Salford JSNA

Cancer Needs Assessment

21st October 2015
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Executive Summary

Introduction

National research suggests that one in two people will develop some sort of cancer during their lifetime and cancer is now the main cause of death in Salford. National strategy in 2011\(^1\) and in 2015\(^2\) focuses on improving early detection of cancer to lead to less aggressive treatments, better survival and longer life expectancy. Strategy also focuses on people living with and beyond cancer with recommendations to improve patient experiences as well as outcomes. This needs assessment presents cancer data for Salford with the aim to inform future local strategy and actions to improve cancer outcomes in Salford and to reduce inequalities.

Summary of findings

i. Incidence

- The incidence of all cancers is significantly higher in thirteen of the twenty wards in Salford (2007/11). Incidence is higher in males.
- The main types of cancer incidence for males in Salford are prostate, lung and colorectal, these are the same main types of cancer incidence in England (2011/13).
- In females the incidence of breast, lung and colorectal are the main types of cancer incidence in Salford. The pattern for England is the same (2011/13).

ii. Prevalence

- As of the end of 2010, around 6,200 people in Salford were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 12,100 by 2030 (based on current 20-year prevalence and indicative future estimates).
- Cancers such as lung cancer have proportionally few long-term survivors whereas breast cancer has proportionally more.

iii. Mortality

- Salford and Manchester have had consistently higher mortality rates for cancer since 1999/01, they have followed the reducing pattern of England but remain the highest in Greater Manchester.
- In 2011/13, Salford had the second highest death rate to lung cancer in Greater Manchester in the under 75s at 59.4 per 100,000 compared to 34.3 per 100,000 in England.
- The highest number of deaths in Salford to cancers has been to respiratory and intrathoratic organs (this includes lung cancer) and cancers of the digestive organs. The tumour sites that contribute to the largest number of deaths to overall cancer mortality in Salford are lung, bowel, breast and oesophago-gastric.
- The areas of Barton, Broughton, Irwell Riverside, Langworthy, Little Hulton, Ordsall, Swinton South, Winton and Weaste and Seedley are significantly higher than England. The rate in Ordsall is almost double that of the England average.

iv. Screening

- Breast cancer screening uptake showed a rising trend from Q2 of 2013/14 to Q1 of 2014/15 but in the latest two quarters of available data it has begun to decline. It remains below the 80% achievable standard with around a 4% gap to the Greater Manchester average.
As at March 2015, 74% of women had an adequate cervical screening test in the previous 5 years in Salford compared with 77.3% in England. The coverage rate for Salford as at March 2014 is the second lowest in Greater Manchester.

The trend in uptake of cervical screening in Salford has been declining from 2012/13 and the gap with England is widening.

The uptake of bowel cancer screening in Salford for April 2014 to March 2015 was 52.37%, which is slightly above the minimum standard of 52% but falls below the North West and England averages of 56.1% and 57.8% respectively. The latest quarter (January to March 2015), in Salford, began improving from the previous quarters downward spike to 52.26%.

**v. Survival**

- Survival rates over time have increased and the one year survival rate for all cancers combined in Salford is now at a similar level to England. The rate in Salford has increased from 55% to almost 70% over the 15 year period to 2012.
- Breast cancer survival at one year is the third highest in Greater Manchester and lung cancer 4th.
- Breast cancer survival at one year in Salford has gradually improved from 87.3% in 1990/92 to being slightly higher than the England average in 2008/10 at 96.7%.
- At 5 years the survival rate for all cancer types other than Urology are lower than England and the Northwest. They are significantly worse for breast cancer.

**vi. Emergency presentations**

- The percentage of emergency presentations for cancer has fallen in line with the England average but in Salford remains higher at 23.6% in July-December 2012 compared to 20.6% in England.
- Nationally, Pancreatic and Acute Leukaemia showed cancers diagnosed via an emergency presentation at more than 50%. Breast (in situ) and skin melanomas were less likely to be diagnosed via an emergency route at less than 1%.

**vii. Cancer staging**

- The percentage of cancers diagnosed at an early stage in Salford has fallen from 47% in 2012 to 40.2% in 2013. This was significantly higher (better) than England in 2012 but has fallen to significantly lower (worse) in 2013.
Conclusion and recommendations

Increasing new cases of cancer, declining death rates and improved survival combined with an ageing population mean there are more people living with cancer and managing the impact and health needs after cancer. This will increase future years and therefore planning is required by health services to manage this.

This needs assessment finds cancer outcomes are poorer for those living in more deprived areas of Salford and for males. National literature suggests poorer outcomes also for other groups such as older people, ethnic minorities and those with disabilities. Implementation of the recommendations below should therefore include specific action around these groups.

1. The Salford Healthy Communities programme is an established programme to support early diagnosis commissioned for implementation between July 15 and June 2017. Cancer topic areas and prevention messages for the programme to focus on should be agreed. The impact and activity of the programme should be monitored through performance reviews.

2. Opportunities for other services to promote and support cancer awareness messages should be explored for example, through the Way2Wellbeing website or provision of messages/information in non-clinical settings such as libraries and leisure centres.

3. National Be Clear on Cancer Campaigns should be disseminated and promoted by Salford organisations. Local cancer campaigns or marketing are also recommended and cancer types to focus on should be considered with reference to the data in this needs assessment.

4. Wider awareness and confidence in the screening programmes locally is required to enable professionals to support uptake messages and for local people to recognise the importance of their participation. Salford should continue to work with NHS England and Public Health England to implement innovative approaches to improving uptake and reducing inequalities.

5. Local referral pathways require revision by multi-disciplinary teams to implement the NICE Guidance for suspected cancer.

6. Primary Care to deliver the Cancer Standards within the CCG Salford Standard Agreement, aimed at improving cancer outcomes.

7. Salford Long-term Conditions Strategy Group to consider recommendations in the Taskforce Strategy, 2015 such as the cancer dashboard for reporting cancer outcomes / performance.

8. Primary prevention of cancer through promoting a healthier lifestyle (particularly in relation to tobacco use, maintaining a healthy weight, undertaking physical activity, and drinking alcohol at sensible levels) remains an important part of cancer prevention. Salford to continue to be part of Greater Manchester Transformation work around cancer as part of the Cancer Vanguard Programme.

9. This needs assessment shows that people surviving cancer are increasing and will continue to increase. Services which support survivorship / recovery should therefore be considered including continuation of the current Salford exercise rehabilitation programme for post cancer people.
Cancer in Salford - 2011/13

Most common types
- Lung: 449
- Breast: 391
- Colorectal: 268
- Prostate: 239

(All ages, Salford residents)

Emergency presentations
- Pancreatic: 56%
- Liver: 17%
- Lung: 36%
- Stomach: 32%
- Ovarian: 24%

(July-December 2012, national figures)

Deaths
- Esophageal: 12
- Lung: 138
- Breast: 55
- Colorectal: 35
- Prostate: 22

Total cancer deaths: 519

(Aged under 75 years, Salford residents)

Survival
- 1 year: 32.1%
- 5 years: 20.7%

(1 year: 2006/7, 5 years: 2004/6, Salford residents)

In 2010 Salford had 6,100 living with and beyond cancer up to 20 years after diagnosis. By 2030 this could rise to 12,100.

Lifestyle factors
- 9/10 people who develop lung cancer are smokers
- Lifetime cancer risk: 1 in 2
- Up to 40% of cancers could be prevented by lifestyle changes
- 3 out of 5 people who get cancer are 65 years old
- 1/3 cancer deaths are linked to diet
1. Introduction

a) What is cancer?
Cancers are a large family of diseases that involve abnormal cell growth with the potential to invade or spread to other parts of the body. They form a subset of neoplasms. A neoplasm or tumor is a group of cells that have undergone unregulated growth, and will often form a mass or lump, but may be distributed diffusely. The cancerous cells can invade and destroy surrounding healthy tissue, including organs.

b) National Context

i. Strategy
In 2011, the Coalition Government’s new Cancer Strategy\(^1\) highlighted the poor cancer outcomes in England compared to the best outcomes in Europe, recognising inequalities in mortality and survival rates. To improve cancer outcomes, the renewed emphasis included:
- giving people information,
- improving access to expanding cancer screening programmes,
- achieving earlier diagnosis of cancer,
- ensuring all patients had access to high quality treatment,
- supporting the growing number of survivors.

The Independent Cancer Taskforce was established in January 2015 by NHS England to help develop a five-year strategy for cancer services. The taskforce final report published in July 2015\(^2\) sets out six strategic priorities to improve cancer services in England, as below. The Strategy outlines how an additional 30,000 patients every year could survive cancer for 10 years or more by 2020. Of these, around 11,000 would be through earlier diagnosis. The strategy outlines how the NHS should work with the government to improve public health, including adopting a new tobacco control strategy within the next 12 months, and a national action plan on obesity. The taskforce suggests a reduction in smoking from 18.4% now, to less than 13% by 2020.

The six main strategic priorities are:

- Spearhead a radical upgrade in prevention and public health
- Drive a national ambition to achieve earlier diagnosis
- Establish patient experience as being on a par with clinical effectiveness and safety
- Transform our approach to support people living with and beyond cancer
- Make the necessary investments required to deliver a modern high-quality service,
- Overhaul processes for commissioning, accountability and provision

ii. Guidance and interventions

- National Institute for Health and Care Excellence (NICE) guidance

In 2015 NICE guidance for primary care for suspected cancer\(^3\) was also updated in order to support earlier diagnosis of cancer and so save lives. The guidelines detail cancer symptoms and next steps such as further investigation or tests and when to refer as an urgent suspected cancer. It is expected that referrals direct for certain tests will also speed up diagnosis. The revised guidelines have a lowered referral thresholds (any symptom which...
has a 3 in 100 chance of being cancer) and this means that referrals are expected to increase by around 15%.

A new recommendation is ‘safety netting’. This is where individuals are kept under review by the doctor where they have a symptom which is associated with cancer but where other criteria for referral are not met. There are also recommendations for how to reassure and support patients with suspected cancer.

Within Salford an early diagnosis education event was held with GPs in November 2014 and a number of referral pathways were considered. The new Long Term Conditions Support Service in Salford can also use the guidance in relation to the symptoms given. This service supports early diagnosis through raising awareness of cancer signs and symptoms and encouraging visiting GPs early.

- **National Awareness and Early Diagnosis Initiative**
  The National Awareness and Early Diagnosis Initiative (NAEDI) is a public sector/ third sector partnership, which was established in 2008, to co-ordinate and provide support to activities and research to promote the earlier diagnosis of cancer. The streams of work are:
  - Achieving early presentation by public and patients
  - Optimising clinical practice and systems
  - Improving GP access to diagnostics
  - Research, evaluation and monitoring


- **National Screening Programmes**
  There are three national cancer screening programmes which aim to detect cancer at an early stage or prevent cancer from developing. Screening programmes have had a major impact on reducing deaths from cancer.

  The programmes are:

  - Breast cancer screening is offered to women aged 50 to 70 every three years.
  - Cervical cancer screening is offered to women age 25 to 64 (every three years for age 25 – 49 and every 5 years for age 50 – 64)
  - Bowel cancer screening is offered to people age 60 to 75. Bowel scope screening is also being rolled out over the coming years.

- **Be Clear on Cancer**
  Be Clear on Cancer is a programme led by Public Health England working in partnership with the Department of Health and NHS England. Campaigns around certain cancers types are agreed to support early diagnosis through raising public awareness of the signs and symptoms of cancer and to encourage people to see their GP without delay. Reported evaluations indicate success with the approach.

- **Performance targets**
  The NHS Outcomes Framework, the Clinical Commissioning Group Outcome Indicator set and the Public Health Outcomes Framework include cancer measures including quality and experience indicators such as waiting times in additional to mortality and early diagnosis (as measured through improved staging data).
c) Cancer risk

Cancer cases are increasing nationally. 280,000 people were diagnosed with cancer in England in 2013/14 and this is expected to reach more than 300,000 by 2020, and more than 360,000 by 2030. This increase is in part driven largely by the UK’s ageing population. Survival rates also increasing each year, more people are living with cancer.

National research suggests that one in two people will develop some sort of cancer during their lifetime, and certain types of cancers are more prevalent in an elderly, deprived and/or populations with lifestyle factors adversely affecting their health – smoking, excessive alcohol, drug misuse, obesity, lack of exercise can all be linked to cancer. Around 40% of cancers are attributable to lifestyle and environmental factors such as smoking, alcohol consumption, diet and exercise. Preventing cancer though encouraging behaviour change is an essential part of delivering an affordable health service for the future.

Lifetime risk in the UK has been found to have increased over time, due to longer life expectancy, meaning that more people are living into old age, where cancer is more common. In 1975 the lifetime risk of being diagnosed with cancer in the UK was one in four people by the 1990s it has risen to one in three, and by 2010 it was four in ten. In short, one in two people born after 1960 in the UK will be diagnosed with some form of cancer during their lifetime.

![Lifetime risk of all cancers, UK, 1975-2010 and projected to 2030](image)

Source: Cancer Research UK

2. Aim

This needs assessment presents cancer data for Salford with the aim to inform future strategy, interventions and actions to improve cancer outcomes in Salford and to reduce inequalities.
3. Population

In 2013 the Salford CCG total population was 249,987; with 18.1% aged under 14 and 13.9% aged over 65. This demonstrates a younger population structure than England. The population in Salford CCG is generally younger than the England average, however, the proportion of age groups 0-4, 5-9, 20-24, 25-29 and 30-34 are higher than England in both males and females. Cancer incidence and mortality tends to be more prevalent in elderly populations.

Source: National General Practice profiles, APHO
4. Deprivation

The level of deprivation within Salford is significantly higher than England across all areas. In 2010, there were 48,832 people living in means tested benefit households meaning that 21.7% of people are living in income deprivation compared to the England average of 14.7%. The percentage of children living in poverty and older people living in deprivation were ten percent higher than the England average at 32.3% and 27.9%.

Incidence and mortality for all cancers (excluding non-melanoma skin cancer) are generally higher in the more deprived quintiles than the least deprived.

Source: Local Health, Public Health England
5. Incidence of cancers

Cancer incidence is a measure of the number of new cases diagnosed during a given time period. The statistics are provided as the total number of cases or as rates (number of cases per 100,000 population).

Incidence rates can be ‘crude’ or age-standardised. The crude rate is calculated by dividing the number of patients who live in a given area by the population of that area, however, the age-standardised rate (ASR) is more commonly used because the incidence of cancer rises sharply with age. The ASR calculation takes into account the variation in the age structures of populations to allow comparisons between different areas to be made. Cancer is much more common in the elderly, so a more elderly population will in general have a higher crude rate. Therefore age-standardised rates are the figures that should be used when making comparisons between different areas or different time periods. Incidence rates have been calculated using the European Standard Population 2013.

Incidence of cancers – top male causes (2013)

The main types of cancer incidence for males in Salford are lung, prostate and colorectal, these are the same main types of cancer incidence in England but the incidence of prostate is higher than lung.

<table>
<thead>
<tr>
<th>Cancer site</th>
<th>Cases per year</th>
<th>Salford ASIR</th>
<th>England ASIR</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>98</td>
<td>118.1</td>
<td>91.4</td>
<td>Significantly higher than England</td>
</tr>
<tr>
<td>Prostate</td>
<td>133</td>
<td>159</td>
<td>184.9</td>
<td>Lower than England but not significant</td>
</tr>
<tr>
<td>Colorectal</td>
<td>95</td>
<td>111.4</td>
<td>86.5</td>
<td>Significantly higher than England</td>
</tr>
</tbody>
</table>

Source: Cancerstats - North West Cancer Intelligence Service, PHE

Incidence of cancers – top female causes (2013)

In females the incidence of breast, lung and colorectal are the main types of cancer incidence in Salford. The pattern for England is the same.

<table>
<thead>
<tr>
<th>Cancer site</th>
<th>Cases per year</th>
<th>Salford ASIR</th>
<th>England ASIR</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>162</td>
<td>161.0</td>
<td>169.6</td>
<td>Higher than England but this is not significant</td>
</tr>
<tr>
<td>Lung</td>
<td>125</td>
<td>126.8</td>
<td>63.8</td>
<td>Significantly higher than England</td>
</tr>
<tr>
<td>Colorectal</td>
<td>67</td>
<td>67.3</td>
<td>56.1</td>
<td>Similar to England</td>
</tr>
</tbody>
</table>

Source: Cancerstats - North West Cancer Intelligence Service, PHE
Incidence of cancers by type

Salford, in 2011/13, has the second highest incidence rate for all cancers in the North west region and is significantly higher than England and the North West. The male age standardised incidence rate in 2011/13 was 730.4 per 100,000, this is higher than the female rate of 632.9 per 100,000.

The incidence rate for lung cancer is second highest in Greater Manchester behind Manchester. The rate is significantly higher than England and the North West. In 2011/13 there were a total of 367 new cases of lung cancer per year in males and 347 in females with corresponding age standardised incidence rates of 150.7 and 118.5 per 100,000 for men and women. Both the male and female incidence rates are second highest in Greater Manchester behind Manchester itself.
Salford has one of the lowest incidence rates for prostate cancer in the region, at 146.8 per 100,000, and is significantly lower than the North West and England. In 2011/13 there were a total of 361 new cases of prostate cancer.

The incidence of breast cancer in Salford is second highest in Greater Manchester at 173.0 per 100,000. This is not significantly higher than England and the North West. In 2011/13 there were a total of 520 new cases of breast cancer in Salford.
Colorectal cancer in Salford is significantly higher than England at 108.0 per 100,000 for males in Salford compared to 90.1 in England. Females in England had an age standardised rate of 57.9 per 100,000 which is lower than the Salford female rate of 64.5 per 100,000. The Salford male rate is third highest in Greater Manchester behind Wigan and Tameside; females is second highest behind Bury.

Cancer incidence – by ward (2007-2011)

Standardised Incidence Ratios (SIRs) cannot be compared to each other only to the reference population which is always 100 and in this case is England. Areas in Salford where significantly higher than the England average are shown in red, the Salford SIR is shown for information.

The incidence of new cancers is higher than the England average in all but one ward in Salford (Cadishead) but this is not significant. The ratio is significantly higher in thirteen of the twenty wards in Salford.

Source: Local Health, Public Health England
6. **Prevalence**

Cancer prevalence is a count of people still alive who have been diagnosed with cancer in the past. As such it is an indicator of the burden of cancer and can help to inform health care service planning. Cancer prevalence reflects trends in cancer incidence, mortality and survival, as well as advances in cancer treatment and detection, and the ageing of the population. The number of people living with and beyond cancer is increasing and is set to rise further, if existing trends continue.

As of the end of 2010, around 6,200 people in Salford were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 12,100 by 2030 (based on current 20-year prevalence and indicative future estimates).

People’s needs change during the course of their cancer journey. In the first year after diagnosis, patients typically need acute sector care; after this they tend to move into recovery and readjustment and then medium- and long-term survival, requiring care in the primary and community sectors.

**In 2010 Salford had 6,100 living with and beyond cancer up to 20 Years after diagnosis**

**By 2030 this could rise to 12,100**
Local data for all cancers combined gives an indication of the total demand for care at different times after diagnosis, and also serves as an alternative way to look at length of survival. Cancers such as lung cancer have proportionally few long-term survivors whereas breast cancer has proportionally more. Data for England by cancer type are presented to demonstrate this variation. Local data on prevalence by time since diagnosis for specific types of cancer are not currently available.

All cancer prevalence since time of diagnosis follows the pattern in England closely, 9.9% of people diagnosed with cancer are still alive after 15 years compared to 10% in England. After 2-5 years, 26.6% of people are still alive after diagnosis and 23.8% alive following 5-10 years, this compared to 23.5% and 26.6% in England.

Wide variations exist between different cancer types. The number of people who were still alive at the end of 2010, in Salford, who have been diagnosed with each of the four most common cancers during the past 20 years is shown above. Just over 1,600 women are still alive with breast cancer, 858 men with prostate and 815 people with colorectal cancer. Lung cancer has a poorer prognosis which is seen by the 256 people living with the disease. Unfortunately it is not possible to break down the prevalence since time of diagnosis by cancer type within Salford.
7. Mortality

Analysing mortality under the age of 75 years is a useful measure of premature mortality and the health of the population. Cancer mortality records the actual number of deaths that record cancer as being the main cause of death, during a given time period.

Cancer mortality – Greater Manchester

Source: National Compendium of clinical indicators (NCHOD), HSCIC

The mortality rate to all cancers in under 75s is significantly higher than England and Greater Manchester at 190.3 per 100,000. Salford, Manchester, Oldham and Tameside have a significantly higher rate than England.

Source: National Compendium of clinical indicators (NCHOD), HSCIC

The mortality rate in Salford for all cancers aged under 75 years in 2011/13 is second highest in Greater Manchester for both males and females, behind Manchester. Both rates are significantly higher than the Greater Manchester and England averages. For males the Mortality DSR is 210 per 100,000 compared to 183.6 in Greater Manchester and 160.9 in England. For females the rate is 171.8 per 100,000 compared to 146.5 in Greater Manchester and 129.2 in England.
Mortality to all cancers aged under 75 years (persons) – change over time

Salford has had consistently higher mortality rates for cancer, they have followed the reducing pattern of England until 2011/13 where there has been a rise. They remain significantly higher than the North West, Greater Manchester and England over the time period. Overall, the rate in Salford has reduced from 228.4 per 100,000 in 2001/03 to 190.3 per 100,000 in 2011/13, compared to 169.44 in 2001/03 to 144.36 in 2011/13.

Source: Public Health Outcomes Framework, Public Health England

Mortality to males, in Salford, has remained significantly higher than England over the time period and has fallen to 210.0 per 100,000 in 2011/13 from 257.7 per 100,000 in 2001/03, compared to 160.9 per 100,000 in England in 2011/13. The male standardised mortality rate is higher than the female which has fallen from 203.7 per 100,000 in 2001/03 to 171.9 per 100,000 in 2011/13, compared to 129.2 per 100,000 in England in 2011/13.

Source: Public Health Outcomes Framework, Public Health England
Mortality to all cancers considered preventable (persons)

Mortality from cancer considered preventable has shown the second highest fall in rate from 2001/3 to 2011/13 in Greater Manchester and all comparator areas. This is a fall in the rate from 145.7 to 122.5 per 100,000 and a percentage change of 15.9% which is a sharper fall than England and the North West. The rate however, has remained significantly higher than the North West and England over the time frame. The rate in 2011/13 was joint fourth highest (worst) in the country.

Source: Public Health Outcomes Framework, Public Health England

Cancer mortality by ward

Standardised Mortality Ratios (SMRs) cannot be compared to different areas only to the reference population which is always 100 and in this case is England. The Salford SMR has been shown for information. The areas of Barton, Broughton, Inwell Riverside, Langworthy, Little Hulton, Ordsall, Swinton South, Winton and Weaste and Seedley are significantly higher than England. The SMR in Ordsall is almost double that of the England average.

Source: Local Health, Public Health England
Cancer mortality by type

The tumour sites that contribute to the largest number of deaths to overall cancer mortality in Salford are lung, bowel, breast and oesophago-gastric.

Salford observed number of deaths under 75 by tumour site 2011-2013

Source: National Compendium of clinical indicators (NCHOD), HSCIC
In depth analysis of actual deaths in Salford from 2006/08 has shown that the highest number of deaths has been to respiratory and intrathoratic organs (this includes lung cancer) and cancers of the digestive organs. The rise in digestive cancers in 2011/13 has caused the rise in the overall cancer mortality rate for the same time period.

Source: Primary Care Mortality Database (PCMD)

Deaths to individual tumour sites of the digestive organs are quite low so there is a lot of fluctuation. The rise in digestive cancers over 2011/13 is specifically due to oesophagus and colon cancers.

Source: Primary Care Mortality Database (PCMD)
8. Emergency presentations

An emergency presentation is a cancer diagnosed via an emergency route e.g. A&E, emergency GP referral, emergency consultant outpatient referral, emergency transfer, emergency admission or attendance.

Emergency presentations correlate with poor short term and long term survival. These percentages are calculated as proxy measures for the proportion of tumours diagnosed following an initial emergency presentation into secondary care. Data have been presented at 6 month intervals in order to increase the size of the cohort and therefore reduce the expected variation. Confidence intervals are presented to show variation. This is particularly important when looking at small sub-national geographies as large changes between 6 month periods may well be within expected variation.

The percentage of emergency presentations for cancer has fallen in line with the England average but in Salford remains higher at 23.6% in July-December 2012 compared to 20.6% in England. This means that more than the average number of cases are being diagnosed via an emergency presentation in Salford.

Source: Cancer commissioning toolkit

During July – December 2012 the cancer types diagnosed via an emergency presentation were calculated nationally. Pancreatic and Acute Leukaemia showed cancers diagnosed via an emergency presentation at more than 50%. Breast (in situ) and skin melanomas were less likely to be diagnosed via an emergency route at less than 1%.
<table>
<thead>
<tr>
<th>Parent type</th>
<th>cancer type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper GI</td>
<td>Pancreas</td>
<td>56.3</td>
</tr>
<tr>
<td>Acute Leukaemia</td>
<td>Acute myeloid</td>
<td>53.3</td>
</tr>
<tr>
<td>Upper GI</td>
<td>Liver</td>
<td>47</td>
</tr>
<tr>
<td>Lung</td>
<td>Mesothelioma</td>
<td>36.2</td>
</tr>
<tr>
<td>Upper GI</td>
<td>Stomach</td>
<td>31.8</td>
</tr>
<tr>
<td>Lung</td>
<td>Mesothelioma &amp; Pleura</td>
<td>30.7</td>
</tr>
<tr>
<td>Haematology</td>
<td>Multiple Myeloma</td>
<td>27.8</td>
</tr>
<tr>
<td>Haematology</td>
<td>Non-Hodgkin lymphoma</td>
<td>24.8</td>
</tr>
<tr>
<td>Gynae</td>
<td>Ovary</td>
<td>24.2</td>
</tr>
<tr>
<td>Lower GI</td>
<td>Colorectal</td>
<td>22.3</td>
</tr>
<tr>
<td>Urology</td>
<td>Kidney and unspecified urinary organs</td>
<td>20.5</td>
</tr>
<tr>
<td>Upper GI</td>
<td>Oesophagus</td>
<td>19.4</td>
</tr>
<tr>
<td>Acute Leukaemia</td>
<td>Chronic lymphocytic</td>
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</tr>
<tr>
<td>Head &amp; Neck</td>
<td>Larynx</td>
<td>12</td>
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<tr>
<td>Haematology</td>
<td>Hodgkin lymphoma</td>
<td>11.7</td>
</tr>
<tr>
<td>Gynae</td>
<td>Cervix</td>
<td>9.9</td>
</tr>
<tr>
<td>Urology</td>
<td>Prostate</td>
<td>9.4</td>
</tr>
<tr>
<td>Urology</td>
<td>Bladder</td>
<td>8.4</td>
</tr>
<tr>
<td>Testicular</td>
<td>Testis</td>
<td>8.2</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>Oral Cavity</td>
<td>5.8</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>Head &amp; Neck L3 A</td>
<td>5.4</td>
</tr>
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<td>Gynae</td>
<td>Uterus</td>
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<tr>
<td>Gynae</td>
<td>Vulva</td>
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<tr>
<td>Head &amp; Neck</td>
<td>Thyroid</td>
<td>4.4</td>
</tr>
<tr>
<td>Breast</td>
<td>Breast - invasive</td>
<td>3</td>
</tr>
<tr>
<td>Skin</td>
<td>Melanoma</td>
<td>1</td>
</tr>
<tr>
<td>Breast</td>
<td>Breast - in situ</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source: Cancer Commissioning Toolkit, National Cancer Intelligence Service (NCIS)
9. Cancer targets

Cancer waiting times

Waiting times for suspected and diagnosed cancer patients accessing NHS services are calculated quarterly by NHS England. Salford, overall has hit the majority of all targets over the time period apart from, most recently:

- One month wait from a decision to treat to a subsequent treatment for cancer (surgery) – Quarter 4 of 2014/15
- Two month wait from GP urgent referral to a first treatment for cancer – Quarters 3 and 4 2014/15
Two Month Wait from GP Urgent Referral to a First Treatment for Cancer

Source: Commissioner based cancer wait times, NHS England
Two week wait referrals

Two Week Wait referrals represent the best route to diagnosis for symptomatic patients. In Salford in 2013/14, 98.5% of patients referred via this route were seen by a specialist within secondary care within two weeks of the referral being made.

This is measured in two ways:

- **The % of Two Week Wait referrals that are diagnosed with cancer**
  This measure provides a useful assessment of the proportion of two week wait referrals that are eventually diagnosed with cancer. This is an important metric in determining the appropriateness of referrals using a Two Week Wait referral. Nationally, in 2014, 9.5% of Two Week Wait referrals are diagnosed with cancer. Both the national and Salford referrals who go on to be diagnosed with cancer have fallen from 2010 to 2014.

- **The % of new diagnoses that were referred as a Two Week Wait**
  This measure shows the percentage of new patients that were diagnosed via the best route for symptomatic patients. Nationally, in 2014, 48.8% of patients are diagnosed following a Two Week Wait referral. The local and national picture have shown an improving rate from 2010 to 2014 of cancers diagnosed via a two week wait referral.

<table>
<thead>
<tr>
<th></th>
<th>Proportion of Two Week Wait referrals with cancer</th>
<th>Proportion of cancers diagnosed via a Two Week Wait</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salford</td>
<td>England</td>
</tr>
<tr>
<td>2010</td>
<td>13.3%</td>
<td>11.2%</td>
</tr>
<tr>
<td>2011</td>
<td>13.0%</td>
<td>10.9%</td>
</tr>
<tr>
<td>2012</td>
<td>12.0%</td>
<td>10.6%</td>
</tr>
<tr>
<td>2013</td>
<td>10.8%</td>
<td>10.0%</td>
</tr>
<tr>
<td>2014</td>
<td>10.8%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

Source: Cancer Commissioning Toolkit, National Cancer Intelligence Network (NCIN)
10. **National cancer patient experience survey 2014**

The Cancer Patient Experience Survey (CPES) 2014 is the fourth in the series of surveys begun in 2010, covering all adult patients in active treatment for cancer in England. In 2014 the number of respondents was 70,141 from 153 NHS Trusts from a sample of 109,760 (64% response rate). Nationally cancer patients continue to give positive responses about their treatment and care, this is reflected locally within the Salford responses. Scores of 80% and over have been achieved on questions such as: information about their cancer; treatment options; tests and operations; being seen as soon as was necessary for an initial appointment with a hospital doctor; privacy; care by doctors; and being treated with respect and dignity.

94% of respondents in Salford said that their overall care was excellent or very good, this is higher than the national mean of 89%. The responses for Salford resident patients being told sensitively that they had cancer were the highest in the country at 91%, compared to the national mean of 84%.

However, some scores in the survey suggest there may be opportunities for improvement, especially where the scores are lower than the national mean score. These include:

- Saw GP once/twice before being told had to go to hospital (Salford 74.4%, national mean 75%)
- Patient given written information about the type of cancer they had (Salford 71.5%, national mean 72%)
- Patient given written information about side effects (Salford 76.7%, national mean 82%)
- Patient given the name of the CNS (Clinical Nurse Specialist) in charge of their care (Salford 88.2%, national mean 89%)
- Patient given written information about the operation (Salford 69.4%, national mean 76%)
- Got understandable answers to important questions all/most of the time (Salford 72.3%, national mean 76%)
- Hospital staff did everything to help control pain all of the time (Salford 84.9%, national mean 86%)
- Staff definitely did everything to control side effects of chemotherapy (Salford 78.7%, national mean 81%)

Areas where Salford is higher than national include:

- Patient definitely told about treatment side effects that could harm them in the future (Salford 61.1%, national mean 56%)
- Hospital gave information on getting financial help (Salford 54.1%, national mean 54%)
- Patient was able to discuss worries or fears with staff during visit (Salford 69%, national mean 65%)
- Hospital and community staff always worked well together (Salford 66.5%, national mean 63%)
- Patient offered written assessment and care plan (Salford 30.2%, national mean 22%)
- Taking part in cancer research discussed with patient (Salford 31.3%, national mean 31%)
- Always /nearly always enough nurses on duty (Salford 66%, national mean 62%)

Being informed about side effects of treatment that may be delayed in onset could affect informed consent, in situations where treatment may have high impact in future years. Not being given information on financial help and benefits they may be entitled to might cause the patient difficulties in coping with the additional costs known to face cancer patients, such
as any need for supplementary heating. Involvement by patients in research is not evenly spread across Trusts, and there is concern that some patients who might fit the criteria for clinical trials may miss out on opportunities that could exist for them, to the detriment of future patients. Information and support to families is regarded as crucial in situations where patients may struggle to cope emotionally or with the consequences of treatment or disease progression, and the absence of opportunities to talk to a Doctor is important in this respect for carers and families, as is the imparting of information to them on how best to care for the patient when they are discharged from hospital care.

Aspects of personal care are also regarded as important given the large number of cancer patients treated on wards which deal with a wide range of patients, with a clear need for appropriate numbers of nurses in place who are knowledgeable about the treatment that cancer patients receive, and who ask important questions which support the respect and dignity with which the patient is treated - such as addressing them by their preferred name. The absence of a written care plan may also limit the knowledge that patients have of their care pathway, and place obstacles to staff having a full understanding of treatment planned; and lack of support from primary care, social services, and community health services post discharge may have detrimental effects on both patients and carers over time.

Some low scores also reflect points of care transition, which are crucial in ensuring that patients have seamless, organised and personal care which meets their needs. This is typically where hospitals and community staff work together.

Nationally, the single most important factor associated with high patient scores, in every tumour group, is the patient being given the name of a clinical nurse specialist (CNS) in charge of their care. Salford residents were given the name of their CNS in 88.2% of cases and were easily able to contact them in 79.4% of cases.

It is also the case that patients with rarer cancers were more likely to give poorer scores on a range of questions than was the case for patients with more common tumours.

Some patient groups were also less likely to be positive than others about their care and treatment. Patients with a long term condition other than cancer, or multiple long term conditions, were more likely to be critical of care - as were some ethnic minority patients; younger patients aged 16-35; patients attending London hospitals; lesbian, gay, bisexual and patients classifying themselves as ‘other’; and women. Patients who entered the system through emergency routes were less likely to be positive about their care and treatment - on a wide range of questions - than were patients entering through a planned pathway.

It has been proved that better information giving has been at the core of the improved scores registered nationally by the CPES since 2010. This better information has been recognised by patients during the diagnosis phase; during testing and treatment; and at discharge.

The further improvement agenda on cancer might reflect the issues identified through the CPES. The key points are:

- To focus on care in day case units and post discharge, where scores have fallen slightly over time;
- To improve scores on issues such as on financial support, provision of care plans, and participation in research, where scores are low in absolute terms;
- To improve the care and experience of patients with rarer cancers;
- To address the poorer experience of patients entering care through an emergency route and those where new cancers have been found or where cancer has returned;
- To identify methods of support for patients who may have additional needs, such as those with multiple long term conditions.
11. Survival

Survival is the proportion of patients diagnosed with cancer who are still alive after a specified time period. Survival is influenced by the stage at which the cancer is diagnosed, the access a patient has to different services, surgery and follow up services.

Survival index estimates are a way of estimating cancer survival, these are age-standardised to improve the comparability between areas over time. This is because survival varies with age at diagnosis, and the age profile of cancer patients can vary over time and between geographical areas. Age-standardisation therefore requires a survival estimate for each age group.

Survival data at one year and five years after diagnosis are useful indicators of the stage of cancer at diagnosis and the quality of the treatment received.

Survival rates over time have increased and the one year survival rate for all cancers combined is now at a similar level to England. The rate in Salford has increased from 55% to almost 70% over the 15 year period. At 5 years survival rates in England have increased from 41.9% to 49%, the Greater Manchester rate has increased to the same level over the 12 year time frame. Trend data at 5 years is not available for Salford for all cancers combined.

Source: Office for National Statistics
Survival rates 1 year

2008/10

<table>
<thead>
<tr>
<th></th>
<th>Breast</th>
<th>Lower GI</th>
<th>Lung</th>
<th>Urology</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>96.6</td>
<td>76.7</td>
<td>32.8</td>
<td>96.2</td>
</tr>
<tr>
<td>Northwest</td>
<td>96.0</td>
<td>76.3</td>
<td>31.4</td>
<td>95.6</td>
</tr>
<tr>
<td>Salford</td>
<td>96.7</td>
<td>75.2</td>
<td>32.1</td>
<td>96.6</td>
</tr>
</tbody>
</table>

Cancer survival rates in 2008/10 are similar to England and the Northwest and not significantly different at one year. 96.7% of people in Salford contracting breast cancer are expected to survive at least one year, for Urology (prostate) cancer this is 96.6%. Lung cancer has the lowest survival rate of 32.1% which is slightly lower than 32.8% in England.

Cancer net survival estimates in 2012 showed Salford as 3rd highest in Greater Manchester for one year breast cancer survival at 97%. Colorectal cancer survival at 75.9% is a lower survival rate than many peers within Greater Manchester with lung cancer survival at one year being 4th lowest in Greater Manchester at 32.8%.
Cancer Needs Assessment – October 2015

5 year survival

More recent 5 year survival data is not available for local areas, therefore whilst quite out dated the net survival data at 5 years has been shown for the period 2004/6.

2004/6

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>England</th>
<th>Northwest</th>
<th>Salford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>85.7</td>
<td>84.5</td>
<td>80.6</td>
</tr>
<tr>
<td>Lower GI</td>
<td>54.6</td>
<td>52.1</td>
<td>52.0</td>
</tr>
<tr>
<td>Lung</td>
<td>8.5</td>
<td>8.6</td>
<td>7.8</td>
</tr>
<tr>
<td>Urology</td>
<td>86.6</td>
<td>85.8</td>
<td>88.0</td>
</tr>
</tbody>
</table>

Source: CCT Toolkit

At 5 years the survival rate for all cancer types other than Urology are lower than England and the Northwest. 80.6% of people are surviving breast cancer for 5 years in Salford, this however is a significantly worse rate than for England. 52% of people in Salford are surviving 5 years following a lower GI cancer diagnosis, for lung cancer this is 7.8%.

Breast cancer survival at 5 years is second lowest (worse) in Greater Manchester behind Manchester, with lung cancer 4th lowest at 7.8%. Lower GI survival rates at 5 years are 4th highest in Greater Manchester at 52% and Urology cancers at 88% are third highest in Greater Manchester behind Stockport and Bury.

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Bolton</th>
<th>Bury</th>
<th>Manchester</th>
<th>Oldham</th>
<th>Rochdale</th>
<th>Salford</th>
<th>Stockport</th>
<th>Tameside</th>
<th>Trafford</th>
<th>Wigan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>84.2</td>
<td>87.0</td>
<td>79.5</td>
<td>82.9</td>
<td>83.1</td>
<td>80.6</td>
<td>88.9</td>
<td>82.2</td>
<td>87.0</td>
<td>84.6</td>
</tr>
<tr>
<td>Lower GI</td>
<td>48.5</td>
<td>53.5</td>
<td>46.0</td>
<td>47.1</td>
<td>50.5</td>
<td>52.0</td>
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<td>46.3</td>
</tr>
<tr>
<td>Lung</td>
<td>9.1</td>
<td>6.9</td>
<td>10.8</td>
<td>8.0</td>
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<td>7.8</td>
<td>7.6</td>
<td>7.7</td>
<td>10.3</td>
<td>9.4</td>
</tr>
<tr>
<td>Urology</td>
<td>84.2</td>
<td>88.5</td>
<td>85.9</td>
<td>87.5</td>
<td>79.7</td>
<td>88.0</td>
<td>92.2</td>
<td>83.1</td>
<td>86.0</td>
<td>83.3</td>
</tr>
</tbody>
</table>

Source: CCT toolkit
12. Cancer Screening

It is recommended that systematic population screening programmes for breast cancer, cervical cancer and bowel cancer are completed. A key measure used is screening ‘coverage’.

Breast screening

Breast screening is intended to detect breast cancer at an early stage, enabling more effective treatment. In the UK, women aged 50 to 70 are routinely invited for breast screening every three years under a national programme. Women over the age of 70 can request screening every three years by making an appointment at their local screening unit, but they do not receive invitations. The NHS Screening Programme in England has, since 2010, been phasing in an extension of the age range of women eligible for breast screening to those aged 47 to 73. It is estimated that the breast screening programme prevents 1,300 deaths nationally per year. Coverage is defined as the percentage of women resident and eligible for screening at a particular point in time who had a test with a recorded result within the last three years.

Breast cancer screening uptake showed a rising trend from Q2 of 2013/14 to Q1 of 2014/15 but in the latest two quarters of available data it has begun to decline. It remains below the 80% achievable standard with around a 4% gap to the Greater Manchester average.

Source: NHS England
Cervical screening

Cervical screening is intended to detect abnormalities within the cervix that could, if untreated, develop into cancer. The cervical screening policy for England invites women for screening every three years for those aged 25 to 49 and every five years for those aged 50 to 64. Coverage is defined as the percentage of women in a population eligible for screening at a given point in time who were screened adequately within a specified period. For women aged 25 to 49, coverage is calculated as the number of women in this age group who have had an adequate screening test within the last 3.5 years, as a percentage of the eligible population aged 25 to 49. For women aged 50 to 64, coverage is calculated as the number of women in this age group who have had an adequate screening test within the last five years, as a percentage of the eligible population aged 50 to 64.

As at March 2015, 74% of women had an adequate test in the previous 5 years in Salford compared with 77.3% in England. The trend in uptake in Salford has been declining from 2012/13 and the gap with England is widening. All areas across Greater Manchester saw a reduction in the coverage, this trend (which is national as well as local) has been occurring for several years.

Source: Primary Care Information Systems, Health and Social Care Information Centre
The coverage rate for Salford as at March 2014 is the second lowest in Greater Manchester. The performance achievable threshold of 80% is only being met by Wigan and Stockport in Greater Manchester.

Source: KC53, Screening and Immunisations update July 2015, PHE

The screening rates are lowest in women aged 25-29 yrs and women aged 60-64 years across all areas in Greater Manchester. Salford reaches the threshold target of 80% in the 35-39 age group but is not achieving this target in all other areas.

Source: KC53, Screening and Immunisations update July 2015, PHE
Bowel screening

Bowel cancer screening aims to detect bowel cancer at an early stage when treatment is more likely to be effective or to help prevent cancer from developing in the first place by allowing the treatment of pre-cancerous conditions. In England, bowel cancer screening is available to those aged 60 to 69, with this age range currently being extended from 60 to 74. A further 1-off diagnostic test using Flexible Sigmoidoscopy is being piloted in England, aimed at men and women aged 55.

Salford has followed the national cyclical pattern of screening uptake since 2011 but is at a lower rate than the England average. The trend is fluctuating. The first 6 months of 2014/15 uptake was above the 52% standard reaching 55.3%. This was the second highest uptake and coincided with a local campaign. The highest uptake in 2012 coincided with the national Be Clear on Cancer Bowel campaign which was enhanced in Salford. In the first quarter of 2015 the England average was above the 52% minimum standard at 58.3%, Salford began to rise again reaching just over the minimum standard at 52.26%.

Cumulatively, the uptake rate in Salford for April 2014 to March 2015 was 52.37%, which is slightly above the minimum standard of 52% but falls below the North West and England averages of 56.1% and 57.8% respectively.

Source: Bowel Cancer Screening Programme, Public Health England
Positivity rates in Salford for 2014/15 are at 1.97% which is on track for the expected standard of less than 2%. This is, however, higher than the North West (1.74%) and England (1.78%) averages.

Source: Bowel Cancer Screening Programme, Public Health England
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13. Cancer staging completeness

Cancer staging completeness 2013

Cancer staging data shows the stage at which a cancer is diagnosed. A later diagnosis of a cancer means poorer outcomes for the patient and a more costly care plan.

Diagnosis at an early stage of the cancer's development leads to dramatically improved survival chances. Specific public health interventions, such as screening programmes and information/education campaigns aim to improve rates of early diagnosis. An indicator on the proportion of cancers diagnosed at an early stage is, therefore, a useful proxy for assessing improvements in cancer survival rates.

In Salford, 68.5% of breast cancers are diagnosed at stages 1 or 2 which links to the higher survival outcomes for such cancers. In 2013, lung cancer was diagnosed at stage 3 and 4 in 57.4% of patients, Salford has very poor outcomes for long term survival (more than 5 years) for lung cancer. Almost half of ovarian and colorectal cancers and around one third of prostate and kidney cancers are diagnosed in the later stages.

Source: Survival by stage 2013, National Cancer Intelligence Service

The reasons for unconfirmed cancer staging could be due to the following:

- older people are more likely than younger people to present with very advanced cancer and die soon after presentation
- it may be clinically inappropriate to stage cancers in some people, for example due to comorbidities, general frailty, or lack of fitness for treatment or other reasons
- some patients will be deemed not fit enough for any active treatment and so staging may be viewed as unnecessary
The percentage of cancers diagnosed at an early stage in Salford has fallen from 47% in 2012 to 40.2% in 2013. This was significantly higher (better) than England in 2012 but has fallen to significantly lower (worse) in 2013, the North West rate has remained stable at around 46% over the time frame.

Source: Public Health Outcomes Framework (PHOF), Public Health England
14. Older people and cancer

Incidence
Cancer is more common in older people, with incidence increasing with age for most cancers. Nearly two thirds of cancers are diagnosed in people aged 65 and over, and more than a third are diagnosed in people aged 75 and over. Nationally, in 2013 there were 105,194 newly diagnosed cases of cancer in the over 75s in England. Salford follows the national pattern with 1306 diagnosed cases in 2012, 432 of which (33%) were in persons aged over 75.

Lung cancer in the over 75s make up 42% of the newly diagnosed lung cancer cases in Salford in 2013, 40% of lower GI newly diagnosed cancer cases were in the over 75s in the same time frame.

Survival
Survival in older people in England has improved in the past decade for many cancer types. Nonetheless, cancer survival decreases with age. Poorer cancer outcomes in older people may be influenced by many factors, including more people being diagnosed with cancer that has already spread, lower rates of treatment, under-representation in clinical trials, ability to tolerate more aggressive treatments, underlying differences in tumour biology and comorbidities.

People who are diagnosed with cancer before it has spread tend to have a greater range of treatment options. Late diagnosis is associated with poorer outcomes and increased treatment costs.

One year survival estimates for all cancers have increased in both the 55-64 and 75-99 age groups, with Salford being in line or slightly below the England average. However, in Salford the older age group is around 15 percentage points lower than the 55-64 age group in 2012.

Source: Cancer Commissioning Toolkit, Public Health England

The needs of all older people are not the same - type of cancer, socio economic status, gender and ethnicity all play a role in shaping people’s needs and outcomes. Equally the needs of active older people in otherwise good health will be very different from those of people living with frailty and other health conditions.
In terms of prevention, older people maybe less likely to practice some of the lifestyle behaviours which would increase the risk of cancer. However, older people may also have the legacy of issues such as smoking or excess alcohol consumption, which may increase their risk. They are also more likely to be overweight or obese and less physically active. Older people need support in reducing their risk of developing cancer and taking action to be fit for more aggressive (but more effective) cancer treatments by changing their lifestyle.

Late diagnosis appears to be a major problem in older people. They are more likely to be diagnosed following an emergency admission, diminishing their chances of long term survival. They also experience poorer survival after diagnosis with a cancer that has already spread. Encouraging earlier diagnosis in older people should be a major priority.

Older patients are also less likely to receive active cancer treatment, be it surgery, radiotherapy or cancer drugs. In some cases frailty and other issues can reduce a person’s ability to withstand treatment and can result in an unacceptable impact on quality of life.

Older people are less likely to have opportunities to participate in cancer research, meaning that opportunities to develop the evidence base on how best to treat older people are missed.

Overall, older people report a positive experience of cancer treatment and care. In particular, they are more likely to have confidence in doctors and nurses and feel that they were treated with dignity and respect. Patient experience surveys do nonetheless also identify areas for improvement. In particular, older people are less likely to have access to a clinical nurse specialist or report being given information on side effects of treatment.
15. Cancers by type

The incidence, mortality and survival of the main cancer types within Salford are included in this chapter, further analysis by individual tumour type can be completed via an information portal.

Lung Cancer (ICD10 C33-34)

**Incidence**

Lung cancer incidence for 0-74 year olds, in England, has remained at a relatively consistent level of around 50 per 100,000 since 2008. In Salford the rate is almost a third higher in 2013 at 83.5 per 100,000. The rate has begun to fall since 2011 where it peaked at 99.6 per 100,000 but it has remained significantly higher than England over the time period.

Source: Cancer Commissioning Toolkit, Public Health England

Lung cancer incidence in the over 75s is almost 8 times higher than the under 75s for both Salford and England. Incidence in Salford has again remained significantly higher than England and is around a third higher than the incidence for England and in 2013 was at 647.2 per 100,000.

Source: Cancer Commissioning Toolkit, Public Health England
Standardised Incidence Ratios (SIRs) cannot be compared to each other only to the reference population which is always 100 and in this case is England. The Salford SIR is shown for reference.

The incidence ratio for lung cancer is lower in Boothstown and Ellenbrook and Worsley than the England average but this is not significant. The SIR is significantly higher in all but five wards in Salford.

Source: Local Health, Public Health England
Lung cancer mortality

Lung cancer contributes to the highest number of cancer deaths in Salford and has the second highest DSR (in Greater Manchester) of mortality to lung cancer in the under 75s at 59.4 per 100,000 compared to England at 34.3. This is significantly higher than both England and Greater Manchester.

Source: National Compendium of clinical indicators (NCHOD), HSCIC

The rate for males and females is also significantly higher than England and Greater Manchester at 63.9 and 55.2 per 100,000 respectively.

Source: National Compendium of clinical indicators (NCHOD), HSCIC
**Lung cancer survival**

Lung cancer survival at one year in Salford has improved over time from 20% in 1990/92 to 32% in 2008/10, with the gap against England closing at 2007/9. The gap has begun to increase again slightly by 2008/10.

At 5 years, cancer survival in England has steadily risen from 6.4% in 1990/92 to 8.5% in 2004/6. The Salford rate remained consistently low at around 5% for ten years until the rate dramatically improved and overtook the England rate in 2002/4 and 2003/5. However, the rate has again fallen under the England average in 2004/6 at 7.8%.

Source: Cancer Commissioning Toolkit, National Cancer Intelligence Network (NCIN)
Breast cancer (ICD10 C50)

Breast cancer incidence has remained similar to the England average from 2008-2013. The rate in 2013 of 136.1 per 100,000 has fallen from 142.4 per 100,000 in 2008. This is lower in 2013 than the England average of 142.8, but this is not significant.

Source: Cancer commissioning toolkit, Public Health England

Breast cancer incidence has remained similar to the England average from 2008-2013. The rate in 2013 of 136.1 per 100,000 has fallen from 142.4 per 100,000 in 2008. This is lower in 2013 than the England average of 142.8, but this is not significant.

Source: Cancer commissioning toolkit, Public Health England

Nine wards within Salford have a higher Standardised Incidence Ratio (SIR) for breast cancer than England, however, it is only significant in Swinton South. The incidence of breast cancer is significantly lower in Cadishead when compared to England.

Source: Local Health, Public Health England
**Breast cancer mortality**

Although breast cancer mortality contributes to the third highest number of cancer deaths in Salford, the difference between death rates with Salford and Greater Manchester or England is not statistically significant. Mortality from breast cancer in females aged under 75, in 2011/13, is lower than England and Greater Manchester at 20.99 per 100,000 compared to 22.7 per 100,000 in Greater Manchester and 22.6 per 100,000 in England. Although lower than both comparator areas the rate is not significant.

Source: National Compendium of clinical indicators (NCHOD), HSCIC

**Breast cancer survival**

Breast cancer survival at one year in Salford has gradually improved from 87.3% in 1990/92 to being slightly higher than the England average in 2008/10 at 96.7%.

At 5 years, the Salford survival rate has increased from 62.1% almost reaching the England average in 2002/4. The rate has begun to decrease down to 80% in 2004/6 compared to 85.7% in England.

Source: Cancer Commissioning Toolkit, National Cancer Intelligence Network (NCIN)
**Lower GI cancers (ICD10 C17-21)**

**Lower GI cancer incidence**

The Age Standardised Incidence Rate for Salford (persons aged under 75 years) remained similar to the England average from 2008 until 2012. In 2013 the rate increased to 60.1 per 100,000 population compared to 46.2 per 100,000 in England and became significantly higher.

**Source:** Cancer commissioning Toolkit, Public Health England

Fifteen wards within Salford have a SIR higher than in England, however no ward is significantly different to England.

**Source:** Local Health, Public Health England
**Lower GI cancer mortality**
Bowel cancer contributes to the second highest number of cancer deaths in 2011/13. Uptake of bowel screening is poor (48.7%, Oct-Dec 2014) and the incidence of bowel cancer (Indirectly standardised registration ratios - SRR) is similar to England in 2009/11 at 112.4 for males and 101.9 for females.

Mortality from colorectal cancer in persons aged 75 and under is significantly higher (at 19.4 per 100,000) than both Greater Manchester and England and is the highest mortality rate in 2011/13 in Greater Manchester.

Source: National Compendium of clinical indicators (NCHOD), HSCIC
Lower GI cancer survival

The one year survival rate for Salford in 1990/92 was 57.5% this has increased to 75.2% by 2008/10. This is slightly lower than the England average but is not significant. The 5 year survival rate has increased from 29.9% in 1990/92 to 51.9% in 2004/6, this is lower than the England average of 54.6% but is not significant.

Given the lower survival rates for colorectal cancer it is likely that the cancer is diagnosed late.

Source: Cancer Commissioning Toolkit, National Cancer Intelligence Network (NCIN)
Urology cancers (ICD10 60-68, includes prostate cancer – C61)

Urologic cancers include cancers of the bladder, kidney, prostate and testicles. Where possible the data has been broken down into specific cancer types, however data is not always available for each type of cancer.

**Urology cancer incidence**

The incidence of urology cancers to persons aged under 75 years has remained similar or lower than the England average since 2009, the rate was significantly higher than England in 2008 but has since fallen to 92.3 per 100,000 in 2013. The rising pattern since 2012 has followed the overall rising trend in England over the same time period.

Source: Cancer Commissioning Toolkit

Thirteen wards have a lower SIR than England for prostate cancer but it is only significant in Little Hulton.

Source: Local Health, Public Health England
**Prostate cancer mortality**

There are a relatively low number of deaths to prostate cancer in Salford and the SMR in 2011/13 was 80.5 meaning there were fewer deaths than expected when compared to England. The Standardised Registration Ratio in under 75s was 86.3 in 2009/11 showing that Salford has a lower incidence rate when compared to England.

Compared to other areas in Greater Manchester the DSR, in 2011/13, for prostate cancer in males under 75s is 3rd lowest within Greater Manchester. The rate at 9.06 per 100,000 is lower than the England (11.72) and Greater Manchester (11.38) averages, although not significantly.

**Urology cancer survival**

The one year survival rate for Urology in Salford has increased from 70.7% to 96.6% in 2008/10, this is significantly higher than the England average. At 5 years, the survival rate has doubled from 41.9% in 1990/92 to 88% in 2004/6 and again is higher, but not significantly, than the England average of 86.6%.

Source: Cancer Commissioning Toolkit, National Cancer Intelligence Network (NCIN)
16. Conclusions

This needs assessment identifies a decline in cancer mortality set against a rising number of new cancer cases. The decline in mortality is partly accounted for by improved survival. One year survival is improving suggesting earlier detection has improved in Salford. These factors combined with an ageing population mean there are more people living with cancer and managing the impact and health needs after cancer.

Screening uptake varies across Salford. All screening programmes, including those for cancer, tend to have higher uptake rates amongst higher socioeconomic groups. Some people do not view screening as an integral part of leading a healthy lifestyle so effective campaigns to reach these groups are required. Cancer screening for breast and cervical is on a downward trend in Salford which needs to be reversed to ensure early diagnosis. Similarly as bowel cancer screening is fluctuating in Salford, and although high positivity rates suggest good detection, bowel cancer has the third highest late diagnosis (after lung and ovarian) and the highest mortality rate in GM. Breast cancer has amongst the best one year survival rates in GM while at 5 years survival the rate in amongst the worst in GM. Breast cancer mortality however is not significantly different to England.

In Salford cancer incidence and mortality overall is amongst the highest in the country. While mortality and one year survival show positive trends there are inequalities across Salford wards for new cancer cases and death rates. A large part of this is likely to be attributable to lifestyle factors, and especially the higher smoking rates in deprived groups. The excess mortality may also be linked to later presentation/diagnosis in more deprived groups.

For the vast majority of cancers, incidence increases with age. Despite this, older people may not be aware of their increased risk and may have lower awareness of cancer symptoms than younger age groups. National data suggest older people present late and so are more likely to have late stage cancer.

There are variations in cancer incidence between ethnic groups, which are likely to be the result of a mixture of lifestyle and genetic factors. White men and women have a higher incidence of many cancers than those from other ethnic groups. Salford has a predominately white population which, along with the high levels of deprivation explains the higher levels of incidence and mortality even though the average population is younger than the England average.

There is little information both locally and nationally on variations in cancer incidence, treatment and outcomes for people with a disability. Screening uptake for those with learning disabilities and mental health needs seems to be lower than the general population. People with physical disabilities may also experience barriers to screening. Those with learning difficulties may struggle to express changes to their health, potentially complicating and delaying diagnosis. This vulnerable population should be included in the cancer pathway.

There is national evidence for differences in health and other behaviours among lesbian, gay and bisexual people compared with the general population and these may lead to differences in cancer incidence. Screening programmes sympathetic to the needs of this population and recognition in the cancer care pathway of differences to the general population would improve their experiences of health care and general screening uptake.

The quality of treatment available to cancer patients is also an important determinant of outcomes. Information about the treatments available and the outcomes of care delivered is necessary for patients to make informed choices, for commissioners to effectively
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performance manage services and for healthcare professionals to identify the need for, and to introduce, improvements.

Addressing health inequality in cancer outcomes should be fundamental to Salford’s local cancer Strategy and form the basis of recommendations of this needs assessment. Actions which focus on prevention and early detection should be a focus as the earlier a cancer is detected the better the chance of successful treatment and survival. Earlier detection can be improved through:

- Raising awareness of cancer signs and symptoms
- Encouraging earlier presentation
- Training and education for professionals covering signs/symptoms and routes to diagnosis
- Improving access to diagnostics
- Improving uptake and coverage of screening programmes particularly in disadvantaged or high risk groups
- Supporting the development and implementation of testing to rule out cancer.

17. Recommendations

For all the recommendations below targeted activity, tailored approach or specific pathways are recommended for the groups highlighted as having poorer outcomes in the above conclusion. i.e. those living in more deprived areas, older people, lesbian gay bisexual trans, people with disabilities and Black Minority Ethnic groups.

1. The Salford Healthy Communities programme is an established programme to support early diagnosis commissioned for implementation between July 15 and June 2017. Cancer topic areas and prevention messages for the programme to focus on should be agreed. The impact and activity of the programme should be monitored through performance reviews.

2. Opportunities for other services to promote and support cancer awareness messages should be explored for example, through the Way2Wellbeing website or provision of messages/information in non-clinical settings such as libraries and leisure centres.

3. National Be Clear on Cancer Campaigns should be disseminated and promoted by Salford organisations. Local cancer campaigns or marketing are also recommended and cancer types to focus on should be considered with reference to the data in this needs assessment.

4. Wider awareness and confidence in the screening programmes locally is required to enable professionals to support uptake messages and for local people to recognise the importance of their participation. Salford should continue to work with NHS England and Public Health England to implement innovative approaches to improving uptake and reducing inequalities.

5. Local referral pathways require revision by multi-disciplinary teams to implement the NICE Guidance for suspected cancer.

6. Primary Care to deliver the Cancer Standards within the CCG Salford Standard Agreement, aimed at improving cancer outcomes.

8. Primary prevention of cancer through promoting a healthier lifestyle (particularly in relation to tobacco use, maintaining a healthy weight, undertaking physical activity, and drinking alcohol at sensible levels) remains an important part of cancer prevention. Salford to continue to be part of Greater Manchester Transformation work around cancer as part of the Cancer Vanguard Programme.

9. This needs assessment shows that people surviving cancer are increasing and will continue to increase. Services which support survivorship / recovery should therefore be considered including continuation of the current Salford exercise rehabilitation programme for post cancer people.

10. It is recommended that the following areas are investigated in more detail:
- The major contributory factors to the unknown routes of diagnosis.
- Characteristics of patients and their cancers who present as emergencies.
- The interaction between cancer type, patient demographics and routes to diagnosis.
- The causes of the discrepancies between the cancer registry and routes to diagnosis classification of DCOs (Death Certificate only)
- Continued analysis of the distribution of the proportion of cases in each route to diagnosis, by tumour type, over time.
- Local outcomes for specific groups such as ethnic minorities, lesbian, gay bisexual, trans, however, access to the required datasets is a challenge to the analysis.
18. References


19. Data sources

Local Health, Public Health England http://www.localhealth.org.uk/#sly=utla_2013_DR;sid=61;v=map9;l=en

National Compendium of Clinical Indicators, HSCIC https://indicators.ic.nhs.uk/

National General Practice profiles, APHO http://fingertips.phe.org.uk/profile/general-practice

Cancer Commissioning Toolkit, National Cancer Intelligence Network (NCIN) https://www.cancertoolkit.co.uk/

National Cancer Intelligence Network http://nww.ncis.nhs.uk/

Cascade, NCIN https://nww.cancerstats.encore.nhs.uk/

Breast screening programme, England. HSCIS http://www.hscic.gov.uk/searchcatalogue?productid=14224&q=title%3a+Breast+Screening+Programme&sort=Relevance&size=10&page=1#top


Bowel screening programme, England http://www.cancerscreening.nhs.uk/bowel/

Cancer by deprivation in England 1996-2011, NCIN
http://www.ncin.org.uk/about_ncin/cancer_by_deprivation_in_england

Index of cancer survival for Clinical Commissioning Groups in England, Adults diagnosed 1997-2012, ONS

Cancer incidence in the UK in 2011, Cancer Research UK
http://publications.cancerresearchuk.org/downloads/Product/CS_REPORT_INCIDENCE.pdf

Incidence rates by LA, 2009/11, NWCIS, PHE

Compendium of population health indicators, HSCIC
https://indicators.ic.nhs.uk/webview/

Breast and cervical screening statistics, Lasca
http://www.lasca.nhs.uk/default.asp

National Cancer Equality Initiative (2010). NCIN.
Reducing cancer inequalities: evidence, progress and making it happen,

Lifetime risk of all cancers combined, Cancer Research UK

Commissioner based cancer waiting times, NHS England

Local Cancer Intelligence, Public Health England
http://lci.cancertoolkit.co.uk/

National Cancer Experience Survey 2014 CCGs report, Quality Health
Commissioning for Value – Pathways on a page

Commissioning for value pathways on a page are intended as a source of insight to support local decision making and prioritisation. They aim to identify areas to look at to help deliver improvement through comparison of indicators with averages from 10 statistical neighbours.

Three cancer pathways are presented below. Breast lower Gastro-intestinal (GI) and lung cancer. The pathway concur with the needs assessment with the areas which are worse than statistical neighbours being breast screening, bowel screening, lung cancer mortality lower GI detected at an early stage. Successful smoking quitters is also worse than statistical neighbours.

The pathways find Salford is better than statistical neighbours for:

- Alcohol attributable admissions for breast cancer and for GI cancer patients
- First cancer definitive treatment in 2 months
- Urgent GP referral for suspected cancer
- Breast and lung cancers detected at an early stage
- Under 75 mortality breast and colorectal cancer
- Non elective spend GI cancer and lung cancer
Lower gastrointestinal cancer pathway

NHS Salford CCG

| = 95% confidence intervals

% difference from similar 10 CGGs:

-60% -40% -20% 0% 20%

- Deprivation
- Colorectal cancer prevalence
- Incidence of colorectal cancer
- Alcohol attributable admissions
- Bowel cancer screening
- Urgent GP referrals (all cancer)
- % first definitive treatment within 2 months (all cancer)
- Elective spend
- Non-elective spend
- Lower GI cancer detected at an early stage
- <75% Mortality from colorectal cancer
- 1 year survival (breast, lung, colorectal)

NICE guidance:
http://pathways.nice.org.uk/pathways/colorectal-cancer
http://pathways.nice.org.uk/pathways/colonoscopic-surveillance
http://pathways.nice.org.uk/pathways/gastrointestinal-conditions

Initial contact to end of treatment
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Lung cancer pathway

NHS Salford CCG

Bar chart showing % difference from similar 10 CCGs with 95% confidence intervals. The metrics include:
- Deprivation
- Lung cancer prevalence
- Incidence of lung cancer
- Smoking prevalence
- Successful quitters
- Urgent GP referrals (all cancer)
- % First definitive treatment within 2 months (all cancer)
- Elective spend
- Non-elective spend
- Lung cancer detected at an early stage
- 5-year mortality from lung cancer
- 1-year survival (breast, lung, colorectal)

NICE guidance:

Initial contact to end of treatment
20. Appendix 2

NHS Atlas of Variation in Healthcare 2015

The NHS Atlas series is pivotal in the interrogation of routinely available data that relate investment, activity and outcome to the whole population in need and not just those who happen to make contact with a particular service. By using this population perspective, unwarranted variation can be interrogated and the value of the healthcare provided both to populations and to individuals assessed.

There are nine indicators presented in the atlas for cancer. Six of which do not contribute to variation and three contribute negatively. There are no positive contributions to the national variation.

Negative contributions

- Rate of mortality from cancer in people aged under 75 years per 100,000 population by CCG, 2013 – contributes to the top (worst) quintile and is the worst in the country.
- Rate of computed tomography (CT) colonoscopy procedures per 10,000 population by CCG, 2013/14 - is in the lowest quintile (worst) and 15th lowest in the country.
- Rate of barium enema procedures per 100,000 population by CCG, 2013/14 – is in the lowest quintile (worst) for the country.

Neutral contributions

- Percentage of people aged 15-99 years who survived one year after being diagnosed with any cancer by CCG, 2012 followed up to 2013
- Percentage of people aged 15-99 years who survived one year after being diagnosed with breast, lung or colorectal cancer by CCG, 2012 followed up to 2013
- Rate of colonoscopy procedures and flexisigmoidoscopy procedures per 10,000 population by CCG, 2012/13
- Ratio of colonoscopy procedures to flexisigmoidoscopy procedures by CCG, 2012/13
- Percentage of all cancer diagnoses that were made at stage 1 or stage 2 by CCG, 2013
- Percentage of new cases of colorectal cancer that were diagnosed at stage 1 or stage 2 by CCG, 2013