

Cancer

JSNA Report

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**Authorised for publication by Dr Sarah McNulty, Assistant Executive Director
(Public Health)**

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1. WHY IS CANCER PREVENTION IMPORTANT?

Cancer is a term that refers to a number of conditions where the body's cells begin to grow and reproduce in an uncontrollable way; there are over 200 different types of Cancer. It was estimated in 2015 that approximately 2.5 million people would be living with cancer in the UK; this is estimated to rise to 4 million by 2030¹.

During 2016, around 166,000 people in the UK died from the disease, with lung, prostate, breast and bowel cancers accounting for 45% of all Cancer deaths in the UK in 2016². Cancer was the cause of over a quarter (28%) of all deaths in the UK in 2016 and is the most common cause of death by broad disease group². Around one in two people will develop cancer at some point in their lives and it causes around one in four deaths³. Cancer is largely preventable and there is a significant focus locally on the prevention and early diagnosis of cancer.

Research has shown that an individual's risk of being diagnosed with cancer is associated with many factors, including age, lifestyle and genetic factors. Below are some examples of modifiable risk factors for different cancers, important to highlight in order to direct preventative action. A number of these risk factors pertain to lifestyle issues, which are the subject of separate strategic needs assessments, for example on alcohol and smoking. This is not an exhaustive list and it should be noted that the strength of association will vary per cancer and factor.

Risk factor	Examples of associated cancer
Smoking	Lung, head and neck
Alcohol	Liver, breast, upper gastrointestinal
Poor diet	Colorectal
Obesity	Breast, colorectal
Sunlight	Malignant melanoma
Some viruses	Cervical, head and neck, liver
Radiation	Thyroid, lung

It is estimated that more than four in 10 cancer cases could be prevented by lifestyle changes, such as not smoking, cutting back on alcohol, maintaining a healthy body weight, and avoiding excessive sun exposure (Parkin et al 2010). Given that there is an ageing population within Knowsley and cancer is predominantly a disease of ageing it is expected that the number of new cases of cancer each year will increase in the future.

Treatments for cancer include surgery, chemotherapy and radiotherapy. Some cancers can be cured if detected early enough, therefore symptom awareness by the public and clinicians, high achievement in screening programmes and good and timely access to assessment and diagnosis is vitally important to detect the early presence of cancer and treat appropriately.

2. WHO IS MOST AT RISK?

The National Cancer Intelligence Network (NCIN) published evidence on cancer inequalities in March 2010⁵. The report identified the following evidence-based findings on inequalities in cancer in England:

- **Gender** - Adjusting for women's longer life expectancy, men are diagnosed with more cancers and have a higher mortality from cancer. As a result, there are more women than men living with or beyond a diagnosis of cancer. Men's one-year survival is generally similar to or slightly better than women's for individual cancer types.
- **Socioeconomic deprivation** - Mortality relating to cancer is considerably higher in deprived groups compared with more affluent groups. 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.

Awareness of the signs and symptoms of cancer is lower amongst socially deprived groups than the population as a whole and, for the cancers where there is a national screening programme, uptake of screening is also lower.

There is a socioeconomic gradient in survival after diagnosis of breast, lung and colorectal cancers and this has widened over recent years. This may be due to a number of factors, but in particular later diagnosis of cancer and factors unrelated to healthcare such as social support.

- **Age** - For the vast majority of cancers, incidence increases with age. Just over half of all cases of cancer diagnosed (50.4%) in 2016 in England occurred in people over 70 years and over a fifth in people over 80 years (22.0%). Despite this, older people may not be aware of their increased risk and may have lower awareness of cancer symptoms than younger age groups.⁶

Significant reductions in cancer mortality have been achieved among the under 75s over the past decade. However, the improvement has been much less marked for the over 75s. Cancer survival decreases with age and there is evidence that older people's cancers are investigated and treated less intensively.

- **Ethnicity** - 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.

Women from BME groups are more likely to present with more advanced breast cancers and have poorer survival than white women.

Awareness of cancer is generally lower in BME groups than amongst white men and women and screening uptake is generally lower in minority ethnic

groups than in the population as a whole. Although there may be some cultural factors involved in this, it is also likely to be related to deprivation.

There is a need for access to culturally relevant information about cancer and its signs and symptoms; existing cancer information rarely reflects multi-ethnicity in terms of images and language.

- **Sexuality** - There is 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.

Perceptions of risk and healthcare-seeking behaviour may also vary. For example, there is some evidence to suggest that lesbians may delay seeking help from a healthcare professional when compared with heterosexual women.

- **Disability** - Disability encompasses a wide range of issues from mental health to learning disability and sensory impairment as well as physical disability. There is no national information on variations in cancer incidence, treatment and outcomes for people with a disability.

There is some evidence for increased incidence of cancer associated with some mental illnesses (although those with schizophrenia may have a lower incidence of respiratory cancers). This is associated with increased cancer mortality.

People with learning disabilities appear to have a similar age standardised incidence to the general population although patterns of incidence may be different.

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.

- **Religion** - There is very little information on differences in cancer incidence, treatment or outcomes by religion and none at a national level. Many issues faced by religious groups are closely linked to ethnicity and culture.

Religious practices (e.g. fasting during Ramadan) can impact upon cancer treatment.

2.1 Lifestyle Factors⁷

You cannot reduce the risk of cancer completely but about 1 in 3 cases of the most common cancers (about 33%) can be prevented by eating a healthy diet, keeping to a healthy weight and being more active.⁷

The most common lifestyle risk factors for cancer are listed below:

- **Alcohol** - Drinking alcohol can increase your risk of cancer of the mouth, breast, throat, oesophagus, larynx, and liver. The more you drink, the higher the Cancer risk. The risk of cancer is much higher for those who drink both alcohol and smoke tobacco.
- **Smoking** - In the UK, more than 1 in 4 cancer deaths (over 25%) are caused by smoking. Smoking increases the risk of the following cancers: Mouth, throat, lung, bladder, kidney, pancreatic, bowel, stomach and cervical.⁷

Chewing tobacco is not a safe alternative as this increases the risk of mouth and oral cancers.

Breathing in other peoples smoke increases risk (passive smoking).

The long-term effects of E-cigarettes is not known but they are thought to be about 95% safer than tobacco cigarette smoking.

- **Healthy Weight** - Keeping to a healthy weight is important to reduce cancer risks. Being overweight increases risk of many cancers such as bowel, kidney, womb and Oesophagus.

Women who are overweight who have been through the menopause are at higher risk.

- **Healthy Diet** - No single food will prevent or cause Cancer but a balanced diet can help prevent some Cancers.

A balanced diet includes lots of fruit and vegetables, starchy foods such as bread, pasta and potatoes, some protein foods such as nuts, fish, meat and eggs, some dairy foods such as milk, cheese and yoghurts and a small amount of foods high in fat, salt and sugar.

Drinks in a balanced diet should mainly be water, coffee, tea and sugar free drinks.

High in fibre foods help to reduce risk of bowel cancer.

Consumption of processed and red meat should be limited as these are linked to higher risks of bowel and prostate Cancer.

- **Physical Activity** - Studies have shown that keeping physical active can reduce risk of Cancer. It is recommended that people should do at least 30 minutes of exercise a day.

A further 30 minutes of exercise reduces risk of Cancer further, with vigorous exercise helping to reduce risks even further.

3. NATIONAL POLICY DRIVERS

3.1 NHS Long Term Plan

Note the statements in the long-term plan are from the Secretary of State for Health so apply nationwide across the NHS, not just in Knowsley:

3.1.1 Cancer in Children and Young People (from Chapter 3, page 54)

From 2019, we will begin to **offer all children with cancer whole genome sequencing** to enable more comprehensive and precise diagnosis, and access to more personalised treatments. This will reduce the use of harmful medications and interventions, support increased access to clinical trials and reduce the number of young patients who experience lifelong health problems caused by high doses of chemotherapy and radiotherapy. **Children and young people in England will also be amongst the very first in Europe to benefit from a new generation of CAR-T cancer therapies.** And children who need proton beam therapy are now for the first time beginning to be able to access the most sophisticated modern precision treatment in the world here in the NHS without needing to travel abroad.

We will actively support children and young people to take part in clinical trials, so that participation among children remains high, and among teenagers and young adults rises to 50% by 2025. More effective consent processes for using data and tissue samples in research will contribute to improving survival outcomes. We will seek the views of patients aged under 16 people. This will be used, alongside other cancer data, to inform service design and transformation.

From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer. This will build on the success of the girls' programme, which has already reduced the prevalence of human papilloma virus (HPV) 16 and 18, the main cancer-causing types, by over 80%. This will reduce cervical and other cancers in both men and women in the future.

3.1.2 Adults (Chapter 3, page 57 onwards)

This Long Term Plan sets a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis. We will build on work to raise greater awareness of symptoms of cancer, lower the threshold for referral by GPs, accelerate access to diagnosis and treatment and maximise the number of cancers that we identify through screening. This includes the use of personalised and risk stratified screening and beginning to test the family members of cancer patients where they are at increased risk of cancer.

We will modernise the Bowel Cancer Screening Programme to detect more cancers, earlier. The Faecal Immunochemical Test for haemoglobin will

be easier to use for patients. In trials it has been shown to improve take up rates by 7%, including among groups with low participation rates such as men, people from ethnic minority backgrounds and people in more deprived areas. We will lower the starting age for screening from 60 currently to 50.

NHS England has asked Sir Mike Richards to lead a review of the current cancer screening programmes and diagnostic capacity. This will make initial recommendations by Easter 2019 and be finalised in the summer 2019, to further improve the delivery of the screening programmes, increase uptake and learn the lessons from the recent issues around breast and cervical screening, and modernise and expand diagnostic capacity. We will take forward the findings of the review as part of this Plan.

Over the next two years, we will extend the lung health checks that have already produced strong results in Liverpool and Manchester. Patients will have a breath test and a discussion to assess their individual lung cancer risk. Any patient assessed as being at high risk of lung cancer will have an immediate low-dose CT scan. During the Manchester trial, 65% of lung cancers were diagnosed at stage 1 and 13% at stage 4, compared to 18% at stage 1 and 48% at stage 4 before the trial. From 2019, we will deploy more mobile lung CT scanners – taking the support to people in supermarket car parks – starting in parts of the country with the lowest lung cancer survival rates. This will identify more cancers quickly, pick up a range of other health conditions, including chronic obstructive pulmonary disease (COPD), and help reduce inequalities in cancer outcomes.

For fast growing cancers, shortening intervals between referral to treatment saves lives. For every person with suspected cancer, shortening the anxious wait between suspicion and exclusion or confirmation of cancer will deliver a far better experience of care. More cancers are being diagnosed following a GP referral or from screening, with reductions in diagnosis through emergency presentation. We want to ensure that all GPs are using the latest evidence-based guidance from NICE to identify children, young people and adults at risk of cancer. Primary care networks will be required to help improve early diagnosis of patients in their own neighbourhoods by 2023/24.

We will begin introducing a new faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening. For people diagnosed with cancer, it will mean they can begin their treatment earlier. For those who are not, this will put their minds at rest more quickly at a very stressful time. To support the delivery of the new standard, we will align our Cancer Alliances with STP and ICS footprints and NHS England and NHS Improvement regions. They will implement a new timed diagnostic pathway for specific cancers, building on the timed pathways already being introduced in lung, colorectal and prostate cancer. Data collection for all patients will start in 2019, with full monitoring against the standard beginning in April 2020, and performance ramping up as additional diagnostic capacity comes online.

The new faster diagnosis standard will be underpinned by a radical overhaul of the way diagnostic services are delivered for patients with suspected cancer. From 2019, we will start the rollout of new Rapid Diagnostic Centres (RDCs) across the country. The Centres will upgrade and bring together the latest diagnostic equipment and expertise, building on ten models piloted with Cancer Research UK. The models piloted focused on diagnosing cancers where patients often present with non-specific symptoms and may go to their GP many times before being sent for tests, such as blood and stomach cancers. In time, RDCs will play a role in the diagnosis of all patients with suspected cancer, including self-referral for people with red-flag symptoms. For patients with cancer, this will mean they can get quicker access to an accurate diagnosis and begin their treatment. The majority of patients who do not have cancer, but may have other conditions, will be referred on quickly to get the right support.

The NHS will use its capital settlement to be negotiated in the 2019 Spending Review in part to invest in new equipment, including CT and MRI scanners, which can deliver faster and safer tests. Broader reforms of the way that diagnostic services are organised – including pathology and imaging networks – will also mean test results can be turned around quickly and staff time and skills will be used most effectively, so that patients can have multiple successive tests in one visit. As set out in Chapter Six, this will improve quality of care (including patient experience) and efficiency, while reducing variation in clinical outcomes.

We will speed up the path from innovation to business-as-usual, spreading proven new techniques and technologies and reducing variation. As part of the NHS' contribution to the Tessa Jowell Brain Cancer Mission, 5-ALA – which enables more accurate surgery on brain tumours – will be available in every neurosurgical centre in England. New investment will ensure the next generation of treatments are implemented rapidly across the NHS.

Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates. We will complete the £130 million upgrade of radiotherapy machines across England and commission the NHS new state-of-the-art Proton Beam facilities in London and Manchester. Reforms to the specialised commissioning payments for radiotherapy hypofractionation will be introduced to support further equipment upgrades. Faster, smarter and effective radiotherapy, supported by greater networking of specialised expertise, will mean more patients are offered curative treatment, with fewer side effects and shorter treatment times. Starting with ovarian cancer, we will ensure greater access to specialist expertise and knowledge in the treatment of cancers where there are fewer or more risky treatment options.

We will extend the use of molecular diagnostics and, over the next ten years, the NHS will routinely offer genomic testing to all people with cancer for whom it would be of clinical benefit, and expand participation in research. The NHS will begin from 2020/21 to offer more extensive genomic

testing to patients who are newly diagnosed with cancers so that by 2023 over 100,000 people a year can access these tests.

By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. This will be delivered in line with the NHS Comprehensive Model for Personalised Care. This will empower people to manage their care and the impact of their cancer, and maximise the potential of digital and community-based support. Over the next three years, every patient with cancer will get a full assessment of their needs, an individual care plan and information and support for their wider health and wellbeing. All patients, including those with secondary cancers, will have access to the right expertise and support, including a Clinical Nurse Specialist or other support worker.

After treatment, patients will move to a follow-up pathway that suits their needs, and ensures they can get rapid access to clinical support where they are worried that their cancer may have recurred. This stratified follow-up approach will be established in all trusts for breast cancer in 2019, for prostate and colorectal cancers in 2020 and for other cancers where clinically appropriate by 2023. From 2019, we will begin to introduce an innovative quality of life metric – the first on this scale in the world – to track and respond to the long-term impact of cancer.

3.1.3 Milestones for Cancer

- From 2019 we will start to roll out new Rapid Diagnostic Centres across the country.
- In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days.
- By 2020 HPV primary screening for cervical cancer will be in place across England.
- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.
- By 2022 the lung health check model will be extended.
- By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers.
- By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.

4. LOCAL POLICY DRIVERS

4.1 NHS Constitution measures and performance (from the Knowsley CCG Annual Report):

NHS Knowsley CCG Constitution Performance		Target	2017/18	2018/19	Year on year Variance
Cancer waiting times - 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	94.7%	90.9%	-3.8%
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	95.0%	90.0%	-5.0%
Cancer waiting times - 31 day standards	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%	97.6%	96.5%	-1.1%
	Maximum one month (31 day) wait for subsequent treatment where that treatment is surgery	94%	99.2%	98.6%	-0.2%
	Maximum one month (31 day) wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	98.8%	98.5%	-0.3%
	Maximum one month (31 day) wait for subsequent treatment where that treatment is a course of radiotherapy	94%	99.1%	99.0%	-0.1%
Cancer waiting times - 62 day standards	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	83.8%	77.9%	-5.9%
	Maximum two month (62 day) wait from an NHS Screening service to first definitive treatment for cancer	90%	92.9%	82.6%	-10.3%

Cancer is the leading cause of death in Knowsley and accounts for almost one-third of deaths locally. Up to 70% of people with cancer in Knowsley are also living with one or more other potentially serious long-term health conditions, which could impact on reduced survival and result in a higher level of need both medically and socially. The picture in Knowsley is one of low socio economic mobility and high levels of disease such as cancer - including late diagnosis and low uptake in national screening programmes. Delivering positive cancer outcomes for the population of Knowsley is imperative to improve quality of life and reduce early mortality; this is reflected in the key national, regional and

local deliverables to drive improvement in diagnosis, treatment and cancer care.

The focus for cancer commissioning in 2019/20 includes the Cheshire and Merseyside Cancer Alliance and two Cancer Partnership Local Delivery Systems - North Mersey and Mid Mersey. Through these local delivery systems, considerable work has been undertaken to improve cancer delivery and provision across the region - focusing on delivering against Achieving World-Class Cancer Outcomes: A Strategy for England 2015/2020. The Cancer Alliance was successful in gaining funding from the National Cancer Transformation Fund for a 2 year improvement programme, which includes the elements below:

4.1.1 Early diagnosis

- a) Implementation of best practice colorectal and lung cancer pathways.
- b) Development and implementation of vague symptoms pathways.
- c) Delivering improvements in pathology, imaging and endoscopy services.
- d) Delivering improved multi-disciplinary team video conferencing.

The implementation and delivery of the above projects will allow an optimal patient journey, ensuring that the 62 day pathway is delivered and building a foundation for the 28 day pathway, working towards compliance by 2020.

4.1.2 Living with and beyond cancer

- a) Implementing the recovery package.
- b) Implementing risk stratified pathways.

Cancer is now viewed as a long-term condition. The needs of people living with and beyond cancer and the supportive mechanisms required are being addressed by holistic needs assessments, end of treatment summaries, health and wellbeing events, recommended exercise programmes and self-supported care.

The CCG secured funding from Macmillan to pilot a community based holistic needs assessment service for those people with a new cancer diagnosis. The aim of this assessment is to look beyond the medical needs of the patient and include wider factors such as the need for emotional and psychological support, financial impact due to potential loss of income and wider family impact. Knowsley is the only pilot that is directly working with general practice. The pilot went live in February 2019 and has been well received by patients and health professionals. Implementation and evaluation of outcomes will continue into 2019/20. The Knowsley model of delivery has been commended as a National exemplar by Macmillan; this comment was given by the Chief Medical

Officer to Knowsley Stakeholders while she and her team visited Knowsley in August.

During the year the Governing Body has maintained a strong focus on delivery and in particular gaining assurance that our patients are able to access high quality services in a timely manner. Where breaches of the 62 day cancer standard have been reported the Governing Body has required a more detailed understanding of the root cause of these delays including at patient level. To this end, the CCG's Cancer Manager and the Clinical Lead for Cancer have worked with providers to review root cause analyses and agree improvement actions.

Knowsley has lower levels of uptake of the 3 national cancer screening programmes than the England average. The CCG continues to work closely with public health and other partners to improve uptake. This has included a number of GP education events, sharing of good practice and regular reporting of performance information. The CCG has also undertaken some baseline work with patients to understand barriers for attending breast screening and helping resolve simple barriers to attendance. The CCG and Public health are to work with a cohort of General Practices, who will identify a member of staff to receive expert training in bowel screening. This person will work for the practice to increase uptake of bowel screening and have protected time to do this work.

Engagement with local support groups and lead cancer nurses at local NHS Trusts has been an important focus, including Lyndale Cancer Support Centre, Breast Mates, the Carer' Centre and Kirkby Breast Support. This has allowed those affected by cancer to shape the agenda of the Cancer Clinical Reference Group (CRG) and influence consultation at wider regional level. Building partnerships with the cancer leads from Aintree University Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust has improved communication and links with Primary care.

The CCG has been funded for two years by Macmillan for a Practice Nurse Champion, who works with practices nurses and community staff to improve their knowledge of cancer and dealing with those affected by cancer. The work is also cross cutting, working to improve systems across a cancer patient's journey, with secondary, community and primary care, this post commenced in October 2018.

The CCG, in collaboration with Halton, St. Helens and Warrington CCGs, has commenced work with Clatterbridge NHS Foundation Trust on the Eastern Sector Cancer Hub, which is focused on review of the current configuration of out-patient non-surgical oncology services for Mid-Mersey area (Eastern Sector). Work in 2018/19 has focused on the case for change, review of current services and pre consultation engagement with stakeholders. This will continue into 2019/20.

The CCG has been identified as one of 10 national first wave CCG areas, to implement the new Targeted Lung Health Checks Programme. The

programme aims to support the early detection of lung cancer, through community based engagement programmes, risk assessments and the use of low dose CT scans to identify cases of lung cancer. This implementation will commence in 2019, with the programme planned for four years.

4.1.3 Cancer 62 day for Urgent GP Referrals

The CCG did not achieve the 85% target in 2018/19, reaching 77.9%. The issues that are impacting on the achievement of the target include secondary and tertiary care capacity issues related to workforce, equipment and pathways. Late referral within the pathways for treatment planning and some targets within the 62 day pathway relate to small numbers of patients. The CCG has put measures into place to better understand the issues relating to breaches as to ensure that they are analysed, lessons are learnt, and actions taken by NHS trusts are sufficient to reduce breaches in the future.

4.1.4 Knowsley CCG Operational Plan

- a) The CCG plans a continued focus on cancer access, working as a key partner within the Cheshire and Merseyside Cancer Alliance and in line with NHS Constitutional Standards.
- b) Further work is required to improve screening rates to achieve national targets for breast, cervical and bowel screening uptake working in close collaboration with the local screening hubs, public health and general practice.
- c) Implementation of the Lung Health Checks Programme within the borough is planned in partnership with Halton CCG and Cheshire and Merseyside Cancer Alliance. The CCG has been identified as a first wave implementer site for the new national programme designed to support earlier detection and timely treatment for lung cancer. This four year programme will see targeted, public engagement, to identify patients at risk and invite them for low dose CT scans and supportive services e.g., smoking cessation.
- d) Implementation of the Macmillan Holistic Needs Programme will continue which is designed to deliver holistic needs assessments, care planning and wellbeing support allowing individuals to have greater control over their needs beyond the medical aspects of their condition.
- e) The CCG will support earlier diagnosis of cancers through improved education for general practice and implementation of new models through teledermatology.
- f) Consideration will be given to the development of Lynch Syndrome Screening for people with colorectal cancer, designed to improve earlier detection and reduce the associated risk of colorectal cancer.

5. THE KNOWSLEY PICTURE

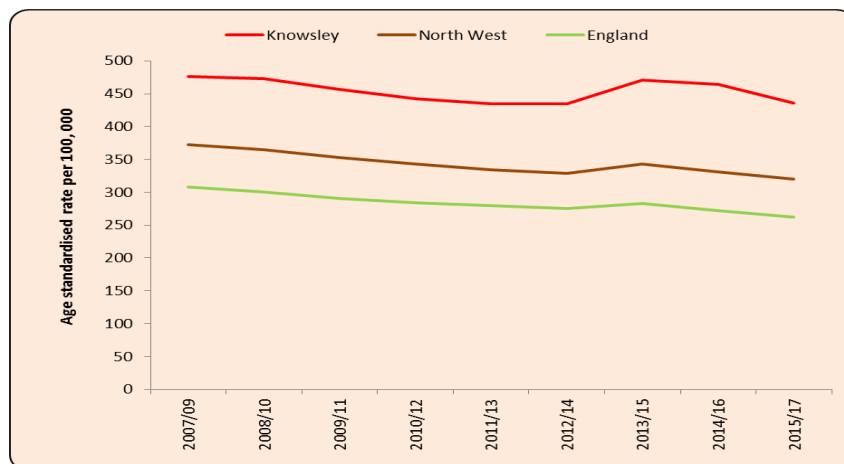
The health of people in Knowsley is generally worse than the England average with life expectancy in 2014-16 being 10.1 years lower for men and 9.6 years lower for women in the most deprived areas of Knowsley than in the least deprived areas⁴.

5.1 Smoking

Smoking attributable deaths are the numbers of deaths per 100,000 population aged 35 and over that are thought to be directly related to smoking. Each cause of death is ascribed a relative risk and these risks are applied to the deaths in a given population over a period of time in order to calculate the number of deaths attributable to smoking. The smoking attributable mortality rate in Knowsley between 2015 and 2017 was estimated to be 435.4 deaths per 100,000 population. This was significantly higher than the North West region (320.5) and England (262.6).

Knowsley had the 4th highest smoking attributable mortality rate of all upper tier local authorities in England during 2015-17 (152 authority areas). Local analysis estimates that 22.6% of all deaths in Knowsley between 2015 and 2017 for people aged 35 or over were attributable to smoking. In comparison, 18.5% of deaths in the North West region and 16.4% of deaths across the whole of England were attributable to smoking.

There has been an 8.5% reduction in Knowsley between 2007/09 and 2015/17, which was a smaller reduction when compared to the North West and England (13.8% and 14.9% reduction respectively). Similarly, the gap between Knowsley and England has widened by 3.2% between during the same period (Graph 1).



Graph 1: Smoking attributable mortality rate per 100,000 age standardised rate 2007/09 to 2015/1. Source: ONS and Public Health Profiles, Public Health England Fingertips

5.2 Alcohol

In terms of alcohol hospital admission episodes, there were an estimated 4,363 hospital admissions related to alcohol within the borough during 2017/18, a rate of 3,084 admissions per 100,000 population, significantly higher than the England rate (2,224) and North West region (2,590). Since 2008/09, there has been a 21.7% increase in the rate of alcohol related hospital admissions in Knowsley, although the increase has not been as large as for the North West region (26.0%) or England (35.6%).

As discussed later, coverage rates for the three cancer screening programs fall below target with wide variation seen at practice level. Late presentation of cancer is also an issue, which can have an impact on survival. An ageing population, higher incidence, and improved survival rates are all making the needs of people living with cancer more complex.

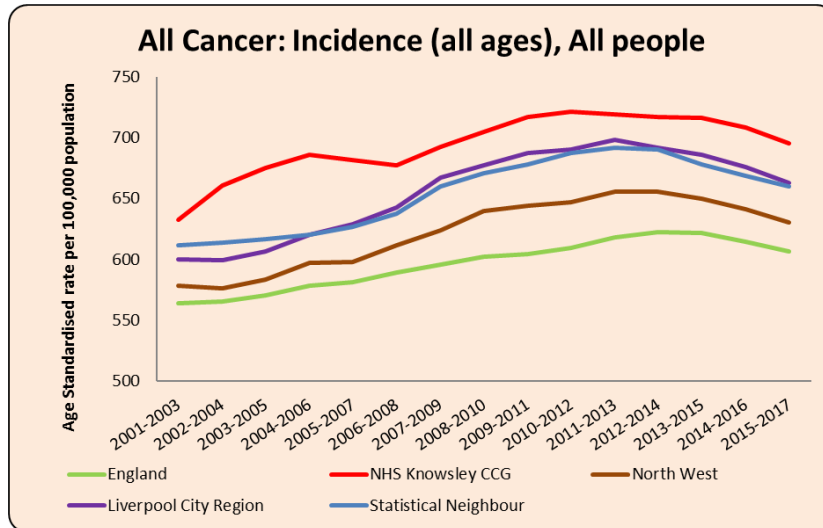
5.3 Cancer Incidence

Cancer incidence is the number or rate (per head of population) of new cases of cancer diagnosed in a given population in a defined time period (in this case a year), this does not include secondary cancers or recurrences. Knowsley CCG area has the 2nd highest incidence all cancers combined (out of 195 CCG areas) in the 2015/17 period.

There were 8,242 new cases of cancer diagnosed in Knowsley between 2009 and 2017 (average of 916 per year). Of these, just under half are cases related to males, (48.5% of total cases). There were 3,994 cancer cases related to males (circa 444 per year). The rate of cancer incidence for males was 761.5 per 100,000 males in 2015-17, an increase of 1.9% since 2001-03. The most prevalence Male cancers in Knowsley were prostate cancer (21%) and Lung cancer (18%) in 2015-17, totaling nearly 40% (2 in 5 cases) of all Cancer incidences.

There were 4,248 cancer cases related to females in Knowsley between 2009 and 2017 (circa 472 per year). The rate of cancer incidence for females was 629.3 per 100,000 females in 2015-17, an increase of 21.6% since 2001-03. The most prevalence female cancers in Knowsley were Breast cancer and Lung cancer in 2015-17, responsible for 27.7% and 19.0% of all new cases each, totaling 46.7%, nearly half of all cancer incidences in females.

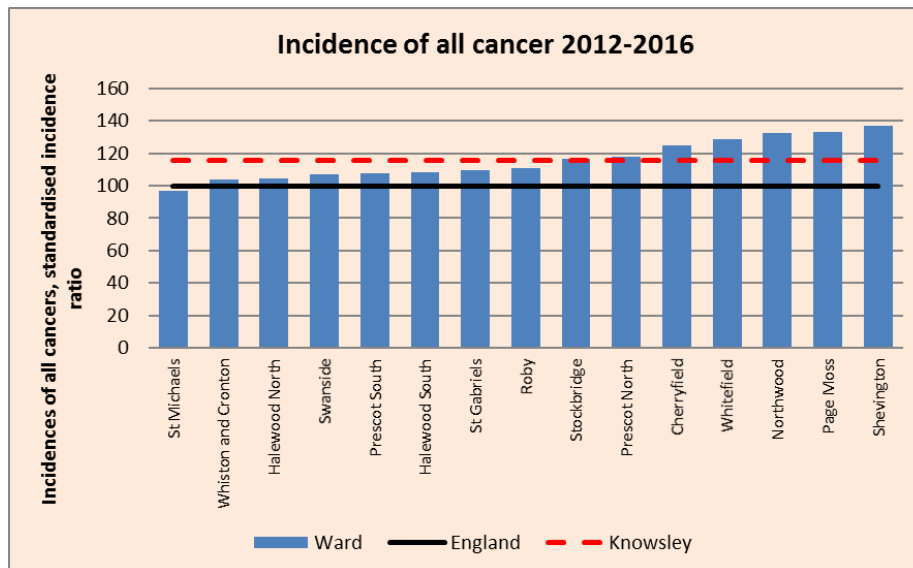
In 2015/17, new incidence of cancer rate for all people, all ages in Knowsley CCG was 695 per 100,000 population; this was significantly above England 606 and North West 631. Knowsley CCG, new incidence of cancer rate decreased by 3.6% from 2010/12 to 2015/17. This rate of increase was greater than England (0.5% decrease) and the North West (2.6% decrease) (See graph 2).



Graph 2: New Cancer cases, 2001/03 to 2015/17, Age standardized rate per 100,000 population. Source: National Cancer Registration Service

5.3.1 Cancer Incidence by Ward

Incidence of Cancer by ward, measured by the standardised incidence ratio (which takes into account age profiles of the wards) shows that in 2012-16, Shevington (136.9), Page Moss (132.9) and Northwood (132.5) wards had the highest ratios. Those wards with the lowest ratios were St Michaels (97.1), Halewood North (104.4) and Whiston and Cronton (103.8). St Michaels is the only ward in the borough that is below the England index of 100.



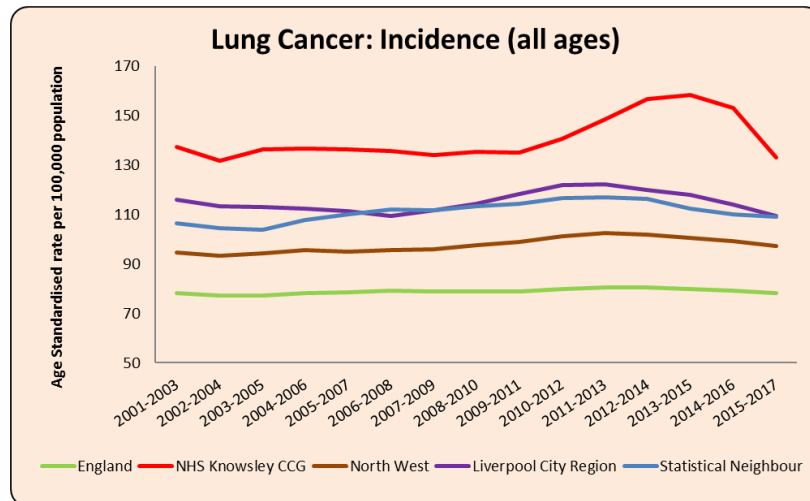
Graph 3: Incidence of Cancer by Ward, 2012 to 2016, Age standardized rate per 100,000 population. Source: PHE Local Health, National Cancer Registration Service

5.3.2 Lung Cancer Incidence

The age standardised Lung Cancer Incidence rate in NHS Knowsley CCG has been consistently significantly higher than England, North West, Liverpool City Region and Statistical Neighbours.

In the latest reporting period (2015-17) the Lung Cancer Incidence age standardised rate (all ages) in Knowsley CCG is 132.8 per 100,000 populations, this rate is almost double the England rate of 78.2 and is higher than North West 97.2).

Over the last five years 2010-2012 to 2015-17, the Lung Cancer age standardised rate (over the last five years) for Knowsley CCG has decreased by 5.4%, over the same period the England rate has decreased by 2.1% and North West decreased by 3.8%.

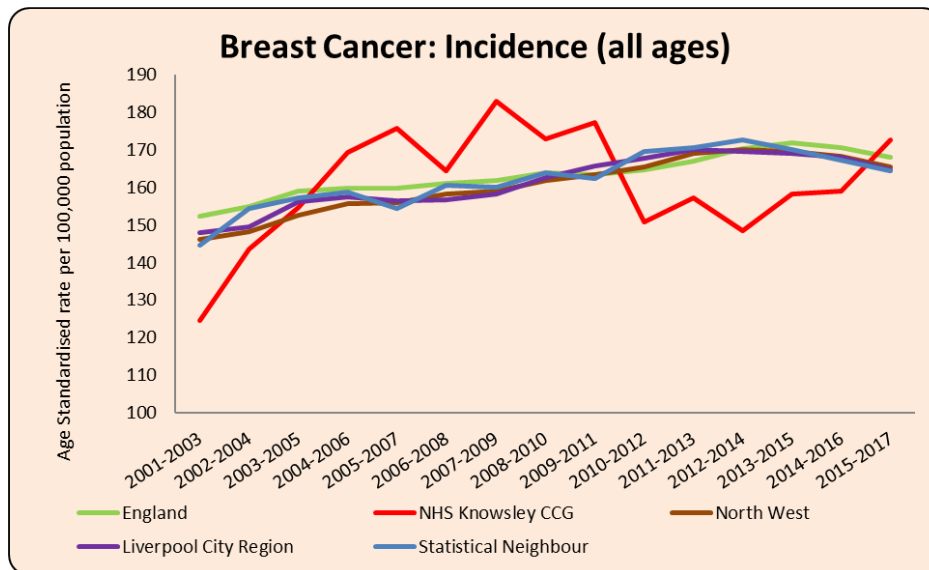


Graph 4: Incidence of Lung Cancer, 2001-03 to 2015-17, Age standardized rate per 100,000 population. Source: National Cancer Registration Service

5.3.3 Breast Cancer Incidence

In the reporting period (2015-17) the Breast Cancer Incidence age standardised rate (all ages) in Knowsley CCG is 172.6 per 100,000 populations, this rate is slightly higher than the England rate of 168.0 and that of the North West (165.5)

Over the last five years 2010-2012 to 2015-17 the Breast Cancer age standardised rate for Knowsley CCG has increased by 5.4%, over the same period the England rate has increased by 3.6%, North West increased by 1.7%, Liverpool City region increased by 0.2% and Statistical Neighbours decreased by 1.4%.

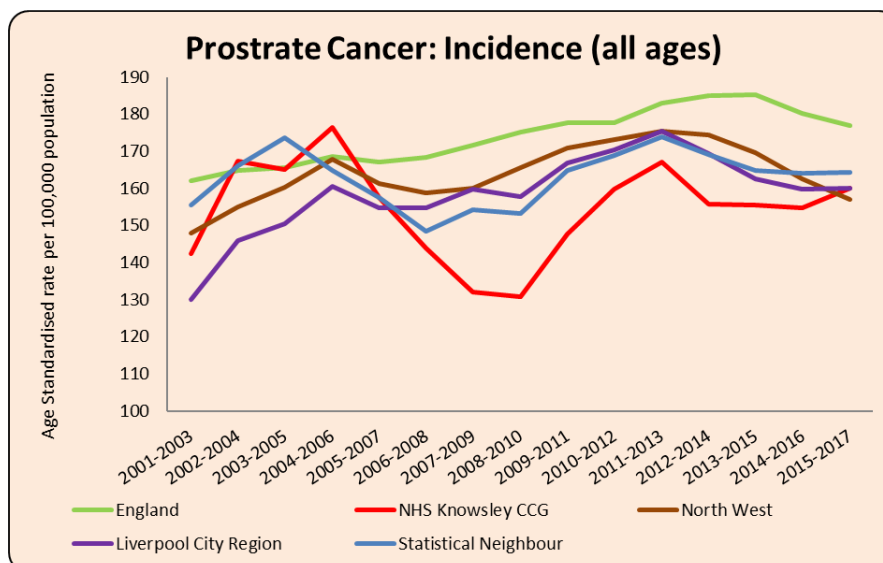


Graph 5: Incidence of Breast Cancer, 2001-03 to 2015-17, Age standardized rate per 100,000 population. Source: National Cancer Registration Service

5.3.4 Prostate Cancer Incidence

In the reporting period (2015-17) the Prostate Cancer Incidence age standardised rate (all ages) in Knowsley CCG is 159.9 per 100,000 populations, this rate is lower than the England rate of 177.0 and slightly higher than that of the North West (157.1)

Over the last five years 2010-2012 to 2015-17 the Prostate Cancer age standardised rate for Knowsley CCG has remained static increasing by 0.2%, over the same period the England rate has decreased by 0.4%, North West decreased by 9.3%, Liverpool City region decreased by 6.0% and Statistical Neighbours decreased by 2.6%.

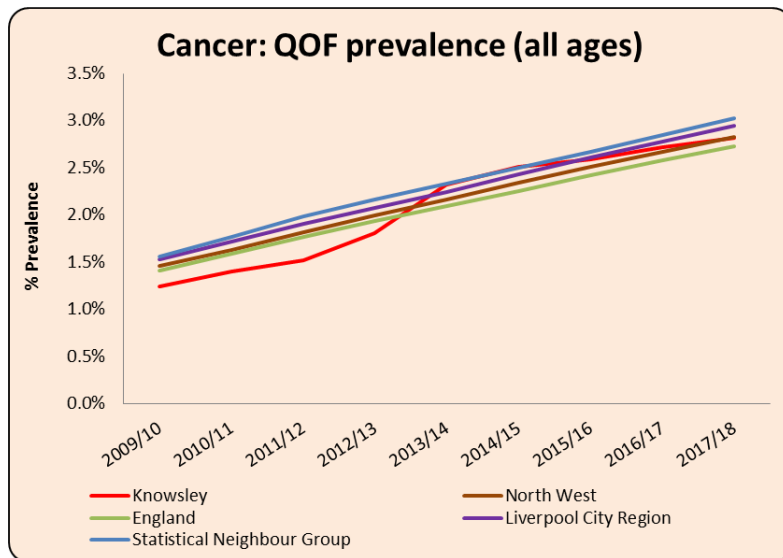


Graph 6: Incidence of Prostate Cancer, 2001-03 to 2015-17, Age standardized rate per 100,000 population. Source: National Cancer Registration Service

5.4 Cancer Prevalence

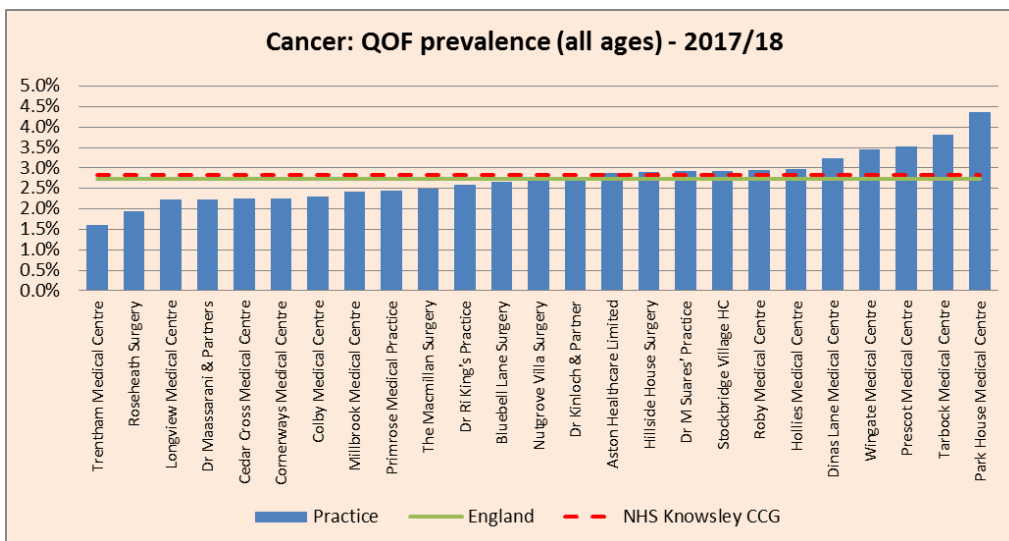
Cancer prevalence is a count of people still alive who have been diagnosed with cancer in the past. The chart below, figure 2, shows the relative practice cancer prevalence in the current year (QoF 2017/18).

In 2017/18, prevalence of cancer in Knowsley was 2.82%; this was above England (2.73%) and North West 2.83%. Knowsley cancer prevalence increased from 1.24% in 2009/10 to 2.82% in 2017/18. Over the same period, cancer prevalence has increased significantly both nationally and locally, with Knowsley more than doubling (increase of 127.8%), this increase being higher than England (92.9%) and the North West (94.0%) (See graph 7).



Graph 7: Cancer Prevalence, 2009/10 to 2017/18
 Source: Quality and Outcomes Framework (QOF) and PHE GP Practice Profiles

In the 2017/18 year, the Cancer prevalence rates at GP practice level varied from 1.6% to 4.4%.

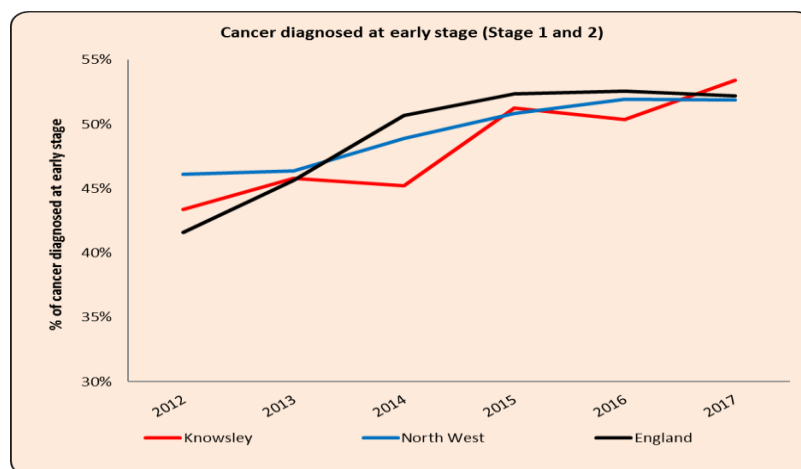


Graph 8: Cancer Prevalence by GP Practice, 2017/18
 Source: Quality and Outcomes Framework (QOF) and PHE GP Practice Profiles

5.5 Cancer Stages

Cancers caught at an early stage (stage 1 or stage 2) typically achieve better outcomes. In 2016, 50.4% of cancers in Knowsley were caught at an early stage, this is lower than England 52.6% and North West 51.9%.

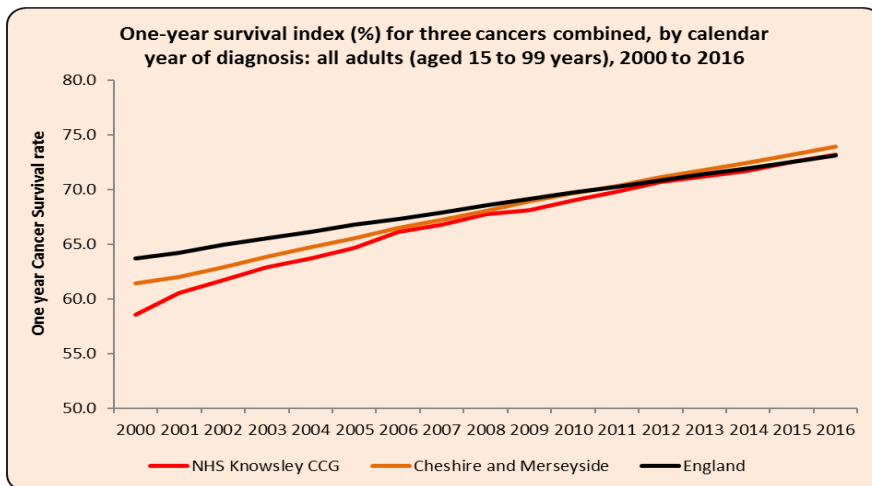
The proportion of cancers caught at an early stage has increased significantly both locally and nationally over the period 2012 to 2017. In Knowsley between 2012 and 2017 the rate of cases diagnosed at stage 1 and 2 increased by 23.1%, slower than the England rate of 25.5% but faster than the North West rate of 12.5%. Cancers caught at stages 3 and 4 are often detected via emergency routes, these include cancers of the liver, small intestine, stomach and thoracic (chest) cavity.



Graph 9: One-year survival index (%) for all cancers combined, all adults (aged 15 to 99 years), 2000 to 2017. Source: ONS

5.6 Cancer Survival

One year cancer survival is defined as the proportion of individuals that survive for a year after diagnosis. One year cancer survival in 2016 is 73.2% for NHS Knowsley CCG patients. This is close to the England average of 73.1% and Cheshire and Merseyside average of 73.9%. One year cancer survival has improved significantly both locally and nationally. NHS Knowsley CCG patients, has improved at a faster rate over the years than England. The period 2000 to 2016, the NHS Knowsley CCG rate has increased by 30.2%, compared 20.8% for England and 27.1% for Cheshire and Merseyside.



Graph 10: One-year survival index (%) for all cancers combined, all adults (aged 15 to 99 years), 2000 to 2016. Source: ONS

5.7 Screening

Some cancers can be cured if detected early enough, therefore high achievement in screening programmes is vitally important to detect the early presence of cancer and treat appropriately.

The three cancer screening programmes for breast, bowel and cervical cancer are evidence based: only where independent scientific authority supports them as being effective in identifying pre cancer and low in unintended harm, are they implemented. They are applied to specific, defined populations where the risk of cancer is highest and the potential benefits greatest. They are implemented systematically, rigorously quality assured, and are subject to clear national specifications and have health inequalities targets.

Screening is undertaken on asymptomatic individuals and identifies an increased risk of cancer. This triggers the application of further diagnostic tests, which will indicate if a cancer or pre cancer is there. The aim of screening is to detect cancer early or at a pre-cancerous stage, so effective treatments can be given

Screening only works when certain criteria are met. In essence these are:

- That we understand the disease in question fully.
- That it is serious and common.
- That there is a test and early treatment that works.
- That we do the screening systematically, in clearly defined groups of people who will benefit.
- That we can evaluate whether screening works in practice.
- That we have the resources to do it.

The Health and Social Care Act 2012 changes meant that breast, cervical and bowel cancer screening programmes became the commissioning responsibility of the Public Health team at NHS England, with public health and the CCG locally working with partners to improve uptake. The Director of Public Health has an additional role of assuring that the services are effective.

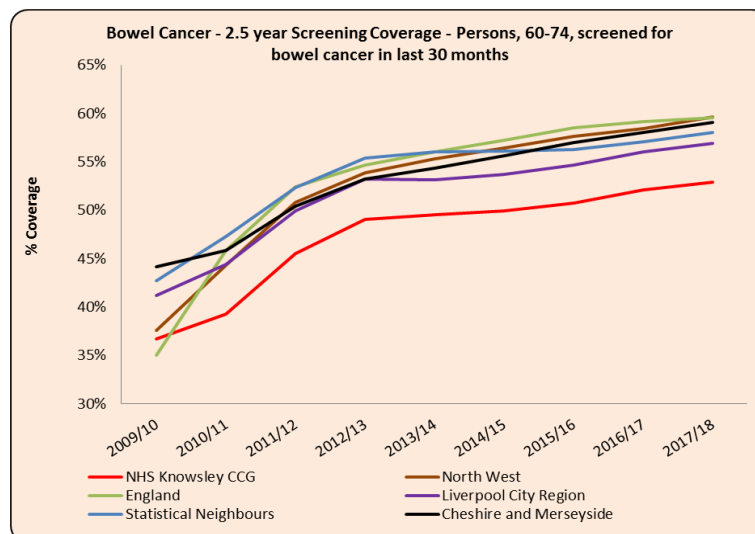
In Knowsley, the coverage of screening services for breast, bowel and cervical cancer screening are lower than national anticipated levels.

5.7.1 Bowel Screening

Screening is offered to every man or woman aged 60-74, every two years, as long as they are registered with a GP. A laboratory in Rugby sends out postal kits, for completion at home and the returned samples are tested for traces of blood. About 2 % test positive.

Anyone with a positive test is invited to a local Screening Centre for interview, and then for a colonoscopy examination of the bowel. About half of these examinations show polyps, some of which are early cancers. Often they can be treated there and then. A new, additional bowel screening test has commenced in Knowsley (as part of a Merseyside wide roll out). This is the once only Bowel Scope invitation to all 55 year olds, which will detect pre cancers years before they become dangerous.

There is a national target of 60% for bowel screening. Coverage is slowly increasing but it remains disappointingly low in Knowsley and across the Mersey region. Bowel screening rates for Knowsley are amongst the worst in the North West and the Merseyside area. Coverage for Knowsley is at 52.9% (2017/18) significantly below the England and North West averages of 59.6% and 59.6%. Bowel screening coverage in GP practices how ranged from 39.4% to 67.1% through the period from 2017/18. In 2017/18, Knowsley CCG has the 36th lowest rate of Bowel screening out of 208 CCG areas



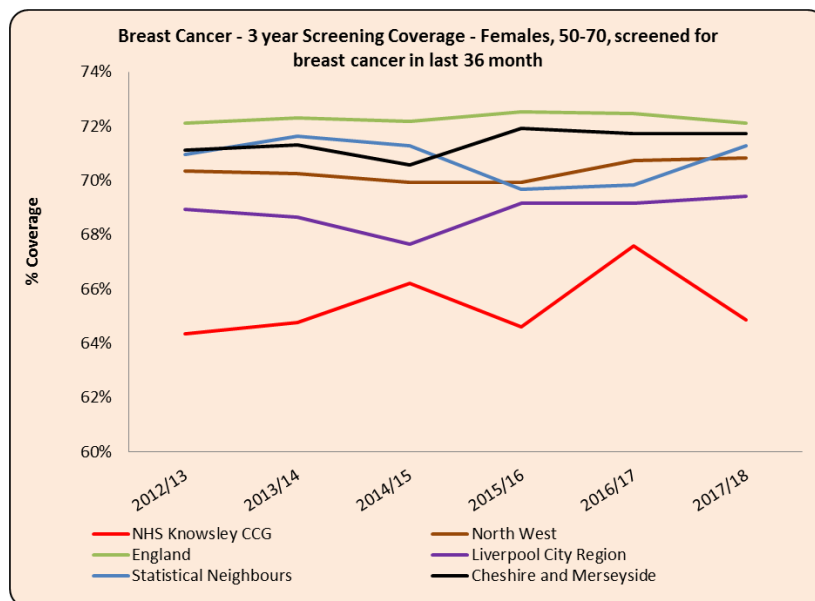
Graph 11: Bowel Cancer, 2.5 years screening coverage, female, 2009/10 to 2017/18
Source: Health and Social Care Information Centre (Open Exeter)/Public Health England Fingertips

5.7.2 Breast Screening

Although most experts agree that breast screening saves lives, for every woman diagnosed through screening who benefits, several receive treatment that they would not have needed had screening not been done.

Every woman between 50 and 70, who is registered with a GP, is invited three yearly for screening. Women are sent a timed appointment either at a mobile or fixed site. At the mammography consent is obtained and a trained screener explains the process. The special photographs are sent digitally to dedicated readers and results issued within 3 weeks. Women who are “screen positive” are contacted and asked back for further investigations.

Breast screening rates for Knowsley are amongst the worst in the North West and the Merseyside area. Coverage for Knowsley is at 64.9% (2017/18) against the national target of 80%. Knowsley is below the England and North West averages of 72.1% and 70.8%. There is a wide variation between GP practices ranging from 52.6% to 78.4%. In 2017/18, Knowsley CCG has the 24th lowest rate of Breast screening out of 208 CCG areas.



Graph 12: Breast Cancer, 3 years screening coverage, female, 2012/13 to 2017/18

Source: HSCIC (Open Exeter)/Public Health England Fingertips

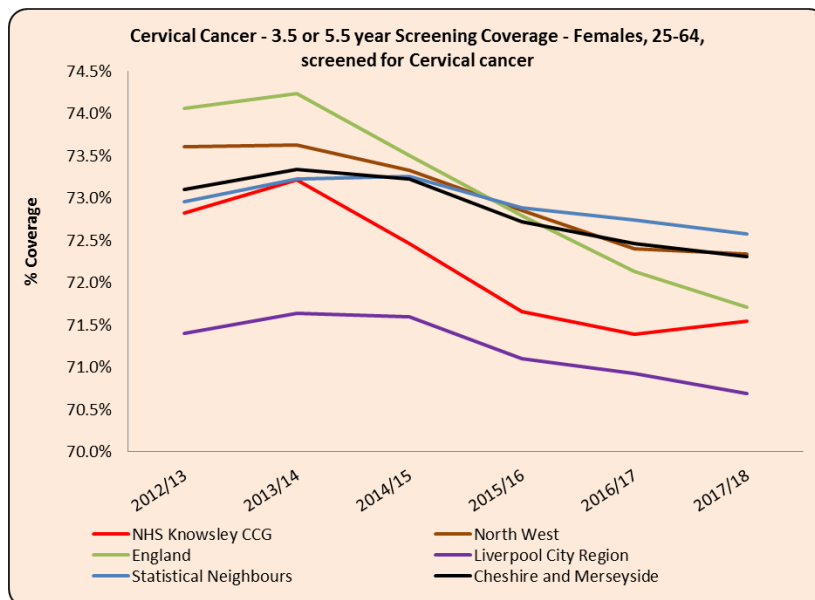
5.7.3 Cervical Screening

Screening is offered to every woman aged 25-64, registered with a GP. Every three years from age 24.5, and every five years from age 50, women are sent a letter asking them to make an appointment at their GP or a clinic.

A trained sample taker, usually a nurse, explains the process and obtains consent, and then they look at the cervix and take a sample. It is sent to a lab for testing and a result sent to the GP and the woman usually within 2 weeks. About 5% of samples test positive. If the result is positive, a “Direct Referral” is made to a Colposcopy outpatient clinic, and the woman sent an appointment.

Following the Colposcopy procedure, a “test of cure” is made and the woman discharged for early or routine screening.

In Knowsley, cervical screening coverage remains relatively static at 71.5% (2017-18). Coverage is slightly lower in Knowsley than England 71.7% and North West 72.3%. Practice level screening data 2016/17 for those women aged 25-64 who have had a record of cervical screening in the last 5 years, shows a variation in the practices from 63.0% to 81.8%. Practices may exception report women from cervical screening under the Quality and Outcomes Framework. This ensures that practices may continue to work towards improving quality and are not penalised for factors such as patients who fail to attend appointments. Practices are encouraged to consider using a variety of methods to encourage women to attend for screening before exception reporting. In Knowsley (March 2017-18) the exception report rate was 7.1%; however a wide range was noted ranging from 2.2%-15.4%. In 2017/18, Knowsley CCG has the 65th lowest rate of Cervical screening out of 208 CCG areas.



Graph 13: Cervical Cancer, 3.5 or 5.5 year screening coverage, female, 2012/13 to 2017/18. Source: HSCIC (Open Exeter)/Public Health England Fingertips

5.8 Cancer Mortality in Knowsley

Successful cancer management starts with an understanding of the burden of disease in the community and the proportion of patients dying from cancer. Mortality is defined as the number of deaths in a given area or period, or from a particular cause. Cancer mortality measures the number of people who have died from cancer in a given period of time. Age-standardised mortality data are important as they help to establish how effective local cancer services are at helping cancer patients to prolong life.

More than four in ten cases of cancer could be prevented by lifestyle changes, such as not smoking, keeping a healthy body weight, cutting back on alcohol, eating a healthy balanced diet, keeping active and by staying safe in the sun.

Knowsley Summary

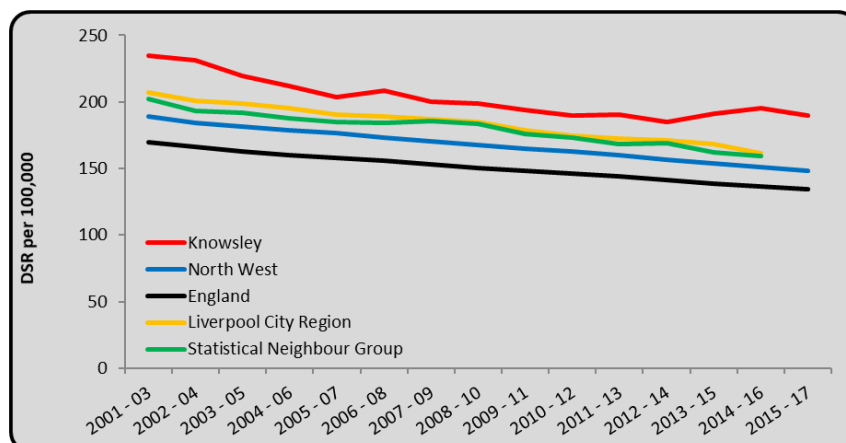
- Main cause of death in Knowsley in 2017 was cancer
- 1,408 cancer deaths in Knowsley in 2015/17
- Almost half of cancer deaths were under the age of 75
- The premature mortality rate from cancer in Knowsley in the last decade decreased by 6.7%
- The absolute gap in the premature cancer mortality rate between Knowsley and England widened by 21.0% in the last 10 years
- The male cancer mortality rate in Knowsley was higher than that for females
- In 2014/16, the ward with the highest mortality rate was Park (505.6)
- In 2014/16, the ward with the lowest mortality rate was Whiston North (242.2)
- 2nd highest rate in the country for premature cancer mortality in 2015/17 out of 326 local authorities
- 2nd highest rate of premature cancer mortality from causes considered preventable in 2015/17 out of 326 local authorities

5.8.1 Knowsley, North West and England Level

The main cause of death in Knowsley in 2017 was cancer, which accounted for 27.9% of all deaths. Between 2015 and 2017 in Knowsley, there were 1,408 deaths attributable to cancer, approximately 470 per year. Of these deaths, almost half (695) were people under the age of 75 (premature) with a premature cancer mortality rate during 2015/17 of 190.1 deaths per 100,000 population.

Since 2005/07, the premature cancer mortality rate has fallen by 6.7% in Knowsley and over the same period the absolute gap in the mortality rate between Knowsley and England has widened by 21.0%. However, the premature cancer mortality rate in Knowsley remains significantly higher than England and the North West (134.6 and 148.5 deaths per 100,000 population respectively). Indeed, in 2015/17 Knowsley has the 2nd highest premature mortality rate for cancer in England out of 326 local authority areas (See Graph 14).

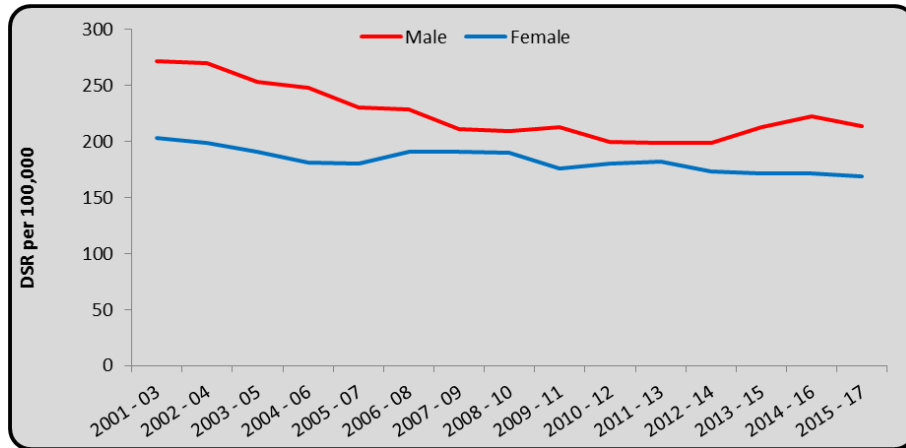
Between 2015 and 2017, there were 401 deaths due to lung cancer (approximately 134 per year), this accounted for 28.5% of all cancer deaths.



Graph 14: Under-75, Cancer mortality rate, all persons, 2001/03 to 2015/17, ONS

5.8.2 Premature Cancer Mortality by Gender

The premature male cancer mortality rate in Knowsley was 213.6 in 2015/17, compared to 168.7 for females. However, since 2005/07, the premature cancer mortality rate has fallen by 7.2% in males compared to 6.4% in females in Knowsley (See Graph 15).

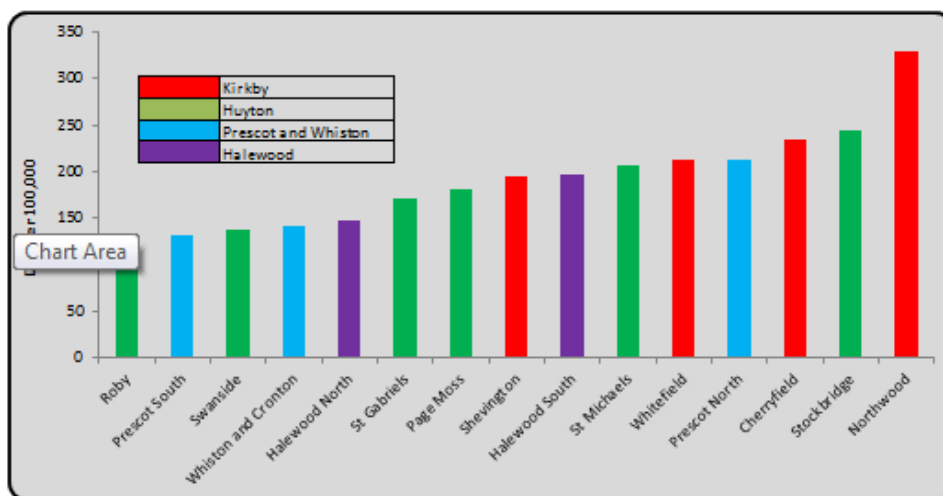


Graph 15: Under-75, Cancer mortality rate, male & female, Knowsley, 2001/03 to 2015/17, ONS

In 2015/17, Knowsley ranked 2nd highest in the country out of 326 local authorities (1st is the highest rate and 326th is the lowest) for premature cancer mortality. The ranking for male and female is similar with males ranked 1st and females ranked 3rd.

5.8.3 Cancer Mortality by Ward (all ages)

In 2015/17, the ward with the highest premature cancer mortality rate was Northwood (329.5), compared to the lowest rate which was in Roby (123.7). Overall, the Kirkby area has the highest rates with three of the four Kirkby wards in the top five highest ward rates in the borough (See Graph 16).

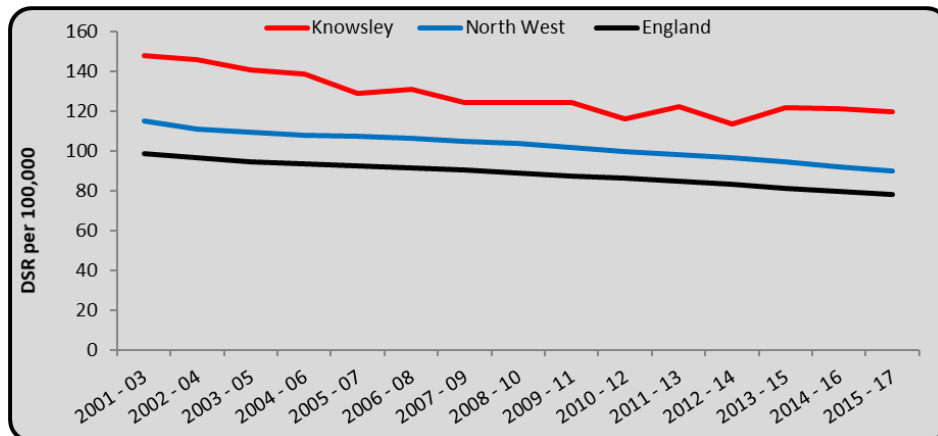


Graph 16: Under 75, CVD mortality rate, by Ward, 2015/17

Source: ONS

5.8.4 Cancer Deaths Considered Preventable, Under 75

The under-75 mortality rate from cancer considered preventable in Knowsley for 2015/17 was 119.5 deaths per 100,000 population, approximately 435 deaths over the period. Knowsley's rate was significantly higher than then North West (89.7) and England (78.0). Since 2005/07 the under 75 mortality rate from cancer considered preventable in Knowsley decreased by 7.3% and the absolute gap between Knowsley and England has widened by 13.1% during the same period (See Graph 17).



Graph 17: Under-75 Cancer mortality rate from causes considered preventable, all persons, 2001/03 to 2015/17 Source: PHOF, PHE

In 2015/17, Knowsley was ranked the 2nd highest in the country for premature cancer mortality considered preventable out of 326 local authorities (1st is the highest rate and 326th is the lowest). The ranking for male and female is similar with males ranked 7th and females ranked 2nd.

6. COMMUNITY, PATIENTS AND STAKEHOLDER VIEWS

6.1 Perception of Cancer in Knowsley

During 2015, insight work was undertaken to better understand Knowsley residents' perceptions of cancer. Ten focus groups were undertaken across Huyton Halewood and Kirkby localities, ages ranged from 25-65+. In line with similar work conducted locally in 2008, the defining health belief about cancer locally continues to be fatalism. Fatalism is the health belief that death is inevitable when cancer is diagnosed, and presents a real barrier to cancer awareness and early detection messages. Fatalism has been linked to reluctance to engage in healthy lifestyle behaviours to reduce cancer risk, low uptake of cancer screening programmes and delays in cancer treatment due to later diagnosis. This can have the unfortunate consequence of inadvertently reinforcing the belief that a cancer diagnosis is always fatal. Work is currently underway to develop a local cancer campaign based on acknowledgement of local health beliefs.

7. EVIDENCE OF WHAT WORKS

NHS England's Five Year forward view gave a commitment to improve outcomes in relation to cancer, particularly in terms of 1 year and 5 year survival rates and that such improvement would require improvements on three fronts, namely;

- Better Prevention
- Faster Diagnosis
- Better Treatment and Care

7.1 NICE Guidelines

In June 2015, the National Institute for health and Care Excellence NICE published *Suspected cancer: recognition and referral*, updating the guidelines previously published in 2005 to help give guidance to support improvements in the early diagnosis of cancer.

The guidelines provide evidence-based advice on the recognition of and referral for suspected cancer in children, young people and adults and exist alongside a wide range of current NICE guidance relating to specific cancer types, which in themselves provided evidence for the development of the revised recognition and referral guidelines.

The guidelines are wide ranging and are divided into 3 sections:

Recommendations organised by symptom and findings of primary care
Recommendations organised by disease site, as shown below;

- Lung and pleural cancers
- Upper gastrointestinal tract cancers
- Lower gastrointestinal tract cancers
- Breast cancer
- Gynaecological cancers
- Urological cancers
- Skin cancers
- Head and neck cancers
- Brain and central nervous system cancers
- Haematological cancers
- Sarcomas
- Childhood cancers
- Non-site-specific symptoms

Recommendations on patient support, safety netting and the diagnostic process including;

- Information on how patients should be supported and informed during the process.

- How processes should be put in place to ensure there is appropriate follow-up in place.
- How local diagnostic processes are appropriately supported and developed

The guidelines, supported by related actions within the health economy, are designed to increase the opportunity for cancers to be identified earlier and therefore to increase the opportunities for improving survival rates.

7.2 Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020.

The Independent Cancer Taskforce was established in January 2015 by NHS England on behalf of the Care Quality Commission, Health Education England, Monitor, National Institute for Health and Care Excellence, Public Health England and the Trust Development Authority to help develop a five-year strategy for cancer services. The aim was to improve survival rates and save thousands of lives. The taskforce was asked to deliver the vision set out in the NHS Five Year Forward View.

In July 2015, it published '*Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020*'. The five year strategy sets out a vision for what cancer patients should expect from the health service with key themes being;

- Effective prevention (so that people do not get cancer at all if possible).
- Prompt and accurate diagnosis.
- Informed choice and convenient care.
- Access to the best effective treatments with minimal side effects.
- Always knowing what is going on and why.
- Holistic support.
- Best possible quality of life, including at the end of life.

The recommendations contained in the strategy are themed around 6 key areas:

1. Spearheading a radical upgrade in prevention and public health:

Driving improvements in public health, including a new tobacco control strategy within the next 12 months, and a national action plan on obesity. It recommends reducing adult smoking prevalence to less than 13% by 2020 and less than 5% by 2035.

2. Driving a national ambition to achieve earlier diagnosis:

A shift towards faster and less restrictive investigative testing, quickly responding to patients who present with symptoms, by ruling out cancer or other serious disease. It recommends setting an ambition that by 2020, 95% of patients referred for testing by a GP are definitively diagnosed with cancer, or cancer is excluded, and the result communicated to the patient, within four weeks. Delivering this will require a significant increase in diagnostic capacity, giving GPs direct access to key investigative tests, and the testing of new models, which could reduce the burden and expectation on GPs.

3. Establishing patient experience as being on a par with clinical effectiveness and safety:

Recognising the opportunity to revolutionise the way health professionals communicate with, and the information provided to, cancer patients, using digital technologies. From the point of cancer diagnosis onwards, it is recommended giving all consenting patients online access to all test results and other communications involving secondary or tertiary care providers by 2020. It is recommended that there is systematised patient access to a Clinical Nurse Specialist (CNS) or other key worker to help coordinate their care. It is recommended that the NHS should continue to drive improvement through meaningful patient experience metrics, including the annual Cancer Patient Experience Survey, which should be embedded in accountability mechanisms;

4. Transforming the approach to support people living with and beyond cancer:

Recommends accelerating the rollout of stratified follow up pathways and the "Recovery Package". The aim should be that by 2020 every person with cancer will have access to elements of the Recovery Package, and stratified pathways of follow-up care will be in place for the common cancers. A national quality of life measure should be developed by 2017 to ensure monitoring and learning to support people better in living well after treatment has ended. It is recommended that CCGs should commission appropriate End of Life care, in accordance with the NICE quality standard, and taking into account the independent Choice Review and forthcoming Ambitions;

5. Making the necessary investments required to deliver a modern high-quality service, including:

- *Implementing a rolling plan to replace linear accelerators (linacs) as they reach 10-year life and to upgrade existing linacs when they reach 5-6 years.*
- *Working to define and implement a sustainable solution for access to new cancer treatments, building from the Cancer Drugs Fund.*
- *Rolling out a molecular diagnostics service which is nationally-commissioned and regionally delivered, enabling more personalised prevention, screening and treatment.*

- *Implementing plans to address critical workforce deficits and undertaking a strategic review of future workforce needs and skills mix for cancer. The priority deficit areas to address should be radiology, radiography and endoscopy for diagnosis; and clinical oncology, medical oncology and clinical nurse specialists for treatment and care.*
- *Supporting a broad portfolio of cancer research.*

6. Overhaul processes for commissioning, accountability and provision.

Recommending setting clearer expectations for how cancer services should be commissioned. For example, most treatment would be commissioned at population sizes above CCG level. By 2016, Cancer Alliances should be established across the country, bringing together key partners at a sub-regional level, including commissioners, providers and patients. These Alliances should drive and support improvement and integrate care pathways, using a dashboard of key metrics to understand variation and support service redesign. Recommends piloting of new models of care and commissioning. For example, the entire cancer pathway in at least one area should have a fully devolved budget over multiple years, based on achieving a pre-specified set of outcomes.

8. LINKS TO OTHER PRIORITIES

Interdependencies with Council, CCG and wider Partnership priorities and strategies

The CCG and council work closely together on a range of issues relating to cancer as well as sharing responsibilities for commissioning services relevant to cancer. Public Health, including NHS England, holds responsibility for those issues that relate to the population as a whole including screening and prevention strategies whilst also supporting local intelligence around both cancer and related mortality. Because of this relationship there is a shared goal of addressing issues around cancer, necessary to ensure Knowsley is able to reduce late presentations, reduce mortality and improve the general health of the population, necessary to reduce the prevalence of cancer in Knowsley.

There are links to a number of other areas of work that the CCG and Council are addressing, namely;

- Long-term conditions, many people diagnosed with cancer also face other illnesses and diseases which need treatment whilst cancer issues are being addressed.
- Support for vulnerable groups, the need to ensure groups of people who face specific challenges (e.g. those with learning disability) are able to effectively access support across cancer pathways.

- Links to mental health given the impact that cancer may have on individuals and their families.
- End of life care, whilst more people survive cancer than do not, it is nevertheless important to ensure that support for those who require palliative and end of life care is sufficient and appropriate.

9. FUTURE CHALLENGES

- The major challenge for the CCG is to increase early diagnosis of cancer and reduce premature mortality; Knowsley is a national outlier, second in the country for premature death caused by cancer, which links to late diagnosis.
- The implementation of the Targeted Lung Health Checks pilot will help address and support the early diagnosis of lung cancer across the population, which is Knowsley's biggest cause of premature mortality.
- The challenge will be encouraging the eligible population to come forward for screening to allow early detection. Increasing uptake of the three cancer screening programmes needs to dramatically improve to impact positively on the population's health, the borough is an outlier. Work to improve perception of cancer screening and understanding barriers will be essential for improvement, as will the introduction of The Faecal Immunochemical Test for bowel screening.
- Knowsley has the 2nd highest rate of premature cancer mortality from causes considered preventable in 2015/17 out of 326 local authorities. Preventable causes include smoking and alcohol consumption. The gap between Knowsley and England has widened by 3.2% for smoking and 21.7% increase in the rate of alcohol related hospital admissions, challenges include finding innovative ways of commissioning services to support populations with behavior changes and engagement.
- Finally the introduction of the new faster diagnosis standard from 2020 to ensure patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening will be a challenge for local delivery. Currently local Trusts are challenged with 62 day capacity and access to diagnostics, in particular radiology and endoscopy. Tumour pathways such as urology, breast and skin are still under considerable pressure despite work being undertaken to deliver optimal cancer pathways across Cheshire and Merseyside and investment from the Cancer Alliance.

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