

# Cancer in the South West Peninsula - a baseline assessment

## 1 The Cancer Reform Strategy

- 1.1 The Cancer Reform Strategy, published in December 2007<sup>1</sup>, built on the progress already achieved since the publication of the NHS Cancer Plan in September 2000. Where the NHS Cancer Plan concentrated on improving and developing the range of hospital and specialist services available for people with cancer, the Cancer Reform Strategy places a great emphasis on prevention, early diagnosis and reducing cancer inequalities. Over half of all cancers are potentially preventable, with smoking being the single largest preventable cause of death. Obesity is now the most important preventable risk factor for cancer in non-smokers and the incidence of skin cancers is rising, associated with the dangers of over exposure to sunlight and sun-beds.
- 1.2 The focus on prevention and on early intervention was underlined in the Interim Review by Lord Darzi on the NHS<sup>2</sup>. The Review emphasised the need to pursue evidence-based interventions that support people to make healthy choices and prevent ill health. The scope for early diagnosis to improve health outcomes is seen as key to better survival rates along with new vaccines and new and extended approaches to screening.
- 1.3 Despite, improvements in mortality over recent years survival rates in England are lower than those achieved in many European and other countries. The main issue is the stage of diagnosis of cancer in England. Patients in England are diagnosed later and with more advanced disease.
- 1.4 The second annual report of the Cancer reform strategy is titled achieving local implementation<sup>3</sup>. Primary care trusts and cancer networks are urged to undertake baseline assessments of their performance in identifying and treating cancers and to develop a strategic approach locally to raising awareness and promoting early diagnosis of cancer. Support and advice is available through the national awareness of early diagnosis initiative. This national initiative has the potential to save thousands of lives every year.
- 1.5 This baseline assessment examines the incidence of cancer in the Peninsula, trends in survival for common cancers and where appropriate, comparisons between primary care trusts.
- 1.6 The baseline assessment will encourage commissioners to consider how best to improve services for prevention, screening, identification, early diagnosis and treatment. Health inequalities are also important aspects of all aspects of cancer treatment and this baseline assessment draws upon local work carried out by the Network Health Equity Audit Group and primary care trusts.
- 1.7 The Network has worked closely through the site-specific groups to develop cancer care pathways and to include these on the Map of Medicine. These pathways need to be further developed to include aspects of identification, diagnosis and referral

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<sup>1</sup> *Cancer Reform Strategy*. Department of Health, London, Dec 2007

<sup>2</sup> *NHS Next Stage Review Interim Report*. Department of Health, London, Oct 2007

<sup>3</sup> *Cancer Reform Strategy Achieving local implementation – second annual report*. Department of Health, London Nov 2009

from primary care. This is the first baseline assessment and will continue to grow and develop as information systems to regularly monitor and assess cancer outcomes improve.

- 1.8 The role of the South West Public Health Observatory incorporating the cancer registry is key to the information needed within the Peninsula. However, alongside this, management information from trusts and primary care commissioners on two-week wait outcomes for people referred with suspected cancer is vital.
- 1.9 All of these aspects are touched upon in the baseline assessment, which follows.

## **2 Health and cancer in the Peninsula**

- 2.1 The Peninsula Cancer Network covers Devon, Cornwall and the Isles of Scilly and covers a large geographical area. Apart from the cities of Plymouth and Exeter, most people live in small towns (population less than 10,000) and in scattered rural communities. Along with the issues of rurality, the Peninsula faces the challenges of 'peripherality'. The Peninsula juts out into the sea and the urban centres are widely separated from the nearest major urban centres such as Bristol and Southampton. The combination of rurality and peripherality means that the opportunities for market testing and contestability through a range of health service providers is limited compared to other parts of the country.

### **Demography**

- 2.2 The population of Devon, Cornwall and the Isles of Scilly is older than that of England. This ageing population of the South West is projected to increase with time. Devon and Cornwall are areas of inward migration for older people who wish to retire to the West Country. The coastal areas are particularly popular and many older people live around the coast line. This has an impact on access to services when the main arterial roads run through the middle of the Peninsula.

### **Health Inequalities**

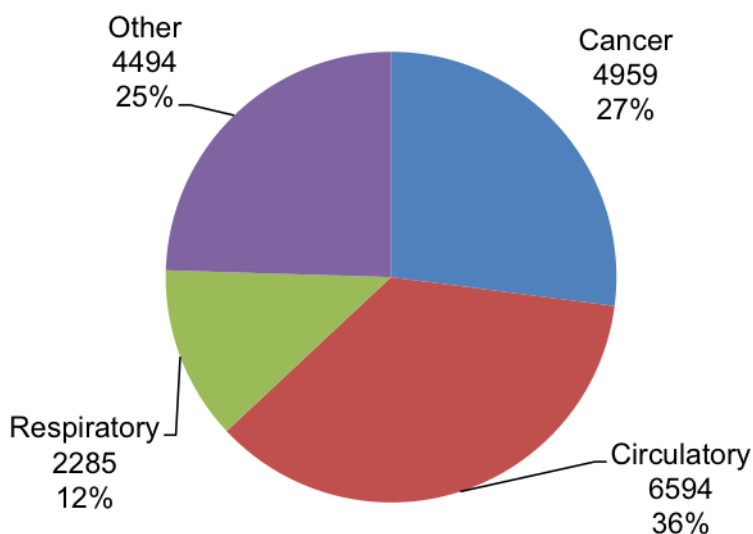
- 2.3 The population of Plymouth is younger but faces more severe problems linked to deprivation. Devon and Cornwall have relatively low wages compared to England and wards within the West of Cornwall along with areas of Plymouth and some wards in Torbay suffer marked unemployment and social and economic deprivation. Social and economic deprivation leads to ill health and premature death. There is a social gradient to many cancers, with those in deprived areas having a greater incidence of cancer and likelihood of premature death. Life style factors play a significant part with increased rates of smoking and obesity in deprived populations. However, the effects of social and economic deprivation, poor housing, low educational attainment and un-employment have a greater and more pervasive effect on health than life style factors alone.

## **3 Cancer Statistics**

- 3.1 Deaths from cancer account for 27% of deaths in the Peninsula – see the pie chart below.

### Causes of Death in the Peninsula (2007)

Cause, Number of deaths, percentage of total



3.2 However, cancer is the greatest cause of premature death (deaths under the age of 75 years) and accounts for 38% of deaths compared to 28% caused by heart disease and strokes.

### Deaths from cancer in the Peninsula in 2007

Site	Age < 74	Total deaths
Lung & bronchus	424	835
Colorectal	196	493
Breast	214	413
Prostate	88	367
Oesophagus	115	261
Pancreas	118	236
Ovary	88	173
Bladder	48	159
Stomach	50	152
Lymphoma	52	146
Leukaemia	56	142
Other Urological	72	138
Brain	90	120
Melanoma of skin	67	106
Head and neck inc. thyroid	61	105
Other Gynae	33	91
Other Haematology	37	89
Cervix	19	29
<b>All cancers</b>	<b>2127</b>	<b>4811</b>

Source: South West Public health Observatory QuickStats

Note: The total figures for all cancers include cancers where the primary is not known and cancers not listed by site in the table – hence the columns will not tally to the total figures.

- 3.3 Cancer of the lung and bronchus remains the commonest cause of premature death and this highlights the need to continue and strengthen the initiatives to prevent and stop smoking.
- 3.4 The causes of death from cancer in the Peninsula mirror those nationally, apart from malignant melanoma where the Peninsula has highest rates in England and malignant mesothelioma, which is a legacy of occupational exposure to asbestos from the ship building industry, mainly in Plymouth. The South West Public Health Observatory has produced specific reports on these cancers in the West Country and these are attached as **appendices (i) and (ii)**. Although, both these cancers lead to relatively small numbers of deaths compared to breast, prostate and gastrointestinal cancers, they are important as the potential for prevention is so great.
- 3.5 Restrictions on asbestos will prevent future workers and their relatives developing malignant mesothelioma but there is a great challenge to limit sun exposure to prevent the steadily increasing rates of malignant melanoma and the far greater numbers of people with non-melanoma skin cancer.

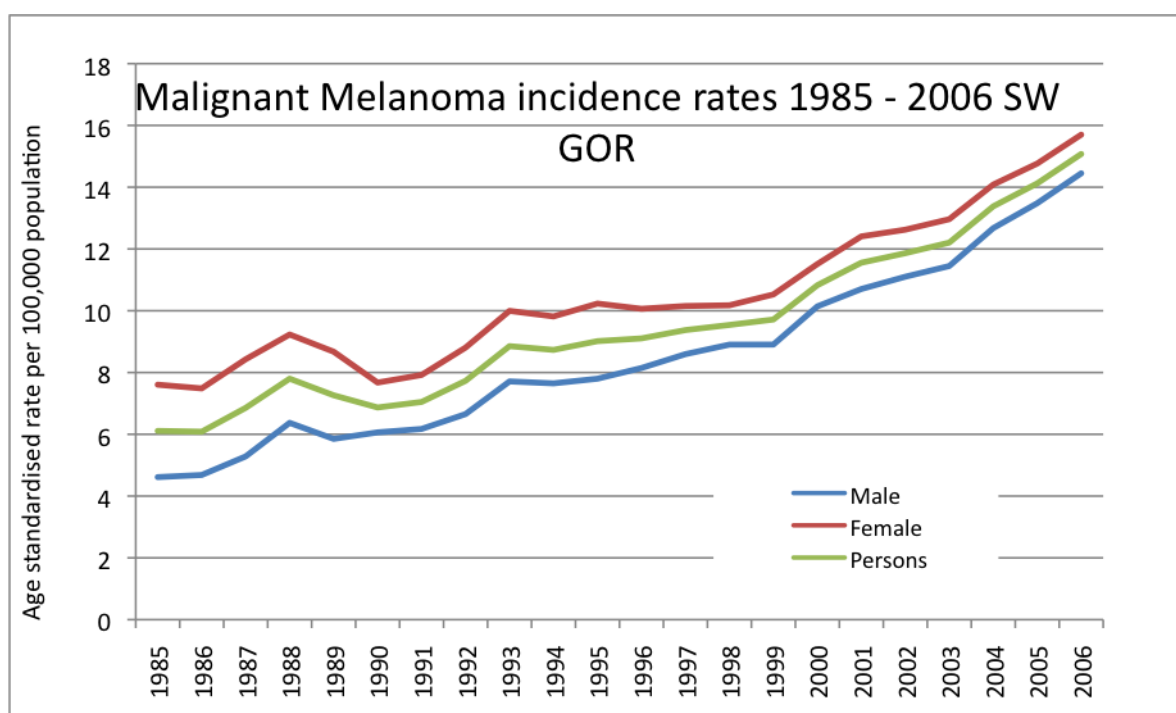
### Cancer Incidence and trends in the Peninsula

- 3.6 The table below shows the incidence of new registrations for cancer in England and the Peninsula for 2007 excluding non-melanoma skin cancers. In total, all skin cancers account for one third of all new cancers. However, the data collection of non-melanoma skin cancers is incomplete. The South West Public Health Observatory is taking a national role in improving registry information.

### Incidence of cancer in England and the Peninsula for 2007

	PENINSULA	ENGLAND
Breast	1647	38291
Colorectal	1361	30727
Prostate	1249	30201
Lung & bronchus	1069	31522
Melanoma of skin	509	8809
Other Urological	394	6701
Lymphoma	425	19841
Other Gynae	337	7576
Bladder	323	8567
Head and neck inc. thyroid	310	8786
Ovary	232	5366
Leukaemia	254	5847
Oesophagus	262	6487
Pancreas	234	6401
Stomach	207	6330
Other Haematology	157	3533
Brain	143	3728
Cervix	73	2276
All cancers	10058	314408

- 3.7 The number of new cases of cancer in England is predicted to increase by 33% by 2020<sup>4</sup>. Much of the increase in cancer deaths is related to the ageing population as cancer becomes more common as people are older. However, this is not the case for all cancers and the projected increase in malignant melanoma relates to cancer presenting in middle-aged people.
- 3.8 The chart below shows the relentless increase in diagnoses of malignant melanoma in the South West Region. The Peninsula contains areas with the highest rates in the South West Region. Full details on all aspects of skin cancer and figures for each local authority area are available on the South West Public Health Observatory Skin Cancer Hub.  
<http://www.swpho.nhs.uk/skincancerhub/>



#### 4 Survival rates

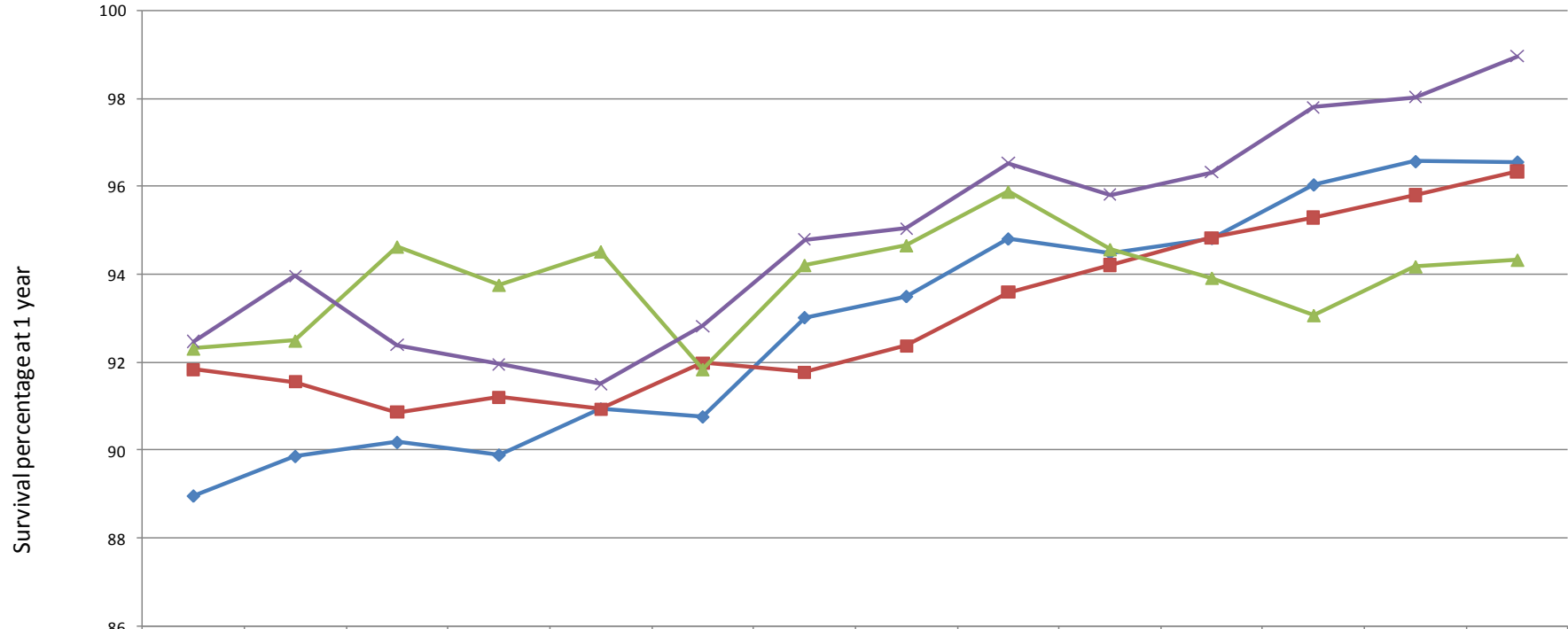
- 4.1 The four most common cancers -- breast, lung, colorectal and prostate account for over half of all new cases of cancer, excluding non-melanoma skin cancers.
- 4.2 With larger numbers of the people across the Peninsula developing these more common cancers it is possible to look at the trends for survival by primary care trust. Even so, the variation year on year will be more marked for the smaller primary care trusts and the numbers are not sufficient to draw conclusions from statistical tests.
- 4.3 The charts that follow show the trends in survival over one and five years for each of the common cancers.

<sup>4</sup> The future burden of cancer in England: incidence and numbers of new patients in 2020. *British Journal of Cancer* (2007) 96, 1484-1488

Source:  
Cancer Information Service Database.  
3 year rolling cohorts

### Breast Cancer (C50,D05) 1 year survival trend by PCT 1990 - 2005

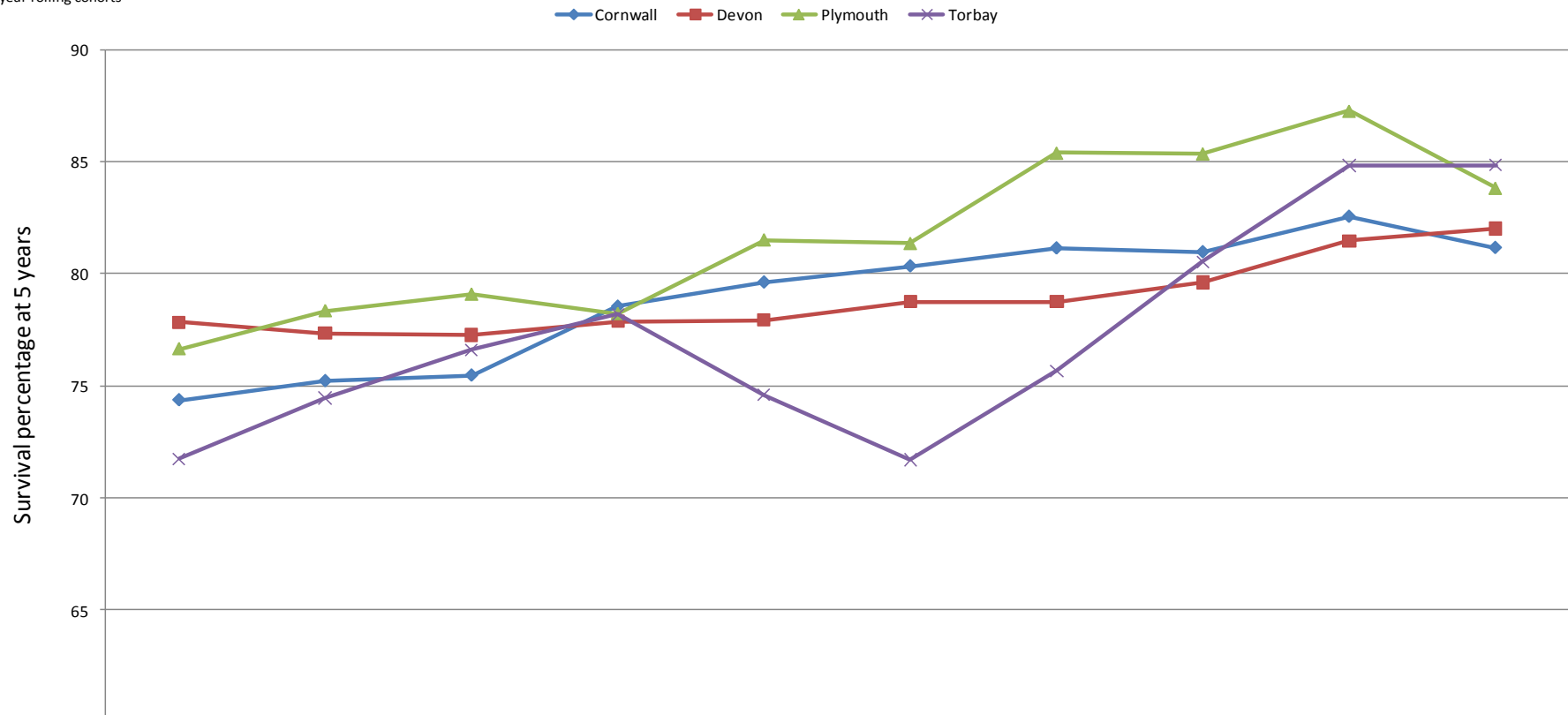
—●— Cornwall —■— Devon —▲— Plymouth —×— Torbay



	1990-1992	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005
—●— Cornwall	88.96	89.86	90.18	89.89	90.94	90.76	93.02	93.5	94.81	94.49	94.82	96.04	96.57	96.56
—■— Devon	91.83	91.55	90.86	91.2	90.93	91.98	91.77	92.37	93.59	94.21	94.83	95.29	95.8	96.34
—▲— Plymouth	92.31	92.49	94.63	93.76	94.52	91.84	94.21	94.66	95.88	94.57	93.92	93.07	94.18	94.33
—×— Torbay	92.47	93.96	92.39	91.95	91.5	92.82	94.79	95.04	96.53	95.81	96.32	97.8	98.03	98.96

Source:  
Cancer Information Service Database.  
3 year rolling cohorts

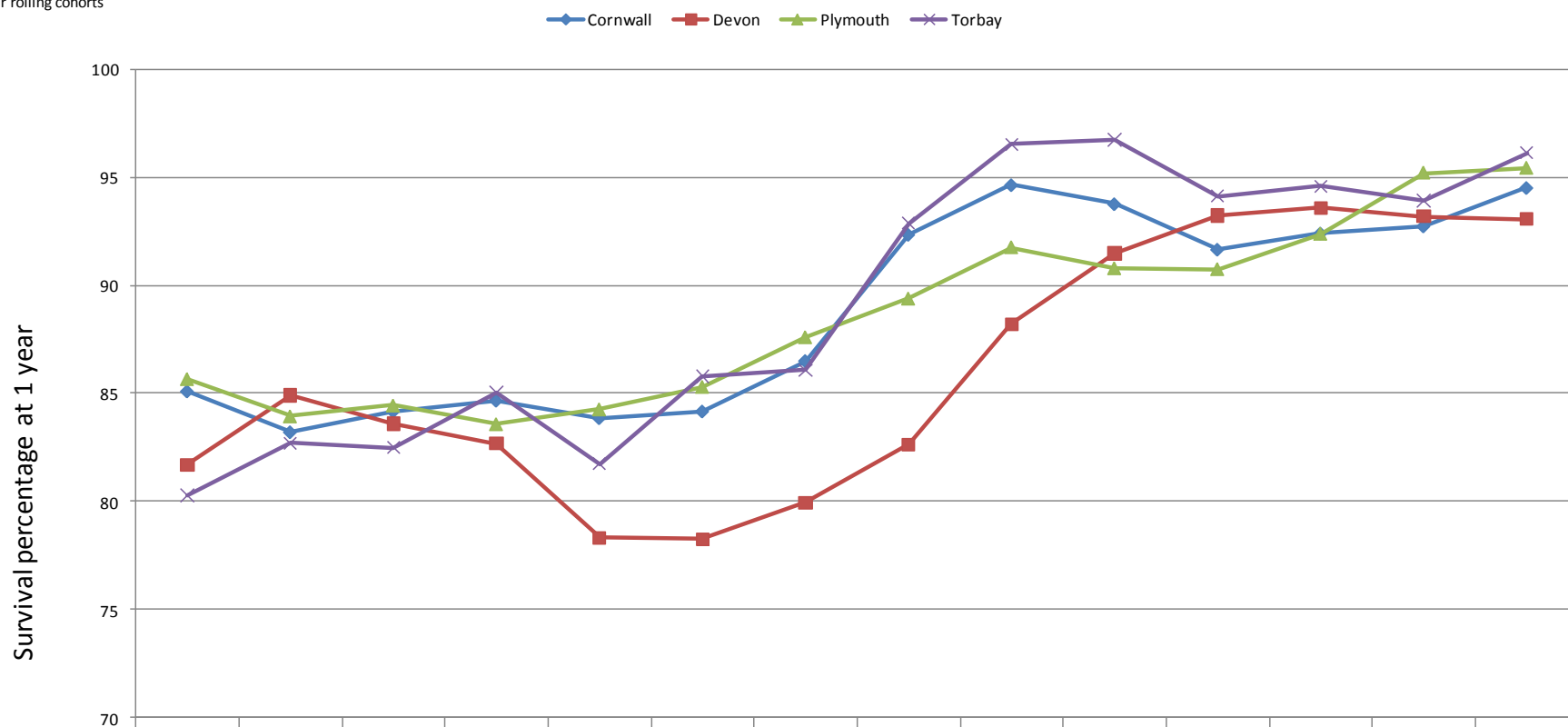
### Breast cancer (C50, D05) 5 year survival trend by PCT 1990 - 2001



	90-92	91-93	92-94	93-95	94-96	95-97	96-98	97-99	98-00	99-01
◆ Cornwall	74.35	75.2	75.45	78.52	79.6	80.32	81.12	80.95	82.53	81.14
■ Devon	77.83	77.33	77.25	77.87	77.93	78.75	78.74	79.6	81.47	82.01
▲ Plymouth	76.64	78.34	79.08	78.21	81.51	81.35	85.39	85.36	87.27	83.82
✕ Torbay	71.73	74.44	76.59	78.18	74.58	71.69	75.66	80.53	84.82	84.85

Source:  
Cancer Information Service Database.  
3 year rolling cohorts

### Prostate Cancer (C61) 1 year survival trend by PCT 1990 - 2005

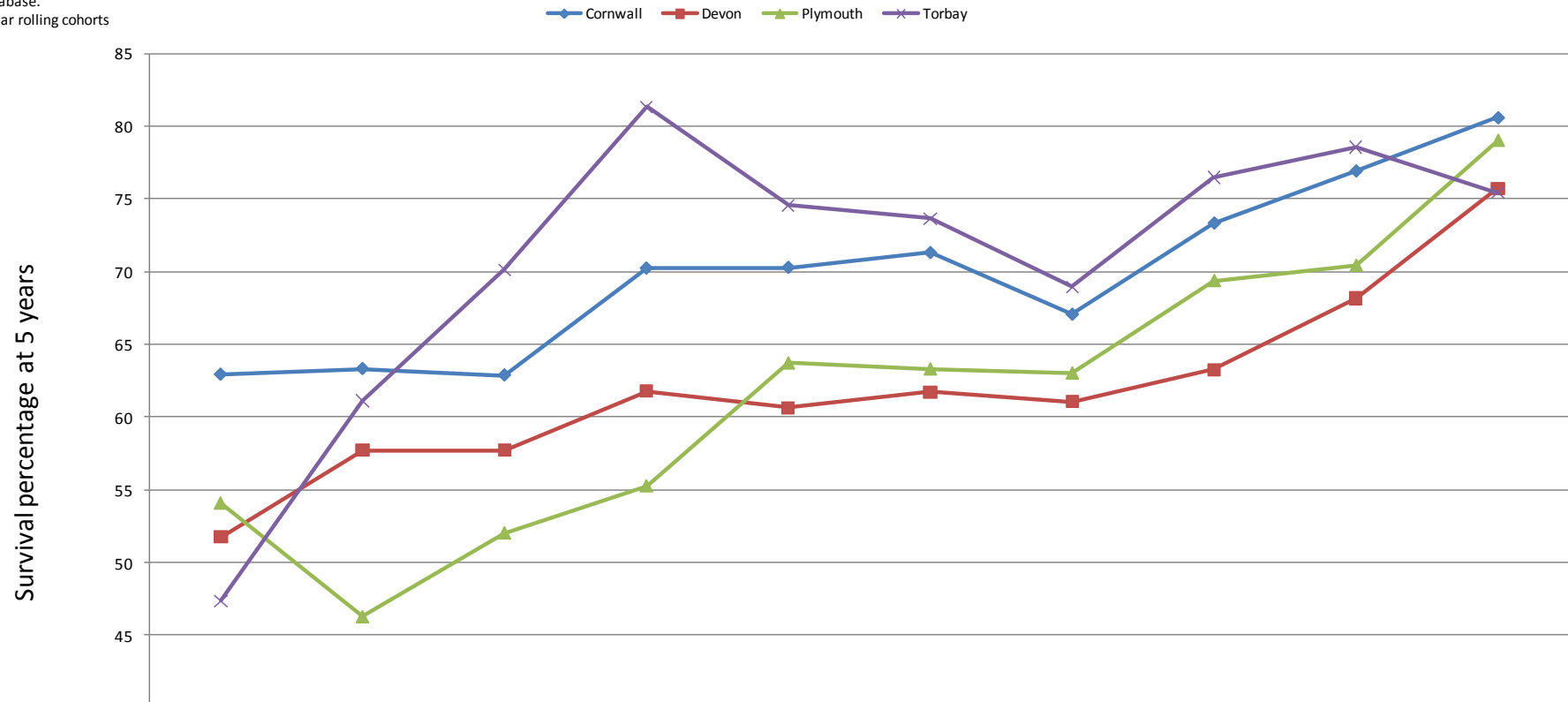


	1990-1992	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005
◆ Cornwall	85.09	83.2	84.16	84.66	83.85	84.16	86.5	92.35	94.65	93.77	91.66	92.41	92.74	94.52
■ Devon	81.69	84.91	83.6	82.68	78.31	78.25	79.94	82.64	88.2	91.48	93.23	93.57	93.19	93.06
▲ Plymouth	85.67	83.95	84.45	83.59	84.27	85.31	87.6	89.38	91.75	90.78	90.74	92.37	95.19	95.41
✕ Torbay	80.28	82.7	82.48	85.04	81.74	85.79	86.08	92.87	96.51	96.72	94.13	94.59	93.92	96.13



Source:  
Cancer Information Service  
Database.  
3 year rolling cohorts

### Prostate cancer (C61) 5 year survival trend by PCT 1990 - 2001

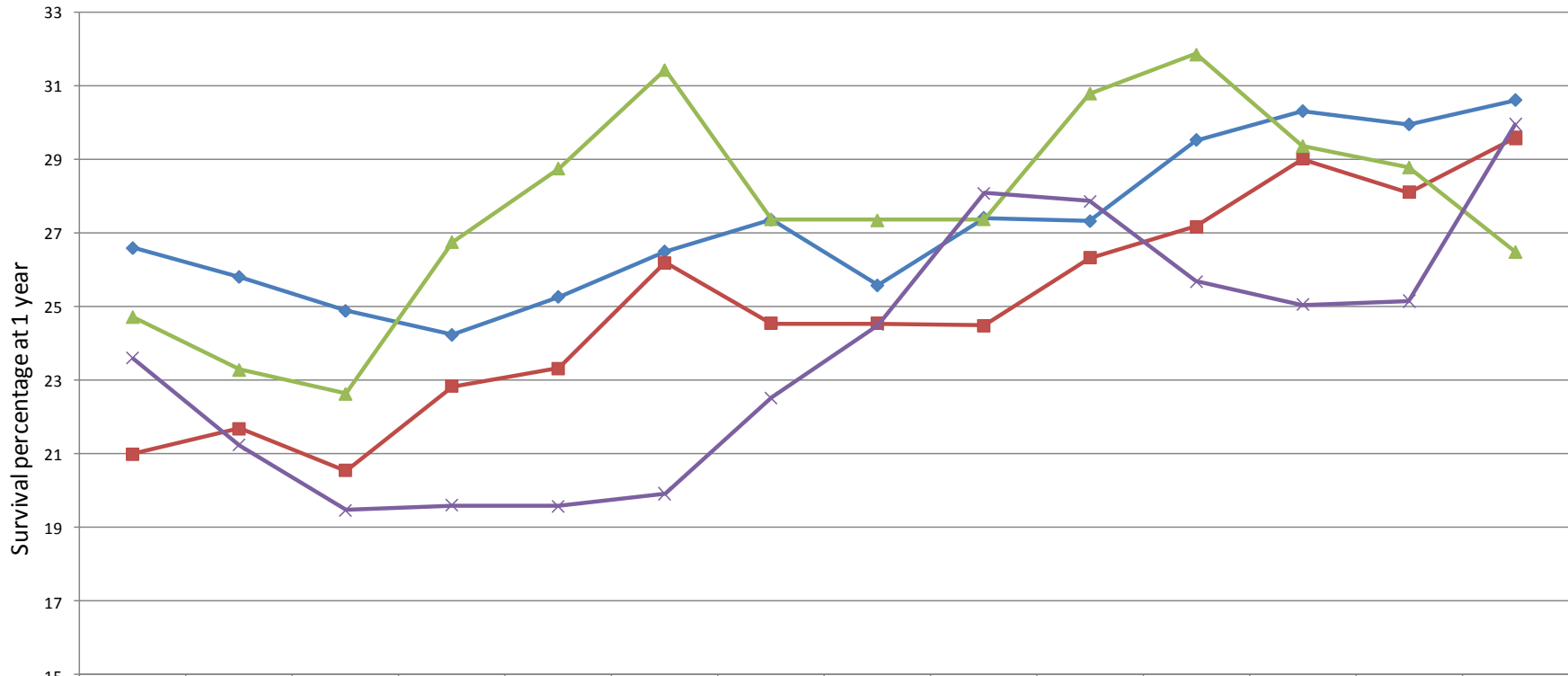


	90-92	91-93	92-94	93-95	94-96	95-97	96-98	97-99	98-00	99-01
◆ Cornwall	62.89	63.28	62.84	70.22	70.27	71.29	67.03	73.33	76.93	80.6
■ Devon	51.72	57.69	57.69	61.77	60.63	61.72	61.03	63.23	68.15	75.72
▲ Plymouth	54.05	46.23	52	55.24	63.69	63.28	63	69.36	70.41	79.01
× Torbay	47.33	61.09	70.11	81.32	74.56	73.65	68.93	76.49	78.56	75.41

Source:  
Cancer Information Service Database.  
3 year rolling cohorts

### Lung cancer (C33 - C34) 1 year survival trend by PCT 1990 - 2005

—●— Cornwall —■— Devon —▲— Plymouth —×— Torbay

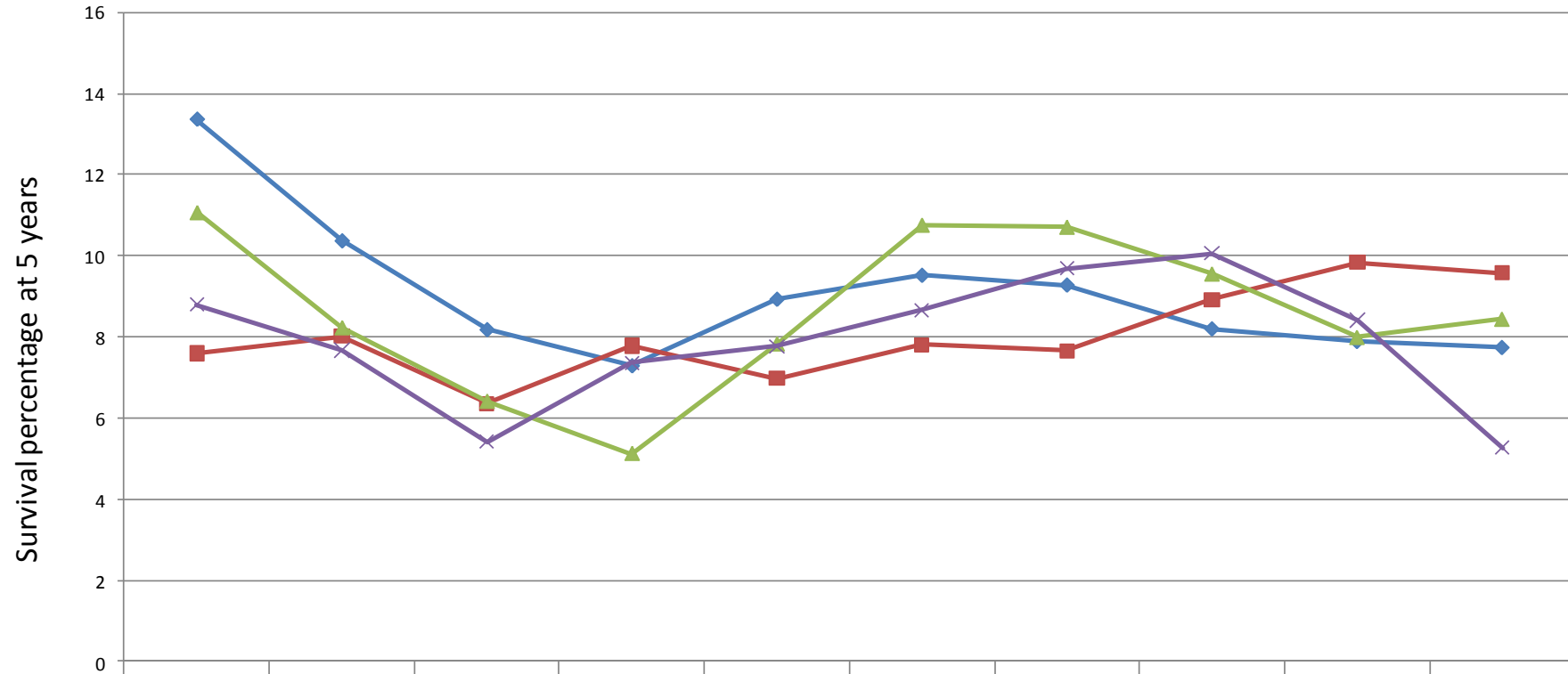


	1990 -1992	1991 -1993	1992 -1994	1993 -1995	1994 -1996	1995 -1997	1996 -1998	1997 -1999	1998 -2000	1999 -2001	2000 -2002	2001 -2003	2002 -2004	2003 -2005
—●— Cornwall	26.58	25.8	24.88	24.23	25.26	26.49	27.35	25.57	27.4	27.31	29.51	30.29	29.93	30.59
—■— Devon	20.98	21.68	20.54	22.83	23.31	26.18	24.53	24.54	24.48	26.31	27.16	29.01	28.1	29.57
—▲— Plymouth	24.71	23.27	22.62	26.75	28.75	31.43	27.37	27.34	27.37	30.79	31.85	29.36	28.78	26.48
—×— Torbay	23.59	21.23	19.46	19.59	19.57	19.91	22.51	24.5	28.07	27.85	25.67	25.04	25.14	29.94

Source:  
Cancer Information Service  
Database.  
3 year rolling cohorts

## Lung cancer (C33 - C34) 5 year survival trend by PCT 1990 - 2001

—●— Cornwall —■— Devon —▲— Plymouth —×— Torbay

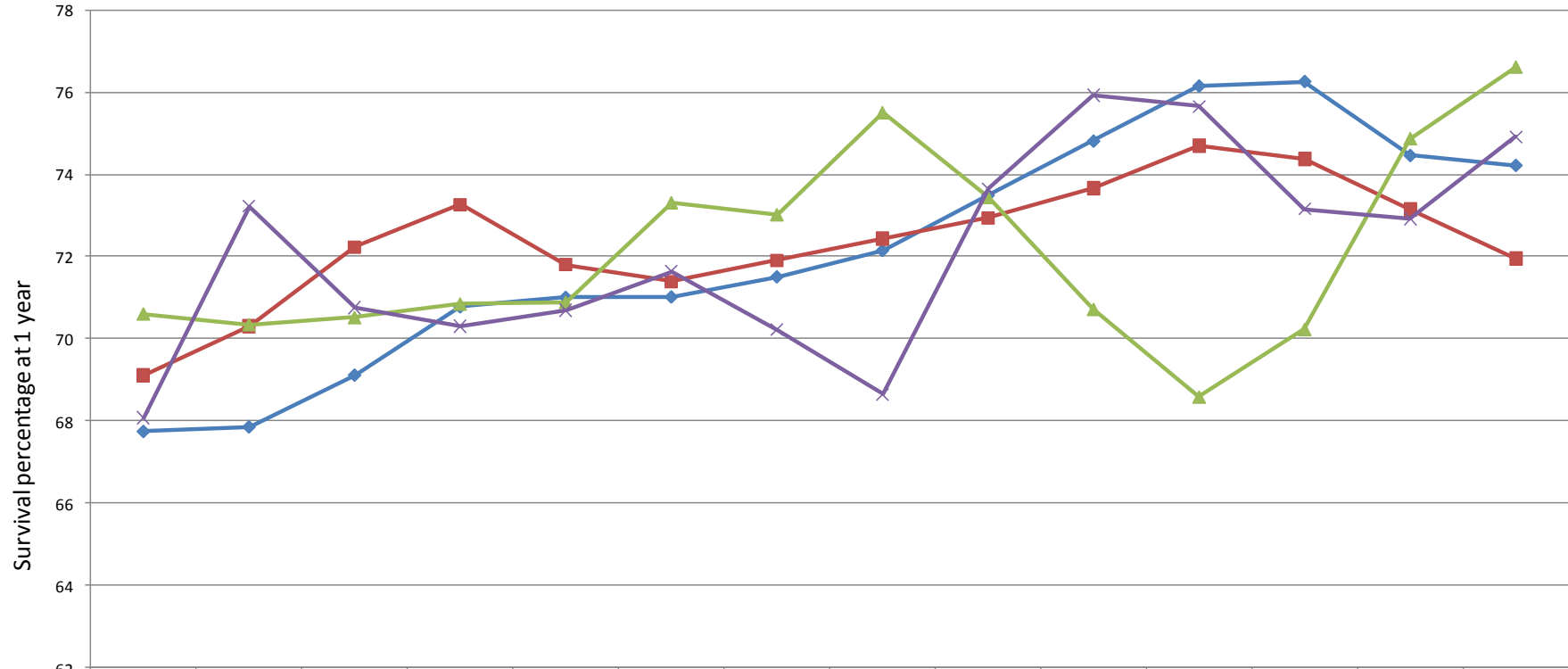


	90-92	91-93	92-94	93-95	94-96	95-97	96-98	97-99	98-00	99-01
—●— Cornwall	13.37	10.37	8.18	7.29	8.93	9.52	9.28	8.2	7.89	7.74
—■— Devon	7.6	8.01	6.36	7.78	6.97	7.8	7.66	8.92	9.84	9.57
—▲— Plymouth	11.08	8.23	6.41	5.12	7.83	10.77	10.72	9.56	7.99	8.44
—×— Torbay	8.8	7.67	5.42	7.36	7.77	8.66	9.69	10.06	8.41	5.27

Source:  
Cancer Information Service Database.  
3 year rolling cohorts

### Colorectal cancer (C17 - C21) 1 year survival trend by PCT 1990 - 2005

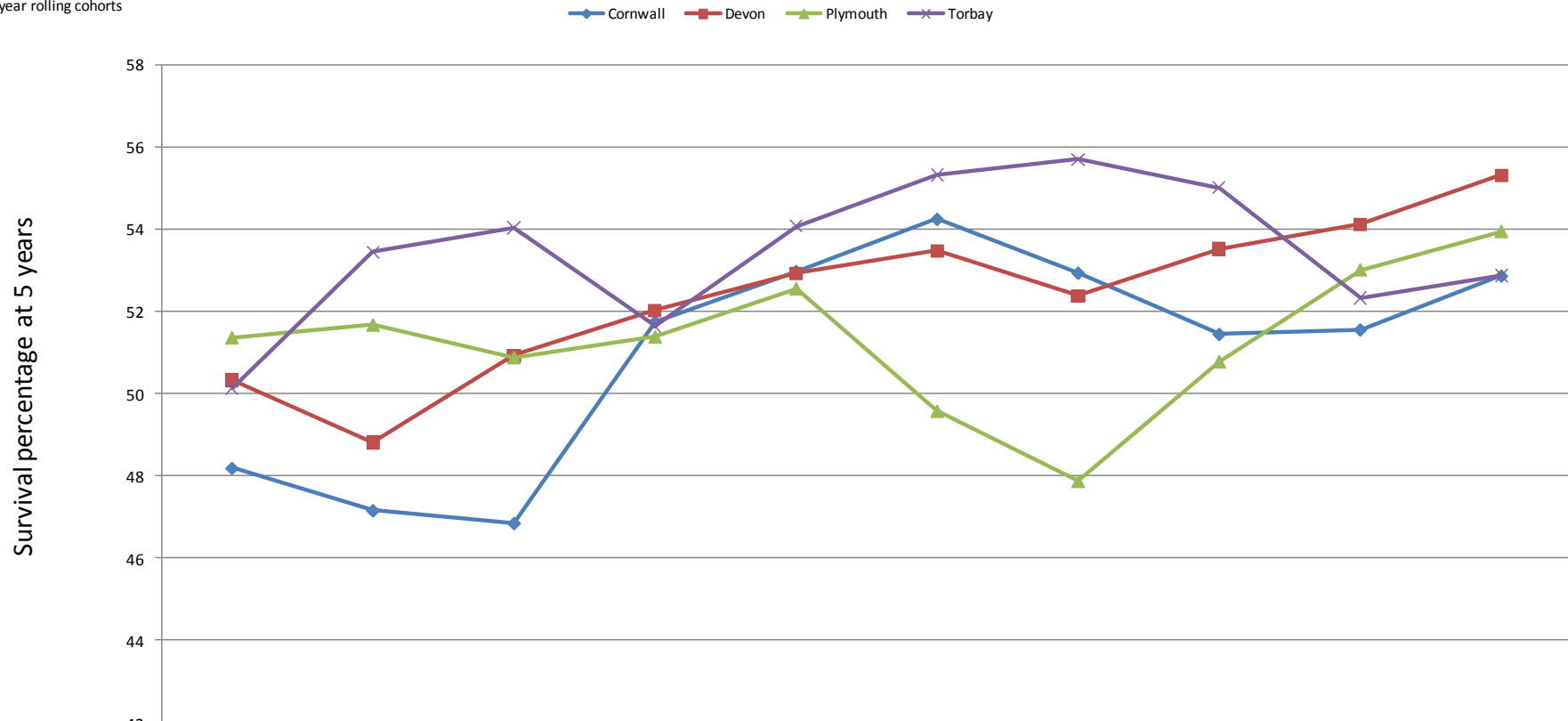
—●— Cornwall —■— Devon —▲— Plymouth —×— Torbay



	1990 -1992	1991 -1993	1992 -1994	1993 -1995	1994 -1996	1995 -1997	1996 -1998	1997 -1999	1998 -2000	1999 -2001	2000 -2002	2001 -2003	2002 -2004	2003 -2005
—●— Cornwall	67.75	67.86	69.12	70.78	71.01	71.02	71.51	72.15	73.49	74.81	76.15	76.26	74.46	74.22
—■— Devon	69.11	70.3	72.23	73.26	71.8	71.39	71.91	72.43	72.94	73.66	74.7	74.37	73.15	71.95
—▲— Plymouth	70.61	70.35	70.52	70.85	70.89	73.31	73.02	75.5	73.44	70.72	68.59	70.23	74.87	76.61
—×— Torbay	68.07	73.22	70.75	70.3	70.69	71.64	70.22	68.65	73.65	75.92	75.65	73.16	72.92	74.91

Source:  
Cancer Information Service Database.  
3 year rolling cohorts

## Colorectal cancer (C17 - C21) 5 year survival trend by PCT 1990 - 2001



	90-92	91-93	92-94	93-95	94-96	95-97	96-98	97-99	98-00	99-01
◆ Cornwall	48.19	47.16	46.85	51.75	52.98	54.25	52.94	51.45	51.56	52.87
■ Devon	50.33	48.81	50.93	52.02	52.92	53.47	52.38	53.52	54.12	55.31
▲ Plymouth	51.36	51.67	50.88	51.38	52.55	49.58	47.88	50.78	53.01	53.94
✕ Torbay	50.13	53.44	54.03	51.65	54.07	55.32	55.69	55.01	52.32	52.87



- 4.4 The survival from breast cancer has steadily improved and reflects the success of screening in identifying cancers at an earlier stage and the impact of new drug treatments. The Cancer Reform Strategy sets out plans to extend the breast screening programme to include women from the age of 47 and routinely up to the age of 73.
- 4.6 The survival from prostate cancer is also improving. It is difficult to tell to what extent increased diagnosis of prostate cancer, which may not have led to death, has improved survival rates. Increasing awareness of prostate specific antigen testing has led to many more men being diagnosed with cancer of the prostate but in many cases this may well remain confined to the prostate gland and not lead to invasive and metastatic disease, which affects survival. The National Screening Committee has resisted the introduction of prostate screening, as the natural history of the disease cannot be accurately predicted in many individual cases.
- 4.7 The most concerning figures relate to lung cancer. Although there has been some improvement in one year survival rates of lung cancer this improvement is small and lung cancer surgical resection rates in the Peninsula and in England remain at about 10% compared to 20% in some European countries. Surgical resection of an early stage lung cancer provides the best hope of cure.
- 4.8 Survival rates for colorectal cancer are also improving and it is anticipated that with the roll out of bowel cancer screening to all areas and age extension planned up to the age of 75, there will be a sustained improvement in survival rates by diagnosing bowel cancer at an earlier stage. The South Devon Bowel Cancer Screening Service is well-established and provides services to people in the Plymouth area. Exeter and Cornwall bowel cancer screening centres were accredited in 2009 and are now screening so all residents in the Peninsula age 60 to 75 years will receive bowel cancer screening invitations every 2 years.

### International comparisons

- 4.9 The National Cancer Intelligence Network has developed benchmarks of good performance on one-year survival rates for the four commonest cancers, based upon the EUROCORE-4 findings for patients diagnosed in 1995-99. "Average" is based upon the average one-year survival rate. "Good practice" is based on the average achieved across a whole country by the best performing countries in EUROCORE-4
- 4.10 The table below, from the Cancer Reform Strategy –second annual report, shows the performance for the four commonest cancers

### Consensus benchmarks for one-year survival rates for the four commonest cancers

	EUROCORE-4 Average (1995-1999)	EUROCORE-4 Good Practice (1995-1999)	English Cancer Networks (Range) (1991-2001)	Peninsula Network (1994-1996)
Breast	93.8	97	90.0-95.8	93
Colon	74.2	79	63.0-72.2	72
Lung	36.0	37	21.5-29.7	26
Prostate	92.7	96	84.1-92.9	85

- 4.11 The survival rate for lung cancer in England compares poorly to the European average.

## **5 Screening uptake and coverage by primary care trust and general practice**

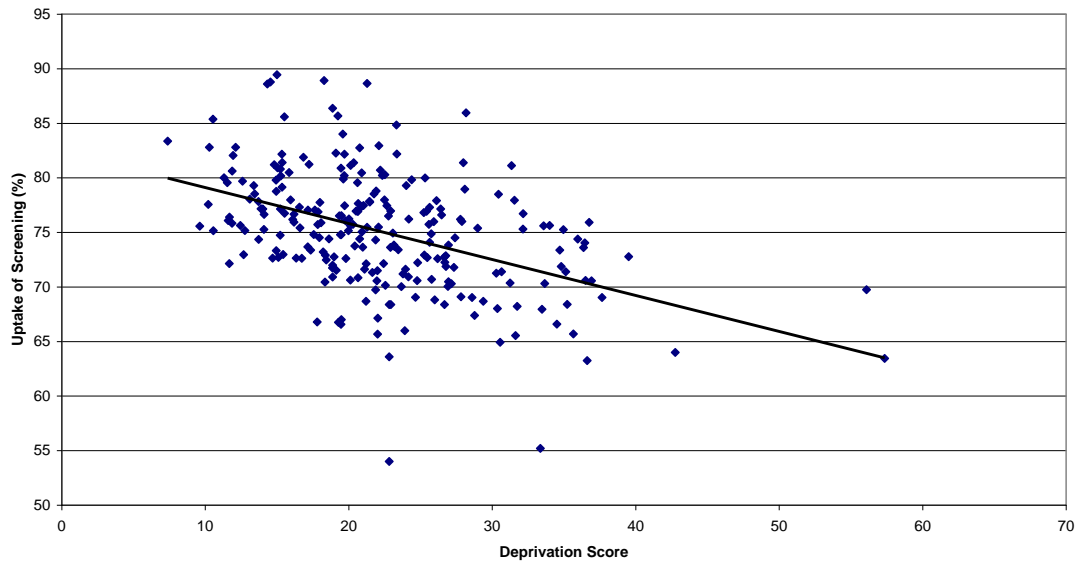
- 5.1 The Directors of Public Health for the Primary Care Trusts, the Director of the Public Health Observatory and the Strategic Health Authority supported a Peninsula Cancer Network proposal to establish a group to study health inequalities in cancer. Collaboration across the Peninsula provides a larger and more varied population to identify health inequalities and to share initiatives and best practice to reduce health inequality.
- 5.2 The work programme of the group was agreed with the Directors of Public Health with a priority to provide an estimate of socio-economic deprivation for general practice populations in the Peninsula. This would allow the study of associations between deprivation at practice level and a range of health measures related to cancer.
- 5.3 A deprivation score has been calculated for each of the 243 practices in the Peninsula. The deprivation score is estimated from the Index of Multiple Deprivation 2007 by identifying the practice patients registered in each census area (using post-code of registered patients), attributing the census measures of deprivation to these patients and then producing an average deprivation score for each general practice. This method takes account of all the patients registered with the practice and is more accurate than making assumptions about the areas from which the practice population is drawn e.g. in a large town there may be two or three practices with which patients may register – and assuming that a practice draws patients just from their immediate area can be misleading.
- 5.4 A similar methodology has been used to estimate practice population density. Practice population density is broken into the categories, 'most rural', 'rural' and 'mid-rural' as chosen in the National GP Workload survey. Practices have also been categorised into small (<4000), medium (4000 to 7999) and large (8000 and above) according to list size.
- 5.5 Key findings include:
- Uptake of both breast and cervical screening is inversely associated with increasing socio-economic deprivation. The uptake falls as deprivation increases. The same inverse association holds for all primary care organisations in the Peninsula.
  - Practice size and rurality have little influence on this association with deprivation except for cervical screening in small practices. Small practices achieved a better uptake of cervical screening in more deprived populations. Only 9.2% of the eligible population for cervical screening is registered with small practices.
  - Cervical screening uptake is lower in 25-29 year old women but the inverse association with deprivation persists.
- 5.6 The scatter graphs below show the association between practice deprivation score and the uptake of breast and cervical screening. Each point represents the deprivation score for the general practice population plotted against the screening uptake rate. A full report of this work is available from the Peninsula Cancer Network office.



5.7 A similar association has been demonstrated for bowel cancer screening using general practice uptake rates for people offered screening through the South Devon Bowel Cancer Screening Centre.

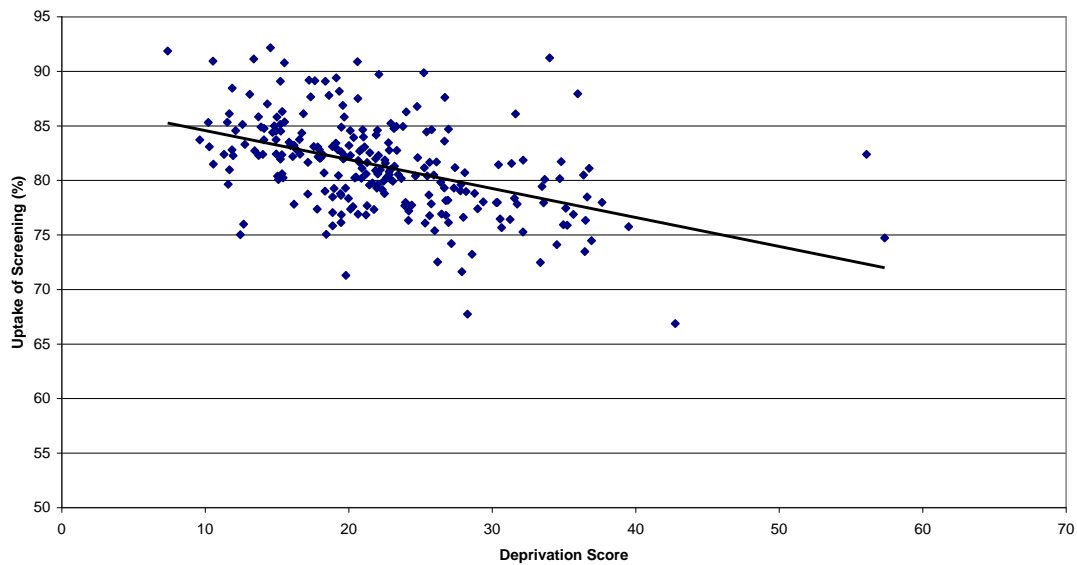
**Uptake of Breast Screening in the South West Peninsula 2007/08 and the relationship with practice deprivation score (IMD 2007)  $r = - 0.429$  ( $p = < 0.001$ )**

Uptake of Breast Screening (2007/08) across the SW Peninsula by IMD score



**Uptake of Cervical Screening in the South West Peninsula 2007/08 and the relationship with practice deprivation score (IMD 2007)  $r = - 0.464$  ( $p = < 0.001$ )**

Uptake of Cervical Screening (2007/08) across the SW Peninsula by IMD score



## 6 Referral rates, by PCT and general practice

- 6.1 The introduction of two week waits for people suspected to have cancer has led to a fast track for cancer diagnosis from primary care. About half of the cases of cancer are diagnosed through a two week wait referral but many people with cancer continue to be diagnosed as a result of the cancer causing a hospital admission or when referred as a routine outpatient appointment.
- 6.2 The proportion of people in the Peninsula with cancer who are diagnosed through the two week wait referral system are shown in the table below.

**Table showing 2 week wait (2WW) information by primary care trust**

PCT	Referrals per 100,000 population through 2WW	% 2WW with cancer	% diagnosed through 2WW
Cornwall and isles of Scilly	225	15%	54%
Devon	205	13%	43%
Plymouth	240	13%	54%
Torbay Care Trust	209	13%	38%

### Notes:

Referrals per 10,000 population through two-week wait (2WW)

This shows the number of cases (per 10,000 population) referred as an urgent GP referral for suspected cancer (two-week wait) within a PCT.

Data are from Q1 2009/10.

Percentage two-week wait with cancer

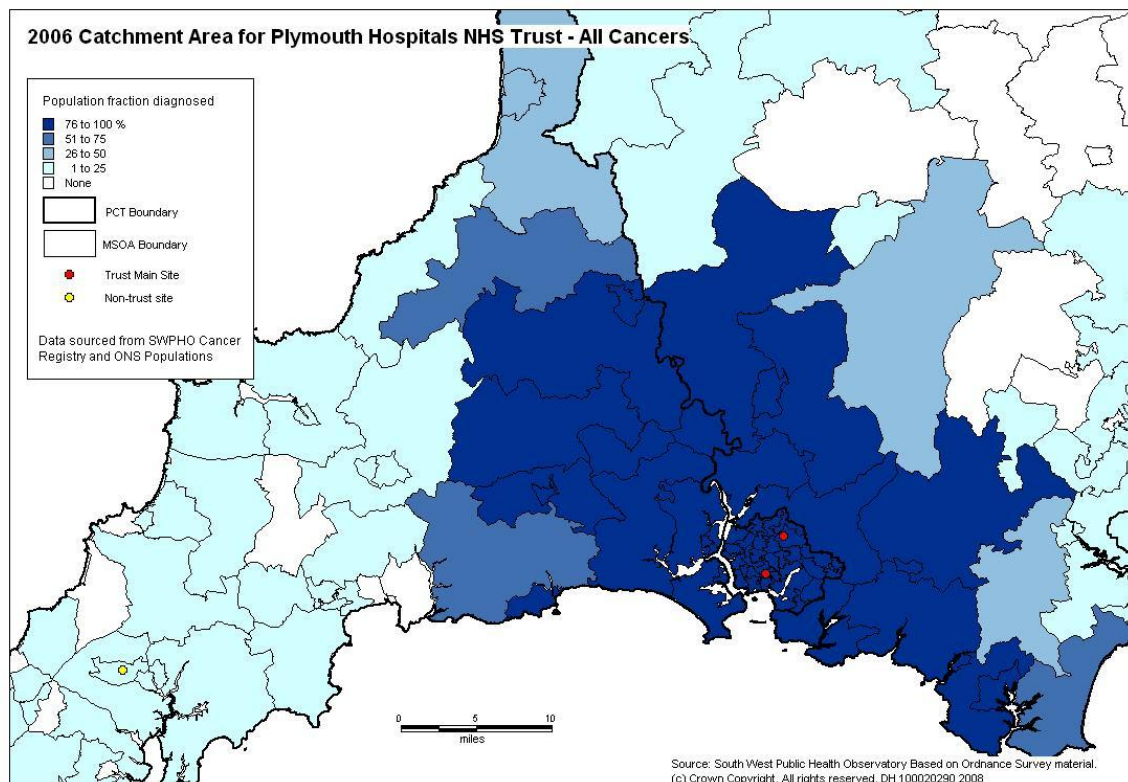
This shows the percentage of two-week wait referrals who were then diagnosed with cancer. Data are extracted from the Cancer Commissioning Toolkit for Q3 2008/09.

Percentage diagnosed through two-week wait

This shows the percentage of all cancer patients who were referred urgently for suspected cancer (two-week wait) by their GP.

Data are extracted from the Cancer Commissioning Toolkit for Q3 2008/09.

- 6.3 The proportion diagnosed through referrals through the two week wait process varies with the type of cancer and also by general practitioner and general practice. Identifying cancer at an early stage is a challenge for all clinicians. Cancer remains an uncommon diagnosis when set within the wide range of conditions seen every day by general practitioners. Detailed guidance by NICE and other expert bodies can help categorise warning signs and symptoms and cancer prediction software is now under development to help assist the clinician.
- 6.4 Clinical pathways rely upon the interaction between primary care teams and the local secondary care clinicians. In the Peninsula, the geography is such that primary care teams tend to refer consistently to secondary care colleagues in their nearest district general hospital. The catchment areas of district general hospitals in the Peninsula do not mirror the primary care trust boundaries. For example, the map below shows the referrals for cancer to Plymouth Hospitals NHS trust. The catchment area extends well into South East Cornwall and West Devon



6.5 To mirror more appropriately the clinical pathways for cancer referral we intend in future baseline assessment work, to examine the outcome of referrals for two-week waits by hospital and the general practices that customarily about refer cases to that hospital. This fits more closely with the clinical flows and the discussions and developments that need to take place between primary and secondary care colleagues. The development of Peninsula wide guidelines linked to the Map of Medicine will help aid consistency, but local discussions and development of best practice need to feed into arrangements for improved early diagnosis.

## 7 Delivering care in the most appropriate setting

7.1 Ideally, people with cancer should be diagnosed at a stage when planned care can be carried out rather than when a crisis or serious complication leads to emergency admission.

7.2 Increasingly, operations for cancer can be carried out using minimally invasive techniques. These lead to reduced length of stay in hospital. Also, chemotherapy and procedures related to chemotherapy can often be carried out on an outpatient basis leading to reduced number of elective admissions.

7.3 The table below is an extract from the second annual report of the Cancer Reform Strategy and shows information on elective inpatient stays and emergency inpatient stays for the primary care trusts in the Peninsula. Figures marked with an exclamation mark are in the highest quartile for all England's performance and those marked with an asterisk in the lowest quartile.

### Elective inpatient stays

PCT	Bed days per registration	Average LOS Breast	Average LOS Colorectal	Average LOS Gynaecology	Average LOS Urology
Cornwall and isles of Scilly	8.9!	3.1	8.1*	3.8	1.4*
Devon	7.5	2.5	10.3	4	2
Plymouth	7.2	1.6*	9.5	5.3	1.5*
Torbay Care Trust	6.8	3.3	10.4	3.9	1.6*

### Emergency inpatient stays

PCT	Admissions per registration	Bed days per registration	Average LOS Total
Cornwall and isles of Scilly	1.7	7.5*	4.5*
Devon	1.3*	6.8*	5.1*
Plymouth	1.3*	9.7*	7.2!
Torbay Care Trust	1.9	7.6*	4.1*

#### Notes:

##### Elective bed days per registration

Data are sourced from the National Cancer Services Analysis Team and are from HES for 2008/09. The number of bed days is adjusted for PCT crude incidence – a higher incidence would expect a higher number of bed days.

PCTs in the England quartile that has the lowest number of bed days per registration are shown with \* alongside the figure.

PCTs in the England quartile with the highest number of beds per registration are shown with !.

##### Elective – average lengths of stay (LOS)

Shown for elective admissions for four main tumour sites, using HES data for 2008/09 supplied by the National Cancer Services Analysis Team.

PCTs in the England quartile with the lowest average length of stay are shown with \* alongside the figure.

PCTs in the England quartile with the highest average length of stay are shown with !.

##### Emergency admissions per registration

Data are sourced from the National Cancer Services Analysis Team and are from HES for 2008/09. The number of emergency admissions is adjusted for PCT crude incidence – a higher incidence would expect a higher number of admissions.

PCTs in the England quartile with the lowest number of emergency admissions per registration are shown with \* alongside the figure.

PCTs in the England quartile with the highest number of emergency admissions per registration are shown with !.

7.4 The South West Public Health Observatory is working on behalf of the primary care trusts in NHS South West to examine the rates of emergency admission with cancer across the South West region

7.5 Allied to emergency admission rates there is interest in the proportion of people who die in hospital with cancer. An acute hospital ward is often an inappropriate setting for people who dying with cancer. The proportion of people with cancer who die in an acute hospital as a proportion of all deaths from cancer is a measure, which has been suggested to Peninsula groups studying End of Life care.

7.6 Future baseline assessments will examine these measures in more detail, study trends and aim to provide comparative data across individual hospital and primary care trusts.

## **8 Mortality by primary care trust, and local mortality targets**

8.1 One of the NHS vital signs is to reduce the premature mortality rate (in people aged under 75 years) from cancer. All primary care trusts are working to achieve this reduction but face different challenges. Deprivation and health inequality leads to higher rates of cancer in certain communities and groups.

8.2 The London Health Observatory has produced a health inequalities intervention tool which allows local authorities to identify the life expectancy gap due to health inequalities and those cancers diseases, including which contribute to the gap in life expectancy.

8.3 The chart at **appendix (iii)** shows as an example the potential benefit to life expectancy if the most deprived quintile shared the same mortality as the least deprived quintile in the unitary authority of Plymouth (which is coterminous with NHS Plymouth).

8.4 This tool may be of value to primary care trusts in considering and setting local cancer mortality reduction targets. The tool is available through the following link: [http://www.lho.org.uk/LHO\\_Topics/Analytic\\_Tools/HealthInequalitiesAllAreas2008.aspx](http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesAllAreas2008.aspx)

## **9 Cancer awareness**

9.1 Public awareness of the symptoms of cancer and when to seek advice is felt to be a crucial determinant for improving earlier diagnosis.

9.2 The National Cancer Action Team has funded a project across the Peninsula which will provide an opportunity to test the appropriateness and value of using the national Cancer Awareness Measure to establish a baseline. Although, only 200 Cancer Awareness Measure interviews will be carried out these will be linked with focus groups in deprived areas exploring in particular the awareness of lung cancer and the perceived barriers to seeking advice on symptoms.

9.3 The project is being undertaken by Forster, a social marketing company, and the results will be reported to the Network Public Health and Primary Care Group on March 31.

9.4 Primary care trusts may wish to consider whether to carry out a baseline assessment of cancer awareness on a statistically representative sample of the Peninsula population.

9.5 A further project funded by the National Cancer Action Team in the Peninsula is focused upon public awareness and prevention of skin cancer. Each primary care trust is holding health community workshops to bring together key commissioners from health and local authorities, with dermatologists to develop a systematic approach to the commissioning of a awareness raising and skin cancer prevention. This will be allied to a five-year communication and marketing program based around groups identified through social marketing research.

## **10 Stage at diagnosis and participation in national cancer audits**

- 10.1 The Network is working with the cancer registry to ensure that the quality of registration data is improved in line with the requirements set out in the national NHS contracts. Across the country, and indeed within the Peninsula the quality of data completion has been variable with many key fields incomplete or inaccurate.
- 10.2 The Network Executive Board has agreed that improving the quality of cancer registration data is a priority in order to be able to properly study cancer outcomes related to the stage at presentation and treatment.
- 10.3 Similar importance needs to be accorded to the national audits of cancer outcomes and PCT commissioners will increasingly be using trust performance within the national audits as a marker of quality of care and areas for improvement.

## **11 Conclusion**

- 11.1 This baseline assessment has identified the key areas of information necessary to be able to understand and monitor the outcomes of cancer care across the peninsula.
- 11.2 High-quality information will help steer and direct improvement in cancer outcomes for patients and through the National Cancer intelligence network and cancer commissioning Toolkit commissioners will be better able to direct resources to improve care.
- 11.3 The findings of this assessment and the particular nature of the people and health services across the Peninsula will help shape the Peninsula strategy for prevention, awareness and early diagnosis of cancer.