Key messages

- More than a quarter of breast cancer cases are preventable through maintaining a healthy weight, engaging in physical activity and reducing alcohol consumption so steps should be taken to support this.
- In addition, steps should be taken to ensure adequate access to preventative drugs for those at defined high risk of breast cancer in Cheshire East.
- Breast screening remains an important means of diagnosing breast cancer at an early stage when treatment is likely to be more straightforward and thus more successful. **Particular efforts should be made to improve breast screening uptake in Crewe Town and Chelford, Alderley Edge, Wilmslow and Handforth** where women appear to be less likely to respond to invitations to screening. It is also necessary to **ensure** that access to screening programmes is equitable e.g. **that reasonable adjustments are made and support provided to women with learning disabilities**. Screening of high risk women appears to be increasing in Cheshire East and this should continue.
- Commissioners should ensure that there is sufficient capacity to manage increasing numbers of referrals for breast symptoms in Cheshire East, given the increase in breast cancers and demand upon diagnostic services.
- Less than 1% of breast cancers occur in males but there is still a need to address the needs of this specific group.
- Breast cancer incidence is higher in Cheshire East than England average with rates being particularly high in NHS Eastern Cheshire CCG. Despite this, breast cancer mortality and one year survival locally is similar to England average. This could reflect better screening uptake locally, earlier presentation and diagnosis of those women with breast symptoms (e.g. because of better symptom awareness) or indeed over-diagnosis.
- Overall, breast cancer outcomes have vastly improved and the prognosis for many women is excellent.
Reducing the risk of developing breast cancer

27% of all UK female breast cancers could be prevented—this equates to 13,400 preventable cases per year.

There are a number of lifestyle factors that can help prevent breast cancer:

- Keeping a healthy weight could prevent 9% of cases of female breast cancer per year (which would equate to roughly 105 cases in Cheshire East)
- Drinking less alcohol could prevent 6% of cases (which would equate to roughly 70 cases per year in Cheshire East)
- Being more physically active could prevent 3% of cases (which would equate to roughly 35 cases per year in Cheshire East)

There is evidence of the protective effect of around a 15-20% reduction in risk in women who exercise for half an hour, five times a week. A diet higher in fruit and vegetables, and low in saturated fats also helps to reduce the risk of breast cancer.

Source: Cancer Research UK (accessed May 2017)
Breast Screening

Breast screening aims to detect breast cancer at an early stage when treatment is more likely to be successful. Women between the ages of 50 and 70 are invited for regular breast screening every three years. Because the programme is a rolling one which invites women in a three year cycle, not every woman will receive an invitation as soon as she is 50. Every woman who is registered with a general practitioner should however, receive her first invitation before her 53rd birthday. This age is gradually being lowered, so that women will have had their first screening invitation by their 50th birthday. The NHS Breast Screening Programme is extending the age range for breast screening from 50-70 to include women aged 47-49 and 71-73. In Cheshire East this age extension started in 2009 and is now fully completed, so women between the ages of 47 and 73 are now being invited for regular breast screening every three years. Women who are having their final routine screen before they turn 73 are informed that they can continue to be screened at 3-yearly intervals on request, but that they must arrange this with the breast screening unit themselves.

Of all women with breast cancers detected through screening in 2014-15, around 40.5% (7,301) had invasive but small cancers less than 15mm in diameter which are usually too small to detect by hand. If we looked at 1000 women over 20 years, 5 lives are saved by screening but 17 women are also treated for possible breast cancers, including changes to the lining of the breast duct which may not have developed into cancer and others that ultimately would not have caused them harm (Cancer Research UK). Typically, 41 out of 1000 women require further tests and of these, 8 women are diagnosed with cancer (Cancer Research UK).

Coverage is defined as the percentage of women in the population who are eligible for screening at a particular point in time, who have had a test with a recorded result within the last three years. Coverage of women aged 50-70 in Cheshire East was 75.7% for 2015/16. Although coverage has fallen compared to 76.0% for 2013/14, it remains above the NHS Cancer Screening Programmes’ minimum standard of 70% and was 3.2% higher than the 72.5% in England. Coverage for women was 70% or above (the national minimum standard) in all but one cluster.

In Cheshire East, data from 2015/16 indicates that coverage is of concern in Crewe Town and Chelford, Alderley Edge, Wilmslow and Handforth. In addition to coverage that is much lower than Cheshire East as a whole, many women are not responding to their invitation to screening within the first 6 months. Of further note is the poor response in the Knutsford area, however their coverage overall is good.

Data for 2015/16 (from PHE, Fingertips accessed September 2017)
Breast screening in women with learning disabilities in Cheshire East

Data collected by NHS Digital in 2015-16 showed that the overall coverage of breast screening for women in NHS Eastern Cheshire CCG and NHS South Cheshire CCG was 73.3% and 77.4% respectively, with the youngest eligible group having lower coverage rates than any of the older age groups.

People with learning disabilities in NHS Eastern Cheshire CCG had better screening coverage than for the population as a whole at 76.8% and in all age groups except for the 65-69 age group. In contrast, coverage in NHS South Cheshire CCG for women with learning disabilities was only 53.3% and was much lower than coverage for women overall, particularly in the 55-59 and 60-64 age groups.

When compared to data collected for 2014/15, coverage for women with a learning disability has fallen however the numbers of those eligible are fairly small.

It is important that women with learning disabilities have access to breast screening and that reasonable adjustments are made to ensure that women can take part. The Community Learning Disability Team work with women on an individual level to support them to access regular screening.
Some women may be assessed by a specialist in genetics or oncology as being at more risk of developing breast cancer than women in the general population. This may be due to a genetic predisposition to the disease, or a significant family history of breast cancer (assessed by a family history service), or previous supradiaphragmatic radiotherapy (radiation therapy to the chest above the diaphragm).

These women can be offered NHS breast screening at an earlier age than women from the general population. They must be referred via a specialist service, as direct referrals from general practitioners are not accepted. The type of breast screening offered to these high-risk women depends on their age and type of risk. Women below the age of 40 are screened annually using magnetic resonance imaging (MRI), while women between the ages of 40 and 50 will be screened annually using a combination of both digital x-ray mammography and MRI. On reaching the age of 50, most high-risk women will change to being screened by digital x-ray mammography every three years as this is better than MRI at detecting breast cancers in this age group.

See: Guidelines on organising the surveillance of women at higher risk of developing breast cancer in an NHS Breast Screening Programme. NHSBSP Publication No 73 March 2013

Local breast screening units are responsible for inviting these women at appropriate intervals and for ensuring that imaging is performed to the required standards. Statistics of the number of high-risk women being screened by the NHS Breast Screening Programme showed a marked increase between 2013-14 and 2014-15. Around 22 high-risk women from Cheshire East would have been screened by the NHS in 2014-15.

<table>
<thead>
<tr>
<th>High-risk women screened by Breast Screening Units</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crewe</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>East Cheshire &amp; Stockport</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>North West</td>
<td>105</td>
<td>386</td>
</tr>
<tr>
<td>England</td>
<td>1231</td>
<td>2908</td>
</tr>
</tbody>
</table>


Pre-menopausal women at high risk of developing breast cancer should receive Tamoxifen for five years. High-risk post-menopausal women should receive Tamoxifen or drugs called aromatase inhibitors. The current national cancer strategy ‘Achieving World Class Cancer Outcomes’ outlines the need to take a more systematic approach to making these drugs available and reducing variation in their availability and use.
In Cheshire East seven women are diagnosed with a new breast cancer every week. The occurrence of breast cancer has increased by over a third during the last ten years and this increase is predicted to continue for at least the next decade and probably longer. Breast cancer is now by far the most common cancer in women. Because of this, high numbers of women are referred every year by general practitioners to breast care units.
Urgent suspected cancer referrals

In 2000 the NHS Cancer Plan introduced a service standard of 2 weeks waiting time from urgent general practitioner referral for suspected cancer to first hospital assessment. The Cancer Reform Strategy expanded this standard so that from January 2010 any patient referred with breast symptoms (excluding family history clinics or cosmetic breast surgery) will be seen within 2 weeks, whether cancer is suspected or not.

The key reason for introducing this change was that only half of diagnosed breast cancers were coming through the urgent 2 week wait cancer route. A significant proportion of breast cancer patients were being referred through other routes and were not benefitting from the faster pathways.

The table shows the numbers of people who were referred through both pathways over the last three years. If tracked back further, when data were collected for the area previously covered by Central and Eastern Cheshire Primary Care Trust, it shows a similar year on year increase.

### Data for 2014/15

<table>
<thead>
<tr>
<th>QOF practice list sizes</th>
<th>2ww referrals for breast symptoms</th>
<th>Referrals per 100,000 population</th>
<th>2ww referrals for suspected breast cancer</th>
<th>Referrals per 100,000 population</th>
<th>New breast cancer cases</th>
<th>Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nantwich and Rural</td>
<td>117</td>
<td>368</td>
<td>51</td>
<td>147.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crewe town</td>
<td>358</td>
<td>434</td>
<td>52</td>
<td>117.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMASH</td>
<td>355</td>
<td>554</td>
<td>35</td>
<td>121.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Cheshire CCG total</td>
<td>223</td>
<td>515</td>
<td>830</td>
<td>465</td>
<td>138</td>
<td>130.0</td>
</tr>
<tr>
<td>Congleton &amp; Holmes Chapel</td>
<td>266</td>
<td>619</td>
<td>72</td>
<td>133.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Macclesfield</td>
<td>311</td>
<td>509</td>
<td>53</td>
<td>142.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bollington, Poynton and Disley</td>
<td>142</td>
<td>431</td>
<td>14</td>
<td>137.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chelford/AEdge/Wilm/Handforth</td>
<td>234</td>
<td>515</td>
<td>29</td>
<td>139.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knutsford</td>
<td>155</td>
<td>684</td>
<td>15</td>
<td>167.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern Cheshire CCG total</td>
<td>186</td>
<td>383</td>
<td>1108</td>
<td>540</td>
<td>183</td>
<td>140.0</td>
</tr>
<tr>
<td>Cheshire East total</td>
<td>409</td>
<td>445</td>
<td>1938</td>
<td>505</td>
<td>321</td>
<td>135.0</td>
</tr>
<tr>
<td>England</td>
<td>391</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Breast cancer incidence is 9% higher in Cheshire East than the England average with rates being particularly high in NHS Eastern Cheshire CCG. The chart above illustrates the variation in incidence across the GP clusters in the Cheshire East area.

Overall the incidence of breast cancer across Cheshire East is higher than the average for England in all clusters apart from the one for SMASH (Sandbach, Middlewich, Alsager, Scholar Green and Haslington) though not necessarily significantly so. In contrast to some other types of cancer, variation between areas is not as marked.

There were 133,802 new breast cancer cases diagnosed amongst women across England in the three year period 2012 – 2014. Of these, 1,154 occurred in women in Cheshire East. 641 cases occurred in women in NHS Eastern Cheshire CCG and 513 occurred in women in NHS South Cheshire CCG.

New breast cancer cases occurred amongst women at a directly standardised rate of 169.9 per 100,000 per year in England in 2012-2014. Cheshire East as a whole has an incidence rate that is significantly (8.9%) higher than England average (185.0 per 100,000; 95% CI:174.4 – 196.1). In NHS Eastern Cheshire CCG, this rate was 188.0 per 100,000 (95% CI: 173.5 -203.5) indicating a rate significantly higher than the rate for England. In NHS South Cheshire CCG, the incidence rate was 181.3 per 100,000 per year (95% CI: 165.9 – 197.9).

Breast cancer does also occur in males. There were 903 cases of breast cancer in males across England in 2012-2014. This is less than 1% of the overall number of breast cancer cases. Given the small numbers involved, it is difficult to pass further comment on local patterns amongst males.
Around a third of breast cancers are diagnosed at a very early stage (Stage 1) in Cheshire East, and nearly 70% at Stage 1 or 2, which has a positive impact on survival rates. The rates are similar in both of our CCGs.

The most common route to diagnosis locally was through two week wait (TWW), with more women being diagnosed via that route in NHS Eastern Cheshire CCG. In NHS South Cheshire CCG, more women were diagnosed following screening.

In 2006-2013 routes to diagnosis data, 59% of breast cancers in England were diagnosed via the managed route (TWW, inpatient elective, GP referral and other outpatient) and 29% via screening. In this same time period, in NHS Eastern Cheshire CCG, 55% were diagnosed via the managed route and 33% via screening. In NHS South Cheshire CCG, 58% were diagnosed via the managed route and 32% via screening. These figures were thus similar to England average.

Nationally, only 4% of breast cancers were diagnosed via the emergency route indicating that other effective pathways are in place.

Some common benign breast problems:

Fibroadenomas are solid lumps that develop from a milk-producing gland in the breast, and are usually around 1–3 cm in size. They often develop during puberty and therefore tend to occur in young women. Most fibroadenomas will stay the same size and do not require treatment, but they can be removed if they are getting bigger or causing anxiety.

Breast cysts are fluid-filled sacs that develop in the breast tissue, and are most common in women over 35. They usually develop as women get closer to the menopause and stop once a woman has been through the menopause. Treatment involves drawing off the fluid using a fine needle and syringe.

Gynaecomastia is a hormonal enlargement of male breast tissue, and can range from affecting the breast tissue behind the nipple to a larger, more female-looking breast. It can affect up to two out of three teenage boys and leads to anxiety and embarrassment. It reduces during the late teenage years but treatments can also be given. Gynaecomastia may also occur in older men as part of the natural ageing process.
Among women with operable breast cancer, randomized trials have demonstrated equivalent disease-free and overall survival between mastectomy and lumpectomy (breast-conserving therapy). Criteria that allow for breast-conserving therapy are: multicentric disease, large tumour size in relation to breast, presence of diffuse malignant appearing calcifications on imaging, prior history of chest radiotherapy, pregnancy and persistently positive margins despite attempts at re-excision.

**Most common type of breast cancer, these breast cancers have the most favourable prognosis of all subtypes, according to a study in Surgery, Gynecology & Obstetrics. They typically respond to hormone therapy. Even with a relapse, this type is easier to manage than hormone receptor negative tumours.**

Women younger than 40 years old were more likely to have TNBC (triple negative Breast cancer) than older women. In the ethnic groups examined, the highest proportion of women with TNBC was in Black breast cancer patients (25%), followed by South Asian (19%), other (14%), White (8%) and those where ethnicity was not known (6%). Triple negative disease was more common in women who lived in more socioeconomically deprived areas. Women who were diagnosed with metastatic disease (TCR stage 4) also had a higher proportion of TNBC. There was no real difference in the proportion of patients with TNBC diagnosed each year.

### Treatment of breast cancer by stage

<table>
<thead>
<tr>
<th>Stage IA + IB (1A - Tumour up to 2cm and no spread 1B -tumour/no tumour in breast + microscopic lymph node spread)</th>
<th>Stage II (No breast tumour but 1-3 nodes/2cm tumour + lymph node spread/2-5cm tumour no spread)</th>
<th>Stage IIIA (No breast tumour, but 4-9 axillary nodes/5cm tumour +/- 1-3 nodes)</th>
<th>Stage IIIB (Any size tumour with spread to chest wall/skin. May have 9 axillary nodes. May be inflammatory)</th>
<th>Stage IIIC (Any tumour in breast + 10 axilla nodes/ spread to clavicular nodes/spread to sternal nodes)</th>
<th>Stage IV (breast cancer that has spread beyond the breast -- distant metastases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>38% breast cancer diagnosed at this stage</td>
<td>34% breast cancer diagnosed at this stage</td>
<td>8% of breast cancer diagnosed at this stage</td>
<td>5% breast cancer diagnosed at this stage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Most common type</th>
<th>Triple negative breast cancer (15% of patients)</th>
<th>Total mastectomy + radiation OR Lumpectomy + radiation OR Lumpectomy alone*</th>
<th>Mastectomy + radiation OR Lumpectomy + radiation +/- chemotherapy</th>
<th>For IIA and operable IILC - Total mastectomy + lymph node clearance + radiation OR Lumpectomy + lymph node clearance + radiation + chemotherapy For IIB and inoperable IILC – Chemotherapy then total mastectomy and lymph node clearance followed by radiotherapy</th>
<th>Chemotherapy +/- radiotherapy +/- surgery – dependant on many individual factors. Usually for symptomatic relief Lymph nodes only treated if symptomatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive carcinoma – Non specific (90%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarer types</td>
<td>Medullary (5%)</td>
<td>Total mastectomy + radiation</td>
<td>Mastectomy + radiation OR Lumpectomy + radiation +/- chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mucinous (2%)</td>
<td>Lumpectomy alone*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tubular (1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Others (2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oestrogen/progesterone receptor positive ** (70% of patients)</th>
<th>Above + hormone therapy</th>
<th>Above + hormone therapy</th>
<th>Above + hormone therapy</th>
<th>Above + hormone therapy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HER-2 positive *** (20% of patients)</td>
<td>As for triple negative +/- chemotherapy +/- targeted therapy</td>
<td>As for triple negative + targeted therapy</td>
<td>As for triple negative + targeted therapy</td>
<td>As for triple negative + targeted therapy</td>
<td></td>
</tr>
</tbody>
</table>

**Among women with operable breast cancer, randomized trials have demonstrated equivalent disease-free and overall survival between mastectomy and lumpectomy (breast-conserving therapy). Criteria that allow for breast-conserving therapy are: multicentric disease, large tumour size in relation to breast, presence of diffuse malignant appearing calcifications on imaging, prior history of chest radiotherapy, pregnancy and persistently positive margins despite attempts at re-excision.**

**Most common type of breast cancer, these breast cancers have the most favourable prognosis of all subtypes, according to a study in Surgery, Gynecology & Obstetrics. They typically respond to hormone therapy. Even with a relapse, this type is easier to manage than hormone receptor negative tumours.***

***HER-2 receptor positive patients have 77.1% five-year survival rate with no recurrence but around five times the recurrence risk of those who were HER-2 negative. up to 70% of patients with HER2-positive breast cancer respond to treatment. However, total remission for the condition occurs in around 7-8% of patients.***
Funnel plot of the 1-year age-sex-standardised survival (per cent) for breast cancer, for Clinical Commissioning Groups (CCG): England, adults (aged 15 to 99) diagnosed in 2000 and in 2015

In England, 1-year survival (age-sex-standardised) for patients diagnosed with breast cancer increased from 92.8% in 2000 to 96.7% in 2015. Among the 209 CCGs, the difference between the highest 1-year survival estimate in 2015 (98.8%) and the lowest (92.1%) was nearly 7 percentage points.

Interpretation should focus on overall trends and the relative position of each CCG in the funnel plots throughout the years. In 2015, one year survival in NHS Eastern Cheshire CCG was 97.9% and in NHS South Cheshire CCG it was 96.7%. These are both statistically similar to the England average (96.7%).

The funnel plot for 2015 shows less variation between CCGs, compared to 2000. This may be due to the increased awareness of breast cancer, and the positive messages about the treatment and breast cancer care having an impact on women attending for screening and being aware of potential early signs of breast cancer.

There were 28,740 deaths amongst women due to breast cancer across England in the three year period 2012-2014. Of these 217 breast cancer deaths occurred in Cheshire East. Across the CCG areas there were 117 deaths in NHS Eastern Cheshire CCG and 100 NHS South Cheshire CCG.

Breast cancer deaths amongst women occurred at a rate of 35.4 per 100,000 per year in England in 2012-2014 (95% CI: 35.0 -35.8). Cheshire East as a whole has a female breast cancer mortality rate of 33.0 per 100,000 (95% CI: 28.7-37.8). In NHS Eastern Cheshire CCG, the female breast cancer mortality rate was 32.4 per 100,000 (95% CI: 26.7-39.1) which is on a par with the rate for England. In NHS South Cheshire CCG the mortality rate is 34.0 per 100,000 (95% CI: 27.6-41.5) which is consistent with England average. NHS Eastern Cheshire CCG had a slightly lower mortality rate than NHS South Cheshire CCG, despite higher incidence.

Nationally, only 196 deaths amongst males were attributed to breast cancer and the mortality burden of male breast cancers in Cheshire East is very small.

This chart illustrates the variation in mortality between the GP clusters in the Cheshire East area.

The reasons for this could include the difference in uptake of breast screening, and women being well informed and knowledgeable about early signs and seeking early help or advice about changes in their breasts.
NHS Rightcare is a programme committed to improving people’s health and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources. This is achieved through the use of intelligence and innovation to enable the implementation of sustainable change. The Rightcare programme provides CCGs with focus packs which identify areas that they should be focusing on to improve variation.

**Cancer Focus Packs**
Focus packs compare the performance of a CCG to the 10 most demographically similar CCGs. This is used to identify realistic opportunities to improve health and healthcare for the population.

**NHS Eastern Cheshire CCG**
Breast cancer prevalence is higher than peer group average though incidence and premature mortality are consistent with peer group average. Breast screening coverage rates are on a par with peer group average. Whilst emergency presentations and conversely breast cancers detected at an early stage appear to be higher than peer group average, these do not reach statistical significance. Overall this suggests that local breast cancer outcomes are consistent with what might be expected in similar CCG areas.

Emergency presentations with breast cancer, however, appear to be significantly higher than emergency presentation rates observed across the top 5 CCGs in peer group suggesting that there is some opportunity to improve outcomes in NHS Eastern Cheshire CCG. Similarly breast cancer detection at an early stage and breast screening coverage is significantly lower than the top 5 CCGS in peer group with respect to breast screening.

One year survival from breast cancer in NHS Eastern Cheshire CCG is higher than for all other CCGs in its peer group.

**NHS South Cheshire CCG**
Breast cancer prevalence is significantly lower than peer group average; though incidence and premature mortality are consistent with peer group average. Breast screening coverage and detection of breast cancers at an early stage are higher than peer group average. Whilst emergency presentations appear to be higher than peer group average, these do not reach statistical significance.

Emergency presentations with breast cancer, however, appear to be significantly higher than emergency presentation rates observed across the top 5 CCGs in peer group suggesting that there is some opportunity to improve outcomes in NHS South Cheshire CCG. Breast cancer detection at an early stage and breast screening coverage in NHS South Cheshire CCG are the highest within peer group despite uptake following invite being lower than the average of the top 5 CCGs. Worryingly however, one year survival from breast cancer is the second lowest within peer group.
Metastatic cancer

Metastatic (also known as secondary or advanced) breast cancer occurs when breast cancer cells spread from the breast through the lymphatic or blood system to other parts of the body. The most common parts of the body that breast cancer spreads to are the bones, liver, lungs and brain. A diagnosis of metastatic breast cancer means that the cancer cannot be cured, although it can be controlled, sometimes for years.

Research has shown that patients with a diagnosis of metastatic breast cancer experience a wide range of symptoms and much variation in the route back to the breast care team. General practitioners have an important role in referring women with symptoms for urgent investigation, although research suggests that these women are likely to receive less supportive care by breast care teams compared to when they had their primary breast cancer diagnosis.

Assets:

**National Cancer Strategy:** In July 2015, the National Cancer Strategy ‘Achieving World Class Cancer Outcomes’ was published. This set out a number of ambitions for outcomes which matter most to patients and society by 2020 e.g. a reduction in cancer incidence and number of cancer cases linked to deprivation; 62% of cancers to be diagnosed at an early stage (stage 1 or 2); 75% of people with cancer should survive to at least 1 year following diagnosis; 57% of people with cancer should survive to at least 10 years following diagnosis; and continuous improvement in patient experience and improved quality of life following diagnosis. More recently, a Cancer Alliance for Cheshire and Merseyside has been established which aims to be the local delivery vehicle for national Cancer Strategy.

**Be Clear on Cancer Campaigns:** These campaigns are led by Public Health England in partnership with NHS England, the Department of Health and Cancer Research UK. They aim to improve early diagnosis of cancer by raising public awareness of signs and/or symptoms of cancer, and thus promote presentation to GPs as soon as possible. [http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/be-clear-on-cancer](http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/be-clear-on-cancer)

**Action on Cancer in Central Cheshire:** Through the Cancer Commissioning Board for South Cheshire and Vale Royal which has representation from several local partners including CCGs, Mid-Cheshire NHS Foundation Trust, Public Health, Cancer Research UK and Healthwatch, there is an Action on Cancer initiative. Partners aim to inform, educate and empower our local population, communities (e.g. through targeted social marketing and recruitment of community cancer champions) and a range of professionals to be more aware of signs and symptoms, to present earlier to their GP and to participate in the cancer screening programmes where appropriate.
Opportunities for improvement / future developments

- Steps should be taken to empower women to maintain a healthy weight, drink less alcohol and do more physical activity as 27% of breast cancers could be prevented in this way and breast cancer incidence is higher than England average in Cheshire East, particularly in NHS Eastern Cheshire CCG.
- Steps should also be taken to ensure adequate access to preventative drugs for those at defined high risk of breast cancer in Cheshire East.
- Breast screening remains an important means of diagnosing breast cancer at an early stage when treatment is likely to be more straightforward and thus more successful. Particular efforts should be made to improve breast screening uptake in Crewe Town and Chelford, Alderley Edge, Wilmslow and Handforth where women appear to be less likely to respond to invitations to screening. Furthermore, it is necessary to ensure that access to screening programmes is equitable e.g. that reasonable adjustments are made and support provided to women with learning disabilities.
- Commissioners should ensure that there is sufficient capacity to manage increasing numbers of referrals for breast symptoms in Cheshire East, given the increase in breast cancers and demand upon diagnostic services.

Further information:

- Alcohol and drugs JSNA: [www.cheshireeast.gov.uk/jsna](http://www.cheshireeast.gov.uk/jsna)

What we don’t know but would like to know...

- Why breast cancer incidence rates are highest in Bollington, Disley and Poynton
- If an apparent deterioration in the relative positioning of NHS Eastern Cheshire CCG’s one year survival is part of a continuing trend

Version control

<table>
<thead>
<tr>
<th>Publication date</th>
<th>Changes made</th>
<th>Content sponsor</th>
<th>Sign-off</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2018</td>
<td>New JSNA section created to replace the breast cancer screening and survival sections</td>
<td>Charlotte Simpson (Public Health)</td>
<td>Tracey Wright (Service Delivery Manager, CCGs)</td>
</tr>
</tbody>
</table>

JSNA section contributors: Helen John, Rhonwen Ashcroft (Public Health)