

# JSNA: Cancer

## Introduction

After circulatory disease, cancers account for the largest numbers of deaths each year in Bolton. Around 650 deaths each year in Bolton are attributed to cancer, which accounts for just over a quarter of all local deaths. Digestive cancers and lung cancer are the most significant cancers when we consider mortality in Bolton, accounting for around 180 and 170 deaths respectively. Regarding the main gender specific cancers, breast cancer accounts for 12% of all female cancer deaths, and prostate cancer accounts for 11% of all male cancer deaths. In general, cancer mortality rates are similar to the national average; however, lung cancer mortality is the exception, being much higher in Bolton than seen nationally.

Approximately 1,350 new cases of cancer are diagnosed each year in Bolton. The most commonly diagnosed cancers are lung, breast, bowel, and prostate – and these account for over half of all cancer deaths. However, these cancers vary in the likelihood of mortality following diagnosis with bowel cancer the lowest, breast and prostate follow with a similar risk, and finally lung cancer is significantly the highest. In addition, due to its association with deprivation (smoking rates being much higher in more deprived population groups) lung cancer is one of the main causes of the gap in life expectancy between Bolton and England, as well as within Bolton itself. In the future, we can expect skin cancer to become more prominent as it is increasingly accounting for more new local cases of cancer; it does however have a very low mortality rate.

Finally, it is wrong to assume that cancer has had more than its fair share of the growth in NHS funding in recent years as it still only accounts for 6.1% of the NHS budget nationally (6.7% in Bolton) and this has remained static for several years. Its importance is reflected in the fact that survival rates following diagnosis remain poor and that earlier diagnosis could save thousands of lives nationally each year. It is also important to note that cancer should not be considered a secondary or tertiary issue that has little to do with primary and community care – rather, primary care plays a major role in early diagnosis, ongoing support, and end of life care for cancer patients. Finally, many interventions with the greatest impact are highly cost effective (e.g. smoking cessation, screening, early diagnosis campaigns, surgery, radiotherapy, and some curative chemotherapy). However, it is true that some chemotherapy given at the end of life is much less cost effective. Whilst being cost effective, upstream interventions (screening, early diagnosis, and primary treatment) can make the difference between a long life and an early death<sup>1</sup>.

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<sup>1</sup> Cancer Commissioning Toolkit (2013)

## Implications for commissioning

### Investment priorities

1. Investment should be made in earlier diagnosis. This should include public awareness campaigns, ensuring equitable access to existing screening programmes for all who can benefit, improving access to lower gastrointestinal endoscopy (e.g. flexible sigmoidoscopy and colonoscopy) for patients with bowel symptoms, and improving access to chest X-Ray (lung cancer) and ultrasound (especially pelvic ultrasound for ovarian cancer). Preparations should also be made for flexible sigmoidoscopy screening – this has been shown to prevent cancer and to be cost saving;
2. Ensure that capacity exists to cater for the extension of the screening programmes currently running in Bolton. All eligible people should have the opportunity to be screened and in a timely fashion with Dignity and Respect ensured throughout the screening process (i.e. adequate changing facilities, pleasant environment, choice where appropriate). Ensure prompt follow-up of screening issues, adequately funded with appropriate psychological/social support as required;
3. Prevention activities to reduce the prevalence of smoking and inhalation of second hand smoke, improvements in diet and halting the increase in levels of obesity are key to reducing cancer incidence and mortality rates in Bolton. Continue awareness campaigns into the dangers of sunbed use and the need for methods of sun protection and the links to skin cancer – incidence of which is projected to increase into the future;
4. Commission appropriate diagnostic capacity, especially in endoscopy. Treatment capacity should be such that there are no delays in chemotherapy, radiotherapy, and surgical interventions;
5. Staging is now a duty for Multi-Disciplinary Teams (MDTs) to record. In time this will enable improved monitoring of local services, a more accurate picture of cancer in Bolton, and permit the evaluation of local cancer preventative work by enabling equity audit work across key equality groups;
6. Monitor the number of new cancer patients presenting as emergencies and incentivise reductions;
7. Reduce emergency admissions of existing cancer patients through funding of proactive support including acute oncology services. Properly funded and supported acute oncology services give patients better experience and does keep patients out

- of hospital beds/reduces hospital stays. Also ensure prompt treatment from experienced staff in cases of neutropenic sepsis;
8. Promote uptake of enhanced recovery programmes for elective cancer surgery. However, these programmes are not in isolation and funds are needed to ensure patients are supported for admittance on same day as surgery as well as appropriate support in the community after discharge;
  9. Continue monitoring of inequalities in uptake of screening and target promotion in response to this;
  10. Further investment in psychological support for cancer patients and their families. If support is given early enough then more expensive psychological intervention may be avoided and patients better supported can mean improved self-management and fewer hospital admissions.

### Disinvestment

1. Reduce emergency admissions by providing better proactive support (e.g. for patients on chemotherapy) and ambulatory services (e.g. for symptom control);
2. Increase day case or single overnight stay surgery (e.g. for breast cancer);
3. Reduce lengths of stay through introduction of enhanced recovery programmes (e.g. for colorectal, urological, and gynaecological cancer surgery);
4. Reduce follow up through promotion of supported self-management following primary treatment.

## Who's at risk and why?

### Fixed risk factors

Age and gender are the two most important fixed risk factors for cancer. Cancer incidence and mortality increases with age; for example, males 75 years or older are most likely to die from cancer than any other group. Men are more likely to die from cancer than women, although the gender gap in cancer incidence has reduced. The overall trend for both cancer incidence and mortality is downwards for men in Bolton. In contrast, cancer incidence shows a slight increase for women in Bolton.

Genetic predisposition and family history are two other fixed risk factors that are important in the development of some cancers.

### Modifiable risk factors

Smoking is the single largest preventable risk factor for cancer, especially given the high mortality rate of lung cancer. Approximately 84% of lung cancer deaths are attributable to

smoking/passive smoking. Smoking is also a risk factor for other cancers, including mouth, throat, liver, pancreas, stomach, kidney, bladder, leukaemia, lymphoma, and cervical.

Other reversible risk factors for cancer include: alcohol, high fat intake, low fruit and vegetable diet, obesity, lack of exercise, and exposure to ultraviolet light. Air pollution and occupational exposure to certain dusts and materials are also risk factors.

### Lung cancer

In the majority of cases lung cancer is caused by cigarette smoking. Although some people may get lung cancer that have never smoked, in 84% of cases smoking is the cause. Other risk factors include exposure to radon gas, exposure to certain chemicals (asbestos etc.), and air pollution – but these present a far lower risk than smoking<sup>2</sup>.

### Bowel cancer

The single biggest risk factor for bowel cancer is age with 85% diagnosed in people aged 60 or over. However, many bowel cancers may be prevented by changes in diet and lifestyle. A high intake of dietary fibre (cereal and whole grains) reduces bowel cancer risk, while eating red and processed meat increases risk. Other factors interact with dietary factors to increase bowel cancer risk including drinking alcohol, being obese, and taking little or no exercise.

### Breast cancer

Most of the risk factors for breast cancer relate to a woman's reproductive history such as an early first period, a late first pregnancy, low parity, and a late menopause. Using oral contraceptives, having hormone replacement therapy (HRT), being obese, and drinking alcohol can also increase the risk. Women with a strong family history of breast cancer are also at increased risk<sup>3</sup>.

### Prostate cancer

Prostate cancer is quite rare in men under 50, while over half of all cases are diagnosed in men over 70, and so age is a risk factor. Other factors include family history, having had bowel cancer, being of Black ethnicity, and diet.

## The level of need in the population

### The contribution of cancer to the life expectancy gap

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<sup>2</sup> Cancer Research UK (2013)  
[www.cancerresearchuk.org](http://www.cancerresearchuk.org)

<sup>3</sup> Cancer Research UK (2013)  
[www.cancerresearchuk.org](http://www.cancerresearchuk.org)

Premature lung cancer mortality contributes 8.4% to our male life expectancy gap to England and 6.8% to our female gap. For men this is second only to CHD (17.3% of the gap) and stroke (9.4%) and for women follows CHD, stroke, other CVD, and pneumonia. Lung cancer is certainly the most significant cancer to address regarding our gap to England; the other major cancers are not significant contributors to the gap, if contributing at all.

## All cancers

The mortality rate for all cancers in Bolton fluctuates somewhat annually but is generally lower than that of the rate for the North West but higher than the national average. Both genders show a downward mortality trend since 1993, which is in line with the national picture. For cancer mortality Bolton is better than average for its statistical peer group, and is around average for premature cancer mortality (aged <75 years). There persist significant inequalities in Bolton regarding cancer, with those living in Bolton's most deprived neighbourhoods having SMRs twice that of lesser deprived neighbourhoods. The National Cancer Action Team (NCAT)<sup>4</sup> report that 10,000 deaths per year in England could be prevented if survival following diagnosis matched the best in Europe.

Nationally, cancer incidence is rising. There are currently 265,000 new cases each year in England and this is expected to rise to 300,000 by 2030. Locally, incidence in Bolton men is lower than the regional average but higher than that seen nationally. Whilst fluctuating, the rate for Bolton women is generally higher than both the regional and national average. Nationally, cancer services and outcomes have improved over the past 10-15 years, with much of the improvements being made in the hospital sector (Multidisciplinary Teams etc.). Despite this, survival for many cancers remains poor in comparison with other developed countries. Though incidence is rising, late diagnosis is the major factor underlying the poor survival rates in England.

Primary Care registers (QOF) collect the prevalence of all cancers in the population. In 2010/11, there were 4,143 patients on the cancer register in Bolton, a prevalence of 1.4%. This compares to 1.6% for both the North West and England. When most recently calculated by NHS Comparators, the ratio of reported against expected prevalence for the cancer register was 1.5; this means there are likely to be additional cases in Bolton not currently on the register – by not having their condition identified these cases are at risk of becoming an emergency admission or only diagnosed later when their performance status (condition/fitness for particular interventions) is unsuitable for the more effective treatments. This contributes to the higher mortality rates for particular cancers that we see in Bolton compared to the national average.

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<sup>4</sup> Cancer Commissioning Toolkit (2013)  
[www.cancertoolkit.co.uk](http://www.cancertoolkit.co.uk)

As mentioned above, the main cancers in Bolton are lung, bowel, breast and prostate.

### Lung cancer

Whilst the national mortality rate for lung cancer has been declining over past couple of decades, the rate in Bolton remains fairly static. Whilst the male rate is still higher in Bolton, the stasis we see in the trend is primarily due to the locally increasing female mortality rate. In comparison, the female rate is quite stable nationally and regionally. At present the male mortality rate is 10% higher than England and the female rate is 36% higher. The mortality gap between Bolton and England widens further for premature lung cancer mortality (30% higher rate for men; 50% higher for women). In 2010, 82 men and 89 women died of lung cancer in Bolton – this is a change from the historic picture of lung cancer and, though the direction of the rates have suggested it for several years, this is the first time more women than men have died of the condition in Bolton. Due to the close association of smoking and deprivation, lung cancer has one of the strongest inequality gaps of the cancer types in Bolton with the most deprived areas having the highest SMRs. This maps across the geography of Bolton where more deprived areas such as Brightmet, Crompton, and Farnworth have a 65% higher mortality rate than England, compared to others such as Bradshaw, Bromley Cross, and Heaton which have rates up to 70% lower than England.

Incidence rate trends for cases of lung cancer are relatively stable with decreases in the male rate but increases in the female rate, to the extent that the male rate is 21% higher than average for England compared to the female rate which is 33% higher. During the 2007-09 period, there were on average 201 new cases each year (108 men, 93 women). The pattern of hospitalised prevalence of lung cancer across Bolton is strongly associated with patterns of smoking and deprivation and is in excess of 110% higher than England in the areas of Brightmet, Lower Deane & The Willows, and the Town Centre. For both genders incidence is more common for those of White ethnicity, but is especially high in White men. Survival is increasing in Bolton at both one and five years, and is consistent with the Greater Manchester and Cheshire Cancer Network (GMCCN) picture. Approximately 8.0% of people diagnosed with lung cancer in the GMCCN survive for five or more years after diagnosis; this compares to 7.8% nationally and 10.3% for the highest performing Cancer Network (West London). With such a low figure being the highest percentage nationally, survival in general can be said to be very poor for lung cancer.

### Bowel (colorectal) cancer

Mortality from bowel cancer is gradually declining in Bolton, regionally, and nationally. Current mortality rates in Bolton are below that of the North West and England. Men in Bolton continue to have a higher mortality rate than women; over recent years on average 67 deaths have been attributed to bowel cancer (40 male, 27 female).

Incidence rates in men are higher than women in Bolton but the trend shows a slightly declining trend for men and an increasing trend for women. On average, in recent years, approximately 169 new cases of bowel cancer have been found each year in the Bolton population. Geographically, high rates are seen in areas of Bolton that are at both ends of the deprivation scale. People of White ethnicity are more likely to be diagnosed with bowel cancer than those of South Asian descent. This may be a result of lower uptake of bowel cancer screening (and so a lower diagnosis rate) amongst the South Asian population as only half are likely to take up the screening offer, and this falls to a quarter for Muslims. Survival in Bolton is increasing at both one and five years, and this is consistent with the GMCCN picture. In the GMCCN 49.2% of people diagnosed with bowel cancer survive for five or more years after diagnosis; this compares to 50.6% nationally and 58.7% for the highest performing Cancer Network (Dorset).

### Breast cancer

Breast cancer is by far the most common cancer seen in women in the UK. A large proportion of cases are detected through routine screening of women aged 50-70. Mortality from breast cancer has fallen in the UK since the introduction of screening in 1988 – this fall is due in part to earlier diagnosis and in part to improved treatment.

After lung cancer, breast cancer is the second most common cause of death from cancer. Mortality rates in Bolton women from breast cancer are lower than the regional and national averages as the declining trend in recent years has shown. The same is also true for premature breast cancer mortality (<75 years). There are approximately 40 breast cancer deaths each year in Bolton.

In the UK approximately one in nine women will develop breast cancer at some point in their lives. Over the past couple of decade's breast cancer incidence has increased as screening methods and coverage have improved and more cases are being diagnosed. The trend for Bolton is very similar to that of the region and England as a whole. Approximately, 200 new cases of breast cancer are diagnosed in Bolton each year. There appears to be no association between breast cancer prevalence and deprivation. The areas of Bolton with a higher proportion of South Asian residents show some of the lowest local prevalence rates. Survival rates are high for breast cancer with 83.3% of women in the GMCCN surviving five years after diagnosis; this compares to 82.9% nationally and 87.2% for the highest performing Cancer Network (Surrey, West Sussex & Hampshire).

### Prostate cancer

Prostate cancer is now the most common form of cancer seen in males in the UK.

Whilst erratic, the mortality rate is generally lower than the regional and national average. In recent years, it has accounted for less than 40 annual deaths in Bolton men.

Trends in the incidence of prostate cancer show an upward trend over the past couple of decades in Bolton, which is generally in line with the regional and national picture. Approximately 140 new cases of prostate cancer are diagnosed each year in Bolton. There seems to be no association between deprivation and the prevalence of prostate cancer. However, the most deprived group, while having a similar incidence rate, do have a lower survival rate. Survival rates are high for prostate cancer with 80.4% of men in the GMCCN surviving five years after diagnosis; this compares to 78.8% nationally and 85.2% for the highest performing Cancer Network (Pan Birmingham).

### Skin cancer

The incidence of skin cancer has grown substantially in recent years and the increase in Bolton has been faster than seen regionally and nationally. The most recent year saw over 400 new cases of skin cancer in Bolton with more observed in men (227 compared to 182 women). Bolton is higher than average for its statistical peers and many of its peer local authorities have rates below the national average. Bolton receives fewer hours of sunshine than is average for England, but the town has a much higher sunbed outlet density. Lesser deprived areas such as Over Hulton, Daisy Hill, Westhoughton East, Turton, and Egerton & Dunscar have the highest incidence rates locally. Skin cancer has a very low mortality rate.

### Cancer mortality changes in recent years

The rate of all cancer mortality in Bolton for those aged under 75 between 1995-97 and 2008-10 has decreased by over 20%, which puts Bolton amongst the most significant group of areas in the North West for this change. However, the female rate has only reduced between 10%-20% over the same period. Bolton has made less of an improvement compared to the North West for lung cancer mortality, only decreasing between 10%-20% over the same period. There is a real split between the genders for lung cancer in Bolton, where the male rate has reduced by over 20% while the female rate has actually increased over this period (by less than 10%). Changes in both breast cancer and prostate cancer mortality fall into the highest 20% decrease group of the North West local authorities. In line with the majority of North West areas, colorectal cancer mortality has decreased by over 20% over the period.

### Key JSNA Indicator Sheets

[MORTALITY: Cancer](#)

[MORTALITY: Lung Cancer](#)

MORTALITY: Colorectal Cancer

PREMATURE MORTALITY: Cancer

PREMATURE MORTALITY: Lung Cancer

DISEASE AND ILL HEALTH: Cancer

DISEASE AND ILL HEALTH: Lung Cancer

DISEASE AND ILL HEALTH: Colorectal Cancer

DISEASE AND ILL HEALTH: Breast Cancer

DISEASE AND ILL HEALTH: Prostate Cancer

DISEASE AND ILL HEALTH: Skin Cancer

## Current services in relation to need

Healthy lifestyle changes can help prevent more than half of all cancers, with stopping smoking being the most significant. Lifestyle behaviours are discussed in more detail in other chapters.

Early diagnosis and treatment is vital to improved survival rates from cancer. Screening programmes provide an opportunity to early diagnose those populations potentially at risk of developing cancer who may already have an undiagnosed cancer. The National Screening Committee, based on evidence from clinical trials, have criteria set out for which populations will benefit most from screening programmes.

### Breast cancer screening

Early diagnosis can have a major impact on breast cancer survival; as such, breast screening works by identifying breast cancers at an earlier stage when treatments are more effective. The NHS Breast Cancer Screening Programme provides screening every three years for all women aged 50 and over. Women aged 50-70 are invited for screening on seven occasions, whilst women over 70 years of age may opt in for further screening. The age group will be widened to 47-73 in 2012, with all women guaranteed a first screening by age 50. Take up of breast cancer screening in Bolton is very similar to the regional and national average. In 2002 the WHO's International Agency for Research on Cancer (IARC) concluded that mammography screening for breast cancer reduced mortality. The IARC working group, comprising 24 experts from 11 countries, evaluated all the available evidence on breast cancer screening and determined there to be a 35% reduction in mortality from breast

cancer among screened women aged 50-69 years of age. This means that for every 500 women screened, one life will be saved<sup>5</sup>.

As of March 2011 Bolton has 76.1% breast screening programme coverage. This is based on 21,211 covered women from 27,885 eligible women in the borough.

Though there is no clear association between breast cancer prevalence and deprivation there is a clear difference when we consider treatment for the condition. The affluent breast cancer patients are more likely to have a screen-detected breast cancer, while the most deprived patients have a higher mastectomy rate and receive less immediate reconstruction<sup>6</sup>; 48% of the most deprived having a mastectomy compared to 40% of the most affluent, and 34% of the most deprived having immediate reconstruction compared to 43% of the most affluent. Concerning tumour characteristics, patients in the most affluent quintile had better prognosis tumours with 39% having tumours greater than 20mm (compared to 44% for the most deprived), 38% were node positive (compared to 41% in the most deprived), and 35% were classed Grade 3 (compared to 39% in the most deprived). Furthermore, the national picture shows that the most affluent breast cancer patients have a younger age profile; this, coupled the higher screen-detected breast cancer compared to the most deprived group, suggests that more affluent women exercise their right to self-refer for breast screening.

Elderly breast cancer patients are less likely to receive surgical treatment or radiotherapy than younger patients. Although women aged over 70 may self-refer for the screening service, as discussed above, only 9% of breast cancers nationally in patients aged over 70 were screen-detected. However, those with screen-detected cancers had a higher proportion of breast conserving surgery (71%) than those who presented with symptoms (40%).

### Cervical cancer screening

Cervical screening is not a test for cancer, but a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in the cervix. Early detection and treatment can prevent 80-90% of cancers developing<sup>7</sup>. Cervical cancer is caused by Human papillomavirus (HPV); this virus is more common in younger women than older women and is rarely detected in those with no previous sexual activity. Risk factors for HPV infection include number of sexual partners, a relatively recent new sexual relationship, and a history of previous miscarriage<sup>8</sup>. Women aged between 25 and 64 are entitled to a

<sup>5</sup> NHS Information Centre (2013) *The Indicator Portal*, Department of Health.

<sup>6</sup> National Cancer Intelligence Network (2013)

[www.ncin.org.uk](http://www.ncin.org.uk)

<sup>7</sup> NHS Information Centre (2013) *The Indicator Portal*, Department of Health.

<sup>8</sup> Cancer Research UK (2013)

cervical screening test every 3-5 years. Screening is offered at different intervals for different age groups, backed up by evidence of its effectiveness. For instance, those aged 25-49 are screened every three years and those aged over 50 screened every 5 years. Screening coverage in Bolton, as of March 2011, is similar to the national average for women aged 50-64 years at 77.7%, with 17,207 women covered from 22,140 eligible women. A similar picture is seen for women aged 25-64 years with 78.3% coverage in Bolton (55,880 covered women from 71,351 eligible women).

### Bowel cancer screening

This programme of screening began in February 2007 and provides a screening service every two years to both sexes aged between 60 and 69 years. In October 2010 this was extended to people aged up to 75 years. Screening coverage in Bolton is currently slightly lower than seen nationally with 56% of people taking a screening test, compared to over 58% nationally.

### Diagnosis route

In the GMCCN, 25% of all cancers are diagnosed through the emergency route; this is slightly higher than the national average (23%). Diagnosis of new cancers through the emergency route should be reduced as cancers identified earlier are more susceptible to curative treatment. Diagnosis route does vary by cancer type with lung most likely to come through emergency admissions (38% compared to the same at 38% of all national lung cancer diagnoses). The GMCCN does have a higher rate of breast cancer diagnoses coming through the emergency route (6% compared to 4% nationally), but breast cancer is split by screening (20%), two week wait (38%), GP referral (13%) and other outpatient (13%). Colorectal cancer is very unlikely to be diagnosed through the emergency route (1%). Finally, prostate cancer is diagnosed in 11% of cases through emergency in GMCCN (compared to 9% nationally), with 44% coming through GP referral (compared to 38% nationally).

### Other gaps

Poor lymphoedema service provision in Bolton and Greater Manchester for cancer patients. This needs to be addressed to avoid patients suffering unnecessarily and keeping them more active and able to control symptoms. Some small provision in Greater Manchester for breast patients but other cancers not provided with service.

Many Bolton patients could have their chemotherapy closer to home and are currently having to travel to Christie for this service. Improved access for patients needing chemotherapy closer to home - Christie strategy is to provide this nearer to home.

Local availability for DEXA Scans for cancer patients to identify risk of cancer treatment on bones so earlier intervention/monitoring possible.

## Projected service use and outcomes

Historically, as screening programmes have become more established, the incidence of those associated cancers has increased as diagnosis has improved. This may well continue to be the case, especially as the programmes are increasing the range of population to be screened.

Predicting future levels of cancer in Bolton is difficult but some work has taken place nationally and regionally. Much of this work points to a predicted increase in the incidence of cancer over the next twenty years due to the anticipated effects of population growth and ageing. Inequalities in death rates from cancer across levels of deprivation continue and may increase if patterns in such lifestyle factors as smoking and obesity in poorer areas continue.

The Cancer Research UK 'Cancer Incidence Projections Project' estimates the extent to which incidence rates of specific cancers will change in the future. This project does not take into account any changes in population lifestyle that may affect incidence and estimates are based on 2007 incidence rates. However, based on these findings Bolton's overall cancer incidence (age standardised DSR) is likely to reduce by 2030; the reduction is estimated to be around 1.0% for men and 1.9% for women. This may still lead to an increase or stasis in the number of actual diagnoses due to population increases up to 2030. The table below applies these predictions to Bolton's incidence rates to illustrate which cancers are likely to increase and decrease in significance. In 2030 prostate cancer is set to become the most common cancer overall, being the fourth most common today; currently, the four most common cancers are breast, lung, colorectal, and prostate and this will still be the case in 2030. Finally, the standout cancer site, though the DSR is relatively low, is malignant melanoma which shows an increase of 52.3% for men and 51.8% for women.

Cancer	Gender	DSR 2007	DSR 2030	Direction
All (exc. NMSC)	Male	465.32	460.67	↓
	Female	363.50	356.59	↓
Lung	Male	83.46	76.94	↓
	Female	41.37	44.36	↑
Colorectal	Male	64.54	60.02	↓
	Female	34.26	35.05	↑

Prostate	Male	95.44	102.88	↑
Breast	Female	126.30	117.08	↓
Malignant melanoma	Male	11.10	16.91	↑
	Female	13.16	19.98	↑

Outside of the main cancer sites above, increases are also expected in oral and kidney cancer for both sexes (the former will come to be one of the top ten cancers by 2030), as well as liver cancer in men.

Going forward, increased investment in survivorship will be required as many more patients are surviving longer and often with consequences of treatment.

### Evidence of what works

Bolton’s Health Matters has created a collection of evidence and intelligence to ensure best practice in decision within this area. To view this collection, [please click here](#)

### Community views and priorities

- The following are the views and priorities of local patient liaison groups (Bolton Cancer Patients and Carers Consultative Group and Greater Manchester and Cheshire Cancer Network Patient and Carer Group).
- Savings from reductions in emergency admissions should be reinvested in acute oncology services, Cancer Nurse Specialist support and community support for those who require it, and cancer information and support services.
- The group encourages awareness amongst GPs that unexplained symptoms that persist warrant investigation. Greater consideration should be given if it is a patient who does not often attend surgery. They need to ensure the patient knows if symptoms persist they must return to their GP.
- Whilst accepting that better promotion of self-management is necessary, systems should be in place to ensure patients can ‘opt back in’ to services if issues arise. This would give patients more confidence to self-manage long-term.
- Investment to ensure patients are given opportunities to take part in clinical trials. Research staff to recognize potentially eligible patients and then recruit and support them to ensure equitable access to everyone.
- More support for patients and families with cancers that have been identified as hereditary. Genetic predisposition and family history.
- The groups are keen to see investment in a Cancer Information and Support Centre for patients, carers, and professionals with the aim of helping to support the cancer

journey. In addition, informed and supported patients are better able and more confident to deal with their own care needs.

## Equality impact assessments

No recent local equality impact assessments have been carried out that we are aware of. If you are aware of any such work locally please let us know at [Bolton Health Matters](#)

## Unmet needs and service gaps

Nationally, the NHS spends around £6bn on cancer each year. The largest component of expenditure relates to inpatient care (exclusive of surgery and exclusive of chemotherapy costs). Investment in cancers services is currently inefficient – the National Cancer Action Team recommends a redirection of resources from inpatient care to earlier diagnosis. This should include improving access to lower gastrointestinal endoscopy (e.g. flexible sigmoidoscopy and colonoscopy) for patients with bowel symptoms, and improved access to chest x-ray (lung cancer) and ultrasound (especially pelvic ultrasound for ovarian cancer). These are the key gaps identified nationally regarding early diagnosis.

The National Cancer Action Team recommends providers should aim to reduce lengths of stay for elective cancer surgery, for instance concerning day case/overnight breast surgery and enhanced recovery programmes. Lengths of stay for cancer patients should also be reduced for cancer patients admitted as emergencies through the introduction of inpatient care pathways. Finally, providers should reduce follow-up by promoting supported self-management.

Particular attention should be given to reducing emergency presentations (around 25% of all cancers in the GMCCN – higher than the national average) as these have very poor survival, as well as to the elderly who often present late.

All cancer screening coverage in Bolton shows some variation across population groups. People living in more deprived areas are generally less likely to take up the option of screening. For instance, the latest analysis of bowel cancer screening data, some very deprived areas of Bolton have coverage rates of only 17% compared to 51% overall for the borough. There is also a tendency for people from BME communities to be less likely to use cancer screening services. Men are also less likely to return the bowel cancer screening kit. Whilst men have always been lower users of health care services, this will also be affected by the fact that men have not been exposed to other screening services in the past like women have with breast and cervical screening.

## Recommendations for further needs assessment work

Assessment and regular monitoring/analysis of the Public Health Outcomes Framework indicators linked to cancer are necessary. These are: 2.19 Cancer diagnosed at Stage 1 and 2; 2.20 Cancer screening coverage; 4.5 Mortality from cancer in <75s.

Monitoring of the uptake of screening services to look for inequalities in coverage is vital to target those population groups with lower uptake rates. Equity audits should continue to be performed to monitor change.

There is a need to investigate the stage of cancers at diagnosis to give an indication of nature of late presentation. Ideally this would be in the form of retrospective audits of cancers to look at the route to diagnosis, giving an insight into factors contributing to late diagnosis.

Focus is understandably on the major cancers but little needs assessment work is done concerning what rarer cancers are seen in Bolton and survival rates. Some information of incidence (numbers) of these rare cancers in Bolton should be included in the JSNA and areas they are found (locations). Approximately half of cancer incidence is rarer cancers and whilst the more common cancers are often highlighted it is the rarer cancers that may be missed and then present as an emergency.

There is a need to collate feedback from cancer patients and their carers on the treatment and care received to identify any gaps and improvements required.

### Key contacts

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