

Cancer Needs Assessment: 2020/21

**Cheshire and Merseyside
Public Health Analysts
Network**

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Sharon McAteer, Public Health Development Manager, Halton Borough Council; Champs Strategic Intelligence Programme Lead

John Highton, JSNA Manager, Wirral Borough Council

Sarah Kinsella, Senior Public Health Analyst, Wirral Borough Council

Jenny Hampson, Performance Information Analyst, Cheshire and Merseyside Cancer Alliance

Rachel Lunt, Cheshire LRF Public Health Analyst, hosted by Halton Borough Council

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Key organisations websites:

- [Cheshire and Merseyside Cancer Alliance](#)
- [Macmillan cancer support](#)
- [Wirral Intelligence Service](#)

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Background

Cancer is a leading public health challenge – a condition that in all its forms (and there are over 200 different kinds of cancer), is likely to affect one in two during their lifetime. Over 40% of cancers are thought to be preventable however, so working with partners across the system to tackle inequalities, improve screening rates, increase awareness among the public of signs and symptoms (which in turn can improve earlier diagnosis and more effective treatment) and reduce the impact of the major risk factors such as smoking, obesity and alcohol, is crucial.

The COVID-19 pandemic has presented the NHS with perhaps its most challenging period in its 73 year history. Clinical and non-clinical healthcare professionals have gone to extraordinary lengths to maintain cancer services in Cheshire and Merseyside throughout the crisis.

At the start of the pandemic the number of people seeking advice from their GP regarding symptoms that could be cancer, and hence the number of urgent suspected cancer referrals to hospitals, fell dramatically. Referrals were lower than expected between April and September 2020 but have since recovered and are now approximately 20% greater in number each week than before the pandemic. This is positive because it means that the public's confidence to seek medical advice from their GP about potential signs of cancer has, in general, been restored. However, there are some differences at tumour level. Referrals for suspected urological cancers (primarily suspected prostate cancer), suspected lung cancers and suspected haematological (blood) cancers remain lower than expected.

Although referral rates have, in most cases, returned to at least pre-pandemic levels, the impact of the dramatic fall in referrals at the beginning of the crisis means that the total number of referrals received in the year from April 2020 to March 2021 was 8% lower than the previous 12 month period (i.e. the year before the pandemic). The biggest shortfalls are in the tumour groups that still have not returned to normal referral levels, i.e. urological, lung and haematology and, to a lesser degree, skin (although skin referrals are now 28% higher than pre-COVID-19). Whilst 8% is the average shortfall in referrals in 2020/21 compared to 2019/20 across Cheshire and Merseyside, there is variation by CCG. NHS Halton CCG has seen the greatest shortfall with 17% fewer referrals across the year.

During 2020/21, the reduction in referrals was significantly greater amongst people living in the most deprived areas, with a 9% reduction in the most deprived areas (areas ranked in the 20% most deprived nationally), compared to a 5% reduction in the least deprived (areas ranked in the 20% least deprived nationally). However, by April 2021 referrals from all five deprivation quintiles had returned to pre-pandemic levels.

The proportional impact on referrals during 2020/21 increased with age. Referrals for patients aged 0-49 reduced by 1%, compared to a 13% drop for those aged over 80. Referrals for men fell by 11% compared to 5% for women.

The impact of COVID-19 on referrals from different ethnic backgrounds is more difficult to assess due to small numbers in some ethnic communities. Suspected cancer referrals for people from ethnic diversity groups fell by 6% during 2020/21 compared to 2019/20, and by 8% for White British. Referrals for people of all ethnic backgrounds have now returned to at least pre-pandemic levels.

In total, 14% fewer patients were treated for a new cancer in 2020/21 compared to 2019/20 in Cheshire and Merseyside. Beneath this headline figure there are differences between CCGs, tumour groups and routes to diagnosis, but no statistically significant variation by gender, deprivation, age, or ethnicity.

In all cases, first treatment rates have now returned to pre-COVID-19 levels.

In Cheshire and Merseyside, over 13,000 new patients were treated for cancer between April 2020 and March 2021. This was 14% fewer than were treated in the previous year. The reduction varies by CCG with NHS Liverpool CCG and NHS St Helens CCG experiencing the biggest reductions (19% and 22% respectively).

Treatments for prostate cancer reduced by the greatest proportion, dropping 30% in 2020/21 compared to 2019/20. Breast (-24%) and other urological cancers (excluding prostate) (-20%) saw the next largest proportional reductions.

The route to diagnosis had a big impact upon the number of first treatments delivered in 2020/21. For several months the cancer screening programmes were paused in Cheshire and Merseyside due to the pandemic, as they were across England, other than for high risk patients. Consequently, the number of new cancer patients diagnosed and referred for treatment by the screening programmes reduced by 52% compared with 2019/20. In comparison, the number of patients diagnosed and treated following an urgent suspected cancer referral from a GP fell by 9% (which is in line with the previously mentioned 8% drop in GP referrals).

There was a 14% reduction in the number of first treatments for patients in the most deprived neighbourhoods (most deprived 20% nationally) during 2020/21 compared to a 9% reduction in the least deprived (least deprived 20% nationally). The smallest reduction (5%) was in the second most deprived neighbourhoods (Quintile 4) The differences are not considered statistically significant primarily because the number of first treatments are relatively small compared to the number of referrals.

Three percentage points separate the reduction in treatments for males and females. This is not considered to be statistically significant.

With regard to the age of patients, the greatest reduction in first treatments during 2020/21 was seen in the 60 to 69 year olds (13%) and the smallest reduction was in the 50 to 59 year olds (6%). The variation is not considered statistically significant.

Approximately four percent fewer patients from ethnic diversity groups received first treatments in 2020/21 compared to 2019/21. Eleven percent fewer White British patients received first treatments in the same period. The difference is not considered statistically significant due to the small numbers in the non-White British group.

The Cancer Alliance will continue to monitor the ongoing impact of Covid-19 on cancer services and follow the mantra of 'building back fairer'¹ in acknowledgement that inequalities existed before the pandemic, and these still need to be addressed.²

¹ [Build Back Fairer: The COVID-19 Marmot Review](#), Sir Michael Marmot et al, The Health Foundation, Dec 2020

² Cheshire and Merseyside Cancer Alliance: Cancer Inequalities Covid Impact Analysis

Risk Factors

- Smoking rates in Cheshire and Merseyside have fallen substantially and are now similar to England, but Halton, Knowsley and Liverpool Local Authorities have the highest rates in Cheshire and Merseyside
- However, successful smoking quit rates in all Local Authorities in Cheshire and Merseyside – except Cheshire East and Warrington – are higher than in England
- Of concern is the widening inequality in smoking behaviour, both nationally and locally. In some of our boroughs, residents are four times as likely to smoke if they are in routine and manual occupations, compared to those in managerial and professional occupations
- Smoking during pregnancy remains a significant issue. Even though smoking prevalence amongst pregnant women has fallen, rates generally are higher in Cheshire and Merseyside than the England average
- 2019/20 data illustrates that between 43.8% and 55% of adults in Cheshire and Merseyside local authorities eat the recommended five or more daily portions of fruit and vegetables, compared with 51.2% in the North-West and 55.4% in England. Overall, there has been a slight decline in most recent years, between 2015/16 and 2019/20, both locally as well as regionally and nationally
- Data from the National Childhood Measurement Programme shows that Cheshire and Merseyside had a significantly higher prevalence of excess weight than England in both Reception-age children and in those in Year 6 in 2019/20. Overweight children and adolescents are around 5 times more likely to become obese adults than those who their non-obese peers
- 2018/19 data shows between 64.9% - 73.7% of adults (aged 18+) are overweight or obese. Rates are statistically significantly higher than the England average in Knowsley, Halton, St Helens, and Liverpool. The other boroughs are statistically similar even though the England rate is lower than any of the Cheshire and Merseyside boroughs (62.3%)
- Only Cheshire East and Cheshire West & Chester have a higher percentage of adults who are physically active compared to the England average
- The rate of hospital admissions related to alcohol is high in Cheshire and Merseyside compared to England. For most local authorities it is statistically significantly higher

Prevention

- Cervical screening declined during the course of the pandemic in both cohorts eligible (those aged 25-49 and 50-64); over the longer time period provided in this report however, (since 2017/18), coverage had increased in younger women in Cheshire and Merseyside overall
- Cervical screening was higher in the older cohort (50-64) compared to younger women (25-49); Liverpool CCG had the lowest coverage of all CCGs in Cheshire and Merseyside and also showed the largest declines over the time period shown (in both age cohorts)
- In 2019/20, more than two in three of all females in Cheshire and Merseyside eligible for breast screening (aged 50-71 were screened for breast cancer (70.5% coverage rate), just exceeding the 70% target
- Data from during the pandemic however (Quarter 3 of 2020/21) shows that compared to the same quarter the year before, breast screening coverage in Cheshire and Merseyside fell by just over 11% (all CCGs decreased)
- The proportion of people screened for bowel cancer in Cheshire and Merseyside between 2009/10 and 2019/20 improved; overall the national target of 60% coverage was exceeded in Cheshire and Merseyside (although coverage was still lower than the England average)
- Bowel screening coverage fell in Cheshire and Merseyside during the pandemic by just under 5% with all CCGs showing a decrease

- There are inequalities in screening uptake for those with severe mental illness (SMI) and those with learning disabilities (LD) compared to those without those conditions. For people with LD the difference is most marked for cervical screening, remains for breast screening but is nearly identical or in some areas better for bowel screening compared to those with no LD

Incidence and Prevalence

- Cancer incidence (newly diagnosed) rates are higher among men than women
- Newly diagnosed cancer rates are higher in nearly all local authorities in Cheshire and Merseyside than England
- Cancer incidence in Cheshire and Merseyside, as with England, have increased steadily in the last 2 decades
- A greater number of cancers in Cheshire and Merseyside are in the most deprived areas
- The majority of cancer in Cheshire and Merseyside are diagnosed early (stage 1 or 2)
- There are more women living with cancer than men, with the majority aged 45 and older
- There was a higher prevalence of diagnosed cancers in Cheshire and Merseyside compared to England overall in 2020/21 (3.21% in England compared to 3.62% in Cheshire and Merseyside)
- Prevalence has risen in Cheshire and Merseyside in recent years, from 3.40% in 2018-19, to 3.55% in 2019-20, to 3.62% in 2020/21 (prevalence has also risen in England, from 2.98% in 2018-19 to 3.13% in 2019-20, and then 3.21% in 2020/21)

Referrals, diagnosis and treatment

- The majority of cancers are diagnosed through 'managed routes' (e.g., urgent GP referrals)
- Around 1 in 5 cancers were diagnosed via emergency presentations and relatively few via screening
- Cheshire and Merseyside has lower bowel, similar breast, and higher cervical screening rates than England (Halton, Knowsley and Liverpool CCGs broadly had the lowest screening rates in Cheshire and Merseyside)
- Cheshire and Merseyside continue to have a lower proportion of cancers diagnosed early than England
- Colonoscopy procedures increased between 2009/10 and 2019/20 (by 69% in Cheshire and Merseyside, versus 49% increase in England) and the majority Cheshire and Merseyside CCGs had higher rates than the England average (only NHS Warrington CCG and NHS Liverpool CCG were lower)
- All but one Cheshire and Merseyside CCG (NHS Liverpool) had rates of sigmoidoscopy higher than the England average; Cheshire and Merseyside overall had rates higher than England and there was an 18% increase in sigmoidoscopy procedures in Cheshire and Merseyside between 2009/10 and 2019/20 (vs a 45% increase in England overall)
- The rate of in-patient or day-case upper GI endoscopy procedures in Cheshire and Merseyside overall was significantly higher than that of England in 2019/20
- All but one Cheshire and Merseyside CCG improved the rate of In-patient or day-case upper GI endoscopy procedures between 2009/10 to 2019/20; the overall Cheshire and Merseyside rate improved by 21% (22% in England) although it should be noted that improvements appear to have levelled off since 2015/16 (reasons for this are unclear)
- Between 2013 and 2018, Cheshire and Merseyside had a lower proportion of cancers diagnosed at an early stage (1 and 2) compared to England
- Cheshire and Merseyside showed a very similar picture to England overall in the proportion of treatment combinations for cancer between 2013-16; around a third of people received 'Other Care' in both England and Cheshire and Merseyside, while the next most common treatment option was 'Tumour Resection' (around 1 in 5 patients in both England and Cheshire and Merseyside had this treatment)

Rapid Registrations

New Cancer Diagnoses

- There was a fairly consistent number of estimated new cancer diagnoses recorded in the rapid cancer registrations dataset in the pre-COVID-19 period up to March 2020, for England and Cheshire and Merseyside
- Following the arrival of COVID-19, the estimated number of new cancer diagnoses per month dropped, to around 64% of the pre-COVID numbers for England and 60% of the pre-COVID numbers for Cheshire and Merseyside
- For June 2020 onwards, the estimated number of new cancer diagnoses increased again from their lowest levels for all cancer groups and by September 2020, the estimated number of diagnoses had reached 95% (for both England and Cheshire and Merseyside) of previous activity for all malignant cancers, excluding NMSC
- For all malignant cancers excluding NMSC, the pattern and size of changes in new cancer diagnoses were similar for most demographic factors, including for both men and women and for all income deprivation quintiles (refers to England level data only)

Surgical tumour resection activity

- There was a reasonably consistent number of surgical tumour resection procedures before the arrival of COVID-19
- Following the arrival of COVID-19, surgical tumour resection activity was much lower than usual for all cancer groups
- The number of surgical tumour resection procedures per month subsequently decreased to around two-thirds of the previous activity for April to May 2020 for all included malignant cancers, to around 67% of the pre-COVID numbers for England and 65% of the pre-COVID numbers for Cheshire and Merseyside
- Since May 2020, surgical tumour resection activity increased for most cancer groups and by December 2020, had reached 91% of previous activity for England and 99% of previous activity for Cheshire and Merseyside for all cancer sites combined (some cancer groups had a higher proportion of previous activity for September or October)
- For all malignant cancers excluding NMSC, the pattern and size of changes in surgical tumour resection activity for all included malignant cancers were similar for most demographic factors (refers to England level data only)

Treatment proportions

- For diagnoses with complete follow-up between January 2018 and February 2021, around 36-39% of all malignant cancers excluding NMSC were recorded as receiving a tumour resection, around 28-31% chemotherapy and 26-28% radiotherapy at England level. Very similar proportions were seen at a Cheshire and Merseyside level with around 36-45% of all malignant cancers recorded as receiving a tumour resection, 26-34% chemotherapy and 25-31% radiotherapy
- For patients diagnosed between December 2019 and March 2020, there was a decrease in the proportion recorded as receiving chemotherapy with an increase for those diagnosed between April and June 2020. A similar pattern was seen for this period for most cancer groups
- For all malignant cancers excluding NMSC and patients diagnosed in 2020, there was a steady decline in the proportion of patients recorded as receiving radiotherapy due to the current availability of follow-up data
- There were similar changes to the patterns of treatment proportions by many demographic factors, including for men and women, for all deprivation quintiles and for all ethnicities (refers to England level data only)

Survival and Palliative Care

Survival

- The gap in survival from cancer between England and Cheshire & Merseyside narrowed considerably between 2003 and 2018 (England historically had higher survival rates compared to Cheshire and Merseyside)
- In fact, in the case of 1 year survival, improvements in Cheshire and Merseyside mean survival rates are now in excess of England (as of 2018)
- Survival from all cancers in Cheshire and Merseyside improved drastically between 2003 and 2018:
 - Around 75% of people survived at least 1 year beyond diagnosis
 - More than 50% survived beyond 5 years beyond diagnosis
 - More than 40% survived over 10 years beyond diagnosis
- Although 1 year survival has improved between 2003 and 2018 (15% improvement in Cheshire & Merseyside overall, compared to 10% improvement in England) in all local CCG areas; it was still however, lower in the more deprived local authorities of Cheshire and Merseyside (e.g., Liverpool, Knowsley and Halton)

Palliative Care

- There were just over 15,000 (or 0.6% of the population of the Cheshire and Merseyside area) on GP palliative care registers in 2021; similar to national prevalence (0.5%)
- Those areas with higher prevalence of older people had the highest prevalence of people on palliative care registers (e.g., Southport & Formby CCG, Wirral CCG)

Mortality

- Around 1 in 3 of people dying with cancer in Cheshire and Merseyside are died at home in 2016-18, slightly higher than England
- Recent research indicates there was public avoidance of hospital care for non-COVID-19 conditions, such as cancer during the pandemic and that this resulted in an increase in deaths at home and a reduction in hospital deaths in cancer patients
- The rate of deaths at home from cancer in Cheshire and Merseyside varied by Local Authority and gender (e.g., highest in Knowsley at 38.6%, lowest in Liverpool at 29.5% for men; highest in Knowsley at 38.4% and lowest in Cheshire East 27.9% for women)
- Avoidable mortality from cancer (deaths among those aged <75) fell all Cheshire and Merseyside Local Authorities between 2001-2003 to 2017-19
- Rates of avoidable mortality from all cancers were consistently higher in the more deprived areas of Merseyside, compared to those in Cheshire
- Rates of avoidable mortality from breast, colorectal and lung cancer mortality were also consistently higher in the more deprived areas of Merseyside, compared to those in Cheshire

Demographics of Cheshire and Merseyside

Population



Cheshire & Merseyside Health & Care Partnership comprises 9 local authorities and 9 CCGs.

All are coterminous apart from:

- Cheshire CCG covers the local authorities of Cheshire East and Cheshire West and Chester.
- Sefton local authority is split into South Sefton CCG and Southport and Formby CCG

It has a total population of just under 2.5 million people.

It is more deprived than England as a whole, although there are significant differences in health

Source: [Cheshire and Merseyside Cancer Alliance, 2021](#)

The Office for National Statistics (ONS) puts the Cheshire and Merseyside resident population at an estimated 2,496,557 people. Liverpool has the largest single population and Halton the smallest.

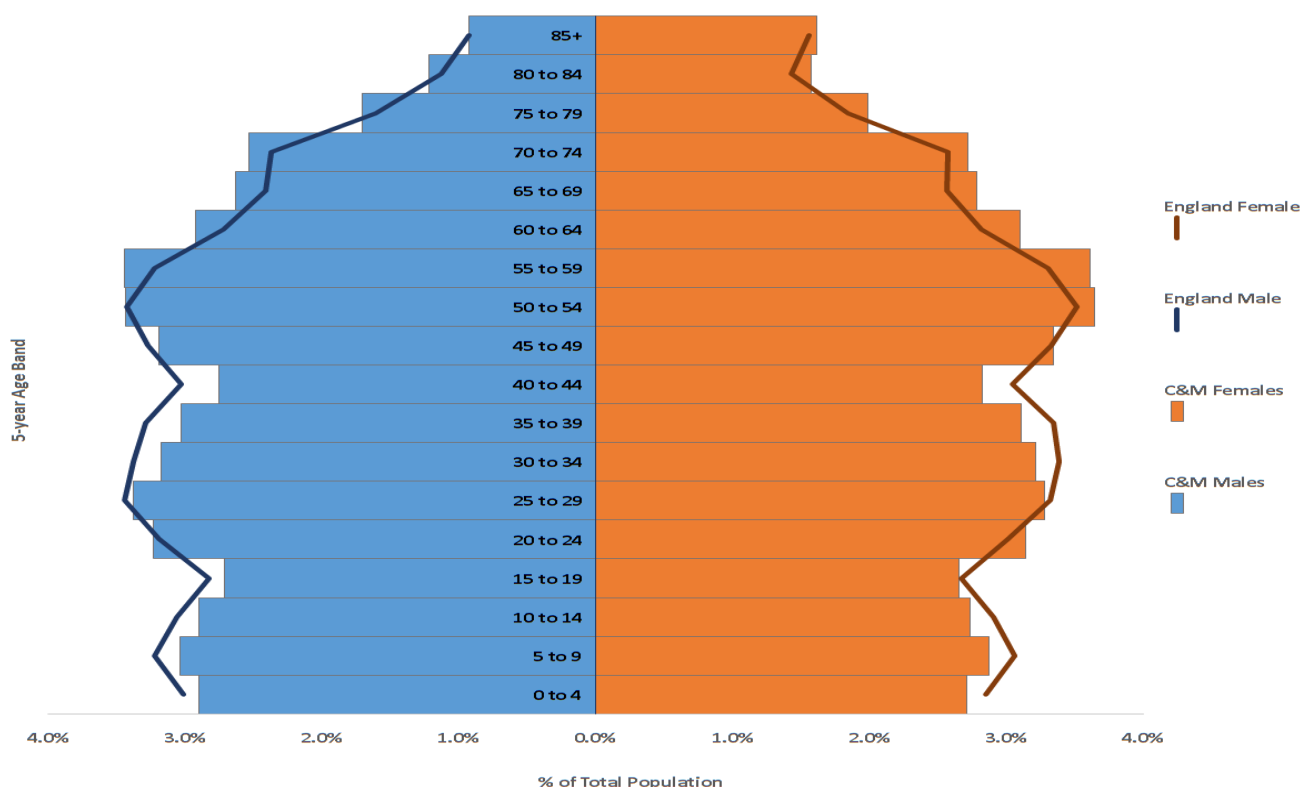
Figure 1: Population age breakdown, 2019 mid-year estimate, England and Comparators, 2021

Age	0 to 17	18 to 24	25 to 49	50 to 64	65 to 74	75+
Cheshire East	20.1%	6.2%	29.0%	21.7%	12.2%	10.8%
Cheshire West and Chester	20.0%	7.6%	29.8%	20.9%	11.7%	9.9%
Halton	22.2%	7.4%	31.8%	20.1%	11.0%	7.4%
Knowsley	22.4%	8.1%	31.3%	20.9%	9.6%	7.7%
Liverpool	19.3%	13.8%	35.1%	17.0%	8.1%	6.6%
Sefton	19.6%	6.8%	28.3%	21.8%	12.0%	11.5%
St. Helens	20.4%	7.3%	31.5%	20.2%	11.4%	9.2%
Warrington	21.1%	7.0%	32.4%	20.6%	10.3%	8.6%
Wirral	20.8%	6.9%	29.5%	20.9%	11.8%	10.1%
Cheshire & Merseyside	20.3%	8.4%	31.1%	20.2%	10.8%	9.2%
England	21.4%	8.4%	32.8%	19.0%	9.9%	8.5%

Source: [ONS](#) via [NOMIS](#), 2021

The proportions in each age group (**Figure 1 and Figure 2**) are fairly similar in each local authority apart from Liverpool which has a higher proportion of its population in the 18-24 age group and slightly lower proportions in the 50 and over age categories. Sefton and Cheshire East have the highest proportion of those aged 75 and over, with the percentage in this age group lowest in Liverpool, Halton, and Knowsley. It is similar to England although it does have slightly lower percentages in the younger age bands and slightly higher percentages from age 50-54.

Figure 2: Proportion of total population in each broad age band, 2019 mid-year estimates, Cheshire and Merseyside compared to England, 2021



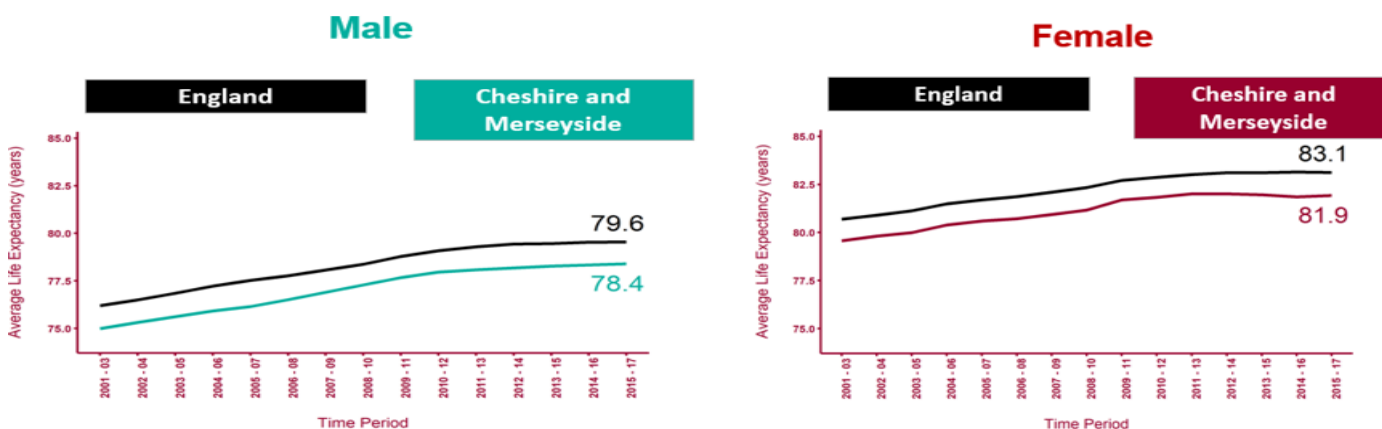
Source: [ONS, 2021](#)

Life expectancy and mortality

2011 marked a turning point in long-term mortality trends in England, with improvements stalling for the first time in 20 years. The emergence of COVID-19 in 2020 will have significant implications for life expectancy.

Healthy life expectancy³ has also increased, but not as much as life expectancy, so more years are spent in poor health. This gap tends to be wider in the most deprived groups.

Figure 3: Trend in life expectancy, comparing England and Cheshire and Merseyside, 2001-03 to 2015-17



Source: PHE Health Inequalities STP pack (not publicly available)

Note: Although data for individual LA's is available for later periods, life expectancy for Cheshire and Merseyside overall is not yet available for later time period than 2015-17

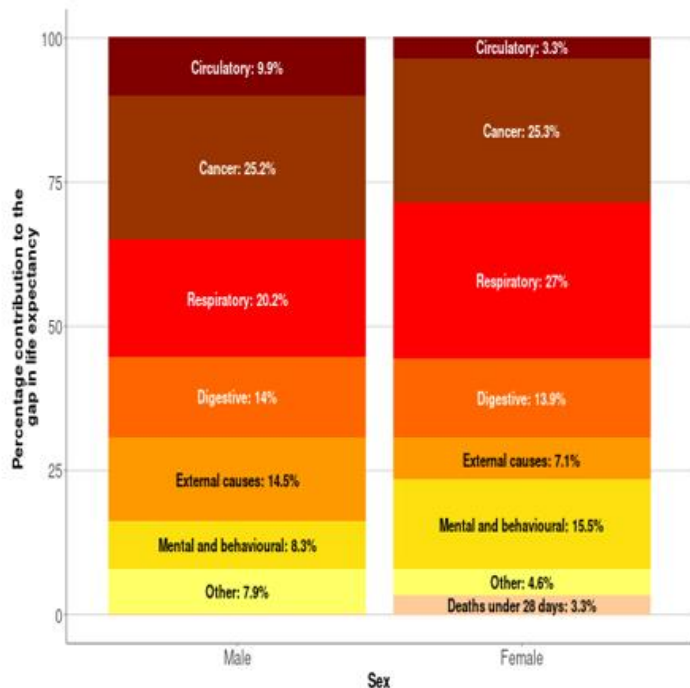
³ Healthy life expectancy is an estimate of the number of years lived in 'very good' or 'good' general health, based on how individuals perceive their general health. Disability-free life expectancy is an estimate of the number of years lived without a long-lasting physical or mental health condition that limits daily activities

In **Figure 3** above, it demonstrates that for both men and women, life expectancy is below the England average for those living in Cheshire and Merseyside . Not only is this persistent inequality worrying but it masks inequalities across the sub-region and within the sub-region.

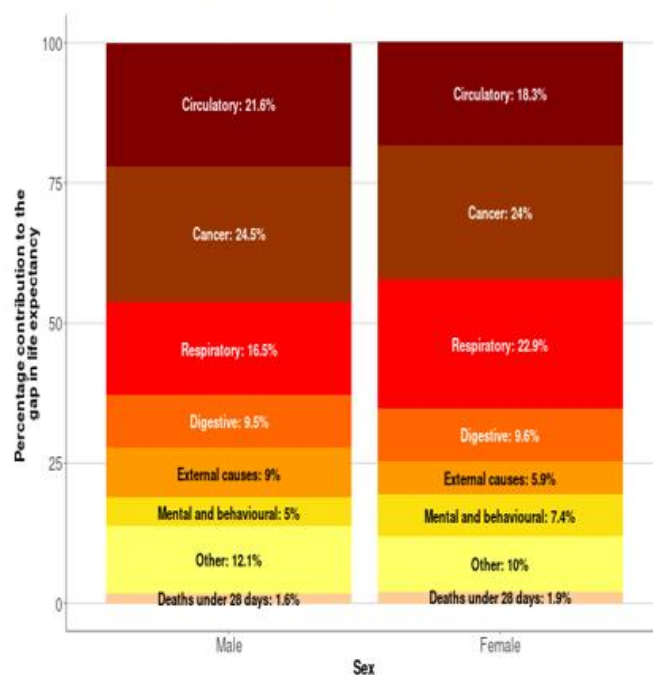
As seen in **Figure 4**, a number of causes account for the majority of the difference, with cancer accounting for around a quarter of the difference compared to England and when comparing the most and least deprived quintiles across Cheshire and Merseyside .

Figure 4: Causes of the gap in life expectancy between Cheshire and Merseyside and England (left) and within Cheshire and Merseyside (right), 2015-17

Scarf chart showing the breakdown of the life expectancy gap between Cheshire and Merseyside as a whole and England as a whole, by broad cause of death, 2015-17



Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Cheshire and Merseyside, by broad cause of death, 2015-17

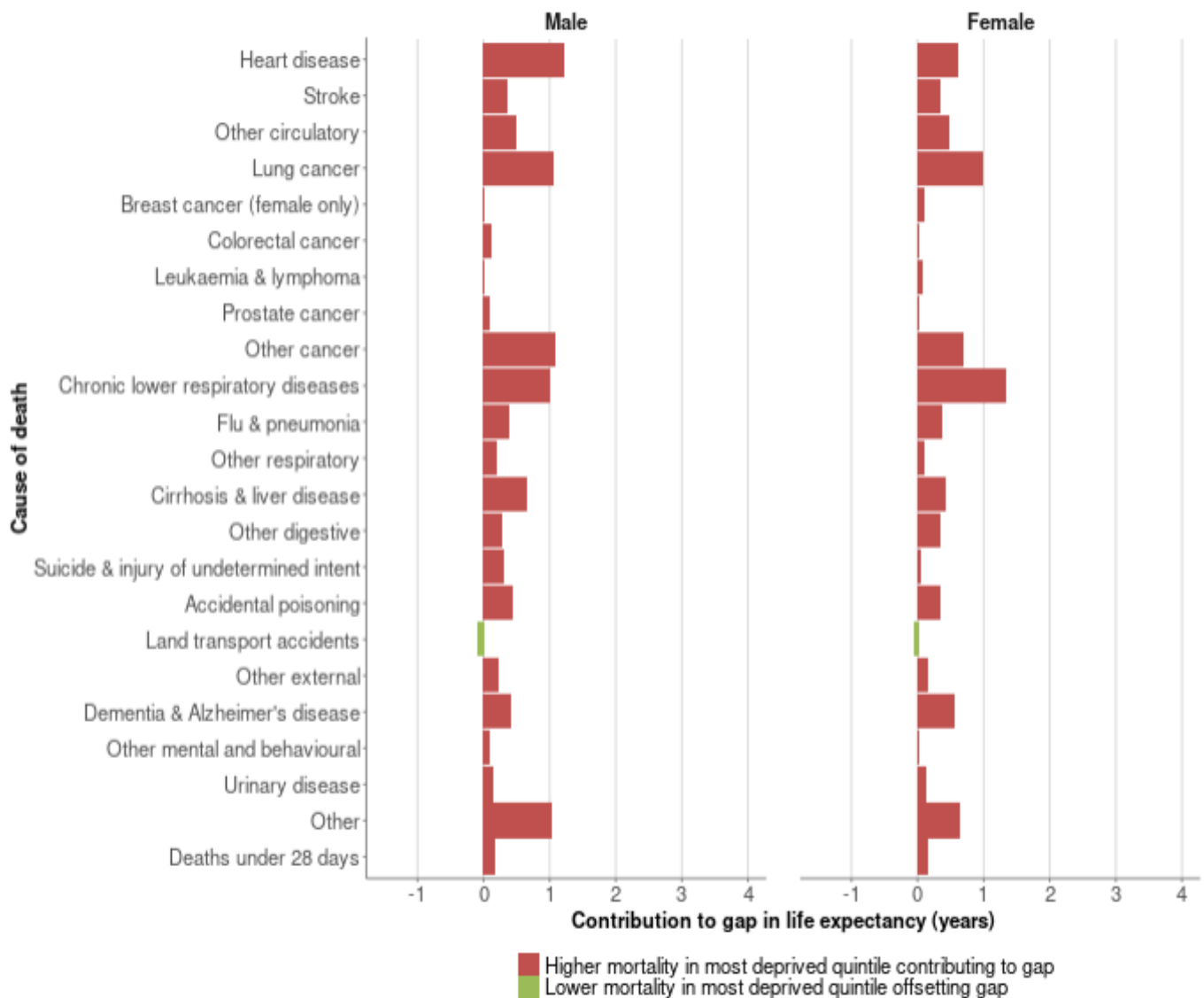


Source: [PHE Segment Tool](#), 2021

Lung cancer is type of cancer that is the most significant contributor when comparing the most and least deprived quintiles across Cheshire and Merseyside , although other cancers not listed separately in **Figure 5** below also make a substantial contribution.

Figure 5: Detailed breakdown of the causes of life expectancy gap across Cheshire and Merseyside , 2015-17

Bar chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Cheshire and Merseyside, by detailed cause of death, 2015-17



Source: Public Health England based on ONS death registration data and mid year population estimates, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2015

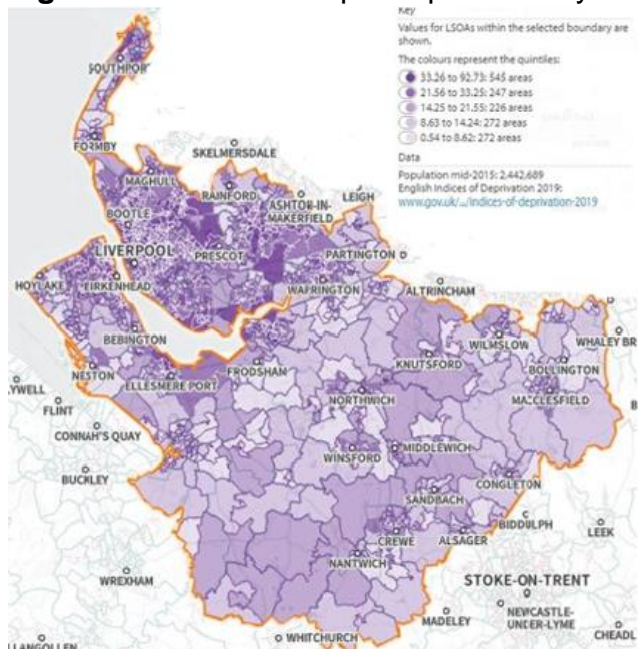
Source: [PHE Segment Tool](#), 2021

Deprivation

Whilst the overall Cheshire and Merseyside combined area is much more deprived than England as a whole, using the national Index of Multiple Deprivation (IMD) 2019, 6 CCGs had scores lower than England and 6 were higher (see Figure 6). Knowsley followed closely by Liverpool, were the most deprived CCG areas within Cheshire and Merseyside, South Cheshire and Eastern Cheshire were the least deprived. Even within CCGs, practice deprivation scores varied considerably.

Note: Deprivation scores are only available for the old Cheshire CCG boundaries i.e. the 4 CCGs that now make up Cheshire CCG.

Figure 6: Index of Multiple deprivation by lower super output area (LSOA) and CCG scores, 2019



Overall IMD 2019 scores per CCG (most deprived to least deprived CCG area) (range of IMD scores of practices in CCG)

- England 21.7
- Cheshire & Merseyside 28.1
- Knowsley 43.0 (range 59.2-25.7)
- Liverpool 42.4 (range 68.7-16.9)
- South Sefton 32.6 (range 59.3-11.7)
- Halton 32.3 (range 45.0-17.6)
- St. Helens 31.5 (range 45.7-13.1)
- Wirral 29.6 (range 58.6-9.8)
- Southport & Formby 19.4 (range 31.3-9.4)
- Vale Royal 19.2 (range 30.9-12.6)
- Warrington 18.9 (range 36.4-7.1)
- West Cheshire 17.6 (range 38.9-7.1)
- South Cheshire 17.0 (range 27.7-9.2)
- Eastern Cheshire 12.2 (range 17.5-4.6)

Source: [PHE SHAPE tool](#)

Risk Factors

Whilst the aetiology of cancer is multi-factorial and complex, there are a number of factors that can increase the risk of developing the disease.⁴ A risk factor can be broadly categorised as either 'modifiable' where the factor is avoidable or 'non-modifiable' where the factor is inevitable. Where a risk factor is non-modifiable, little can be done to circumvent its effects; in cancer, this would include risk factors such as age, sex, and genetic make-up.

Therefore, it is the modifiable risk factors which are central to cancer prevention strategies, and which have therefore been detailed in this document. This includes lifestyle factors such as smoking, poor diet, physical inactivity, obesity and high alcohol consumption or exposure to carcinogenic chemicals, radiation, and infections.

Whilst deprivation may be modified as a risk factor, this is dependent on population-level, social, economic, and political policies and interventions that influence the wider determinants of health such as education and employment and welfare benefits rather than actions of individuals (hence it has been included in this document under 'Demographics' rather than 'Risk Factors', despite there being a good case for it being a risk factor).

Changing population-level exposure to modifiable risk factors is a key driver of changing cancer incidence. Using the evidence-base to calculate population attributable fractions (PAF), 2015 UK research⁵ found tobacco and overweight/obesity remain the top contributors of attributable cancer cases. Tobacco smoking has the highest PAF (14.7%; 12.1% in females and 17.3% in males) because it greatly increases cancer risk and has a large number of cancer types associated with it. Overweight/obesity has the second-highest PAF because it affects a high proportion of the UK population and is also linked with many cancer types. Obesity had a PAF of 6.3%, slightly higher in females at 7.5% than males at 5.2%.

⁴ S Steel N, Ford J, Newton J, Davis A, Vos T, Naghavi M et al. (2018) Changes in health in the countries of the UK and 150 English Local Authority areas 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *The Lancet*. 392 (10158), 1647-1661.

⁵ Brown KF et al The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015 *British Journal of Cancer* (2018) 118:1130–1141; <https://doi.org/10.1038/s41416-018-0029-6>

Smoking & Tobacco

Smoking can increase the risk of numerous different illnesses and can increase the likelihood of developing long-term health conditions. The risk of cancer, specifically cancers of the respiratory system can increase substantially if somebody smokes, and therefore reducing the prevalence of smoking in our population is vital in improving population health in Cheshire and Merseyside.

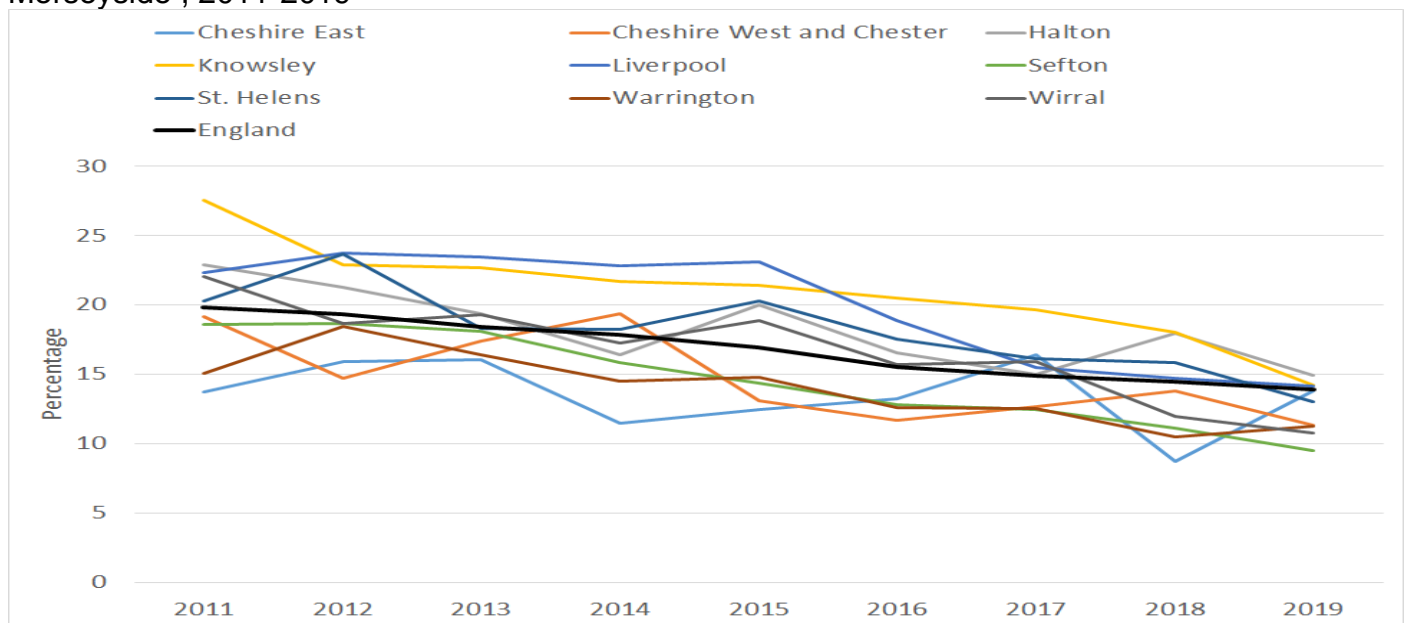
Tobacco remains the leading cause of death and disability in the North-West, contributing to cardiovascular disease and stroke, COPD, as well as lung and other cancers.

Smoking prevalence amongst young people is unknown at a local level. Nationally, survey data shows around 5-6% of 15 year olds are regular or occasional smokers (Smoking, Drinking and Drug Use Among Young People in England, SDD survey 2018)⁶. There has been a significant reduction from 2004 when 21% of 15 year olds identified themselves as regular smokers. Estimates from the 2019 Annual Population Survey suggested that:⁷

- In the UK, 15.9% of men smoked compared with 12.5% of women.
- Those aged 25 to 34 years had the highest proportion of current smokers (19.0%).
- In the UK, around 1 in 4 (23.4%) people in routine and manual occupations smoked, this is around 2.5 times higher than people in managerial and professional occupations (9.3%).
- In Great Britain, more than half (52.7%) of people aged 16 years and above who currently smoked said they wanted to quit

After many years when smoking prevalence across Cheshire and Merseyside was significantly higher than the England average, great strides have been made in reducing adult smoking prevalence. As **Figure 7** suggests, Cheshire East, Cheshire West & Chester, Warrington, and Sefton rates have consistently been below or similar to the England rates. In contrast those in the Liverpool City Region apart from Sefton have been higher until recently. For 2019 Warrington, Wirral and Sefton's rate was statistically better than England and all the others were statistically similar to England.

Figure 7: Trend in smoking prevalence, based on annual population survey data, Cheshire and Merseyside, 2011-2019



Source: [PHE Fingertips Health Profiles](#), 2021

⁶ Note that the Smoking Drinking and Drug Use Survey 2020 fieldwork was cancelled due to the coronavirus (COVID-19) pandemic. It will now go ahead Autumn 2021.

⁷ <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019>

However, there are a range of sources of smoking prevalence statistics so giving absolute figures is difficult. Typically, as described in **Figure 8**, rates are highest in Halton, Knowsley, and Liverpool, reflecting the relationship between smoking and deprivation, with these areas also having the lowest levels of the population who have never smoked. Those in routine and manual occupations have higher smoking prevalence. Interestingly for this indicator, it is the two most affluent boroughs where rates are highest.

Figure 8: Smoking prevalence across Cheshire and Merseyside local authorities (2018/19)

Indicators	Smoking prevalence in adults (15+) - current smokers	Smoking Prevalence in adults (18+) - current smokers	Smoking prevalence in adults (18+) - current smokers	Smoking Prevalence in adults (18+) - never smoked	Smoking prevalence in adults (18+) - never smoked	Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers	Smoking prevalence in adults with a long term mental health condition (18+) - current smokers	Smoking status at time of delivery
Source	QOF (note 2019/20 QOF does not include prevalence)	Annual Population Survey (APS)	GP Patient Survey (GPPS)	Annual Population Survey (APS)	GP Patient Survey (GPPS)	Annual Population Survey (APS)	GP Patient Survey (GPPS)	NHS Digital
Year	2018/19	2019	2018/19	2019	2018/19	2019	2018/19	2018/19
England	16.5%	13.4%	15.2%	62.2%	61.6%	23.2%	26.9%	10.3%
Cheshire East	14.2%	17.8%	12.0%	57.2%	59.4%	29.2%	26.6%	10.9%
Cheshire West and Chester	14.9%	14.5%	12.4%	62.0%	58.9%	28.1%	26.0%	10.6%
Halton	19.2%	18.0%	16.8%	56.0%	52.8%	23.5%	23.1%	17.3%
Knowsley	21.1%	15.3%	16.6%	55.7%	55.7%	19.9%	33.3%	14.6%
Liverpool	20.4%	15.1%	18.7%	59.5%	56.3%	23.2%	34.0%	13.0%
Sefton	16.3%	12.2%	12.4%	63.6%	57.2%	19.0%	21.3%	12.9%
St. Helens	16.8%	15.8%	14.9%	60.6%	55.1%	22.8%	20.4%	16.2%
Warrington	15.4%	15.1%	13.8%	61.6%	58.4%	23.4%	24.3%	8.1%
Wirral	16.7%	13.6%	14.2%	60.8%	56.0%	21.4%	27.3%	13.9%

Source: [PHE Fingertips Health Profiles](#), 2021

Of concern is the widening inequality in smoking behaviour, both nationally and locally. As seen in **Figure 9** below, residents in some boroughs of the sub-region, are four times more likely to smoke if they are in routine and manual occupations, compared to those in managerial and professional occupations.

Figure 9: Gap in smoking prevalence between overall prevalence and prevalence amongst routine and manual workers, Cheshire and Merseyside (2019)



Smoking prevalence in adults (18-64) - socio-economic gap in current smokers (APS) 2019

Area	Recent Trend	Count	Value
England	—	-	2.46
C&M	—	-	-
Warrington	—	-	4.22
Cheshire West and Chester	—	-	4.07
St. Helens	—	-	3.85
Sefton	—	-	3.52
Cheshire East	—	-	3.37
Wirral	—	-	3.20
Liverpool	—	-	3.10
Knowsley	—	-	2.21
Halton	—	-	2.21

Source: [PHE Fingertips Health Profiles](#), 2021

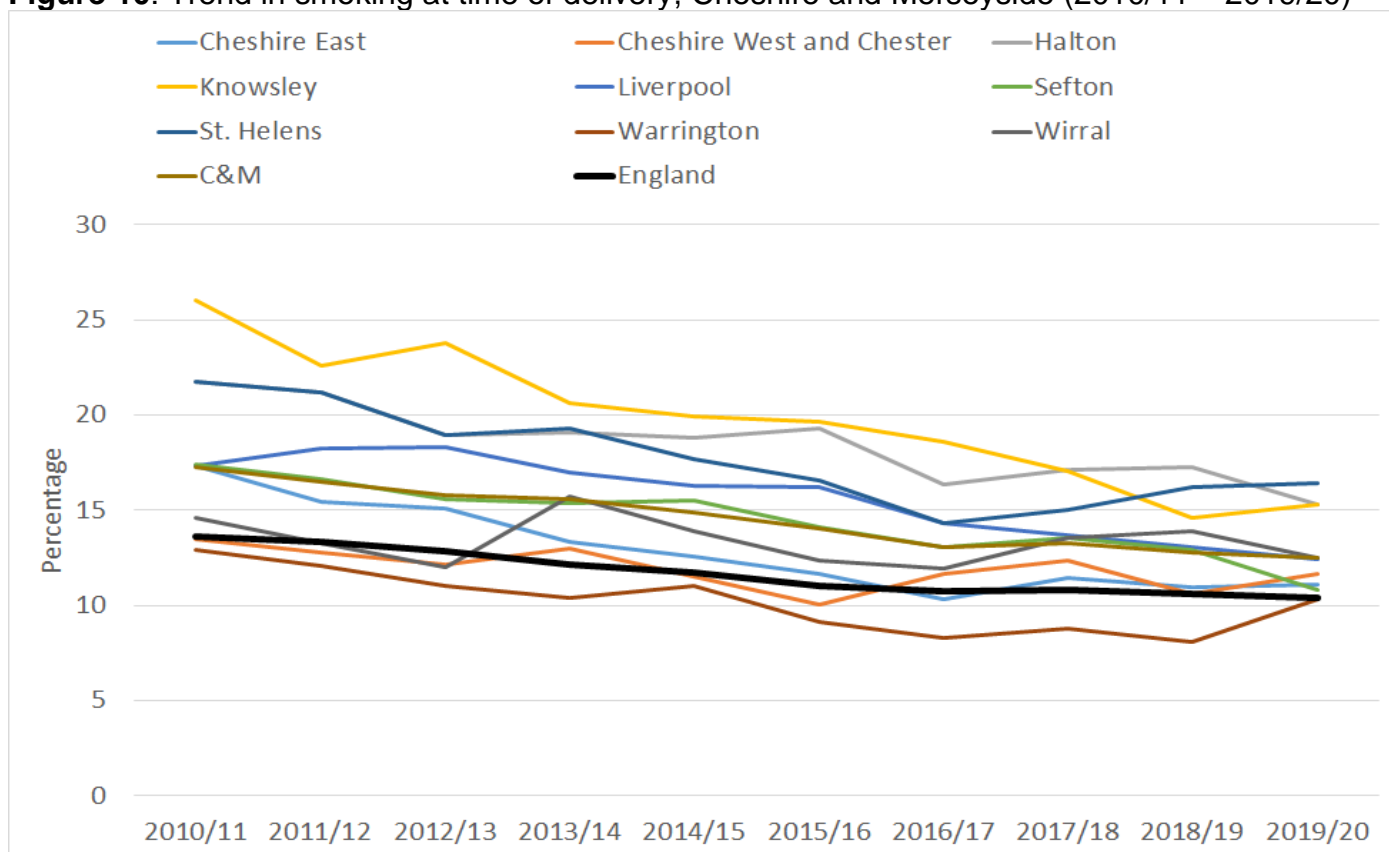
While Cheshire and Merseyside rates seem to be improving, smoking remains a major cause of morbidity and mortality in the region and those in routine and manual occupations are much more likely to be exposed. However, most smokers want to quit, and efforts must continue to support them to do so.

Smokers that manage to quit reduce their lifetime health and social care costs by 48% and the biggest short-term savings come from helping those in contact with the NHS to stop smoking. Delivering assessment, very brief advice (VBA) and referral during every patient episode in secondary care would increase quit rates and be cost-saving within 5 years.⁸

Smoking in pregnancy

As with overall population prevalence, the proportion of women recorded as smoking at time of delivery has reduced in recent years (**Figure 10**). However, apart from Warrington and to a lesser extent both Cheshire East and Cheshire West & Chester, rates have consistently been higher than the national average.

Figure 10: Trend in smoking at time of delivery, Cheshire and Merseyside (2010/11 – 2019/20)



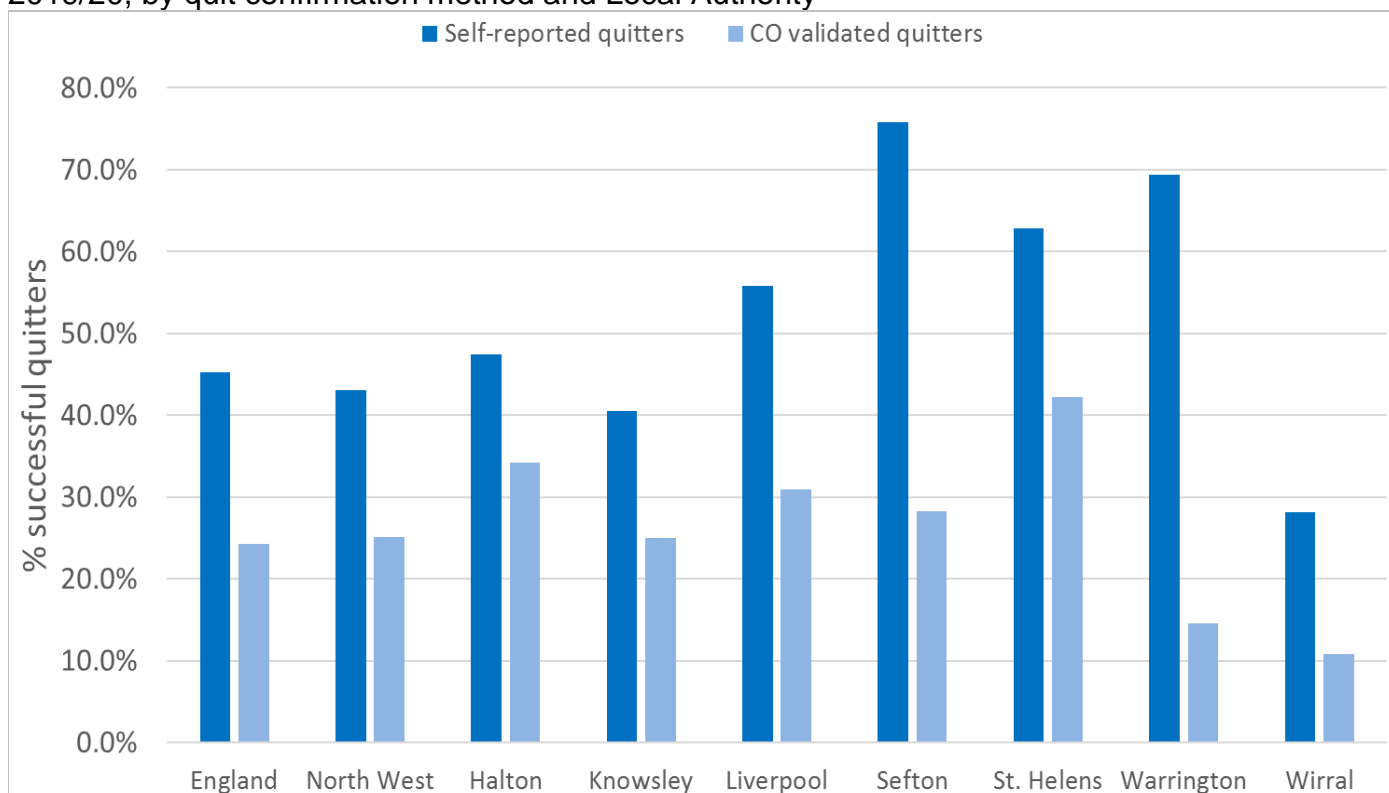
Source: [PHE Fingertips Health Profiles](https://www.phe.gov.uk/publications/fingertips/health-profiles/), 2021

As with the general population quit rates, there is variance among the successful quitting among women smoking during pregnancy (see **Figure 11**). St Helens had the highest Carbon Monoxide (CO) validated quit rate in this population group, with around 2 in every 5 pregnant women quitting smoking (42.3%). This is in contrast to around 1 in every 10 pregnant women successfully quitting in Wirral (10.8%). Again, the disparity between self-reported and CO validated quit rates is seen in this specific population group, as it was for all adults.

Across Cheshire and Merseyside, around half, or 1 in every 2 pregnant women self-reported successful smoking quit.

⁸ <https://www.gov.uk/government/publications/local-health-and-care-planning-menu-of-preventativeinterventions>

Figure 11: Percentage of pregnant women successfully quitting smoking during pregnancy, 2019/20, by quit confirmation method and Local Authority



Source: NHS England, 2021

Note: No data available for Cheshire East or Cheshire West and Chester (not submitted)

Smoking on admission to hospital

Although comparable data for levels of smoking upon admission to hospital is not routinely available for all hospitals in the Cheshire and Merseyside, some hospital sites are now part of the CURE initiative. CURE is a Secondary Care led programme of supporting patients to quit smoking. [Based on the Ottawa model, and further developed in Greater Manchester](#), the CURE programme engages all patients entering a hospital about their tobacco addiction.

Importantly, it treats tobacco addiction as a medical issue, rather than treating it as a lifestyle choice. Clinicians receive training in how best to approach patients about their addiction. They are also provided with the tools to appropriately and effectively refer patients to stop smoking services in their area. CURE is currently adopted in Liverpool and Mid-Cheshire hospital trusts, and the Cancer Alliance is working with the ICS (Integrated Care System) and national funding, to further roll out this highly effective model of intervention in the Cheshire and Merseyside region.

Diet

The 2020 World Cancer Report from WHO⁹ states that whilst some of the recent evidence has not supported earlier beliefs, for example that high total fat intake and low intake of fruits and vegetables are key cancer risk factors, other factors related to nutrition, such as overweight and alcohol consumption, have emerged as clearly important, and evidence for a role of overall healthy dietary patterns has strengthened. An estimated 1 in 20 cancers could be prevented by people eating healthier diets with obesity being a contributing cause to over 13 different types of cancer ([Cancer Research UK, 2021](#)).

⁹ <https://publications.iarc.fr/586>

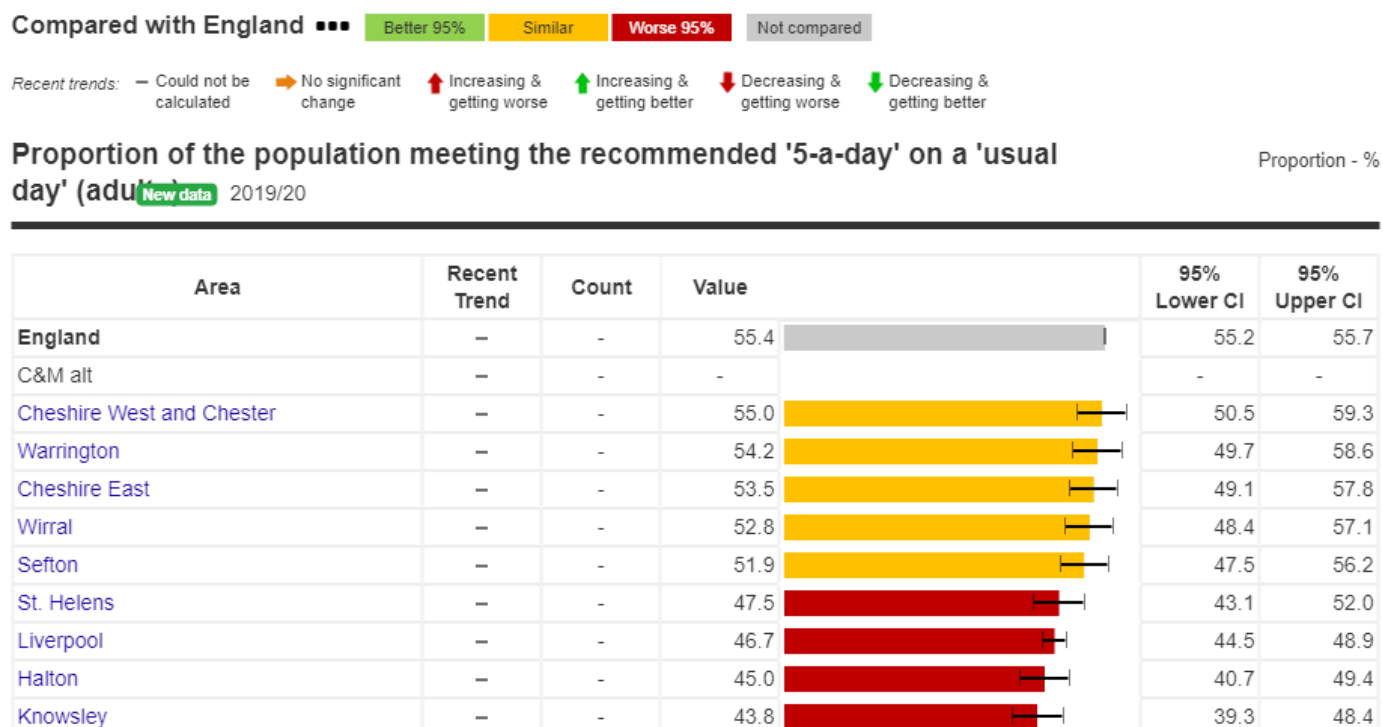
Although the evidence that fruits and vegetables independently decrease cancer risk has weakened during recent decades, there remains sufficient evidence to conclude that greater consumption of non-starchy vegetables or fruits probably protects against several cancers of the aerodigestive tract, higher concentrations of β -carotene, α -carotene, and other carotenoids found in fruits and vegetables are associated with lower risk of more aggressive and deadly breast tumours, including oestrogen receptor-negative breast tumours, that consumption of whole grains (i.e. grains in which 100% of the original kernel is retained) decreases risk of colorectal cancer

Studies of specific nutrients and foods provide important insights on diet and cancer, but studies of overall dietary patterns may provide the most useful guidance for individuals and policies. A dietary pattern that emphasizes abundant intake of fruits and vegetables, whole grains rather than refined grains, and low intake of red meat and processed meat, sugar-sweetened beverages, and salt will reduce risk of cancer, as well as of cardiovascular disease, diabetes, and overall mortality. This is why meeting dietary guidelines on intake of fruit and veg is an indicator which is reported by PHE.

Although research on the relationship between diet after the diagnosis of cancer and survival is still limited, recent evidence supports a benefit on survival from the same dietary pattern recommended to lower risk, for at least some cancer types.

2019/20 data (**Figure 12** below) illustrates that between 43.8% (Knowsley) and 55.0% (Cheshire West & Chester) of adults in Cheshire and Merseyside local authorities eat the recommended five or more daily portions of fruit and vegetables, compared with 51.2% in the North-West and 55.4% in England. Overall, there has been a slight decline in most recent years, between 2015/16 and 2019/20, both locally as well as regionally and nationally.

Figure 12: Adult 5-a-day consumption across Cheshire and Merseyside compared to England. 2019/20



Source: [PHE Fingertips Health Profiles](#), 2021

All of our areas have higher levels of obesity than the England average. In four of the nine local authorities the level is statistically significantly higher.

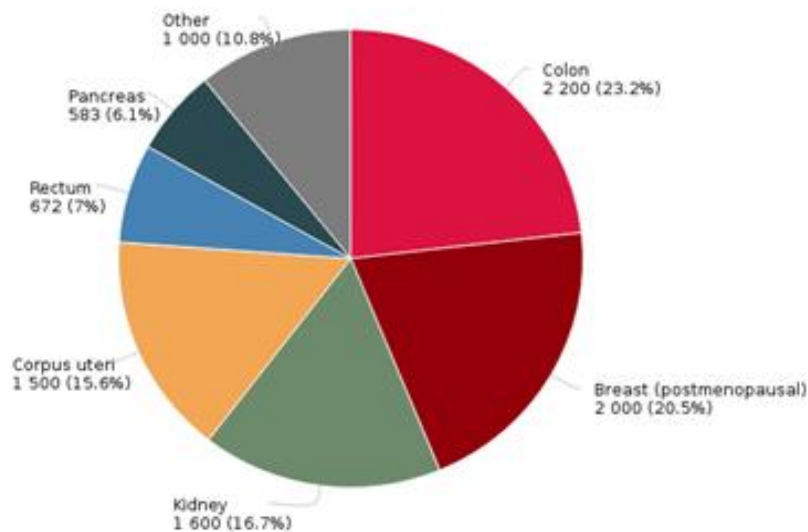
Adults

Being overweight or obese and having a poor diet are the most preventable causes of cancer after smoking, linked to 6.3% and 4.7% of cancers in the UK respectively.¹⁰ Obesity increases the risk of several cancers including bowel, uterine, kidney, liver, oesophageal, pancreatic and breast after the menopause.¹¹ As well as the implications for body fat content, a healthy diet has been shown to be protective against cancer. Diets high in fibre, fruit, and vegetables and low in processed or red meat have been linked to a lower risk of bowel and other cancers.⁷ Overweight and obesity is related to access to and uptake of a healthy diet as well as exercise and other health factors.

Although smoking is currently the major cause of preventable cancer cases and accounts for 22% of cancer deaths, a 2018 report from Cancer Research UK¹² estimated that high BMI (overweight and obesity) now causes more cases of four common cancers (bowel, kidney, ovarian, and liver) in the UK than does smoking, and could overtake smoking as the biggest cause of cancer in women in the UK by 2043. The success in reducing smoking prevalence has been mirrored by an increase in the proportion of children and adults who are overweight and obese.

WHO have calculated (**Figure 13**) how many 2012 cases of cancer (and what proportion of the total number) could have been prevented if mean body mass index had remained at 1982 levels. The analysis clearly demonstrates the impact overweight, and obesity have on cancer levels.

Figure 13: Estimate number and percentage of cancers that could have been prevented across Western Europe if body mass index had remained at 1982 levels comparison in 2012



Data source: GLOBOCAN 2012
Graph production: SARC
World Health Organization



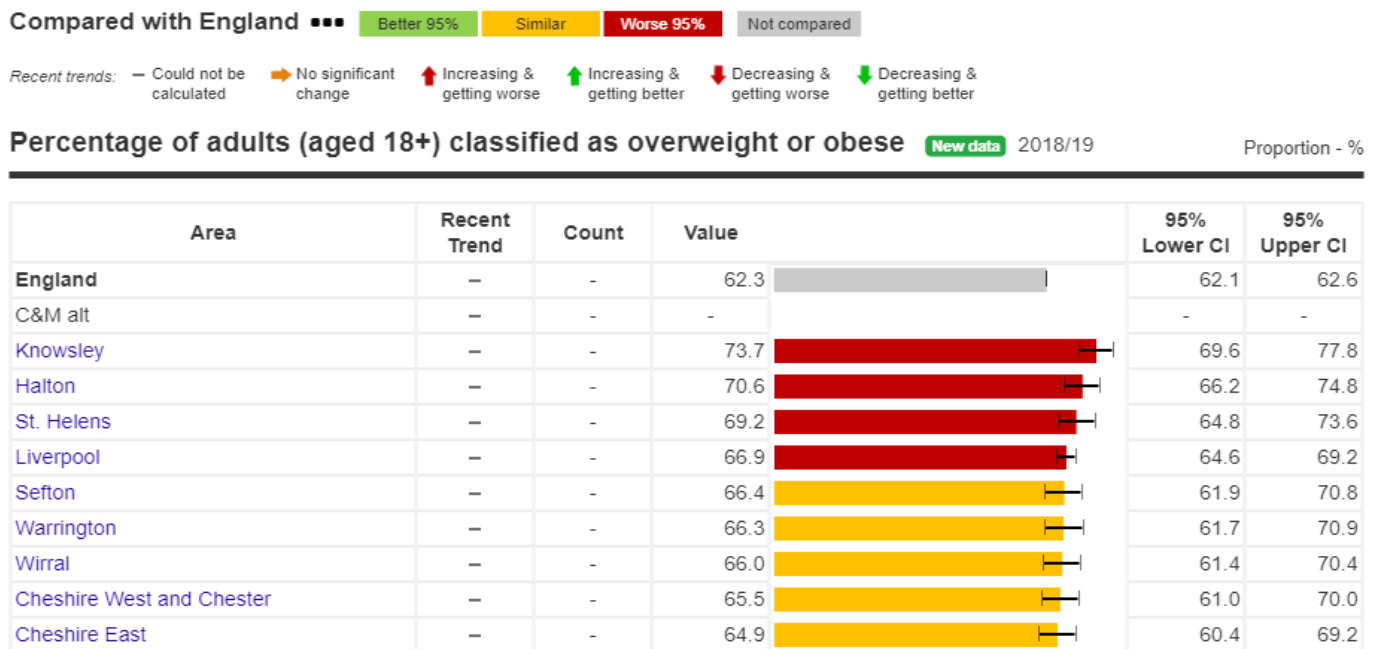
Source: [WHO, 2021](#)

¹⁰ Cancer Research UK (2015). Statistics on Preventable Cancers. Available at: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading-Zero>

¹¹ Macmillan Cancer Support. Age, lifestyle, diet and reducing your risk. Available at: <https://www.macmillan.org.uk/information-and-support/diagnosing/causes-and-risk-factors/potential-causes-of-cancer/age-lifestyle-diet-reducing-risk.html#2957>

¹² https://www.cancerresearchuk.org/sites/default/files/obesity_tobacco_cross_over_report_final.pdf

Figure 14: Percentage of adults who are overweight and obese, Cheshire and Merseyside, 2018/19



Source: [PHE Fingertips Health Profiles](#), 2021

Data indicates that those with obesity are particularly vulnerable to COVID-19 with many intensive care admissions and deaths being in those who are overweight or obese. Lockdowns and local restrictions may have increased sedentary behaviour, but there also appears to have been an increased uptake of walking and cycling. Many cycling infrastructure projects have proven very popular and the uptake of active transport as well as activity for leisure should be encouraged. Data for 2018/19 suggests that all areas of Cheshire and Merseyside have higher levels of adults classified as overweight or obese than England average (**Figure 14**).

Children and young people

Data from the National Childhood Measurement Programme show that Cheshire and Merseyside have a significantly higher prevalence of excess weight than England in both Reception (age 4/5) and in those in Year 6 (age 10/11) (**see Figure 15 and Figure 16 below**). Halton, Knowsley, St. Helens, and Liverpool had higher obesity rates than the England average at both ages, with Sefton higher at year 6. Overweight children and adolescents are around 5 times more likely to become obese adults than those who are not obese¹³.

Education of children and parents will have a marginal impact on these rates, as the causes of obesity are complex and extend beyond knowledge and information. The government updated their childhood obesity action plan in 2017, with measures such as the soft drinks levy, product reformulation, improved labelling and help for school sports¹⁴. Much of the action needed are at national level, especially those that limit the acceptability, availability and affordability of unhealthy and high calorie food and drinks. However, local organisations can do much to make the healthy choice the easy choice and to increase access to physical activity in schools and communities.

¹³<https://pubmed.ncbi.nlm.nih.gov/26696565/#:~:text=Obese%20children%20and%20adolescents%20were,be%20obese%20over%20age%2030>

¹⁴<https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action/childhood-obesity-a-plan-for-action>

Figure 15: Obesity in Reception children, Cheshire and Merseyside, 2019/20

Area	Recent Trend	Count	Value
England	↑	39,404	9.9
C&M	↑	1,105	11.3*
Halton	→	160	14.3*
Knowsley	→	155	13.8*
St. Helens	→	165	12.1*
Liverpool	→	270	11.6*
Sefton	→	90	10.0*
Wirral	→	135	9.5*
Warrington	→	130	8.5*
Cheshire East	-	-	*
Cheshire West and Chester	-	-	*

Source: [PHE Fingertips Health Profiles](#), 2021

2019/20 data is not published for Cheshire East or for Cheshire West and Chester but the prevalence of obesity at Reception in 2018/19 was 9.1% in both areas.

Figure 16: Obesity in Year 6 children, Cheshire and Merseyside, 2019/20

Area	Recent Trend	Count	Value
England	↑	103,362	21.0
C&M	↑	3,845	23.7*
Knowsley	→	350	27.2*
St. Helens	→	415	25.8
Liverpool	→	1,195	25.7
Halton	→	275	25.7*
Sefton	→	630	22.7
Wirral	→	700	20.7
Warrington	→	280	18.7*
Cheshire East	-	-	*
Cheshire West and Chester	-	-	*

Source: [PHE Fingertips Health Profiles](#), 2021

Note: 2019/20 data is not published for Cheshire East or for Cheshire West & Chester due to missed data submission date but the prevalence of obesity at Year 6 in 2018/19 were 17.9% and 19.4% for those authorities respectively.

Physical activity

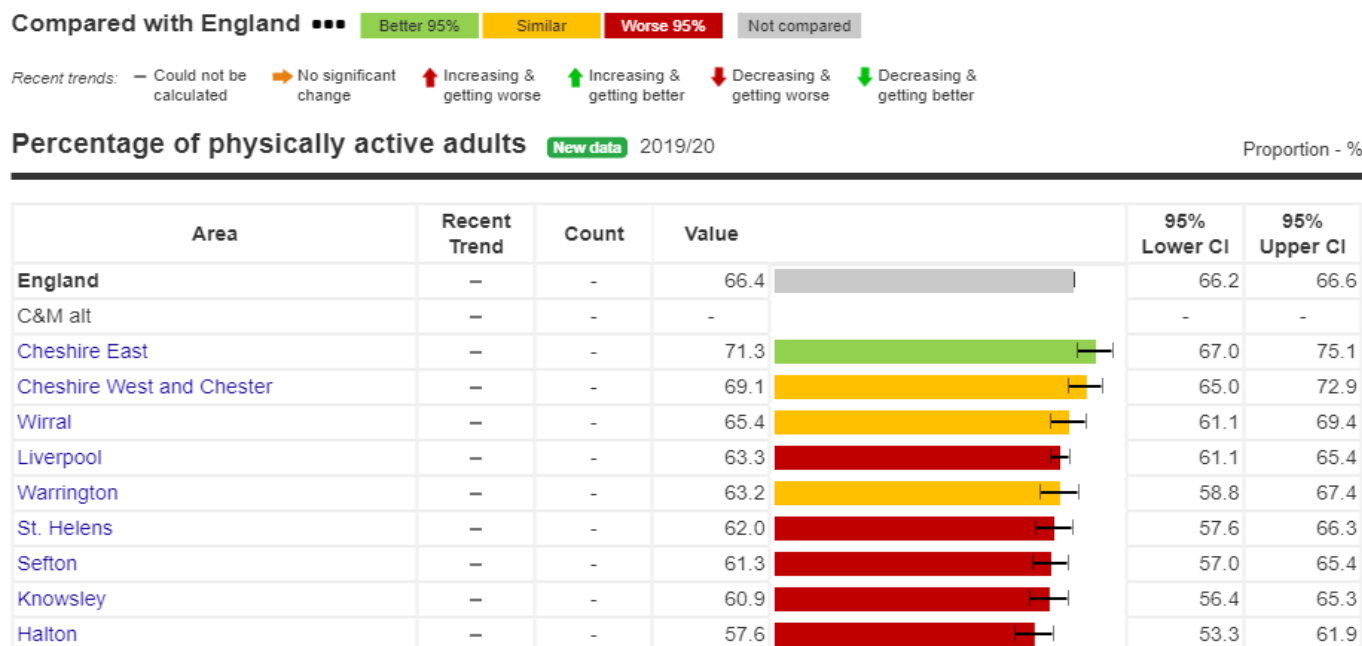
Physical inactivity increases the risk of bowel, uterine and post-menopausal breast cancer, accounting for 0.5% of cancers in the UK. Maintaining regular levels of physical activity is therefore a protective factor against cancer.

The Chief Medical Officer (CMO) currently recommends that adults undertake a minimum of 150 minutes (2.5 hours) of moderate physical activity per week, or 75 minutes of vigorous physical activity per week or an equivalent combination of the two (MVPA), in bouts of 10 minutes or more. The overall amount of activity is more important than the type, intensity, or frequency.¹⁵

Across Cheshire and Merseyside the percentage of adults achieving this level is statistically significantly lower than England in five of the nine local authorities (see **Figure 17**). Only Cheshire East and Cheshire West and Chester have levels above the England average.

¹⁵ Department of Health, 2011. Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers see: http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152108/dh_128210.pdf

Figure 17: Percentage of adults achieving Chief Medical Officers (CMO) recommended physical activity levels, Cheshire and Merseyside, 2019/20



Source: [PHE Fingertips Health Profiles](#), 2021

Alcohol consumption

There is increasing debate regarding what constitutes a ‘safe’ or ‘lower risk’ level of alcohol consumption in relation to cancer prevention. Alcohol is a carcinogen and is associated with around three in every 100 cancers (3.3%).⁶ High to moderate consumption increases the risk of cancer of the oesophagus, liver, bowel, and breast.¹⁶

National guidelines recommend that men and women should not regularly drink more than 14 units of alcohol, spread over three or more days, per week to reduce the risk to health.¹⁷ Data on alcohol consumption is no longer available via the PHE Local Alcohol Profiles for England. We only know of the harm alcohol does through things like hospital admissions related to alcohol and deaths associated with its misuse.

From the 2019 Health Survey for England we know that:

- A higher proportion of men than women drink more than 14, up to 50 units (increasing risk) and over 50 units (higher risk) per week: men drinking to increasing risk = 25% compared to women at 12% with men drinking to higher risk = 5% compared to women at 3%
- Levels of increasing risk and higher risk weekly alcohol consumption are higher in the North West and the English average (North East has the highest rates). This is the case for both men and women. In particular 9% of men in the North West drink 50+ units a week. For other categories the difference is 1-2 percentage points.

The rate of hospital admissions related to alcohol is high in Cheshire and Merseyside compared to England. For most local authorities it is statistically significantly higher (**Figure 18**).

¹⁶ Coglianò VJ, Baan R, Straif K, Grosse Y, Lauby-Secretan B et al (2011). Preventable Exposures Associated with Human Cancers. Available at: <https://academic.oup.com/inci/article/103/24/1827/937010>

¹⁷ NHS (2019) Alcohol Units. Available at: <https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/>

Figure 18: Key alcohol indicators for Cheshire and Merseyside, 2021

Better 95% Similar Worse 95% Not compared

Indicator	Period	England	C&M 3	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St. Helens	Warrington	Wirral
Alcohol-related mortality	2018	46.5	-	45.4	48.7	57.0	56.5	67.0	48.5	59.1	47.4	58.9
Alcohol-specific mortality	2017 - 19	10.9	-	8.9	10.9	17.9	14.4	17.6	13.7	17.1	12.3	17.0
Admission episodes for alcohol-related conditions (Narrow)	2018/19	664	-	615	641	863	940	997	912	883	733	895
Admission episodes for alcohol-related conditions (Broad)	2018/19	2367	-	2102	2030	2995	3294	3376	2962	3034	2427	3162
Admission episodes for alcohol-specific conditions	2019/20	644	-	609	642	1105	1164	1360	1187	1117	913	1231
Admission episodes for alcohol-specific conditions - Under 18s	2017/18 - 19/20	30.7	-	37.0	34.3	58.3	44.9	52.7	62.0	81.6	41.2	46.9

Source: [PHE Fingertips Health Profiles](#), 2021

In July 2021, PHE published a report [Alcohol consumption and harm during the COVID-19 pandemic](#) collating data on alcohol consumption and alcohol-related harm in England throughout the coronavirus (COVID-19) pandemic and compares it to data from previous years.

The report's aim is to understand how indicators of alcohol consumption and harm have changed while the social and physical restrictions to prevent and control COVID-19 were in place. These restrictions led to changes in the availability of alcohol, most notably the approximately 31-week closure of on-trade premises, such as pubs and restaurants, during national lockdowns.

The reports include findings and patterns on alcohol consumption, morbidity and mortality and concludes that long-term, sustained action to prevent and reduce liver disease remains a priority for public health, given the stark trends in significantly higher alcoholic liver deaths, likely because of increased consumption among an already at-risk group of heavy drinkers.

It highlights that before the pandemic, there were already increased alcohol-related hospital admissions and deaths and that the pandemic seems to have accelerated these trends.

Prevention

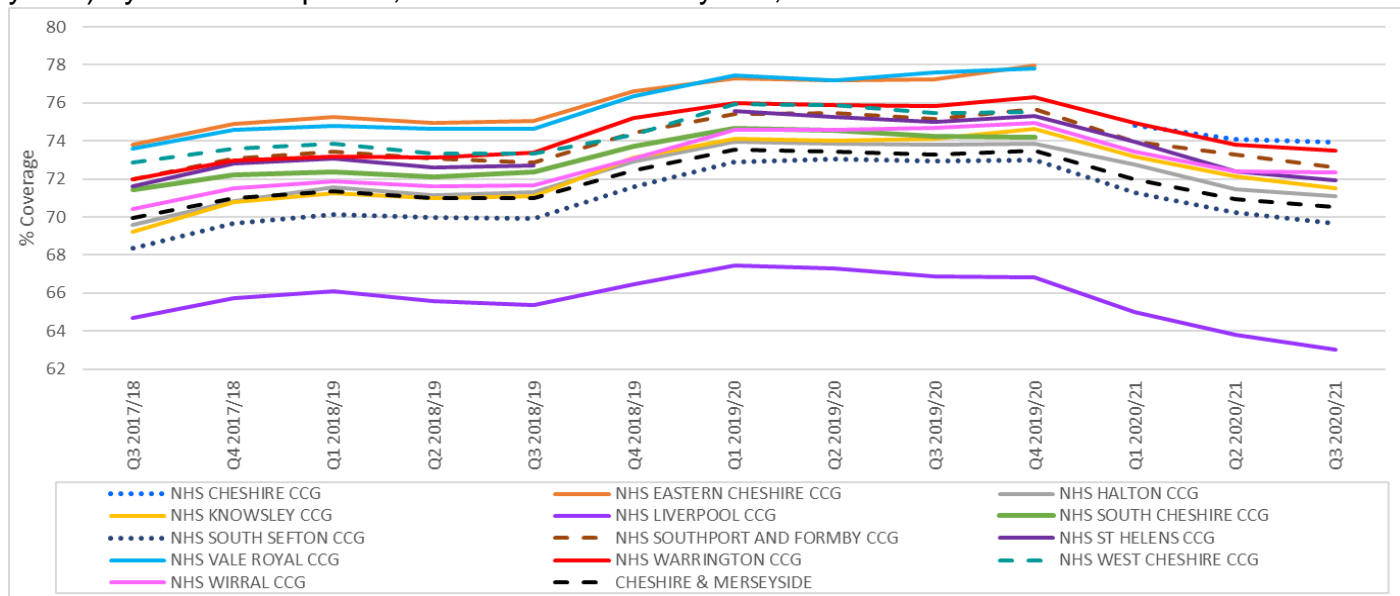
Local and National screening programmes and campaigns such as Be Clear on Cancer, aim to improve uptake of testing and increase early diagnosis of specific cancers. Focused on targeting specific age groups, there are three primary NHS cancer screening programmes running across England: [breast \(women aged from 50 to 71\)](#) cervical (women aged 25-64) and colorectal (bowel; all people aged 60-74).

It should be noted that the age guidelines have changed over time (or will change imminently) to some of these programmes. For example, the bowel cancer screening programme will be expanding to include 56-year-olds from 2021.

Also, although breast screening is ordinarily offered to all women aged 50-71, all women over the age of 71 are still entitled to screening (and can arrange an appointment through their GP or local screening unit).

Cervical Screening

Figure 19: Trend in coverage rate in women aged 25-49 (screened by local authority every 3.5 years) by CCG and quarter, Cheshire and Merseyside, 2017/18 – 2020/21

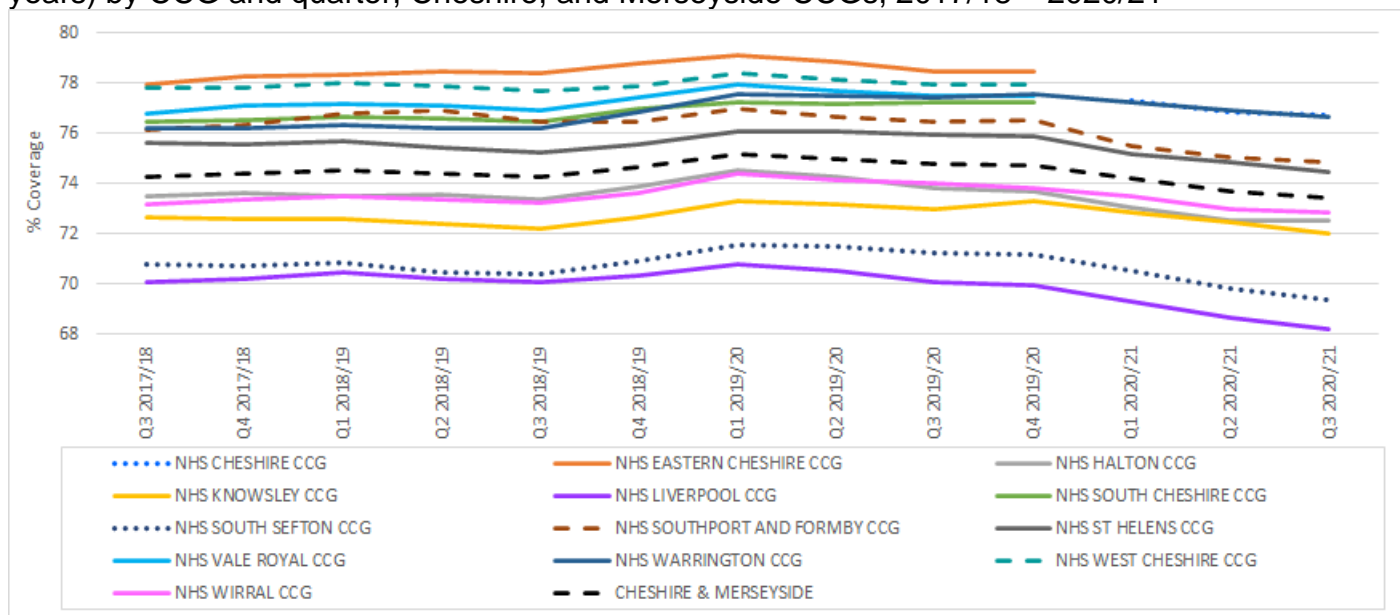


Source: Open Exeter accessed via NHS Digital (not publicly available)

Note: Some areas have incomplete data for the time periods shown due to the amalgamation of several Cheshire CCGs

Although overall coverage in younger women aged 25-49 in Cheshire and Merseyside decreased during the time period covered by the pandemic, it actually increased over the whole time period shown in **Figure 19** above. In Q3 of 2017/18, coverage was 69.9% which increased to 70.5% in Q3 of 2020/21. The largest improvement was seen in NHS Knowsley (increase of 2.3% in coverage), the largest decrease was seen in NHS Liverpool (decrease of 1.6%).

Figure 20: Trend in coverage rate in women aged 50-64 (screened, by local authority every 5.5 years) by CCG and quarter, Cheshire, and Merseyside CCGs, 2017/18 – 2020/21



Source: Open Exeter accessed via NHS Digital (not publicly available)

Note: Some areas have incomplete data for the time periods shown due to the amalgamation of Cheshire CCGs

In contrast with the trend observed in the younger cohort (**Figure 19**), overall coverage in the older cohort of women eligible for cervical screening (aged 50-64) in Cheshire and Merseyside declined both over the whole time period shown in **Figure 20** above (from 74.3% in Q3 of 2017/18 to 73.4% in Q3 of 2020/21), but particularly during the pandemic.

It should be noted however, that overall coverage in the 50-64 cohort in Cheshire and Merseyside (73.4% in Q3 of 2020/21) still out-performs coverage in the 25-49 cohort (70.5% in Q3 of 2020/21).

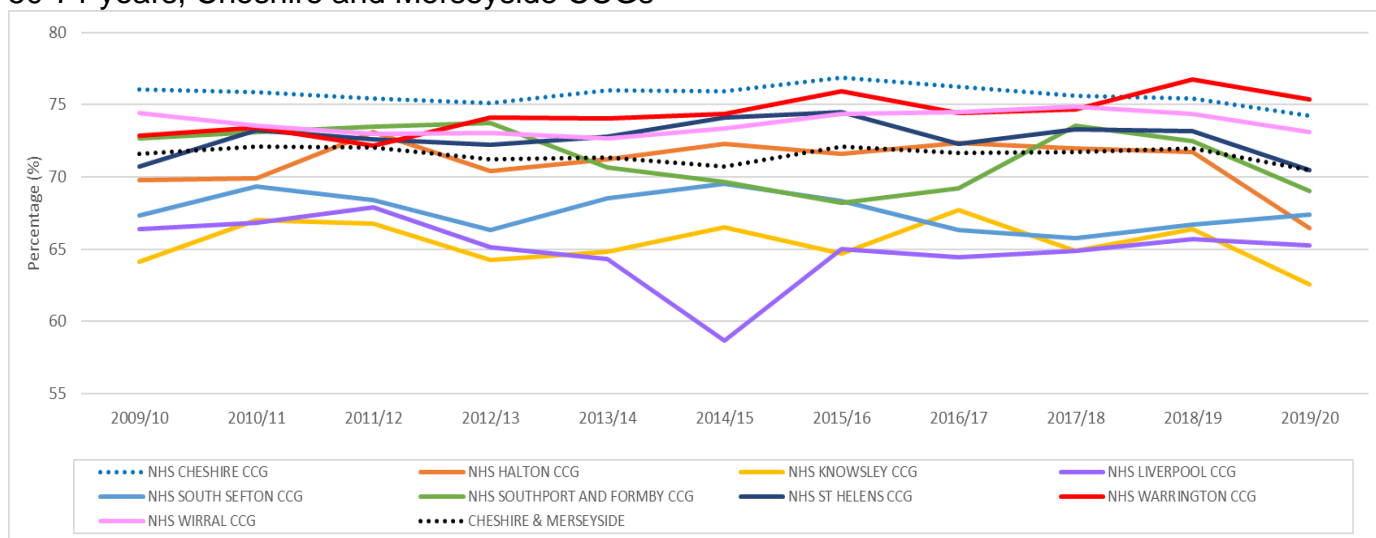
The only area to have observed an improvement over the period was NHS Warrington (increase of 0.5% in coverage), the largest decrease was seen in NHS Liverpool (decrease of 1.6%).

Breast Screening

As of 2019/20, more than two in three females in Cheshire and Merseyside eligible for breast screening (aged 50-71) received a breast cancer screening test (70.5% coverage rate), just exceeding the target of 70% coverage.

Coverage ranged from 75.3% in Warrington to 62.6% in Knowsley. (**Figure 21** and **Table 1**). Between 2009/10 and 2019/20, there were only two Local Authorities in Cheshire and Merseyside where coverage for breast cancer screening increased; South Sefton and Warrington, see **Table 1**. The remainder saw reductions ranging between 0.3% and 5.0% in coverage over the decade.

Figure 21: Trend in breast cancer screening coverage (%), 2009/10 to 2019/20 in women aged 50-71 years, Cheshire and Merseyside CCGs



Source: Open Exeter via [PHE Fingertips Health Profiles](#), 2021

Note: Rolling average of women aged 50-70 screened within the previous 36 months

Table 1: Trend in breast cancer screening coverage (%), 2009/10 to 2019/20 in women aged 50-71 years, Cheshire and Merseyside CCGs (and difference between 2009/10 and 2019/20)

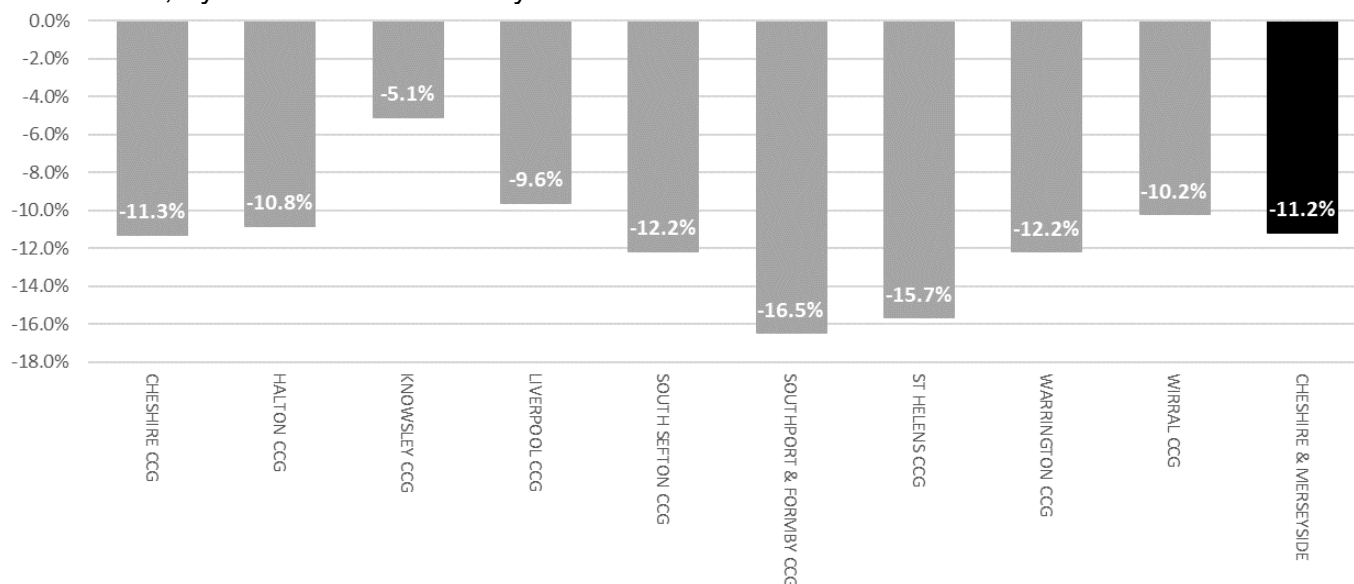
Organisation	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	% diff
	%	%	%	%	%	%	%	%	%	%	%	
NHS CHESHIRE CCG	76.0	75.9	75.4	75.1	76.0	75.9	76.9	76.2	75.6	75.4	74.2	-2.4
NHS HALTON CCG	69.8	69.9	73.1	70.4	71.2	72.3	71.6	72.4	72.0	71.7	66.4	-4.8
NHS KNOWSLEY CCG	64.1	67.0	66.7	64.3	64.8	66.5	64.7	67.7	64.9	66.4	62.6	-2.5
NHS LIVERPOOL CCG	66.4	66.8	67.9	65.2	64.3	58.7	65.0	64.4	64.9	65.7	65.3	-1.7
NHS SOUTH SEFTON CCG	67.3	69.4	68.4	66.3	68.5	69.5	68.3	66.3	65.7	66.7	67.4	0.1
NHS SOUTHPORT AND FORMBY CCG	72.7	73.1	73.5	73.7	70.6	69.6	68.2	69.2	73.5	72.5	69.0	-5.0
NHS ST HELENS CCG	70.7	73.2	72.6	72.2	72.8	74.1	74.5	72.3	73.3	73.1	70.5	-0.3
NHS WARRINGTON CCG	72.8	73.4	72.1	74.1	74.1	74.4	75.9	74.4	74.7	76.7	75.3	3.4
NHS WIRRAL CCG	74.4	73.5	72.9	73.1	72.6	73.4	74.3	74.5	74.8	74.4	73.1	-1.7
CHESHIRE & MERSEYSIDE	71.6	72.1	72.1	71.2	71.3	70.7	72.1	71.7	71.7	72.0	70.5	-1.6

Source: Open Exeter via [PHE Fingertips Health Profiles](#), 2021

Note: Rolling average of women aged 50-70 screened within the previous 36 months

Figure 22 below, shows the latest position with regard to breast cancer screening across Cheshire and Merseyside . Although actual rates cannot yet be published, the change over the course of the pandemic is shown by comparing rates in Quarter 3 of 2019/20 to Quarter 3 of 2020/21. It shows that overall in Cheshire and Merseyside , breast screening coverage fell by just over 11% with all CCGs showing a decrease. There was considerable variation across CCGs however, with NHS Southport & Formby showing the largest drop (16.5% decrease), and NHS Knowsley showing the smallest drop (5.1% - although it should be noted that Knowsley already had the lowest rate of coverage in Cheshire and Merseyside in 2019/20).

Figure 22: Percentage variance/change in breast screening coverage between Q3 2019/20 and Q3 2020/21, by Cheshire and Merseyside CCG



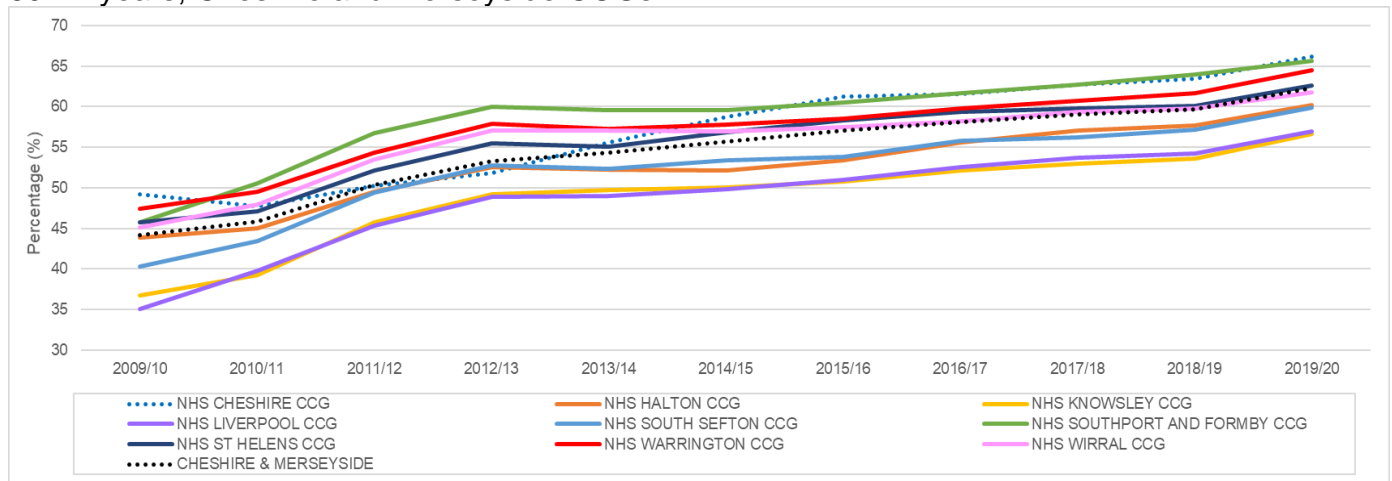
Source: NHS England (based on currently unpublished data)

Bowel Screening

Screening for bowel cancer was introduced in 2006 and is therefore the newest cancer screening programme run by the NHS. All those aged 60 to 74 who are registered with a GP and live in England are automatically sent a bowel cancer screening kit every 2 years. The programme is expanding to include those aged from 56 from 2021.

The proportion of people aged 60-74 being screened for bowel cancer improved in Cheshire and Merseyside between 2009/10 and 2019/20; (**Figure 23 and Table 2**). Although 62.3% of 60–74-year-olds screened in Cheshire and Merseyside during 2020 was still lower than the England average, it exceeded the national target of 60% coverage. Locally, only Knowsley (56.6%), South Sefton (59.9%) and Liverpool (56.9%) failed to meet the national 60% coverage target in 2020.

Figure 23: Trend in bowel cancer screening coverage (%), 2009/10 to 2019/20 in persons aged 60-74 years, Cheshire and Merseyside CCGs



Source: Open Exeter via [PHE Fingertips Health Profiles](#), 2021

As **Figure 23** above shows, although coverage of bowel screening improved in all areas of Cheshire and Merseyside in the decade shown, overall trends remained, e.g. those with the lowest coverage in 2009/10, still had the lowest coverage in 2019/20 (Liverpool and Knowsley); while the organisation with the highest coverage (Cheshire), still had the highest coverage in 2019/20.

Table 2: Trend in bowel cancer screening coverage (%), 2009/10 to 2019/20 in persons aged 60-74 years, Cheshire and Merseyside CCGs (and difference between 2009/10 and 2019/20)

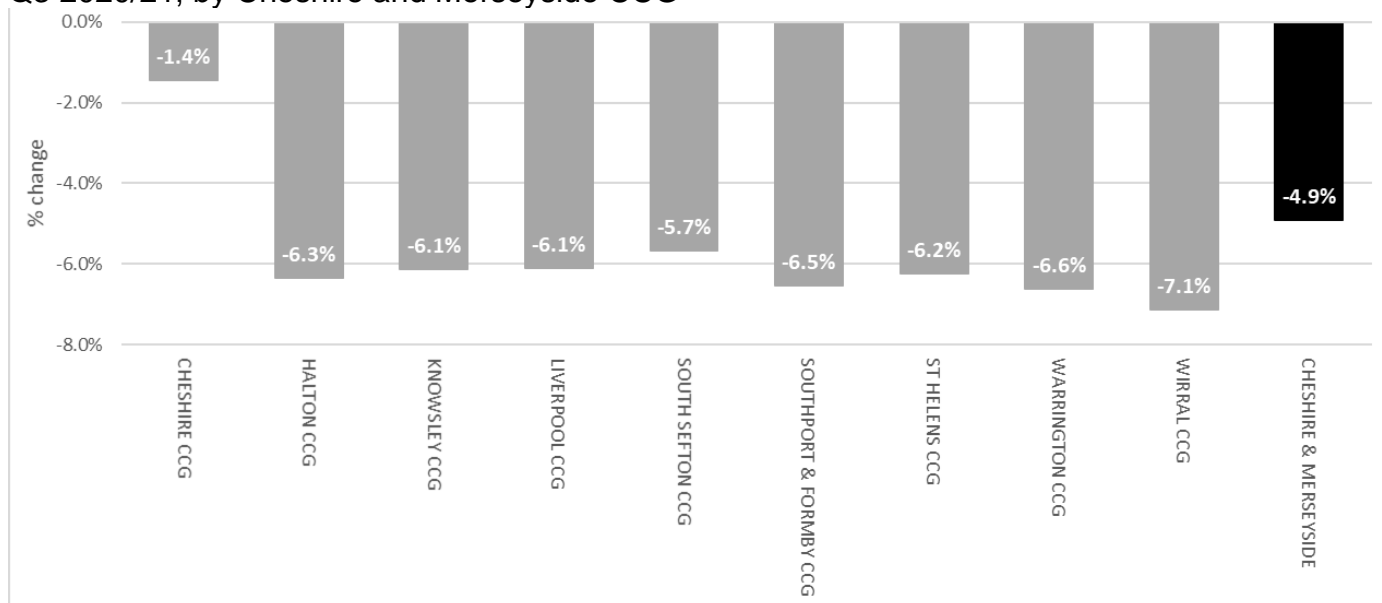
Organisation	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	% diff
	%	%	%	%	%	%	%	%	%	%	%	
NHS CHESHIRE CCG	49.2	47.7	50.2	51.8	55.6	58.7	61.3	61.6	62.7	63.5	66.2	34.4
NHS HALTON CCG	43.9	45.1	49.5	52.5	52.2	52.1	53.4	55.6	57.0	57.7	60.2	37.1
NHS KNOWSLEY CCG	36.7	39.3	45.7	49.2	49.8	50.0	50.8	52.1	52.9	53.6	56.6	54.1
NHS LIVERPOOL CCG	35.1	39.8	45.3	48.8	49.0	49.9	51.0	52.5	53.7	54.2	56.9	62.2
NHS SOUTH SEFTON CCG	40.3	43.4	49.4	52.7	52.3	53.4	53.8	55.8	56.3	57.1	59.9	48.6
NHS SOUTHPORT AND FORMBY CCG	45.7	50.6	56.7	60.0	59.6	59.6	60.5	61.6	62.7	64.0	65.7	43.6
NHS ST HELENS CCG	45.7	47.2	52.2	55.5	55.1	56.9	58.3	59.4	59.8	60.1	62.6	36.9
NHS WARRINGTON CCG	47.4	49.5	54.3	57.8	57.3	57.8	58.5	59.8	60.7	61.7	64.5	36.2
NHS WIRRAL CCG	45.1	47.9	53.5	57.1	57.1	57.0	57.5	58.2	59.3	59.8	61.8	36.8
CHESHIRE & MERSEYSIDE	44.2	45.8	50.4	53.3	54.4	55.7	57.1	58.1	59.1	59.7	62.3	41.1

Source: Open Exeter via [PHE Fingertips Health Profiles](#), 2021

Table 2 above shows that across Cheshire and Merseyside CCGs, the average improvement in bowel cancer screening coverage between 2009/10 and 2019/20 was 41%. This ranged from an increase of 62% in Liverpool CCG (although this large improvement was positive, it was still not enough to meet the 60% target), to 34% in Cheshire CCG.

Figure 24 below, shows the latest position with regard to bowel cancer screening across Cheshire and Merseyside. Although actual rates cannot yet be published, the change over the course of the pandemic is shown by comparing rates in Quarter 3 of 2019/20 to Quarter 3 of 2020/21. It shows that overall in Cheshire and Merseyside, coverage fell by just under 5% with all CCGs showing a decrease. There was considerable variation across CCGs however, with NHS Wirral showing the largest drop (7.1% decrease), and NHS Cheshire showing the smallest drop (1.4%).

Figure 24: Percentage variance/change in bowel screening coverage between Q3 2019/20 and Q3 2020/21, by Cheshire and Merseyside CCG



Source: NHS England (based on currently unpublished data)

Inequalities in screening uptake

People with Serious Mental Illness

Public Health England's (PHE) report on [Severe mental illness \(SMI\) and physical health inequalities](#) highlights that people with a recorded diagnosis of SMI are more likely than the general population to experience poor physical health and to die prematurely. People with SMI in England:

- [die on average 15 to 20 years younger than the general population](#)
- [are 4.7 times more likely to die under the age of 75 than people without SMI](#)

International research suggests that the incidence of most cancers is similar among people with and without SMI, but among people with a cancer diagnosis, those who also have SMI are more likely to die from the cancer (the case fatality is higher).

Recently [published PHE analysis suggests](#) that between 2016 and 2018 adults with SMI were 2.1 times more likely to die from cancer under the age of 75 than people without SMI, and that cancer was the leading cause of premature mortality among people with SMI, above cardiovascular, respiratory and liver diseases. This is in line with [previous data about the period between 2004 and 2013](#).

It has been suggested that this is contributed to by reduced uptake of cancer screening services, delayed cancer diagnosis, treatment choices and adherence to treatment plans. Analysis of inequalities carried out by PHE into the uptake of bowel, breast, and cervical screening by people with and without SMI. These are the 3 national cancer screening programmes in England. The report found that people with SMI were 18% more likely not to have participated in breast screening; 20% more likely not to have participated in cervical screening; and 31% more likely not to have participated in bowel screening, within the recommended time period than people without SMI. This is evidence of an inequality in the uptake of each of England's national cancer screening programmes.

See [full PHE report](#) for more details.

People with Learning Disabilities

[PHE Screening's inequalities strategy](#) (2017) showed that that people who don't access screening come from particular groups. They tend to be:

- people living in poorer areas
- people with a learning or physical disability
- black, Asian or people from other ethnic minority groups
- lesbian and bisexual women
- men – who are less likely to be screened than women

A recent PHE publication¹⁸ showed that those with severe mental illness (SMI), have lower cancer screening uptake rates than those without SMI. Whilst this analysis is only at an England level, it is something to be considered and further investigated across Cheshire and Merseyside .

It found that whilst international research suggests that the incidence of most cancers is similar among people with and without SMI, those with a cancer diagnosis who have SMI are more likely to die from the cancer (the case fatality is higher); that the excess premature mortality (aged under 75 is 2.1 times higher in those with SMI compared to people without SMI, the reduced uptake of cancer screening services, delayed cancer diagnosis and adherence to treatment plans all contribute to this.

This analysis shows evidence that bowel, breast, and cervical screening services are not currently used by people with SMI to the same extent that they are used by people without SMI. People with SMI were 18% more likely not to have participated in breast screening; 20% more likely not to have participated in cervical screening; and 31% more likely not to have participated in bowel screening, within the recommended time period than people without SMI.

This is an inequality in service use (in this case uptake of screening) and does not necessarily reflect an inequality in access or need. However, existing legal, contractual and policy infrastructure does mandate increased effort to encourage use of services by vulnerable groups.

A [mental health condition is considered a disability](#) if it has a long-term effect on a person's normal day-to-day activity. Under the [Equality Act 2010](#), public sector organisations must make changes in their approach or provision to ensure that services are accessible to disabled people as well as everybody else. These changes are referred to as '[reasonable adjustments](#)' and can range from building alterations to changes to policies, procedures and staff training.

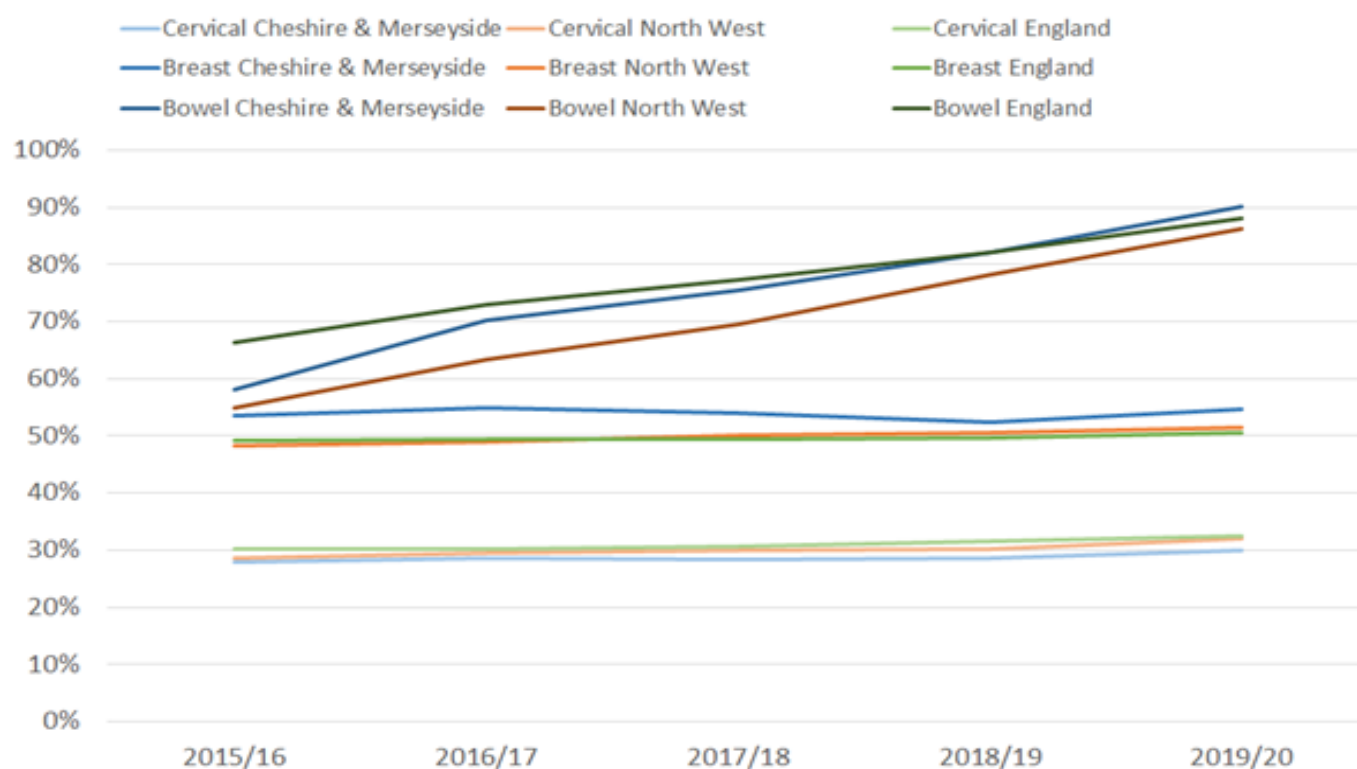
Another mental health related population group where uptake of cancer screening is lower is amongst those with learning disabilities (LD). Annual data from NHS Digital, shows lower uptake of all three screening programmes, both nationally and locally.

The standardised mortality ratio for people with LD is 405 (CI 393 to 417), meaning they have a more the 4 times higher death rate than those without LD. Across Cheshire and Merseyside this ranges from 354 to 541 with an average of 464.

For people with LD, uptake is lower for both breast screening and especially for cervical screening, compared to those with no LD. The difference is most marked for cervical screening. There has been very little improvement in uptake rates for cervical screening over the last 5 years (see **Figure 25** below), a small improvement in breast screening and a more substantial improvement in bowel screening uptake. For bowel screening, uptake rates are similar and in cervical and breast screening cases better, for those with LD compared to those with no LD (see **Table 3** below).

¹⁸ <https://www.gov.uk/government/publications/severe-mental-illness-inequalities-in-cancer-screening-uptake/severe-mental-illness-smi-inequalities-in-cancer-screening-uptake-report>

Figure 25: 5-year trend in uptake of cervical, between 2015/16 – 2019/20, for breast and bowel screening amongst people with Learning Disabilities comparing Cheshire and Merseyside, North-West England and England



Source: [NHS Digital, 2021](#)

Table 3: Uptake rates in cancer screening, Learning Disabilities compared to those with no Learning Disabilities, Cheshire and Merseyside CCGs, 2019/2020

	Cervical		Breast		Bowel	
	LD	no LD	LD	no LD	LD	no LD
Cheshire	32.4%	73.4%	64.4%	75.6%	92.1%	92.4%
Halton	29.1%	67.0%	46.8%	71.6%	97.3%	92.4%
Knowsley	27.1%	69.8%	41.4%	59.6%	89.2%	90.4%
Liverpool	25.7%	64.2%	55.8%	63.4%	91.3%	93.9%
South Sefton	28.7%	67.7%	44.7%	65.0%	90.3%	92.9%
Southport & Formby	35.1%	71.7%	45.8%	70.7%	90.8%	94.1%
St Helens	29.9%	70.3%	51.1%	58.0%	91.0%	90.7%
Warrington*	40.0%	74.1%	56.3%	82.7%	88.0%	86.9%
Wirral	31.8%	68.4%	55.9%	71.5%	82.7%	85.0%
Cheshire & Merseyside	30.0%	69.4%	54.6%	69.4%	90.1%	91.5%
England	32.4%	68.5%	50.5%	65.0%	88.1%	90.0%

Source: NHS Digital

Note: Warrington based on just 22.2% patient coverage. C&M average 84.5%, range 76%-96%

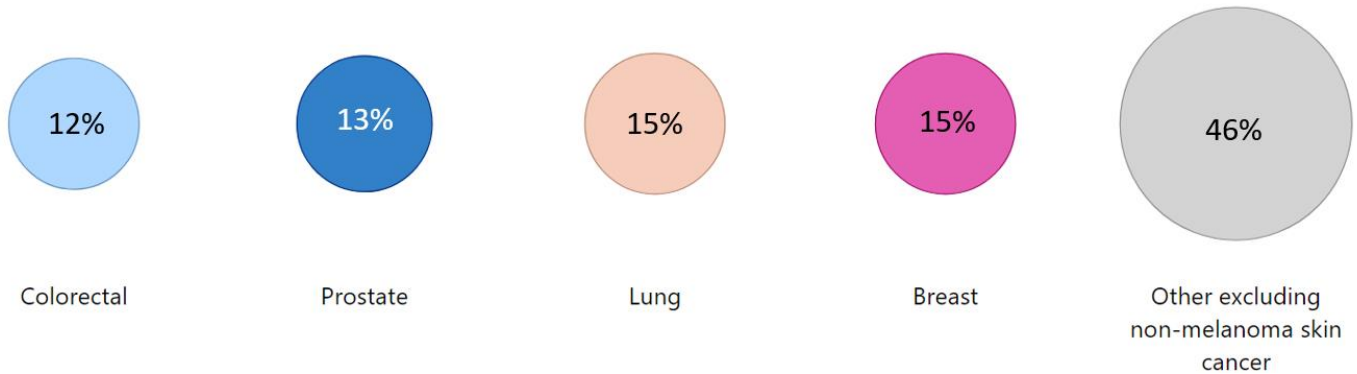
Source: [NHS Digital, 2021](#)

Note: Warrington based on only 22.2% coverage (Cheshire and Merseyside average was 84.5%, range 76%-96%)

Incidence

Cancer incidence describes the number of newly diagnosed cases of cancers, and this should be considered with the following analyses. Cancer incidence rates tend to be published at Clinical Commissioning Group (CCG) level and will be different to the analyses involving local authorities. Incidence of cancers in Cheshire and Merseyside overall are summarised in **Figure 26**, **Table 4**, and **Figure 27** below.

Figure 26: Cancer incidence (proportion of new cancers) by type in Cheshire and Merseyside in 2018



Source: [CancerData](#), 2018 incidence data

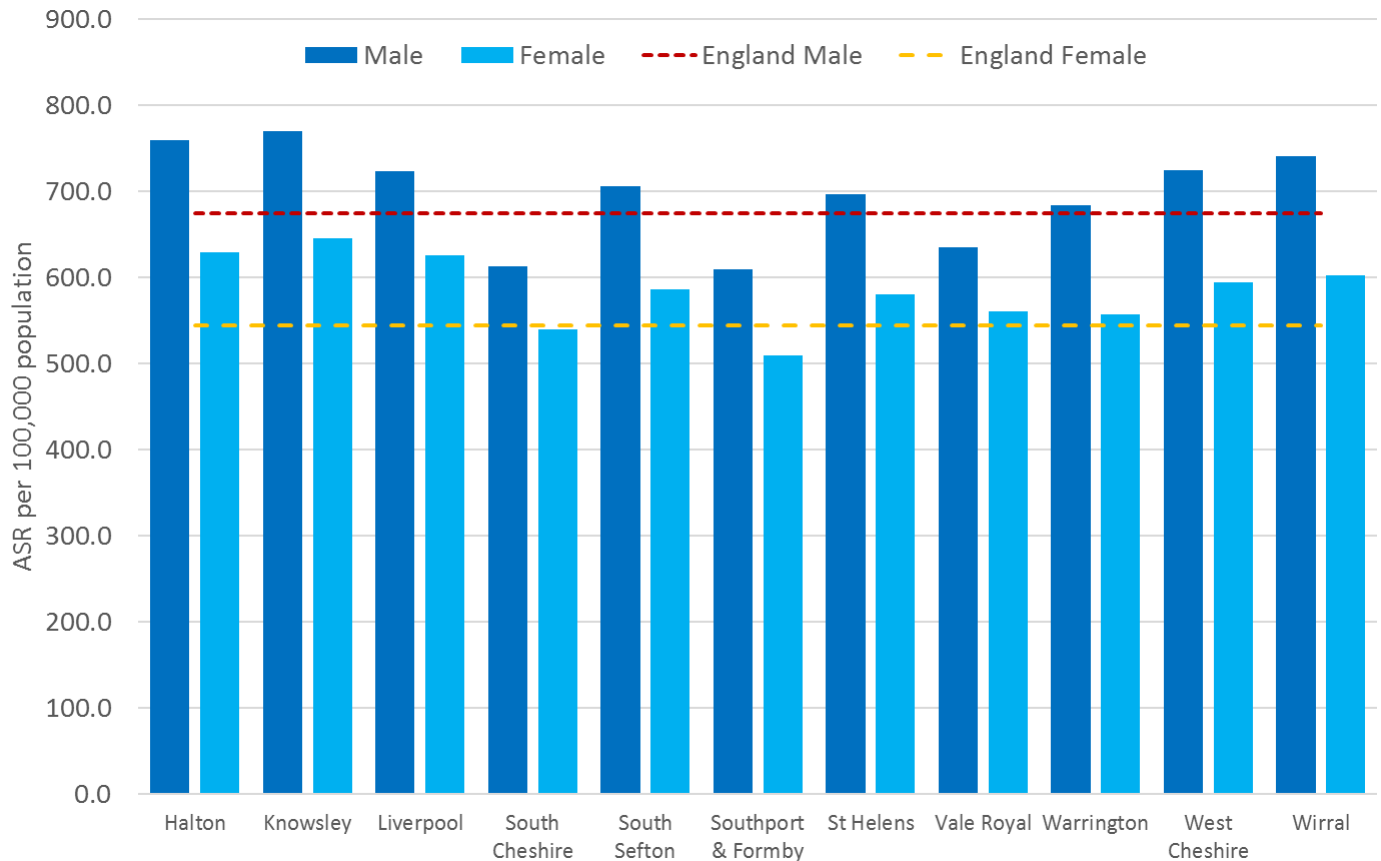
Table 4: Age Standardised Rate (ASR) per 100,000 population, of cancer incidence by type in Cheshire and Merseyside during 2018

Incidence of common cancers in Cheshire and Merseyside with 95 % confidence limits, 2018, Age Standardised Rates (ASR)					
Gender	Tumour Site	Number	ASR	LCI	UCI
Persons	All Cancers (excluding Non-Melanoma Skin Cancer)	12989	632.35	621.46	643.38
	Cancer of the Trachea, Bronchus and Lung	1792	86.72	82.72	90.85
	Colorectal cancer	1541	74.82	71.11	78.68
	Skin cancer	654	32.38	29.93	34.97
	Kidney Cancer (not including Renal or Pelvis)	396	19.37	17.50	21.39
	Oesophageal cancer	365	17.89	16.10	19.84
	Pancreatic cancer	357	17.33	15.57	19.24
	Bladder cancer	332	16.74	14.98	18.65
	Leukaemia	317	15.46	13.79	17.27
	Liver cancer	228	11.30	9.87	12.88
	Brain and Central Nervous System Cancer	210	10.32	8.96	11.82
	Stomach cancer	208	10.20	8.85	11.69
	Multiple Myeloma and Malignant Plasma Cell Neoplasms	147	7.25	6.12	8.53
	Gallbladder cancer	39	1.75	1.24	2.39
	Male	Prostate Cancer	1702	175.91	167.64
Female	Breast cancer	1945	179.69	171.76	187.89
	Cervical cancer	123	12.16	10.10	14.51
	Uterine cancer	294	26.60	23.63	29.83
	Ovarian cancer	251	23.01	20.24	26.06

Source: [CancerData](#), 2021

Note: LCI – lower confidence interval, UCI – upper confidence interval

Figure 27: Age Standardised Rate (ASR) per 100,000 population, of all cancers incidence in Cheshire and Merseyside CCGs during 2016-18, by Sex



Source: [PHE Fingertips Cancer Data](#), 2021

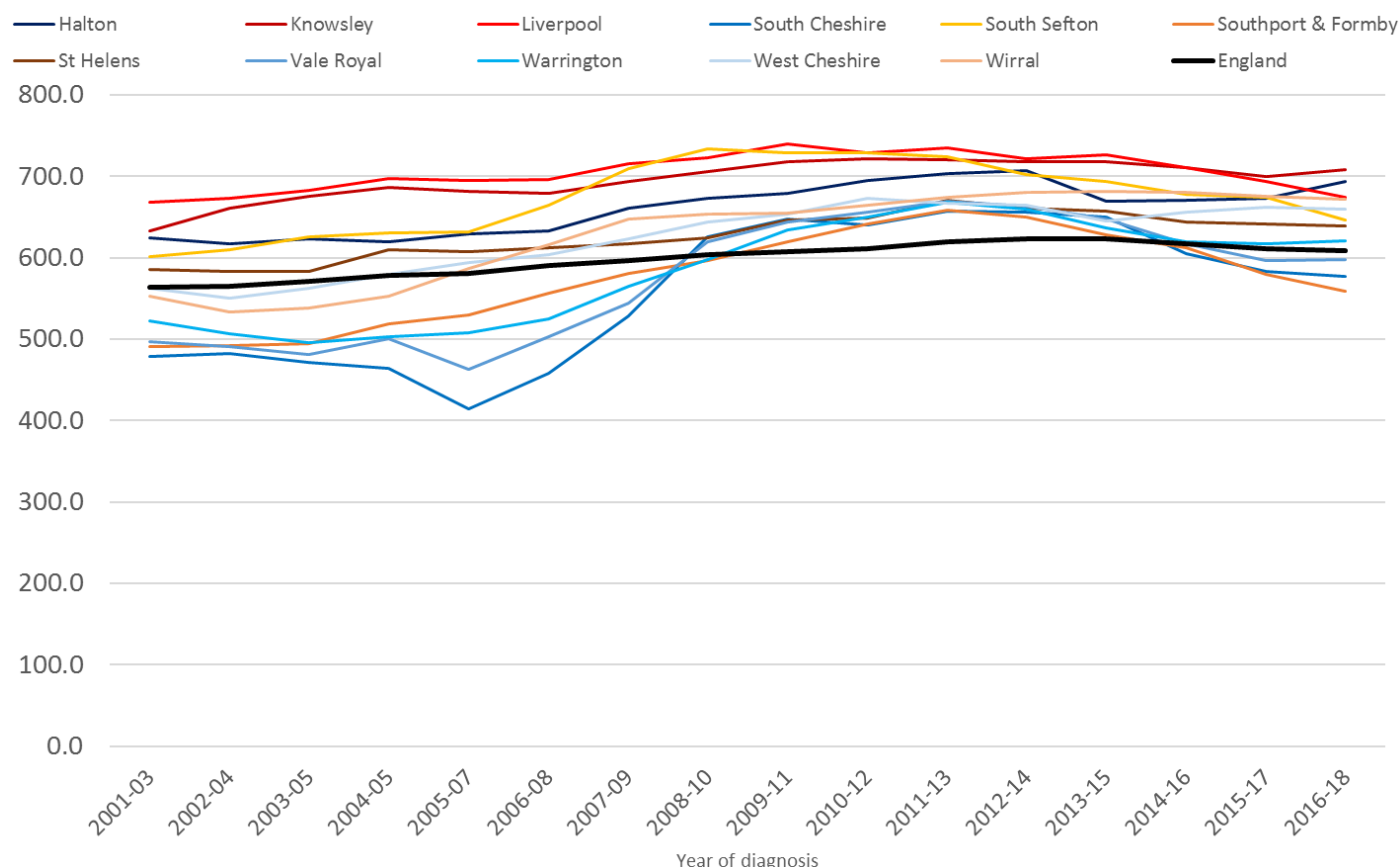
The rates of cancer incidence for both males and females vary across the Cheshire and Merseyside area. Male cancer incidence is higher than female in all CCGs and in England as a whole (**Figure 27**).

However, the rates of male and female cancer incidence are higher than England, in all CCGs except for South Cheshire and Southport and Formby – who have significantly lower rates of all persons and male cancer incidence than England.

There was a period between 2009-11 and 2013-15 when all CCG across Cheshire and Merseyside had higher rates of all cancer incidence than England. However, since then three CCGs have witnessed a reduction in their rates of cancer incidence. In 2016-18, South Cheshire, Southport & Formby and Vale Royal had a lower rate of cancers diagnosed than England.

Knowsley, Halton, Wirral, South Sefton, West Cheshire, and Liverpool had the highest rates of cancer incidence across Cheshire and Merseyside.

Figure 28: Trend in cancer incidence (newly diagnosed cancers) rate per 100,000 population in Cheshire and Merseyside CCGs, and England, 2001-03 to 2016-18



Source: [PHE Fingertips Cancer Data](#), 2021

There is a disparity in the cancer incidence rates particularly in the most recent periods between the Cheshire (**Figure 28** above; blue lines) and Merseyside (**Figure 28**; red/orange lines) CCGs.

Broadly speaking, the CCGs with the highest incidence rates for 2016-18 tend to be in Merseyside, and the lowest rates are in Cheshire CCGs (exceptions are Halton, which is in Cheshire, but has high incidence, and Southport and Formby, which has the lowest incidence rate of all CCGs in Cheshire and Merseyside but is in Merseyside).

Prevalence

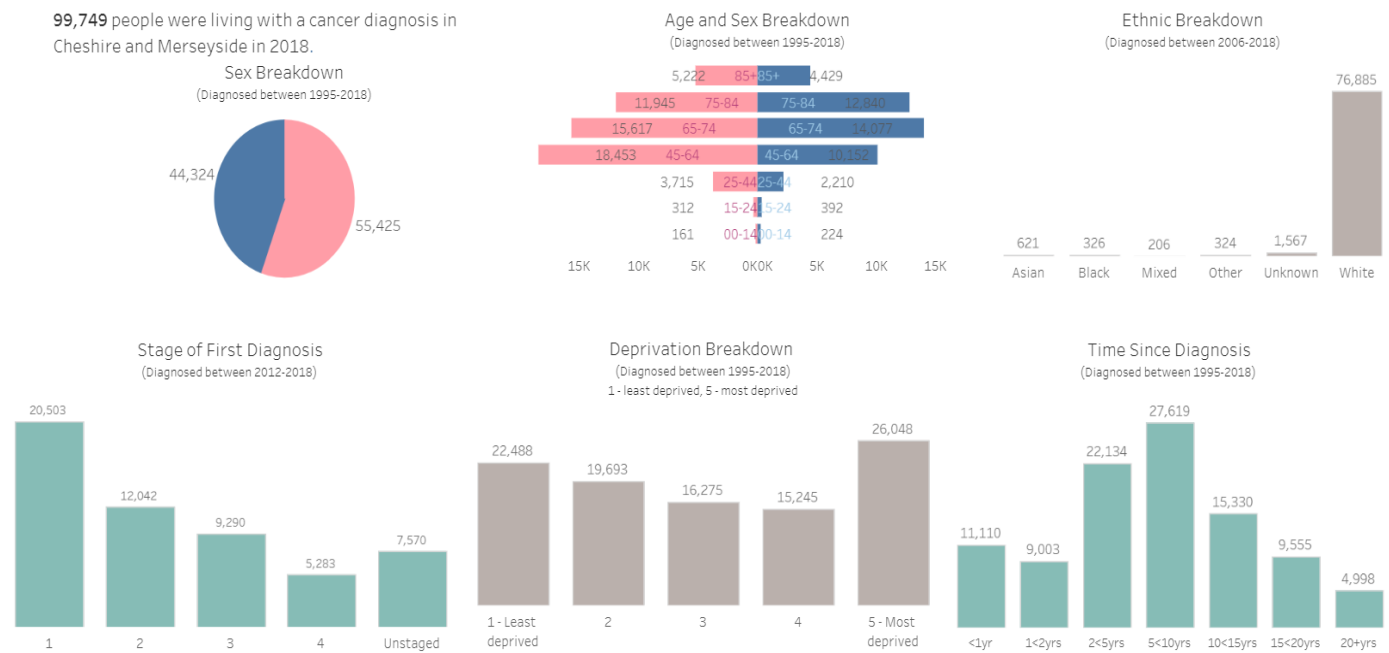
Cancer prevalence is defined as people living with a cancer diagnosis at the time of data collection. Public Health England annually publish cancer prevalence dashboards by Cancer Alliance area for England.

Demonstrating only numeric totals of prevalence (those living with cancer) during the year(s) specified, the dashboard illustrates variance in the numbers of people living with cancer in Cheshire and Merseyside as a whole, by demographic and temporal variables.

There are again, variances in the prevalence of cancer in Cheshire and Merseyside by various socio-economic factors (**Figure 29**). In 2018, there were more people living with cancer in the most deprived quintile than any other quintile.

As may be expected given the population breakdown of Cheshire and Merseyside, the greatest number of cancers were among the White ethnic group (n=76,855), with BAME groups ranging between 206 (Mixed ethnicity) and 621 (Asian ethnicity).

Figure 29: Prevalence of population with cancer in Cheshire and Merseyside during 2018, by demographics



The above figures show patient level prevalence, counting people ever diagnosed with a cancer in C00-C97 (excluding C44) between 1995-2018, except where indicated otherwise.

Source: [CancerData, 2021](#)

Note: Deprivation quintiles are presented differently to other NHS and local government sources in this visual (Quintile 1 is usually the Most Deprived, but in this visual, that is reversed); CancerData have indicated in future documents, they will harmonise with PHE and other NHS organisations, but they cannot at the time of writing, however, amend this visual

There were more females with cancer than males during 2018. However, during 2018 there were variances in the age groups. The majority of males with cancer were aged 65-74, whereas among females, the majority were 45-64 years of age. Females had larger numbers of cancers in all age bands except youngest age groups (0-24).

The demographics emphasise that the vast majority (excluding those where a stage was not available in the data), were diagnosed at stage 1 or 2 (early stage), improving the chances of longer survival. This is further emphasised when looking at time since survival, with the majority of people alive 5 years following diagnosis.

Prevalence in GP registered patients

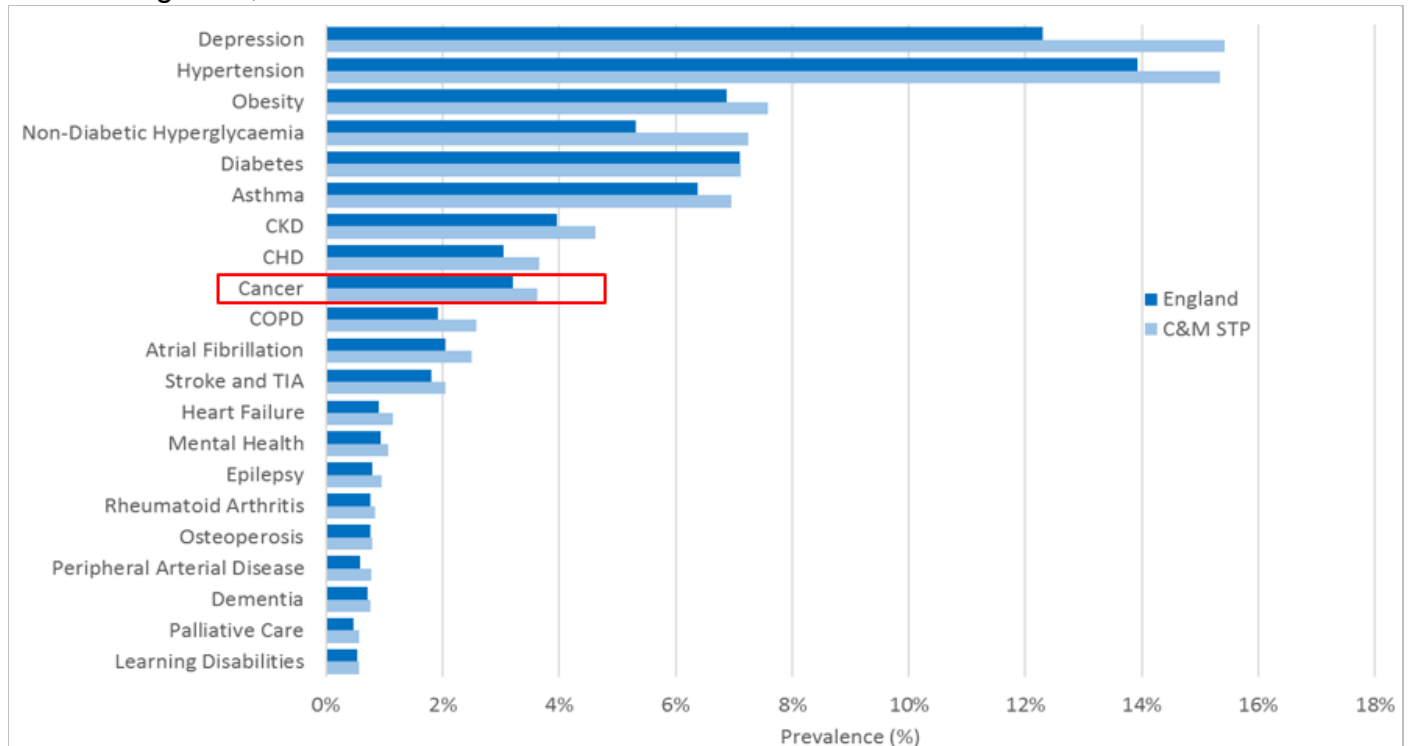
In 2020/21 there were 97,176 people recorded as having a diagnosis of cancer in Cheshire and Merseyside on the Quality & Outcomes Framework (or QOF - a disease register kept by all GPs in England).

This is higher than England overall, which had a prevalence of 3.21% of the total registered population, compared to 3.62% (2020/21) in Cheshire and Merseyside .

Prevalence has also risen in recent years, from 3.40% in 2018-19, to 3.55% in 2019-20, to 3.62% in 2020/21. In England overall, there was also a rise in prevalence from 2.98% in 2018-19 to 3.13% in 2019-20, and then 3.21% in 2020/21.

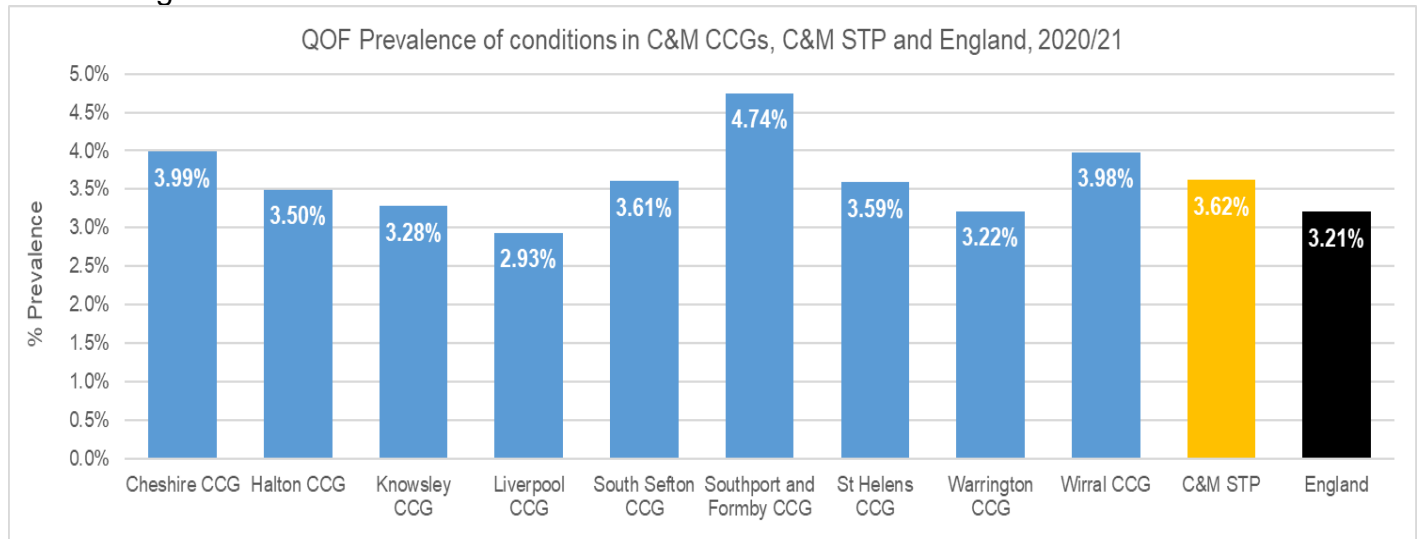
As **Figure 30** shows, there was a greater proportion of patients on *all* disease and condition registers in Cheshire and Merseyside GP practices compared to England in 2020/21 and cancer was no exception. Overall, a higher proportion of GP registered patients in Cheshire and Merseyside were on the QOF Cancer register (3.62%), compared to England overall (3.21% of all patients).

Figure 30: Prevalence (%) of GP registered patients in Cheshire and Merseyside and England on disease registers, 2020/21



Source: GP QOF register, 2020/21, [NHS Digital](#)
Note: patients can appear on more than 1 register at a time

Figure 31: Prevalence (percentage) of residents of Cheshire and Merseyside CCGs on the GP disease register with cancer in 2020/21



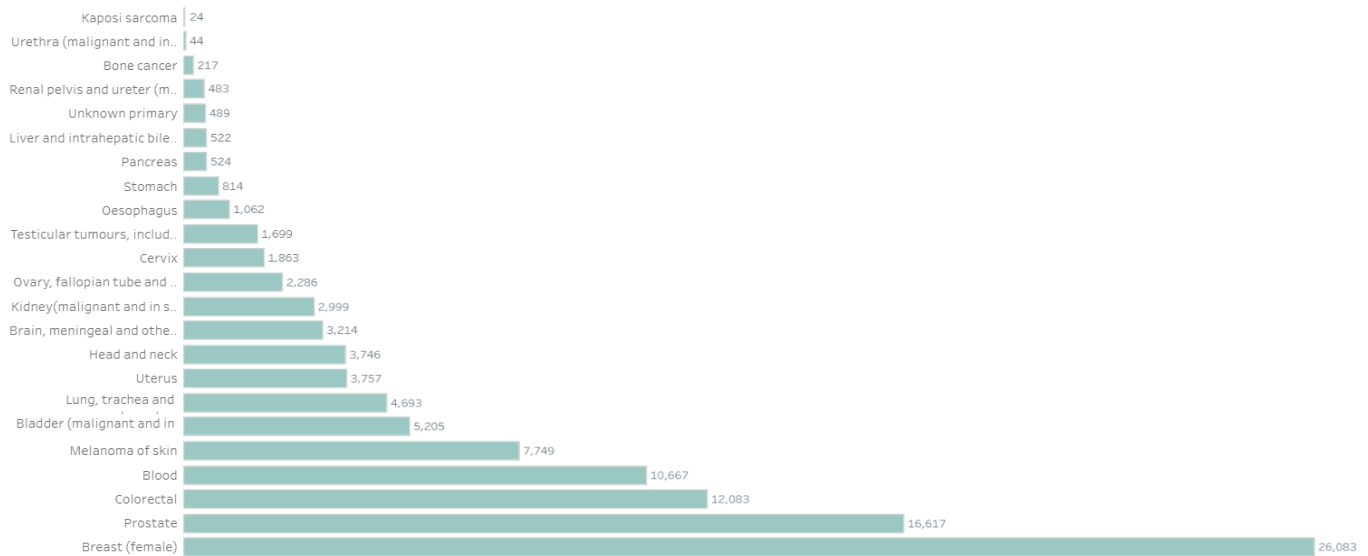
Source: GP QOF register, 2020/21, [NHS Digital](#)

As **Figure 31** shows, there was considerable variation in cancer prevalence between CCGs in Cheshire and Merseyside in 2020/21. It is worth noting that broadly, those CCGs with the oldest age profiles, have the highest prevalence (e.g. Southport & Formby CCG), while those with younger populations (e.g. Liverpool CCG), have the lowest prevalence.

Prevalence by specific cancers

Prevalence (numbers) by specific cancers is shown below in **Figure 32** at Cheshire and Merseyside level.

Figure 32: Prevalence (numbers) of people living with cancer, by tumour group in Cheshire and Merseyside, 2018



Source: [CancerData](#), 2021

As **Figure 32** shows, the most prevalent cancers in Cheshire and Merseyside residents in 2018 were breast cancer, followed by Prostate and Colorectal. It is worth noting that although cancers of the Lung, Trachea & Bronchus have one of the highest incidence rates, they do not have one of the highest prevalence rates. This is due to lower survival rates for these types of cancer, compared to many of those where prevalence is much higher.

Referrals, diagnosis and treatment

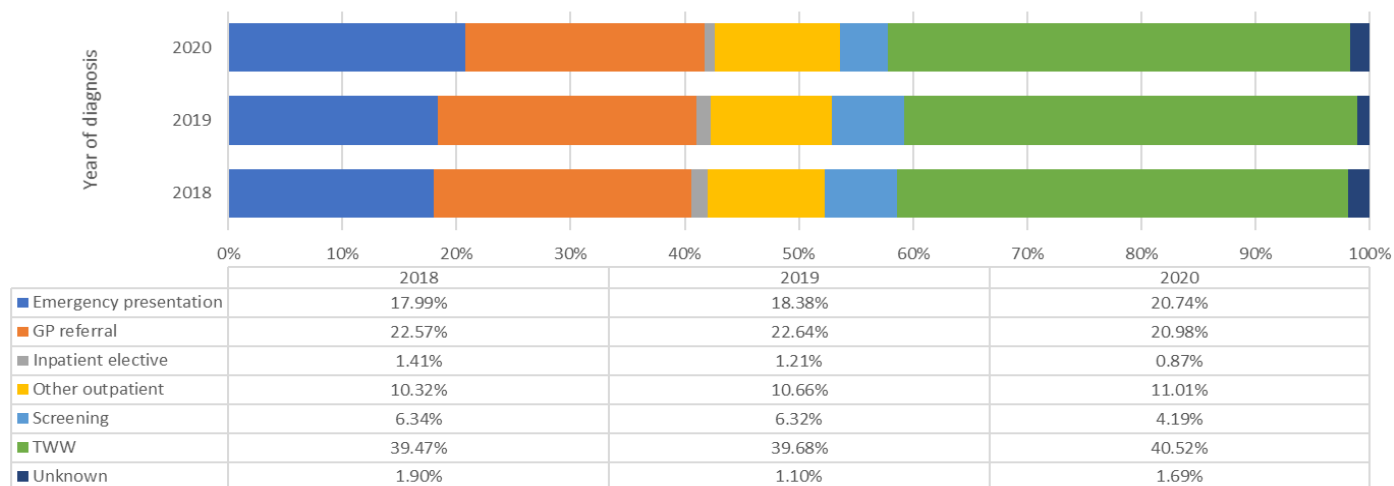
Routes to diagnosis

Across all of the CCGs of Cheshire and Merseyside, the majority of cancers diagnosed during 2017 were via ‘Managed’ methods, such as GP urgent suspected cancer referrals (**Figure 32**). Although there is some difference between CCGs in the proportion diagnosed with cancer via the ‘Managed’ route – Knowsley, Liverpool and St. Helens all have lower proportions than both Cheshire and Merseyside and England. There were similar proportions of cancers diagnosed through emergency presentations for all the CCGs in the region.

The smallest proportion of cancers diagnosed in all the Cheshire and Merseyside CCGs and indeed, England, were via screening programmes, with around 5% of all cancers diagnosed during 2017 (although it should be noted of course, that screening programmes exist only for 3 types of cancer – breast, bowel and cervical). It is worth noting however, that both the bowel and breast screening programmes have been further developed since 2017 (age extensions have, or will soon come into effect), meaning that additional cancers are likely to be diagnosed as a result of these extensions to the upper/lower screening age guidelines. As there is a lag on available data, this is not necessarily apparent from the data in this report.

With approximately one in five cancers diagnosed through emergency presentations and fewer diagnosed through the 3 screening programmes, this impacts the proportion of cancers which are diagnosed at an early stage. This in turn affects the proportion of cancers which are likely to be both treatable and treatable to the extent of providing longer survival times for the individual.

Figure 33: Trend in route of cancers diagnosed among Cheshire and Merseyside GP registered patients, during 2017, by the route of diagnosis



Source: Rapid Registrations Dataset via [CancerStats](#), 2021

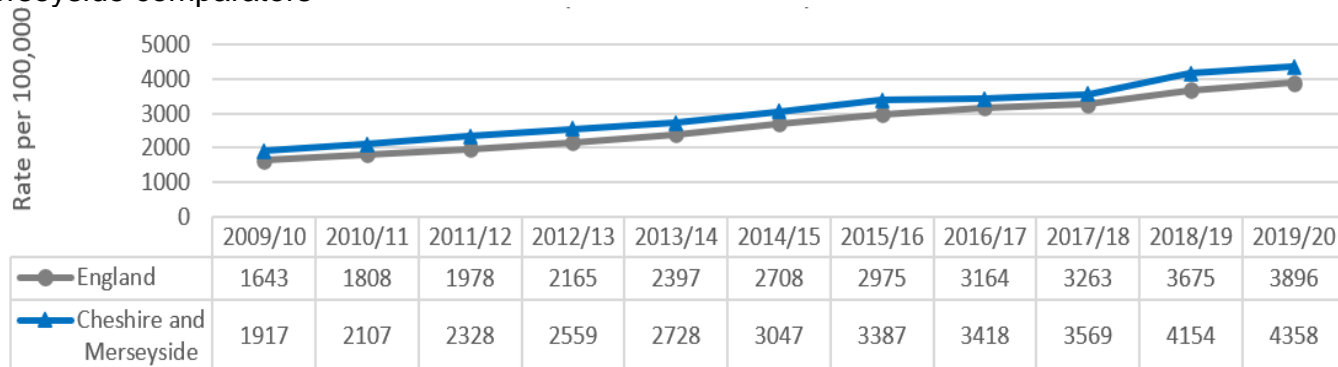
As **Figure 33** shows, proportionally there was a slight increase in emergency presentations in 2020, compared to 2018 and 2019. In terms of numbers however, this represented an increase of just 23 more patients diagnosed following emergency presentation in 2020 compared to 2019. The proportional increase is due to reductions in the numbers of patients presenting via other routes, which dropped markedly. For example, the number of patients presenting via screening reduced by 40% between 2019 and 2010, compared to a 1% increase in the number of patients identified following emergency presentation.

Urgent referrals from a GP for suspected cancer (2 week wait)

Trend in Two-week wait referrals

Referrals for suspected cancer from a GP to hospital cancer services are urgent and therefore subject to Two-Week Wait guidelines, whereby patients should be seen within 14 days (two weeks) of their GP referral. In 2019/20 there were almost 116,500 urgent two week wait referrals made within Cheshire and Merseyside. This equates to 4,358 referrals per 100,000 population, which is significantly higher than the England average¹⁹ (see **Figure 34**). Between 2009/10 and 2019/20, rates of referral for suspected cancer per 100,000 population have increased both nationally and within the Cheshire and Merseyside area, with rates in 2019/20 more than double the rates of referral in 2009/10.

Figure 34: Trend in two week wait referral rates, 2009/10 to 2019/20, England and Cheshire and Merseyside comparators



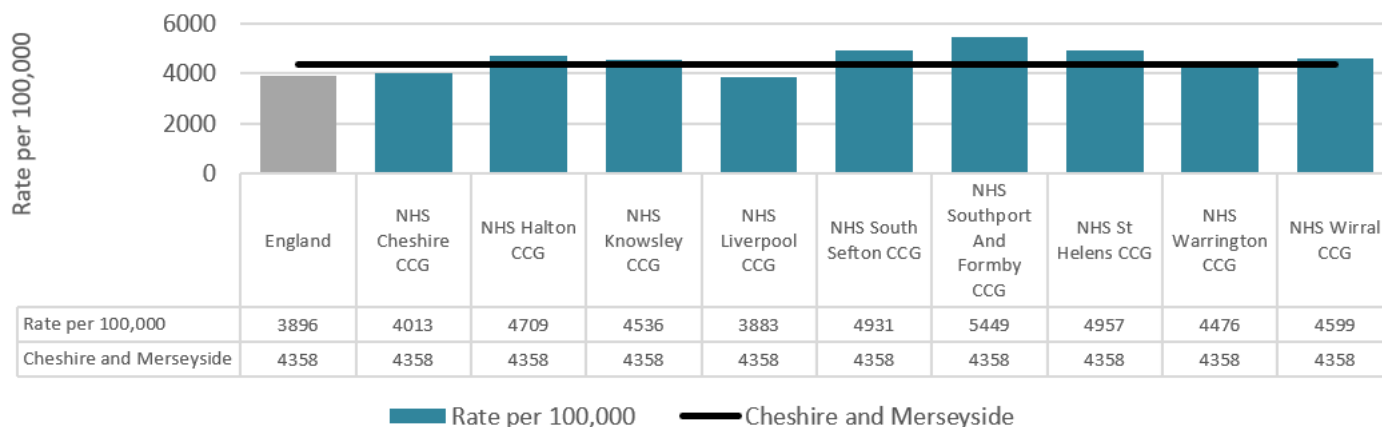
Source: [PHE Fingertips Cancer Services](#), 2021

¹⁹ PHE Fingertips Cancer Services

Rates of referral for suspected cancer in Cheshire and Merseyside have consistently been significantly higher than in England as a whole.

In 2019/20, at CCG level, there were considerably lower rates of referral in Cheshire²⁰ and Liverpool CCGs, with rates in other CCGs having significantly higher rates of referral compared to Cheshire and Merseyside as a whole (**Figure 35**).

Figure 35: Two week wait referral rates in Cheshire and Merseyside , rate per 100,000 by CCG, 2019/20

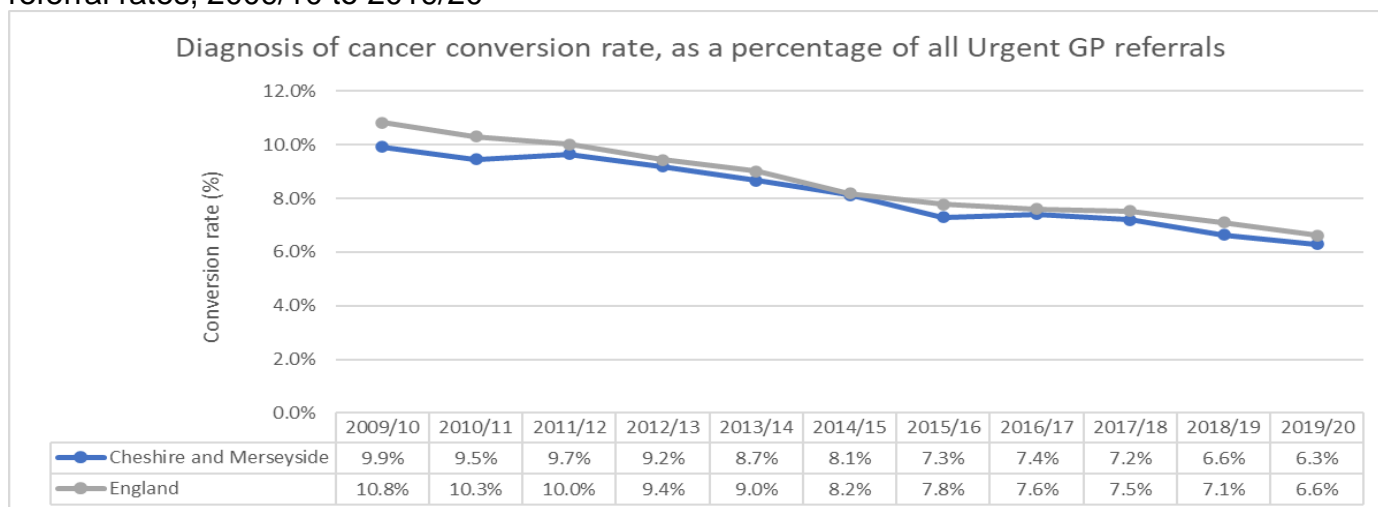


Source: [NHSE Cancer Waiting Times](#), 2021

The percentage of referrals which result in a diagnosis of cancer is referred to as the conversion rate. Conversion rates have declined over the past 10 years as referrals via the GP suspected cancer referral pathway have increased. This is a positive change as it increases the likelihood that cancers will be identified at an earlier stage, reducing the chances of later, emergency presentations. It is the case however, that high volume referrals can also put pressure on services, so it is important for referrals to be made appropriately.

In 2019/20, 6.3% of all suspected cancer referrals resulted in a diagnosis of cancer in Cheshire and Merseyside, compared to 6.6% in England as a whole (**Figure 36**). This did, however, vary considerably by cancer. Conversion rates ranged from 27.3% (respiratory/lung) and 21.6% (haematological) to 2.7% (lower GI) and 3.1% (gynaecological).

Figure 36: Trend in diagnosis of cancer conversion rate, as a percentage of all suspected cancer referral rates, 2009/10 to 2019/20



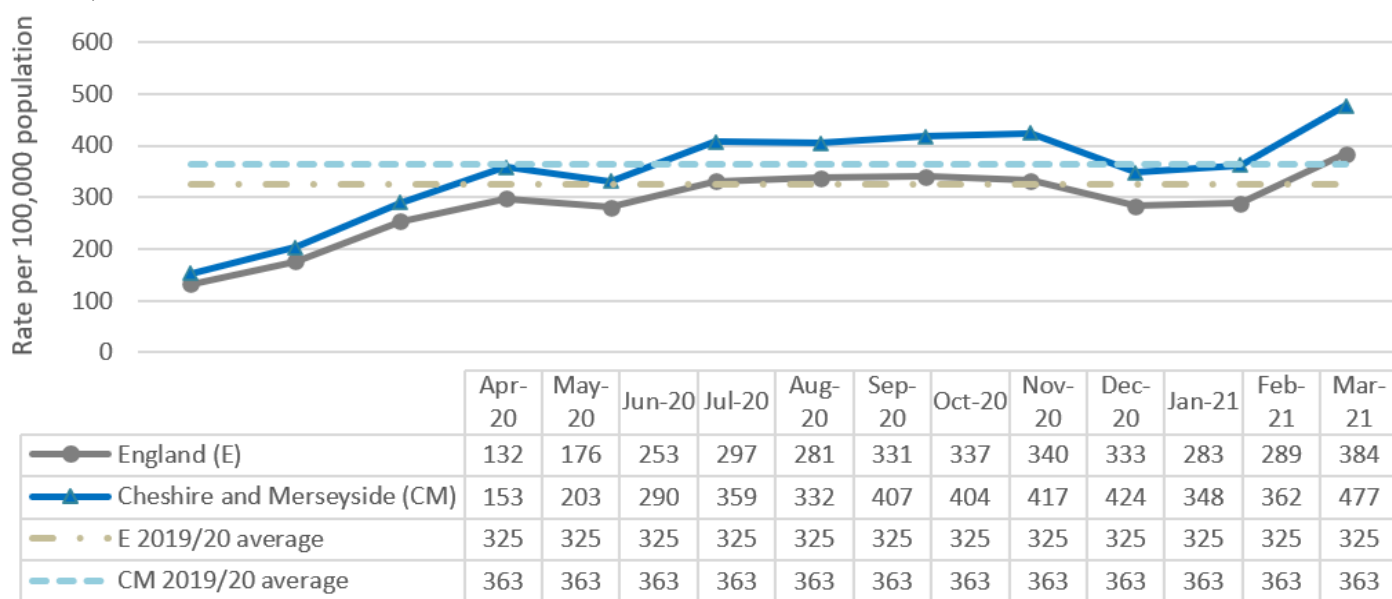
Source: [PHE Fingertips Cancer Data](#), 2021

²⁰ Cheshire CCG was formed in April 2020, prior to this the CCGs of East Cheshire, South Cheshire, Vale Royal and West Cheshire existed. Data have been aggregated to the Cheshire CCG footprint.

Monthly breakdown of 2020/21 referrals

- In 2020/21 there were around 111,600 patients seen in Cheshire and Merseyside²¹ following a suspected cancer referral from GPs. This equates to around 4,200 per 100,000 population, significantly higher than the England average (3,400)
- The COVID-19 pandemic impacted referral numbers at the start of the financial year, with referral rates in April 2020/21 at less than half of the 2019/20 monthly average
- Throughout 2020/21, referral rates recovered, rising above the 2019/20 monthly average between July and December 2020 (**Figure 37**). A dip in referral rates corresponded with rising pandemic cases in January and February, however in March 2021 referral rates had again recovered to above the 2019/20 monthly average. Currently across Cheshire and Merseyside they are 18% above pre-pandemic levels

Figure 37: Trend in suspected cancer (2 week wait) referral rates in Cheshire and Merseyside by month, 2020/21



Source: [NHSE Cancer Waiting Times](#) and [ONS Annual Population Estimates](#) (2019)

Referral breakdowns by cancer type are available for providers (NHS trusts) within the Cheshire and Merseyside footprint²². **Figure 38** below shows volumes of referrals by cancer type in 2020/21 and the proportion of those referrals which were seen within 14 days.

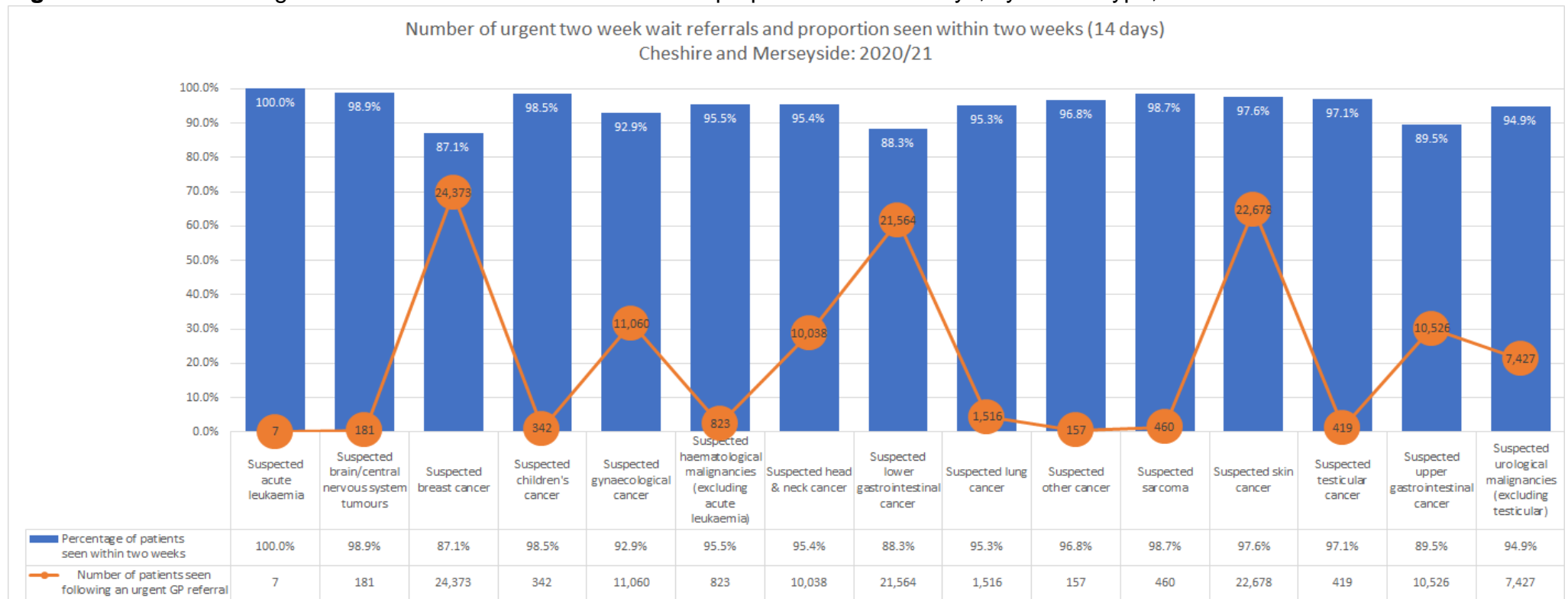
The national operational standard states that 93% of suspected cancer patients should be seen within 14 days. During 2020/21, 91.9% of 111,600 suspected cancer patients were seen within 14 days in Cheshire and Merseyside, compared to 88.7% in England as a whole.

The highest numbers of referrals seen were for suspected breast cancer, suspected lower gastrointestinal (GI) cancer and suspected skin cancer.

²¹ NHS England monthly Cancer Waiting Times (provisional) – commissioners

²² NHS England monthly Cancer Waiting Times (provisional)-providers

Figure 38: Number of urgent two week wait referral referrals and proportion seen 14 days, by cancer type, 2020/21



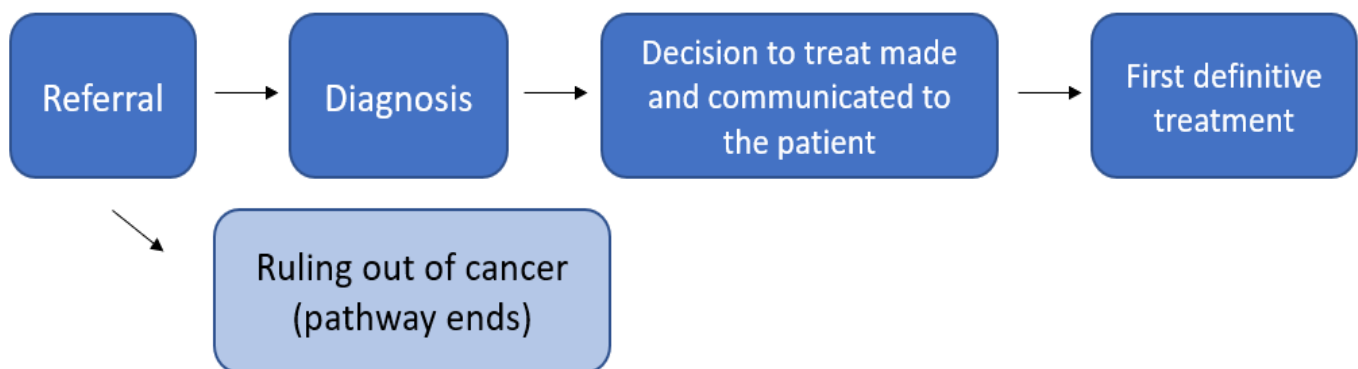
Source: [NHSE Cancer Waiting Times](#)

Referral to first definitive treatment: 62 day pathway

In 2019/20, just over half (50.2%) of all cancer diagnoses were made following an urgent GP referral²³. Patients who receive a diagnosis of cancer following an urgent GP referral (two week wait referral), should receive their first definitive treatment for cancer within 62 days of the urgent GP referral.

Within the “62-day pathway” the patient will move through different stages, although only the overall wait time for first definitive treatment is relevant to the 62 day standard.

In most cases the patient will follow a 62 day pathway as shown in the infographic below. In some cases – such as skin excisions, the treatment may occur prior to diagnosis, with a sample of the excised tissue being sent for analysis following the procedure to remove it.



Referral to First definitive treatment - Urgent GP Referrals:

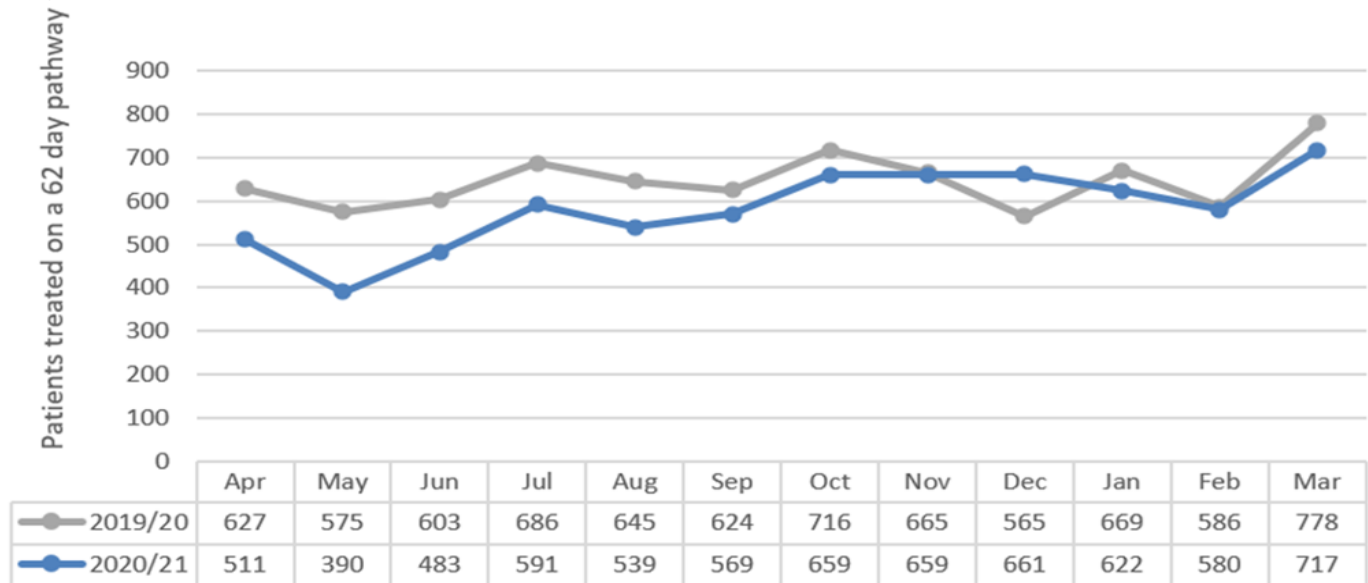
During 2020/21, 6,981 patients were treated for a new diagnosis of cancer in Cheshire and Merseyside (patients treated at Trusts in Cheshire and Merseyside), compared to 7,739 in the previous year²⁴.

This 10% reduction in treatments compared to the previous year, relates to the early months of the pandemic when NHS services reduced. From October 2020 onwards, treatment numbers were comparable with the previous year.

²³ PHE fingertips cancer services

²⁴ NHS England Cancer Waiting Times Statistics

Figure 39: Number of Urgent GP Referral patients receiving a first definitive treatment for a diagnosed cancer Cheshire and Merseyside (2019/20 and 2020/21)



Source: NHS England Cancer Wait Times data Commissioner based (data not published)

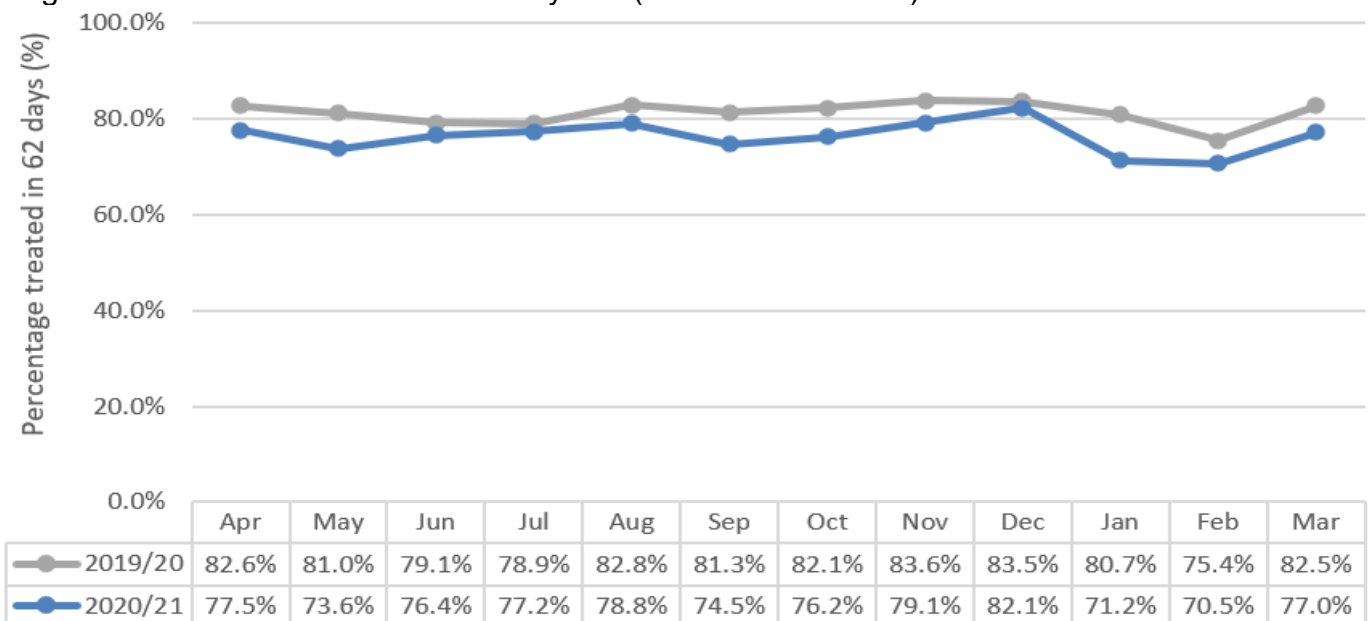
Numbers of patients being treated on a 62 day pathway following an urgent GP referral, had returned to pre-pandemic levels by November 2020 (**Figure 39**), however, the proportion of patients being treated within 62 days was consistently lower in 2020/21, compared to 2019/20.

Overall, 76.31% of patients received their first definitive treatment within 62 days in 2020/21, compared to 81.2% in the previous year).

Cheshire and Merseyside performed below the national operational standard for urgent GP referrals in 2020/21, however Cheshire and Merseyside performed better than England as a whole (74.3% in 2020/21 and 77.1% in 2019/20) (**Figure 40**).

This reflects increased pressure of services due to the pandemic, and increased numbers of referrals coming through later in 2020/21.

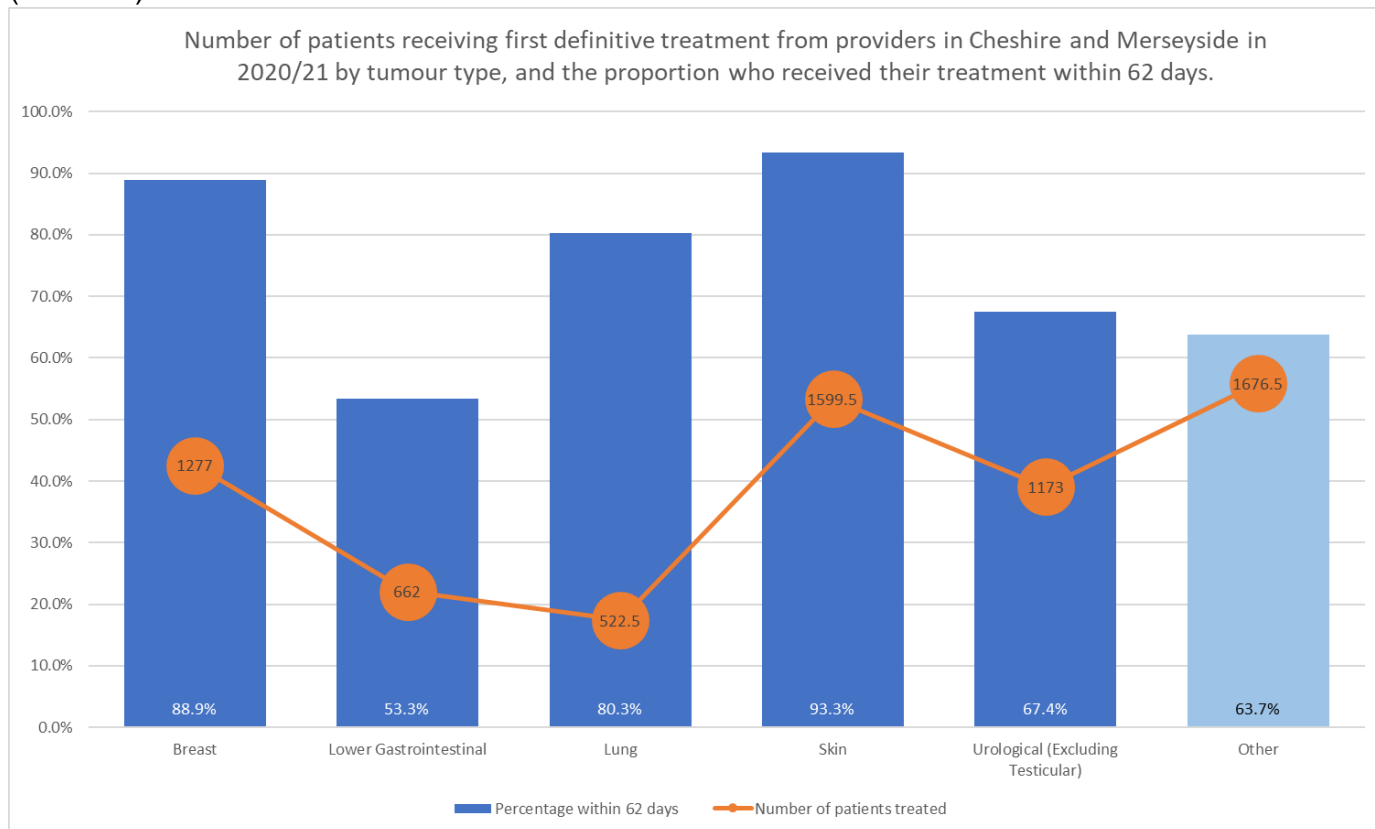
Figure 40: Percentage of Urgent GP Referral patients receiving a first definitive treatment for a diagnosed cancer Cheshire and Merseyside (2019/20 – 2020/21)



Source: NHS England Cancer Wait Times data Commissioner based (data not published)

Treatment breakdowns by the more common cancer types are available for providers (NHS Trusts) within the Cheshire and Merseyside footprint²⁵ Patients can be recorded as a fraction (usually 0.5) if their treatment was split between multiple providers (Trusts).

Figure 41: Number of Urgent GP referral patients receiving first definitive treatment, by tumour and proportion who received treatment within 62 days, Cheshire, and Merseyside Providers (2020/21)



Source: NHS England Cancer Wait Times data Commissioner based (data not published)

In the main cancer types, the largest number of Urgent GP Referral treatments was for skin cancers (**Figure 41**), however, it should be noted that this includes non-malignant tumours, due to the fact that suspected skin cancers are often fully excised and then diagnosed. Skin cancer is an unusual pathway, as the decision to treat and first definitive treatment, often come prior to diagnosis. As a result skin cancer pathways see the greatest proportion of patients within 62 days (93.3% in 2020/21).

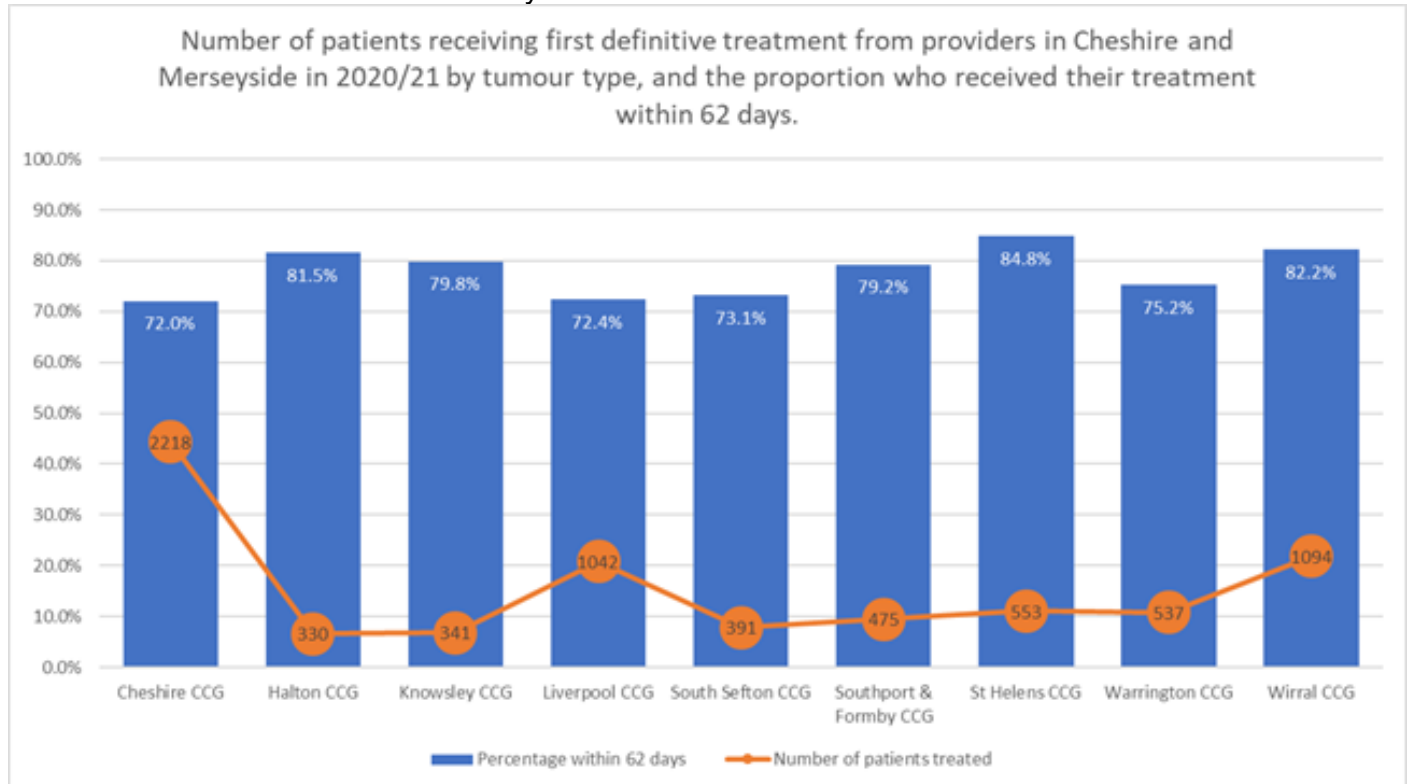
Breast cancer pathways also achieved the national operational standard (85%), with 88.9% of breast cancer patients treated within 62 days in 2020/21. Performance in Lower GI cancer (53.3%) and Urological cancer (67.4%) pathways was much lower. For Lower GI cancer, endoscopy is part of the diagnosis route. The pandemic adversely affected endoscopy services across the region, which has contributed to the low proportion of Lower GI cancer patients being treated within 62 days of referral.

In 2020/21, 6,911 patients registered with GPs in Cheshire and Merseyside and referred urgently for suspected cancer, received a first definitive treatment for cancer. There is slight variation from the number of patients treated at Trusts in Cheshire and Merseyside, since some patients registered will receive treatment outside of the area, whilst other patients registered outside of the area will be treated by Cheshire and Merseyside Trusts.

²⁵ NHS England monthly Cancer Waiting Times (provisional)-providers

In 2020/21 at CCG level, achievement of the 62 day standard for urgent GP referrals varied from 72.0% in Cheshire CCG to 84.8% in St. Helens CCG. No CCGs achieved the national operational standard of 85% (**Figure 42**).

Figure 42: Proportion of urgent GP referral patients receiving first definitive treatment from providers in Cheshire and Merseyside in 2020/21 by tumour type, with the proportion who received their treatment within 62 days



Source: NHS England Cancer Wait Times data Commissioner based (data not published)

Referral to First definitive treatment – Screening referrals

The national operational standard states that 90% of patients identified via screening should have their first treatment for cancer within 62 days of referral. This standard is deemed to be met if the patient has their first definitive treatment for cancer within 62 days. Screening relates to Breast, Cervical and Bowel cancers, however on rare occasions patients will be referred via a screening pathway and, upon investigation are diagnosed with a primary cancer of a different type.

During 2020/21, 530 screening patients were treated for a new diagnosis of cancer in Cheshire and Merseyside (patients registered with GPs in Cheshire and Merseyside), compared to 1,703 in the previous year²⁶.

A 70% reduction. In 2020/21, 81.3% of Cheshire and Merseyside patients identified via screening received a First Definitive Treatment within 62 days, compared to 85.9% in the previous year.

Referral to First definitive treatment – consultant upgrades

There is no national operational standard for patients who originally attended a medical setting for an unrelated condition, and who were subsequently upgraded onto a 62 day pathway for suspected cancer.

²⁶ NHS England Cancer Waiting Times Statistics

During 2020/21, 2,291 patients were upgraded onto a 62 day pathway, and subsequently treated for a new diagnosis of cancer in Cheshire and Merseyside (patients registered with GPs in Cheshire and Merseyside), compared to 2,368 in the previous year²⁷. A one percent reduction.

Although there is no operational standard relating to consultant upgrades onto a 62 day pathway, the proportion of patients treated within 62 days can still be used as an indication of pathway length. In 2020/21, 83.5% of Cheshire and Merseyside patients who moved onto a 62 day pathway following a consultant upgrade received a First Definitive Treatment within 62 days, compared to 84.3% in the previous year.

Referral to Diagnosis

Historically there has been no set timeframe from referral, for a patient to receive a diagnosis, however from October 2021 patients should receive a diagnosis or ruling out of cancer within 28 days of an urgent suspected cancer referral from a GP, a screening referral, or an urgent referral from a GP for breast symptoms where cancer is not initially suspected. This is the Faster Diagnosis Standard (FDS), it will exist alongside the 62 day standard.

This new standard was originally due to be introduced in April 2021, however this was delayed due to the pandemic. Initially the national operational standard for FDS will be set at 75% of patients to be seen within 28 days.

Decision to treat to first definitive treatment

Once a patient has received a diagnosis of cancer, and agreed to a treatment plan, they should receive their first definitive treatment for cancer within 31 days.

The 31-day treatment pathway is separate a standard linked to the 62 day pathway, but with additional complexities. 31-day treatment pathways are described in more detail in the next section.

Long waiters

A long waiter is defined as those who have waited more than 104 days for their first treatment following referral on a 62 day pathway OR someone who has waited more than 73 days (following the decision to treat) to their first treatment on a 31 day pathway.

The number of long waiters has grown through the pandemic due to delays with diagnostics, treatments and is now further exacerbated by a higher rate of GP referrals.

Urgent GP referrals awaiting cancer treatments remain high and are currently around 20% above pre-pandemic baselines. This is due to increased urgent GP referrals as people have gone back to their GPs after lockdowns and delays in accessing diagnostic tests (particularly endoscopy). Urgent GP referrals have been above pre-pandemic levels since November 2020. Cancer treatments are similar to pre-pandemic levels (within 5%).

As of August 2021, there were around 950 people who had waited over 62 days from GP referral for cancer treatment, compared with a pre-pandemic baseline of 559 people. Almost 200 of these people have waited over 104 days (baseline 125 people).

²⁷ NHS England Cancer Waiting Times Statistics

Decision to treat to treatment: 31 day pathway

The 31-day treatment pathway is a standard which sits alongside the 62-day pathway, but with additional complexities. The 31-day pathway applies to the First Definitive Treatment of cancer following a diagnosis and decision to treat; it also applies to subsequent treatments, where a further decision to treat has been made.

First Definitive Treatments

When a patient has been diagnosed with cancer a “Decision To Treat” (DTT) will be agreed between the patient and the clinician. Treatment can take the form of Surgery, Chemotherapy, Radiotherapy, Palliative Care or Active Monitoring.

When a decision to treat is made, the patient should receive their first definitive treatment for cancer within 31 days. For the first definitive treatment following diagnosis, the national operational standard states that:

96% of patients should receive their first definitive treatment within 31 days, regardless of the treatment modality.

In 2019/20, providers in Cheshire and Merseyside treated 95.8% of patients within 31 days (n=13,764), just below the operational standard. From November onwards, providers in Cheshire and Merseyside achieved the operational standard each month, however overall performance was impacted by the period from May to October, where the standard was not achieved. The lowest monthly performance was in September 2020, when 93.8% of patients were treated within 31 days of DTT.

Subsequent treatments

A patient may require subsequent treatment following their first definitive treatment. When this occurs a separate decision to treat is made, and the patient should then receive that subsequent treatment within 31 days.

The national operational standards for subsequent treatments vary depending on treatment modality. Subsequent treatment operational standards are:

- Surgery: 94% within 31 days of DTT
- Radiotherapy: 94% within 31 days of DTT
- Chemotherapy: 98% within 31 days of DTT

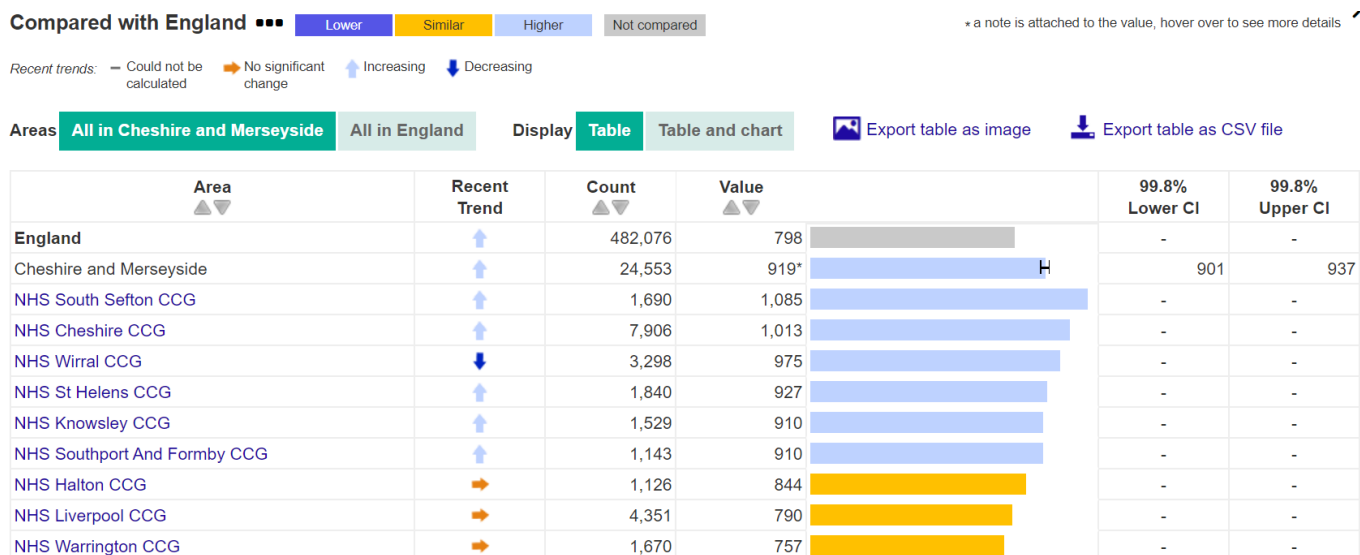
Subsequent treatment types not included in these categories – such as Palliative Care and Active Monitoring, are not assessed against a national operational standard. In 2019/20, providers in Cheshire and Merseyside treated:

- 87.9% of surgical patients within 31 days (n=2,309), below the operational standard. Monthly performance was consistently below the operational standard with the lowest performance occurring in May 2020 (84.0%).
- 98.3% of radiotherapy patients within 31 days (n=3,945), above the operational standard.
- 99.4% of chemotherapy patients within 31 days (n=3,471), above the operational standard.

In-patient or day-case colonoscopy procedures

Figure 43 below shows the rate (per 100,000) of in-patient or day-case colonoscopy procedures in all Cheshire and Merseyside CCGs in 2019/20; the England average and Cheshire and Merseyside average are also shown for comparison.

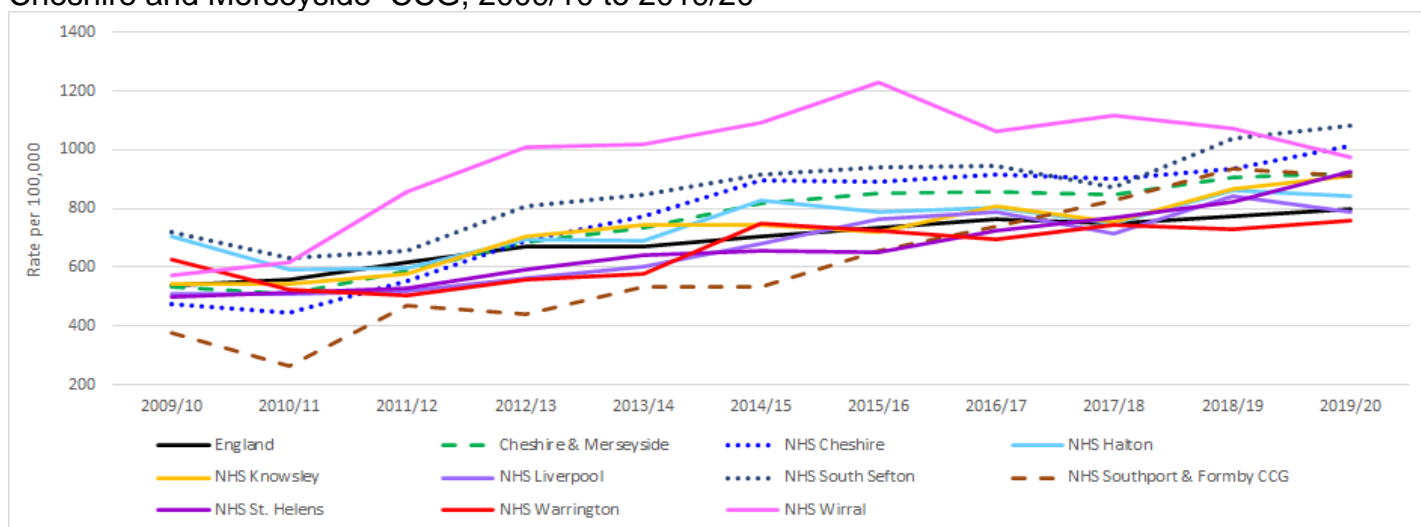
Figure 43: Rate of In-patient or day-case colonoscopy procedures (crude rate per 100,000), by Cheshire and Merseyside CCG, 2019/20



Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

As **Figure 43** and **Figure 44** show, the majority of CCGs in Cheshire and Merseyside had rates for this procedure that were in excess of the England rate of 798 per 100,000 (only NHS Warrington CCG and NHS Liverpool CCG had rates lower than the England average). Rates varied widely, from 1,085 per 100,000 in NHS South Sefton CCG, to 757 per 100,000 in NHS Warrington CCG.

Figure 44: Trend in rate of In-patient or day-case colonoscopy (crude rate per 100,000), by Cheshire and Merseyside CCG, 2009/10 to 2019/20



Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

Figure 44 also shows that all CCGs in Cheshire and Merseyside are showing an improved position in 2019/20 compared to 2009/10, with NHS Southport & Formby and NHS Cheshire showing the largest improvements. After several years of having rates far in excess of England,

Cheshire and Merseyside and other local CCGs, NHS Wirral has recently shown a notable decline in rates for this procedure. Reasons for this are unclear.

Table 5: Trend and percentage change in rate of in-patient or day-case colonoscopy procedures (crude rate per 100,000), by Cheshire and Merseyside CCG, 2009/10 to 2019/20

Year	England	Cheshire & Merseyside	NHS Cheshire	NHS Halton	NHS Knowsley	NHS Liverpool	NHS South Sefton	NHS Southport & Formby CCG	NHS St. Helens	NHS Warrington	NHS Wirral
2009/10	536.0	535.5	473.1326	705.2109	543.3994	511.3	718.6	375.6	501.5	627.5	574.5378
2010/11	555.9	508.9	447.1979	591.0957	542.6739	507.9	630.7	266.5	514.4	525.8	615.6375
2011/12	616.4	586.6	555.4698	599.279	577.7161	516.7	655.1	470.0	528.1	505.3	854.5718
2012/13	669.5	685.0	689.612	693.5158	704.2297	565.3	808.6	441.9	592.5	558.3	1007.914
2013/14	669.5	733.4	775.7549	689.1099	742.0652	603.9	848.9	533.5	641.9	579.4	1018.775
2014/15	707.1	819.8	896.6533	828.102	742.8295	681.0	917.1	535.5	657.1	748.5	1093.355
2015/16	735.6	852.7	890.5388	786.8026	720.7396	762.2	938.8	654.9	649.3	723.3	1227.286
2016/17	764.3	859.2	917.8468	804.9678	807.019	787.3	946.6	737.8	726.3	696.1	1062.429
2017/18	747.5	845.8	901.9241	749.2035	754.9593	712.6	870.6	828.0	768.5	742.5	1118.944
2018/19	775.8	905.5	933.9978	862.2901	868.7033	841.2	1036.0	935.9	821.2	729.1	1070.731
2019/20	797.8	918.9	1012.959	843.9578	910.3683	789.8	1084.6	909.6	926.8	756.5	974.5316
% Change	48.8	71.6	114.1	19.7	67.5	54.5	50.9	142.2	84.8	20.6	69.6

Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

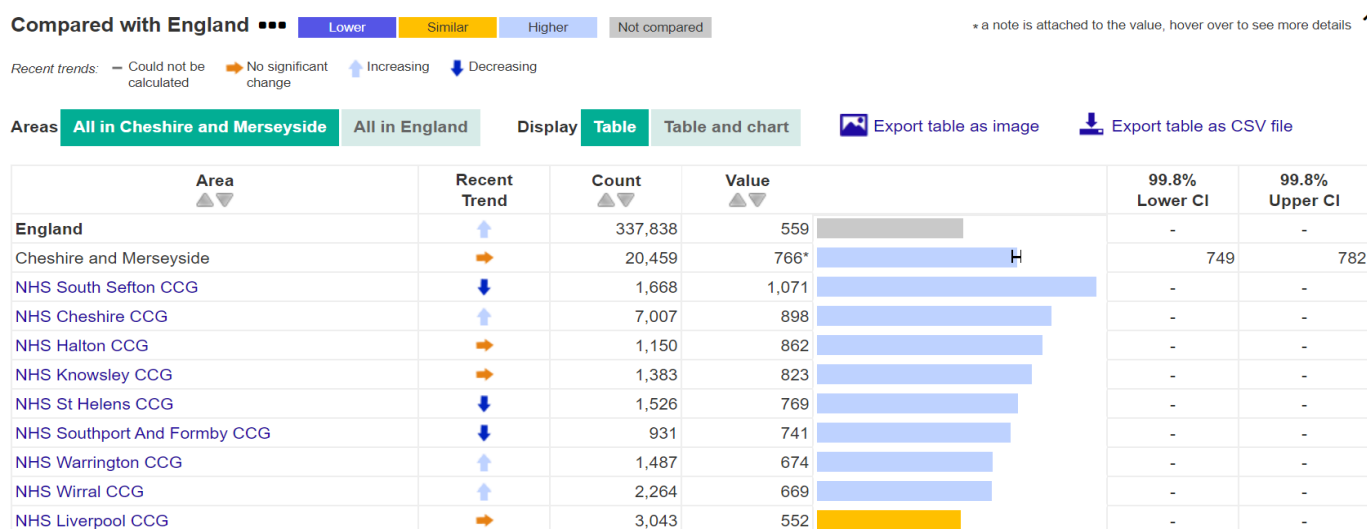
Note: Percentage (%) change refers to the change between 2009/10 and 2019/20

As **Table 5** shows, compared to 2009/10 rates, there was a 49% increase in procedure rates in England overall, compared to a 72% increase in Cheshire and Merseyside. The most improved CCG for colonoscopy procedures was NHS Southport & Formby CCG (142% increase over the period shown). The least improved CCG was NHS Halton (although this was still a 20% improvement).

In-patient or day-case sigmoidoscopy procedures

Figure 45 below shows the rate (per 100,000) of in-patient or day-case sigmoidoscopy procedures in all Cheshire and Merseyside CCG in 2019/20; the England average and Cheshire and Merseyside average is also shown for comparison.

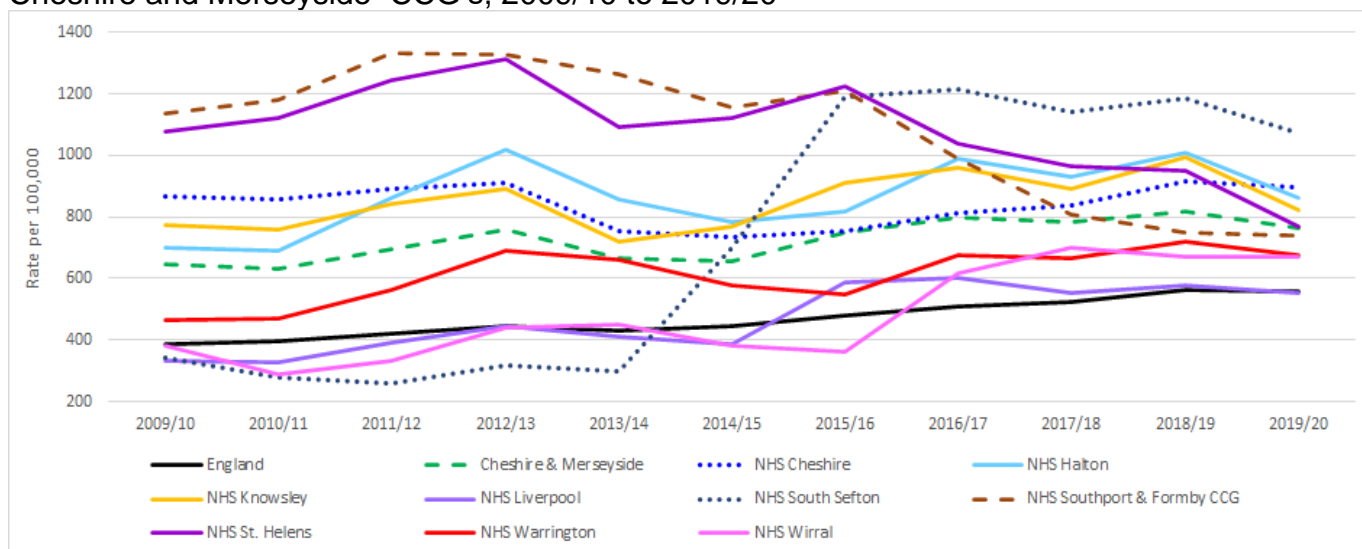
Figure 45: Rate of in-patient or day-case sigmoidoscopy procedures (crude rate per 100,000), by Cheshire and Merseyside CCG's, 2019/20



Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

As **Figure 45** above shows, all but one Cheshire and Merseyside CCG (NHS Liverpool) had rates of sigmoidoscopy that were in excess of the England rate. Cheshire and Merseyside overall had rates of 766 per 100,000 in 2019/20 compared to 559 per 100,000 in England. Rates varied from 1,071 per 100,000 in NHS South Sefton, to 552 per 100,000 in NHS Liverpool CCG.

Figure 46: Trend in rate of in-patient or day-case sigmoidoscopy (crude rate per 100,000), by Cheshire and Merseyside CCG's, 2009/10 to 2019/20



Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

There were some large fluctuations in rates for this procedure for the time period shown (**Figure 46**). Reasons for this are unclear. Rates in England overall increased over the period (from 385 per 100,000 to 559 per 100,000), this is a larger rate of increase than is the case in Cheshire and Merseyside overall. **Table 6** below shows the difference between 2009/10 and 2019/20 as a percentage change.

Table 6: Trend and percentage change in rate of in-patient or day-case sigmoidoscopy procedures (crude rate per 100,000), by Cheshire and Merseyside CCG, 2009/10 to 2019/20

Year	England	Cheshire & Merseyside	NHS Cheshire	NHS Halton	NHS Knowsley	NHS Liverpool	NHS South Sefton	NHS Southport & Formby CCG	NHS St. Helens	NHS Warrington	NHS Wirral
2009/10	384.8	648.7	865.6	701.3	775.7	333.6	343.6	1135.9	1079.2	465.7	382.3222
2010/11	397.0	631.7	854.8	688.8	759.0	329.5	277.9	1179.9	1121.4	467.6	289.6055
2011/12	422.5	697.3	892.0	860.7	842.5	389.7	259.7	1331.2	1242.9	564.2	333.9775
2012/13	445.6	758.6	911.6	1019.3	892.4	443.1	317.9	1327.3	1314.6	688.5	442.1153
2013/14	431.6	665.3	755.4	858.9	721.4	409.7	295.9	1262.3	1094.5	659.9	452.4205
2014/15	444.9	658.3	735.8	785.7	766.4	385.0	699.7	1155.4	1121.5	578.5	381.3958
2015/16	480.5	750.6	752.9	818.3	909.1	587.7	1191.4	1209.6	1223.1	550.4	363.5405
2016/17	508.5	800.2	811.0	987.4	960.0	603.6	1213.9	989.9	1039.4	676.4	614.8449
2017/18	522.7	781.7	835.1	928.3	890.1	555.5	1141.4	808.8	964.4	665.9	700.4551
2018/19	565.2	819.7	916.7	1010.2	993.7	578.8	1186.0	751.0	949.4	719.5	670.8658
2019/20	559.1	765.7	897.8	861.9	823.4	552.4	1070.5	740.9	768.7	673.6	668.9932
% Change	45.3	18.0	3.7	22.9	6.2	65.6	211.5	-34.8	-28.8	44.7	75.0

Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

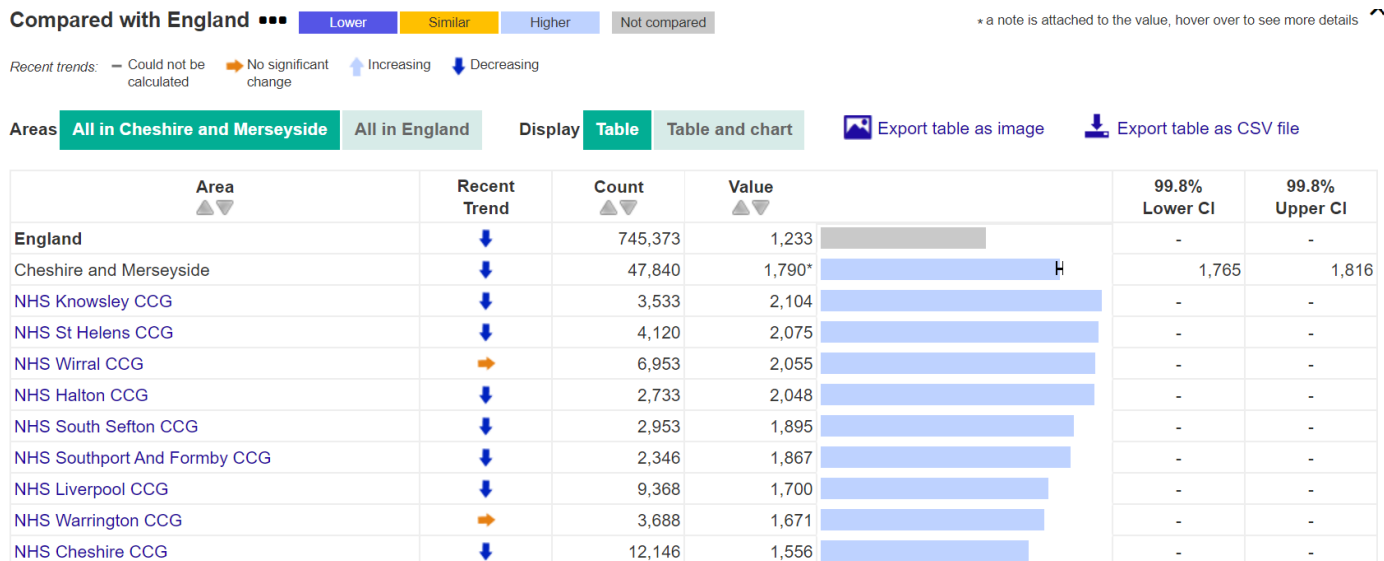
Note: Percentage (%) change refers to the change between 2009/10 and 2019/20

As **Table 6** shows, there was an 18% increase in sigmoidoscopy procedures in Cheshire and Merseyside over the period shown, compared to a 45% increase in England overall. The CCG with the largest percentage increase was NHS South Sefton CCG, with a 212% increase. NHS Southport & Formby CCG however, showed a 35% decrease in procedures over the period shown.

In 2009/10, NHS Southport & Formby was the highest performing CCG in Cheshire and Merseyside for this procedure, while NHS South Sefton was the lowest performing CCG. Both CCGs now appear to have converged (as one decreased and one increased). NHS St. Helens CCG also showed a large percentage decrease (29%) in procedures over the period shown.

In-patient or day-case upper GI endoscopy procedures

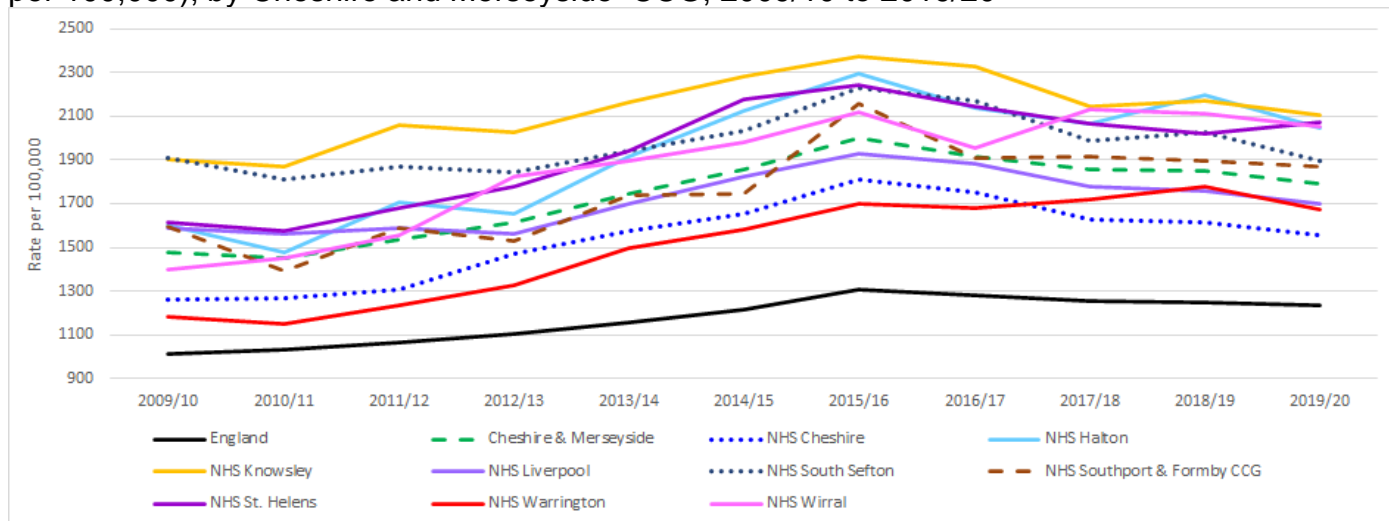
Figure 47: Rate of In-patient or day-case upper GI endoscopy procedures (crude rate per 100,000), by Cheshire and Merseyside CCG, 2019/20



Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

As **Figure 47** shows, the rate of in-patient or day-case upper GI endoscopy procedures in Cheshire and Merseyside were significantly higher than that of England in 2019/20. All CCGs except for NHS Wirral CCG and NHS Warrington CCG were showing a downward trend compared to the previous time period (although all remained higher than England).

Figure 48: Trend in rate of In-patient or day-case upper GI endoscopy procedures (crude rate per 100,000), by Cheshire and Merseyside CCG, 2009/10 to 2019/20



Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

As **Figure 48** shows, rates of In-patient or day-case upper GI endoscopy procedures in Cheshire and Merseyside overall has consistently exceeded that of England from 2009/10 to 2019/20. CCG rates in 2019/20 ranged from 2,104 per 100,000 (NHS Knowsley CCG) to 1,556 per 100,000 (NHS Cheshire CCG). The trend chart appears to show steady increases in rates to 2015/16; after which most areas (including England and Cheshire and Merseyside overall) have seen a decline. Although the observed recent declines have not yet meant rates are lower than 2009/10, but they have now reduced to levels seen in around 2013 and 2014 (and the impact of COVID is still to be observed, as the latest available figures are up to March 2020, the start of the pandemic in England).

Table 7: Trend and percentage change in rate of In-patient or day-case upper GI endoscopy procedures (crude rate per 100,000), by Cheshire and Merseyside CCG, 2009/10 to 2019/20

Year	England	Cheshire & Merseyside	NHS Cheshire	NHS Halton	NHS Knowsley	NHS Liverpool	NHS South Sefton	NHS Southport & Formby CCG	NHS St. Helens	NHS Warrington	NHS Wirral
2009/10	1012.6	1479.5	1259.6	1603.8	1899.1	1589.1	1910.7	1593.9	1614.1	1182.7	1401.8
2010/11	1033.1	1454.4	1269.9	1474.6	1870.9	1562.3	1810.9	1394.7	1576.7	1149.1	1454.7
2011/12	1063.0	1533.8	1308.8	1706.5	2060.6	1588.6	1870.2	1587.9	1683.2	1233.3	1554.2
2012/13	1103.5	1617.1	1474.0	1656.8	2026.1	1561.6	1842.3	1531.0	1775.9	1327.2	1822.0
2013/14	1158.6	1747.6	1578.8	1912.3	2160.6	1696.7	1942.0	1740.3	1939.8	1499.6	1896.2
2014/15	1219.5	1853.5	1656.9	2126.8	2284.4	1822.3	2030.7	1745.3	2174.3	1583.9	1978.0
2015/16	1309.2	1999.1	1811.2	2292.8	2369.6	1925.8	2227.1	2157.6	2242.9	1698.0	2115.0
2016/17	1282.8	1916.5	1749.8	2136.6	2328.1	1885.6	2171.1	1907.3	2145.6	1677.3	1953.8
2017/18	1256.5	1854.1	1630.6	2065.5	2141.9	1780.8	1988.8	1914.4	2068.1	1721.7	2130.2
2018/19	1248.4	1852.3	1612.4	2195.3	2168.2	1756.6	2027.2	1898.9	2017.0	1777.1	2111.7
2019/20	1233.5	1790.5	1556.2	2048.4	2103.6	1700.4	1895.2	1867.0	2075.3	1670.7	2054.6
% Change	21.8	21.0	23.5	27.7	10.8	7.0	-0.8	17.1	28.6	41.3	46.6

Source: HES data held by PHE, provided by NHS Digital (downloaded from [PHOF, 2021](#))

Note: % change refers to the change between 2009/10 and 2019/20

As **Table 7** above shows, almost all Cheshire and Merseyside CCGs improved the rate of In-patient or day-case upper GI endoscopy procedures in the 10 years from 2009/10 to 2019/20. The overall Cheshire and Merseyside rate improved by 21% (similar to the overall England improvement) from 1,479 per 100,000 to 1,790 per 100,000.

The exception was NHS South Sefton CCG, where there was a decrease of 0.8% in rates; the largest rate increase was in NHS Wirral CCG, where a 46.6% increase was observed.

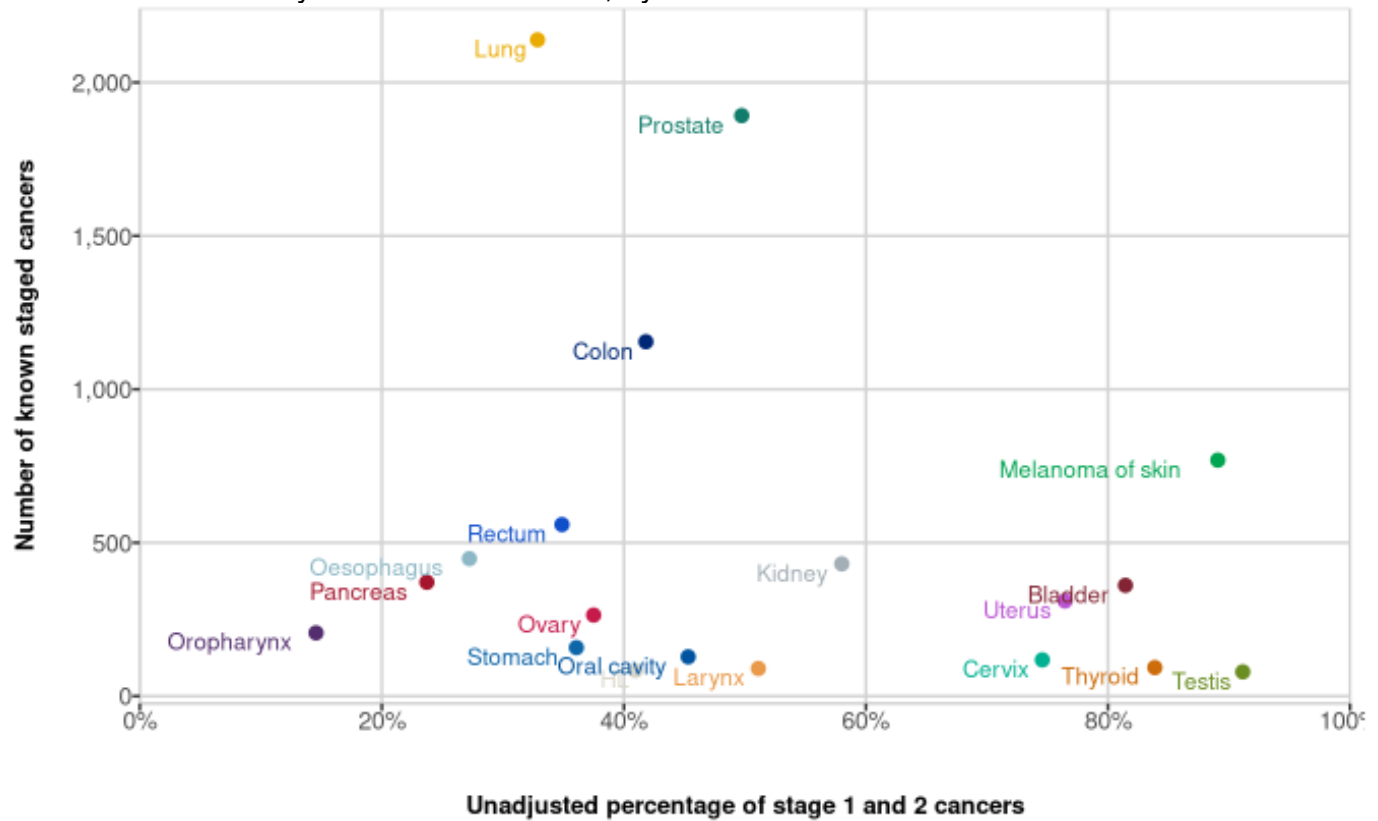
Staging data

There is a wide variance in the proportion of cancers diagnosed at an early stage, based on the tumour site (**Figure 49**).

In Cheshire and Merseyside as a whole, during 2018, malignant skin melanomas, and cancers of the bladder, cervix, uterus, thyroid, and testis had the greatest proportion diagnosed at an early stage.

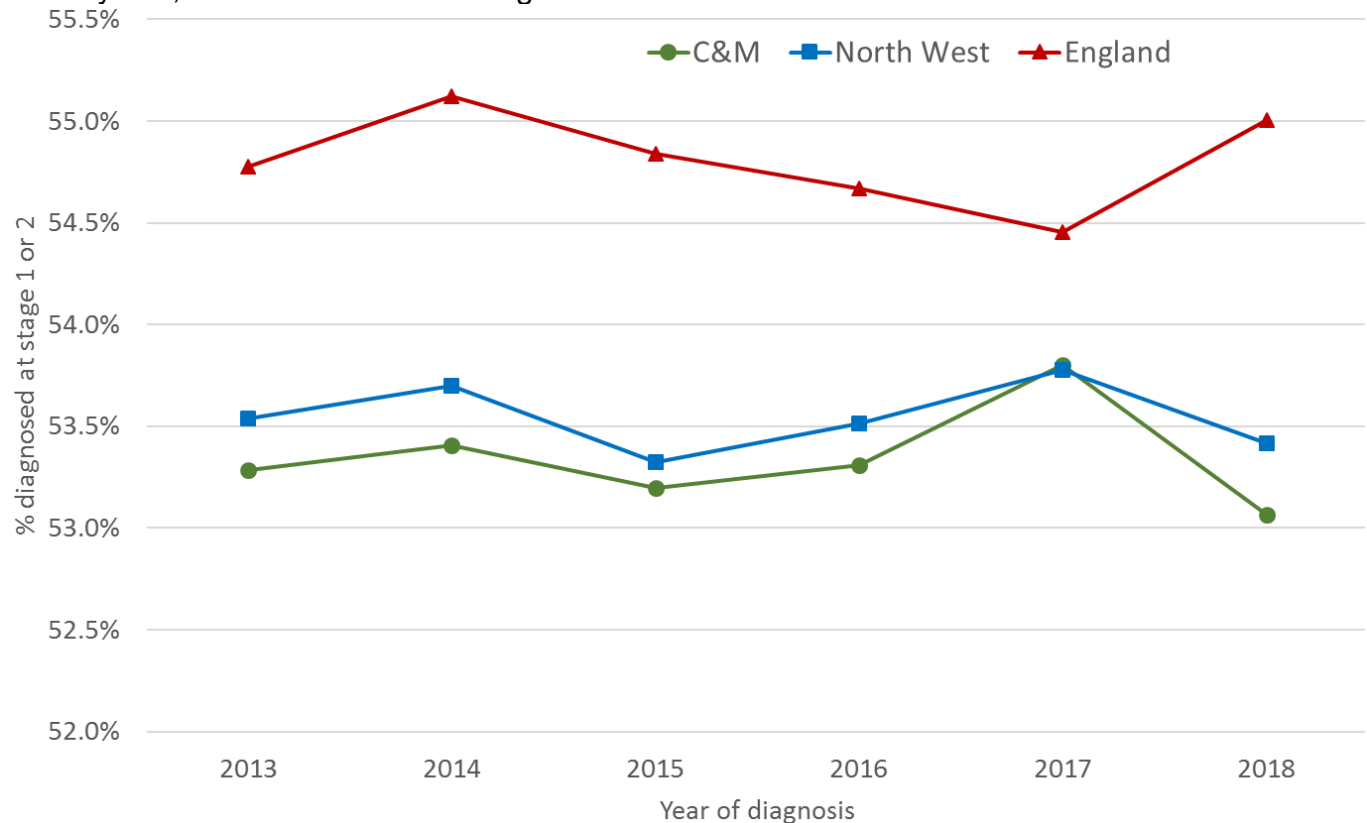
Those cancers which were diagnosed at a late stage (3 or 4), tended to be those of the digestive system, including: oropharynx, oesophagus, stomach, and rectum. The greatest number of cancers were long prostate and colon, which had between 30% and 45% diagnosed at an early stage.

Figure 49: Number and proportion of cancers diagnosed early (at stages 1 or 2) during 2018, in Cheshire and Merseyside Cancer Alliance, by tumour site



Source: [PHE Cancer Stats 2021](#)

Figure 50: Trend in the proportion of cancer diagnose early (stages 1 or 2) in Cheshire and Merseyside, the North-West and England



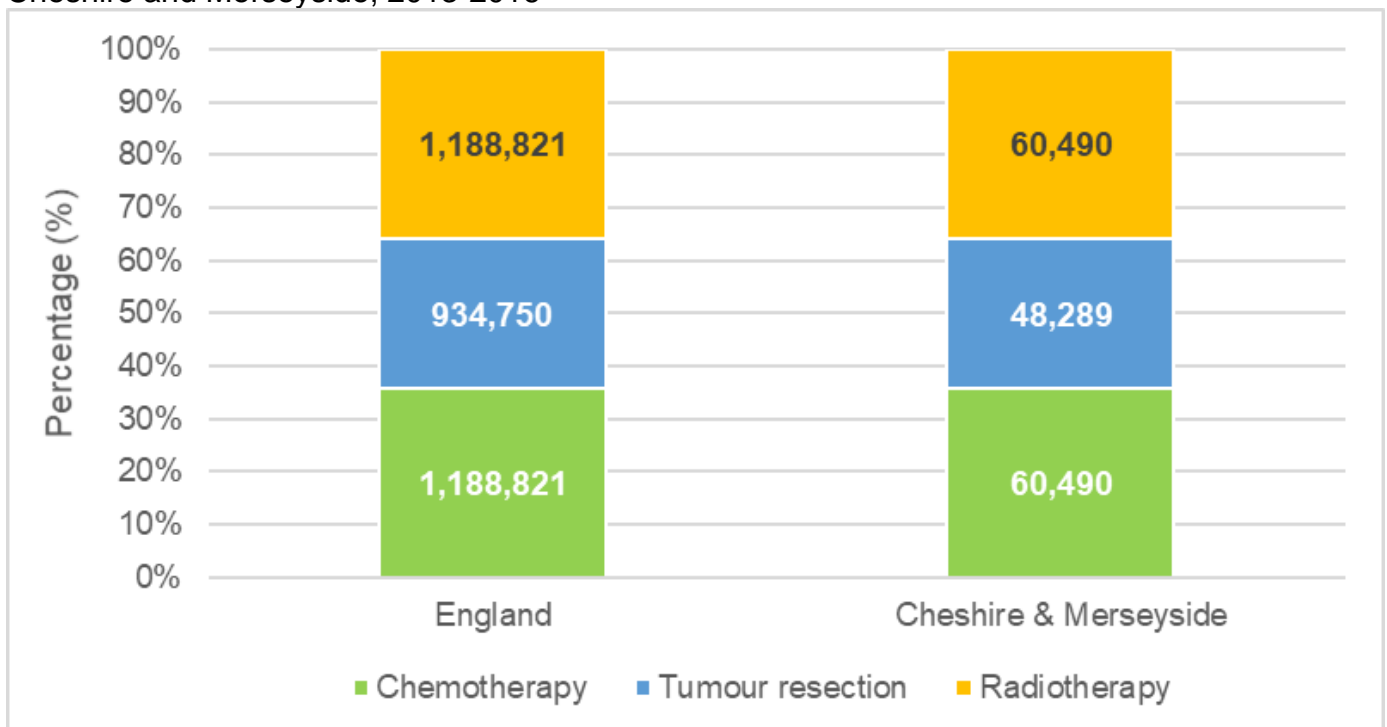
Source: [PHE Cancer Stats 2021](#)

Consistently between 2013 and 2018, Cheshire and Merseyside had a lower proportion of cancers diagnosed at an early stage than England, with 2018 accounting for the lowest proportion of early-stage diagnoses for Cheshire and Merseyside (**Figure 50**). Cheshire and Merseyside is similar to the North-West on this indicator.

Treatment

Figure 51 below presents the number and percentage of all tumours diagnosed in 2013-2016 recorded as receiving radiotherapy, chemotherapy or tumour resection (treatments presented independently). The results are presented by cancer Alliance (Cheshire and Merseyside) and compared to England as a benchmark.

Figure 51: Chemotherapy, Radiotherapy and Surgical Tumour Resections in England and Cheshire and Merseyside, 2013-2016



Source: [CancerData](#), 2021

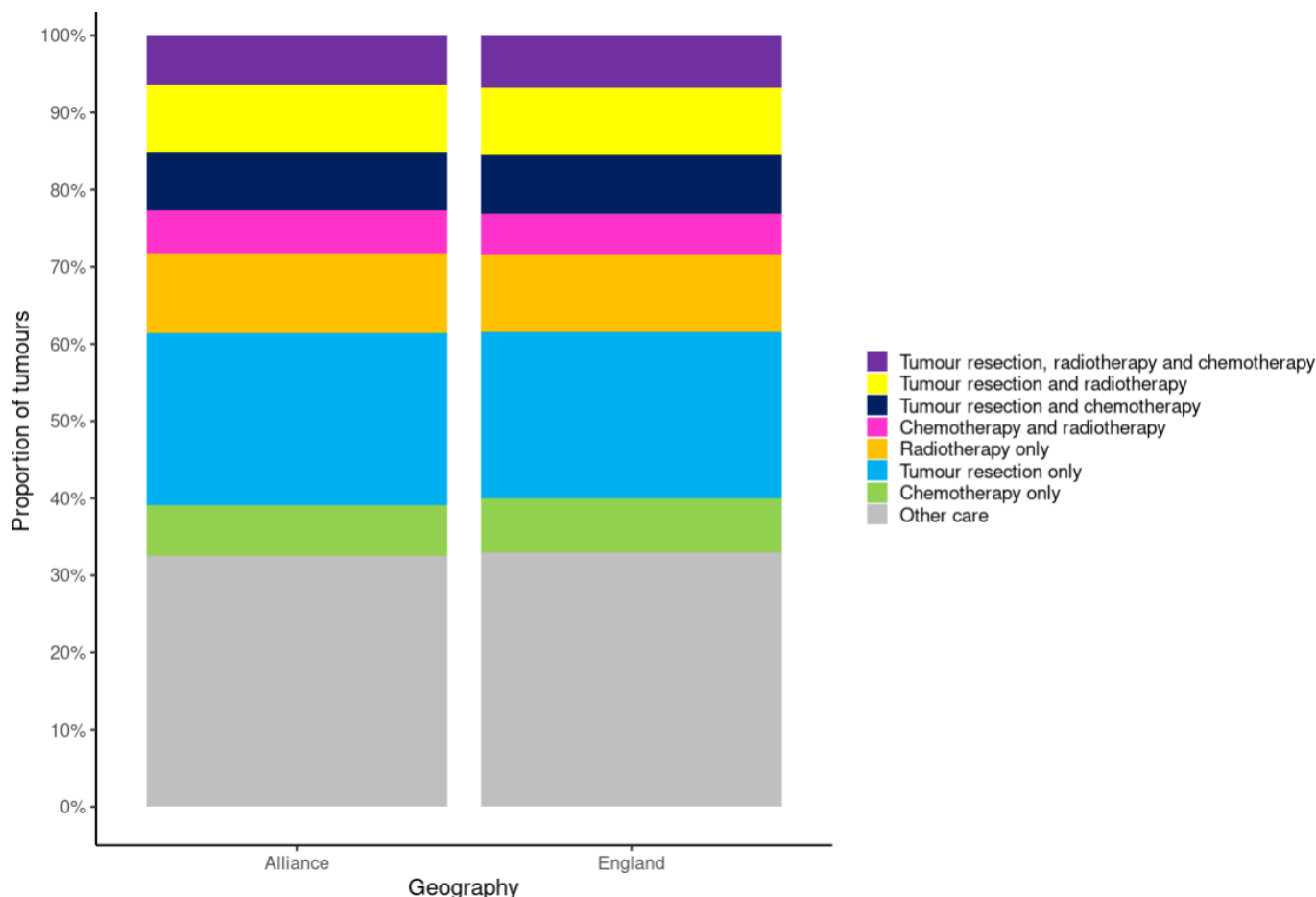
Note: The methodology is described in the standard operating procedure [CAS-SOP #4.5 Linking treatment tables - chemotherapy, tumour resections and radiotherapy](#).

As **Figure 51** above shows, Cheshire and Merseyside data provides a very similar picture to England overall with regard to the proportion of treatments for cancer between 2013-16.

Differences were miniscule, with chemotherapy comprising 35.9% of treatments in England, and 35.7% of treatments in Cheshire and Merseyside.

Resections comprised 28.2% of treatments in England and 28.5% in Cheshire and Merseyside). Radiotherapy comprised 35.9% of treatments in England and 35.7% in Cheshire and Merseyside.

Figure 52: Treatment combinations in England and Cheshire and Merseyside, 2013-2016



Source: [CancerData](#), 2021

As **Figure 52** above shows, Cheshire and Merseyside had a very similar picture to England overall, with regard to the proportion of treatment combinations for cancer between 2013-16. Differences were extremely marginal, with around a third of people receiving ‘Other Care’ in both England (32.5%) and Cheshire and Merseyside (33.0%). The next most common treatment option was Tumour Resection (21.7% in England, 22.3% in Cheshire and Merseyside).

Rapid Registrations dataset

The NHS is actively seeking to adapt, restore, and maintain services, but to do that effectively they need timely evidence on recent trends in service provision to inform their interventions.

Ordinarily, official UK cancer statistics depend on the population-based incidence and treatment data captured by the UK’s cancer registries. The collation of these high-quality registration datasets is, however, a relatively protracted process resulting in around 18 months’ delay in full case ascertainment and official reporting. In the context of the COVID-19 pandemic, therefore, it is not possible to use these registry data to gain a timely population-based perspective on the management and outcomes of cancer care.

As a result, the National Cancer Registration and Analysis Service (NCRAS) developed the Rapid Cancer Registration Dataset (RCRD), based on a rapid processing of all standard administrative datasets which flow rapidly into PHE and are incorporated into the Cancer Analysis System (CAS) of NCRAS, to provide a quicker, indicative source of cancer data to

support the public health response by Public Health England (PHE) and other agencies, and service reorganisation by the NHS.

The data takes the form of a series of significant events that occur to each patient as they proceed through the diagnostic and then therapeutic parts of the cancer pathway, such as chemotherapy cycles, radiotherapy episodes and major cancer surgery as well as events based on the Cancer Waiting Times (CWT) and Cancer Outcomes and Services Dataset (COSD) datasets. It is available at approximately 4-5 months behind real time.

The dataset is explicitly built as a rapid proxy for cancer registration data. There are several known quality and completeness issues. These are more fully documented in this [Data Quality document](#).

In brief, it is known by comparison to historic gold standard registration data that approximately 5% of the proxy tumours in the dataset are incorrectly included in the dataset in that they do not correspond to a registrable cancer, were all data to be fully processed according to cancer registration rules. In addition, approximately 18% of real tumours that can be expected to be eventually registered are missing from the dataset. These missing tumours are disproportionately in older persons and particular cancer types – see the data quality document for more details. These caveats are likely to bias analyses and should be carefully considered when determining whether to request the rapid registration data and also when interpreting results based on the data. The data within this section is based on the data available as of 5 June 2021.

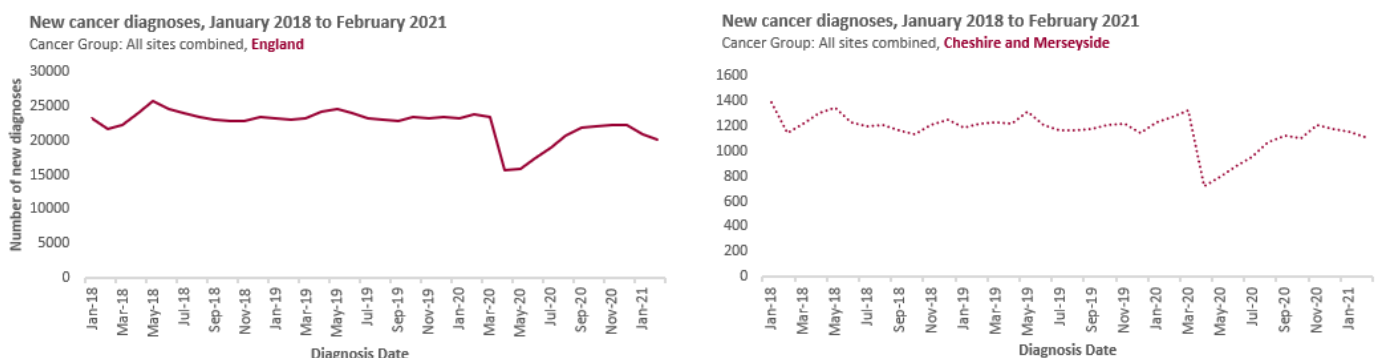
Data is estimated to be near-complete for:

- Diagnoses up to the end of February 2021
- Surgical tumour resections received up to the end of December 2020
- Chemotherapy received up to the end of November 2020
- Radiotherapy received up to the end of February 2021

It is therefore important to note that the **data is not 100% complete**, particularly for diagnoses and treatments in more recent months.

New Cancer Diagnoses

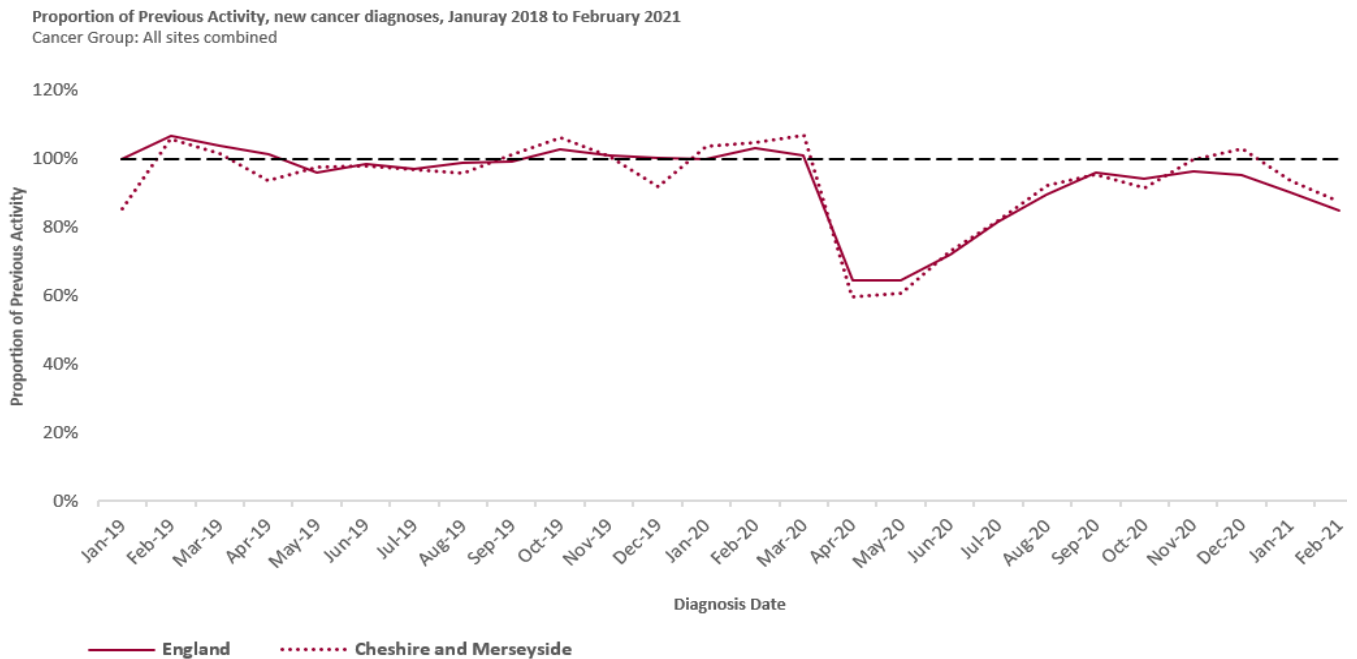
Figure 53 (a) and (b): Number of New Cancer Diagnoses between January 2018 and February 2021 (top) and a comparison to previous activity (bottom) for England (solid line) and Cheshire and Merseyside (dotted line).



Source: [National Cancer Registration and Analysis Service](#) 2021

The comparisons on the bottom graph compare data for a given month to data for the same month in the previous year, for example data for January 2019 is compared to data for January 2018.

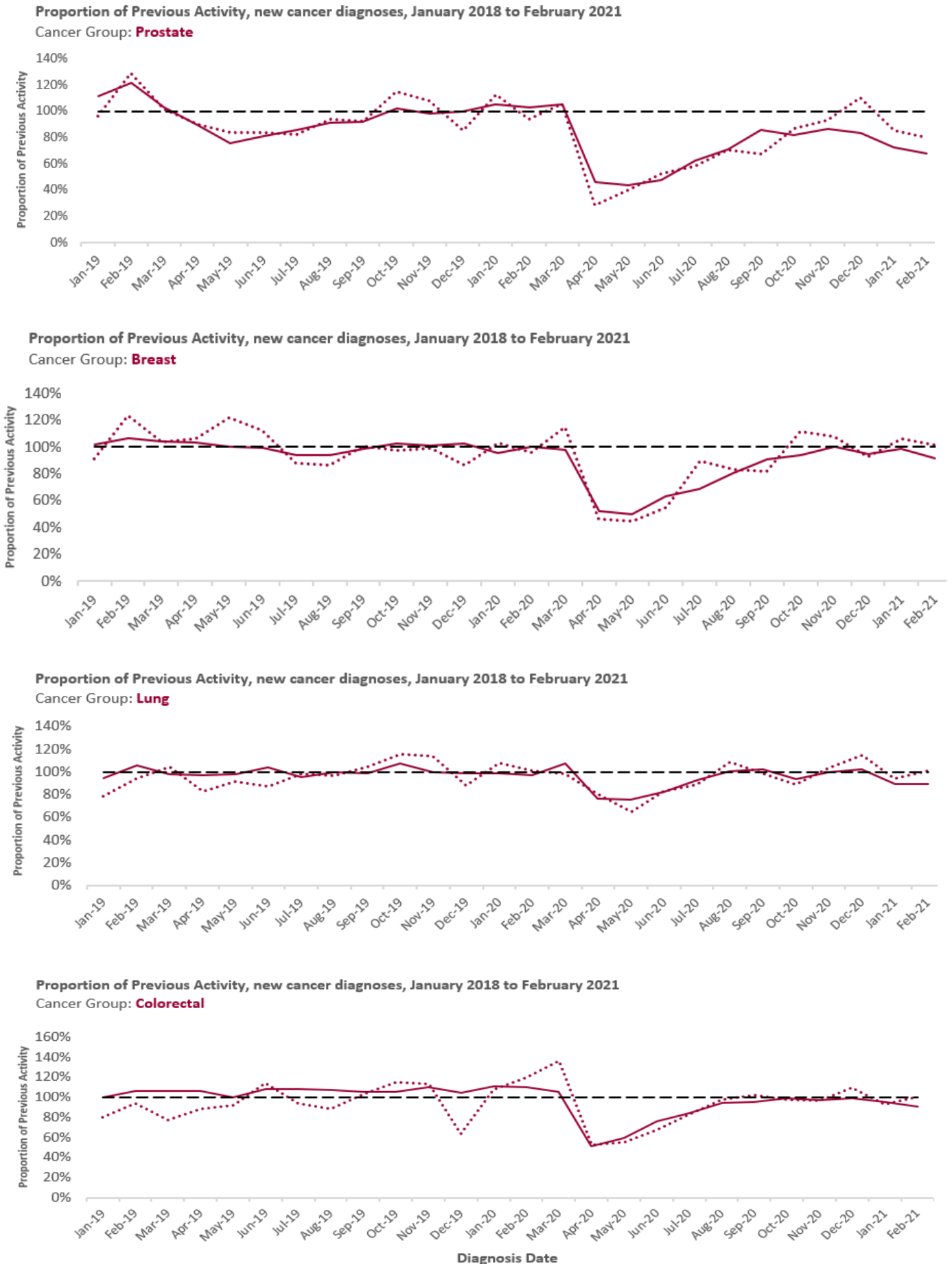
Figure 53 (c)



Source: [National Cancer Registration and Analysis Service](#) 2021

- **Figures 53(a) 53(b) and 53(c)** show there was a fairly consistent number of estimated new cancer diagnoses recorded in the rapid cancer registrations dataset in the pre-COVID-19 period up to March 2020, when the number of new diagnoses reached 101% and 107% of previous activity for all malignant cancers, excluding non-melanoma skin cancer (NMSC), for England and Cheshire and Merseyside respectively.
- For April and May 2020, the estimated number of new cancer diagnoses per month dropped, to around 64% (65% for April, 64% for May) of the pre-COVID numbers for England and 60% (59% for April, 61% for May) of the pre-COVID numbers for Cheshire and Merseyside.
- **Figure 54** shows a comparison to previous activity for the top four cancer types (breast, prostate, lung and colorectal). There were decreases for the top four cancers with the lowest proportion of previous activity for prostate cancer, down to 46% in April for England and 28% for Cheshire and Merseyside and highest proportion of previous activity for lung cancer at 80% for England and 77% for Cheshire and Merseyside.
- For June 2020 onwards, the estimated number of new cancer diagnoses increased again from their lowest levels for all cancer groups.
- By September 2020, the estimated number of diagnoses had reached 95% (for both England and Cheshire and Merseyside) of previous activity for all malignant cancers, excluding NMSC. For England, this includes at least 90% of previous activity for breast (91%), lung (102%) and colorectal (95%) cancers but not prostate cancer (86%). For Cheshire and Merseyside, this includes at least 90% of previous activity levels for lung (99%) and colorectal (102%) cancer but not breast (82%) or prostate cancer (68%).
- October, November, and December 2020 have similar levels of previous activity for new diagnoses of all malignant cancers excluding NMSC, ranging from 94% to 96% for England and 91% to 102% for Cheshire and Merseyside, with a decrease to 87% for England and 90% for Cheshire and Merseyside in January 2021. This decrease may reflect lower completeness for more recent months in the currently available data.

Figure 54: A comparison to previous activity for England (solid line) and Cheshire and Merseyside (dotted line) for the top four types of cancer; prostate (top), breast (second row), lung (third row), and colorectal (bottom row), between January 2018 and February 2021.



Source: [National Cancer Registration and Analysis Service](#) 2021

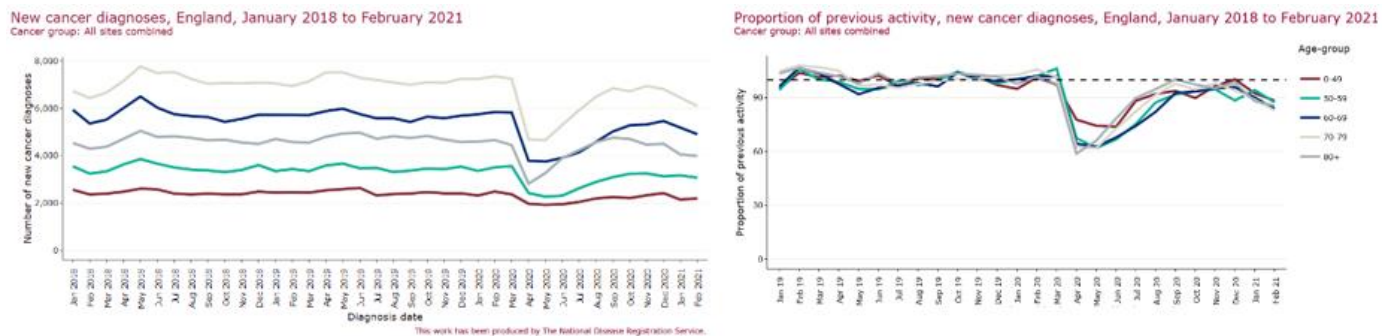
Demographic Factors (England level only)

Data on demographic breakdown is **not available at a cancer alliance level**, therefore this section refers to England level only. For all malignant cancers excluding NMSC, the pattern and size of changes in new cancer diagnoses were similar for most demographic factors, including for both men and women and for all income deprivation quintiles.

Age

Figure 55 shows the number of new cancer diagnoses between January 2018 and February 2021 and a comparison to previous activity by age group at England level. The impact on new cancer diagnoses for those aged 0-49 appeared to be smaller than for older age-groups, with new diagnoses of all malignant cancers excluding NMSC dropping in May to 74% of previous activity for those aged 0-49 compared to lows of between 59% and 62% for April or May for older age-groups. However, after June, as diagnoses increased again, the number of new diagnoses was closer to previous activity for those aged 70-79 and 80+ (both more than 97% for September) than for those aged under 70 (92-94% for September).

Figure 55: Number of New Cancer Diagnoses between January 2018 and February 2021 and a comparison to previous activity for England by age group.

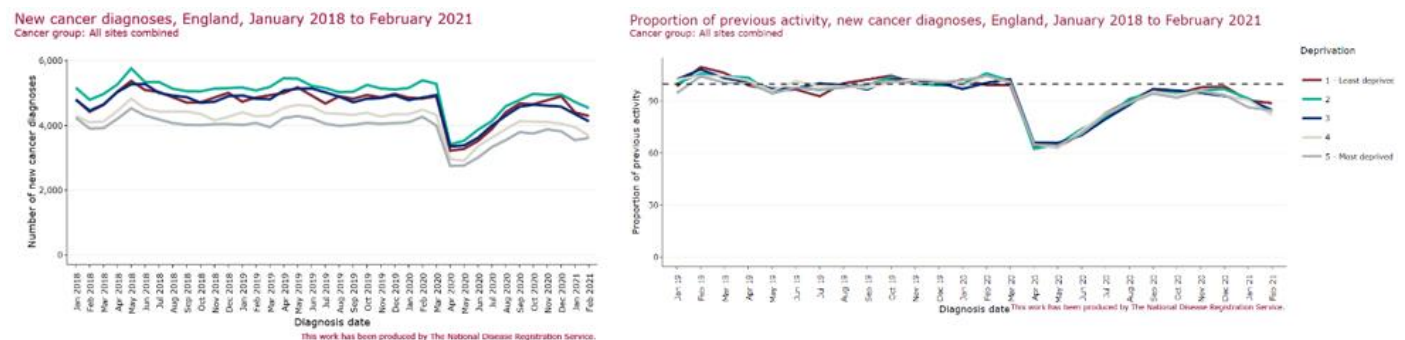


Source: [National Cancer Registration and Analysis Service](#) 2021

Deprivation

Figure 56 shows the number of new cancer diagnoses between January 2018 and February 2021 and a comparison to previous activity by deprivation at England level. For all malignant cancers excluding NMSC, the pattern and size of changes in new cancer diagnoses were similar for all income deprivation quintiles.

Figure 56: Number of New Cancer Diagnoses between January 2018 and February 2021 and a comparison to previous activity for England by deprivation.

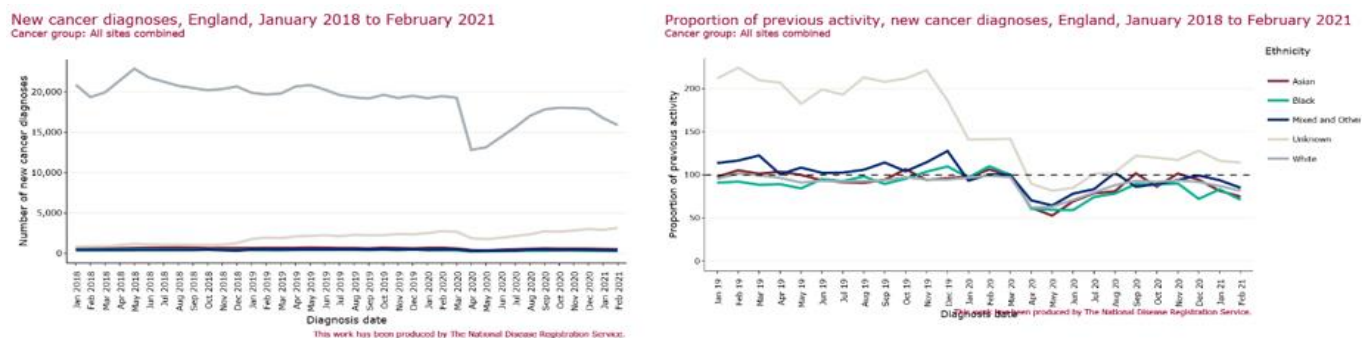


Source: [National Cancer Registration and Analysis Service](#) 2021

Ethnicity

Figure 57 shows the number of new cancer diagnoses between January 2018 and February 2021 and a comparison to previous activity by ethnicity at England level. There was an increase in the proportion of diagnoses with unknown ethnicity but, based on diagnoses where it was recorded, changes in the number of new cancer diagnoses appeared similar for all ethnicity groups.

Figure 57: Number of New Cancer Diagnoses between January 2018 and February 2021 and a comparison to previous activity for England by ethnicity.

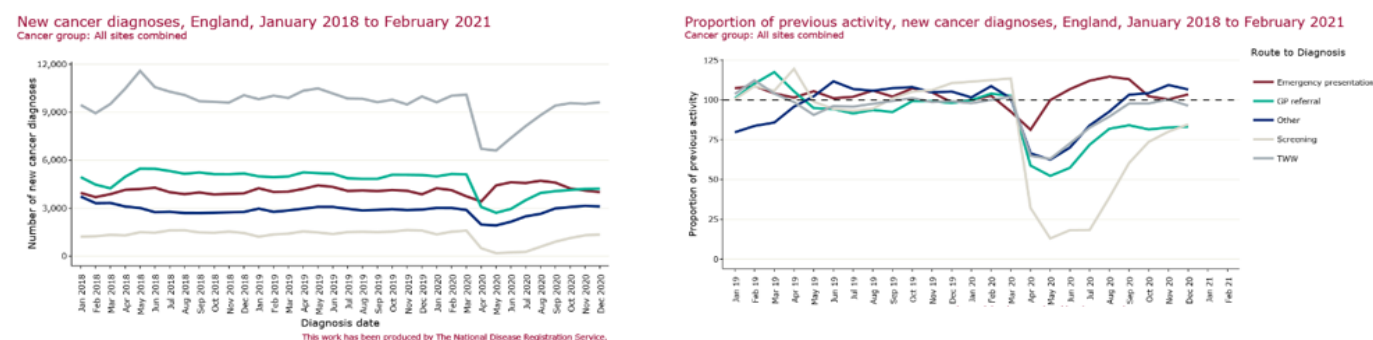


Source: [National Cancer Registration and Analysis Service](#) 2021

Routes to Diagnosis

Routes to diagnosis is a categorisation of the patient pathways which led to a diagnosis of cancer; these different routes have been shown to be associated with different treatment pathways or outcomes.

Figure 58: Number of New Cancer Diagnoses between January 2018 and February 2021 and a comparison to previous activity for England by ethnicity.



Source: [National Cancer Registration and Analysis Service](#) 2021

Figure 58 shows number of new cancer diagnoses between January 2018 and February 2021 and a comparison to previous activity for England by route to diagnoses. For all malignant cancers excluding NMSC, the number of new cancer diagnoses through an emergency presentation route decreased, in comparison to previous activity, for March and April 2020 (down to 81% of previous activity for April), but then increased to 99% or more for May to December (including up to 115% for August).

In contrast, diagnoses through all other routes remained below 100% for April through to August, with decreases for May ranging from 13% for diagnoses from screening to 63% for diagnoses through the Two-Week Wait route.

Surgical tumour resection activity

Figure 59(a) and 59(b): Number of Tumour resection procedures between January 2018 and December 2020 (top) and a comparison to previous activity (bottom) for England (solid line) and Cheshire and Merseyside (dotted line).

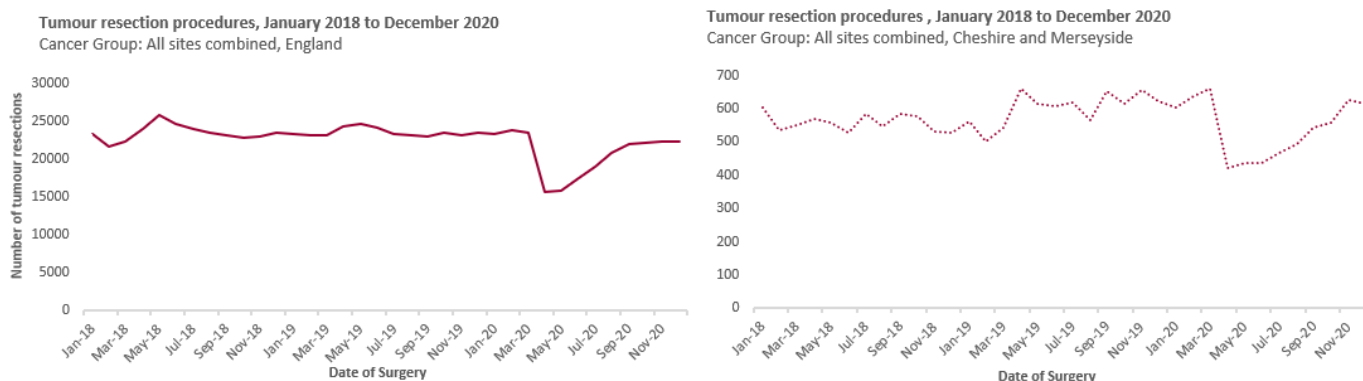
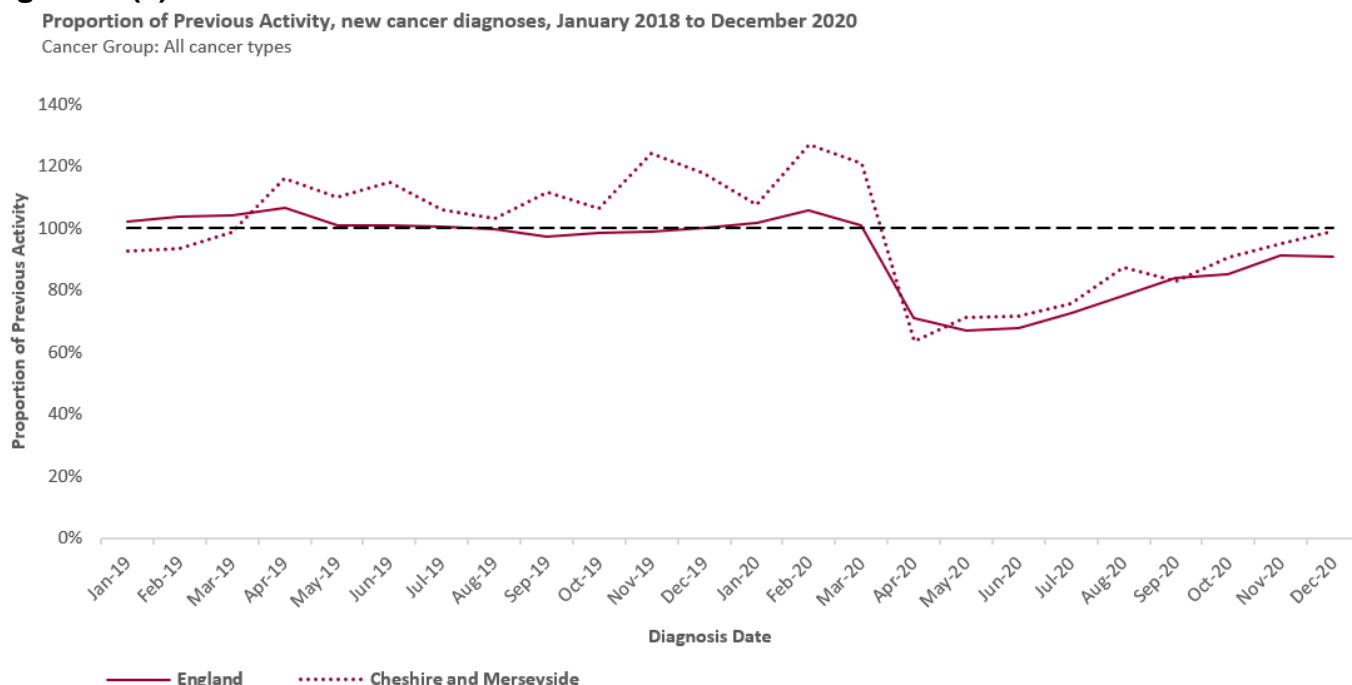


Figure 59(c)

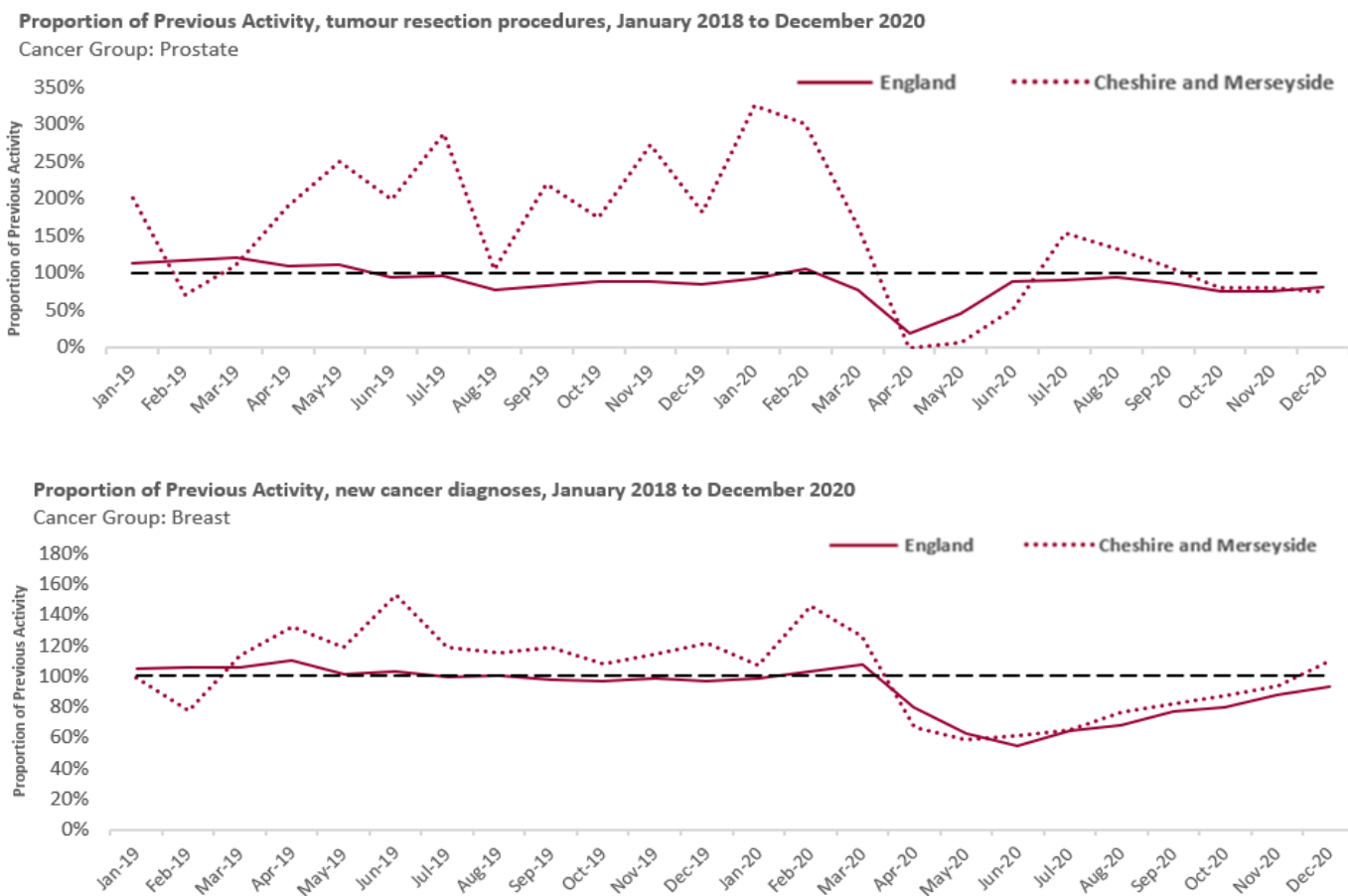


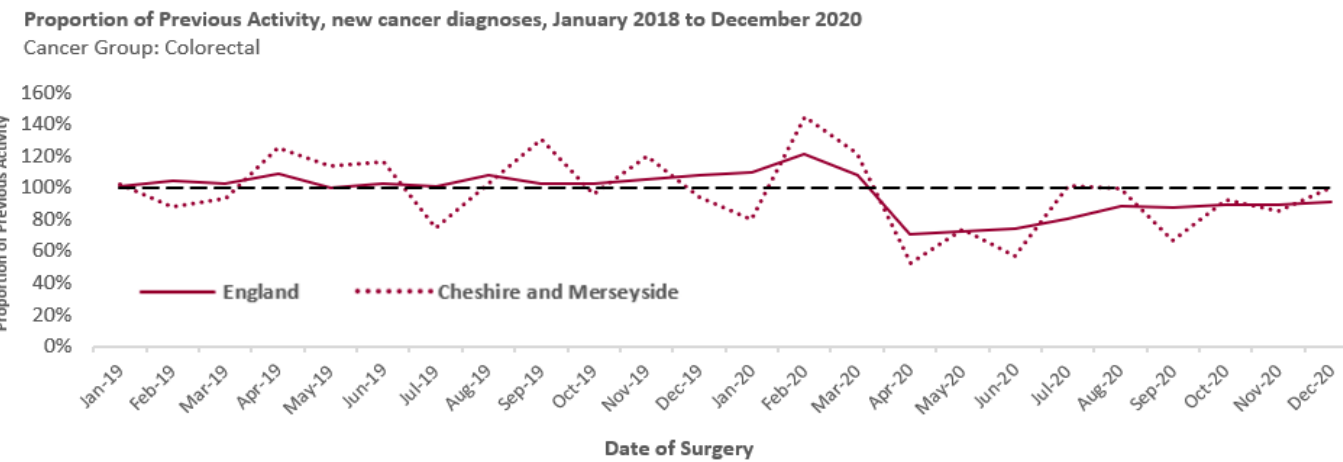
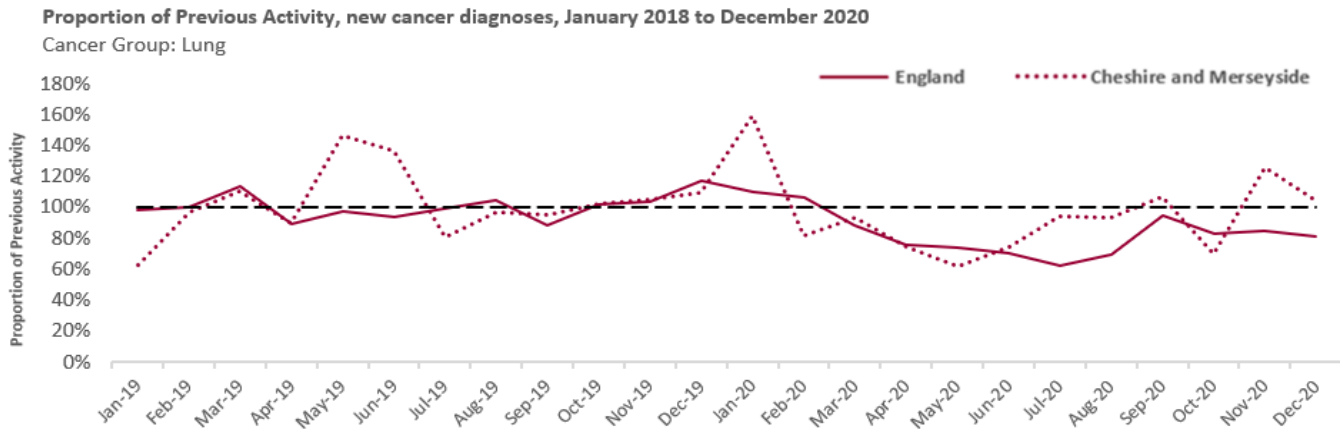
Source: [National Cancer Registration and Analysis Service](#) 2021

- **Figures 59(a) 59(b) and 59(c)** show the number of tumour resection procedures between January 2018 and January 2021 (top) and a comparison to previous activity (bottom) for England (left) and Cheshire and Merseyside (right).
- There was a reasonably consistent number of surgical tumour resection procedures before the initial COVID-19 lockdown period. For March 2020, the number of tumour resection procedures for all included malignant cancers reached 101% of previous activity for England and 107% of previous activity for Cheshire and Merseyside.
- For April 2020, surgical tumour resection activity was much lower than usual for all cancer groups. The number of surgical tumour resection procedures per month subsequently decreased to around two-thirds of the previous activity for April to May 2020 for all included malignant cancers, to around 67% (65% for April, 64% for May and 72% for June) of the pre-COVID numbers for England and 65% (60% for April, 61% for May and 73% for June) of the pre-COVID numbers for Cheshire and Merseyside.

- **Figure 60** shows a comparison to previous activity for the top four cancer types (breast, prostate, lung and colorectal).
- For the top four cancer types this varied from 20% of previous activity for prostate cancer to 77% of previous activity for lung in England. However, activity was also lower than usual in March 2020 for some cancer groups, particularly prostate cancer (77%) and lung cancer (89%).
- For Cheshire and Merseyside, activity varied from 0% of previous activity for prostate cancer to 74% of previous activity for lung cancer. Unlike England, activity compared to previous years was particularly high in the pre-COVID period for Cheshire and Merseyside, particularly for prostate cancer (300%).
- Since April 2020, surgical tumour resection activity has increased again for most cancer groups, by December 2020 reaching 91% of previous activity for England and 99% of previous activity for Cheshire and Merseyside for all cancer sites combined, with some cancer groups having a higher proportion of previous activity for September or October.
- By December 2020, England reached 81% of previous activity for prostate and lung cancer, 91% for colorectal cancer and 93% for breast cancer. Cheshire and Merseyside reached 75% of previous activity for prostate cancer, 105% for lung cancer, 101% for colorectal cancer and 110% for breast cancer.

Figure 60: A comparison to previous activity for England (solid line) and Cheshire and Merseyside (dotted line) for the top four types of cancer; prostate (top), breast (second row), lung (third row), and colorectal (bottom row).





Source: [National Cancer Registration and Analysis Service](https://www.ncra.nhs.uk/) 2021

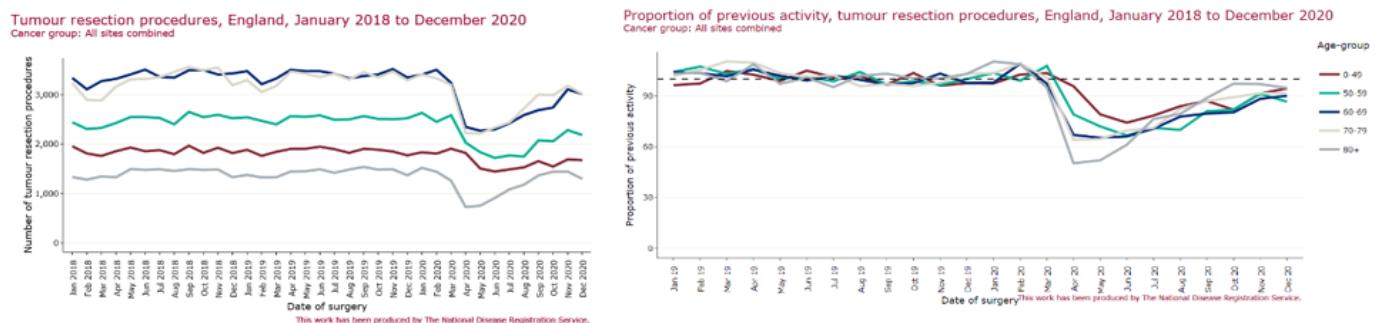
Demographic Factors (England level only)

For all malignant cancers excluding NMSC, the pattern and size of changes in surgical tumour resection activity for all included malignant cancers were similar for most demographic factors.

Age

Figure 61 shows the number of new surgical tumour resections between January 2018 and December 2020 and a comparison to previous activity by age group at England level. For all included malignant cancers, the decrease in surgical tumour resection activity was smaller for patients aged 0-49 (decreasing to 74% of previous activity for June) and larger for those aged 80 and over (decreasing to 50% of previous activity for April).

Figure 61: Number of surgical tumour resections between January 2018 and January 2021 and a comparison to previous activity for England by age group.

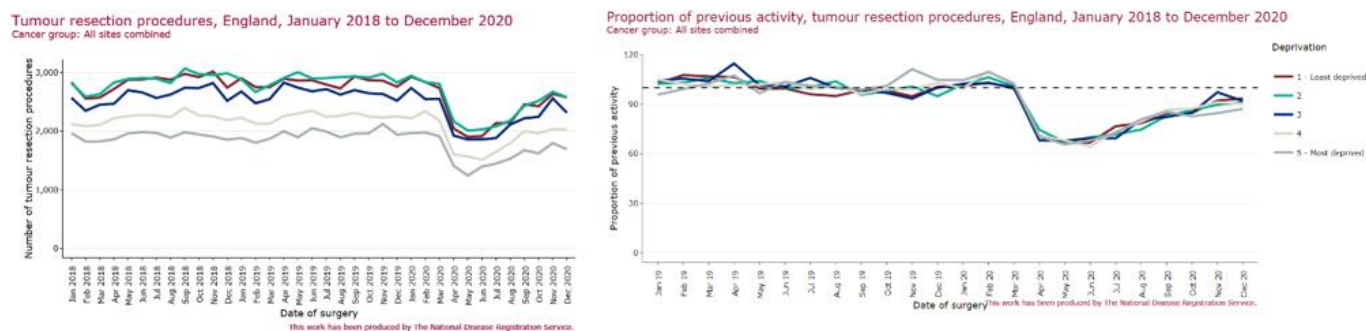


Source: [National Cancer Registration and Analysis Service](https://www.ncra.nhs.uk/) 2021

Deprivation

Figure 62 shows the number of new surgical tumour resections between January 2018 and December 2020 and a comparison to previous activity by deprivation at England level. The pattern and size of changes in surgical tumour resection activity for all included malignant cancers were similar for all deprivation quintiles.

Figure 62: Number of New surgical tumour resections between January 2018 and December 2020 and a comparison to previous activity for England by deprivation.

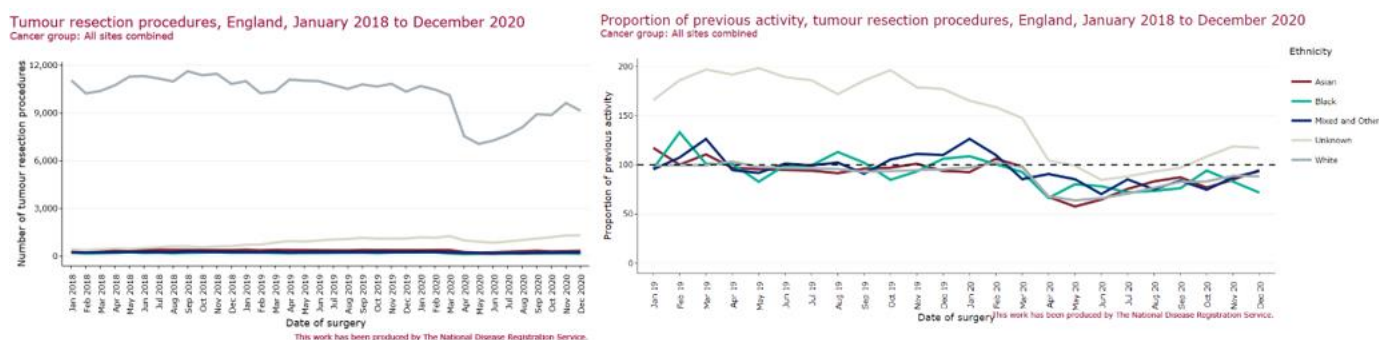


Source: [National Cancer Registration and Analysis Service](#) 2021

Ethnicity

Figure 63 shows the number of new surgical tumour resections between January 2018 and December 2020 and a comparison to previous activity by ethnicity at England level. The pattern and size of changes in surgical tumour resection activity for all included malignant cancers was similar for all ethnicities (except for an increase in the proportion with unknown ethnicity).

Figure 63: Number of New surgical tumour resections between January 2018 and December 2020 and a comparison to previous activity for England by ethnicity.

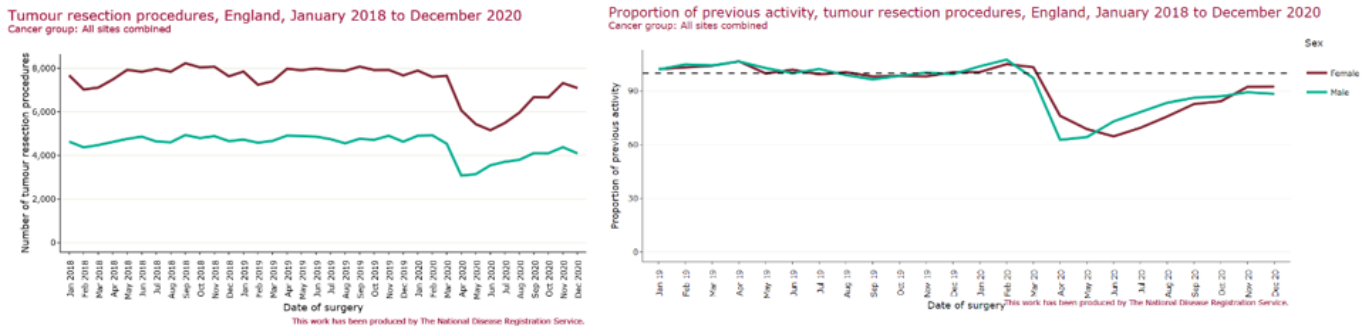


Source: [National Cancer Registration and Analysis Service](#) 2021

Sex

Figure 64 shows the number of new surgical tumour resections between January 2018 and December 2020 and a comparison to previous activity by sex at England level. The decrease in surgical tumour resection activity for all included malignant cancers was initially larger for men than for women (dropping for April to 63% of previous activity for men and 76% for women) but increased more quickly for men after this (up to 88% for December for men). In comparison, activity decreased further for women after April, down to 65% for June, before increasing to 92% by December. This may be related to the different mix of cancers for men and women and the patterns seen for different cancer groups, particularly prostate cancer for men and breast cancer for women.

Figure 64: Number of New Cancer Diagnoses between January 2018 and December 2020 and a comparison to previous activity for England by sex.



Source: [National Cancer Registration and Analysis Service](#) 2021

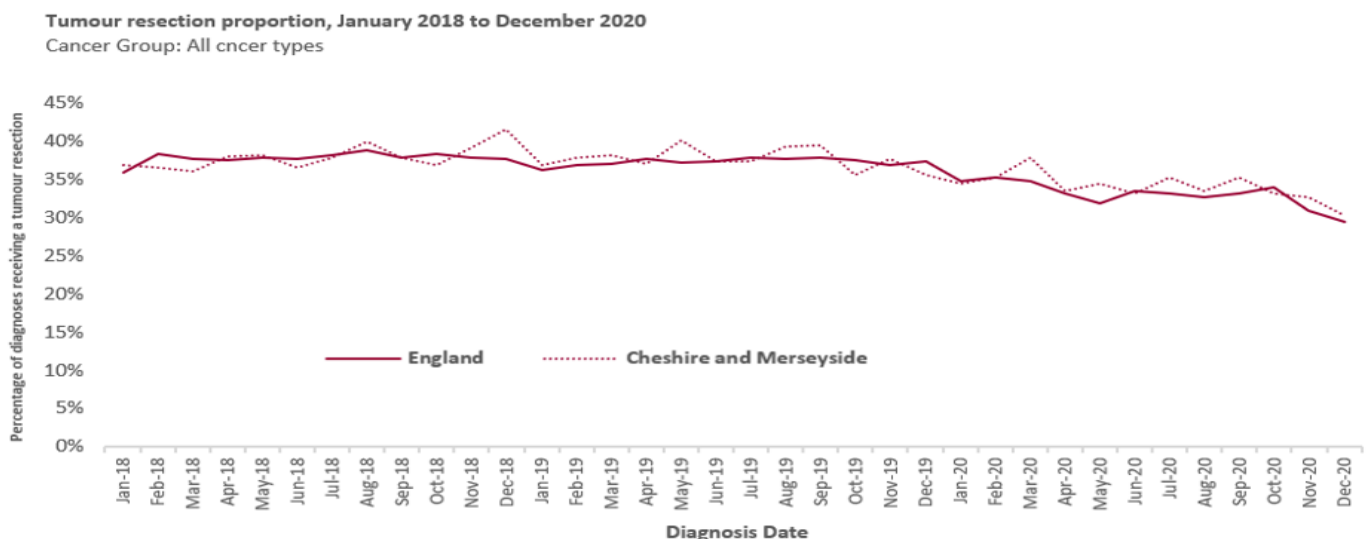
Treatment proportions

This section looks into proportion of cancer diagnoses receiving treatment by treatment type and diagnosis date at England level and Cheshire and Merseyside level. The treatment types are:

- **Tumour resection proportion:** Proportion of cancer diagnoses receiving a tumour resection, by diagnosis date (**Figures 65(a), 65(b) and 65(c)**)
- **Chemotherapy proportion:** Proportion of cancer diagnoses receiving chemotherapy, by diagnosis date (**Figures 66(a), 66(b) and 66(c)**)
- **Radiotherapy proportion:** Proportion of cancer diagnoses receiving radiotherapy, by diagnosis date (**Figures 67(a), 67(b) and 67(c)**)

Recently published treatment proportions data are often lower than for previous months. This data is based on diagnosis date and the time between diagnosis and treatment means patients diagnosed more recently will not have complete follow-up in the available data; some treatments may not yet have occurred or been recorded. In **Figures 65(b) and 65(c), Figures 66(b) and 66(c) and Figures 67(b) and 67(c)**, the solid line fading into dotted lines represent the months that will not have complete follow-up in the available data.

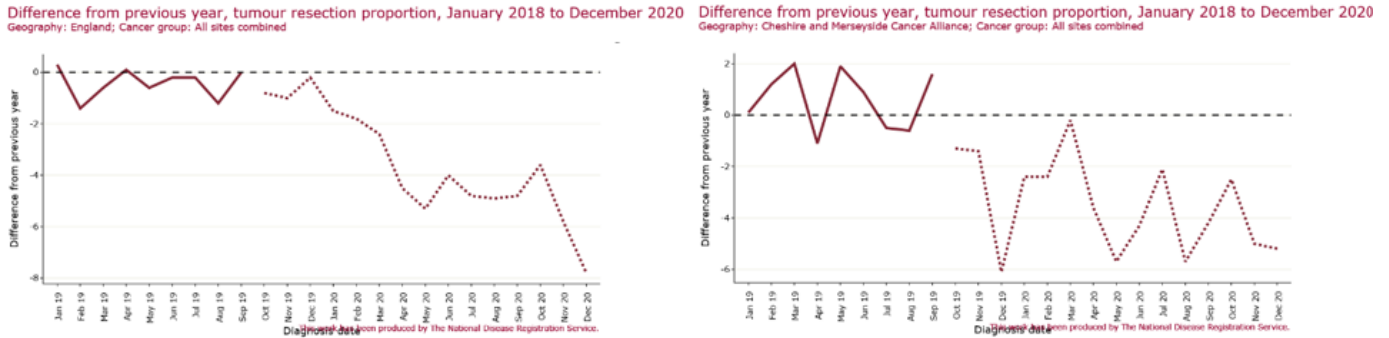
Figure 65(a): Proportion of cancer diagnoses receiving a tumour resection between January 2018 and December 2020 (top) and a comparison to previous activity (bottom) for England (solid line) and Cheshire and Merseyside (dotted line).



Source: [National Cancer Registration and Analysis Service](#) 2021

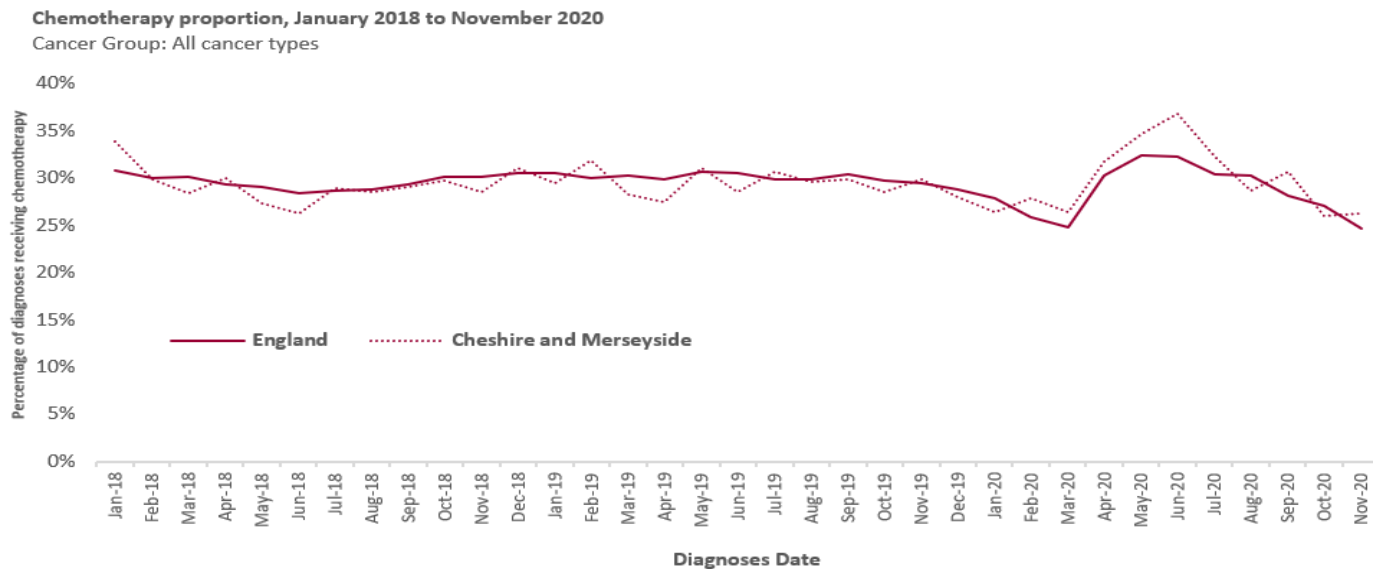
The bottom **Figures 65(b) and 65(c)** refer to England (left) and Cheshire and Merseyside (right) separately and the dotted lines refer to incomplete data.

Figure 65(b) and 65(c)



Source: [National Cancer Registration and Analysis Service](#) 2021

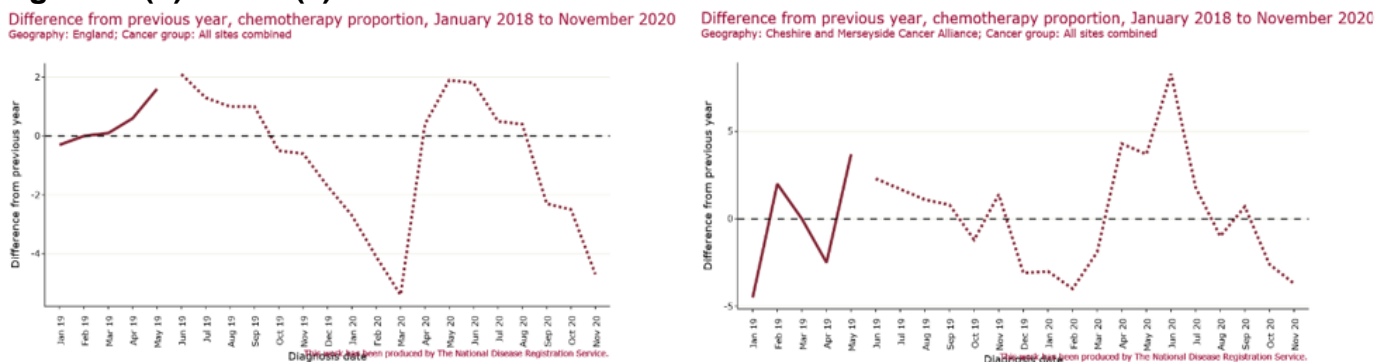
Figure 66(a): Proportion of cancer diagnoses receiving chemotherapy between January 2018 and November 2020 (top) and a comparison to previous activity (bottom) for England (solid line) and Cheshire and Merseyside (dotted line).



Source: [National Cancer Registration and Analysis Service](#) 2021

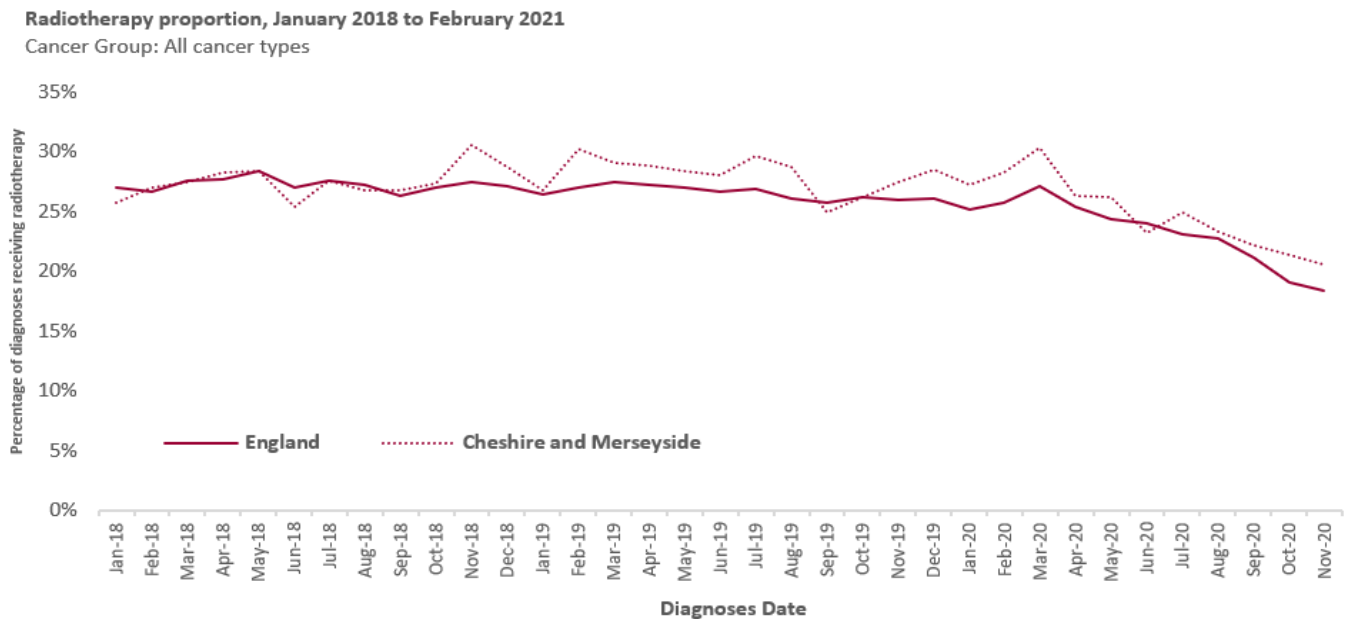
The bottom graphs refer to England (left) and Cheshire and Merseyside (right) separately and the dotted lines refer to incomplete data.

Figure 66(b) and 66(c)



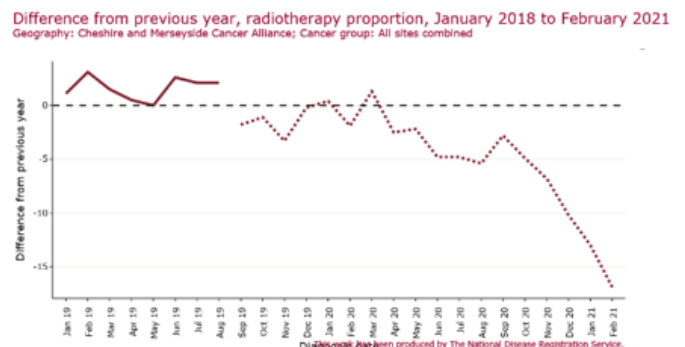
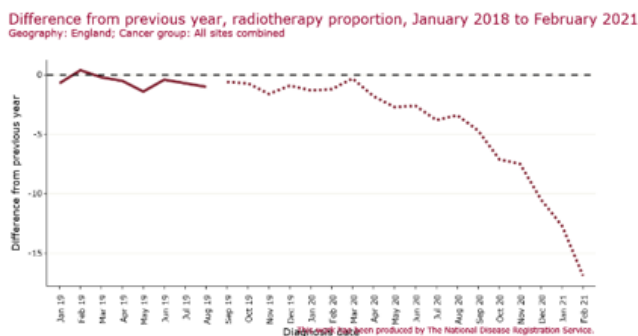
Source: [National Cancer Registration and Analysis Service](#) 2021

Figure 67(a): Proportion of cancer diagnoses receiving radiotherapy between January 2018 and February 2021 (top) and a comparison to previous activity (bottom) for England (solid line) and Cheshire and Merseyside (dotted line). The bottom graphs refer to England (left) and Cheshire and Merseyside (right) separately and the dotted lines refer to incomplete data.



Source: [National Cancer Registration and Analysis Service](#) 2021

Figures 67(b) and 67(c)



Source: [National Cancer Registration and Analysis Service](#) 2021

- All **Figures 65, 66 and 67** show the proportion of cancer diagnoses receiving tumour resections, chemotherapy, or radiotherapy respectively, between January 2018 and January 2021 and a comparison to previous activity at both England and Cheshire and Merseyside level.
- For diagnoses with complete follow-up, around 36-39% of all malignant cancers excluding non-melanoma skin cancer (NMSC) are recorded as receiving a tumour resection, around 28-31% chemotherapy and 26-28% radiotherapy at England level. Very similar proportions are seen at a Cheshire and Merseyside level with around 36-45% of all malignant cancers excluding NMSC recorded as receiving a tumour resection, 26-34% chemotherapy and 25-31% radiotherapy. These proportions continue for those diagnosed up to late 2019 before dropping off due to availability of follow-up data.
- For patients diagnosed between December 2019 and March 2020 there is a decrease in the proportion recorded as receiving chemotherapy (slight increase in February 2020 at a Cheshire and Merseyside level) with an increase for those diagnosed between April and June 2020. A similar pattern is seen for this period for most cancer groups.

- For all malignant cancers excluding NMSC and patients diagnosed in 2020, there is a steady decline in the proportion of patients recorded as receiving radiotherapy due to the current availability of follow-up data.

Demographic Factors (England level only)

- For all malignant cancers excluding non-melanoma skin cancer (NMSC), there were similar changes to the patterns of treatment proportions by many demographic factors, including for men and women, for all deprivation quintiles and for all ethnicities.
- The changes in the proportion of patients recorded as receiving chemotherapy for diagnoses from December 2019 to June 2020 appear similar for most Routes to Diagnosis, although there appears to have been less change for those diagnosed through the emergency presentation route, for all malignant cancers excluding NMSC.
- For all malignant cancers excluding NMSC, it appears there was a decrease in the proportion of those diagnosed through screening who were recorded as receiving radiotherapy for May 2020 to July 2020. However, this seems to be explained by changes in the relative proportions of breast, colorectal and cervical cancers diagnosed through screening during these months (with the largest decrease for breast cancers) and a decrease in the proportion of breast cancers diagnosed through screening who were recorded as receiving radiotherapy.

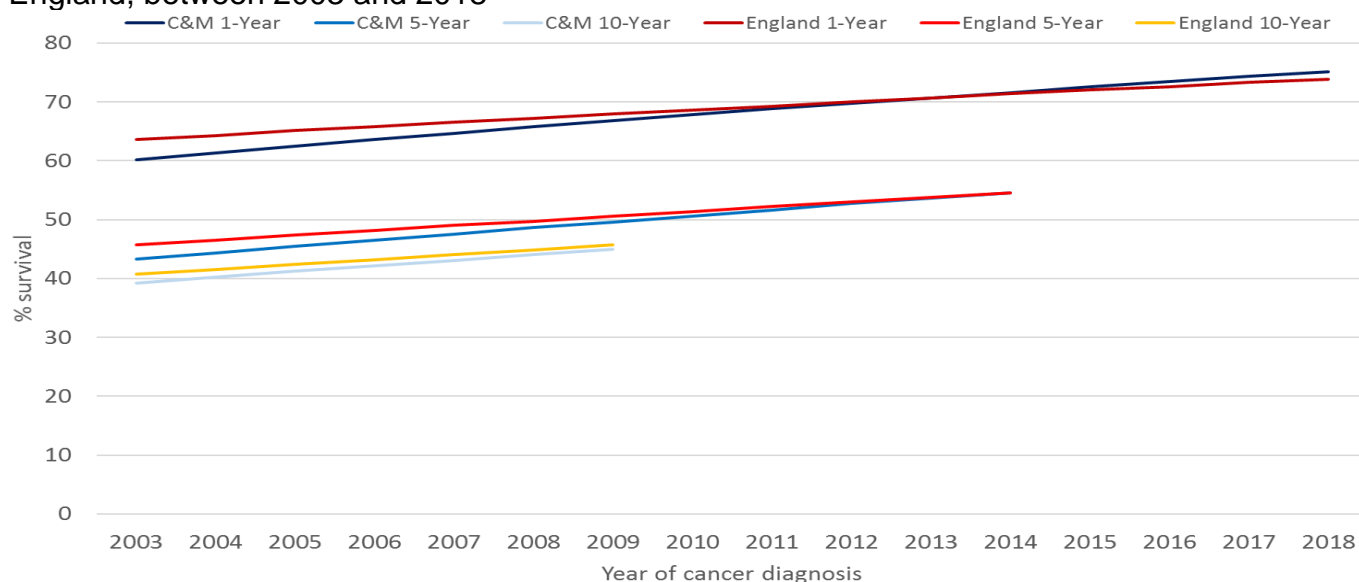
Survival

Survival: All cancers

Survival is a measurement of time since diagnosis for those people living with cancer. Survival is measured and monitored based on the proportion of those people diagnosed who are still alive at 1, 5 and 10 years since diagnosis.

Figure 68 below shows the trend in 1-, 5- and 10- year survival from all cancers in Cheshire and Merseyside and England between 2003 and 2018.

Figure 68: Trend in 1-, 5- and 10- year survival from all cancer in Cheshire and Merseyside and England, between 2003 and 2018

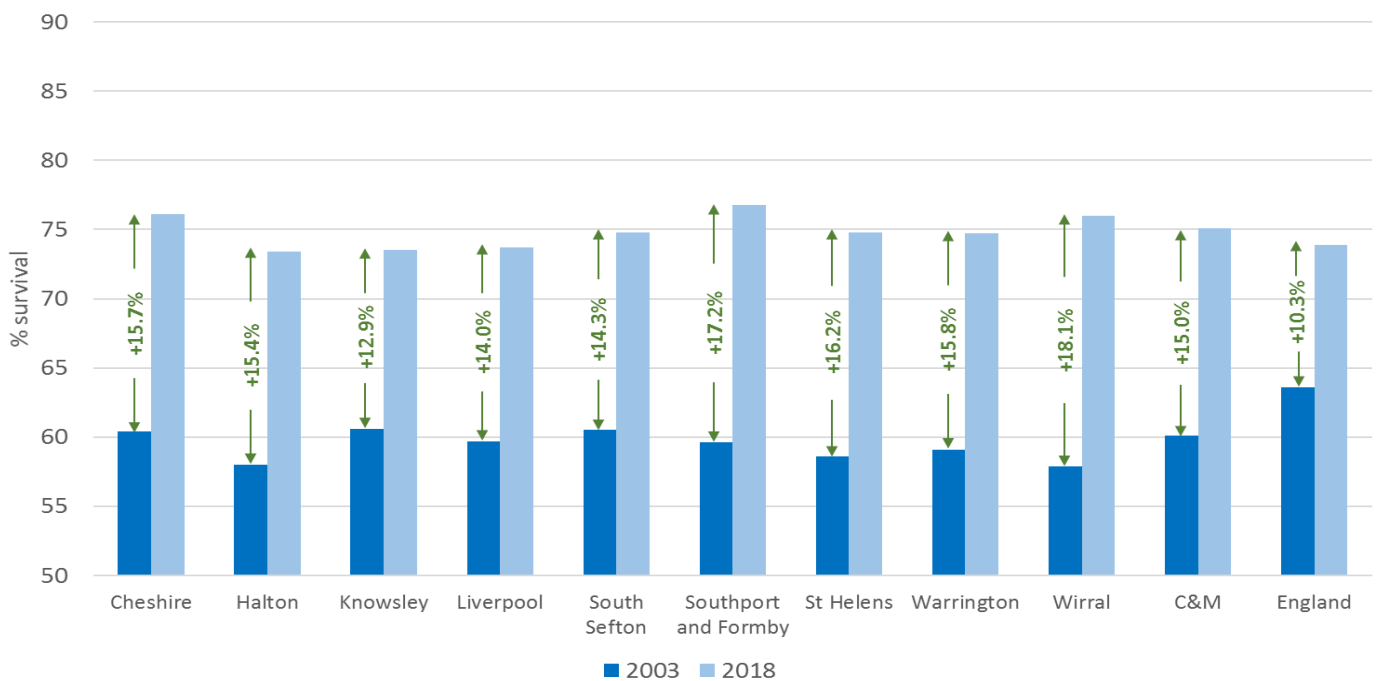


Source: [PHE Fingertips](#), 2021

1-, 5- and 10-year survival from all cancers has increased over time for both Cheshire and Merseyside and England (**Figure 68 above**).

1-year survival from cancer in Cheshire and Merseyside was substantially lower than England for a period of the 2000s, however, from 2012 onwards rates of survival in Cheshire and Merseyside and England have improved at slightly different speeds, with Cheshire and Merseyside rates now higher than England. Although – given that more recent data is not available for 5- and 10-year survival from cancer is not available – a pattern similar to that of 1-year survival is occurring in longer-term survival. With Cheshire and Merseyside survival improving at a faster rate than England.

Figure 69: Change in 1-year survival from all cancers in Cheshire and Merseyside CCG, 2003 to 2018



Source: [PHE Fingertips](#), 2021

Notes: Survival data for lower geographies not available for 5- and 10-year survival

For cancers followed-up to 2018, across Cheshire and Merseyside, there are similar rates of survival for all CCGs. It should be noted however that those CCGs with lower 1-year survival than England are those that tend to be the most deprived in Cheshire and Merseyside; Halton, Knowsley and Liverpool (**Figure 69**).

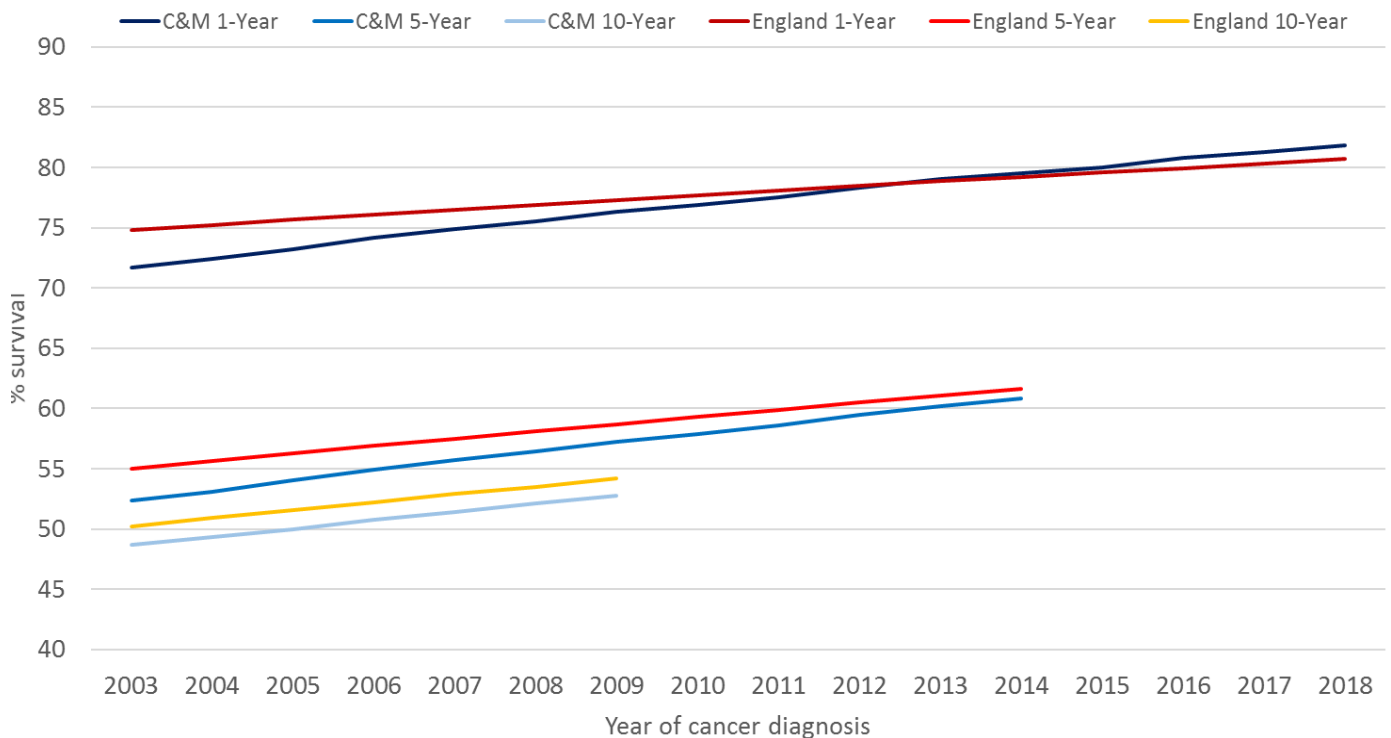
The generally consistent rates of survival across Cheshire and Merseyside for 2018 emphasises the vast improvements seen across the entire area, but specifically in those areas which had fewer than 3 in 5 people diagnosed with cancer surviving at least a year beyond their diagnosis.

Across England comparing 2018 to 2003, there is one more person in every ten surviving at least a year beyond diagnosis, with all CCGs in Cheshire and Merseyside accounting for an even greater improvement in survival rate. The areas to witness the greatest increase in 1-year survival from cancers are: Wirral (18.1% increase in 1-year survival from 2003 to 2018), Southport & Formby (17.2% increase) and St Helens (16.2% increase).

Survival data is also available for three of the primary tumour sites: Breast, Colorectal and Lung. 1-, year survival is available for these three cancers (comparing Cheshire and Merseyside and England).

Survival: Colorectal

Figure 70: 1-, 5- and 10-year survival from colorectal cancer in Cheshire and Merseyside and England, 2003 to 2018



Source: [PHE Fingertips](#), 2021

Notes: Survival data for lower geographies not available for 5- and 10-year survival

Colorectal cancer survival across Cheshire and Merseyside and England followed the same trend as overall cancers (**Figure 70**).

Survival across both areas increased substantially, with the trajectory of improvement in Cheshire and Merseyside steeper in Cheshire and Merseyside to 2018. 1-year survival across the CCGs of Cheshire and Merseyside was between 77.8% – 84.9%, with improvements from 2003 to 2018 for all areas.

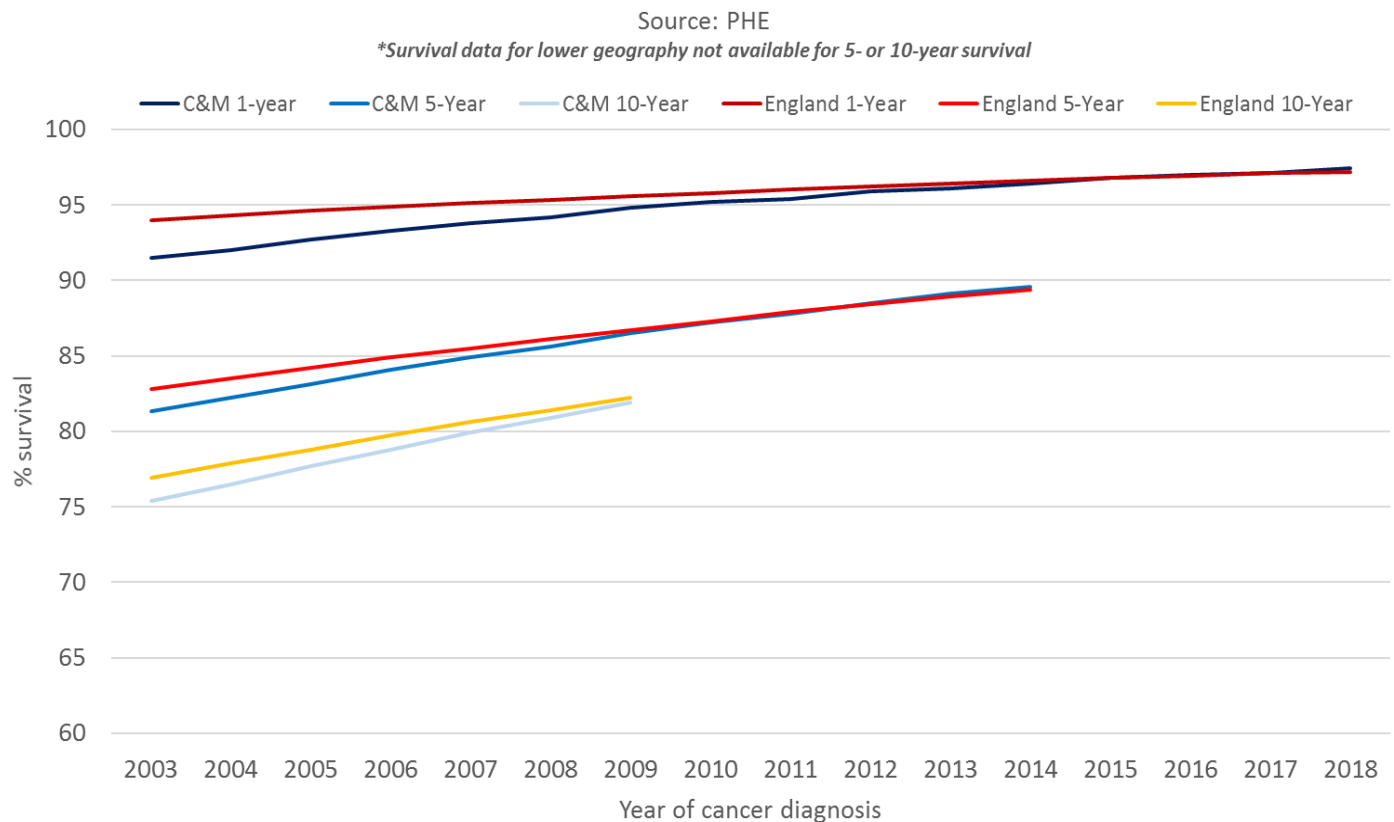
The greatest 1-year survival improvements were seen in: Wirral (16.4%) Southport & Formby (13.3%), St Helens (12.4%) and South Sefton (10.2%) CCGs.

There are improvements in both Cheshire and Merseyside and England 10-year survival from colorectal cancer, with no obvious differences between the two areas bar the actual % survival. 5-year survival however is following a similar pattern to that seen for 1-year colorectal cancer survival, with the two trends converging with a greater rate of improvement in Cheshire and Merseyside compared to England.

Survival: Breast

Figure 71 below shows that survival from breast cancer (1-, 5- and 10-year) has been improving from 2003 onwards.

Figure 71: 1-, 5- and 10-year survival from breast cancer in Cheshire and Merseyside and England, 2003 to 2018



Source: [PHE Fingertips](#), 2021

Notes: Survival data for lower geographies not available for 5- and 10-year survival

At the latest available data point (2009), 10-year survival from breast cancer in Cheshire and Merseyside was over 80% (**Figure 71**), and for 5-year survival (at 2014) was almost 90%.

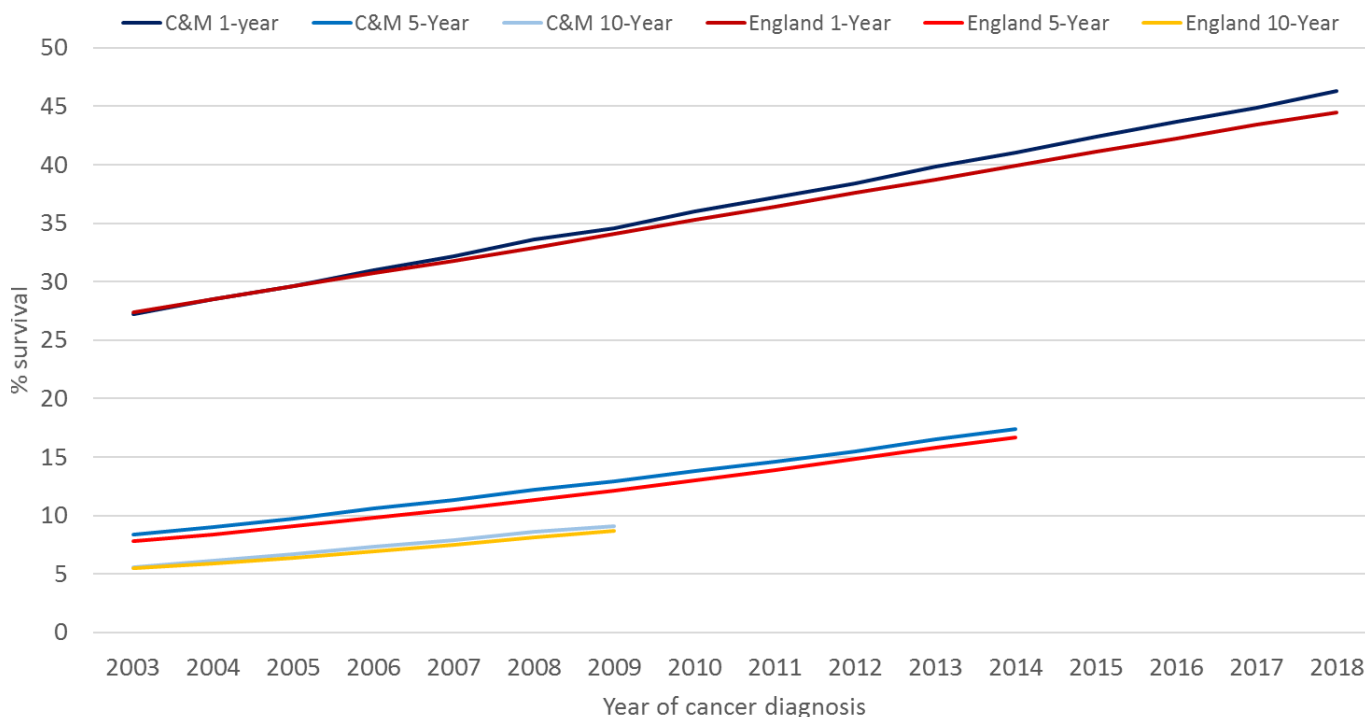
1-year survival from breast cancer has improved to the level that 2.6% of people diagnosed with breast cancer followed-up to 2018 did not survive at least a year beyond their diagnosis.

As with overall cancer and colorectal cancer, the trajectory of survival (for all year periods) has converged in Cheshire and Merseyside and England, with Cheshire and Merseyside tending to greater survival.

Survival: Lung

Of the three cancers with survival data publicly available (breast, colorectal and lung cancer), lung cancer tends to have the lowest 1-, 5- and 10-year survival generally (**Figure 72**). With that said, there have been massive upturns in the rates of survival in recent years for people diagnosed with lung cancer.

Figure 72: 1-, 5- and 10-year survival from lung cancer in Cheshire and Merseyside and England, 2003 to 2018



Source: [PHE Fingertips](#), 2021

Notes: Survival data for lower geographies not available for 5- and 10-year survival

Since 2006, 1-year survival from lung cancer has been greater in Cheshire and Merseyside than England, with the trajectory of 1-year survival improving at a faster rate in Cheshire and Merseyside (**Figure 72**). Just under 1 in every 2 people diagnosed with lung cancer and followed up to 2018, survived at least a year beyond their diagnosis. Improvements in 1-year survival over the period from 2003 to 2018 have been drastic; only Halton has seen less than 15% increase in 1-year survival. However, in 2003, Halton had the greatest 1-year survival, and for 2018 had the lowest 1-year survival across Cheshire and Merseyside.

The outlook for longer-term survival has improved, but still remains at below 1 in every 5 people surviving 5 years or beyond their diagnosis nationally and locally.

Mortality

Cancer mortality varies greatly depending on tumour site. The site of some cancers can make it easier to spot. Promotion campaigns designed to improve awareness of the sign and symptoms can also help improve earlier diagnosis, allowing for a greater range of treatment and improving the chances of both short and long-term survival.

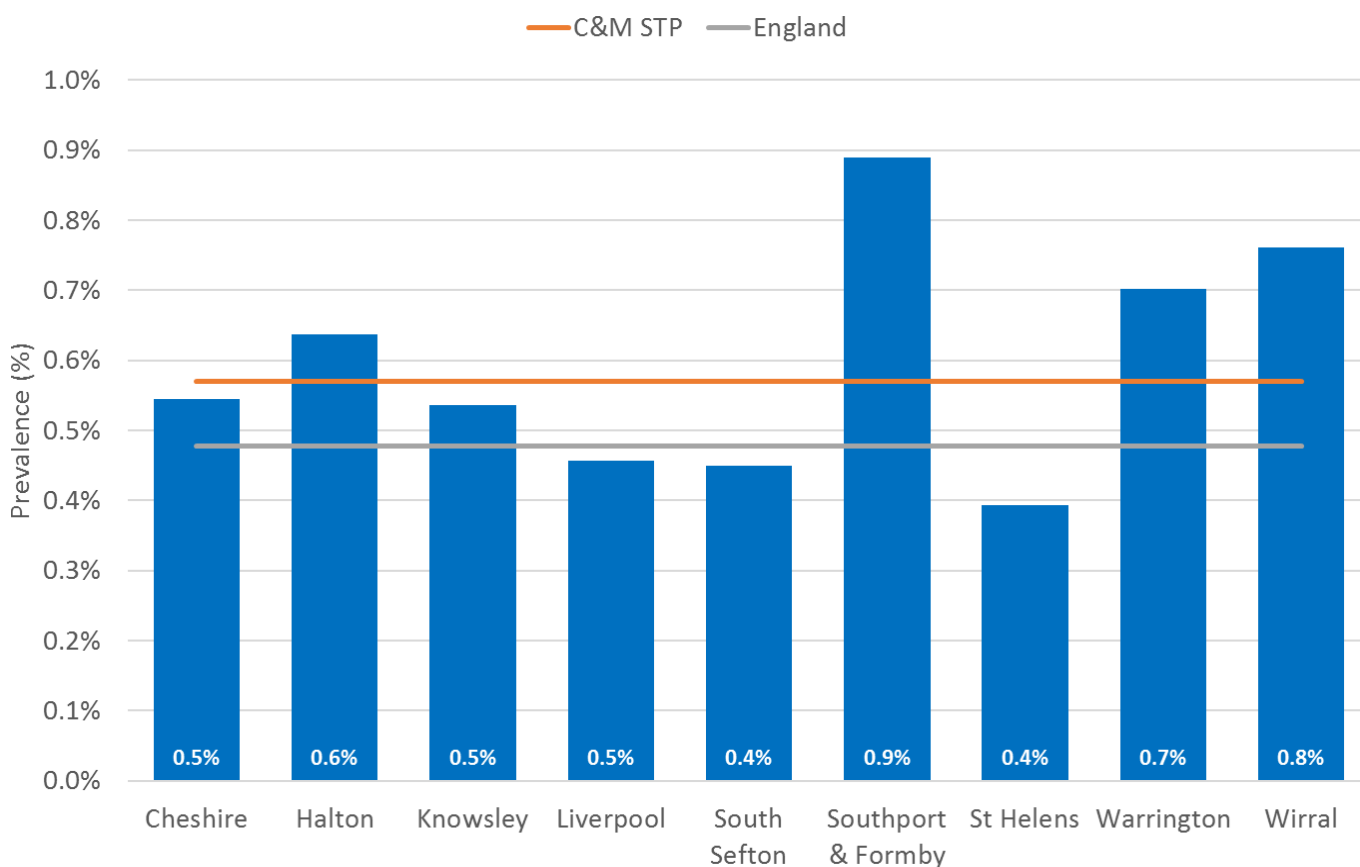
Although definitive datasets have not yet caught up with deaths during the pandemic, the Marie Curie report produced in 2021, '[The Better End of Life Report 2021](#)' along with some national research, the place where people died changed, with many more dying at home.

The report also noted that palliative and end of life care services were a vital part of the pandemic emergency response, switching their services into delivery in community settings and that care was compromised by shortages of essential PPE, medicines, and staff – these were made worse by hospices not being seen as 'frontline NHS'.

Palliative care (end of life)

Palliative care is the supportive care and treatment for people with life-limiting illnesses, to maintain a good quality of life. Good community palliative helps to maintain care and life at home, supporting informal carers, rather than the individual moving into hospital or formal nursing care. Marie Curie produced a report in 2021, '[The Better End of Life Report 2021](#)', which noted that many more people died in 2020 than usual, with many experiencing tremendous hardships at the end of life.

Figure 73: Prevalence of patients on CCG GP practice Palliative Care registers, comparators Cheshire and Merseyside and England, 2021



Source: [NHS England](#), 2021

In Cheshire and Merseyside GP practices in 2021, there were 15,241 patients on palliative care registers. This equates to 0.6% of the entire GP-registered population of the Cheshire and Merseyside STP; this is similar to the prevalence seen nationally (0.5%) (Figure 73). Across the CCGs of Cheshire and Merseyside, there is a range of 0.4% to 0.9% of the population on palliative care registers.

A summary of the latest published literature on the impact of COVID on palliative care found the following:

- The COVID-19 pandemic has been a challenge to community palliative care but has created opportunities to innovate rapidly and learn. Given the risk from face-to-face consultations and

visits for drug administration, care became more virtual and remote, with greater dependence on family caregivers to provide care and administer drugs, often via non-injectable routes. These changes did – and still are - occurring at pace: it remains to be seen how widely they are implemented and how much they will persist after the pandemic (**Source:** Antunes, B., Bowers, B., Winterburn, I., et al. 2020. *Anticipatory prescribing in community end-of-life care in the UK and Ireland during the COVID-19 pandemic: online survey. BMJ Support Palliat Care* 10(3) 343-349. <https://dx.doi.org/10.1136/bmjspcare-2020-002394>)

- Given that deprivation and age are large predictors of use of technology, inequalities in access to tech is a barrier which must be overcome if providing supportive and palliative care interventions using telemedicine in poorer communities settings or among older patients is to be advanced (**Source:** Chavarri-Guerra, Y., Ramos-Lopez, W. A., Covarrubias-Gomez, A., et al. 2021. *Providing Supportive and Palliative Care Using Telemedicine for Patients with Advanced Cancer During the COVID-19 Pandemic in Mexico. The oncologist* 26(3) e512-e515. <https://dx.doi.org/10.1002/onco.13568>)
- As a result of closing hospitals to relatives and visitors, patients dying from COVID-19 more frequently died alone, and healthcare providers felt they were unable to substitute for absent relatives (**Source:** Martinsson, L., Bergstrom, J., Hedman, C., et al. 2021. *Symptoms, symptom relief and support in COVID-19 patients dying in hospitals during the first pandemic wave. BMC Palliative Care* 20(1) 102. <http://dx.doi.org/10.1186/s12904-021-00785-4>)
- Europe's largest prospective COVID-19 dataset (included UK sites) demonstrates that cancer was independently associated with mortality in patients admitted with COVID-19. The study aimed to characterise the supportive care needs of hospitalised patients with COVID-19 and describe end of life (EOL) care for those who died in hospital. Initial results showed that Breathlessness (n=56, 87.5%), agitation (n=31, 48.4%) and confusion (n=23, 35.9%) were most common EOL symptoms and that in the early phase of the COVID-19 pandemic and that the high in-hospital mortality from COVID-19 in cancer patients occurred mostly outside dedicated oncology wards. (**Source:** Soosaipillai, G. B., Benafif, S., Chopra, N., et al. 2020. *Provision of palliative care for patients with cancer and SARS-CoV-2 infection. Annals of Oncology* 31(Supplement 4) S992. <http://dx.doi.org/10.1016/j.annonc.2020.08.1736>)

Deaths at home from cancer

Allowing somebody to stay at home throughout their illness, and to maintain as much independence and promote positive community and GP care is a primary outcome in reducing stress on both the individual and their carers, and reducing the cost and burden which could be placed on the health and social care system if they were to be repeatedly attending A&E, being admitted to hospital with problems which could be managed in the community, and at home.

As **Table 8** describes below, approximately 1 in every 3 people who died from cancer in England, did so at home during 2016-18 (30.8%). The proportion of males and females who died from cancer in Cheshire and Merseyside (32.8% and 31.4% respectively) was higher than that of England as a whole. Nationally and locally the proportion of males who died from cancer at home was higher than that of females. This sex-based disparity could indicate the lower likelihood of community and informal care available to older females, and the likelihood of females living longer and as such not having a partner, or their partner not physically able to provide informal care.

There are variances in Local Authority proportions for people with cancer dying at home; the greatest proportion is in Knowsley (with 38.5%) and the lowest in Liverpool (29.6%) for 2016-18.

Table 8: Deaths from cancer and percentage (%) occurring at home from all cancer in Cheshire and Merseyside Local authorities, 2016-18

Area	Males			Females			Persons		
	Total Cancer Deaths	At Home	% at Home	Total Cancer Deaths	At Home	% at Home	Total Cancer Deaths	At Home	% at Home
Cheshire East	540	169	31.2	385	107	27.9	925	276	29.8
Cheshire West & Chester	490	157	32.1	445	144	32.3	935	301	32.2
Halton	205	69	33.6	165	53	32.4	370	122	33.0
Knowsley	280	108	38.6	255	98	38.4	535	206	38.5
Liverpool	595	176	29.5	535	159	29.7	1,130	335	29.6
Sefton	485	165	33.9	415	129	31.1	900	294	32.7
St. Helens	275	92	33.5	220	68	30.8	495	160	32.3
Warrington	270	87	32.3	230	72	31.5	500	159	31.8
Wirral	545	186	34.1	450	142	31.6	995	328	33.0
Cheshire & Merseyside	3,685	1,208	32.8	3,100	972	31.4	6,785	2,180	32.1
North West	10,155	3,344	32.9	8,415	2,620	31.1	18,570	5,964	32.1
England	69,850	22,268	31.9	56,235	16,572	29.5	126,085	38,840	30.8

Source: NHS England, via ONS

Note: Cheshire and Merseyside based on calculations using constituent LA's number of deaths, % occurring at home and sum of values

Although comprehensive information on place of death during the pandemic is not yet available, research indicates that in the case of cancer patients, more died at home and fewer died in hospital compared to previous years.

A large retrospective cohort study carried out in the UK of deaths between 2014 and June 2020 for example (looking at 3.5million deaths from all cases) found an increase in excess deaths from all causes of 35%. There were fewer deaths in hospital from cancer and cardiac disease during the pandemic and higher deaths at home from cancer and cardiac disease. This suggests public avoidance of hospital care for non-COVID-19 conditions, such as cancer (**Source:** Wu, J., Mafham, M., Rashid, M., et al. 2021. Place and Underlying Cause of Death During the COVID-19 Pandemic: Retrospective Cohort Study of 3.5 Million Deaths in England and Wales, 2014 to 2020. *Mayo Clinic Proceedings* 96(4) 952-963. <http://dx.doi.org/10.1016/j.mayocp.2021.02.007>).

Avoidable mortality

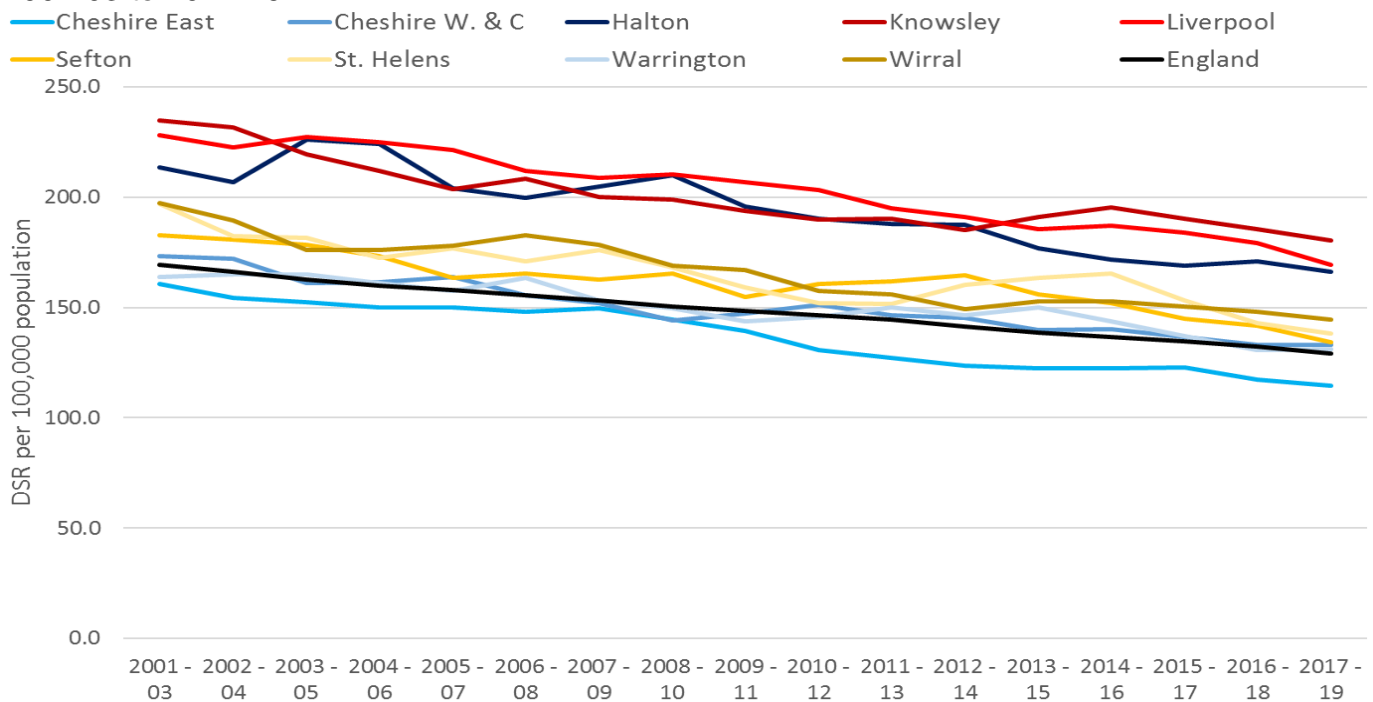
Mortality among people aged under 75 years are often defined as avoidable deaths, this data demonstrates cancer mortality which could be potentially avoidable if risk factors were reduced or negated.

The rate of avoidable mortality from all cancers in every Cheshire and Merseyside local authority has reduced from the turn of the century to 2017-19 (**Figure 74**). As **Figure 74** also shows, Warrington is the only local authority in the area to have a reduction in the rate of mortality lower than that of England.

This further emphasises the improvements in treatment and survival across Cheshire and Merseyside. However, only one local authority in Cheshire and Merseyside had a consistently lower rate of mortality among those aged under 75 than England (Cheshire East).

Those local authorities in Merseyside (**Figure 74**; red/orange lines) tend to have higher rates of avoidable (under 75 years) mortality than Cheshire (**Figure 74**; blue lines). The highest rates of avoidable mortality is among those local authorities with the greatest levels of deprivation; Knowsley and Liverpool in Merseyside, and Halton in Cheshire.

Figure 74: Trend in rate of avoidable cancer mortality (deaths from cancer among those aged under 75 years in Cheshire and Merseyside Local Authorities), DSRs per 100,000 population, 2001-03 to 2017-19



Source: [PHE Fingertips](#), 2021

Across Cheshire and Merseyside local authorities, male mortality rates among those aged under 75 were higher than that of females. The greatest disparity in Male-Female under 75 mortality from all cancers (for 2017-19) was in the same local authorities with the greatest rate of overall under 75 mortality (Halton, Knowsley and Liverpool).

Avoidable mortality (specific cancers)

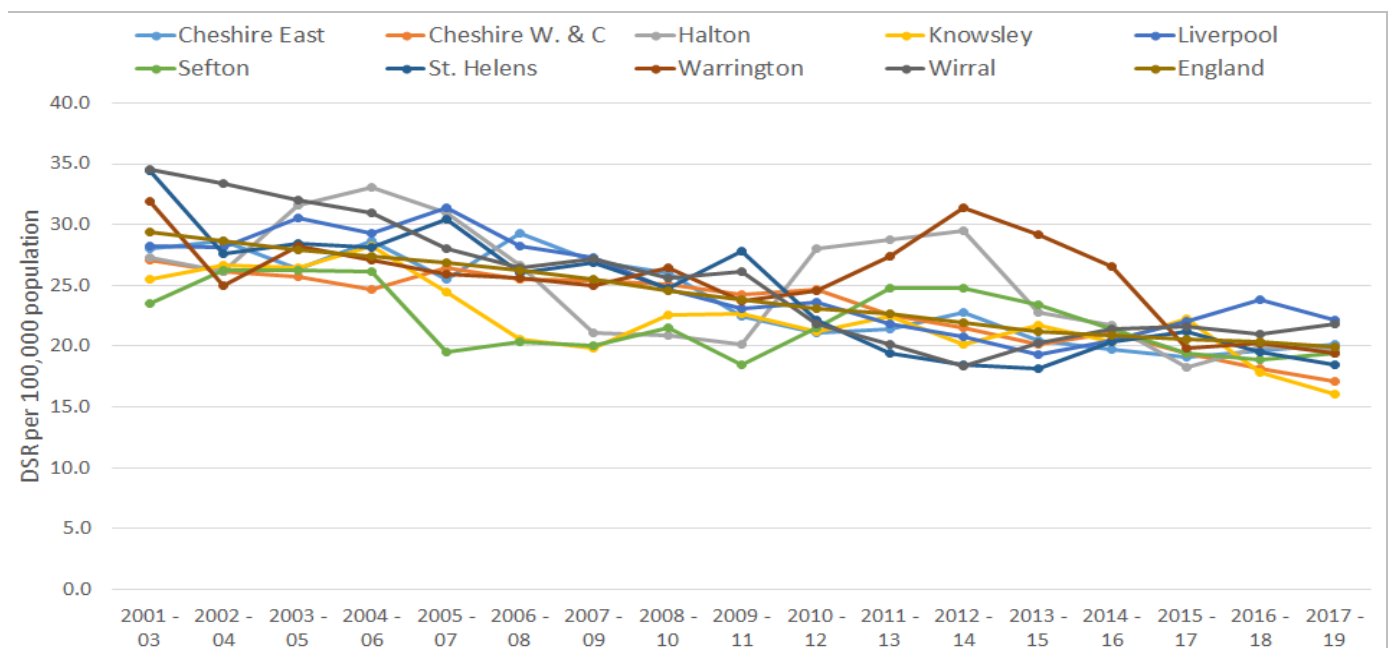
Breast, colorectal and lung cancer mortality among those aged under 75 years (**Figure 75**, **Figure 76**, and **Figure 77**) has consistently fallen among not only England, but all the Cheshire and Merseyside local authorities from 2001-03 to 2017-19.

The rates for breast and colorectal cancer mortality fluctuate from one time period to the next, but the general trend is that of reduction in mortality.

For the years 2017-19, just three of the nine local authorities in Cheshire and Merseyside had higher rates of female breast cancer mortality for those aged under 75 compared to England and they are Cheshire East, Liverpool, and Wirral.

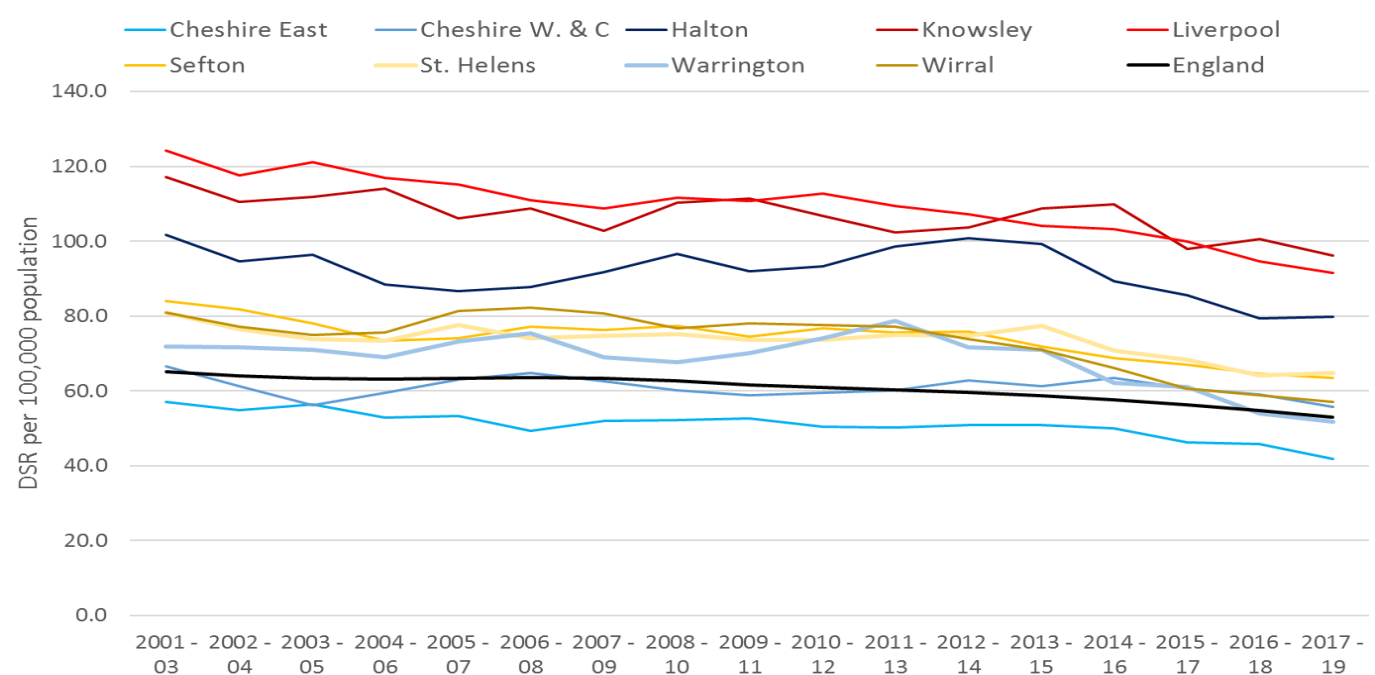
It should be noted however, that these three Local authorities did have substantial reductions in mortality rates from the start of the 2000s to this point (of 7.8, 6.2 and 12.7 per 100,000 respectively).

Figure 75: Trend in rate of avoidable mortality (persons aged <75) from breast cancer in Cheshire and Merseyside Local Authorities, DSRs per 100,000 population, 2001-03 to 2017-19



Source: [PHE Fingertips](#), 2021

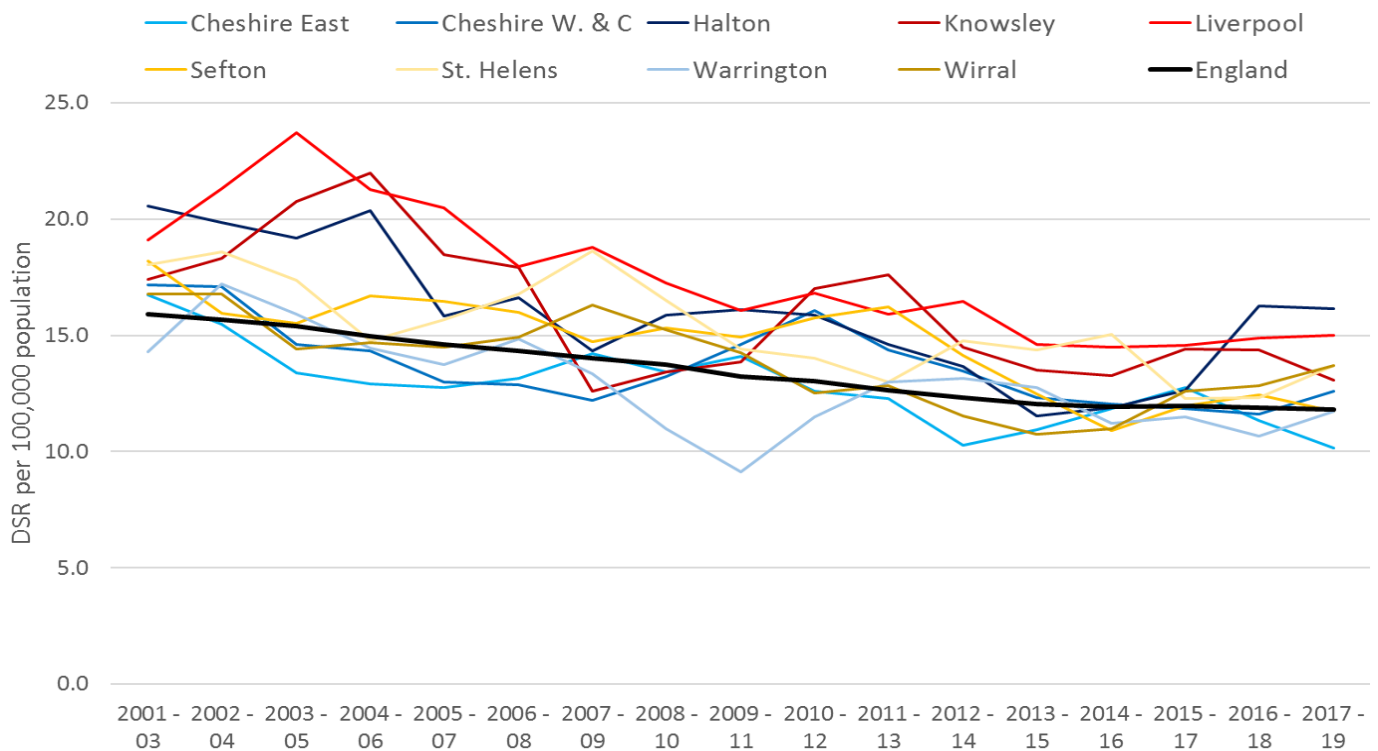
Figure 76: Trend in rate of avoidable mortality (persons aged <75) from lung cancer in Cheshire and Merseyside Local Authorities, DSRs per 100,000 population, 2001-03 to 2017-19



Source: [PHE Fingertips](#), 2021

Colorectal cancer mortality considered avoidable (deaths in those aged <75), does however, continue to be higher across most of Cheshire and Merseyside compared to England (**Figure 77**).

Figure 77: Trend in rate of avoidable mortality (persons aged <75) from colorectal cancer in Cheshire and Merseyside Local Authorities, DSRs per 100,000 population, 2001-03 to 2017-19



Source: [PHE Fingertips](#), 2021

Patient voice

Cancer Research UK first conducted a survey of cancer patients during May 2020, early into the pandemic, to understand their perspectives on the initial impact COVID-19 was having on their testing, treatment, and care. Findings can be found here ([CRUK, 2020](#)).

A second survey conducted between December 2020 and March 2021 aimed to build a more complete understanding of how cancer patients' perspectives of how their testing, treatment and care had been impacted by the pandemic, as well as impact on wellbeing and what they wanted government to do.

The second (2021) survey also included new questions on clinical trials, COVID-19 safety measures, remote consultations, and community-based treatment.

Some key points from the second survey are below:

- Around 1 in 3 cancer patients reported that their testing and treatments had been impacted since the start of the pandemic
- Around 4 in 5 (80%) reported that their care had been impacted in at least one way; most commonly going to treatment alone, having check-ups at hospital cancelled or postponed and receiving less support both from support groups and clinical nurse specialists
- The proportion of cancer patients who rated their overall cancer care as 'very good' reduced from 84% for before the pandemic started, to 60% since the pandemic started
- The majority of cancer patients reported positive experiences of COVID-19 safety measures, particularly safe spaces (89%), wearing masks (80%) and home and community-based treatment (75%)

- The most commonly reported concern was catching and/or becoming seriously ill from COVID-19
- Patients reported feeling more frustrated and anxious compared to before pandemic
- The most highly endorsed Government actions related to ensuring those with signs and symptoms of cancer get diagnosed as quickly as possible and that capacity is put in place to address the backlog

More detail on both surveys can be found at the links below:

- **Cancer Research UK Cancer Patient Survey 2020:** CRUK's first survey studying the impact of COVID-19 on cancer patients in the UK [Cancer Research UK Cancer Patient Experience Survey 2020](#)
- **Cancer Research UK Cancer Patient Survey 2021:** CRUK's second survey studying the impact of COVID-19 on cancer patients in the UK [Cancer Research UK Cancer Patient Survey 2021](#)
- **Marie Curie have also produced a report** "[The Better End of Life Report 2021](#)", which as well as providing quantitative data on the impact of COVID-19 pandemic on those with cancer who were at the end of their lives, highlights the qualitative experience of patients. The findings of the report were that many experienced tremendous hardships at the end of life in 2020. The place where people died changed, with many more dying at home. It also points out that care was compromised by shortages of essential PPE, medicines, and staff and that this was made worse by hospices not being seen as 'frontline NHS'. [A PDF of the full report is also available.](#)

Support organisations across Cheshire and Merseyside

Searchable online directories of available support groups, activities, care services and information are available across the Cheshire and Merseyside region.

Most are not specific to cancer, (users can specify they wish to search only for cancer related support however) but cover a range of health and social issues and are regularly updated. Please see below for the links to directories for each area of Cheshire and Merseyside.

- **Warrington (My Life):** <https://www.mylifewarrington.co.uk/kb5/warrington/directory/home.page>
- **Liverpool (Livewell):** <https://www.thelivewelldirectory.com/>
- **Knowsley (Livewell):** <https://www.thelivewelldirectory.com/>
- **Wirral (InfoBank):** <https://www.wirralinfobank.co.uk/>
- **Sefton (The Sefton Directory):** <https://www.seftondirectory.com/>
- **Halton (The Widnes and Runcorn Cancer Support Group):** <https://www.widnesandruncorncancersupport.org.uk/>

At the time of writing, listings for directories of support organisations have not been supplied for St. Helens, Cheshire East or Cheshire West & Chester.

Macmillan offers support to people living with or affected by cancer from the point of diagnosis. They also offer support to professionals. Please find below details of Macmillan support that can help professionals in their role when supporting people living with or affected by cancer. See below for further information on:

1. **Website**
2. **Telephone Support Line**
3. **Online Community**
4. **In your area**
5. **Telephone Buddies**
6. **Learn Zone**
7. **Be. Macmillan**

If you have any questions or want further details of the support mentioned below, please contact Claire Evans, Macmillan Engagement Lead, on clevans@macmillan.org.uk or 07458 062979.

1. Macmillan website - <https://www.macmillan.org.uk/>

Our website has lots of information for both people living with, and/or affected by, cancer but also, for health care professionals. The links below are a good place to start and are updated regularly.

<https://www.macmillan.org.uk/healthcare-professionals/for-your-role>

<https://www.macmillan.org.uk/healthcare-professionals/for-your-patients>

<https://www.macmillan.org.uk/cancer-information-and-support/get-help>

2. Macmillan telephone support line – 0808 808 0000

Our Macmillan Telephone Support is open 7 days a week from 8am to 8pm and offers a wide range of support including:

- Supporting you through the coronavirus pandemic
- Talk to a Cancer Information Nurse Specialist
- Talk to our Financial Guidance team
- Talk to a Work Support Advisor
- Talk to our Cancer Information and Support Specialists• Sign up for weekly telephone support
- Talk to people on our Online Community
- Find a local support group

3. Online Community - <https://www.macmillan.org.uk/cancer-information-and-support/get-help/emotional-help/online-community>

The Macmillan Online Community is a free online place for people who are living with or who are affected by cancer to chat about the issues affecting them.

“Whether you are having tests, have just been diagnosed, or you are in treatment — or you’re supporting someone who is — the Online Community is the place to talk to people who have similar experiences to yours”!

4. In Your Area - <https://www.macmillan.org.uk/in-your-area/choose-location.html>

This area of the website allows you to search by county, town, or postcode to find local community support. This might be a local peer led support group, the local Macmillan Information and Support Service or other organisations.

5. Telephone Buddies - <https://www.macmillan.org.uk/cancer-information-and-support/get-help/emotional-help/telephone-buddies>

Telephone buddies was launched in 2020 in response to the Covid Pandemic and lockdown to support people living with or affected by cancer. Our free Telephone Buddy service will match the person with someone who understands what they are going through, and they'll give them a weekly call for about 12 weeks.

The volunteer buddy will be a listening ear, ready to talk about how they are feeling and their support needs during this difficult time. They can also let them know about our services, and the many ways Macmillan can help, to ensure they don't face cancer alone.

6. Learn Zone - <https://learnzone.macmillan.org.uk/login/index.php>

Learn Zone is an area of the website which gives access to free learning resources, online courses for professionals, members of the public, volunteers, and groups as well as professional development tools. (A new Hub has recently been launched, which will replace Learn Zone over the coming months – this is currently only available for professionals but will widen to include community groups and people living with or affected by cancer) – for more information about this go to :

<https://macmillan.fuseuniversal.com/communities/1315/contents/169510>

7. Be. Macmillan - <https://be.macmillan.org.uk/be/default.aspx>

Access to a whole host of information and resources that can support professionals or people living with or affected by cancer including (but not exhaustive list):

- Cancer and other health conditions
- Coping with and after treatment
- Diagnosing symptoms, causes, risks and factors
- Easy read titles
- Fundraising
- Information for carers
- Macmillan Organiser
- Organising the practical and financial side