaps in knowledge and services**

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### Cancer Audit

The Royal College of General Practitioners (RCGP) toolkit '[Improving Cancer Diagnosis](#)' illustrated how Significant Event Analysis (SEA) encouraged GPs to think about practice issues. The Cancer Significant Event Audit: Peer Review Pilot was a joint initiative of the RCGP, the National Cancer Action Team (NCAT) and Macmillan Cancer Support. The one year pilot offered anonymised external peer assessment of SEAs of cancer diagnosis from participating networks: Merseyside and Cheshire was one of the pilot sites. It sought to encourage reflection and learning around cancer diagnosis, provide GP practices with an opportunity to develop their SEA technique and also assess the long term impact SEAs can have on practice.

A [cancer audit scheme was developed by Wirral GP Commissioning Consortium \(WGPPC\)](#) which encouraged all member practices to participate; 12 practices took part in the scheme.

### Key recommendations from the Audit were:

- The importance of investigating vague persistent symptoms
- Negative tests should not reassure the patient or GP
- The need for a high index of suspicion in older patients

- Co-morbidity frequently clouds the picture
- The importance of continuity of care and good safety netting

#### At a practice organisational level

- Robust follow up and good quality note keeping essential
- Ensure delegated tasks completed

#### Other reviews a practice may consider include:

- Review all 2 week waits (2WW) referrals for criteria, if not, was it still appropriate?
- Review all cancers diagnosed by a non-urgent/ routine referral route
- Review all emergency admissions which resulted in a cancer diagnosis-were there any missed opportunities for an earlier diagnosis
- If a patient does not attend for screening, what actions does the practice take to promote or increase uptake?
- The Macmillan Revalidation Toolkit provides a useful framework that GPs and practices can use to look at their cancer care and gives ideas for audit

Practices can access their practice cancer profile data through the Cancer Commissioning Toolkit ([www.cancertoolkit.co.uk](http://www.cancertoolkit.co.uk))

#### [Wirral NAEDI Evaluation Review of the Cancer Self-Assessment Tool](#)

The National Awareness and Early Diagnosis Initiative ranges from campaigns for the public (e.g. be clear on cancer) to tools and support for primary care to help diagnose cancer earlier. GPs and primary care teams have a key part to play in achieving earlier diagnosis. Work is being undertaken with clinical leadership around:

- Guidance on direct access tests for GPs
- Pathway analysis
- Clinical decision support
- Risk assessment tools
- Practice profiles
- Significant event analysis

Twenty Wirral practices participated in the project. Eighteen practices completed the cancer self-assessment framework.

#### What is coming on the horizon?

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The Cheshire, Warrington and Wirral Screening and Immunisation Team (SIT) are in the early stages of development of a **Health Inequalities Strategy** for Screening and Immunisation. It is intended that this will improve overall coverage in cancer screening and reduce variation in cancer screening coverage with a focus on vulnerable groups.

There are two key tools in place to support the health inequalities strategy. These are

- Health Inequalities CQUIN  
This CQUIN is in all provider screening and immunisation contracts. In order for providers to comply with the CQUIN they are required to complete an initial benchmarking exercise to gather data on defined vulnerable groups and identify gaps in current service provision. In Year 2 providers are expected to implement an action plan to improve uptake.
- Practice Dashboard  
The most recent coverage figures for the three cancer screening programmes will be included in a practice performance dashboard together with other screening and immunisation practice level results. These will be used to identify practices with lower coverage for a plan of targeted support with key partners.



## Links

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<http://www.macmillan.org.uk/Documents/AboutUs/Research/Researchandevaluationreports/Routes-from-diagnosis-report.pdf> This report summarises the results of the first phase of the Routes from Diagnosis study, including outcome pathways, survival rates, inpatient costs and morbidities associated with breast cancer, lung cancer, prostate cancer and brain and central nervous system tumours.

<https://www.cancertoolkit.co.uk/Home/PublicUsers>. This toolkit is the first point of contact for Cancer Commissioners to benchmark the services they commission at different geographical and provider levels.

<http://www.ncin.org.uk/home> The NCIN is a UK-wide initiative, working to drive improvements in standards of cancer care and clinical outcomes by improving and using the information collected about cancer patients for analysis, publication and research

<http://www.phoutcomes.info/> this sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. Indicators such as cancer screening coverage-breast cancer can be found in the indicator list

<http://www.hscic.gov.uk/>. the national provider of information, data and IT systems for health and social care.

## Notes and Definitions

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List of ICD 10 codes used for Cancer Incidence and Mortality data ([Full list here](#))

Cause	ICD-10 Code
All Cancers	C00-C97
Colorectal Cancer	C17-C21
Lung Cancer	C33-C34
Female Breast cancer	C50
Cervical Cancer	C53
Prostate Cancer	C61

**Data** is based on the HSCIC revised ONS populations

**Prevalence** is defined as the number of people who have been diagnosed with cancer in the past and who are still alive, on a given date.

**Incidence** means how many people get a particular type of cancer every year. It is often written as number of cancer cases per 100,000 people in the general population or as a ratio as described in SRR/SMR.

**Mortality** statistics mean the number of people who have died from a particular type of cancer in a year. It is often written as number of cancer cases per 100,000 people in the general population.

**Indirectly standardised Incidence Ratio (SRR):** A ratio of the observed number of events (i.e. number of cases of cancer) in a population, relative to the expected number of events in that population. It is calculated by dividing the observed number of events by the expected number of events for Wirral. Ratios above 100 indicate that the number of events observed was greater than expected; whilst ratios below 100 that it was lower (England average is always 100). SRRs are also known as indirectly standardised rates.

**Indirectly Standardised Mortality Ratio (SMR)** A ratio of the observed number of deaths in a population, relative to the expected number of deaths in that population. It is calculated by dividing the observed number of deaths by the expected number of deaths for Wirral. Ratios above 100 indicate that the number of events observed was greater than expected, whilst ratios below 100 that it was lower (England average is always 100). SMRs are also known as indirectly standardised rates.

**Cervical Screening Coverage** is defined as the percentage of women in a population eligible (25-64 years) for screening at a given point in time, who were screened within a specified period. Women ineligible for screening, and thus not included in the numerator or denominator of the coverage calculation, are those whose recall has been ceased for clinical reasons (most commonly due to hysterectomy).

**Breast Screening Coverage** is defined as the percentage of women in the population who are eligible for screening at a particular point in time who have had a test with a recorded result at least once within the screening round, i.e. in the previous three years. Currently coverage is best assessed using the 53-70 age group. NB: Women are eligible for screening if they are in the screening age range and are not ineligible due to bilateral mastectomy.

**Bowel Screening Uptake** is defined as the proportion of those invited who returned an adequate kit in the defined time period.

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