Deprivation:

Basic Information	
1. What is being measured?	The proportion of the population classed as income deprived – Income Deprivation Score
2. Why is it being measured?	The choice of the score of income domain over the overall IMD score is based on the inclusion of health related indicators of deprivation in the overall IMD score. It is considered that this amounts to a 'mathematical coupling' of health related deprivation and indicators, and that using the income domain avoids this issue.
3. How is the indicator defined?	The proportion of the population based, on mid-year 2008 population estimates (excluding prisoners), who were experiencing low income
4. Who does it measure?	This domain measures the proportion of the population in an area experiencing deprivation related to low income. A combined count of income deprived individuals per LSOA is calculated by summing the following five indicators: •Adults and children in Income Support families •Adults and children in Income-Based Jobseeker's Allowance families •Adults and children in Pension Credit (Guarantee) families •Adults and children in Child Tax Credit families (who are not in receipt of Income Support, Income-Based Jobseeker's Allowance or Pension Credit) whose equivalised income (excluding housing benefits) is below 60 per cent of the median before housing costs 2 •Asylum seekers in England in receipt of subsistence support, accommodation support, or both.
5. When does it measure it?	Relates to the population during 2008
6. Does it measure absolute numbers, proportions or rates?	It is a proportion of the population and is called a score
7. Where does the data come from?	The data is taken from the English Indices of Deprivation 2010 published by the Department of Communities and Local Government (DCGL) https://www.gov.uk/government/publications/english-indices-of-deprivation-2010 The PCT level summary scores have been calculated by the Association of Public Health Observatories (APHO) and the Cancer Network level have been calculated by the Knowledge and Intelligence Team (East Midlands).

8. How accurate and complete are the data?	Please see the following publication https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6871/1871208.pdf
9. Are there any caveats/ problems/ weaknesses?	Please see the following publication https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6871/1871208.pdf
10. What methods are used to test the meaning of the data and variation?	The indicator is not assigned a measure of statistical significance. The areas are grouped into five quintiles instead. The areas are first ordered by Income Deprivation Score and then grouped into five equal population groups that roughly make up a fifth of the total population. These are then labelled 1-least deprived i.e. those areas with the lowest income score to 5-most deprived i.e. those areas with the highest income score. In the Health profile the symbol in the spine chart is white For all maps the areas are shaded according to the five quintiles
11. Geography provided in this toolkit	Since April 2013 the NHS health boundaries for Primary Care Trusts, Cancer Networks and Strategic Health Authorities have been become non-operational and have been replaced by other organisational structures responsible for the commissioning and performance management of cancer services, namely Clinical Commissioning Groups, Local Area Teams and Strategic Clinical Networks. However, in the absence of established boundaries and available data for these new organisations we have only been able to present sub-national data for the old organisations. The old organisations still retain some currency and relevance to the commissioning and public health structures as redefined and this is explained below: PCTs Many PCTs are coterminous with the Clinical Commissioning Groups and therefore statistics at PCT level for these CCGs will still be largely relevant. Cancer Networks Cancer Networks were formed in order to oversee and organise the local implementation of the Cancer Plan and Cancer Reform Strategy for the areas within their jurisdiction. There were 28 Cancer Networks in England which have now been replaced by 12 Strategic Clinical Networks which will provide support to cancer networks 'nesting' within their boundary. In consultation with the Gynaecological Site Specific Reference Group (SSCRG) it was decided that cancer network levels figures would be carried forward in the absence of any other relevant boundary, particularly as this will provide data for on-going peer review and

	whether improvements are being made over time. NHS Strategic Health Authorities (SHA) Strategic Health Authority data is available for the incidence, mortality and survival data. However, these organisation no longer exist and the figures serve to provide a regional comparison in the absence of any other available data at present. The values for the SHAs can be seen by toggling the map and comparison button on each map. In the health profile, the regional value is shown as a grey diamond. Some cancer networks cross over more than one SHA boundary, the regional average is used for each cancer network and PCT where the majority of the area resides. However, when filtering in the, single, double and health profile map, the cancer networks that have a significant area falling within the boundary of the SHA are shown. The SHAs can be highlighted on the map by ticking the box in the legend. The borders will then be highlight in red.
12. Further data availability	See link in note 7
13. Frequency/ timeliness of data updates	At present the IMD is updated every 3-4 years.
14. Disclosure control	Not Applicable
15. Rationale for inclusion	Deprivation underlies the incidence, mortality and survival from many cancers. Higher levels of deprivation are often related to poorer general health and co-morbidities which may increase the chances of dying from cancer but also life style factors and behaviours that can increase the risk of developing cancer in the first place. For example, more deprived women may be less likely to attend for cervical screening. It is useful to compare levels of deprivation and other indicators as this can help to understand patterns of variation and inform efforts to reduce variation and improve the health inequalities. For more information on risk factors associated with gynaecological cancers please see http://www.cancerresearchuk.org/cancer-info/cancerstats/types/