



Kent and Medway Cancer Network

AWARENESS AND EARLY DIAGNOSIS INITIATIVE

BASELINE ASSESSMENT

NHS WEST KENT

Version 0.1

5th October 2009

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James Westwood, Public Health Analyst, Medway PCT

1.0 Introduction

The National Awareness and Early Diagnosis Initiative (NAEDI) was first announced in the Cancer Reform Strategy (CRS) in December 2007. It was identified as a priority action area to improve cancer outcomes. A year later, the cancer commissioning guidance (DH, December 2008) set out key issues and questions for commissioners and cancer network teams to consider when assessing health needs, reviewing services, developing contract specifications and monitoring performance on improving health. The guidance emphasises that for the NHS to be sustainable, it needs to focus on improving health as well as treating sickness. Some new initiatives, for example vascular risk assessments, have the potential to contribute to cancer prevention, since they focus on overlapping risks such as smoking and obesity.

In general, the earlier a cancer can be diagnosed, the greater the prospect of a cure. While some cancers can be detected early by screening, most cancers cannot be screened for. Late presentation is regarded as one of the major reasons for poor outcomes among cancer patients in England. In addition, treatment of late stage disease is often more costly than early diagnosis and treatment. The CRS recommends that Primary Care Trusts (PCTs) should give high priority to local initiatives to promote early presentation by people with symptoms that may be cancer.

The Public Service Agreement (PSA) target for cancer was set by DH in July 2000 (NHS Plan). The target was defined as 'a reduction of at least 20% in cancer mortality by 2010 from the baseline'. The baseline was taken from three year pooled rate data, with 1995-1997 given as the baseline. The indicator is set at the directly age standardised mortality rate per 100,000 for malignant neoplasms for persons under 75 years of age.

2.0 Development of a Network wide Strategy

The three PCTs in Kent and Medway may wish to establish individual strategies to deliver NAEDI in their localities. However, the Network has an important role to play in ensuring that an overall strategy is in place and that learning is shared appropriately. Whilst key priority areas may vary between PCTs, or indeed within an individual PCT, there may be areas of common ground across the Network. There is a National expectation that Cancer Networks will provide strategic leadership in this area.

2.1 Network LAEDI Leadership

Dr Julia Duke-MacRae, KMCN Co-Medical Director, Public Health and Dr Mike Parks, Co-Medical Director Primary Care will provide medical leadership. Barbara Mercier, KMCN Development Director will manage the programme. Kay Jones, Service Improvement Facilitator will support the programme.

2.2 Strategy Development and Timelines 2009/10

In order to develop and agree a strategy for the Network, the following steps will be taken between June and March 2009:

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Present briefing paper to CNB												
Core Indicators completed												
Present Core Indicator data to appropriate PCT groups and agree priority areas												
Engage Public and Patient Involvement												
Scope local initiatives												
Establish Strategy Steering Group												
Draft Network wide strategy for consultation												
Final Strategy Published												
Strategy Steering Group to devolve into Strategy Implementation Group												
Develop Action/Monitoring Plans												

3.0 Baseline Information

The data in this document is derived from the Office of National Statistics, Thames Cancer Registry, The National Centre for Health Outcomes Development Knowledge Base (NCHOD) and The National Cancer Intelligence Network (NCIN). We are grateful to the Kent and Medway Public Health Observatory for providing all NCHOD source data and for their advice in producing this report. Directly age standardised rates (DSR) per 100,000 European population have been applied.

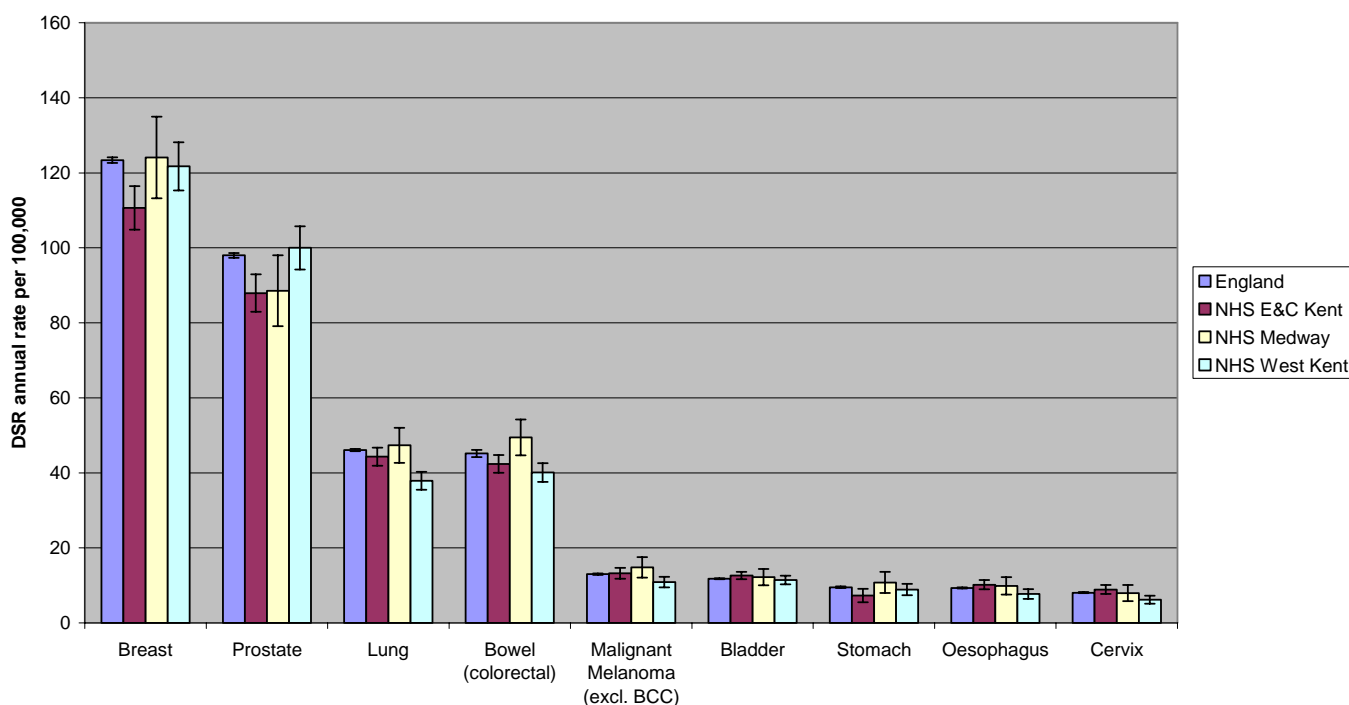
Three year pooled data are presented from years 2003 – 2005 for incidence and years 2005 – 2007 for mortality. The data is provided to assist PCTs in agreeing priorities for commissioning future provision of cancer services.

Incidence and mortality data are presented in graphic format throughout this report and in tabular format in Appendix 1.

3.1 Cancer Incidence

Cancer incidence per tumour group per PCT, pooled for a three-year period (2003 – 2005), is illustrated in figure 1. The English average is included for comparative purposes.

Cancer Incidence: All Persons, All Ages 2003-2005 Three Year Pooled

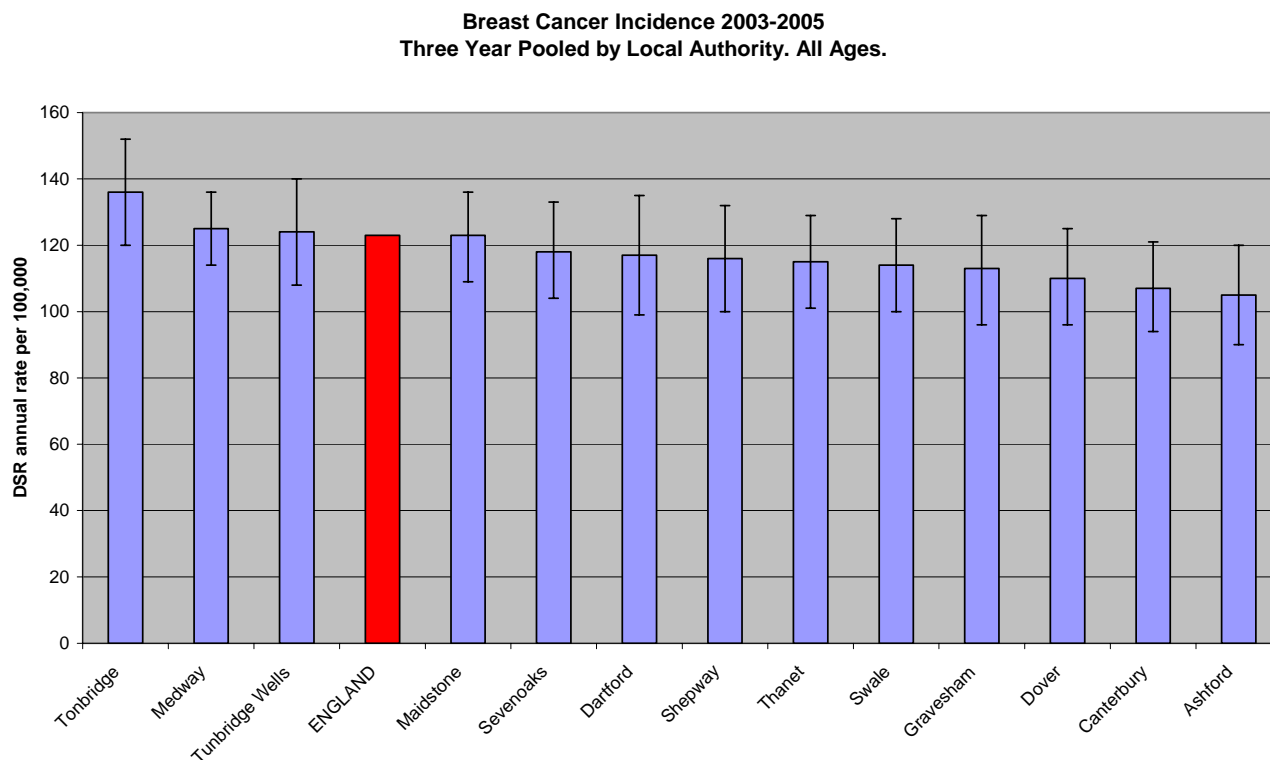


Data source: NCHOD

Figure 1

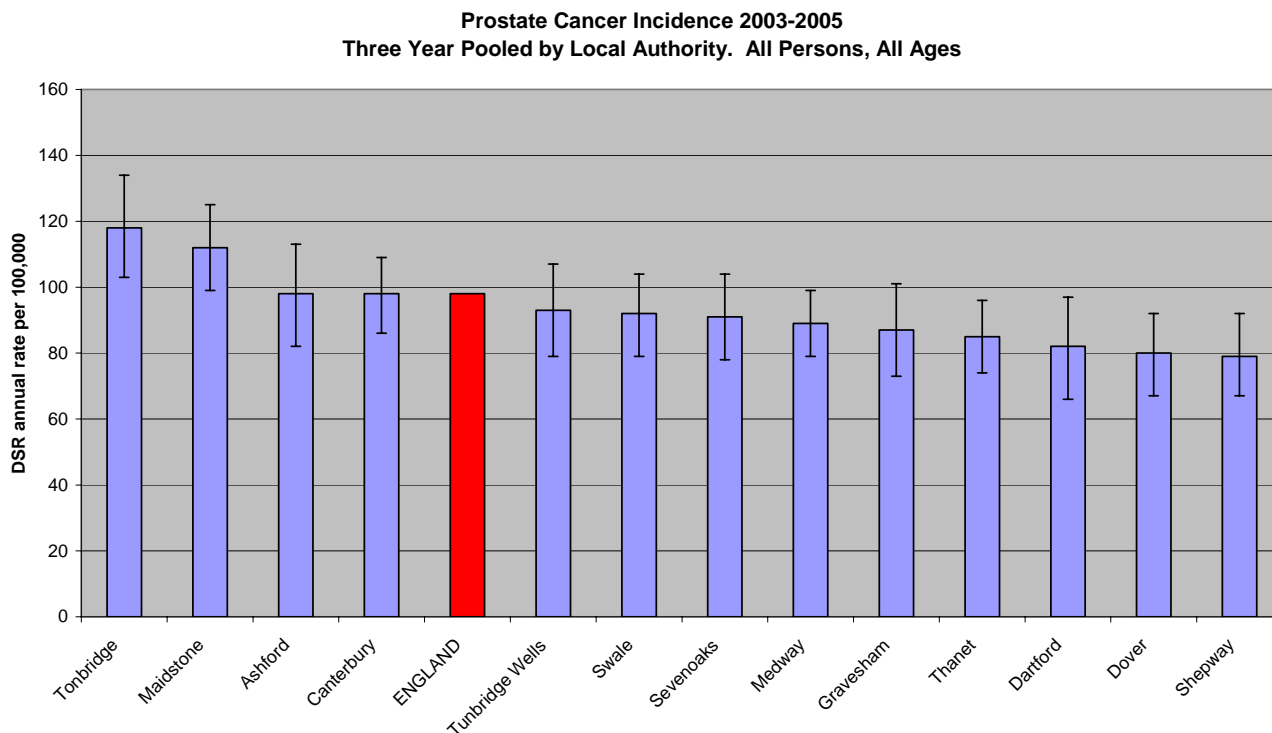
3.1.1 Cancer Incidence per Tumour Group by Local Authority

Cancer incidence for breast, prostate, lung, colorectal and oesophageal cancers are presented per Local Authority in figures 2 – 6.



Data source: NCIN Cancer e-Atlas

Figure 2

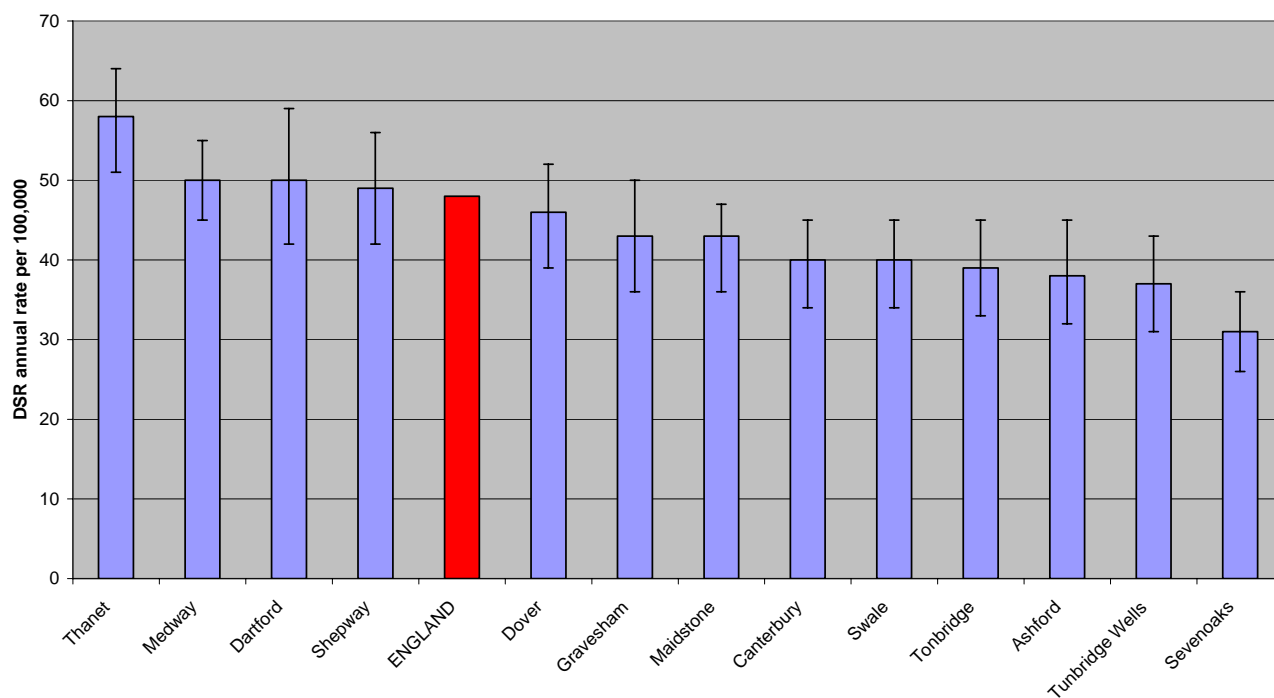


Data source: NCIN Cancer e-Atlas

Figure 3

Kent and Medway Cancer Network Awareness and Early Diagnosis

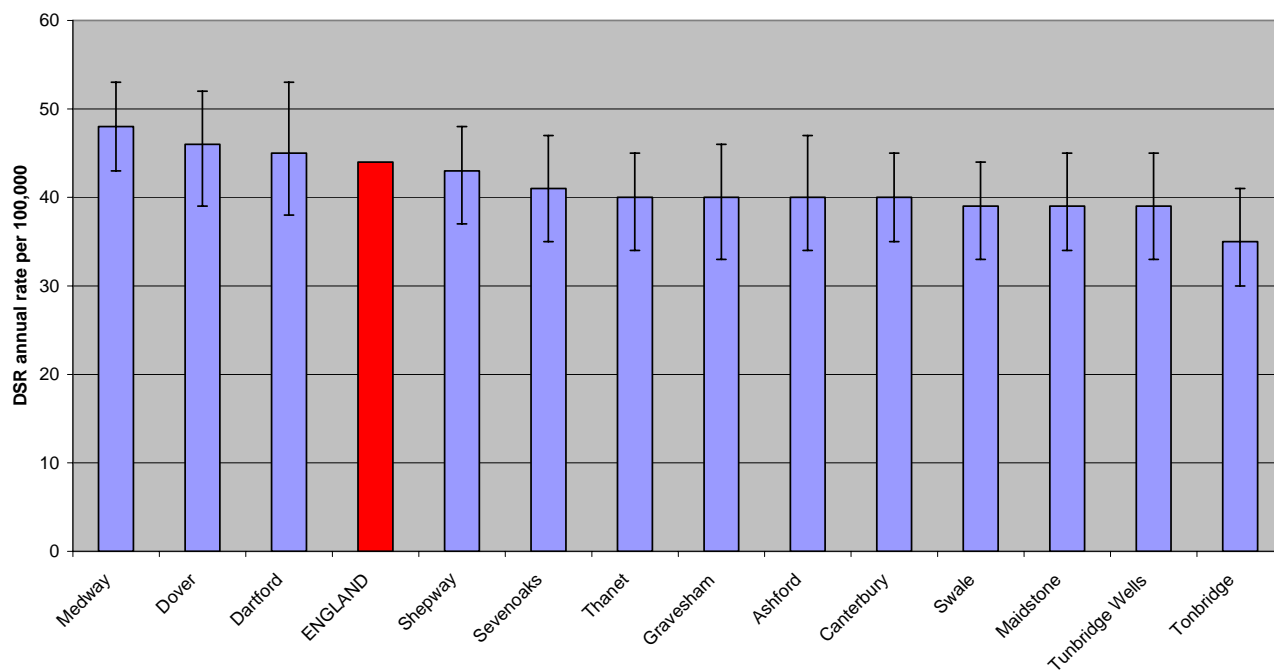
Lung Cancer Incidence 2003-2005 Three Year Pooled by Local Authority. All Persons, All Ages



Data source: NCIN Cancer e-Atlas

Figure 4

Colorectal Cancer Incidence 2003-2005 Three Year Pooled by Local Authority. All Persons, All Ages

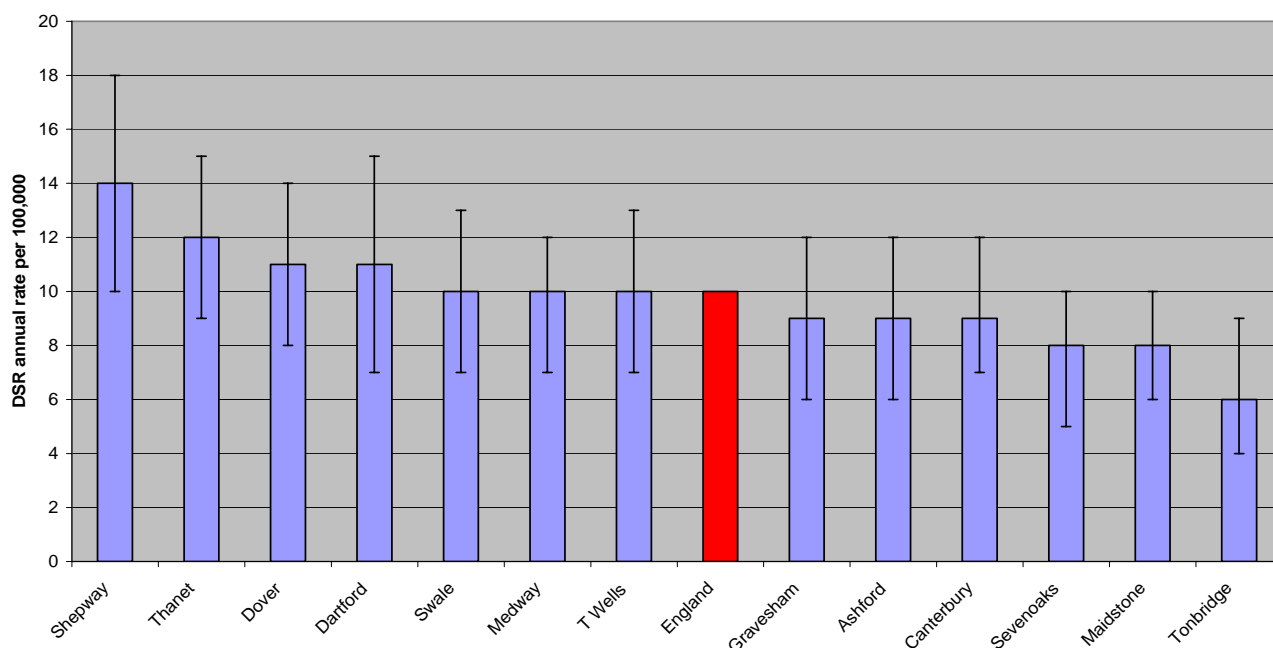


Data source: NCIN Cancer e-Atlas

Figure 5

Kent and Medway Cancer Network Awareness and Early Diagnosis

Oesophageal Cancer Incidence 2003-2005 Three Year Pooled. All Persons, All Ages

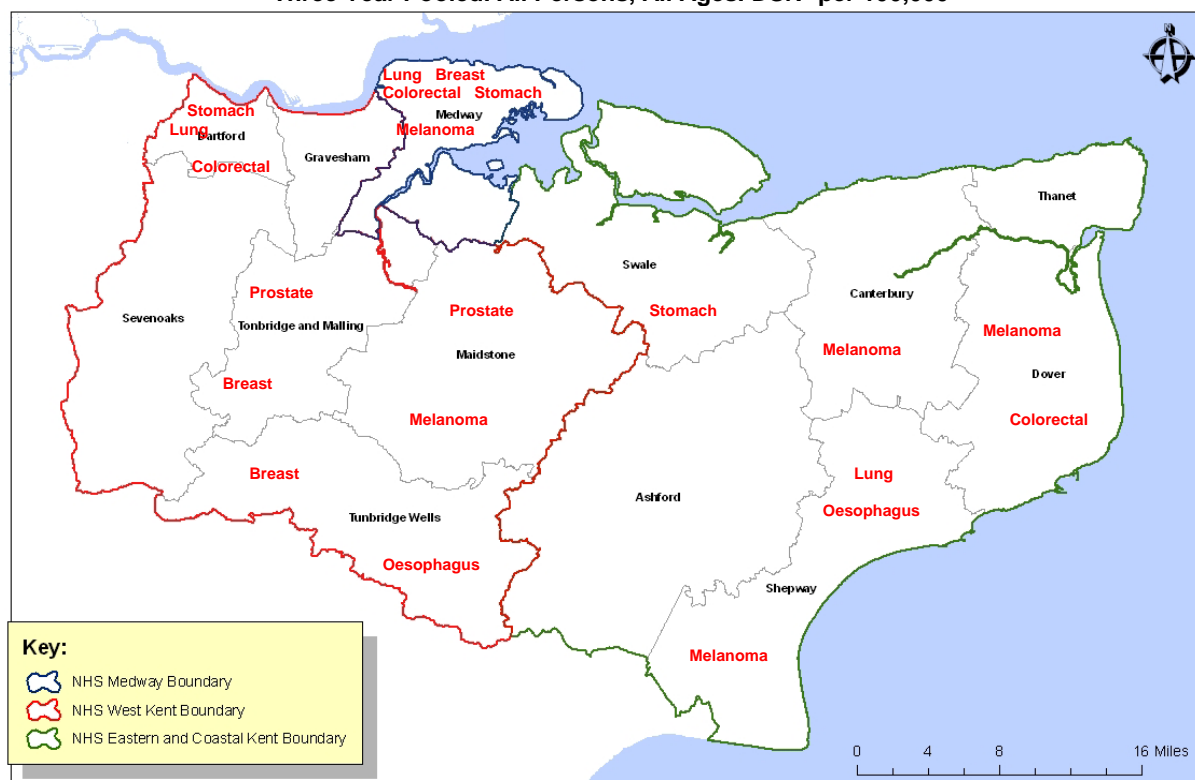


Data source: NCIN Cancer e-Atlas

Figure 6

The geographical distribution of specified cancer sites by local authority with incidence rates above the England average is displayed in Figure 7. This does not imply that the focus should only be on these cancers to the exclusion of others, but merely to highlight those tumour sites where further interventions will be required.

Local Authorities with Tumour Site Incidence Greater than English Average 2003-2005 Three Year Pooled. All Persons, All Ages. DSR* per 100,000



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*DSR = Directly Age Standardised Rates

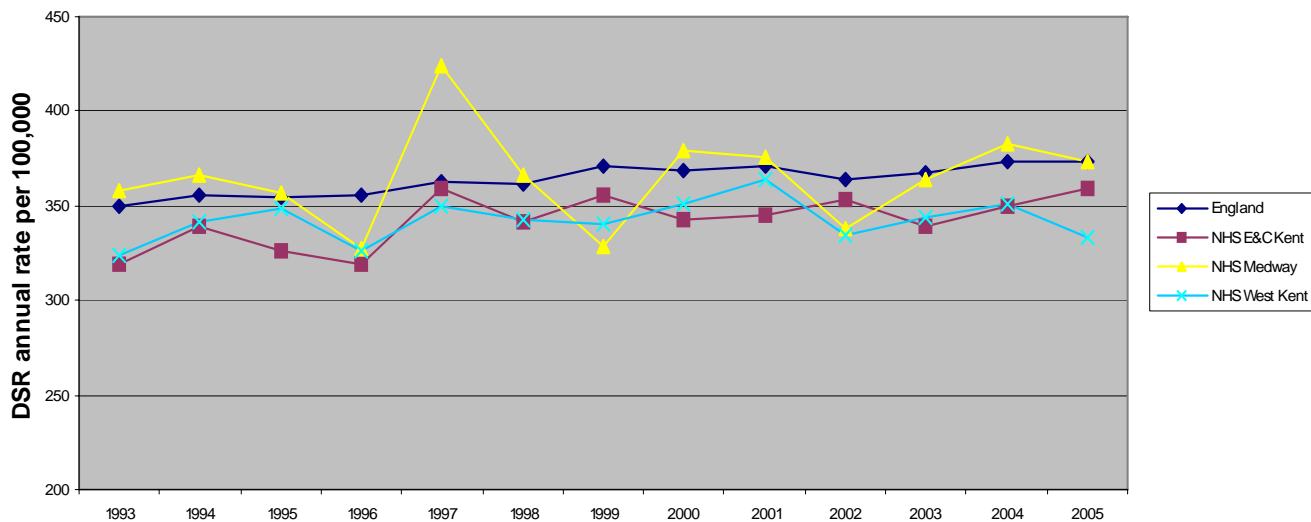
Data source: NCIN Cancer e-Atlas

Figure 7

3.1.2 Trends in Cancer Incidence by PCT

The following graphs (figures 8 – 21) present annual cancer incidence trends. Ideally three year pooled data would better present incidence trends, this data will be included at a later date, when available.

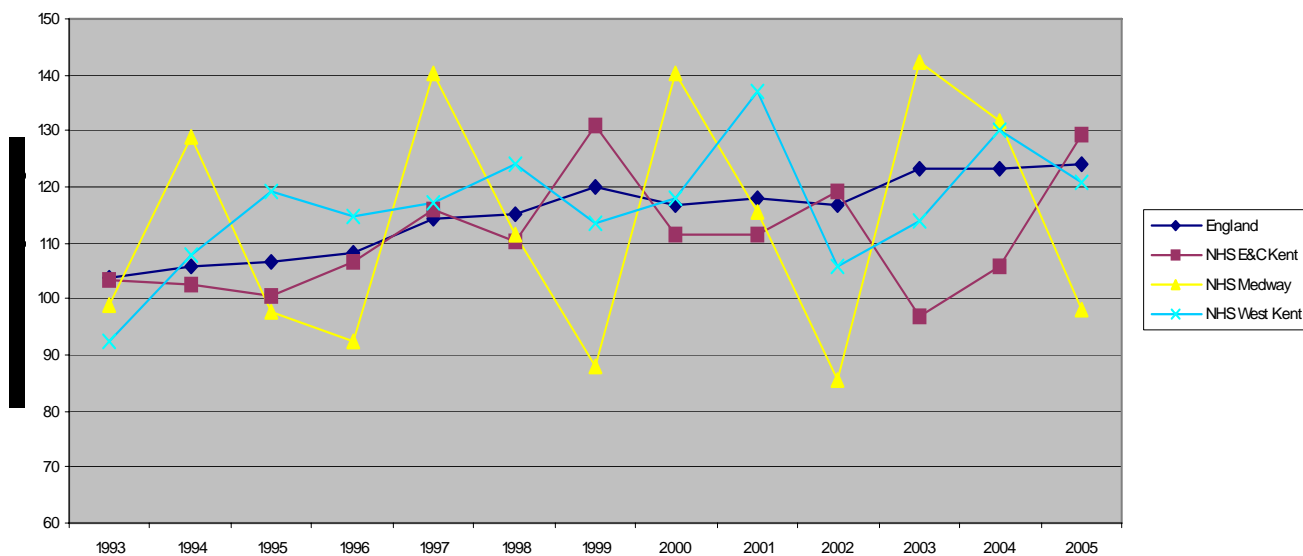
All Cancers Incidence All Ages, All Persons 1993 - 2005



Data source: NCHOD

Figure 8

Breast Cancer Incidence - All Ages Female 1993 - 2005

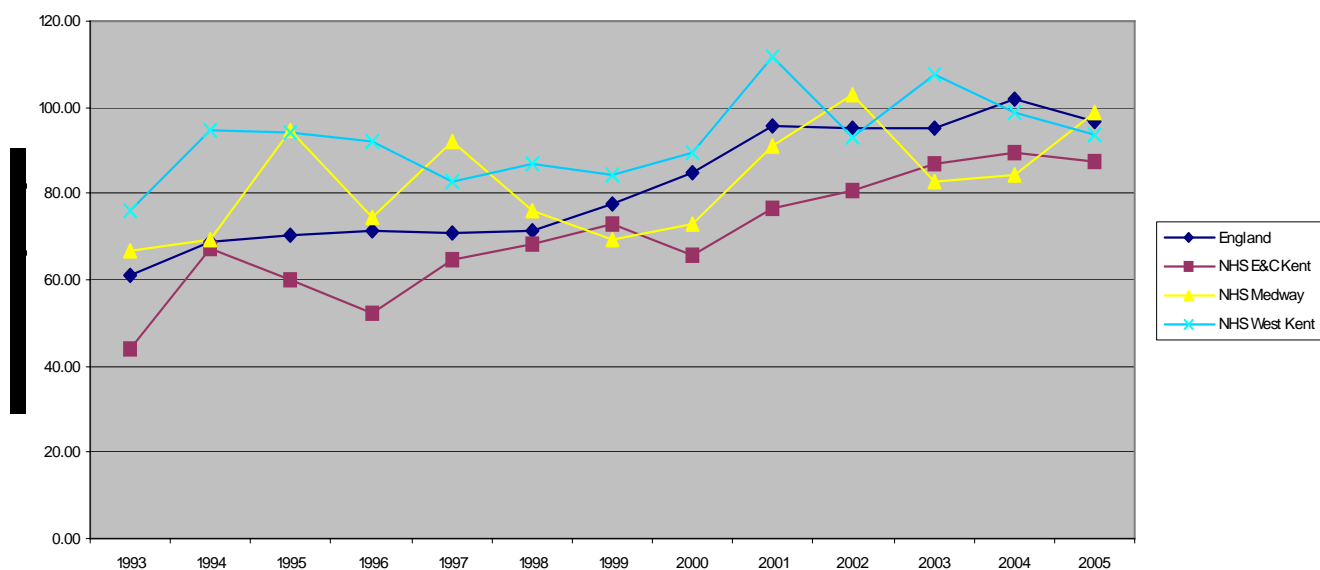


Data source: NCHOD

Figure 9

Kent and Medway Cancer Network Awareness and Early Diagnosis

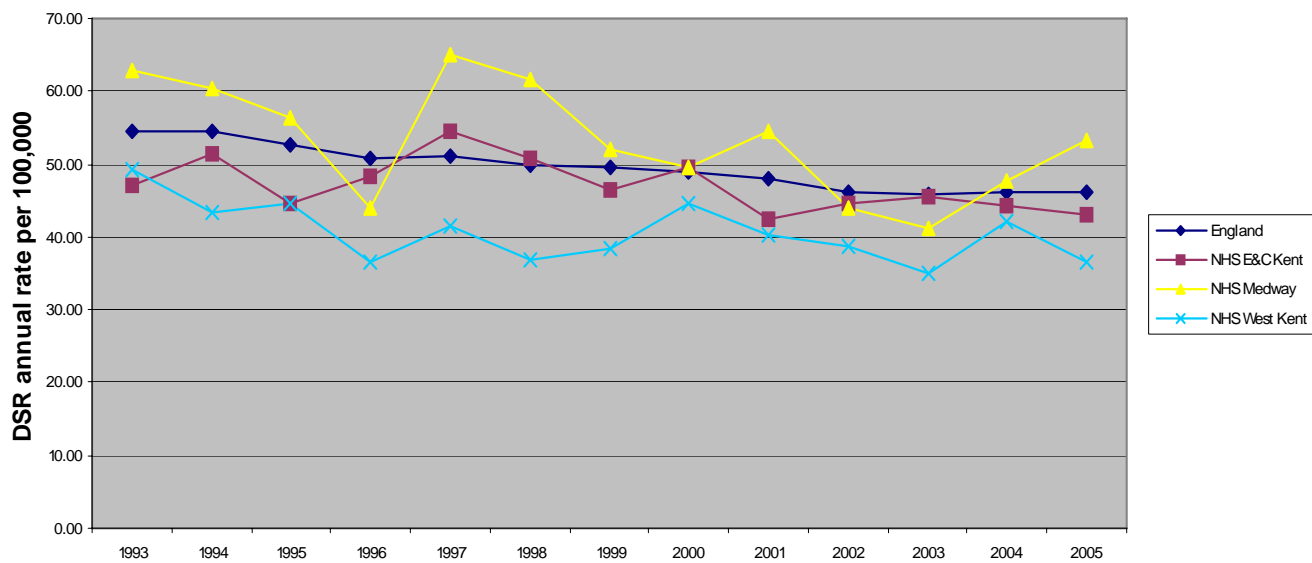
Prostate Cancer Incidence All Ages 1993 - 2005



Data source: NCHOD

Figure 10

Lung Cancer Incidence All Ages, All Persons 1993 - 2005

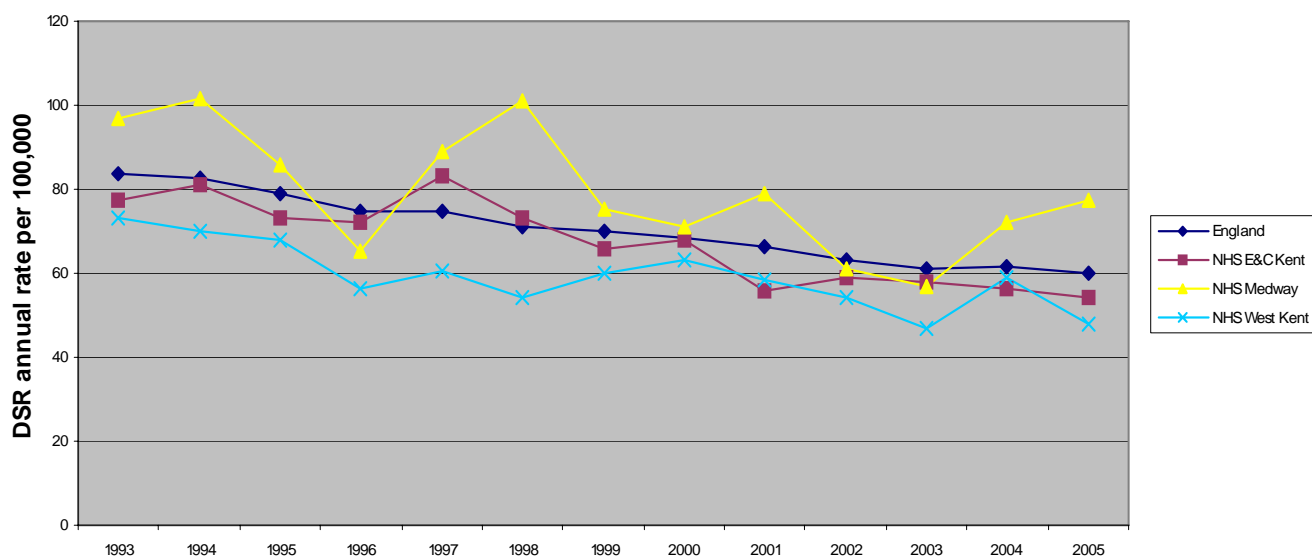


Data source: NCHOD

Figure 11

Kent and Medway Cancer Network Awareness and Early Diagnosis

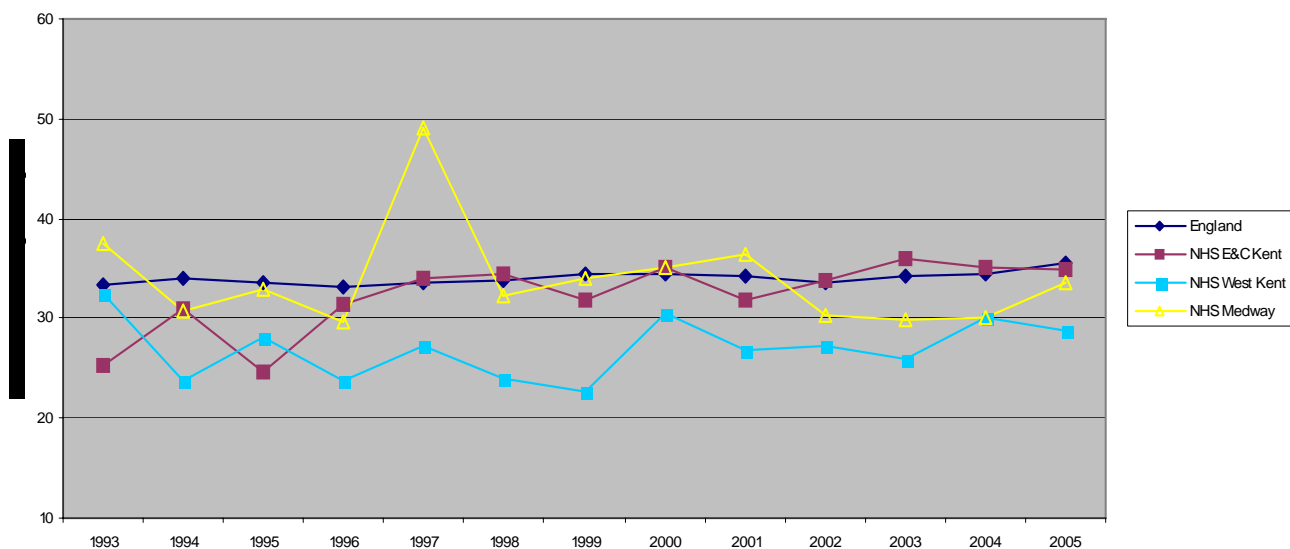
Lung Cancer Incidence - All Ages, Male 1993 - 2005



Data source: NCHOD

Figure 12

Lung Cancer Incidence - All Ages, Female 1993 - 2005

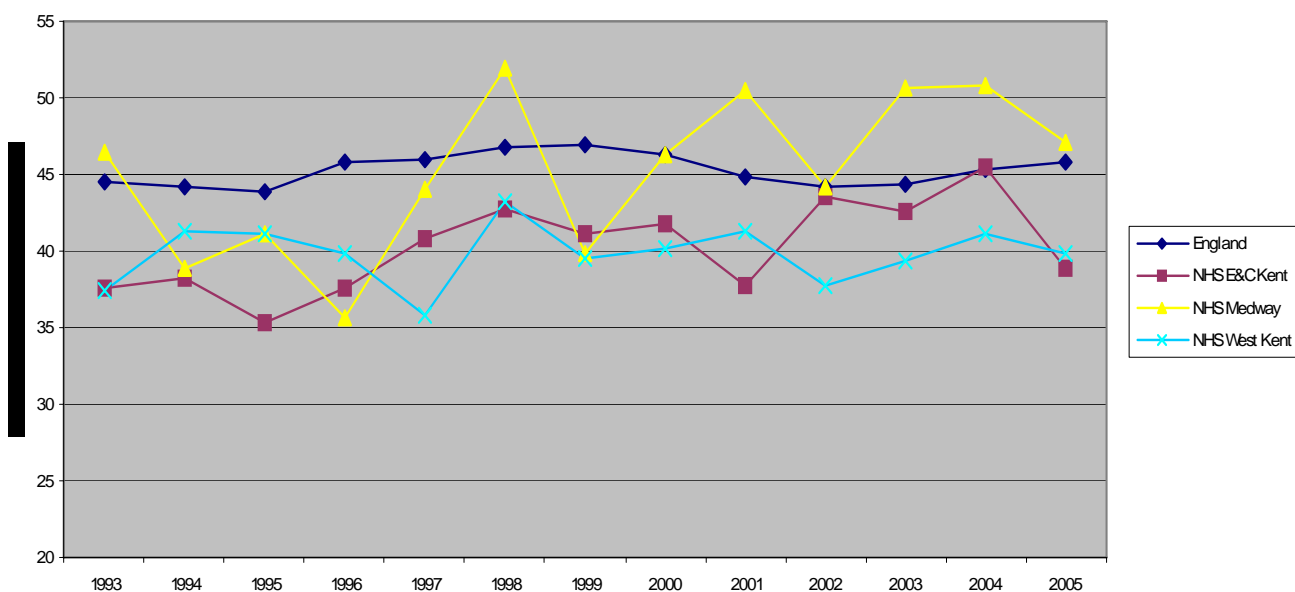


Data source: NCHOD

Figure 13

Kent and Medway Cancer Network Awareness and Early Diagnosis

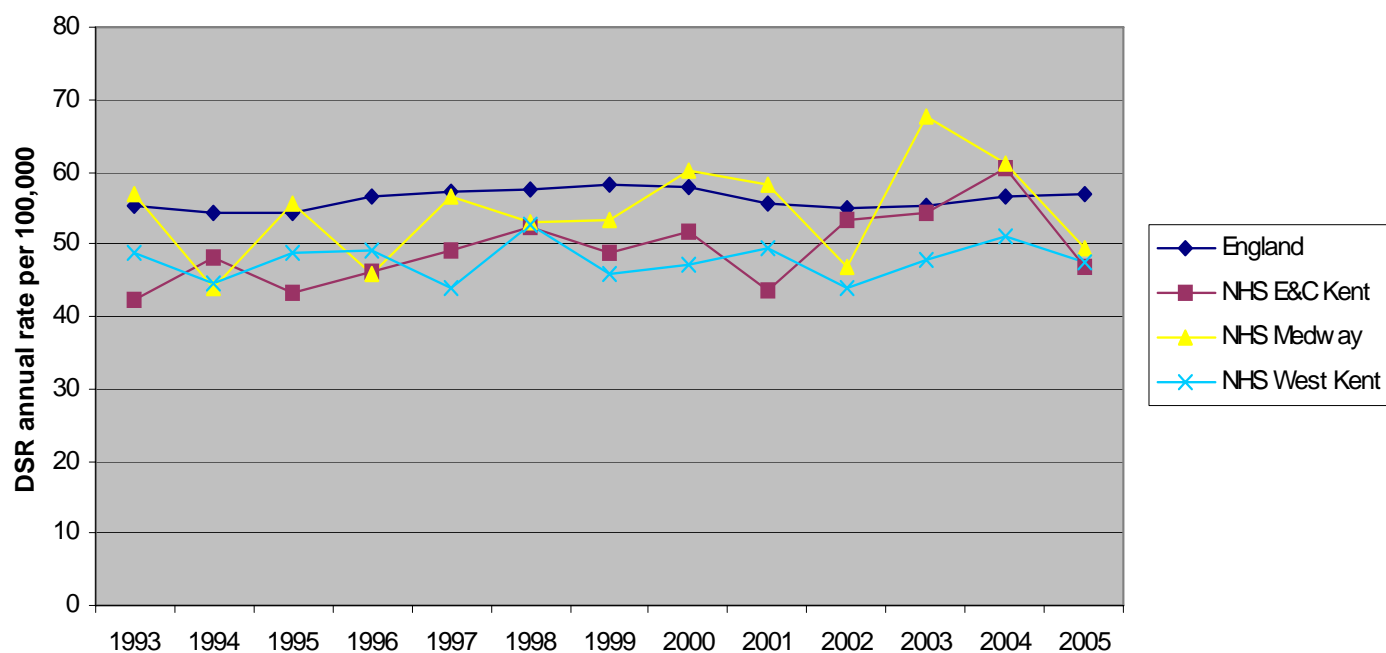
Colorectal Cancer Incidence All Ages, All Persons 1993 - 2005



Data source: NCHOD

Figure 14

Colorectal Cancer Incidence- All Ages, Male 1993-2005

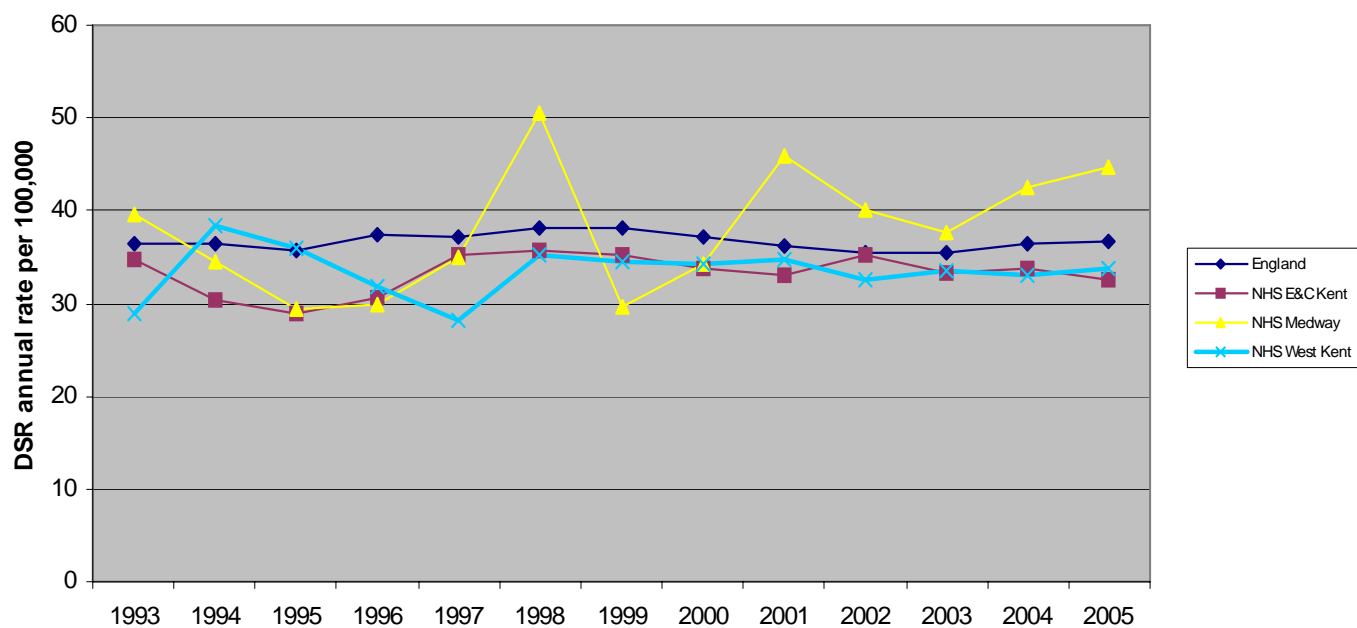


Data source: NCHOD

Figure 15

Kent and Medway Cancer Network Awareness and Early Diagnosis

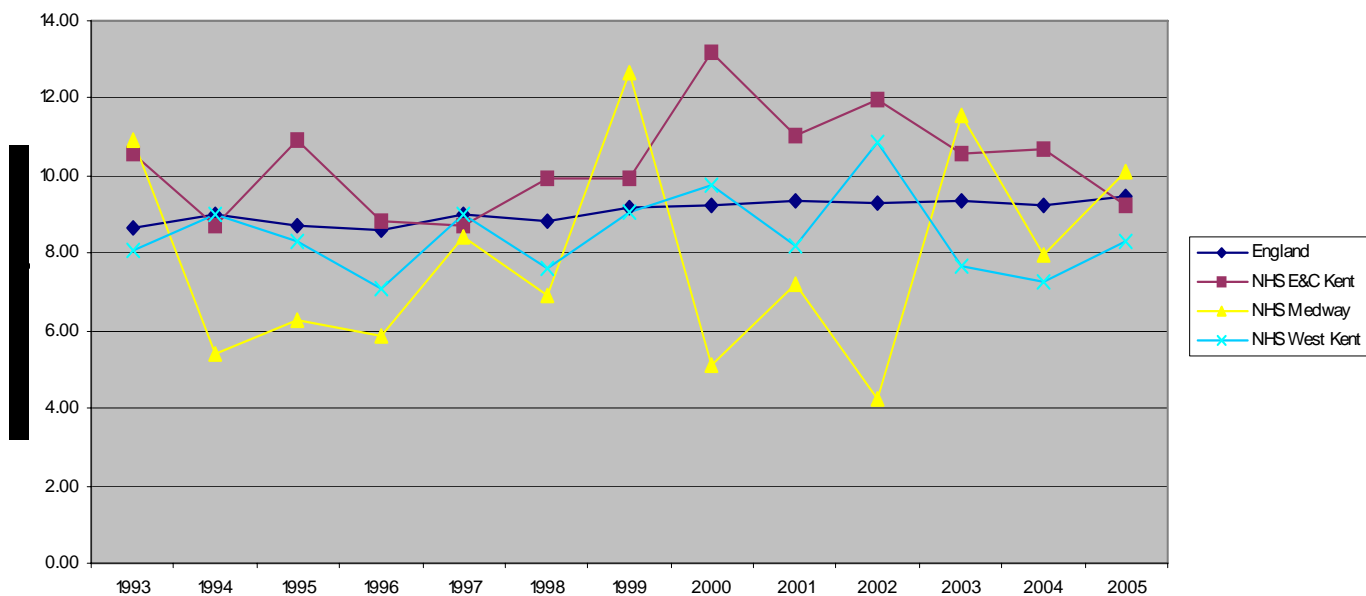
Colorectal Cancer Incidence - All Ages, Female 1993 - 2005



Data source: NCHOD

Figure 16

Oesophageal Cancer Incidence - All Ages, All Persons 1993 - 2005

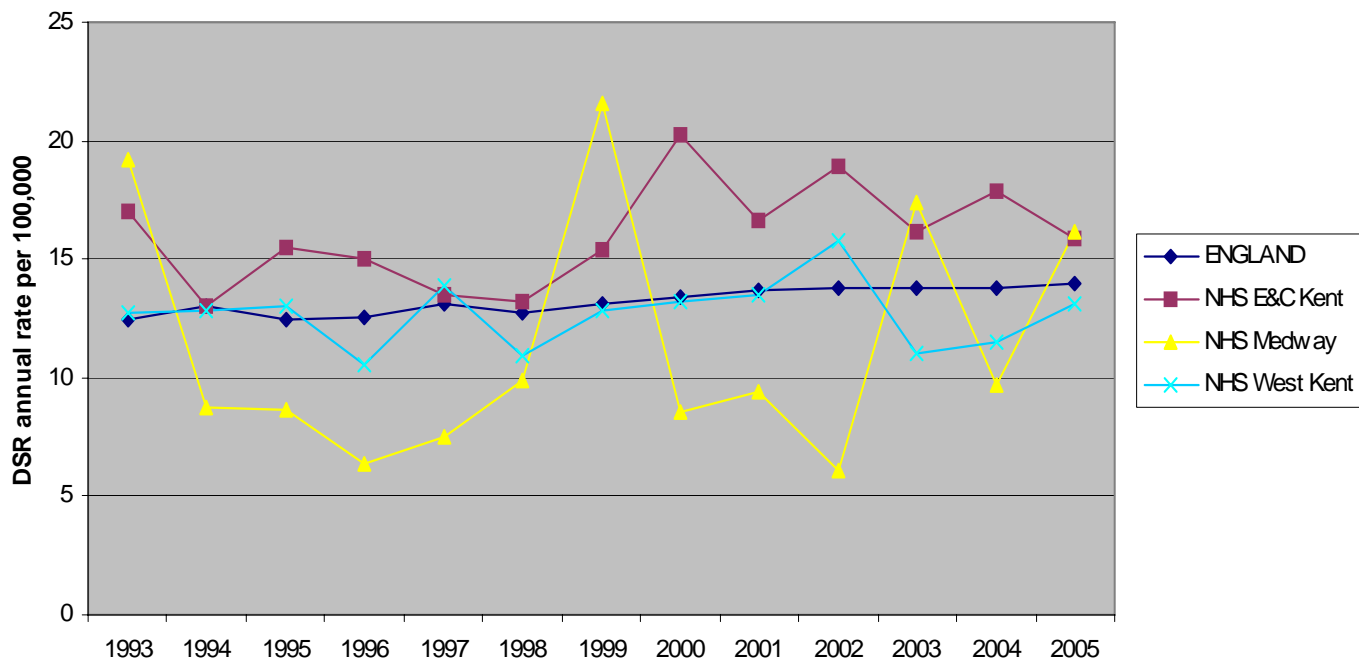


Data source: NCHOD

Figure 17

Kent and Medway Cancer Network Awareness and Early Diagnosis

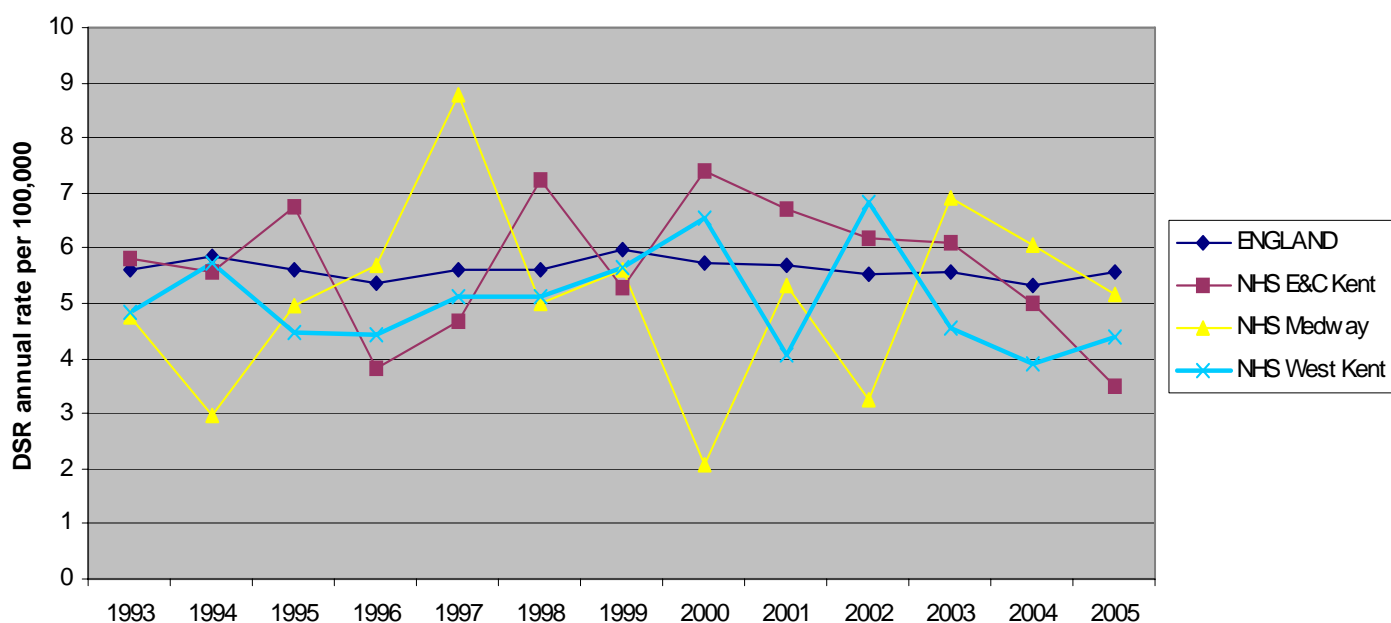
Oesophageal Cancer Incidence - All Ages, Male 1993 - 2005



Data source: NCHOD

Figure 18

Oesophageal Cancer Incidence - All Ages, Female 1993 - 2005

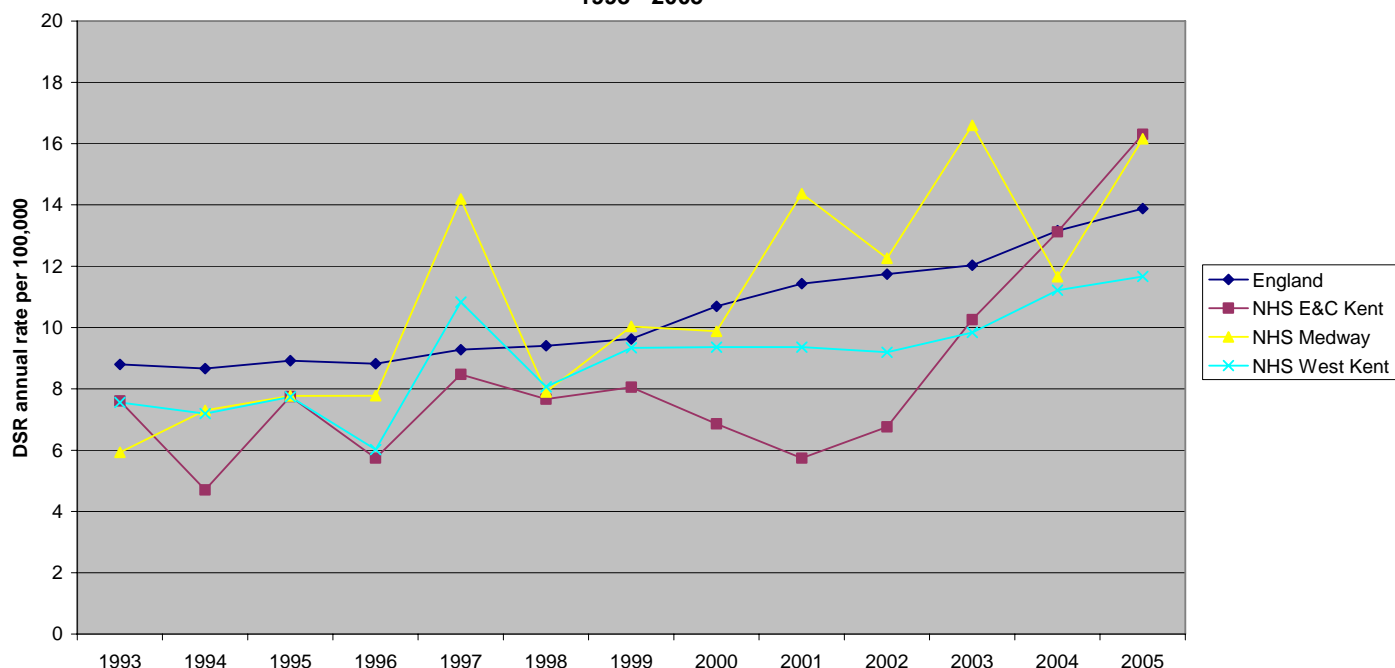


Data source: NCHOD

Figure 19

Kent and Medway Cancer Network Awareness and Early Diagnosis

**Malignant Melanoma Incidence - All Ages, All Persons
1993 - 2005**



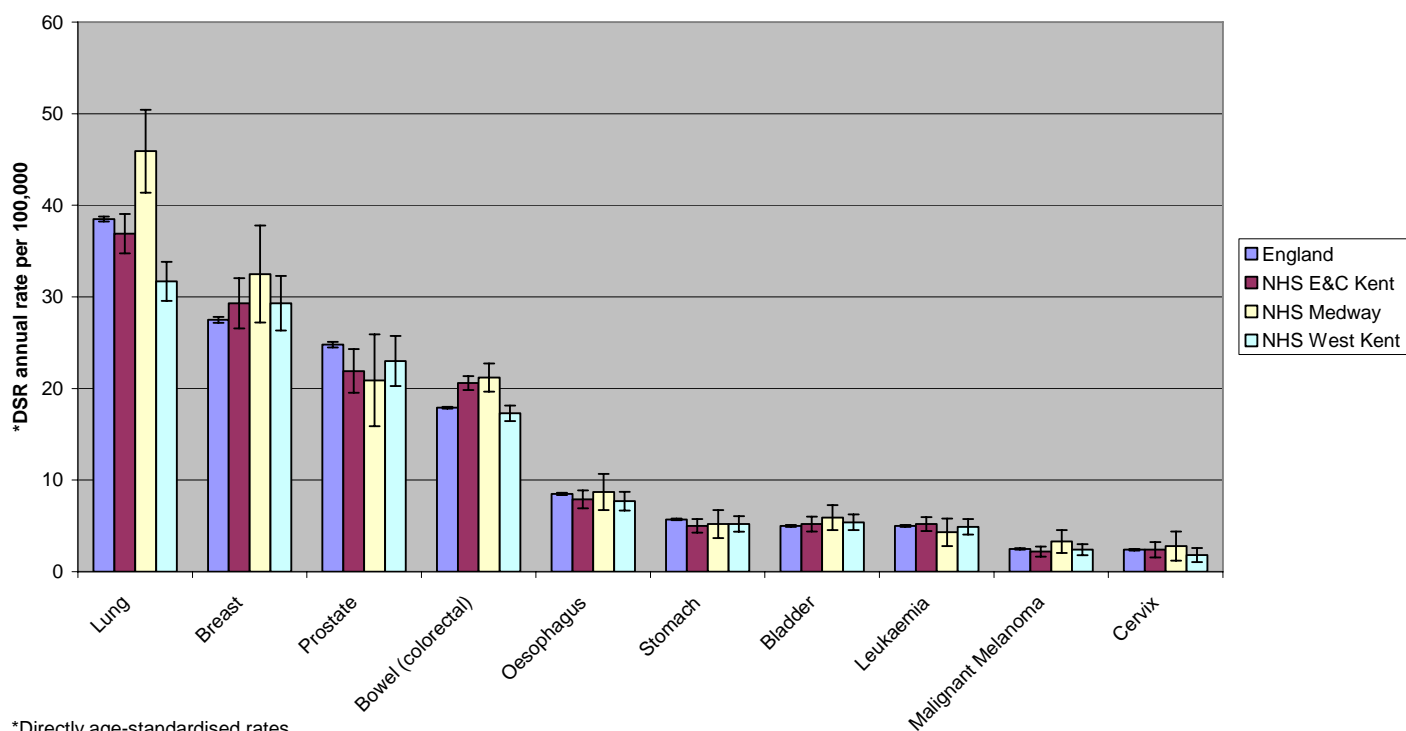
Data source: NCHOD

Figure 20

3.2 Cancer Mortality

Figure 21 illustrates cancer mortality per tumour group by PCT pooled over a three-year period (2005 – 2007). The English average is included for comparative purposes.

Cancer Mortality: DSR* all ages 2005-2007 Three year Pooled



*Directly age-standardised rates

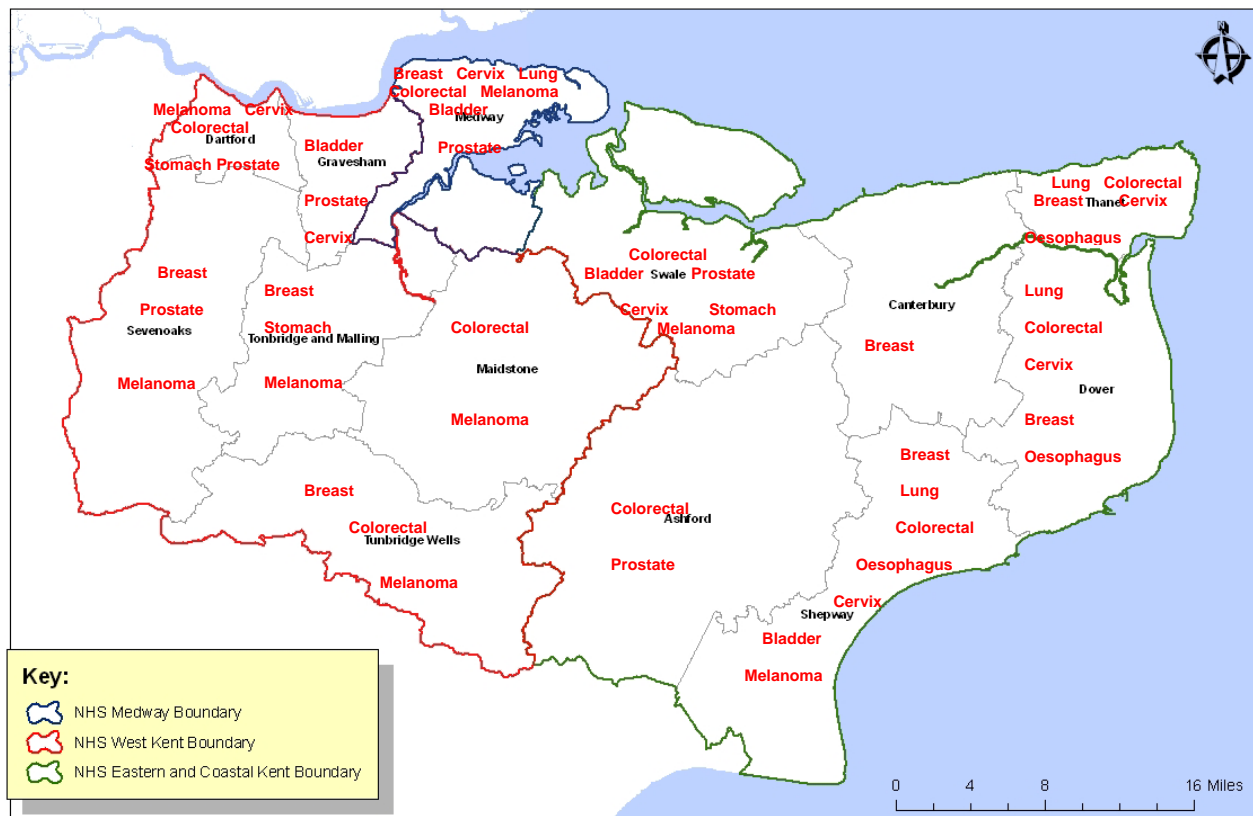
Data Source: NCHOD

Figure 21

Kent and Medway Cancer Network Awareness and Early Diagnosis

Figure 22 illustrates those local authorities that have cancer mortality rates higher than the England average for all persons by cancer site. This is consistent with research findings that the cancer outcomes are worse for people living in the more deprived areas.

**Cancer Mortality Greater than English Average per Local Authority
All Persons 2003-2005 Three Year DSR* per 100,000**



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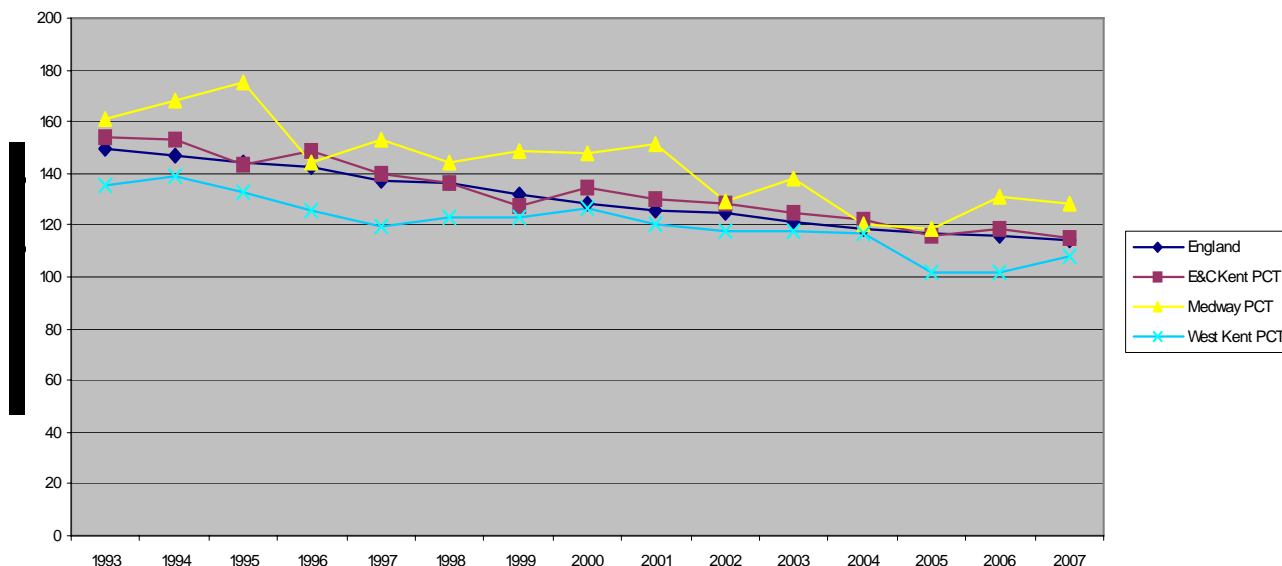
*DSR = Directly Age Standardised Rates

Figure 22

3.2.1 Trends in Cancer Mortality by PCT

The following graphs (figures 23-35) present annual cancer mortality trends. Ideally three year pooled data would better present mortality trends, this data will be included at a later date, when available.

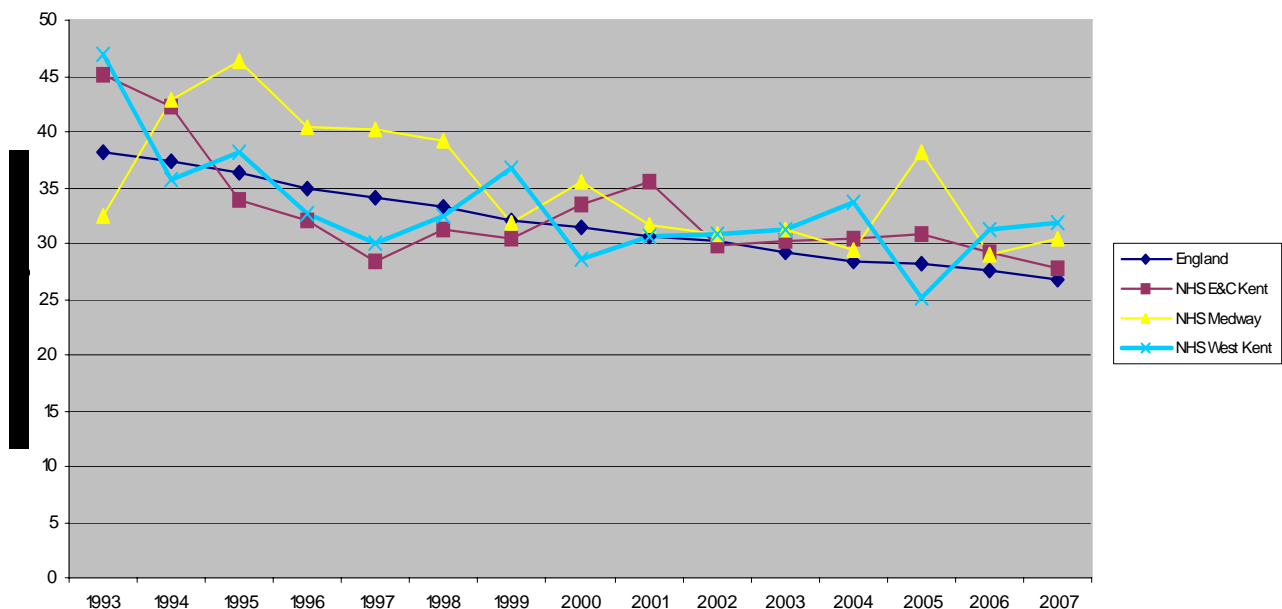
All Cancers Mortality - All Ages, All Persons 1993 - 2007



Data source: NCHOD

Figure 23

Breast Cancer Mortality - Female, All Ages 1993 - 2007

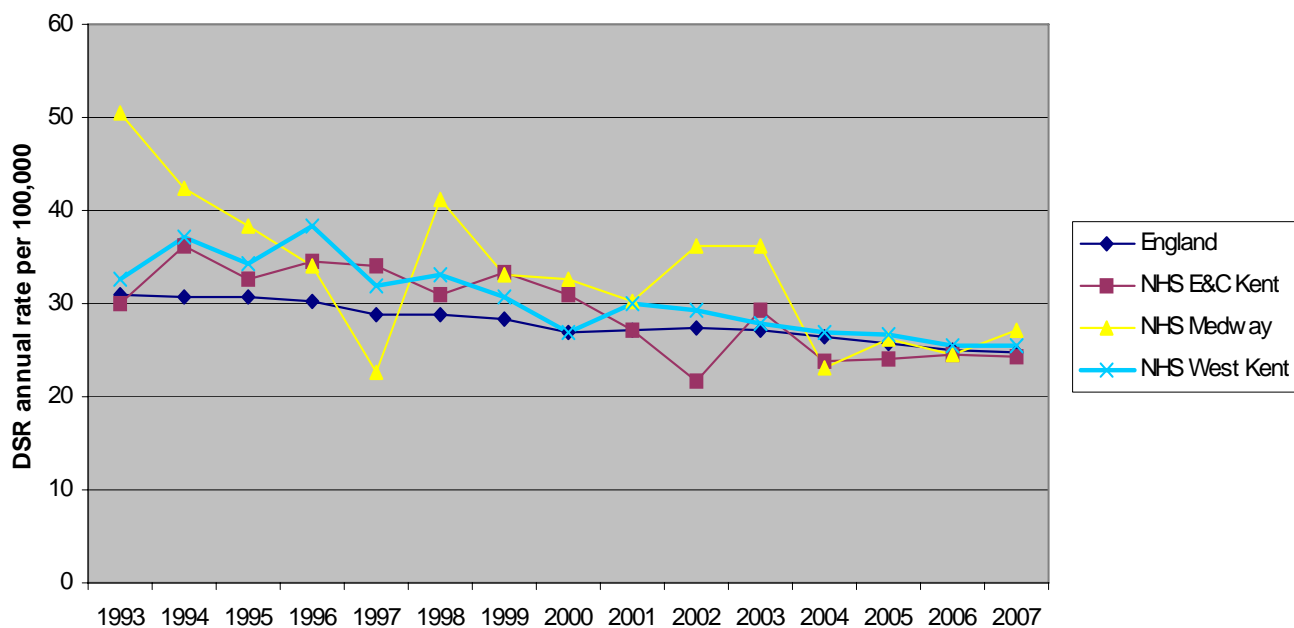


Data source: NCHOD

Figure 24

Kent and Medway Cancer Network Awareness and Early Diagnosis

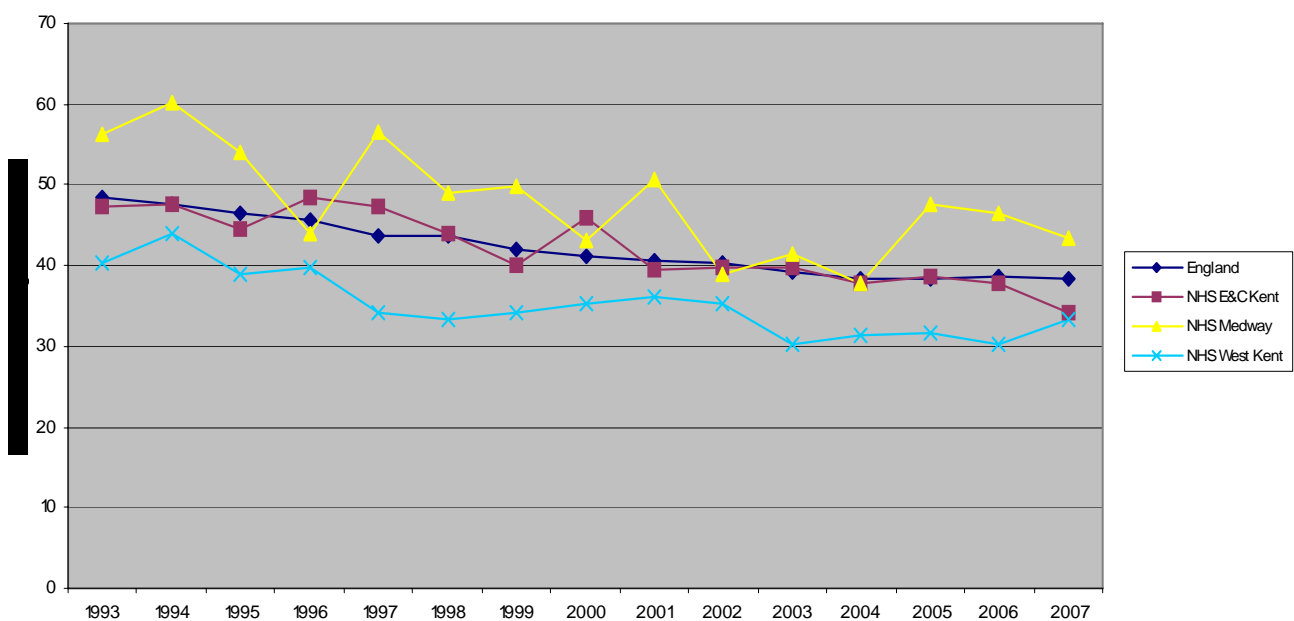
Prostate Cancer Mortality - Male, All Ages 1993 - 2007



Data source: NCHOD

Figure 25

Lung Cancer Mortality - All Persons, All Ages 1993 - 2007

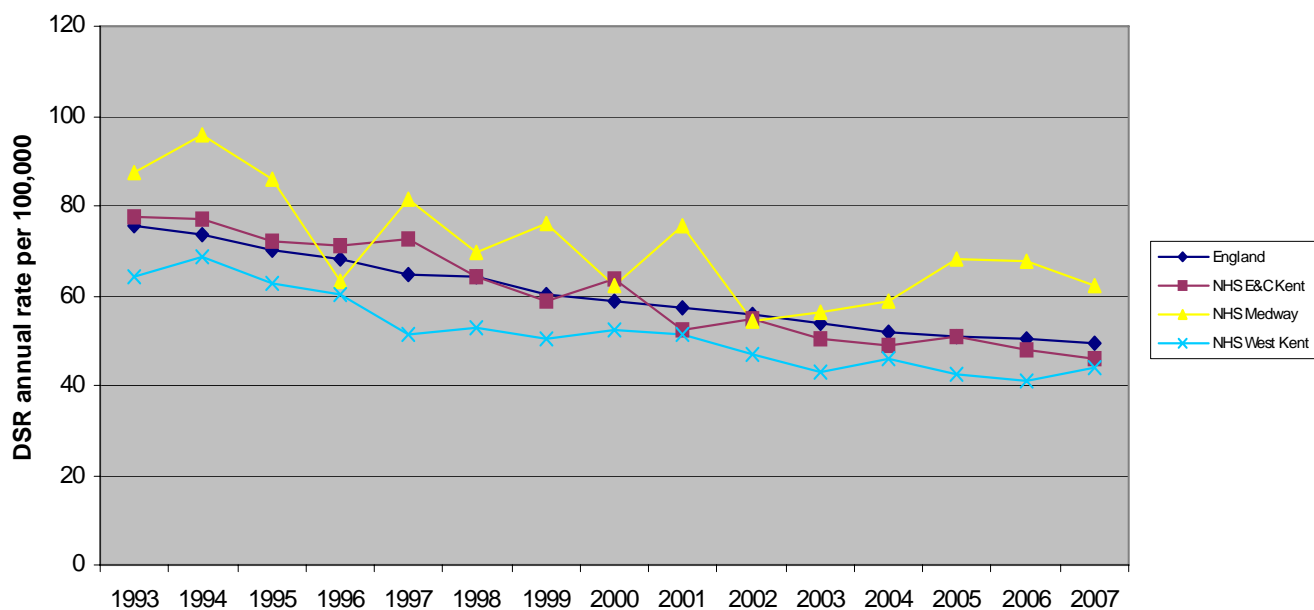


Data source: NCHOD

Figure 26

Kent and Medway Cancer Network Awareness and Early Diagnosis

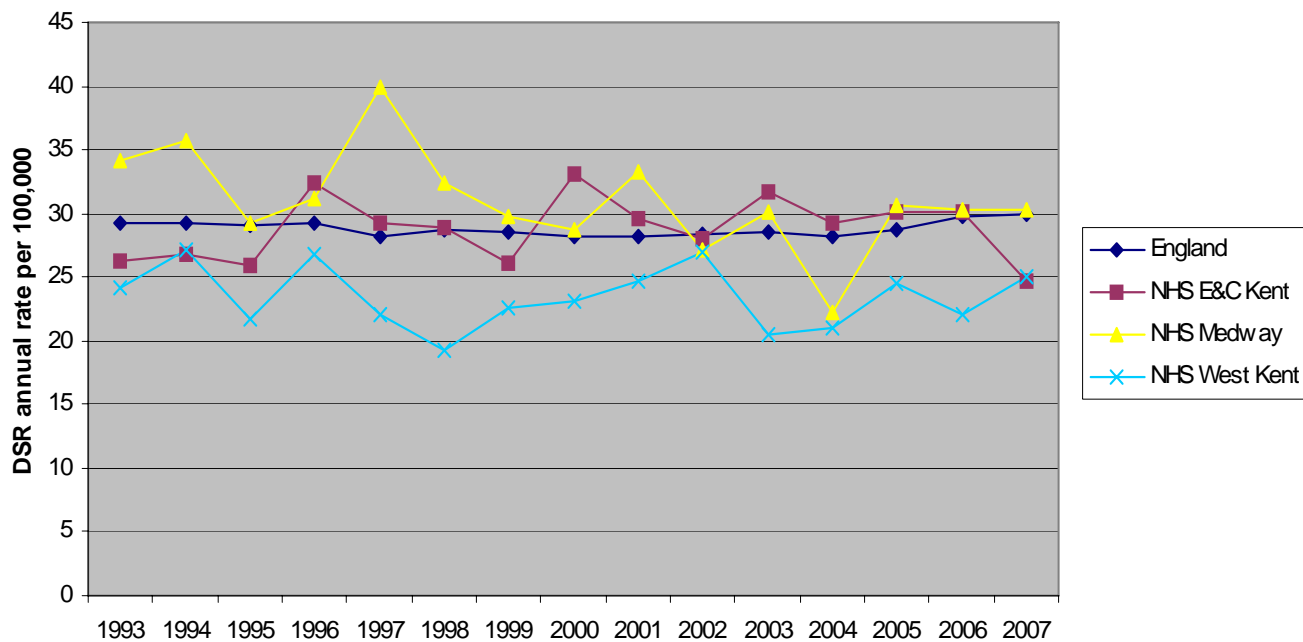
Lung Cancer Mortality - Male, All Ages 1993 - 2007



Data source: NCHOD

Figure 27

Lung Cancer Mortality - Female, All Ages 1993 - 2007

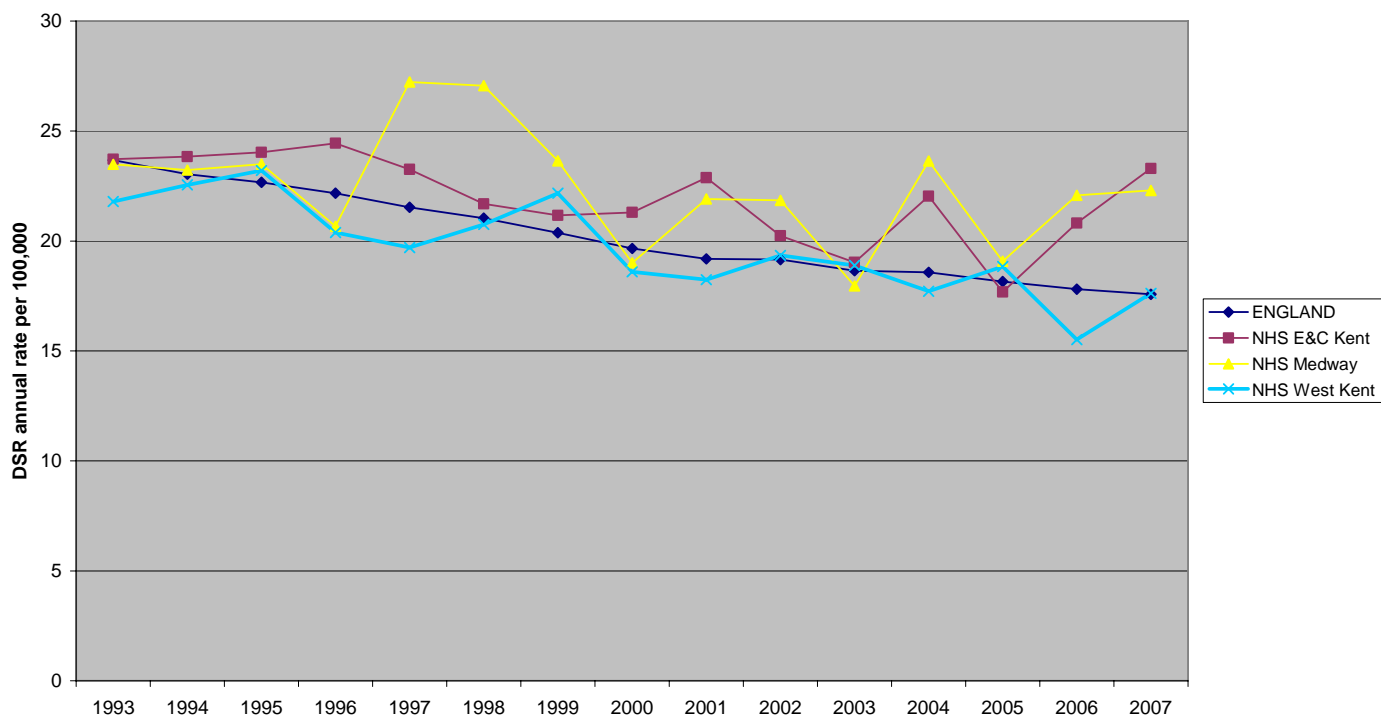


Data source: NCHOD

Figure 28

Kent and Medway Cancer Network Awareness and Early Diagnosis

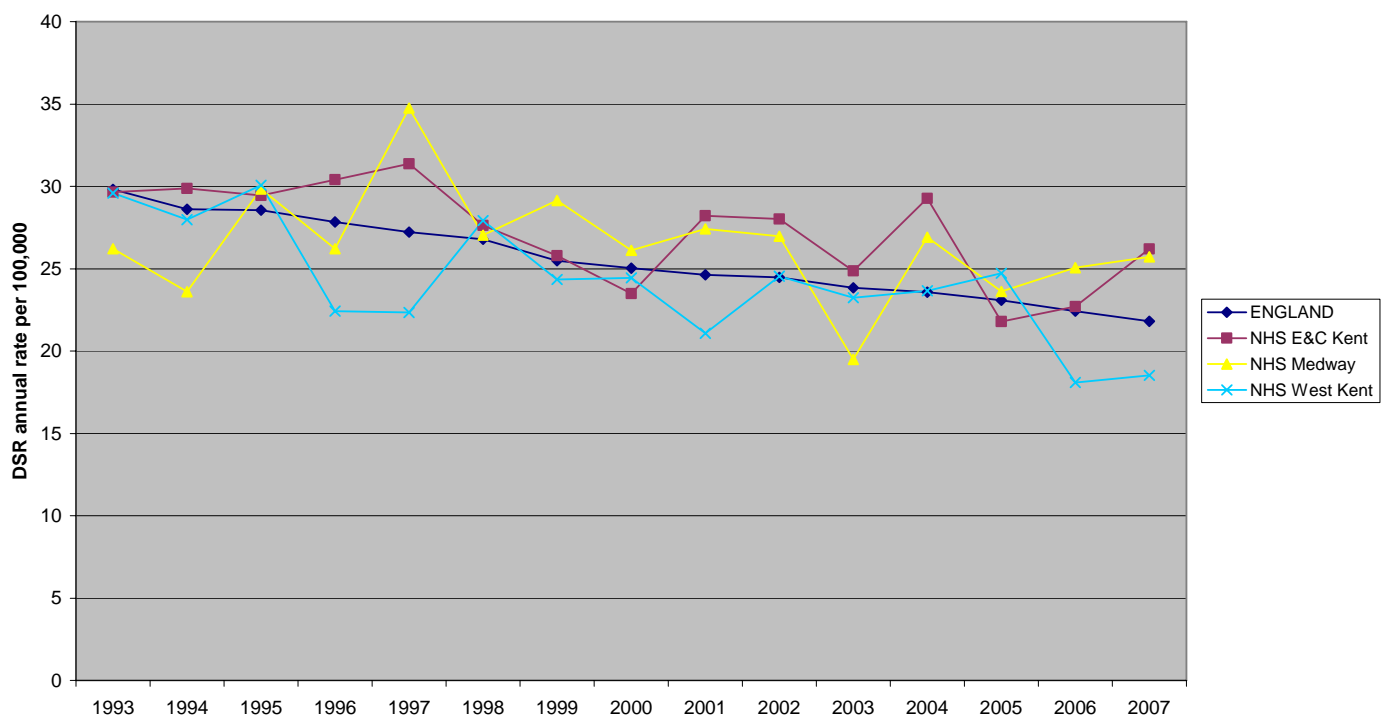
Colorectal Cancer Mortality - All Persons, All Ages 1993 - 2007



Data source: NCHOD

Figure 29

Colorectal Cancer Mortality - Male, All Ages 1993 - 2007

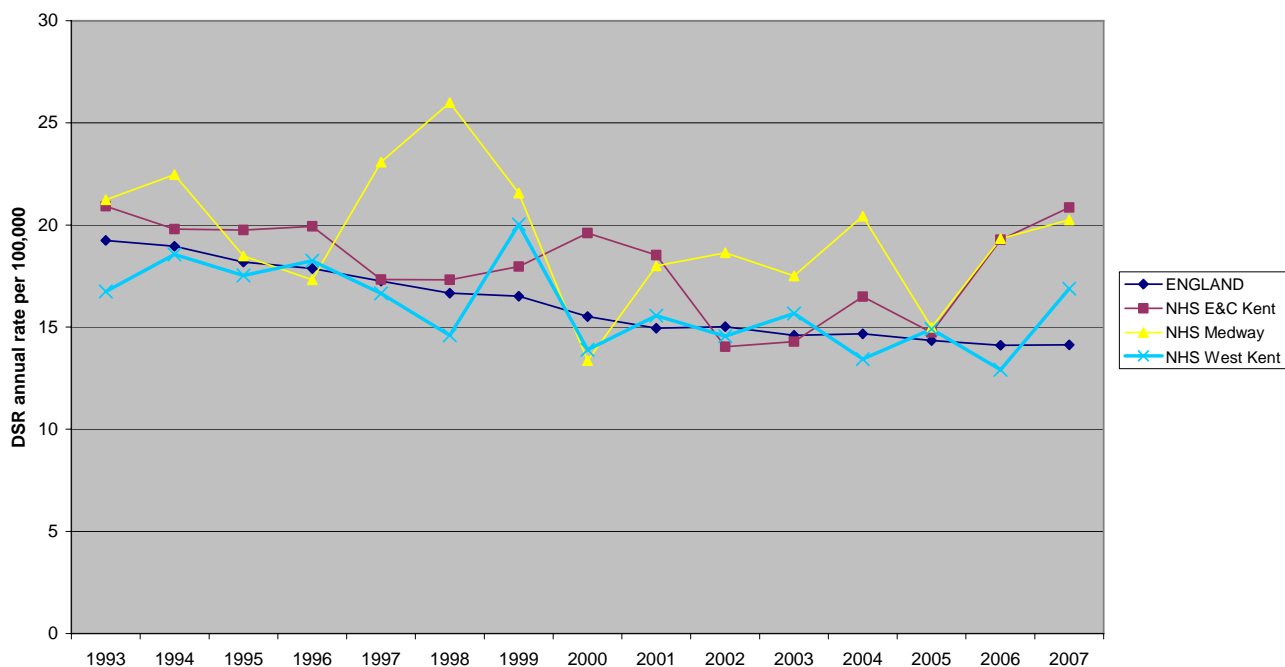


Data source: NCHOD

Figure 30

Kent and Medway Cancer Network Awareness and Early Diagnosis

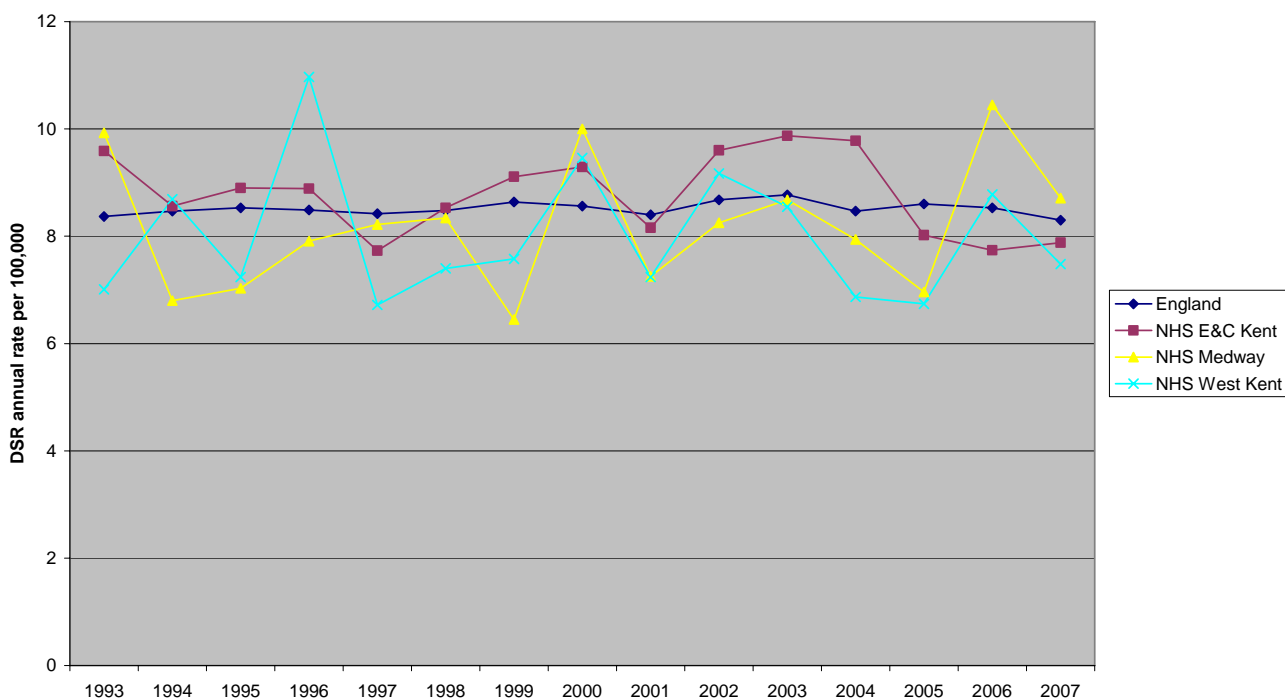
Colorectal Cancer Mortality - Female, All Ages 1993 - 2007



Data source: NCHOD

Figure 31

Oesophageal Cancer Mortality - All Persons, All Ages 1993 - 2007

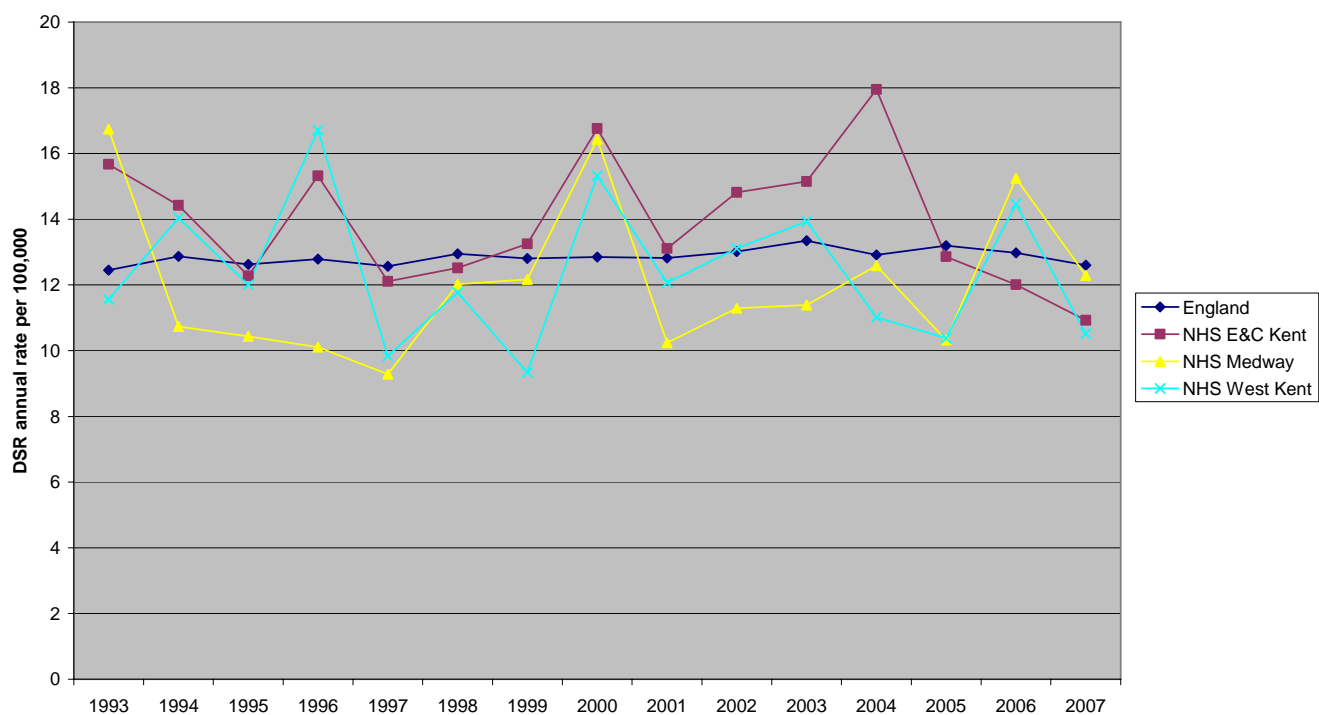


Data source: NCHOD

Figure 32

Kent and Medway Cancer Network Awareness and Early Diagnosis

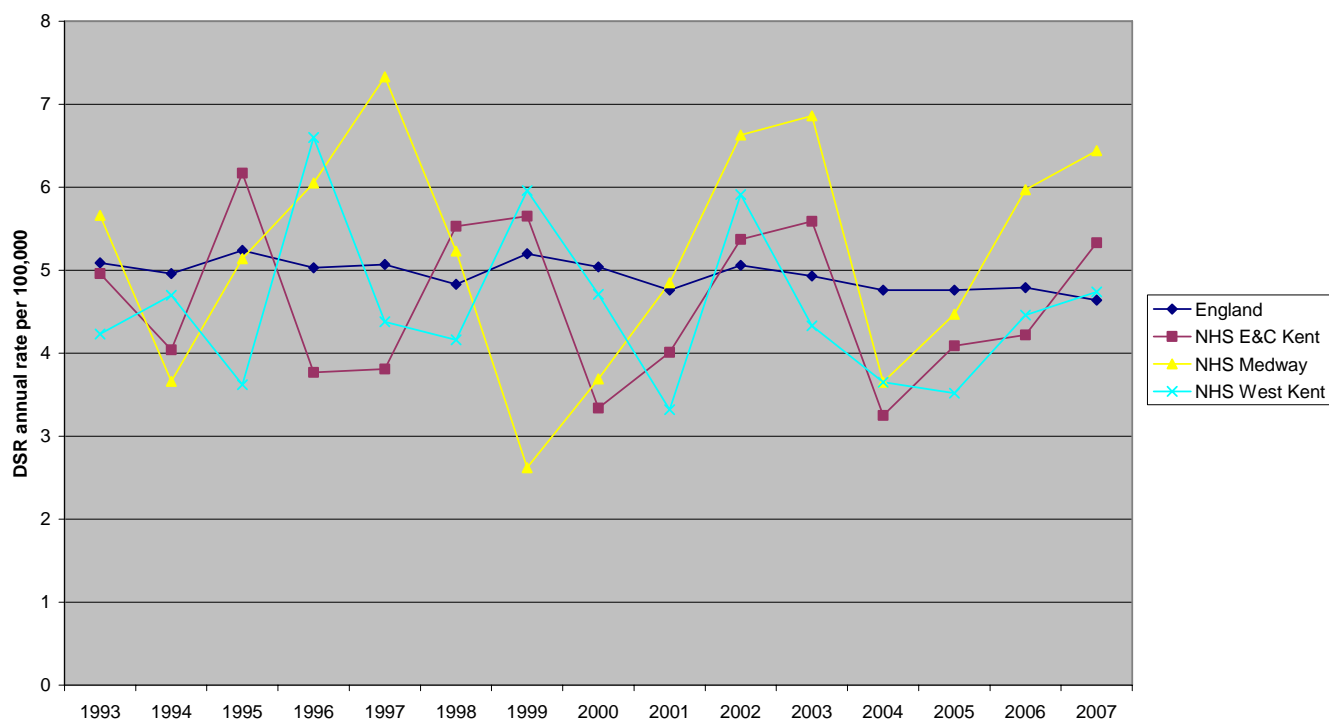
Oesophageal Cancer Mortality - Males, All Ages 1993 - 2007



Data source: NCHOD

Figure 33

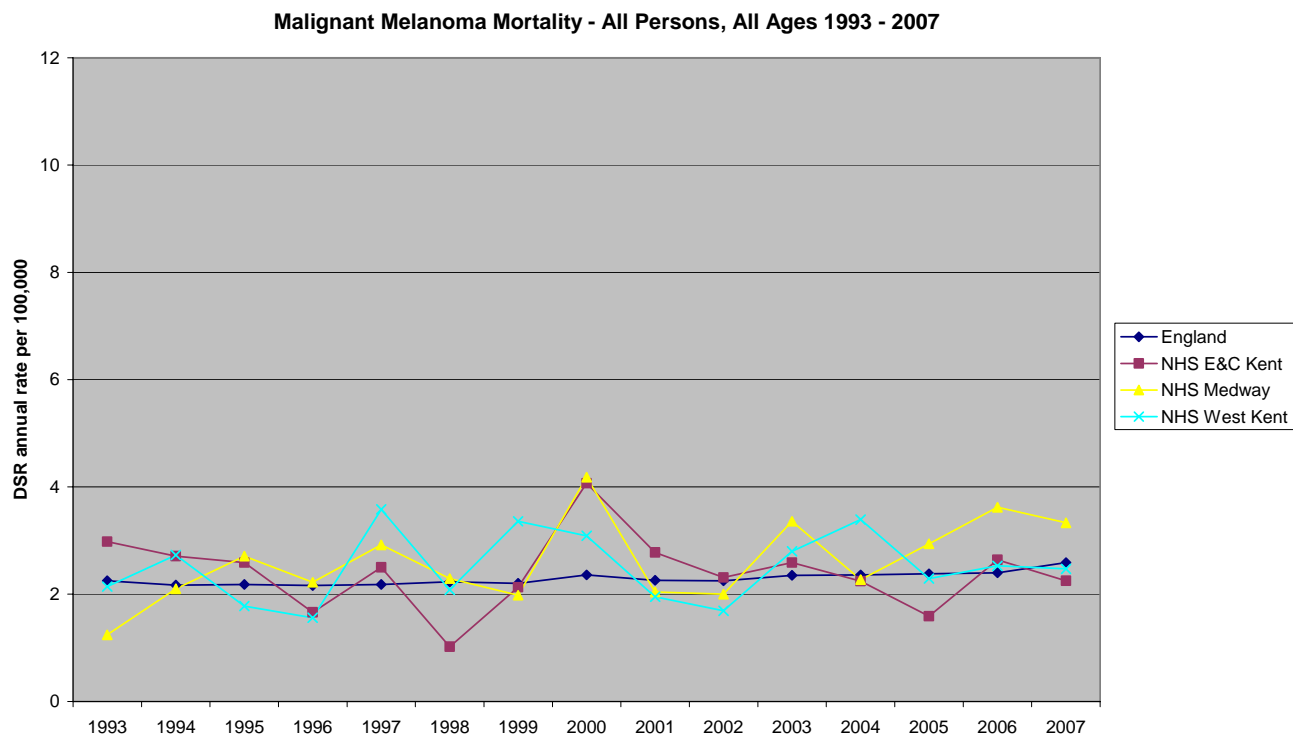
Oesophageal Cancer Mortality - Females, All Ages 1993 - 2007



Data source: NCHOD

Figure 34

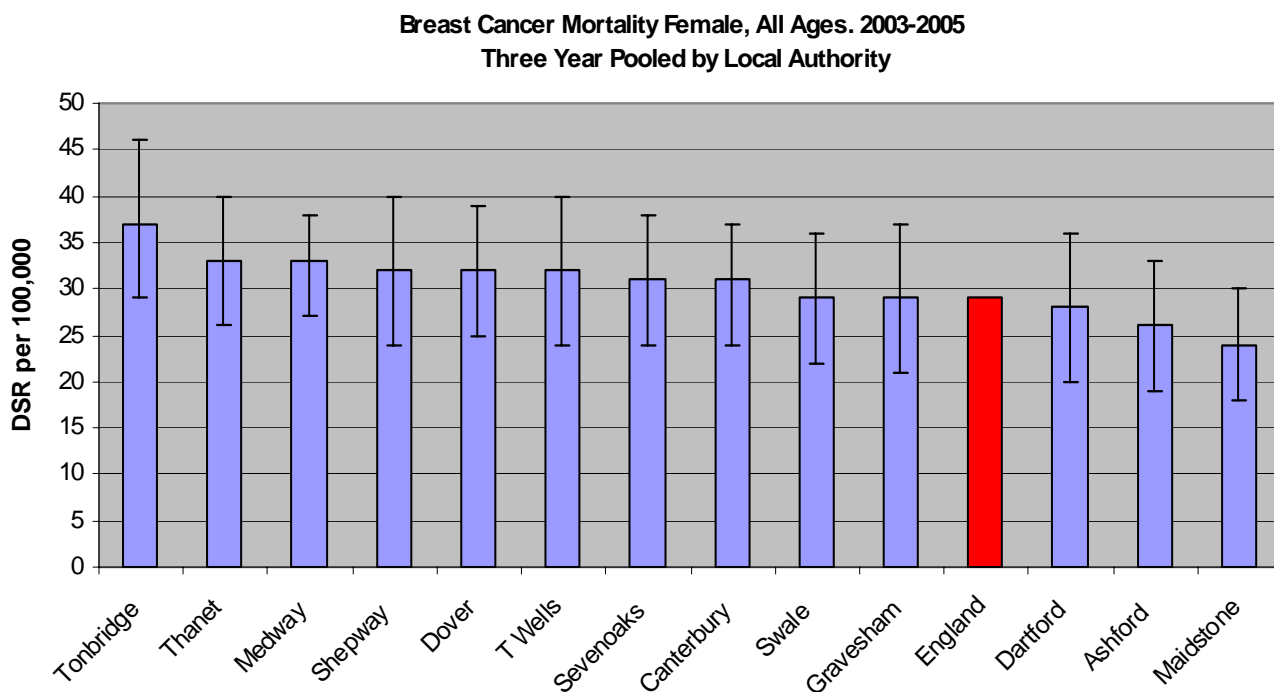
Kent and Medway Cancer Network Awareness and Early Diagnosis



Data source: NCHOD

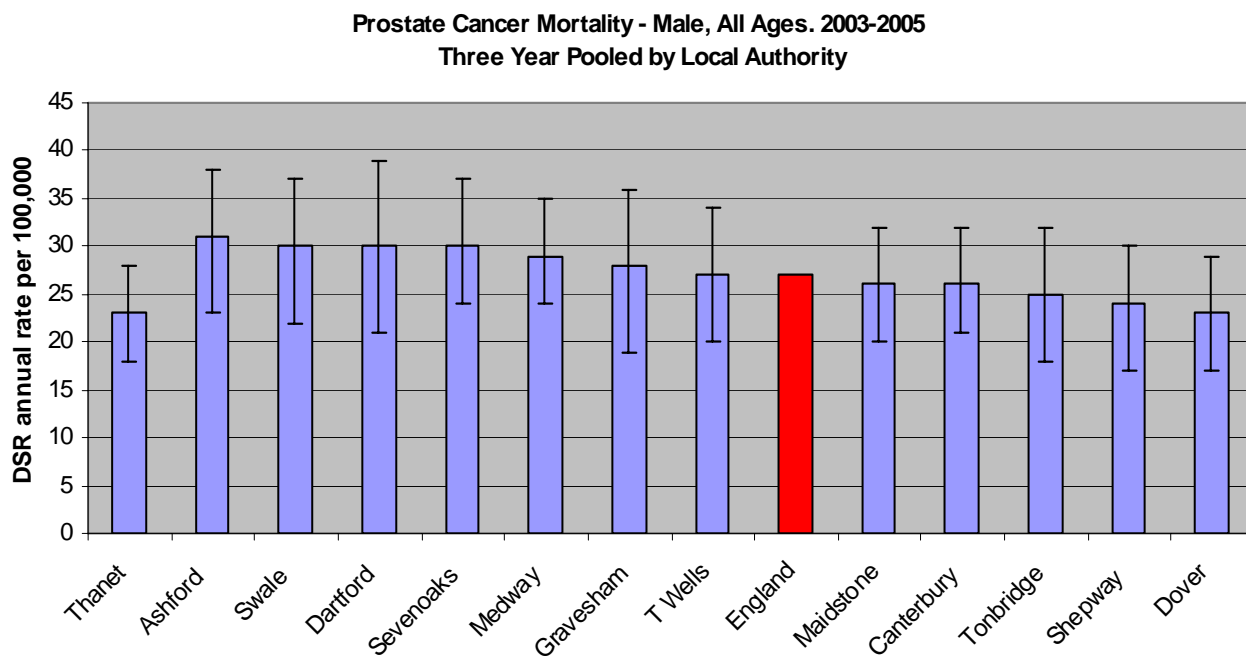
Figure 35

3.2.3 Cancer Mortality per Tumour Group by Local Authority



Data source: NCIN Cancer e-Atlas

Figure 36

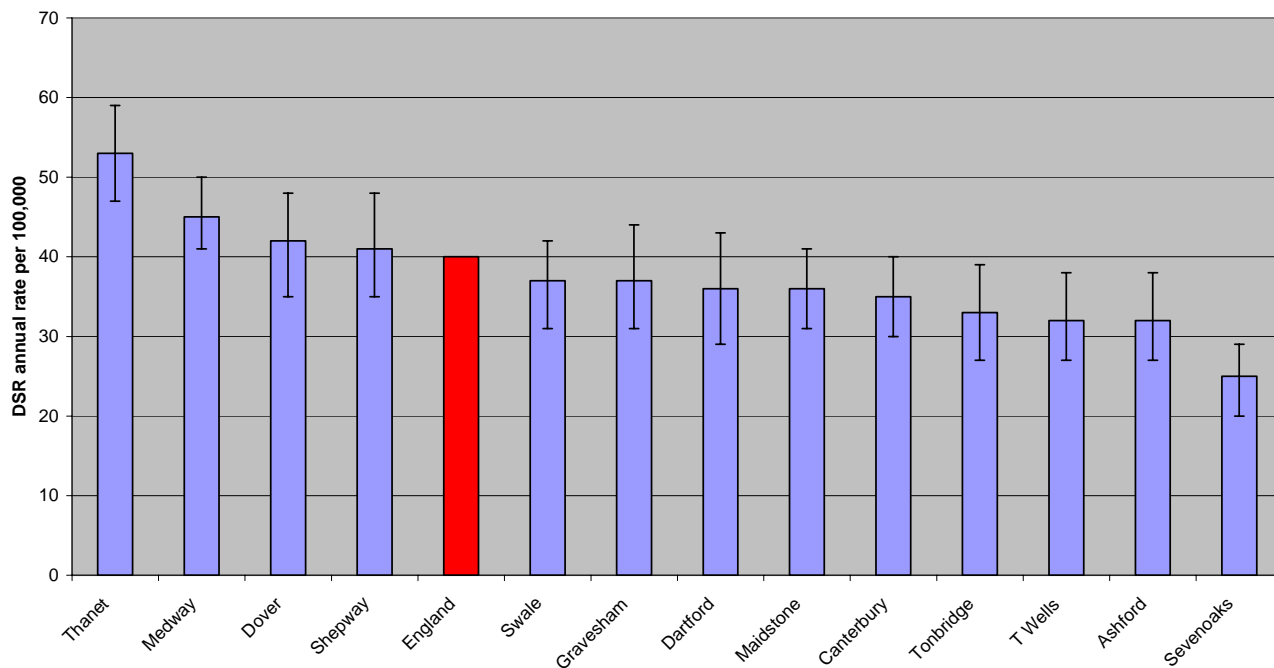


Data source: NCIN Cancer e-Atlas

Figure 37

Kent and Medway Cancer Network Awareness and Early Diagnosis

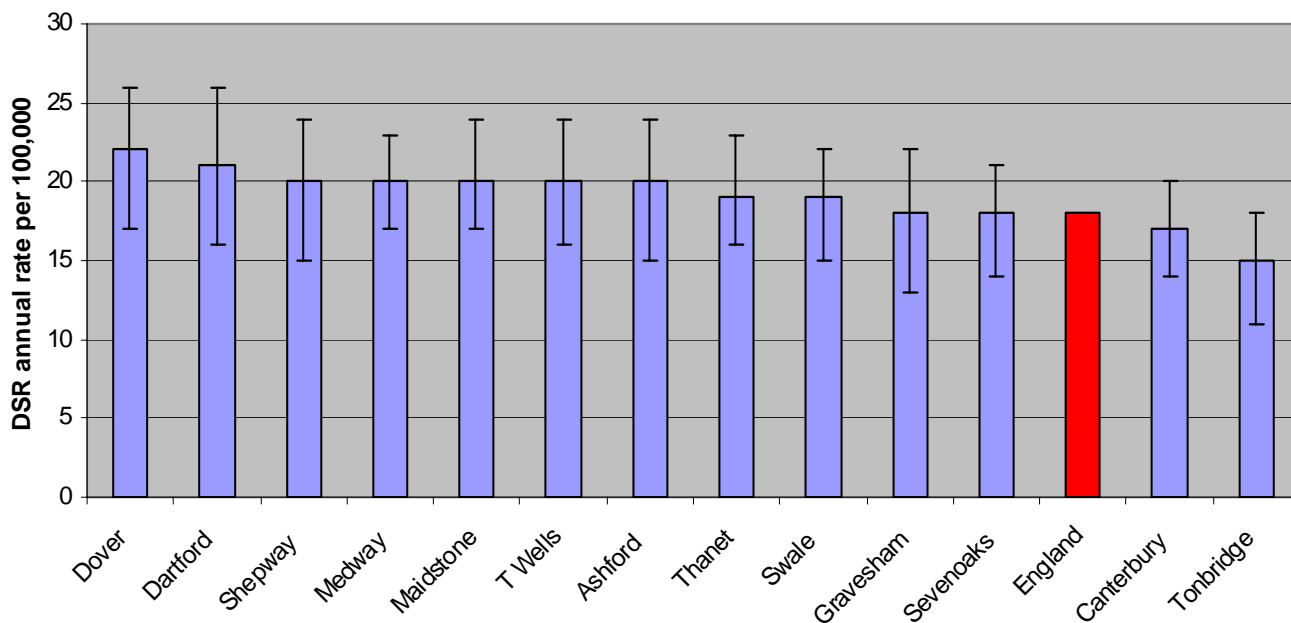
Lung Cancer Mortality All Persons, All Ages
2003-2005 Three Year Pooled by Local Authority



Data source: NCIN Cancer e-Atlas

Figure 38

Colorectal Cancer Mortality All Persons, All Ages. 2003-2005
Three Year Pooled by Local Authority

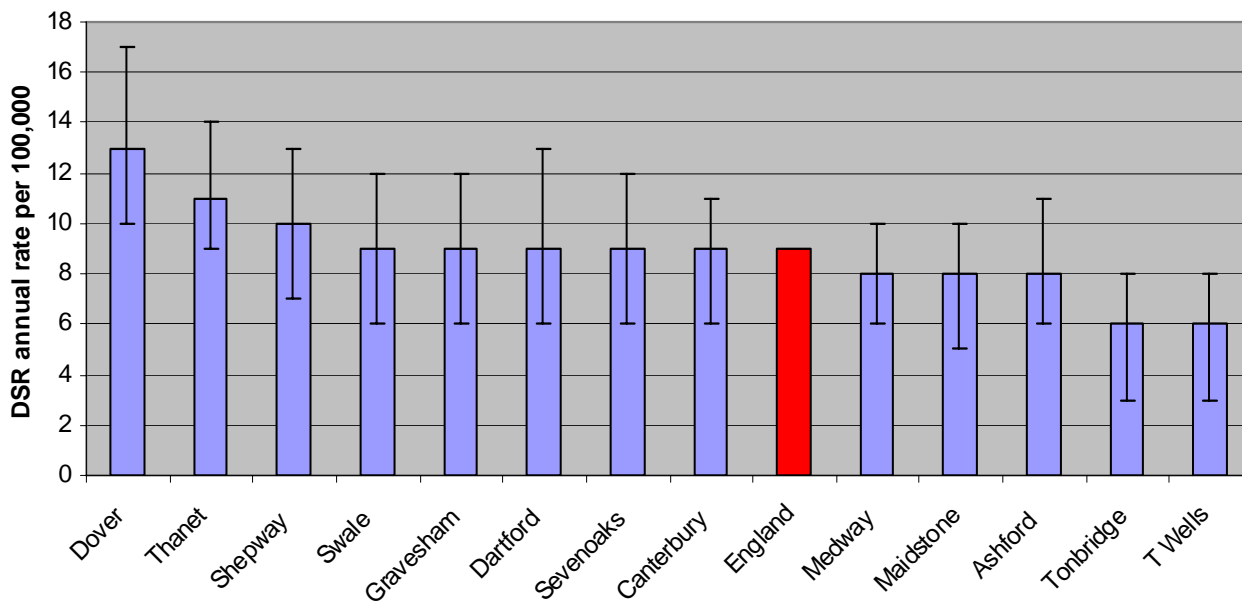


Data source: NCIN Cancer e-Atlas

Figure 39

Kent and Medway Cancer Network Awareness and Early Diagnosis

Oesophageal Mortality All Persons, All Ages.2003-2005
Three Year Pooled by Local Authority

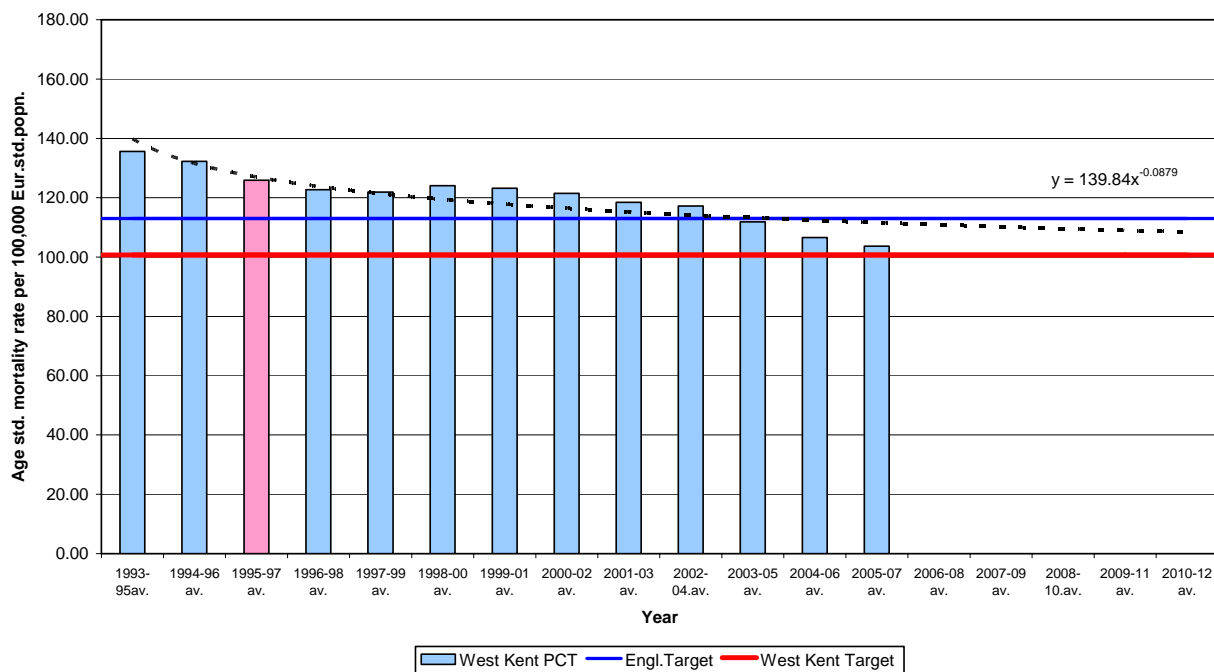


Data source: NCIN Cancer e-Atlas

Figure 40

3.3 Progress against Target

Progress towards 2010 target, all cancers, persons under 75 years old - West Kent PCT



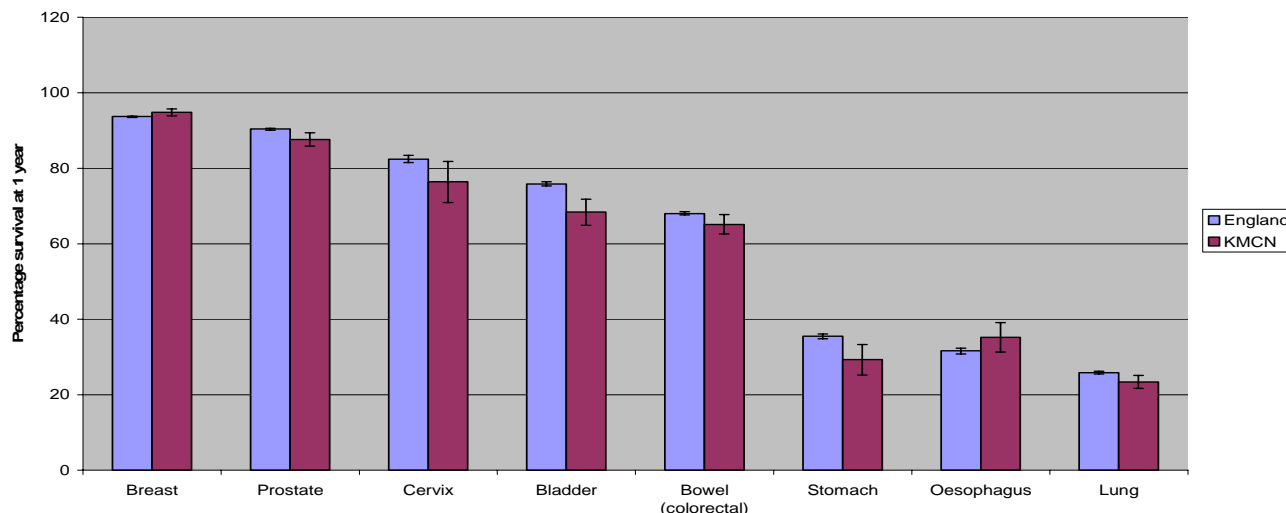
Data source: Kent & Medway Public Health Observatory

Figure 41

4.0 One Year Survival by Network

One-year survival rates for KMCN as compared to the English average are presented in figure 42.

1 Year Survival Following Diagnosis with 95% Confidence Intervals by Tumour Group
(Patients aged 15-99 years diagnosed 1999-2001 followed up to December 2002)



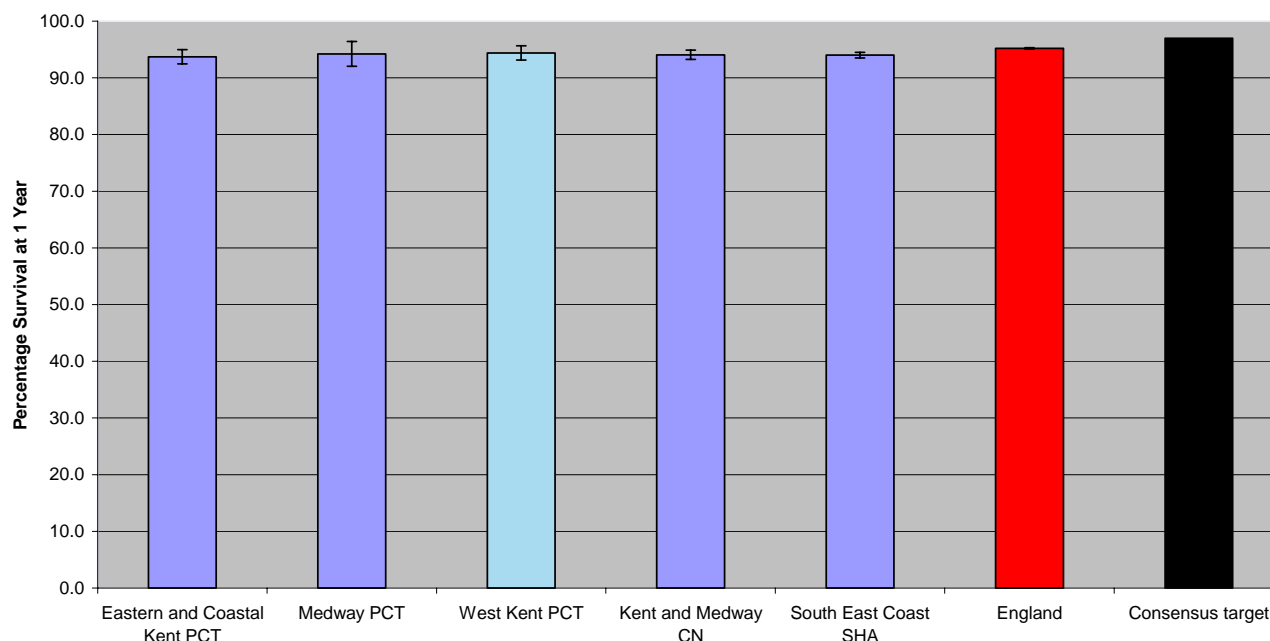
Data source: NCHOD

Figure 42

4.1 One Year Survival by PCT

The following graphs (figures 43-46) illustrate 1 year survival of patients diagnosed with breast, prostate, lung and colorectal cancer during the period 2002-2006. The data are presented at PCT and cancer network level. Data for England, South East Coast Strategic Health Authority and the consensus target derived from the Eurocare – 4¹ study are provided for comparisons.

1 Year Survival Following Diagnosis of Breast Cancer 2002-2006
(Female)



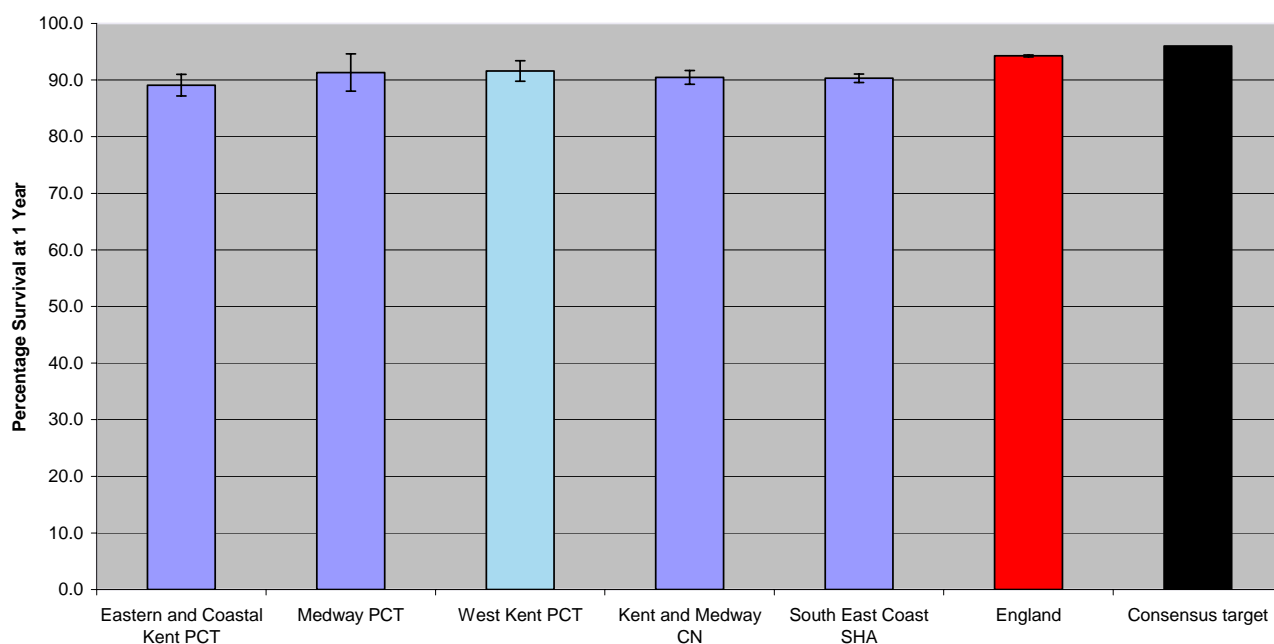
Data source: Thames Cancer Registry

Figure 43

¹ Berrino et al. (2007) Lancet Oncology. DOI:10.1016/S1470-2045(07)

Kent and Medway Cancer Network Awareness and Early Diagnosis

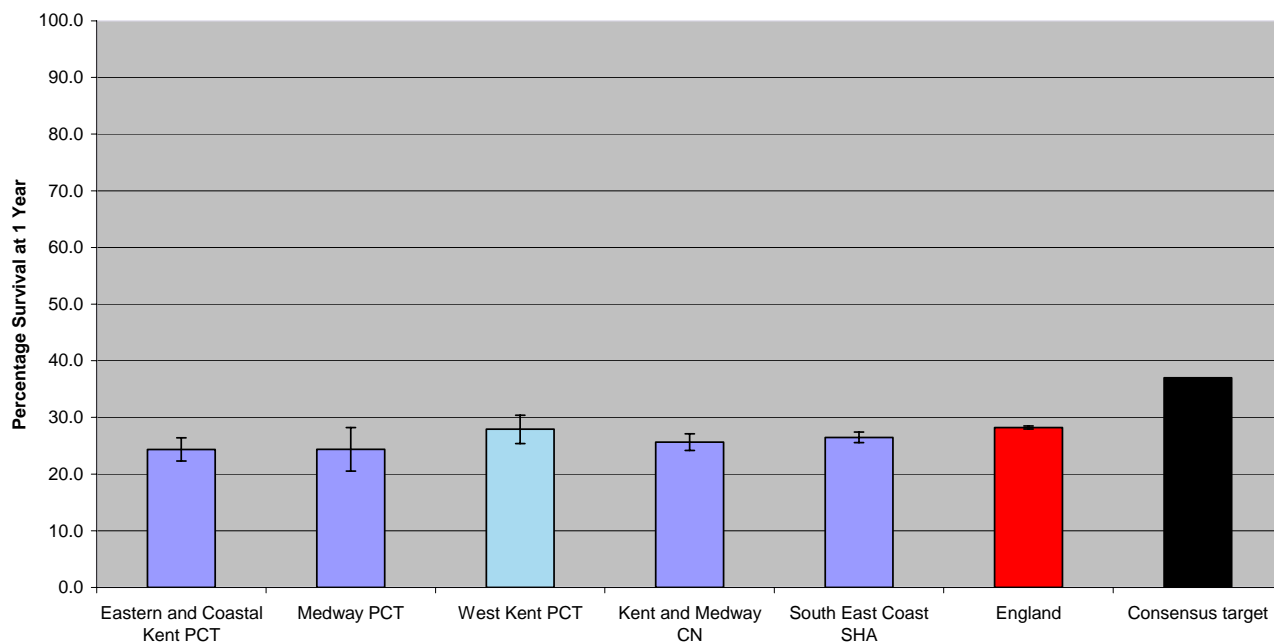
1 Year Survival Following Diagnosis of Prostate Cancer 2002-2006



Data source: Thames Cancer Registry

Figure 44

1 Year Survival Following Diagnosis of Lung Cancer 2002-2006 (Persons)

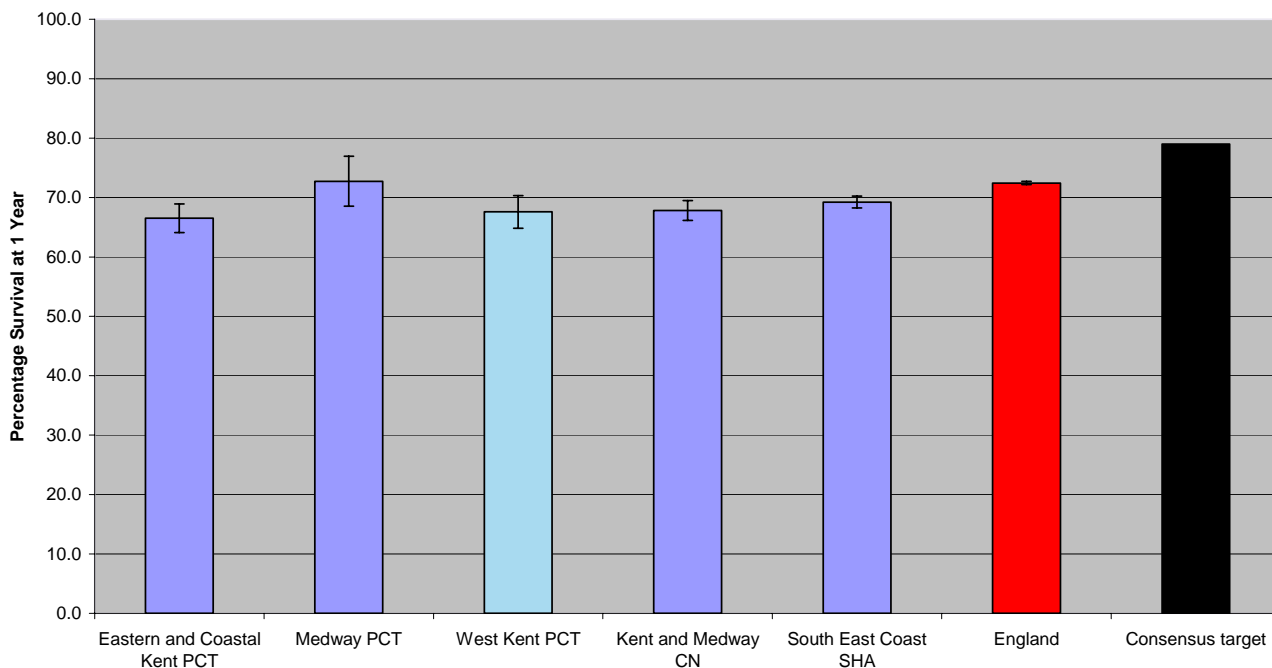


Data source: Thames Cancer Registry

Figure 45

Kent and Medway Cancer Network Awareness and Early Diagnosis

1 Year Survival Following Diagnosis of Colorectal Cancer 2002-2006
(Persons)



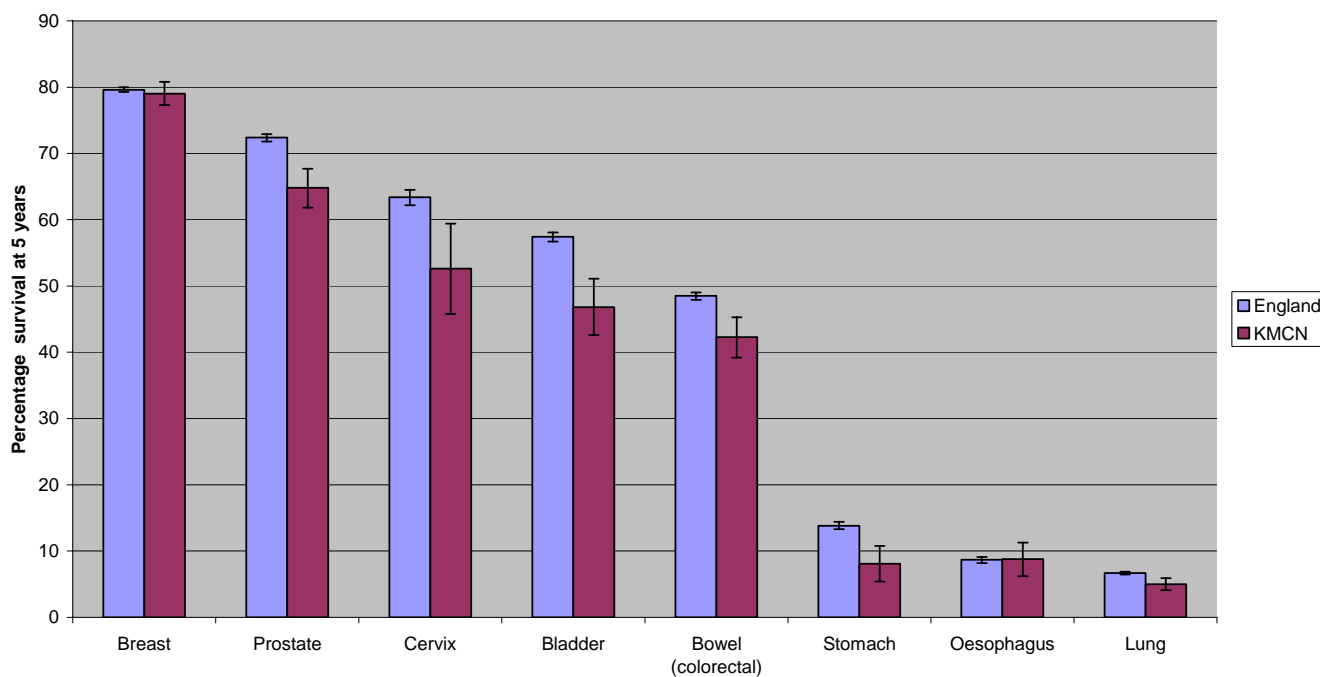
Data source: Thames Cancer Registry

Figure 46

5.0 Five Year Survival by Network

Five-year survival rates for KMCN as compared to the England average are presented in figure 47.

5 Year Survival Following Diagnosis with 95% Confidence Intervals by Tumour Group
(Patients aged 15-99 years diagnosed 1999-2001 followed up to December 2005)



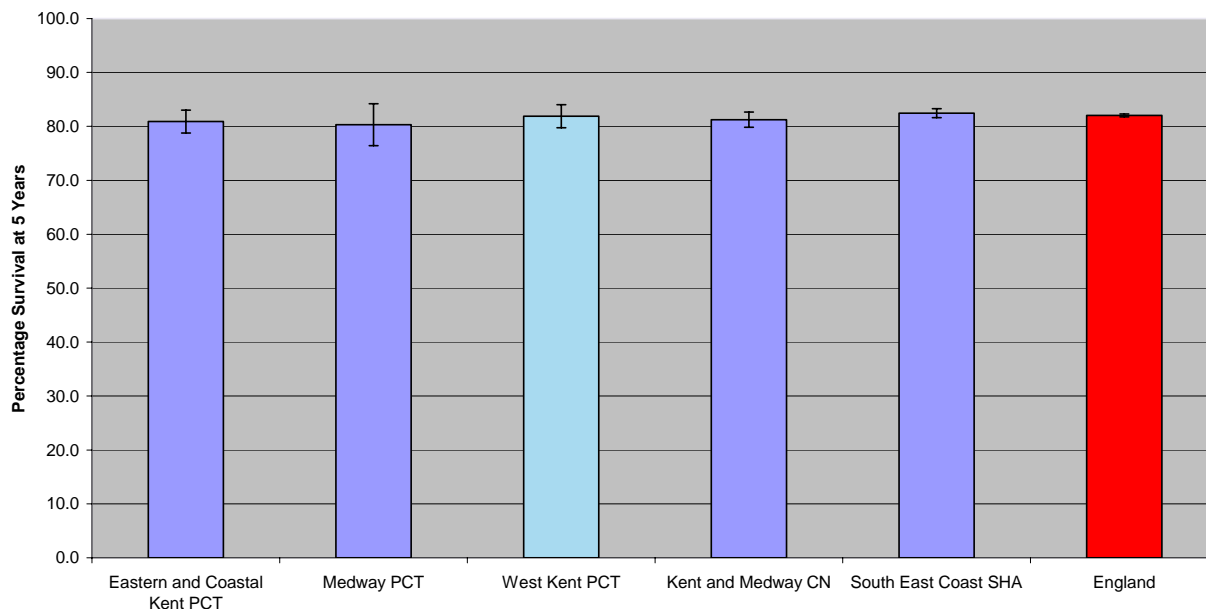
Data Source: NCHOD

Figure 47

5.1 Five Year Survival by PCT

The following graphs (figures 48-51) illustrate 5 year survival of patients diagnosed with breast, prostate, lung and colorectal cancers during the period 2002-2006. The data are presented at PCT and cancer network level. Data for England and South East Coast Strategic Health Authority are provided for comparisons.

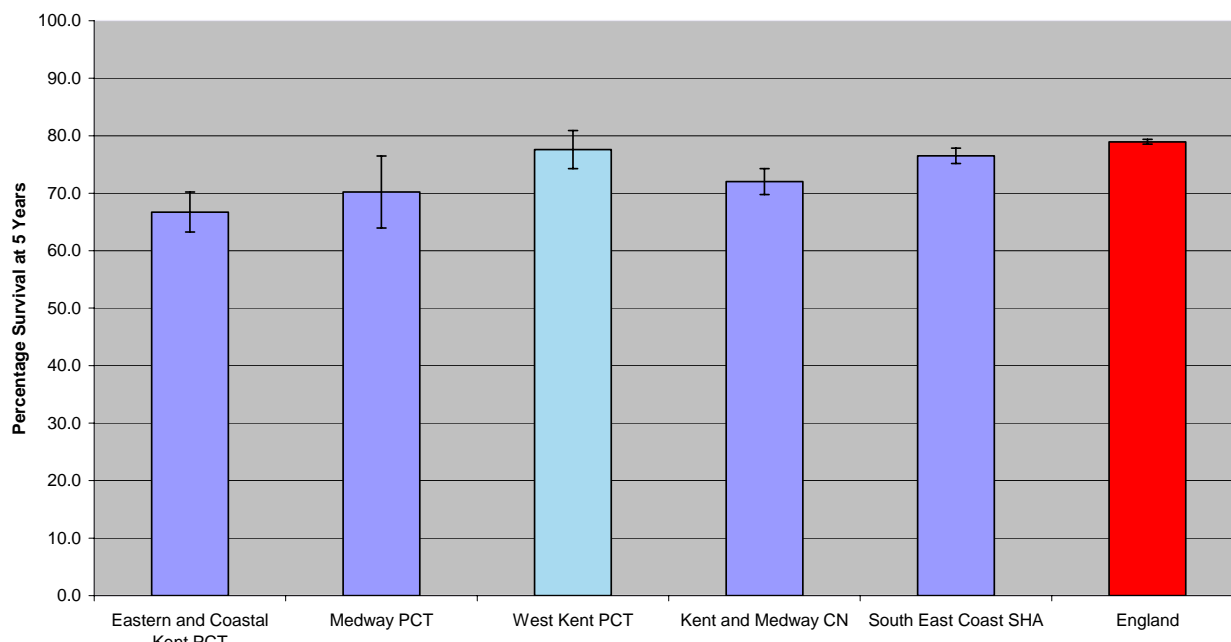
5 Year Survival Following Diagnosis of Breast Cancer 2002-2006 (Female)



Data source: Thames Cancer Registry

Figure 48

5 Year Survival Following Diagnosis of Prostate Cancer 2002-2006

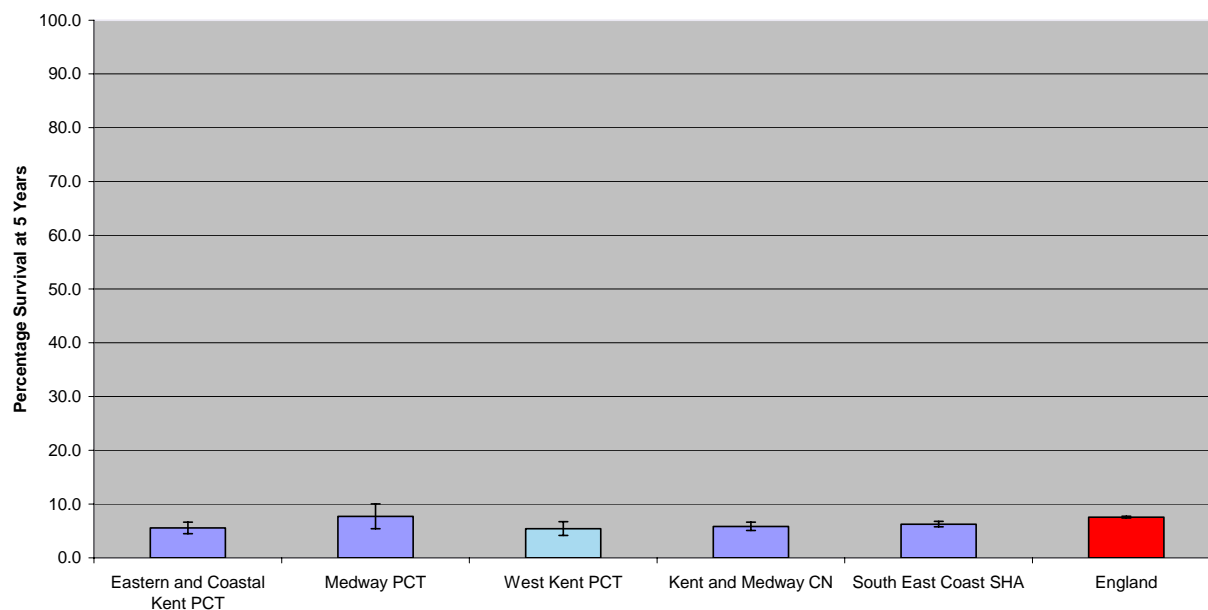


Data source: Thames Cancer Registry

Figure 49

Kent and Medway Cancer Network Awareness and Early Diagnosis

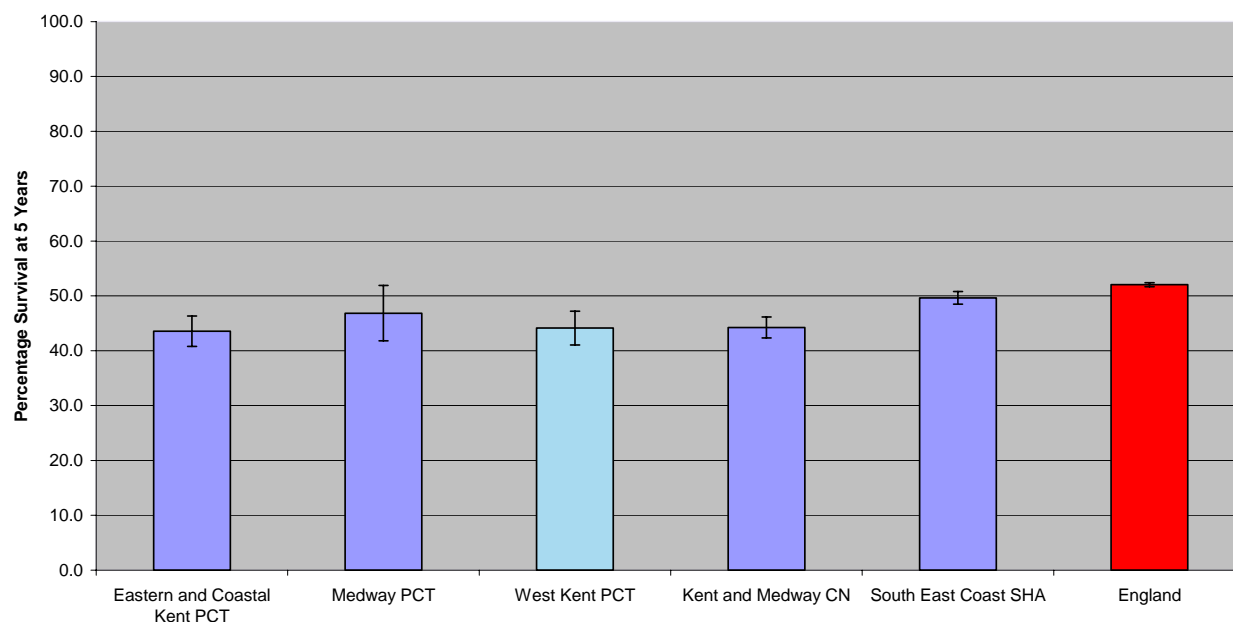
5 Year Survival Following Diagnosis of Lung Cancer 2002-2006
(Persons)



Data source: Thames Cancer Registry

Figure 50

5 Year Survival Following Diagnosis of Colorectal Cancer 2002-2006
(Persons)



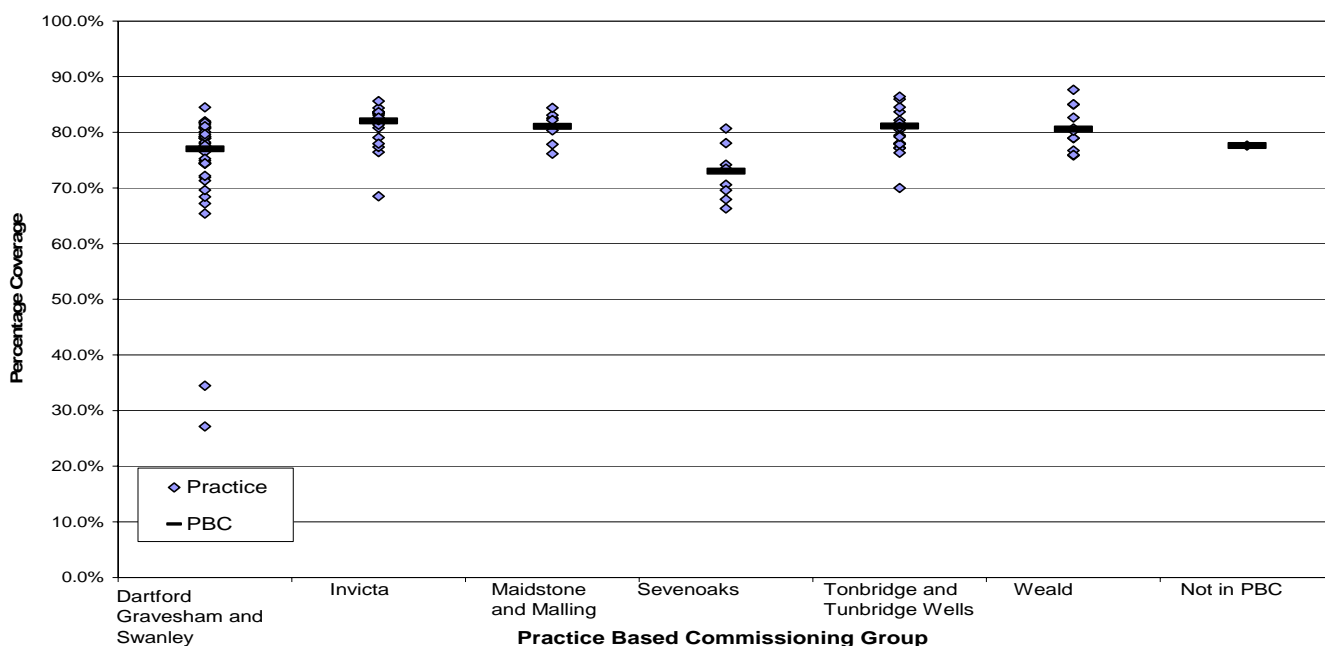
Data source: Thames Cancer Registry

Figure 51

6.0 Breast Screening Coverage

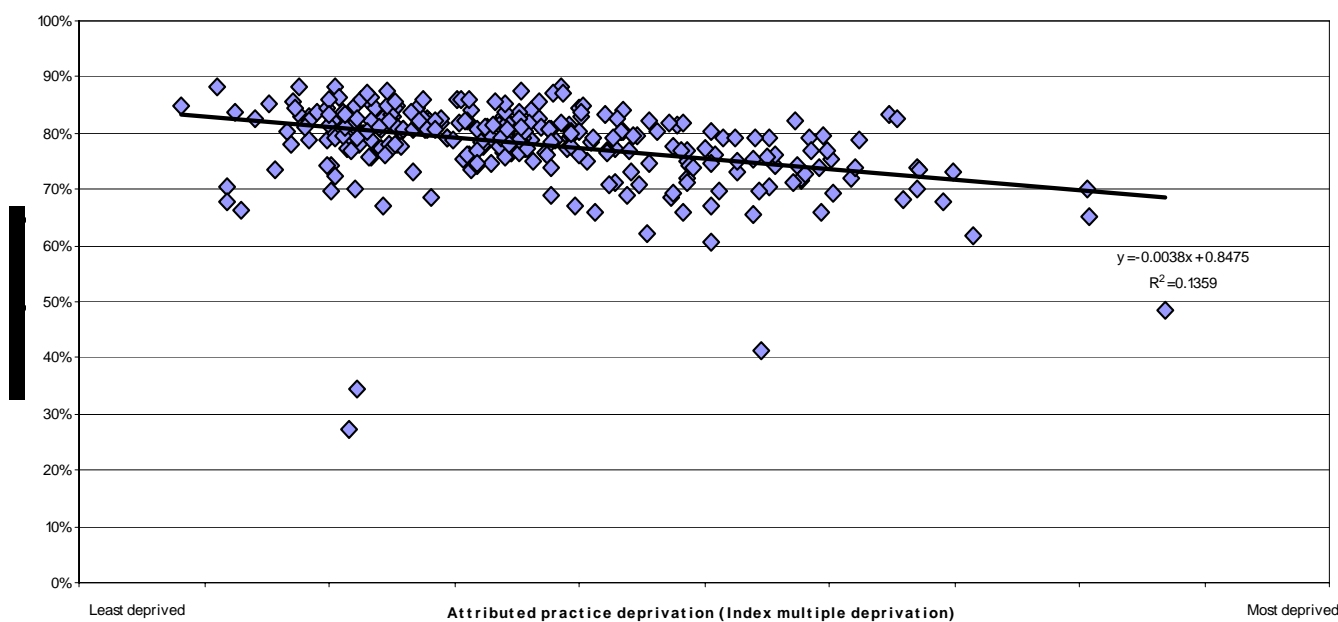
The coverage rate is the proportion of eligible women in the screening target area who have had a test with a recorded result at least once in the previous 3 years. This is one way of examining the effectiveness of the screening programme.

Breast screening coverage in West Kent PCT per Practice Based Commissioning Group is shown in Figure 52 for the calendar year of 2008. This shows variations of breast screening coverage across practices with few outliers and also highlights the overall breast screening coverage by PBC groups. Breast screening coverage for Kent and Medway in 2008 by deprivation score (Index of Multiple Deprivation 2007) served by practices is shown in Figure 53 ($r^2=0.1359$). The variation in the deprivation of practice area explains about 14% of the total variation in screening coverage. The other 86% of variation in screening coverage is unexplained and probably due to other factors not considered in this analysis.



Source: Kent & Medway Public Health Observatory

Figure 52



Source: Kent & Medway Public Health Observatory

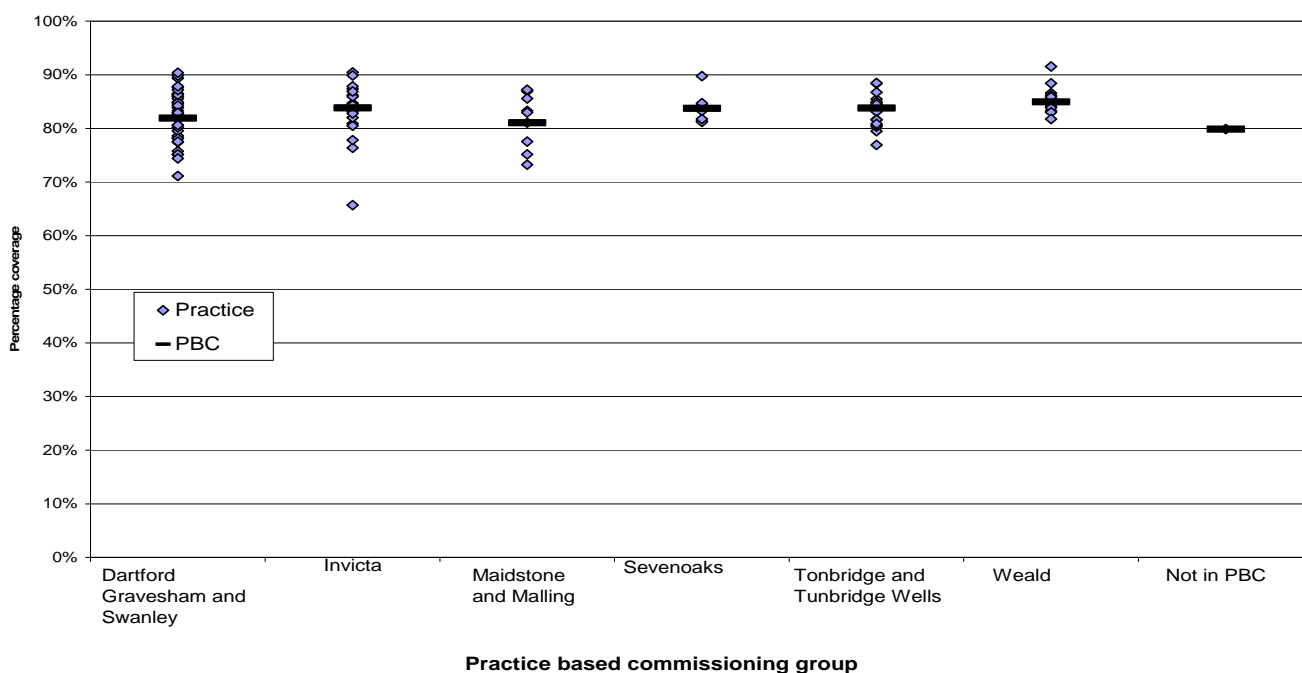
Figure 53

7.0 Cervical Screening

The coverage rate is the proportion of eligible women in the screening target area who have had a test with a recorded result at least once in the previous 5 years. This is one way of examining the effectiveness of the screening programme.

Cervical screening coverage during the calendar year 2008 per Practice Based Commissioning Group is shown in Figure 54. This illustrates the variations across practices and the average cervical screening coverage for each PBC group.

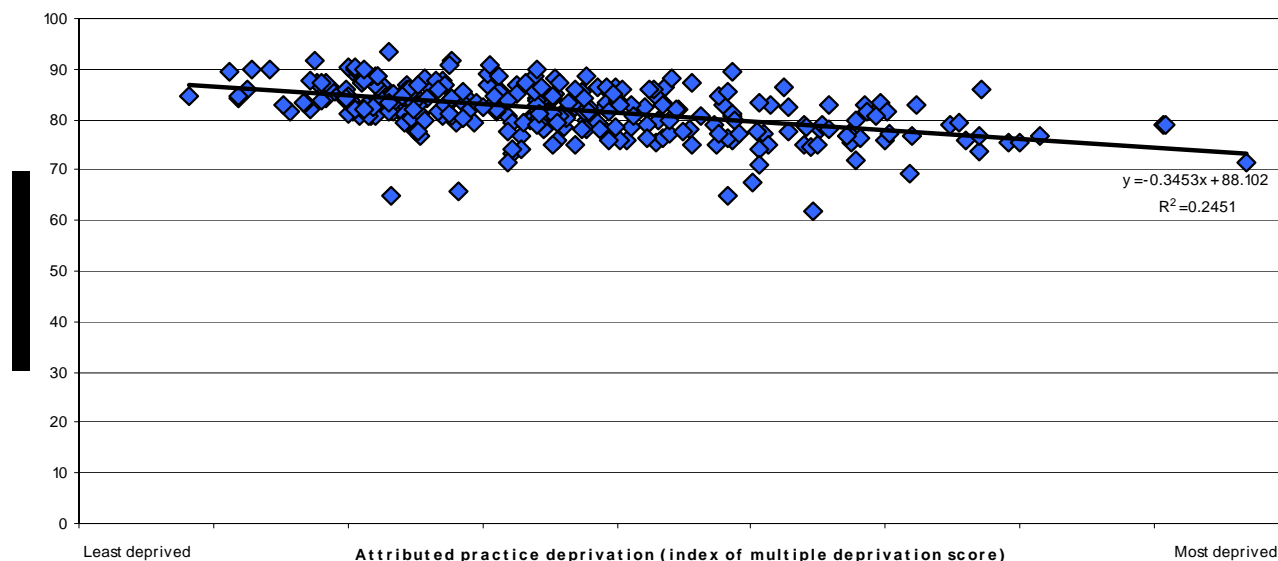
Figure 55 shows cervical screening coverage for Kent and Medway in 2008 by deprivation score (index of multiple deprivation 2007) served by practices ($r^2=0.2451$). The variation in deprivation of practice area explains about 25% of total variation in screening coverage. The other 75% of the variation in screening coverage is unexplained and probably due to other factors not considered in this analysis.



Source: Kent & Medway Public Health Observatory

Figure 54

Cervical Screening coverage by practice and deprivation score as at 31st March 2008



Source: Kent & Medway Public Health Observatory

Figure 55

8.0 Referral Rates

Pending data

9.0 Emergency Admissions

Pending data

10.0 Agreeing Priorities

We request that you complete the forms in appendix 3 (sections A and B) and feedback via your commissioner to the Kent and Medway Cancer Commissioning Group, in order that the information can be included in the Kent and Medway Cancer Network Strategy.

11.0 Scoping Ongoing Initiatives

We request that you complete the form in appendix 4 and feedback via your commissioner to the Kent and Medway Cancer Commissioning Group, in order that the information can be included in the Kent and Medway Cancer Network Strategy.

12.0 Local Awareness and Early Diagnosis Initiative Projects

In March 2009, Cancer Networks were invited to submit proposals to the National Cancer Action Team (NCAT) to obtain funding for one-year time limited projects to support the delivery of NAEDI across individual Networks. KMCN requested proposals from stakeholders across the Network. The short timescale proved challenging, but projects were put forward from Disease Orientated Groups (DOGs) and from Primary Care. These projects were submitted to NCAT on 30th April 2009 and gained approval. Projects are summarised in Appendix 2; full project proposals are available on request.

APPENDIX 1 – Incidence And Mortality Tables

	NHS West Kent													
	England		Dartford		Gravesham		Maidstone		Sevenoaks		Tonbridge		Tunbridge Wells	
	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled
Breast	123	29	117	28	113	29	123	24	118	31	136	37	124	32
Bladder	13	6	8	5	13	7	15	6	12	3	11	6	13	4
Colorectal	44	18	45	21	40	18	39	20	41	18	35	15	39	20
Cervix	8	3	8	5	7	5	7	2	5	2	8	3	2	2
Lung	48	40	50	36	43	37	43	36	31	25	39	33	37	32
Oesophagus	10	9	11	9	9	9	8	8	8	9	6	6	10	6
Prostate	98	27	82	30	87	28	112	26	91	30	118	25	93	27
Stomach	10	7	12	8	9	7	9	6	9	5	10	8	9	6
Total	354	139	333	142	321	140	356	128	315	123	363	133	327	129

			NHS Medway	
	England		Medway	
	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled
Breast	123	29	125	33
Bladder	13	6	13	8
Colorectal	44	18	48	20
Cervix	8	3	8	3
Lung	48	40	50	45
Oesophagus	10	9	10	8
Prostate	98	27	89	29
Stomach	10	7	11	7
Total	354	139	354	153

Kent and Medway Cancer Network Awareness and Early Diagnosis

		NHS E&C Kent													
England		Ashford		Canterbury		Dover		Shepway		Swale		Thanet			
	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	Incidence 2003-5 3 Year Pooled	Mortality 2003-5 3 Year Pooled	
Breast	123	29	105	26	107	31	110	32	116	32	114	29	115	33	
Bladder	13	6	12	6	17	7	15	5	14	7	16	8	12	8	
Colorectal	44	18	40	20	40	17	46	22	43	20	39	19	40	19	
Cervix	8	3	10	2	7	2	7	4	11	4	10	3	11	4	
Lung	48	40	38	32	40	35	46	42	49	41	40	37	58	53	
Oesophagus	10	9	9	8	9	9	11	13	14	10	10	9	12	11	
Prostate	98	27	98	31	88	26	80	23	79	24	92	30	85	23	
Stomach	10	7	8	3	6	5	8	6	6	4	12	8	9	6	
Total	354	139	320	128	314	132	323	147	332	142	333	143	342	157	

APPENDIX 2 – Local Awareness and Early Diagnosis Projects

1. Improving Diagnosis and Prevention of Vulval Cancer

This project seeks to promote the early detection and ultimately the prevention of vulval cancer. The increased incidence of vulval cancer in younger women (age <50) has been linked to low socio-economic groups, smoking and an increasing incidence of vulval intraepithelial neoplasia (VIN), a pre-cancerous lesion caused by HPV infection. Many women in the non-HPV related group (age >50) have previously suffered from lichen sclerosis. Late stage presentation of vulval cancer has been identified as a problem in Kent and Medway. The project will exploit the potential not only for earlier diagnosis, but also for disease prevention.

Key Outputs:

- Analysis of significant events from the patients' histories, using the National Primary Care Audit tool and establishment of enhanced referral guidelines for use in Primary Care
- Analysis of risk factors to inform public health initiatives in identifying women at risk, preventing serious advanced disease and reducing cancer inequalities

2. Improving Early Detection and Diagnosis of Gastro- Oesophageal Cancer in Kent and Medway

Levels of oesophageal and gastric cancer in England are among the worst in Europe; smoking, excessive alcohol consumption and poor diet are strong associative factors. There is thus a potential for disease prevention by raising awareness about common risk factors. Approximately 500 patients annually are diagnosed with the disease in Kent and Medway. Traditional warning signs often represent advanced disease, at which point cure is unattainable. This project sets out to explore the causes of delay in presentation and identify more subtle signs in early detection.

Key Outputs:

- Analysis of significant events from patients' histories and establishment of enhanced educational programmes for use by primary and community care
- Analysis of risk factors to inform public health initiatives supporting reduction in cancer inequalities, identifying those at risk and preventing serious advanced disease

3. Local Enhanced Service to audit Cancer Referrals in Medway

This project has identified the work and the outcome of the Scottish Directed Enhanced Service for cancer which supported GPs to conduct a review of all new cancer cases diagnosed in the previous year, looking at the whole patient pathway, from primary to acute sectors. The Royal College of General Practice within England have recently finalised a national GP audit tool to undertake similar work within England. The Medway project will participate with this primary care audit tool.

Key outputs:

- Completion of the Primary care Audit in GP Practices across Medway, examining factors affecting the patient journey from time of presentation to point of diagnosis.
- Incorporation of significant event analysis into existing educational opportunities for primary care
- Utilise findings to inform any future Public Health initiatives (social marketing approach) supporting reduction in cancer inequalities

APPENDIX 3 – Feedback Forms Sections A and B

Kent & Medway Cancer Network
Cancer Early Detection and Prevention Strategy National Cancer Public Agreement target (PSA) is to reduce mortality rates by 2010 (from 1995-97 baseline) for cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
Section (A) Criteria. Please consider criteria for selecting areas of priority within the Cancer Network Awareness and Early Diagnosis and comment. Add any new criteria that you feel have been missed out.
1. We should be focussing on the cancers with the highest mortality and incidence. Comment:
2. We should be targeting hard to reach groups within local communities. Comment:
3. We should ensure that all eligible people access cancer screening, including groups such as prisoners, travellers, people with disabilities. Comment:
4. We should be focussing on the experience of people attending screening or seeking help with early symptoms.
5. We should be targeting the groups with worst access to services.....
6. Other.

Section (B) Priorities.

Apply the criteria you decided upon in Section (A), please list the priorities for consideration in the strategy.

Top Priorities

(1)

Because...

(2)

Because...

Other High Priorities

(3)

Because...

(4)

Because...

(5)

Because...

APPENDIX 4 – Ongoing Initiatives Feedback Form

Section (C) Innovation.

Please make us aware of any initiatives that you think should be included in the Strategy or any areas of good practice. Use this section to quickly capture any knowledge or ideas that may be helpful to explore at a later date.

1.

2.

3.

4.

5.