

KENT PUBLIC HEALTH OBSERVATORY

Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Cancer' JSNA Chapter Summary Update '2014/15'

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Kent Cancer JSNA Chapter Update 2014

Introduction

The following chapter has been adapted from various reports including the 2013 South East Coast Cancer Strategic Clinical Network Annual report. While information such as prevalence has been described at a Kent level with focus more on cancer prevention and early diagnosis, information on services and recommendations for service improvement have been described at Kent Surrey Sussex (KSS) level. More detailed information for Kent will be made available at a future chapter update.

Who is at Risk and Why?

Risk factors can be categorised as either modifiable risk factors or fixed risk factors. Modifiable or lifestyle risk factors such as smoking, alcohol and obesity are responsible for 42% of deaths from leading causes and account for at least £9.4 billion in annual direct costs to the NHS (*See the Health Intelligence section of our website on [Alcohol](#)*).

Age and gender and, for some cancers, ethnicity, are the most important fixed risk factors for cancer. Cancer incidence and mortality increases with age, for example, males 75 years or older are more likely to die from cancer than any other group. Men are more likely to have cancer and die from it than women, although the gender gap in cancer incidence is reducing.

Genetic predisposition and family history, with or without specific gene markers, are other fixed risk factors that are important in the development of some cancers.

More recently, excessive sun exposure has been acknowledged as the most important preventable cause of skin cancer (*See the JSNA chapter on [Planned Care](#)*). New legislation has come into effect restricting and controlling the use of tanning salons and sun beds which have been identified as a key risk factor.

The Level of Need in the Population

Currently 3.3% of the UK population or two million are cancer survivors. This is rising at an estimated 3.2% per year, with breast cancer contributing the most. In the elderly population, aged 65 and over, the proportion of cancer survival rises to 10%.

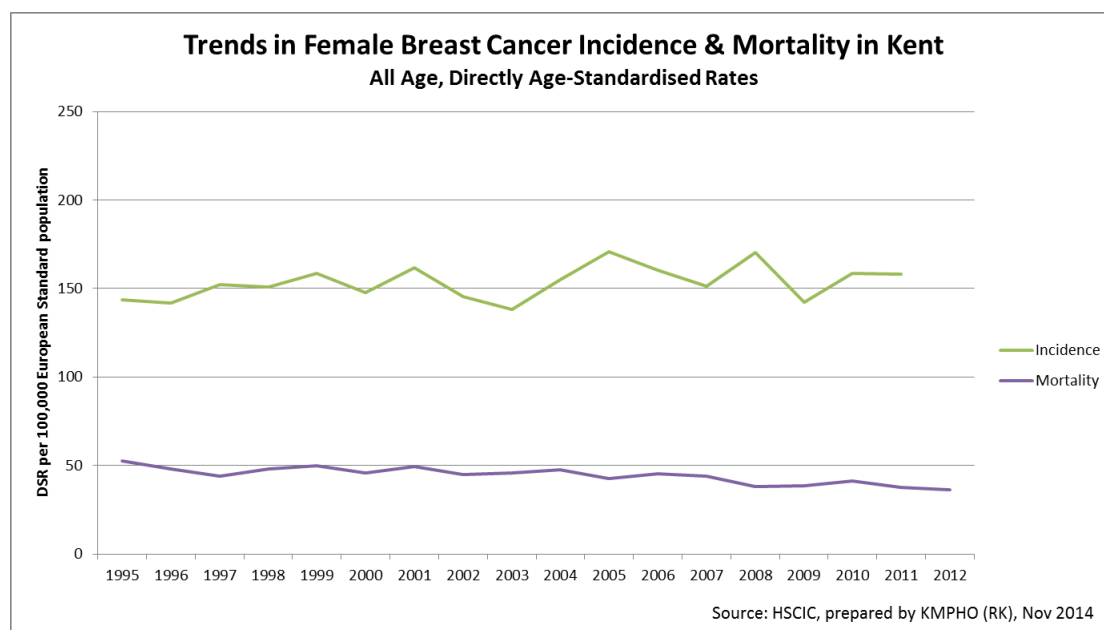
These latest estimates are much higher than previous forecasts of cancer prevalence, mainly because, although incidence has been rising, death rates have continued to fall, leading to better survival. This trend is expected to continue over the coming years as a result of a number of factors, including an ageing population, anticipated effects of population growth, earlier detection of cancer and continued improvements in treatment.

Cancer of the breast, lung, colorectal and prostate together remain the four most common cancers in Kent and Medway and account for about 50% of all cancer diagnosed and deaths from cancer. Lung cancer remains the main cause of death from cancer.

Breast cancer

Whilst the incidence of breast cancer in women increased between 1995 and 2005, there is some evidence to suggest that rates may have now stabilised. Mortality from breast cancer appears to be slowly declining, having decreased by around a third between 1995 and 2012 (from 53 deaths per 100,000 women in 1995 to 36 per 100,000 by 2012). This has in part been directly due to the screening programme and, for the rest, to improvements in chemotherapy and radiotherapy (Figure 1).

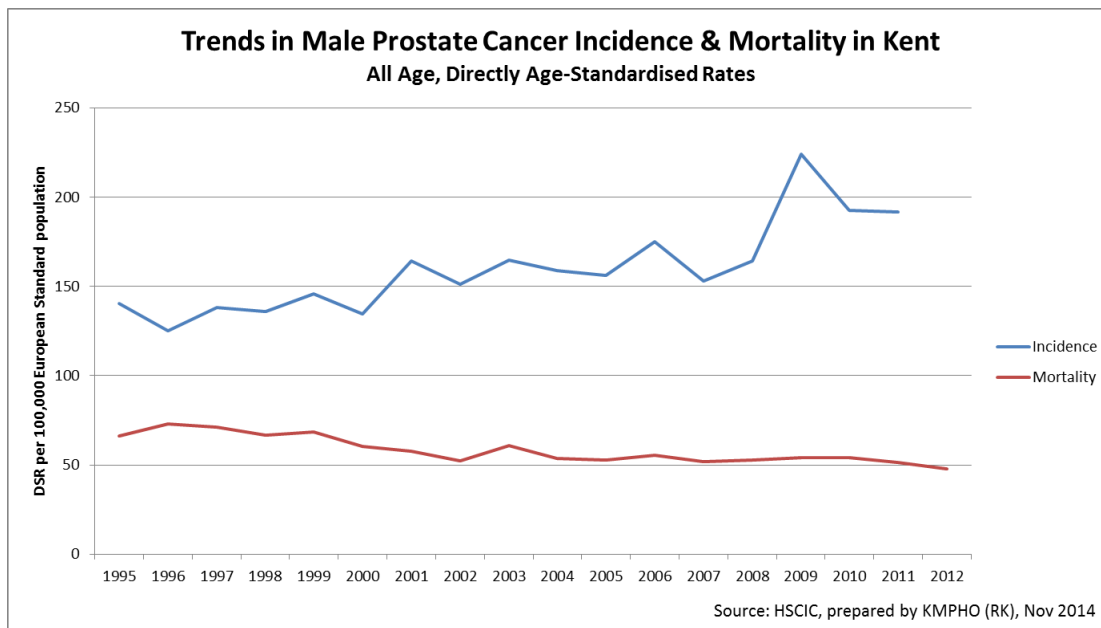
Figure 1:



Prostate cancer

Since 1998, there has been a marked rise in the incidence of prostate cancer, from 136 per 100,000 men in 1998 to 192 per 100,000 men in 2011. Despite this increasing incidence, mortality rates continue to decline, from 67 per 100,000 men in 1998 to 48 per 100,000 by 2012. Much of the increase in incidence both in the UK and in many other countries worldwide can be attributed to incidental detection of prostate cancers following TURP (Transurethral Resection of Prostate) and PSA (Prostate Specific Antigen) testing. (<http://www.cancerresearchuk.org/cancer-info/cancerstats/types/prostate/incidence/uk-prostate-cancer-incidence-statistics>)

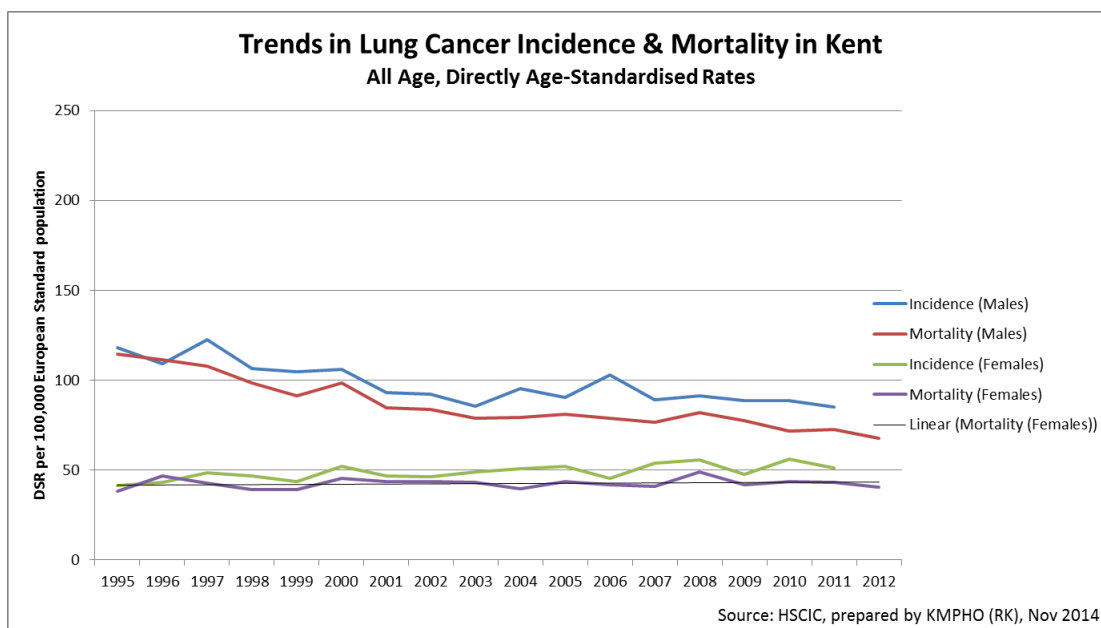
Figure 2:



Lung cancer

Lung cancer remains the most common cause of death from cancer in Kent, with this being true for both men and women (given recent improvements in mortality rates for breast cancer, see Figure 1). Whilst both incidence and mortality from lung cancer appear to be decreasing for men, the incidence of lung cancer amongst women is increasing, and mortality rates remain fairly stable. However, it remains the case that both incidence and mortality for lung cancer are significantly higher for men than women.

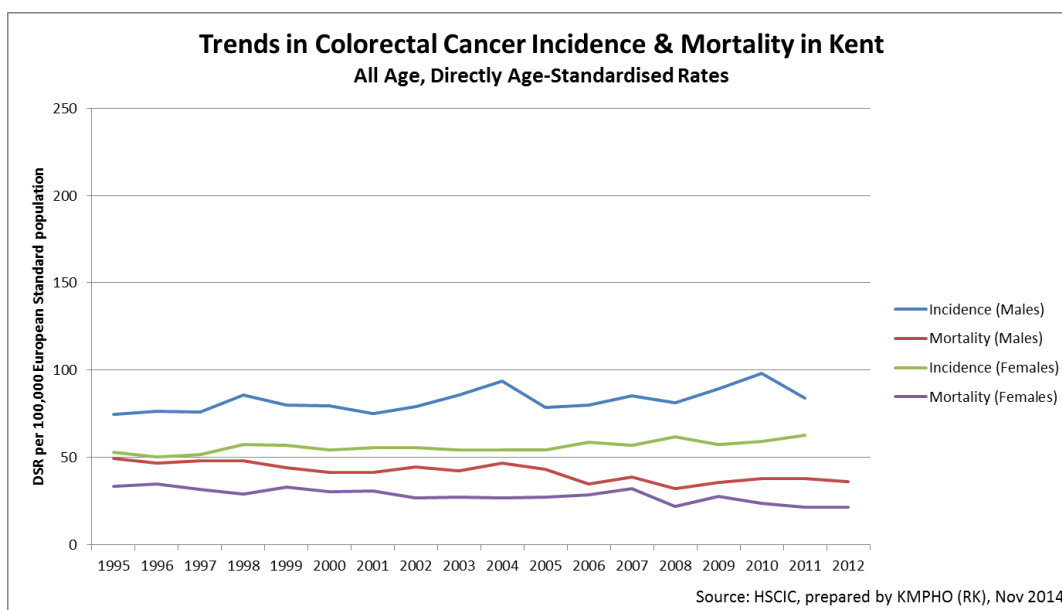
Figure 3:



Colorectal cancer

The long-term trend in the incidence of colorectal cancer continues to show an increase for both men and women, although the incidence rate for men decreased in 2011. In terms of mortality, rates for women appear to be steadily decreasing, with the short term trend for males less clear, potentially suggesting a stabilising of the mortality rate despite the increases in incidence. It remains the case that both incidence and mortality for colorectal cancer are higher for men than women.

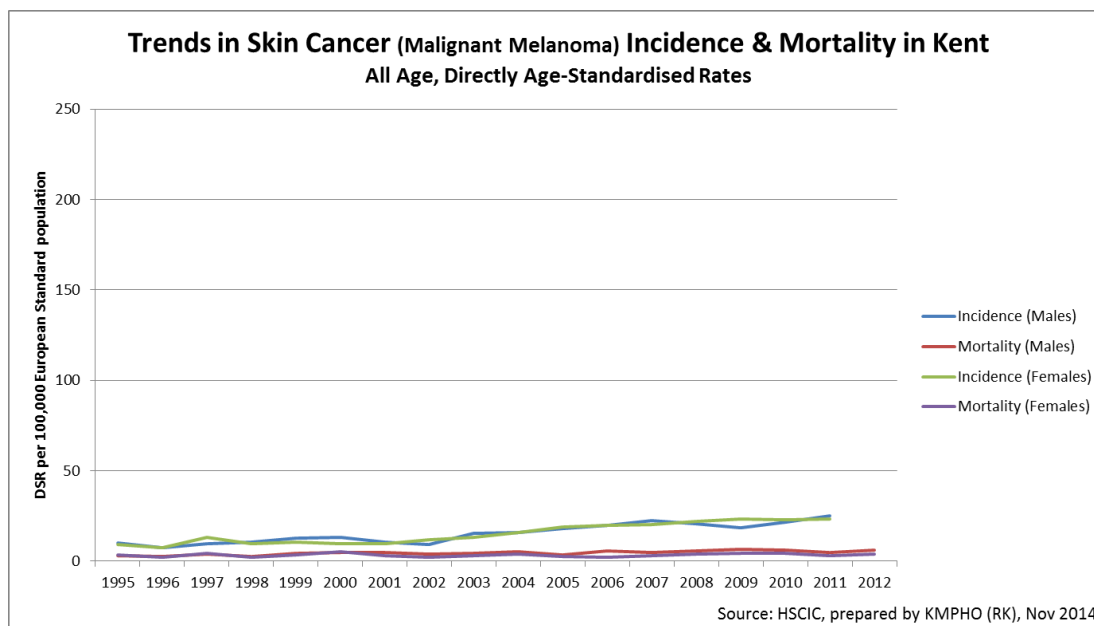
Figure 4:



Skin cancer (malignant melanoma)

The incidence of skin cancer for both males and females continues to rise steeply. Over the 15-year period between 1996 and 2011, age-standardised incidence rates for malignant melanoma in Kent have more than tripled. This rise in skin cancer incidence may be explained by the increased use of tanning salons and sun beds amongst young people. Mortality has also risen, but at a much slower rate. Despite incidence rates being similar for men and women, mortality rates are around 1.5 times higher for men than for women.

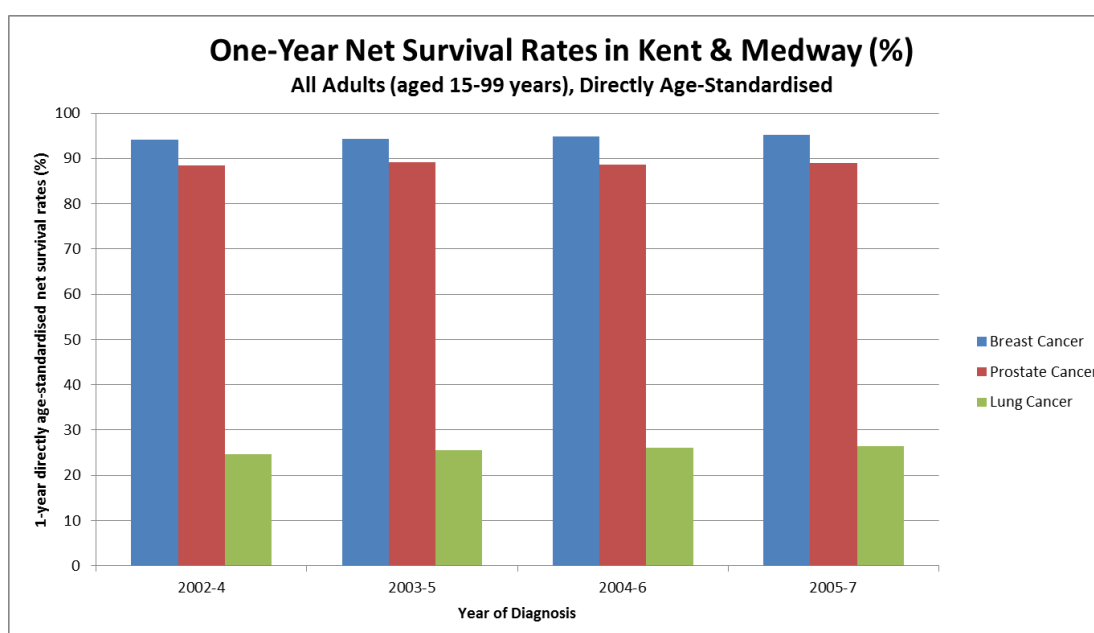
Figure 5:



Survival rates

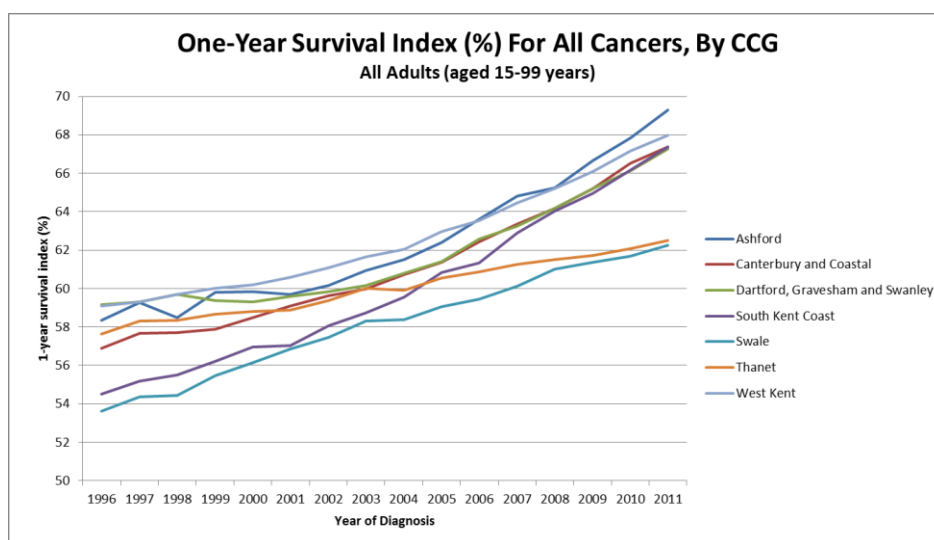
Despite slight year-on-year improvements, one-year survival rates from lung cancer continue to be poor when compared to other cancers (Figure 6). These are a proxy measure of the proportion of patients presenting with late stage disease, as most patients who die within a year of diagnosis have advanced disease at the time of diagnosis, suggesting that delay (by patient, primary care or hospital) in diagnosis and treatment may be an issue. This emphasises the need to increase the public’s knowledge of signs and symptoms of these cancers and to promote earlier presentation.

Figure 6:



Over the last 15 years, there have been significant improvements in Kent in one-year survival rates across all cancers. However, both the overall one-year survival index and the rate of improvement varies markedly across Clinical Commissioning Groups (CCGs) (Figure 7). For patients first diagnosed with cancer in 1996, one-year survival rates were lowest for South Kent Coast and Swale. By 2011, the rate of improvement for South Kent Coast had been such that one-year survival rates had increased to the levels seen in Canterbury and Coastal CCG and Dartford, Gravesham and Swanley, whereas a more modest rate of improvement in Swale has meant that this CCG remains amongst the lowest performing. The rate in improvement in Thanet has been far slower than elsewhere in Kent, resulting in this CCG now having one of the lowest one-year survival rates.

Figure 7:



Current Services in Relation to Need

Preventing cancer

It is estimated that over half of all cancers are preventable. For several major cancers that have well defined risk factors, it should be theoretically possible to reduce incidence and mortality rates everywhere to at least the levels found in the areas with the lowest rates. The majority of cancers can be prevented by adopting healthy lifestyles and refraining from smoking, excessive alcohol consumption and poor diet (See the *Health Intelligence* section of our website on [Lifestyle](#)).

Diagnosing cancer earlier

Late diagnosis of cancer has been a major factor contributing to poor cancer survival in the UK. The earlier a cancer can be diagnosed the greater the chances of a cure. Therefore tackling late diagnosis is crucial to achieving improved outcomes for cancer patients and so it is crucial that people engage with health services at as early a stage of their disease as possible.

Earlier diagnosis can be achieved by:

- ensuring access of eligible people to high quality screening programmes (See *the JSNA chapter on [Screening](#)*). This is explained in detail in another chapter
- raising public awareness of signs and symptoms of cancer
- encouraging people to seek help earlier, facilitating earlier diagnosis of cancer in primary care and prompt referral for treatment in secondary care (explained below).

The National Awareness and Early Diagnosis Initiative (NAEDI) was formally launched in 2008. It seeks to achieve a balance between action and research, as reflected by the four work streams that form its core:

- achieving early presentation by public and patients
- optimising clinical practice and systems
- improving GP access to diagnostics
- research, evaluation and monitoring.

In Kent, funding was approved in late 2010 for a highly targeted social marketing campaign promoting earlier diagnosis and awareness of the signs and symptoms of the biggest cancer killers: breast, bowel and lung cancer. A number of high profile media campaigns were undertaken and distribution of health promotion materials to various sites, such as local pharmacies, GP practices, pubs and sports centres. Social networking sites for the public were used and GP “champions” were recruited to disseminate information across health care professionals.

The following has been extracted from the 2013 South East Coast Strategic Clinical Network (SCN) annual report summarising recent developments across Kent Surrey Sussex (KSS):

- Commissioner engagement:** a commissioner forum was held in September 2013 and provided CCGs with an opportunity to understand the context for cancer commissioning. It agreed the priorities to take forward and has informed the development of the CCG two and five year plans. In addition, the SCN provided guidance to specialised commissioners on derogation issues and provided legacy intelligence on radiotherapy and chemotherapy.
- Clinical engagement:** the SCN has helped facilitate the continuation of the Tumour Site Specific Groups (TSSGs) across Kent, Surrey and Sussex. These groups provide a forum for clinical discussion and patient participation to improve cancer pathways and enable an ongoing link to clinical expertise for advising commissioners. To improve the engagement with primary care clinicians, stronger links have been established with Macmillan GPs who are members of clinical advisory groups (CAGs) in cancer. There are also named contacts in each of the twenty one CCGs across KSS for cancer.
- Patient and public engagement:** a cancer patient forum was held in August 2013. This secured representatives for the Cancer SCN Steering Group and the CAGs. Ongoing support for the previous cancer patient partnership groups is also secured.
- Awareness and Earlier Diagnosis Initiative (AEDI):** as mentioned earlier, this work programme is focussed on achieving increased awareness and

earlier diagnosis of cancer. The SCN has already committed programme monies to work being carried out in three CCGs to complete targeted work. There has also been a review of all AEDI work streams being carried out across all 21 CCGs. The Quality Observatory have been commissioned to produce AEDI dashboards at CCG and GP practice level to identify unwarranted variation in outcomes to enable targeted pieces of work.

- e **Enhanced survival:** this programme is about ensuring patients are as fit as possible before receiving treatment, which increases the chances of a good outcome. The Enhanced Survival Clinical Advisory Group has been established, focussing on optimising patients at the point of cancer treatment. This work in conjunction with the KSS Academic Health Science Network (AHSN) enhanced recovery programme is centred on improving patients' experience, safety and recovery from episodes of illness. The clinical lead for this programme has experience of the AHSN enhanced recovery programme.
- f **Transition from previous cancer networks to the new strategic transformational strategic clinical network (SCN):** The transformational element of the cancer SCN work programme has been developed and shared with all key stakeholders. It has a strategic focus on improving awareness and achieving earlier diagnosis. This shifts the focus to include primary care and requires a significant change in the way primary and secondary care work together in cancer. It provides the greatest opportunity to impact on reducing mortality rates and improve survival from cancer.
- g **Acute oncology:** the acute oncology (AO) project has delivered an understanding of the current service provision for AO across the South East Coast (SEC). It is a priority because it avoids unnecessary hospital admissions and ensures the right treatment is provided in the right place at the right time. The CAG for this work will provide advice to commissioners on how outcomes can best be achieved across Kent, Surrey and Sussex.
- h **Data and intelligence:** CCG level outcome data has been commissioned from the Quality Observatory to produce robust cancer dashboards. Profiles using the Cancer Commissioning Toolkit etc have been compiled. These highlight where there is variation across the CCGs and where attention may need to be focussed in reducing mortality rates. The SCN also provided cancer waiting times advice and expert guidance to the Analytical Service for NHS England during the transition period.

See the [Cancer awareness and early diagnosis CCG dashboard](#)

Projected Service Use and Outcomes in Three-Five Years

As screening programs become more established incidence may increase as well as demand for treatment. An increasing number of people are now surviving cancer or living with it for many years. These survivors have different needs which are not provided by traditional cancer services.

As the population ages and risk factors for specific cancers increase within our population, so the incidence of cancers can be predicted to increase by about one third between 2001 and 2020.

Major inequalities in cancer death rates between rich and poor remain, and may increase if the current trend in lifestyle risk factors, such as obesity, continues.

Evidence of What works

Public Health Outcomes Framework [Helping more people survive cancer](#) (Department of Health and Ellison J 2013)

[Improving Outcomes: A Strategy for Cancer](#) (Department of Health 2011)

[Improving Outcomes: A Strategy for Cancer: Second Annual Report](#) (Department of Health 2012)

Diagnosis and Treatment of Lung Cancer CG121 (National Institute for Health and Care Excellence (NICE) 2011)

Referral Guidelines for Suspected Cancer CG27 (NICE 2011)

Prostate Cancer Diagnosis and Treatment CG58 (NICE 2008)

Early and Locally Advanced Breast Cancer Diagnosis and Treatment CG80 (NICE 2009)

Guidance on Cancer Services: Improving Outcomes in Colorectal Cancers Manual Update (NICE 2004)

Health Economics/cost efficiencies of NAEDI (Department of Health 2011)

Other NAEDI information ([Cancer Research UK 2014](#))

[Cancer Research UK \(2014\)](#)

Department of Health publications

Improving older people's access to cancer treatment services: a report on whether appropriate assessment of older cancer patients would result in better access to cancer treatment (Department of Health 2012)

Cancer Services Coming of Age: Learning from the Improving Cancer Treatment: Assessment and Support for Older People Project (Department of Health 2012)

DH Guidance: The Cancer Drugs Fund: Guidance to support operation of the Cancer Drugs Fund in 2012-13: This document provides guidance to support operation of the Cancer Drugs Fund in 2012-13. It replaces previous guidance for operation of the Cancer Drugs Fund in 2011/12. The Cancer Drugs Fund applies in England only (Department of Health 2012)

Guidance: Commissioning Cancer Services: This best practice document sets out key issues and questions that commissioners and cancer network teams will wish to take into consideration when assessing local health needs and reviewing services, developing their contract service specifications and monitoring performance (Department of Health 2011)

National Institute for Health and Care Excellence (NICE) Publications

Breast cancer

CG164 Familial breast cancer: full guideline (NICE 2013)
Familial breast cancer pathway (NICE 2011)
Early and locally advanced breast cancer pathway (NICE 2011)
Advanced breast cancer pathway (NICE 2011)_

Colorectal cancer

CG131 Colorectal cancer: full guideline (NICE 2011)
CG118 Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas: full guideline (NICE 2011)
Colorectal cancer Pathway (NICE 2011)

Lung

Lung cancer (NICE 2012)

Ovarian cancer

CG122 Ovarian cancer: full guideline (NICE 2011)
Ovarian cancer Pathway (NICE 2012)

Prostate cancer

Prostate cancer Pathway (NICE 2011)

Skin cancer

PH32 Skin cancer prevention: information, resources and environmental changes: guidance (NICE 2011)
Preventing skin cancer Pathway(NICE 2011)

Cochrane database of Systematic Reviews

Screening for breast cancer with mammography (2013)
Screening for lung cancer (2013)
Screening for oesophageal cancer (2012)
Screening for prostate cancer (2013)
Screening for testicular cancer (2011)

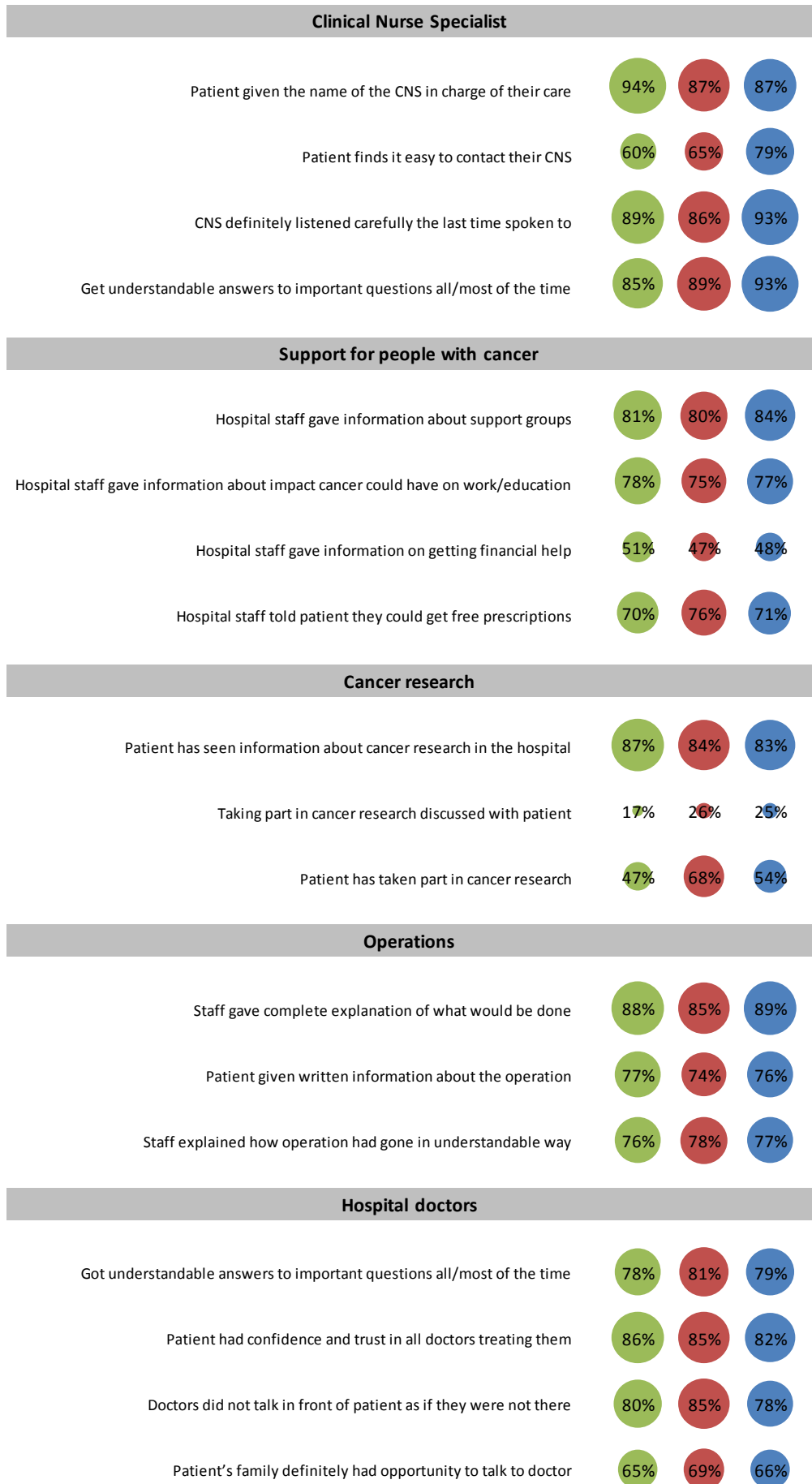
User Views

- a The Cancer Patient Experience Survey (CPES) 2014 is the fourth in the series of surveys begun in 2010, covering all adult patients in active treatment for cancer in England. In 2014 the number of respondents was 70,141 from 153 NHS trusts from a sample of 109,760 (64% response rate). This included responses from the three Kent trusts: Dartford and Gravesham (D&G) (339 responses, 64% response rate), East Kent Hospitals (EKHUFT) (540 responses, 68% response rate) and Maidstone & Tunbridge Wells (MTW) (900 responses, 65% response rate).
- b The chart overleaf provides a summary of the percentage of patients who reported a positive experience across a total of 63 measures included within the 2014 survey, for each of the three Kent trusts.

- c In Kent, cancer patients continue to give positive responses about their treatment and care. Scores of 80% and over across all three Kent trusts have been achieved on questions such as: being given the right amount of information about their cancer; being told sensitively they had cancer; treatment options; tests; support groups; operations; information to support discharge; being seen as soon as was necessary for an initial appointment with a hospital doctor; privacy; confidence and trust in doctors; pain control whilst in hospital; and being treated with respect and dignity.
- d 88-90% of respondents said that their overall care was excellent or very good. However, some scores in the CPES for Kent suggest there may be opportunities for improvement. These include:
- being told about side effects of treatment that might affect the patient in the future (53-58%)
 - being given information on financial help and benefits they might be entitled to (47-51%)
 - having a discussion with staff about taking part in cancer research, and then going on to take part (17-26%)
 - families or someone close to them having the opportunity to talk to a doctor if they wanted (65-69%)
 - patients finding it easy to contact their Clinical Nurse Specialist (particularly for Dartford & Gravesham (60%) and East Kent (65%))
 - there being enough nurses on duty to care for them in hospital (particularly for Dartford & Gravesham (56%) and East Kent (58%))
 - being asked which name they preferred to be called by (45-53%)
 - being able to discuss worries or fears with staff during visit (60-66%)
 - giving families or someone close to them all the information they needed to look after them at home (60-63%)
 - being given enough care and help from health and social services post discharge (60-70%)
 - GPs and nurses at their general practice doing everything they could to support them whilst they were being treated (64-68%)
 - hospital and community staff working well together to give the patient the best possible care (61-66%) and
 - being offered a written assessment and care plan (20-33%).

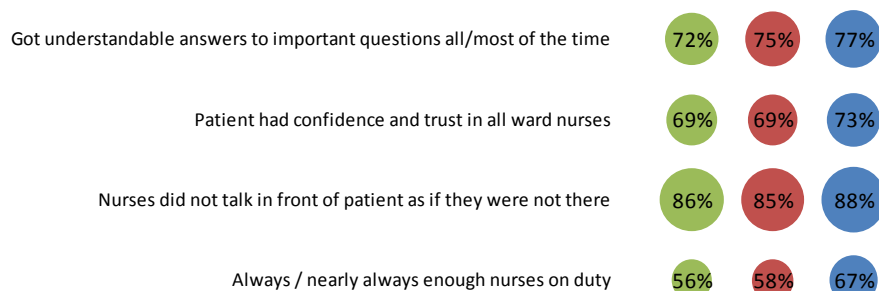
Figure 8

**2014 National Cancer Patient Experience Survey
Kent Trust Results**

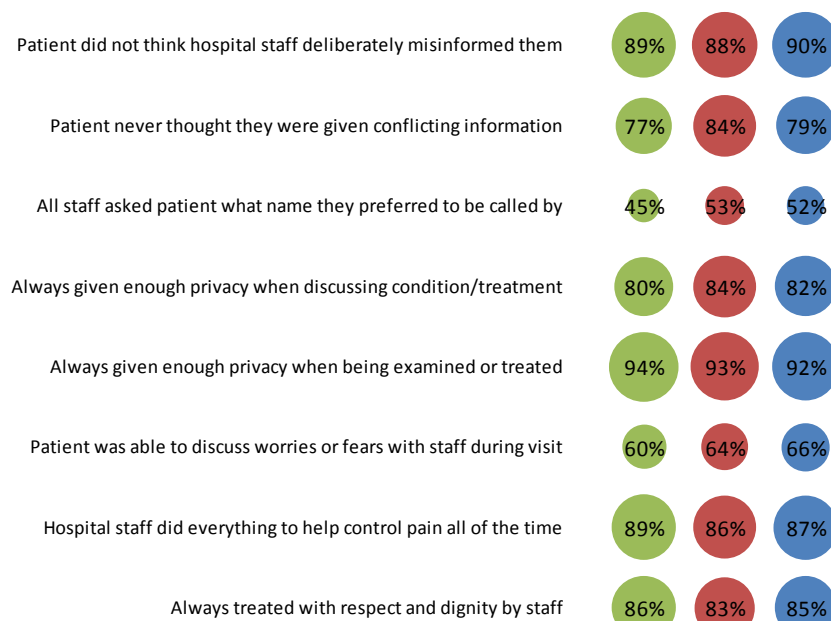


2014 National Cancer Patient Experience Survey Kent Trust Results

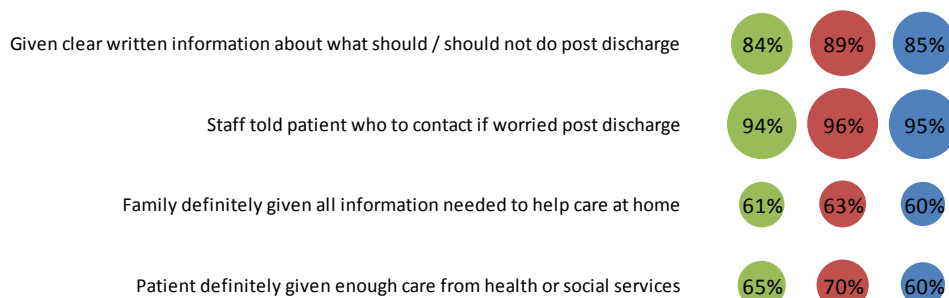
Ward nurses



Hospital care and treatment



Information given to you before leaving hospital and home support



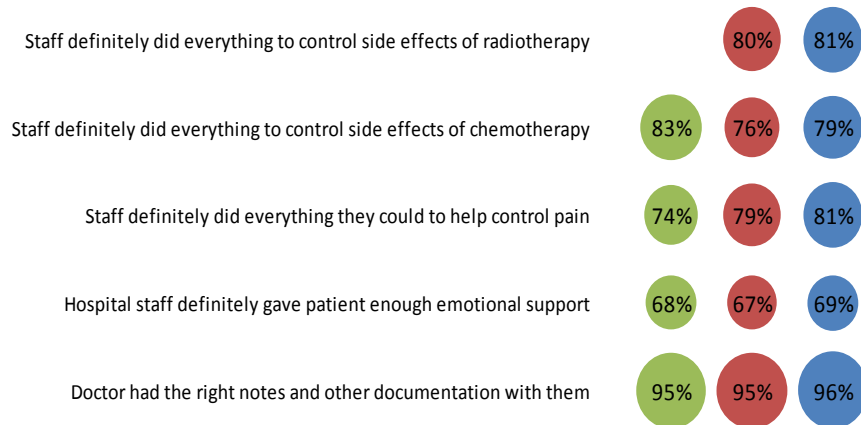
● Dartford & Gravesham
 ● East Kent Hospitals
 ● Maidstone & Tunbridge Wells

Source: 2014 National Cancer Patient Experience Survey, prepared by KMPHO (RK), Nov 2014

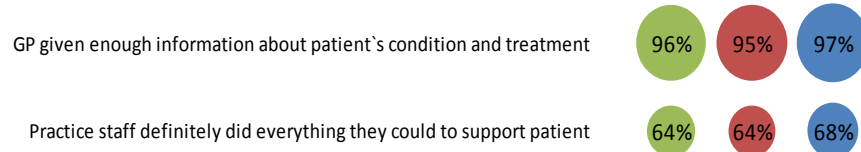
2014 National Cancer Patient Experience Survey

Kent Trust Results

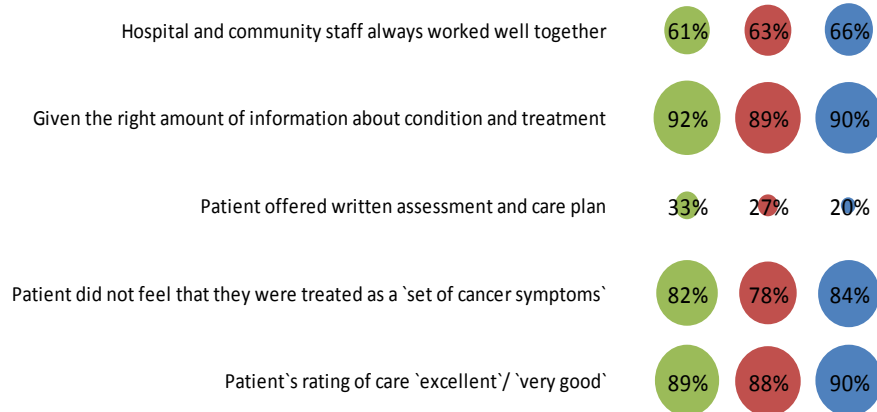
Hospital care as a day patient / outpatient



Care from your general practice



Your overall NHS care



● Dartford & Gravesham
 ● East Kent Hospitals
 ● Maidstone & Tunbridge Wells

Source: 2014 National Cancer Patient Experience Survey, prepared by KMPHO (RK), Nov 2014

To view the full version of the national survey results or the results for each Kent trust please click on the icon below.



Table 1

Tumour Group	Dartford & Gravesham	East Kent Hospitals	Maidstone & Tunbridge Wells
Breast	90	102	213
Colorectal/Lower Gastrointestinal	60	55	112
Lung	31	36	35
Prostate	22	60	110
Brain/Central Nervous System	1	0	4
Gynaecological	5	54	108
Haematological	73	114	140
Head and Neck	0	16	21
Sarcoma	0	4	5
Skin	1	21	1
Upper Gastrointestinal	12	23	61
Urological	32	44	60
Other	12	11	30

Unmet Needs and Service Gaps

The following headline comparisons have been taken from the Quality Observatory spreadsheet ([Cancer CCG Dashboard](#)). Rates have been reported per 100,000 population across KSS CCGs based on 2012-13 data:

Waiting time

- Canterbury and Coastal CCG had the highest two week wait referral rate per 100,000 population across all KSS CCGs.
- Thanet CCG has the second highest two week wait conversion rate towards cancer diagnosis.

Access to diagnostic investigations

- West Kent CCG has a slightly lower percentage of X rays accessed via GP direct access than the SEC and England average. Swale has the highest percentage among all CCGs, well above regional and national average.
- All four East Kent CCGs have rates well above access to brain MRI scans via GP direct access compared to the rest of the KSS CCGs.
- Thanet and South Kent Coast CCGs have the lowest and highest percentage referrals for abdomino-pelvis ultrasound scans via GP Direct access respectively among Kent CCGs.

Screening (uptake rates are shown in the [screening chapter](#))

Practices shown are those included in the 2013 CCT Practice Profiles.

Emergency Admissions for Cancer

- Thanet CCG has the second highest emergency admissions rate for cancer.

Under 75 Mortality Rates for Cancer

- Thanet and Swale CCGs have the highest compared to the other CCGs, well above the regional and national rates.

Staging at Time of Diagnosis

- West Kent CCG has the highest rates of completeness, above the national and regional averages.
- Swale and Canterbury CCGs have the lowest and highest proportion of cancer stage 1 and 2 diagnoses respectively across Kent.

Recommendations for Commissioning

The following represents suggested recommendations for service improvement as outlined by the KSS SCN based on extensive stakeholder engagement:

See the [South East Coast- Strategic Clinical Network for Cancer - Plan on a Page 2014-18](#)

Key Contacts

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References

Cancer Research UK <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/prostate/incidence/uk-prostate-cancer-incidence-statistics>

Public Health Outcomes Framework [Helping more people survive cancer](#)

Department of Health (2011) [Improving Outcomes: A Strategy for Cancer](#)

[Improving Outcomes: A Strategy for Cancer - Second Annual Report](#) has now been published. (11/12/2012)

National Institute for Clinical Excellence (NICE)

[Diagnosis and Treatment of Lung Cancer](#) (CG121, April 2011)

[Referral Guidelines for Suspected Cancer](#) (CG27 June 2005, updated April 2011)

[Prostate Cancer Diagnosis and Treatment](#) (CG58 February 2008)

[Early and locally Advanced Breast Cancer Diagnosis and Treatment](#) (CG80 February 2009)

[Guidance on Cancer Services: Improving Outcomes in Colorectal Cancers Manual Update](#) (2004)

Health Economics/cost efficiencies of NAEDI

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

Other NAEDI information <http://info.cancerresearchuk.org/spotcancerearly/naedi/local-activity/social-marketing/Lung-cancer-projects/>

<http://info.cancerresearchuk.org/spotcancerearly/naedi/local-activity/getting-results/>

Department of Health Publications

Improving older people's access to cancer treatment services 20/12/12 A report on whether appropriate assessment of older cancer patients would result in better access to cancer treatment. <https://www.gov.uk/government/publications/improving-older-peoples-access-to-cancer-treatment-services>

Cancer Services Coming of Age:

Learning from the Improving Cancer Treatment: Assessment and Support for Older People Project (Dec 2012)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213205/DH_Macmillan_Age-UK_Report_Final.pdf

DH Guidance: The Cancer Drugs Fund: Guidance to support operation of the Cancer Drugs Fund in 2012-13

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Guidance: Commissioning Cancer Services DH, 25/7/11 This best practice document sets out key issues and questions that commissioners and cancer network teams will wish to take into consideration when assessing local health needs and reviewing services, developing their contract service specifications and monitoring performance. <https://www.gov.uk/government/publications/commissioning-cancer-services>

National Institute for Health and Care Excellence

Breast Cancer

[CG164 Familial breast cancer: full guideline](#) Published 25/06/2013
[Familial breast cancer pathway](#) Published 26/10/2011
[Early and locally advanced breast cancer pathway](#) Published 09/05/2011
[Advanced breast cancer Pathway](#) Published 09/05/2011

Colorectal Cancer

[CG131 Colorectal cancer: full guideline](#) Published 09/11/2011
[CG118 Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas: full guideline](#) Published 23/03/2011
[Colorectal cancer Pathway](#) Published 09/11/2011

Lung

[Lung cancer Pathway](#) Published 30/03/2012

Ovarian Cancer

[CG122 Ovarian cancer: full guideline](#) Published 27/04/2011
[Ovarian cancer Pathway](#) Published 01/02/2012

Prostate Cancer

[Prostate cancer Pathway](#) Published 25/10/2011

Skin Cancer

[PH32 Skin cancer prevention: information, resources and environmental changes: guidance](#)
Published 26/01/2011
[Preventing skin cancer Pathway](#) Published 25/10/2011

Cochrane Database of Systematic Reviews

[Screening for breast cancer with mammography](#) Published 04/06/2013

<http://www.cancerscreening.nhs.uk/bowel/>

Screening for lung cancer Published 21/06/2013
Screening for oesophageal cancer Published 12/12/2012
Screening for prostate cancer Published 31/01/2013
Screening for testicular cancer Published 16/02/2011