



Public Health  
England

Protecting and improving the nation's health

# **National Cancer Intelligence Network Be Clear on Cancer: Oesophago-gastric cancer awareness regional pilot campaign: Interim evaluation report**

Interim evaluation results

## About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Published July 2015  
PHE publications gateway number: 2015177

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## The intelligence networks

Public Health England operates a number of intelligence networks, which work with partners to develop world-class population health intelligence to help improve local, national and international public health systems.

### **National Cancer Intelligence Network**

The National Cancer Intelligence Network (NCIN) is a UK-wide initiative, working to drive improvements in standards of cancer care and clinical outcomes by improving and using the information collected about cancer patients for analysis, publication and research.

### **National Cardiovascular Intelligence Network**

The National Cardiovascular Intelligence Network (NCVIN) analyses information and data and turns it into meaningful timely health intelligence for commissioners, policy makers, clinicians and health professionals to improve services and outcomes.

### **National Child and Maternal Health Intelligence Network**

The National Child and Maternal Health Intelligence Network (NCMHIN) provides information and intelligence to improve decision-making for high-quality, cost-effective services. Its work supports policy makers, commissioners, managers, regulators, and other health stakeholders working on children's, young people's and maternal health.

### **National Mental Health, Dementia and Neurology Intelligence Network**

The National Mental Health Intelligence Networks (NMHDNIN) brings together the distinct National Mental Health Intelligence Network, the Dementia Intelligence Network and the Neurology Intelligence Network under a single programme. The Networks work in partnership with key stakeholder organisations. The Networks seeks to put information and intelligence into the hands of decision makers to improve mental health and wellbeing, support the reduction of risk and improve the lives of people living with dementia and improve neurology services.

### **National End of Life Care Intelligence Network**

The National End of Life Care Intelligence Network (NEoLCIN) aims to improve the collection and analysis of information related to the quality, volume and costs of care provided by the NHS, social services and the third sector to adults approaching the end of life. This intelligence will help drive improvements in the quality and productivity of services.

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## Executive summary

A regional oesophago-gastric cancer awareness campaign ran in the North East of England (Tyne Tees TV and Borders TV regions) from 10 February to 9 March 2014. The campaign's primary key message was 'Having heartburn, most days, for three weeks or more could be a sign of cancer – tell your doctor', with a secondary message of 'if food is sticking when you swallow, tell your doctor'.

A full and final evaluation report for the regional pilot oesophago-gastric campaign will be published when the analysis of all metrics is complete. In advance of the final evaluation report, this interim report provides the results available to date.

The oesophago-gastric cancer awareness regional pilot campaign was well recognised across all channels. Prior to the campaign, awareness of symptoms was low but afterwards knowledge increased significantly.

The campaign also appears to have caused an increase in the number of urgent GP referrals for suspected upper GI cancers in the regional pilot area. There is some evidence that the campaign may have affected the detection rate, particularly for those aged in their 60s, however, there is little or no evidence of an impact on the number of cancers diagnosed after an urgent GP referral for suspected upper GI cancers, the conversion rate or the number of CWT recorded cancers.

The following points form a summary of the main results detailed in this report:

### Public awareness and knowledge

- 1.1 A quarter (25%) were confident in their knowledge of oesophago-gastric cancer symptoms at the pre stage and this increased to more than one in three (35%) in the pilot region at the post stage. The control region did not experience this increase, suggesting that the positive pilot region results were a consequence of the campaign.
- 1.2 The proportion who stated that persistent heartburn was a definite warning sign of oesophago-gastric cancer increased significantly from one in ten (11%) to three in ten (31%). Likewise, persistent indigestion as a definite warning sign increased from 9% to 25% and food sticking increased from 23% to 38%.

## Urgent GP referrals for suspected upper GI cancers

- 1.3 The regional pilot oesophago-gastric cancer awareness campaign appears to have resulted in a large increase in referrals for suspected upper GI cancers, from February to April 2013 to February to April 2014.
- 1.4 Within the regional pilot area, there was a 52% increase in referrals for suspected upper GI cancers. This compares to an increase of 17% in the control area.
- 1.5 For suspected head and neck cancers<sup>1</sup>, there was also a larger increase in referrals for the regional pilot area (27%) compared to the control area (16%), however, the difference between the two areas was smaller than for upper GI referrals.
- 1.6 Larger increases in suspected upper GI cancer referrals were found for those aged in their 50s (85%) and 60s (69%), with a smaller increase for those aged 80 and over (18%).
- 1.7 The increase in upper GI referrals was larger for men (63%) than for women (44%), resulting in smaller differences, between men and women, in the number and rate of referrals.

## Conversion rate of urgent GP referrals for suspected upper GI cancers

- 1.8 For February to April 2014, compared to February to April 2013, there is little evidence that the regional pilot oesophago-gastric cancer awareness campaign had an impact on either the numbers of cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers or on the conversion rates for these referrals, for any of oesophageal, stomach or upper GI cancers.
- 1.9 There was a large amount of natural variation in the number of oesophageal, stomach and upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers, reflecting the relatively small numbers of such cases, both for the regional pilot area and control area.
- 1.10 There were no statistically significant changes in the number of diagnoses resulting from an urgent GP referral for suspected upper GI cancers, either overall

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<sup>1</sup> For an 'other referrals' comparator in the cancer waiting times analysis, we have used referrals for suspected head and neck cancers for recent evaluations, as this is a common referral type less likely to have been affected by campaigns, with no specific campaign directed at it.

in the regional pilot area or by age group or sex. Neither were there any significant changes in the control area.

- 1.11 However, for those aged 60 to 69, the percentage changes in the number of diagnoses resulting from an urgent GP referral for suspected upper GI cancers were quite large, although the numbers were small, with an 85% increase for oesophageal cancer and a 59% increase for upper GI cancers.
- 1.12 Long-term trends showed decreasing conversion rates for urgent GP referrals for suspected upper GI cancers both for the regional pilot area and control area.
- 1.13 Within the regional pilot area, the stomach cancer conversion rate decreased significantly by 0.5 percentage points, from 0.9% to 0.4% and the upper GI cancer conversion rate decreased significantly by 1.1 percentage points, from 4.1% to 3.0%. As these decreases were slightly larger than those seen for the control area, there may have been a small additional decrease during the campaign period.
- 1.14 There were no statistically significant changes in either oesophageal or upper GI cancer conversion rates by age group.
- 1.15 By sex, the only significant change was a decrease in the upper GI cancer conversion rate for men, although this appeared to largely reflect the longer term decreasing trend.

### Detection rate for upper GI cancers

- 1.16 There is some evidence that the regional pilot oesophago-gastric cancer awareness campaign may have had an impact on detection rate, but not the number of CWT recorded cancers, for oesophageal, stomach and upper GI cancers, for March to May 2014, compared to the same months in 2013, particularly for those aged in their 60s.
- 1.17 However, results were based on a relatively small number of oesophageal, stomach and upper GI cancer diagnoses, with trends in CWT recorded diagnoses and detection rates demonstrating much inherent variation. It is also important to remember that, for these metrics, it is particularly difficult to define a campaign-affected period, due to varying diagnostic routes and time-periods.
- 1.18 For the regional pilot area, there were small decreases in the number of the oesophageal (6%), stomach (10%) and upper GI (4%) cancer diagnoses recorded in the CWT data, but these changes were not statistically significant. Similarly, for the control area, the smaller changes were not significant.

1.19 There were no significant changes in the number of cancers, for any age-group or by sex.

1.20 There were increases in the detection rates in the regional pilot area, ranging from 3.3 percentage points, for upper GI cancer, to 9.5 percentage points, for oesophageal cancer, however, none of these changes were statistically significant and nor were any changes by sex.

1.21 There were statistically significant increases in the detection rates for those aged 60 to 69 for both oesophageal and stomach cancers, as well as all upper GI cancers combined. The detection rate increased by:

- 40 percentage points for oesophageal cancer, from 46% to 86%;
- 50 percentage points for stomach cancer, from 21% to 71%; and
- 29 percentage points for upper GI cancer, from 35% to 64%.

# Introduction

## Be Clear on Cancer awareness campaigns

Be Clear on Cancer campaigns have been developed to improve early diagnosis by raising awareness of the symptoms of cancer and encouraging people with those symptoms to see their GP early.

The Be Clear on Cancer brand has been used to promote awareness and early diagnosis of specific cancer types since January 2011. The oesophago-gastric cancer local campaign was developed using the Be Clear on Cancer branding and ran from April to July 2012. Since 2013 the programme has been led by Public Health England, working in partnership with the Department of Health and NHS England. Each campaign is tested locally and then regionally, with a view to rolling them out nationally if they prove to be effective.

For each Be Clear on Cancer campaign there is a comprehensive evaluation process. Data is collected on a number of metrics to reflect possible campaign impact. These include whether campaigns are raising awareness of signs and symptoms of cancer; more people are going to their GPs with the symptoms highlighted by the campaign; more people are being referred urgently for suspected cancer; there is an increase in diagnostic activity; those referred urgently for suspected cancer are diagnosed with cancer; there are increases in the number of cancers diagnosed and if there is evidence of a shift towards earlier stage disease.

## Oesophago-gastric cancer awareness regional pilot campaign

A local Be Clear on Cancer campaign featuring the symptoms of oesophago-gastric cancer was developed and run in eight areas from April to July 2012. After evaluation of the local campaign it was decided to develop a regional campaign which subsequently ran from February to March 2014.

A mixture of TV, radio, press, poster, out of home (GP surgeries) and digital advertising was used alongside a public relations campaign. Leaflets to target those aged over 50 (as this group are most at risk of oesophago-gastric cancer) were distributed via GP surgeries and at football matches. Direct mail was also sent to men in this region, as they are more at risk of the disease than women.

# Public awareness and knowledge

## Research methodology

The research was conducted through pre and post campaign surveys in test and control areas. The test area was the North East for the oesophago-gastric cancer campaign. The rest of England (excluding the North West, as a similar ovarian cancer regional pilot campaign ran at the same time in this area) provided the control area. Samples of approximately 300 adults aged 50 plus were interviewed face to face in the pilot area at both pre and post stages.

The research was conducted by TNS-BMRB, an independent market research agency specialising in social research. The survey was a face to face survey among a representative sample of adults aged 50 plus in England. This was supplemented with additional face to face interviews in the North East pilot region. The pre campaign interviews took place between 13 January 2014 and 2 February 2014 and the post campaign interviews took place between 17 March 2014 and 6 April 2014.

## Campaign awareness and recognition

Over eight in ten (84%) had seen recent cancer publicity at the pre stage in the pilot region with a similar proportion having seen cancer publicity in the control (79%). An indicative increase occurred at the post stage among pilot region respondents (from 84% to 87%). This resulted in a significantly higher level of awareness for pilot region respondents when compared to the control at the post stage, suggesting that the campaign has had an impact on awareness levels.

There was a significant increase pre to post campaign in the proportion of pilot region respondents who had recently seen publicity relating to heartburn (0% to 13%). Recall of this publicity remained at zero in the control region at both research stages, indicating that the increase in the pilot region was as a result of the campaign. There was also an increase in those in the pilot region recalling publicity that encouraged them to see their doctor (6% to 13%) while the corresponding results remained static among the control group.

In the pilot region eight in ten (79%) recognised at least one of the advertisements from the oesophago-gastric cancer campaign. This was the highest level achieved across the six regional pilots to date. The TV (69%) and press advertisements (35%) achieved above average recognition, while recognition of the radio advertising (26%) and leaflet (19%) was in line with average

## Campaign communication

The call to action message ('go to doctor') was spontaneously taken out by over half of respondents (56%) after seeing the advertisements. The messages concerning symptoms were less commonly received. Less than one in six (15%) mentioned being aware of signs or symptoms and only 7% mentioned heartburn or indigestion for three weeks or more. When prompted, almost nine in ten took out messages relating to heartburn and food sticking.

A quarter (25%) were confident in their knowledge of oesophago-gastric cancer symptoms at the pre stage and this increased to more than one in three (35%) in the pilot region at the post stage. The control region did not experience this increase, suggesting that the positive pilot region results were a consequence of the campaign. Despite the increase in the pilot region, confidence levels remained substantially below average at both stages (25% compared with 40% average pre and 35% compared with 50% post) highlighting the need for a national campaign.

## Knowledge of oesophago-gastric cancer symptoms

Positive increases in prompted knowledge of key symptoms were seen among those in the pilot region. The proportion who stated that persistent heartburn was a definite warning sign of oesophago-gastric cancer increased significantly from one in ten (11%) to three in ten (31%). Likewise, persistent indigestion as a definite warning sign increased from 9% to 25% and food sticking increased from 23% to 38%. None of these increases in understanding were seen among those in the control region, pointing to the campaign as responsible for this change.

## Action taken as a result of the campaign

Eight in ten (82%) agreed that the advertising would make them more likely to go to the GP with any symptoms featured in the campaign. This was around the average level for regional pilot campaigns. One in six (16%) of those who recognised the campaign stated that they had taken some action, with the most common action being to talk to friends or family members to advise them (7%). Just fewer than one in twenty (4%) said they had made an appointment with their GP.

# Urgent GP referrals for suspected cancer and related cancer diagnoses

This chapter considers whether the regional pilot oesophago-gastric cancer awareness campaign had an impact on the number of urgent GP referrals for suspected upper gastrointestinal (upper GI) cancers or on Cancer Waiting Times (CWT) recorded information on upper GI cancer diagnoses.

## Methods

### Metric definitions

Analysis considers the following metrics, all derived from the Cancer Waiting Times data:

#### **Urgent GP referrals for suspected cancer (R)**

Urgent GP referrals for suspected upper GI cancers, presented by month first seen. (Also known as two week wait (TWW) referrals.)

#### **Cancer diagnoses resulting from an urgent GP referral for suspected cancer (TC)**

Those upper GI cancer diagnoses (ICD10 C15-C16, C22-C25) resulting from an urgent GP referral for suspected upper GI cancers, presented by month first seen. (Also known as two week wait (TWW) cancers, or 62 day cancers [based on the waiting times target from urgent GP referral to first treatment].)

#### **Conversion rate (C)**

Percentage of urgent GP referrals for suspected upper GI cancers resulting in a diagnosis of upper GI cancer, presented by month first seen.

#### **Cancer diagnoses recorded in the Cancer Waiting Times database (CC)**

All upper GI cancer diagnoses recorded in the CWT database (CWT-Db), presented by month of first treatment. (Also known as CWT cancers, or 31 day cancers [based on the waiting times target from decision to treat to first treatment].)

#### **Detection Rate (D)**

Percentage of CWT-Db recorded upper GI cancer diagnoses which resulted from an urgent GP referral for suspected upper GI cancers, presented by month of first treatment.

When patients are referred, cancer is only a suspicion, with the cancer or other diagnoses to be confirmed. As a result, specific cancer type diagnoses are unknown and so urgent GP referrals for suspected cancer are recorded against a limited number of broad cancer types. One of these broad cancer types is upper GI cancers, incorporating oesophageal and gastric (also referred to as stomach) cancers, along with several other types of cancer (eg. liver and pancreatic). Therefore, these analyses are repeated for diagnoses of all upper GI cancers, oesophageal cancer (ICD10 C15) and stomach cancer (ICD10 C16), although all related to all referrals for suspected upper GI cancers.

### Defining the campaign period

The campaign ran from 10 February to 9 March 2014. Therefore we might expect an impact on referrals first seen during the campaign months (February and March) and, allowing for reasonable delays from campaign activity to referral, in the month following the end of the campaign (April). These delays may occur for several reasons, for example some patients may need to see the campaign materials multiple times before reacting; some patients may need to wait for a GP appointment, especially if they prefer a convenient time or a specific GP, and so may be seen by the GP after the campaign ended.

Dates are based on 'date first seen' as recorded in the CWT-Db, reflecting the date seen in secondary care rather than primary care, and referrals made towards the end of the campaign may not have been seen in secondary care until after the campaign ended.

Therefore the period from February to April 2014 was considered as the 'campaign period' for referrals, and also for cancer diagnoses resulting from an urgent GP referral for suspected cancer and for the conversion rate, as these were defined using the date first seen recorded for the referral.

There is a necessary period of time between the date first seen following an urgent GP referral for suspected cancer and the start of treatment. This is because of the time required to perform diagnostic tests or to plan and arrange treatment, for example, and will vary for different patients and trusts. This meant that, for cancer diagnoses recorded in the CWT database and the detection rate, it was not possible to identify a clear period relating directly and specifically to the campaign. Diagnoses in the early campaign months could include those resulting from referrals prior to the campaign or at the beginning of the campaign. Similarly, diagnoses in the months after the campaign could include those resulting from referrals during the campaign or after the end of the campaign. Taking into consideration the average interval from date first seen to treatment start date, and the waiting times target of 62 days from urgent GP referral to first treatment, the period from March to May was thought to best represent the

campaign effect. This period should include many of the diagnoses resulting from campaign period referrals without too many diagnoses from pre- or post-campaign referrals.

Therefore the period from March to May 2014 was considered as the 'campaign period' for upper GI cancer diagnoses recorded in the CWT-Db and for the detection rate.

### Comparator referral types

The number of urgent GP referrals for suspected cancer has continued to increase year-on-year. This means that the evaluation's comparison of the change from one year to the next is likely to reflect a combination of the campaign's impact and the general increase in referrals. It is not possible to separate these two reasons for any particular referral type, but it is useful to consider the change in referrals for other suspected cancers to provide an indication of increase that was not associated with the campaign.

However, due to the impact of previous regional and national Be Clear on Cancer campaigns, it was necessary to exclude a number of campaign-affected referral types from this comparison. Therefore, analysis of the change in referrals for other suspected cancers only considered referrals for suspected head and neck cancers.

### Guide to presentation

As the analysis considers a number of breakdowns, the following numbering system has been used throughout the chapter:

1. Total
2. By age
3. By sex

For total referrals only, with nested results to consider how changes in upper GI referrals may differ from general referral changes:

- a. Referrals for suspected upper GI cancers
- b. Referrals for suspected head and neck cancers

For other metrics, with nested results to consider how changes for oesophageal, stomach and upper GI cancers may differ:

- a. Results for oesophageal cancer
- b. Results for stomach cancer
- c. Results for upper GI cancers

For the campaign period (February to April 2014), the number of urgent GP referrals for suspected upper GI cancers were presented, alongside comparable results for the same months in the previous year. Year-on-year percentage change figures were

calculated based on these referral counts, as this reflected the absolute change in levels of activity. A referral rate was also presented, in order to provide some context to explain how differences in the percentage change between areas (or ages) may relate differing referral patterns. Differences in referral rates would suggest there may be underlying differences in referral practices or cancer incidence between groups. It was not possible to assess whether any apparent campaign impact may have resulted from these underlying differences.

Data for upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers and conversion rate were presented for the campaign period (February to April 2014), alongside comparable results for the same months in the previous year and the year-on-year percentage point change in the rate.

Data for upper GI cancer diagnoses recorded in the CWT-Db and detection rate were presented for the campaign period (March to May 2014), alongside comparable results for the same months in the previous year and the year-on-year percentage point change in the rate.

As this report considers a regional pilot campaign, most results were presented for the regional pilot area only. For the purposes of analysis this area was defined using the former North of England Cancer Network area. For overall results, comparison is made to a control area, which was defined as England excluding both the regional pilot area and local pilot areas. For the oesophago-gastric campaign, the local pilot areas were the following 25 former PCTs: Dudley; County Durham; Darlington; Sandwell; Wolverhampton City; Wandsworth; Newcastle; North Tyneside; Northumberland Care Trust; Cumbria Teaching; South Tyneside; Gateshead; Sunderland Teaching; Hartlepool; Middlesbrough; Redcar and Cleveland; Stockton-on-Tees Teaching; Bedfordshire; Cambridgeshire; Peterborough; Suffolk; Norfolk; Great Yarmouth and Waveney; Hertfordshire; and Luton.

## Statistical methods

Urgent GP referral rates vary greatly with age. To take account of differing age profiles of patients in different areas, the rates presented here were directly age-standardised and presented as rates per 100,000 population using the 2013 European Standard Population weights. Age-specific crude referral rates were presented for the age breakdown.

For referrals and cancer diagnoses, the reported p-values were obtained from a likelihood ratio test. The null hypothesis was that the number of urgent GP referrals or cancer diagnoses in the campaign period in 2014 and the same months in 2013 came from the same Poisson distribution.

For conversion and detection rates, the reported p-values are obtained from a two-sample proportion test. The null hypothesis was that the rate in the campaign period in 2014 was equal to the equivalent rate in 2013.

P-values less than 0.05 indicate a statistically significant difference between the two periods, at the 95% level. This chapter provides results from a large number of statistical tests. Please note that, with a considered significance level of 95%, you could expect 5% of tests to provide a “statistically significant” result by chance.

### Data notes

Please note that there were a few data quality issues:

For January to April 2012, no CWT data was uploaded by Imperial College Healthcare NHS Trust. However, this issue is expected to have a very limited impact on the results presented here, as it should only result in small differences to the results presented in the control area trend charts.

For October to December 2012, some referral data was not uploaded for Central Manchester University Hospitals NHS Foundation Trust, however, this issue is expected to have a very limited impact on the results presented here, as it should only result in small differences to the results presented in the control area trend charts.

For March 2013, no treatment data was uploaded by Chelsea and Westminster Hospital NHS Foundation Trust. However, this issue is expected to have a limited impact on the results presented here, as it should only result in small differences to the results presented for the control area’s comparator period (February to April 2013 or March to May 2013), and in the control area trend charts.

For Colchester Hospital University NHS Foundation Trust, it was reported that some Cancer Waiting Times records, possibly until June 2014, were submitted incorrectly. A subsequent investigation into this issue confirmed that only a small number of records were affected. Data used for these analyses are as submitted but, considering the small number of records affected, this issue should not have an impact on these results.

Of 312,015 TWW referrals for suspected upper GI cancers, 302 were excluded from analyses (120 due to missing demographic information; 182 due to null or invalid postcodes).

Of 275,878 TWW referrals for suspected head and neck cancers, 330 were excluded from the analysis (148 due to missing demographics; 182 due to null or invalid postcodes).

Of 21,093 cancers diagnoses resulting from an urgent GP referral for suspected upper GI cancers, including 15,551 upper GI cancer diagnoses of which there were 7,909 oesophageal cancer diagnoses and 2,777 stomach cancer diagnoses, 26 were excluded from analyses (17 due to missing demographic information; nine due to null or invalid postcodes).

Of 45,317 CWT recorded upper GI cancer diagnoses, including 15,932 oesophageal cancer diagnoses and 8,735 stomach cancer diagnoses, 93 were excluded from analyses (70 due to missing demographic information; 23 due to null or invalid postcodes).

Monthly diagnoses, conversion rate and detection rate data can be quite variable because they are based on only a small number of cancer diagnoses, particularly for some of the smaller breakdowns. For this reason, some of the age groups are not plotted on the monthly trend charts, and some trend charts are quarterly rather than monthly.

### Data Source

Cancer Waiting Times data was obtained from the National Cancer Waiting Times Monitoring Dataset, provided by NHS England.

## Urgent GP referrals for suspected cancer

### Total results

Figures R1ai and R1aii both show a general upward trend in referrals for suspected upper GI cancers. Although, for regional pilot areas (Figure R1ai), there was also a notable increase in February to April 2014, particularly in March. This result is also demonstrated in Table R1a, with statistically significant increases in urgent GP referrals for suspected upper GI cancers for both the regional pilot area and the control area, for February to April 2014 compared to the same months in 2013, however, the 52% increase within the regional pilot area, from 2,795 referrals in February to April 2013 to 4,257 referrals in the same months in 2014, was much larger than the 17% increase in the control area.

Referrals for suspected head and neck cancers, a control referral type, also exhibit a general increasing trend (Figures R1bi and R1bii). Table R1b shows that, from 2013 to 2014, the increase for February to April was statistically significant for both the regional pilot area and the control area. Although the increase of 27% in the regional pilot area was again larger than the 16% increase in the control area, it was more similar to the control area increase than for suspected upper GI cancer referrals.

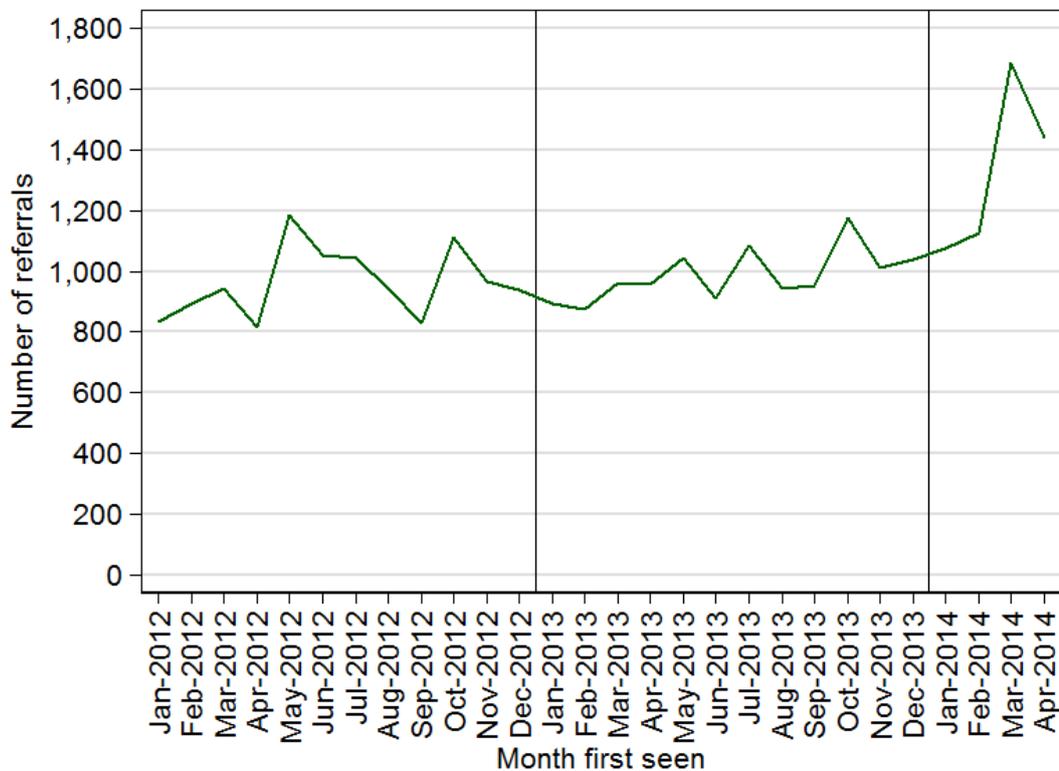
**Table R1a: Number of urgent GP referrals for suspected upper GI cancers, with referral rate and percentage change in number of referrals, from February to April 2013 and February to April 2014**

Overall		February to April				
		Referrals	% Change in number	P-value	Referral rate Estimate	Referral rate 95% CI
Regional pilot area	2013	2,795	52.3	<0.001	401.4	(386.5, 416.7)
	2014	4,257			611.7	(593.3, 630.6)
Control area	2013	26,143	17.0	<0.001	280.8	(277.4, 284.3)
	2014	30,585			327.9	(324.2, 331.6)

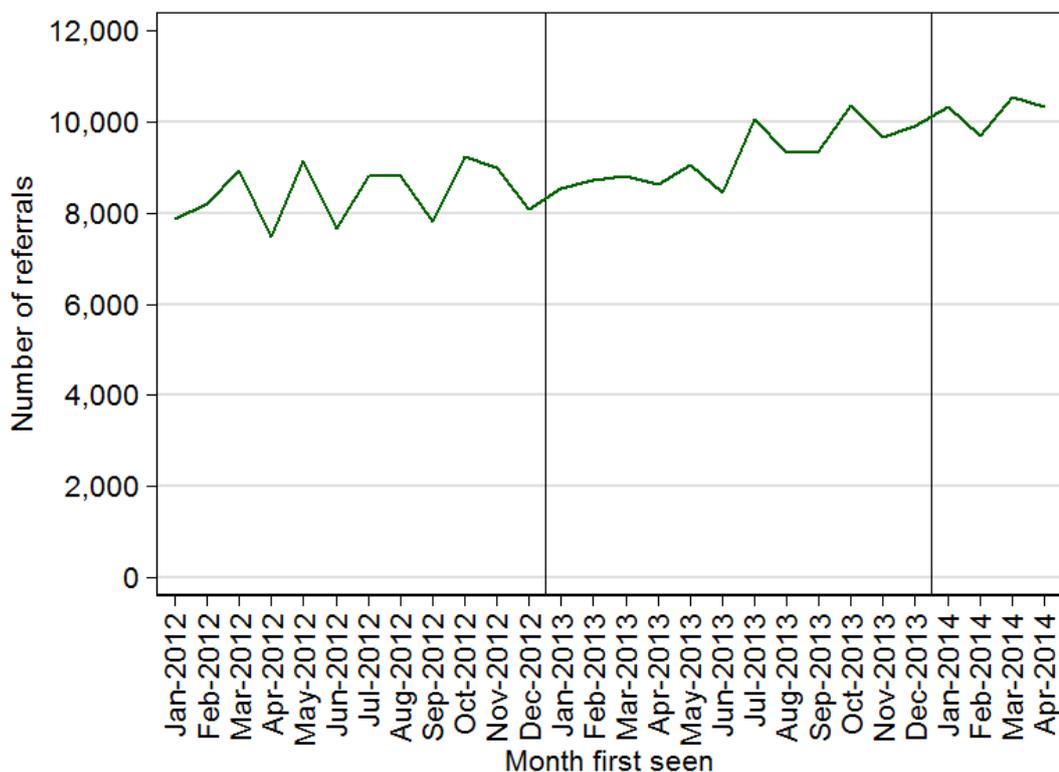
**Table R1b: Number of urgent GP referrals for suspected head and neck cancers, with referral rate and percentage change in number of referrals, from February to April 2013 and February to April 2014**

Overall		February to April				
		Referrals	% Change in number	P-value	Referral rate Estimate	Referral rate 95% CI
Regional pilot area	2013	1,844	26.6	<0.001	259.7	(247.9, 272.0)
	2014	2,335			331.2	(317.8, 345.0)
Control area	2013	23,860	15.9	<0.001	246.2	(243.1, 249.4)
	2014	27,647			285.8	(282.4, 289.3)

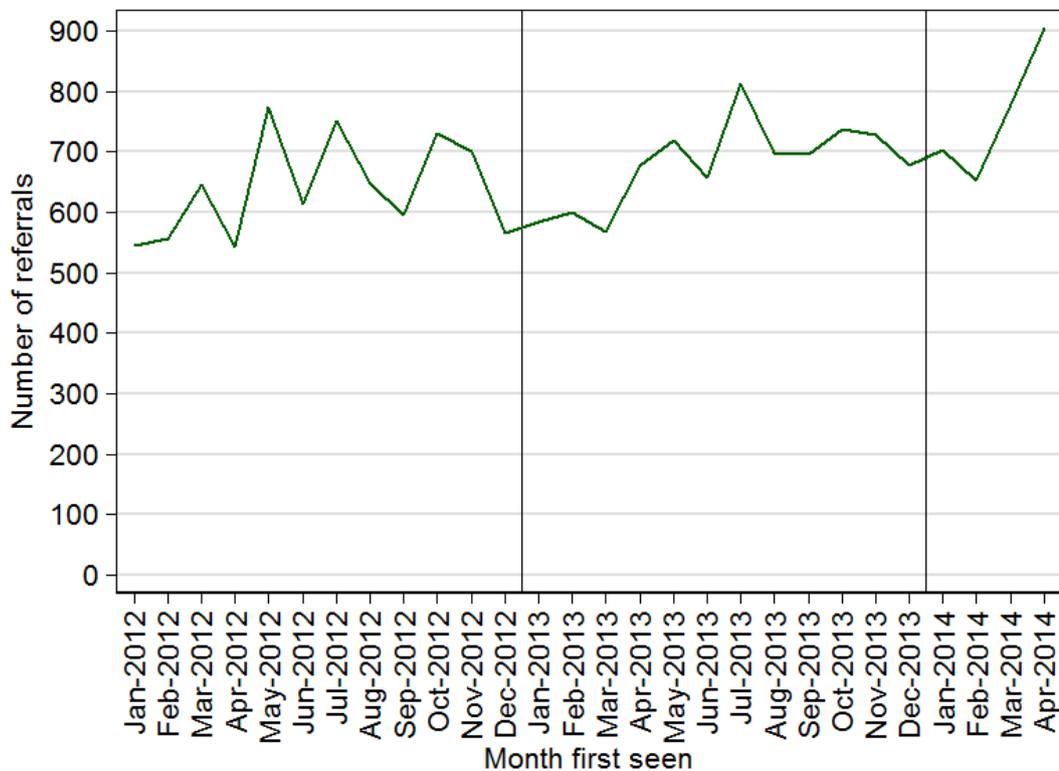
**Figure R1ai: Monthly number of urgent GP referrals for suspected upper GI cancers from January 2012 to April 2014, regional pilot area**



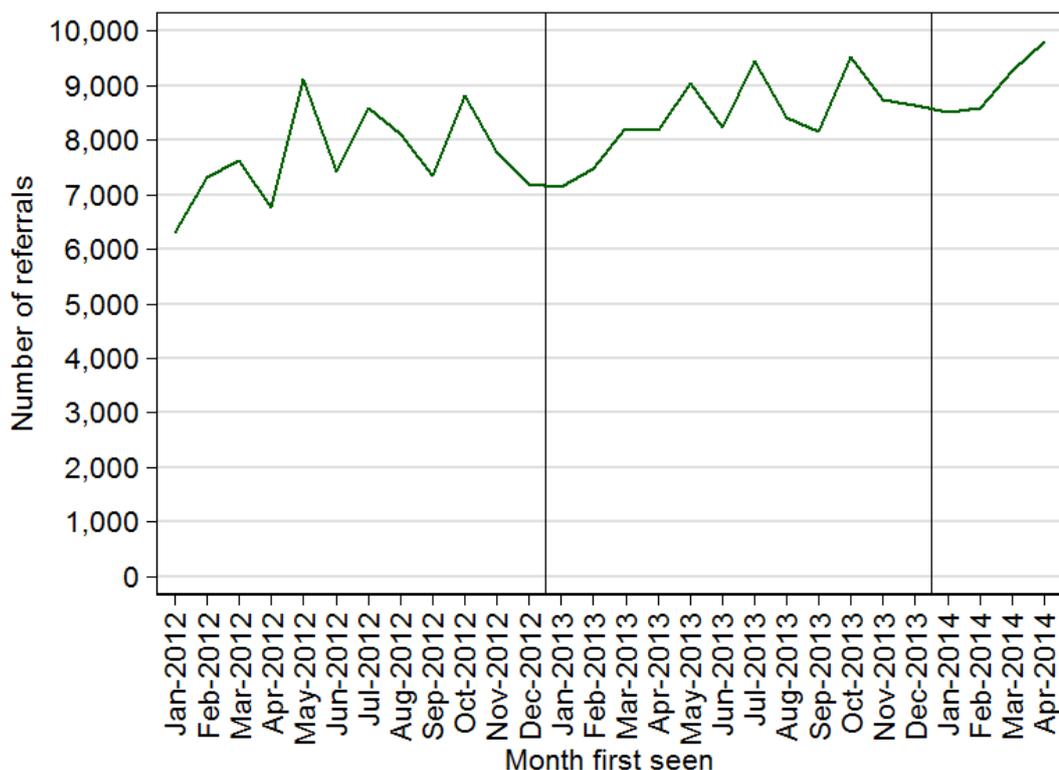
**Figure R1aii: Monthly number of urgent GP referrals for suspected upper GI cancers from January 2012 to April 2014, control area**



**Figure R1bi: Monthly number of urgent GP referrals for suspected head and neck cancers from January 2012 to April 2014, regional pilot area**



**Figure R1bii: Monthly number of urgent GP referrals for suspected head and neck cancers from January 2012 to April 2014, control area**



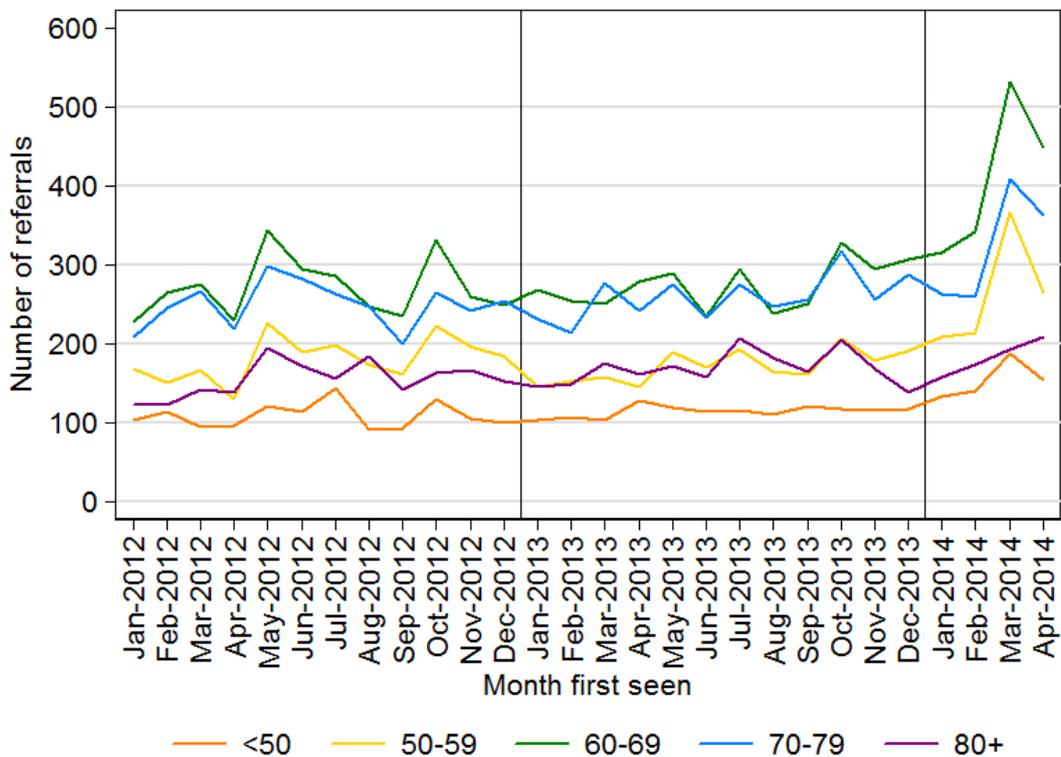
## Age results

For February to April 2014, compared to the same months in 2013, Table R2 shows that there were statistically significant increases in referrals for suspected upper GI cancers for all age-groups. The largest increases were seen for those aged in their 50s (85%, from 337 referrals to 483) and 60s (69%, from 455 to 844). For those aged 80 and over the increase was smaller (18%), with the increase in 2014 also less clear on Figure R2.

**Table R2: Number of urgent GP referrals for suspected upper GI cancers, with referral rate and percentage change in number of referrals, from February to April 2013 and February to April 2014, regional pilot area, by age**

Age group		February to April				
		Referrals	% Change in number	P-value	Referral rate	
					Estimate	95% CI
<50	2013	337	43.3	<0.001	72.8	(65.3, 81.1)
	2014	483			104.4	(95.3, 114.1)
50-59	2013	455	85.5	<0.001	470.1	(427.9, 515.4)
	2014	844			872.0	(814.2, 932.9)
60-69	2013	784	68.8	<0.001	929.3	(865.3, 996.6)
	2014	1,323			1,568.1	(1,484.7, 1,654.9)
70-79	2013	733	40.8	<0.001	1,253.8	(1,164.7, 1,348.0)
	2014	1,032			1,765.3	(1,659.2, 1,876.4)
80+	2013	486	18.3	0.006	1,387.0	(1,266.4, 1,515.9)
	2014	575			1,640.9	(1,509.5, 1,780.7)

**Figure R2: Monthly number of urgent GP referrals for suspected upper GI cancers from January 2012 to April 2014, regional pilot area, by age**



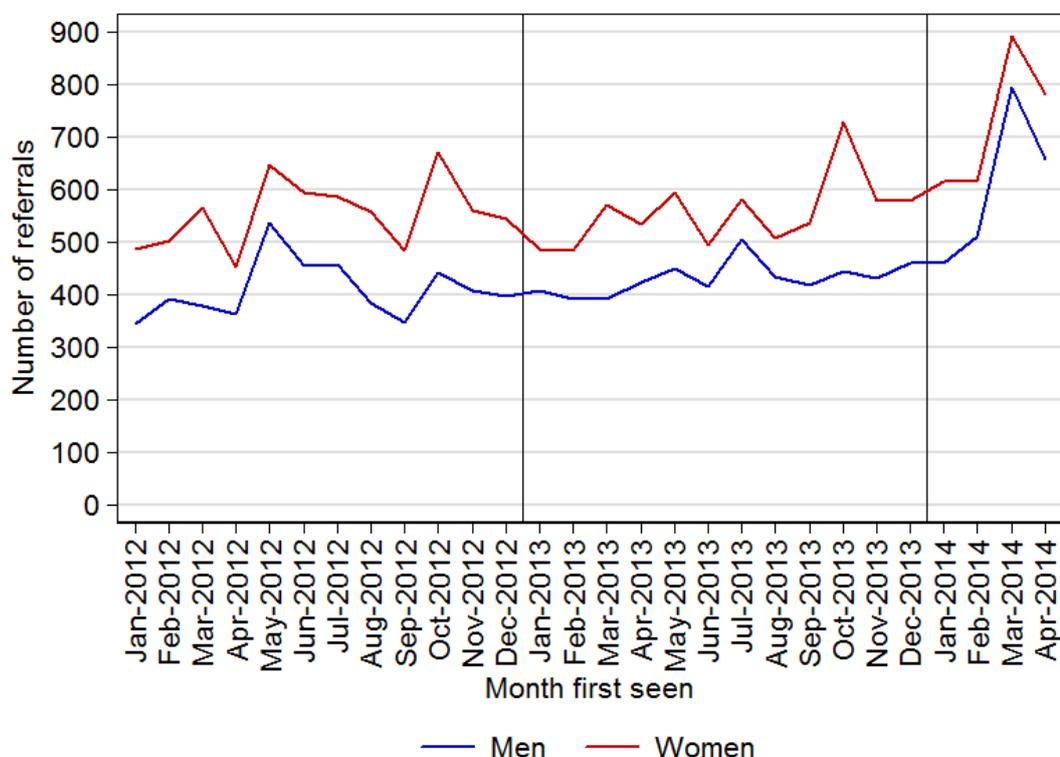
## Sex Results

Table R3 shows that the increase in suspected upper GI cancer referrals, from February to April 2013 to February to April 2014, was larger for men (63%, from 1,206 referrals to 1,964) than for women (44%, from 1,589 to 2,293). The number and rate of referrals remained higher for women throughout the period, but this larger increase for men reduced the difference.

**Table R3: Number of urgent GP referrals for suspected upper GI cancers, with referral rate and percentage change in number of referrals, from February to April 2013 and February to April 2014, regional pilot area, by sex**

Sex		February to April				
		Referrals	% Change in number	P-value	Referral rate Estimate 95% CI	
Men	2013	1,206	62.9	<0.001	379.8	(358.3, 402.1)
	2014	1,964			607.3	(580.4, 635.1)
Women	2013	1,589	44.3	<0.001	423.0	(402.4, 444.4)
	2014	2,293			616.1	(591.1, 642.0)

**Figure R3: Monthly number of urgent GP referrals for suspected upper GI cancers from January 2010 to April 2014, regional pilot area, by sex**



## Cancer diagnoses resulting from an urgent GP referral for suspected cancer

### Total results

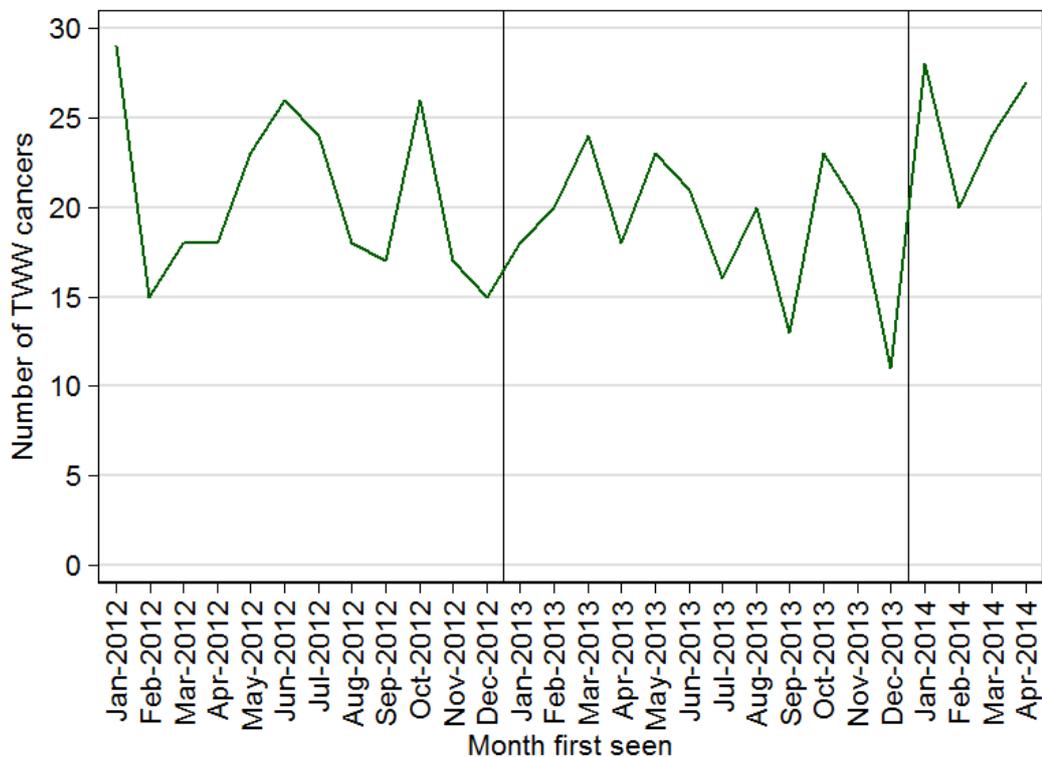
For February to April 2014, compared to the same months in 2013, table TC1 shows that, overall in the regional pilot area, there were no statistically significant changes in the number of oesophageal, stomach or upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers. Similarly, there were no significant changes in the control area.

For the regional pilot area, figures TC1ai, TC1bi and TC1ci show a large amount of natural monthly or quarterly variation in the number of diagnoses resulting from an urgent GP referral for suspected upper GI cancers, reflecting the relatively small numbers of such cases. Even in the larger control area, a large amount of variation is still evident (Figures TC1aii, TC1bii and TC1cii).

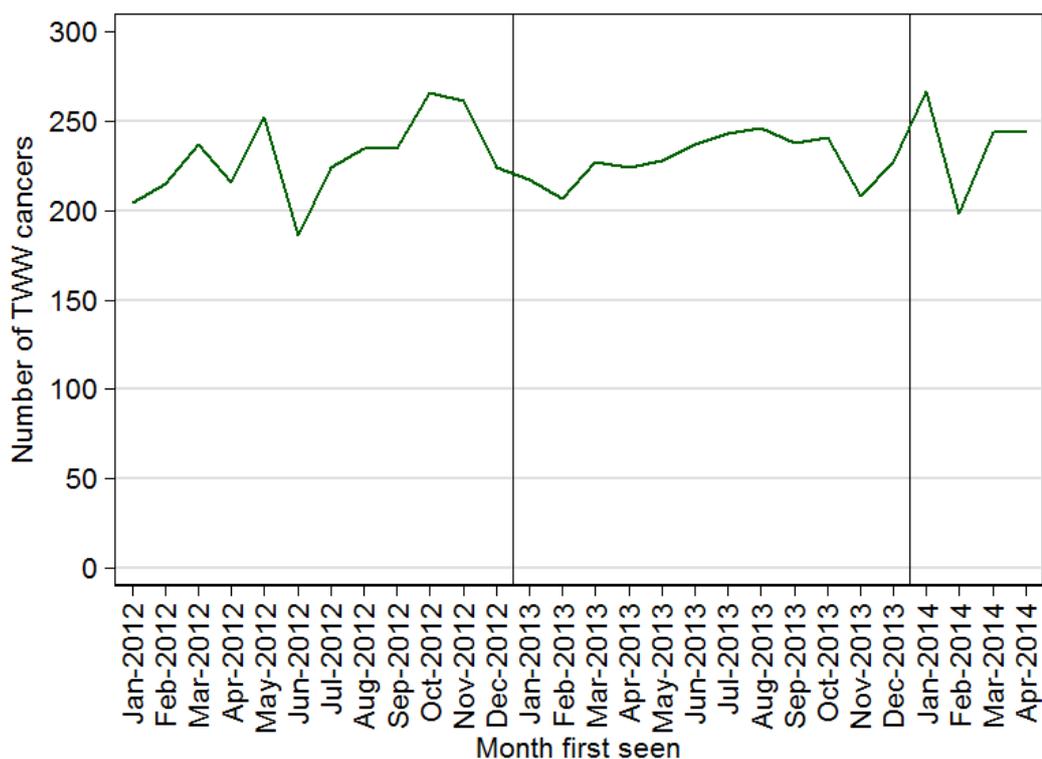
**Table TC1: Number of oesophageal, stomach and upper GI cancer diagnoses resulting from urgent GP referrals for suspected upper GI cancers, with percentage change in number of cancers, from February to April 2013 and February to April 2014**

Cancer type	Overall	February to April			
		TWW cancers		% Change in number	P-value
		2013	2014		
Oesophageal cancer	Regional pilot area	62	71	14.5	0.435
	Control area	658	686	4.3	0.445
Stomach cancer	Regional pilot area	26	18	-30.8	0.227
	Control area	238	202	-15.1	0.086
Upper GI cancer	Regional pilot area	114	126	10.5	0.438
	Control area	1,341	1,304	-2.8	0.472

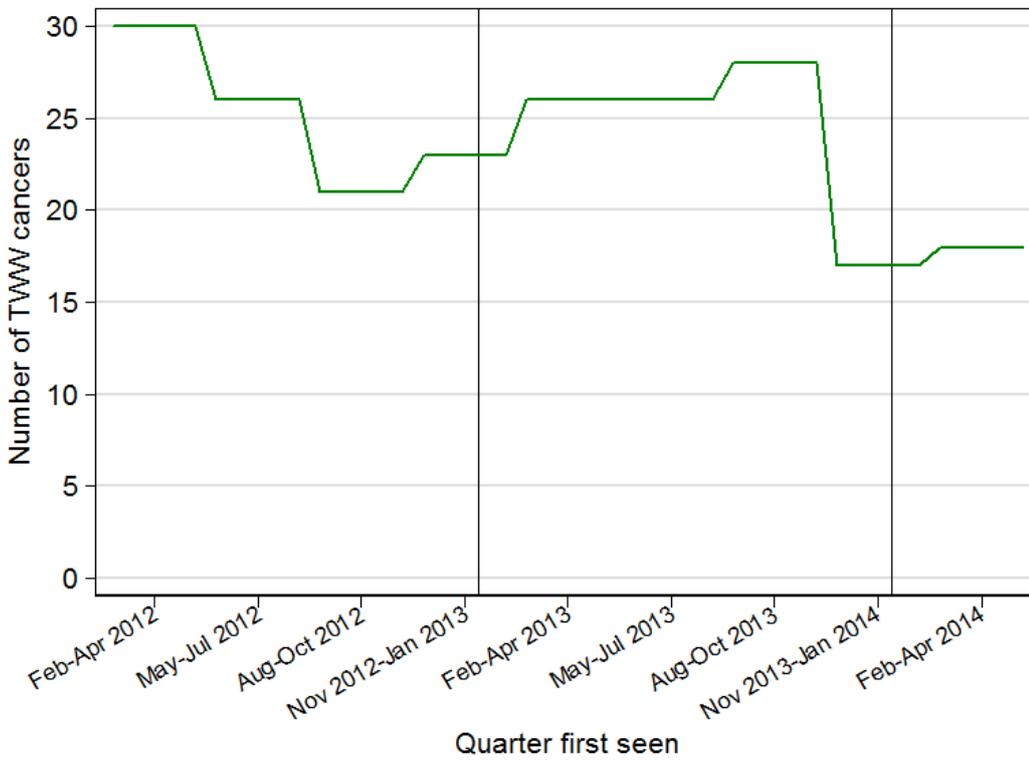
**Figure TC1ai: Monthly number of oesophageal cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from January 2012 to April 2014, regional pilot area**



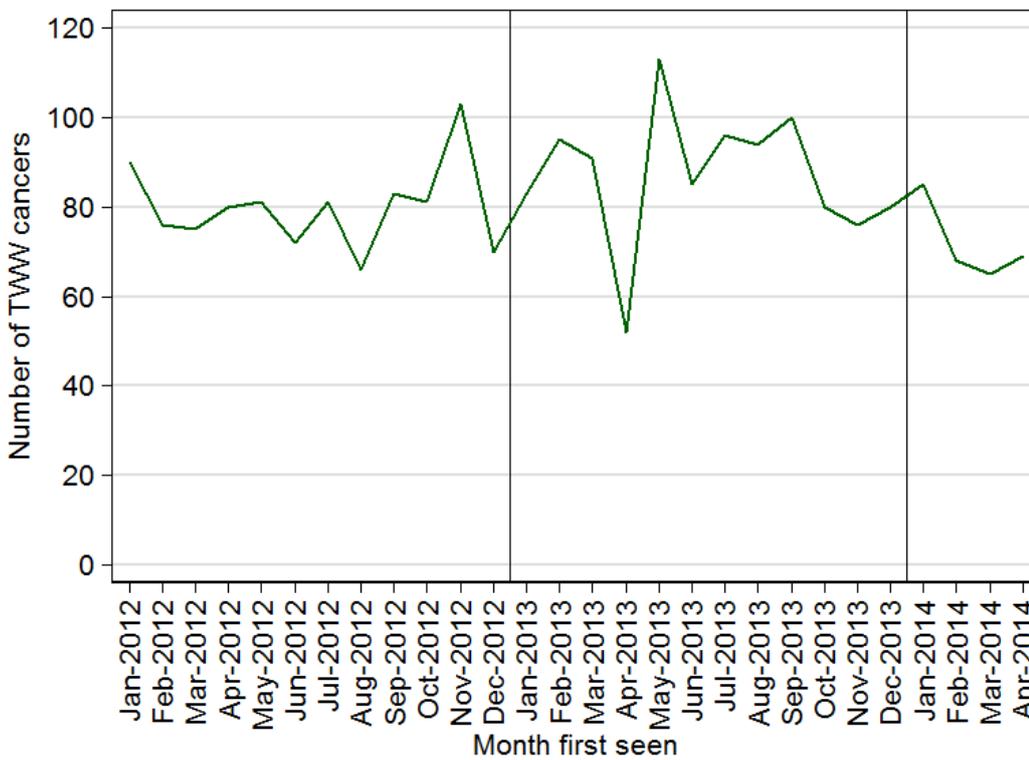
**Figure TC1aii: Monthly number of oesophageal cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from January 2012 to April 2014, control area**



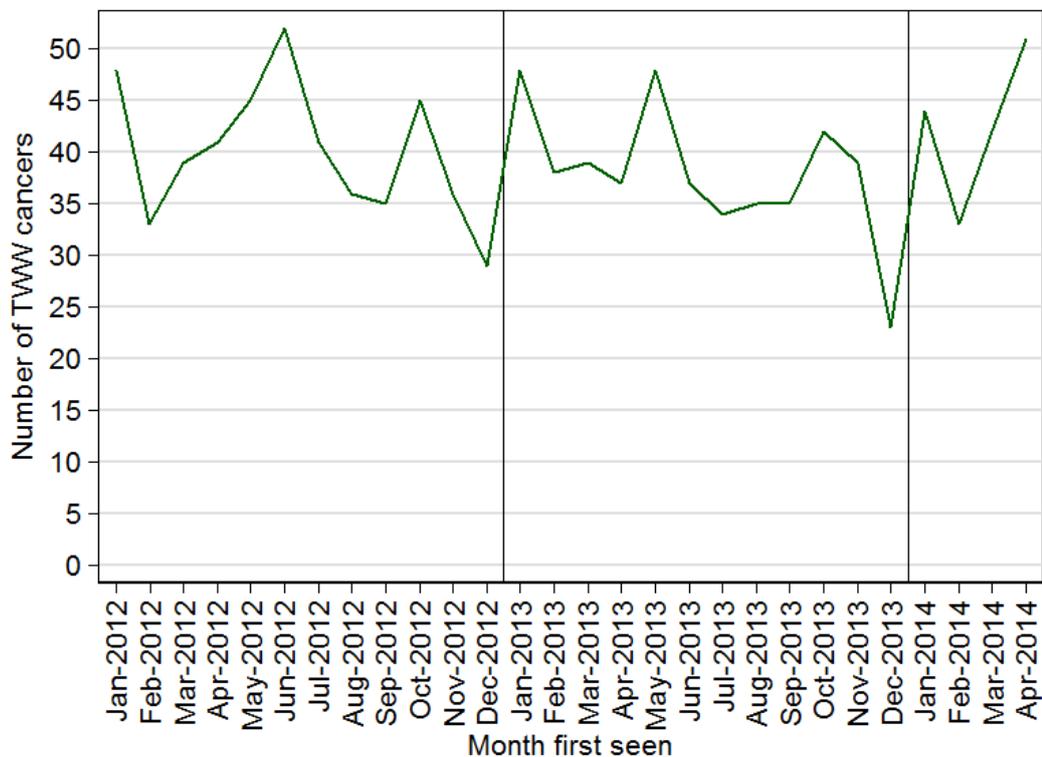
**Figure TC1bi: Quarterly number of stomach cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from January 2012 to April 2014, regional pilot area**



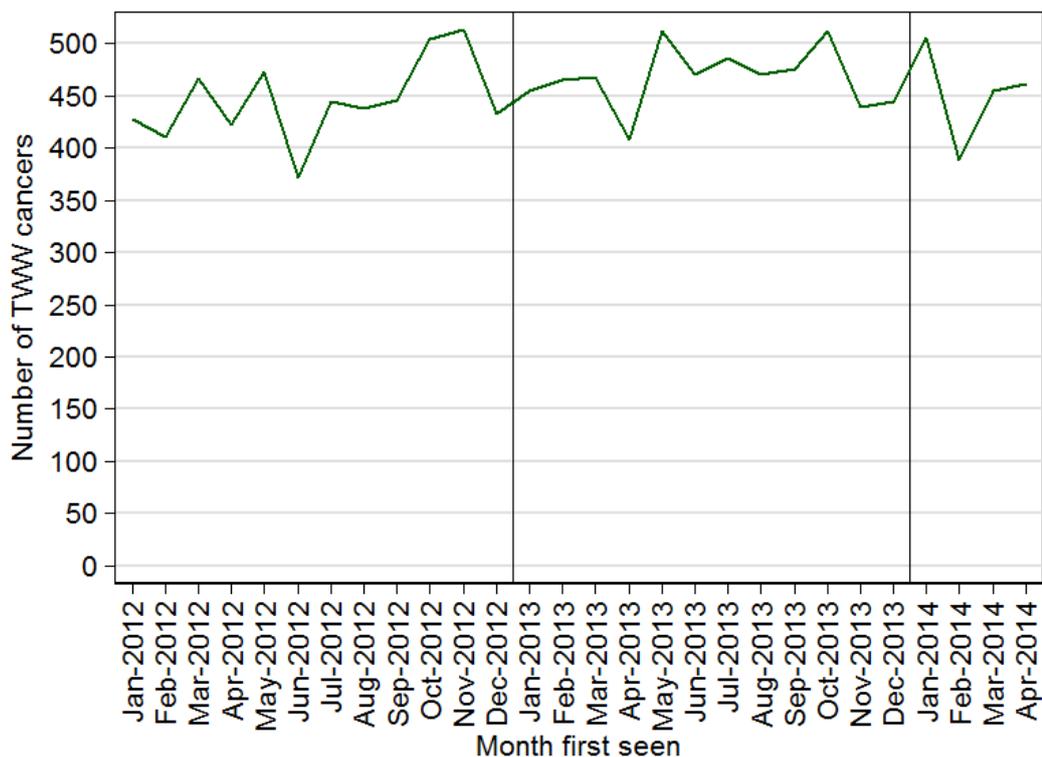
**Figure TC1bii: Monthly number of stomach cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from January 2012 to April 2014, control area**



**Figure TC1ci: Monthly number of upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from January 2012 to April 2014, regional pilot area**



**Figure TC1cii: Monthly number of upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from January 2012 to April 2014, control area**



## Age results

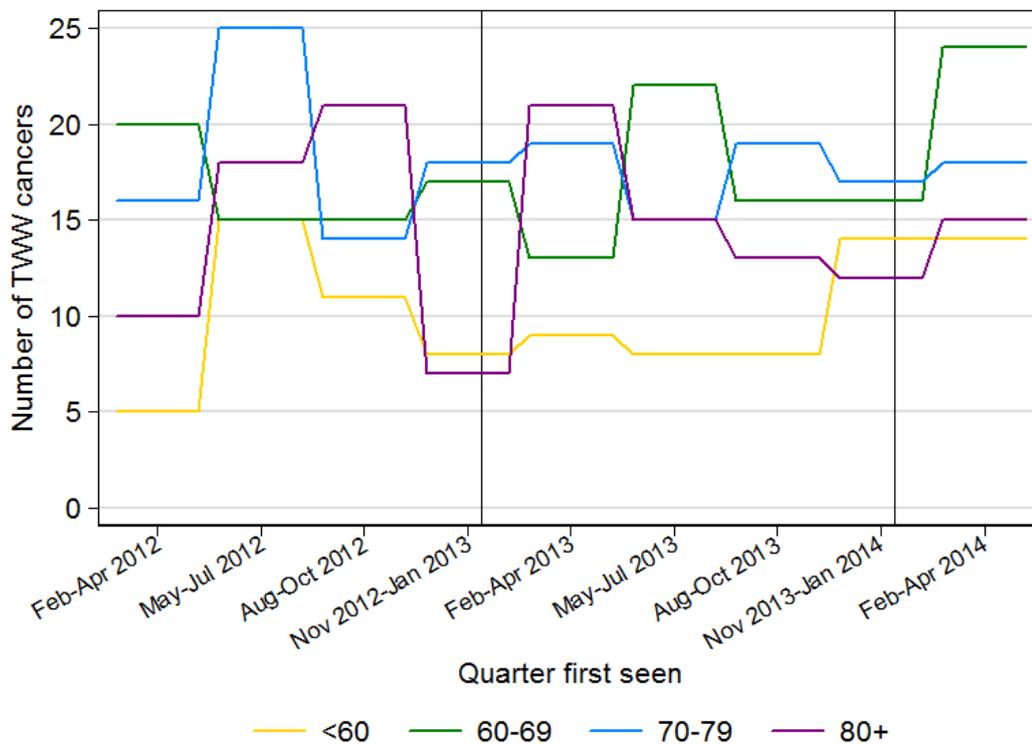
The number of stomach cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers was too small to consider breakdowns by age group.

With figures TC2a and TC2c showing a large amount of variation, there were no statistically significant changes for any age groups in the number of oesophageal or upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers, from February to April 2013 to February to April 2014 (Table TC2), however, for those aged 60 to 69, the percentage changes in the number of such diagnoses were quite large, although the numbers were small, with an 85% increase for oesophageal cancer and a 59% increase for upper GI cancers.

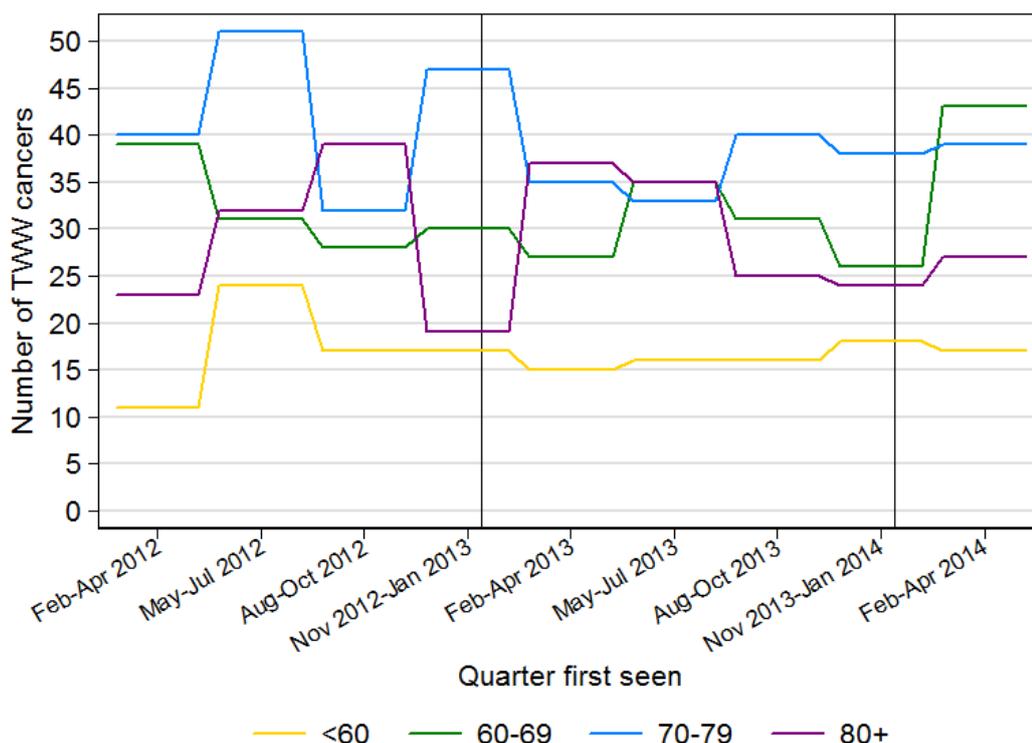
**Table TC2: Number of oesophageal and upper GI cancer diagnoses resulting from urgent GP referrals for suspected upper GI cancers, with percentage change in number of cancers, from February to April 2013 and February to April 2014, regional pilot area, by age**

Cancer type	Age group	February to April			
		TWW cancers		% Change in number	P-value
		2013	2014		
Oesophageal cancer	<60	9	14	55.6	0.295
	60-69	13	24	84.6	0.068
	70-79	19	18	-5.3	0.869
	80+	21	15	-28.6	0.316
Upper GI cancer	<60	15	17	13.3	0.724
	60-69	27	53	59.3	0.055
	70-79	35	39	11.4	0.642
	80+	37	27	-27.0	0.210

**Figure TC2a: Quarterly number of oesophageal cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from February to April 2012 to February to April 2014, regional pilot area, by age**



**Figure TC2c: Quarterly number of upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from February to April 2012 to February to April 2014, regional pilot area, by age**



## Sex Results

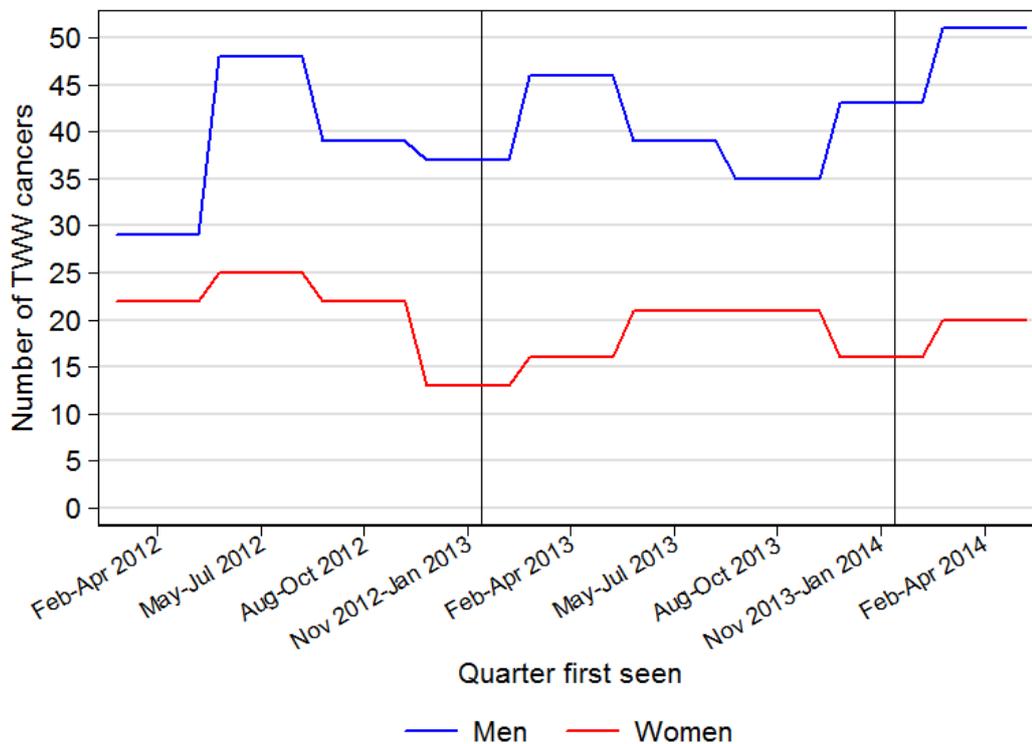
The number of stomach cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers was too small to consider breakdowns by sex.

For February to April 2014, compared to the same months in 2013, Table TC3 shows that there were no statistically significant changes by sex in the number of oesophageal or upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers.

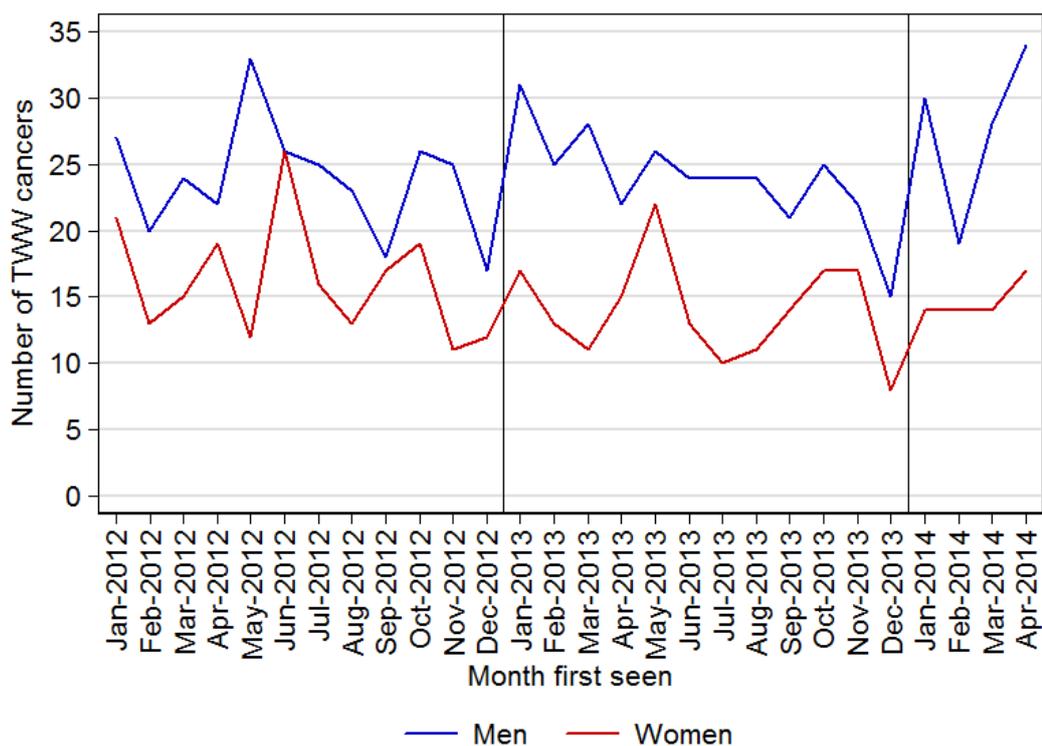
**Table TC3: Number of oesophageal and upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers, with percentage change in number of cancers, from February to April 2013 and February to April 2014, regional pilot area, by sex**

Cancer type	Sex	February to April			
		TWW cancers		% Change in number	P-value
		2013	2014		
Oesophageal cancer	Men	46	51	10.9	0.612
	Women	16	20	25.0	0.505
Upper GI cancer	Men	75	81	8.0	0.631
	Women	39	45	15.4	0.513

**Figure TC3a: Quarterly number of oesophageal cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from February to April 2012 to February to April 2014, regional pilot area, by sex**



**Figure TC3c: Monthly number of upper GI cancer diagnoses resulting from an urgent GP referral for suspected upper GI cancers from February to April 2012 to February to April 2014, regional pilot area, by sex**



## Conversion rate

### Total results

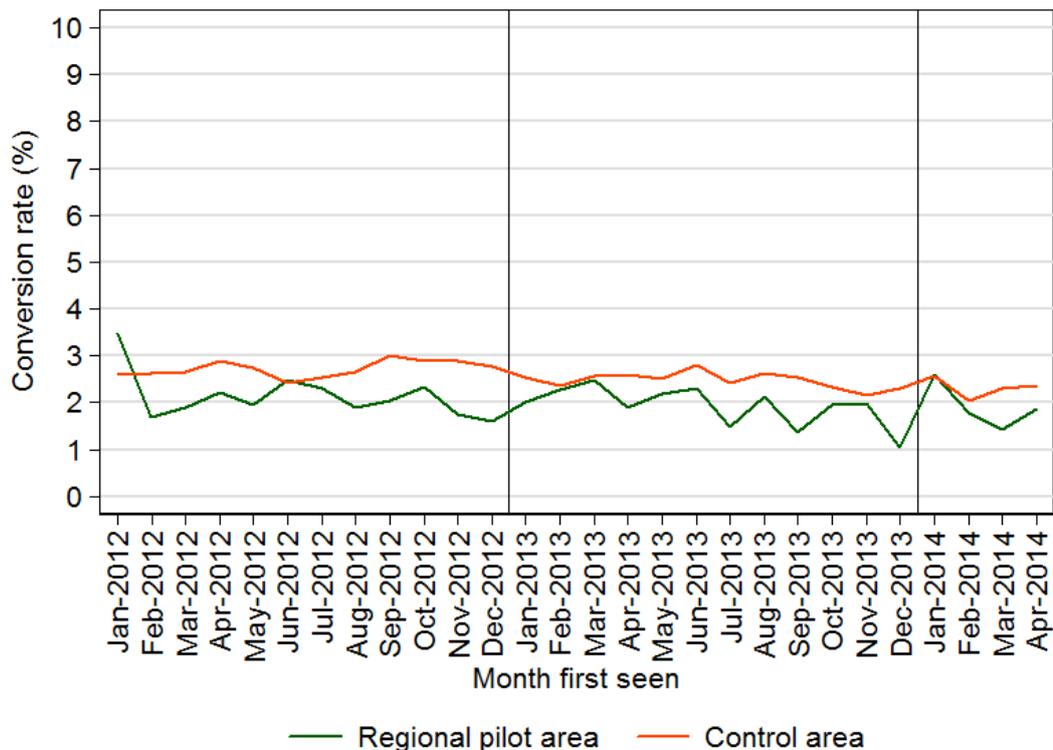
Figures C1a-C1c show general long-term trends for decreasing conversion rates for urgent GP referrals for suspected upper GI cancers, for both regional pilot areas and control areas.

For February to April 2014, compared to February to April 2013, Table C1 shows that there were statistically significant decreases in the stomach and upper GI cancer conversion rates within the regional pilot area; the stomach cancer conversion rate decreased by 0.5 percentage points, from 0.9% to 0.4%; the upper GI cancer conversion rate decreased by 1.1 percentage points, from 4.1% to 3.0%. These changes were similar, although slightly larger, than significant decreases for the control area, for which there was also a significant decrease in the oesophageal cancer conversion rate. This suggests that the long-term decreasing trend accounts for much of the decrease in conversion rates, although there may have been a small additional decrease related to the large increases in referrals in the regional pilot area during the campaign period.

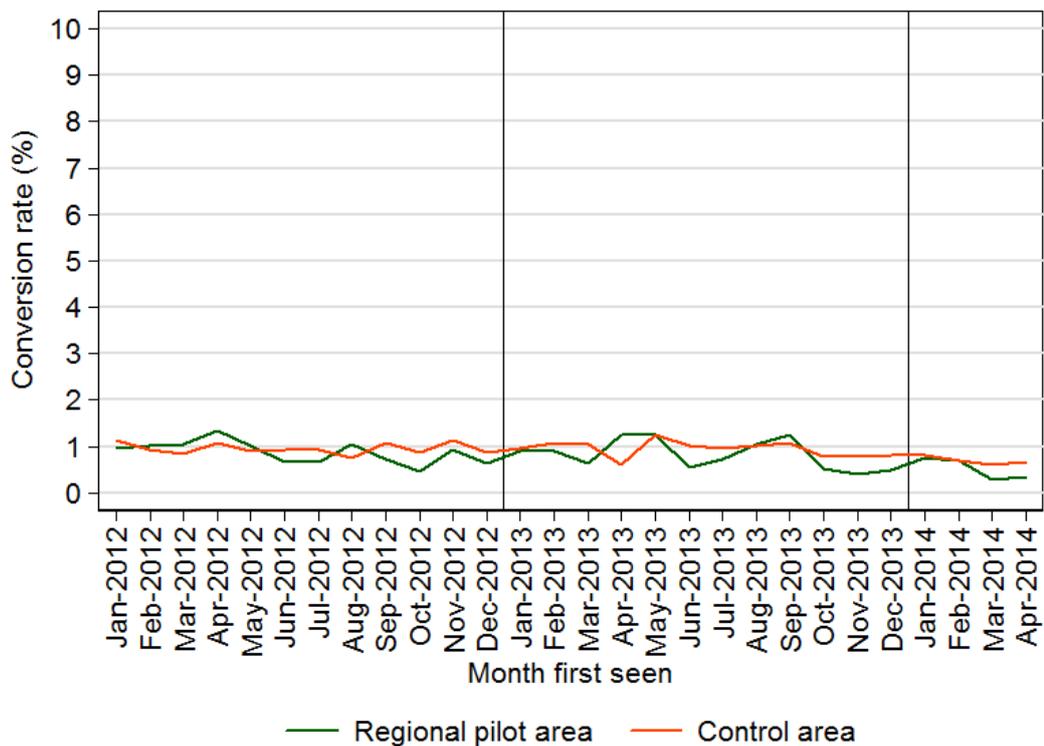
**Table C1: Oesophageal, stomach and upper GI cancer conversion rates for urgent GP referrals for suspected upper GI cancers, with change, from February to April 2013 and February to April 2014**

Cancer type	Overall	February to April					
		2013		2014		% -point change	P-value
		Conv. rate (%)	95% CI	Conv. rate (%)	95% CI		
Oesophageal cancer	Regional pilot area	2.2	(1.7, 2.8)	1.7	(1.3, 2.1)	-0.6	0.097
	Control area	2.5	(2.3, 2.7)	2.2	(2.1, 2.4)	-0.3	0.032
Stomach cancer	Regional pilot area	0.9	(0.6, 1.4)	0.4	(0.3, 0.7)	-0.5	0.008
	Control area	0.9	(0.8, 1.0)	0.7	(0.6, 0.8)	-0.2	<0.001
Upper GI cancer	Regional pilot area	4.1	(3.4, 4.9)	3.0	(2.5, 3.5)	-1.1	0.011
	Control area	5.1	(4.9, 5.4)	4.3	(4.0, 4.5)	-0.9	<0.001

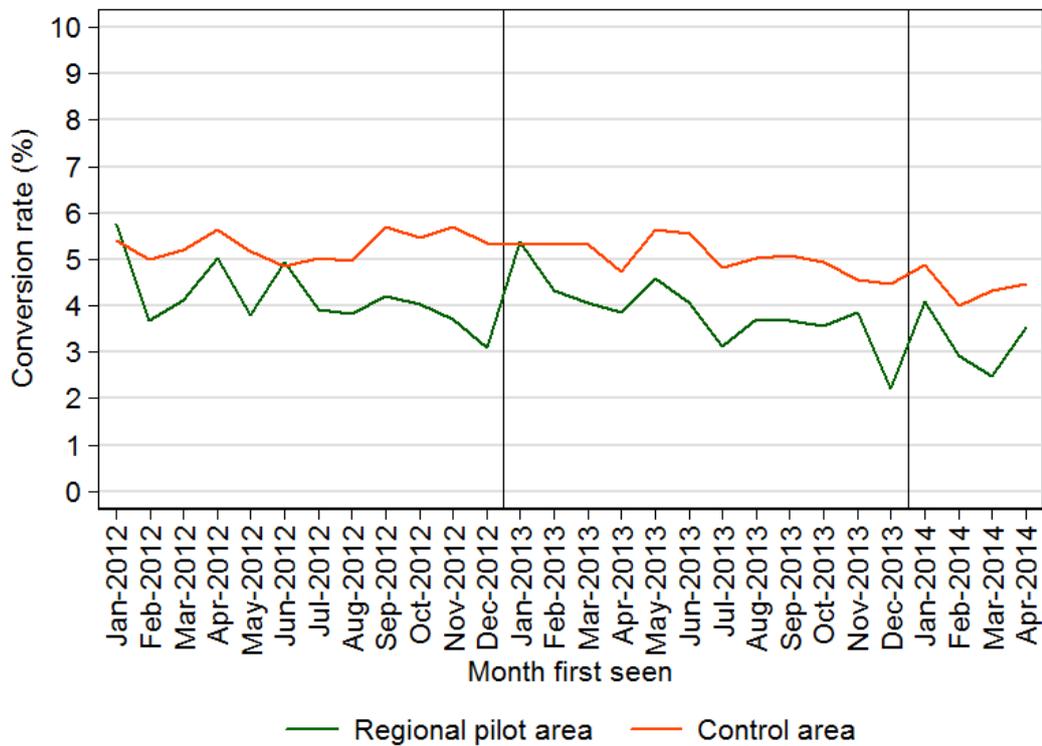
**Figure C1a: Monthly oesophageal cancer conversion rates for urgent GP referrals for suspected upper GI cancers from January 2012 to April 2014**



**Figure C1b: Monthly stomach cancer conversion rates for urgent GP referrals for suspected upper GI cancers from January 2012 to April 2014**



**Figure C1c: Monthly upper GI cancer conversion rates for urgent GP referrals for suspected upper GI cancers from January 2012 to April 2014**



## Age results

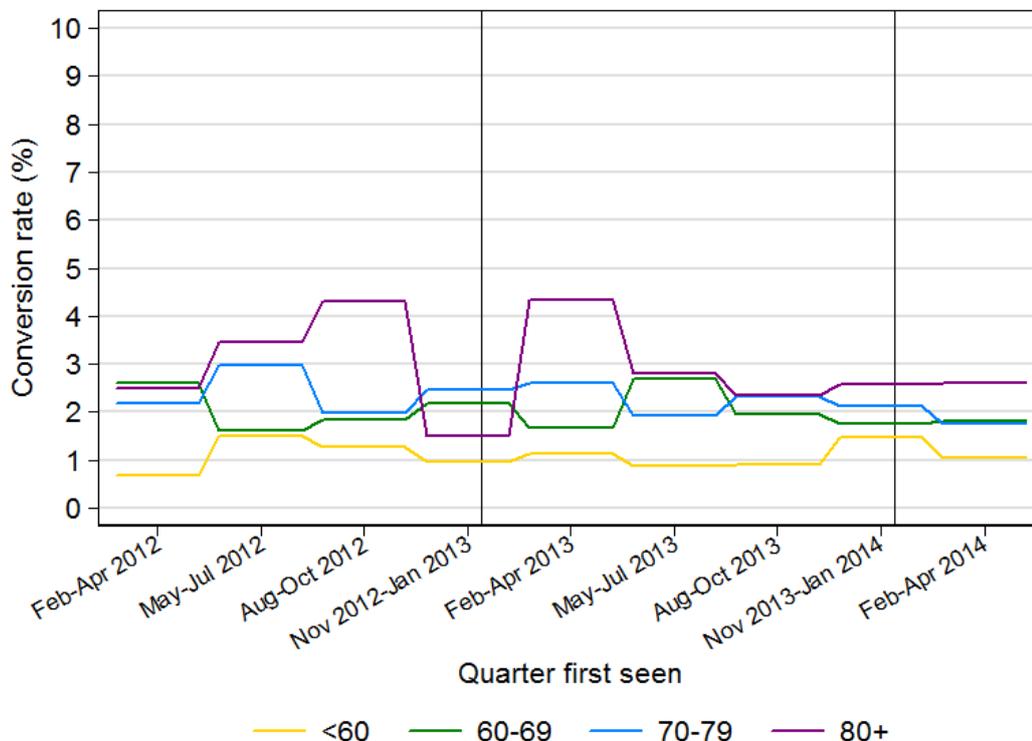
Due to small numbers, it was not possible to consider breakdowns of the stomach cancer conversion rate by age group.

The upper GI cancer conversion rate for those aged 80+ changed significantly, with a 2.9 percentage point decrease, from 7.6% to 4.7%, when comparing February to April 2014 to February to April 2013 (Table C2). There were no other statistically significant changes by age group in either oesophageal or upper GI cancer conversion rates between February to April 2013 and February to April 2014.

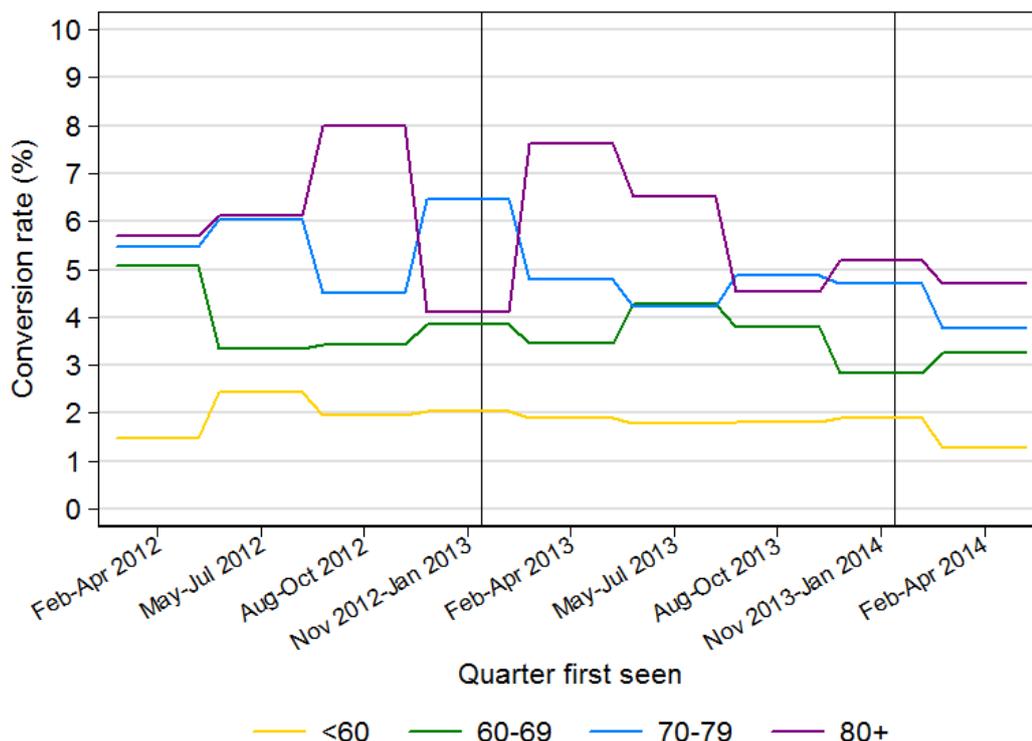
**Table C2: Oesophageal and upper GI cancer conversion rates for urgent GP referrals for suspected upper GI cancers, with change, from February to April 2013 and February to April 2014, regional pilot area, by age**

Cancer type	Age group	February to April					
		2013		2014		% -point change	P-value
		Conv. rate (%)	95% CI	Conv. rate (%)	95% CI		
Oesophageal cancer	<60	1.1	(0.6, 2.1)	1.1	(0.6, 1.8)	-0.1	0.861
	60-69	1.7	(1.0, 2.8)	1.8	(1.2, 2.7)	0.2	0.792
	70-79	2.6	(1.7, 4.0)	1.7	(1.1, 2.7)	-0.8	0.220
	80+	4.3	(2.8, 6.5)	2.6	(1.6, 4.3)	-1.7	0.125
Upper GI cancer	<60	1.9	(1.2, 3.1)	1.3	(0.8, 2.0)	-0.6	0.263
	60-69	3.4	(2.4, 5.0)	3.3	(2.4, 4.3)	-0.2	0.810
	70-79	4.8	(3.5, 6.6)	3.8	(2.8, 5.1)	-1.0	0.304
	80+	7.6	(5.6, 10.3)	4.7	(3.2, 6.7)	-2.9	0.047

**Figure C2a: Quarterly oesophageal cancer conversion rates for urgent GP referrals for suspected upper GI cancers from February to April 2012 to February to April 2014, regional pilot area, by age**



**Figure C2c: Quarterly upper GI cancer conversion rates for urgent GP referrals for suspected upper GI cancers from February to April 2012 to February to April 2014, regional pilot area, by age**



## Sex Results

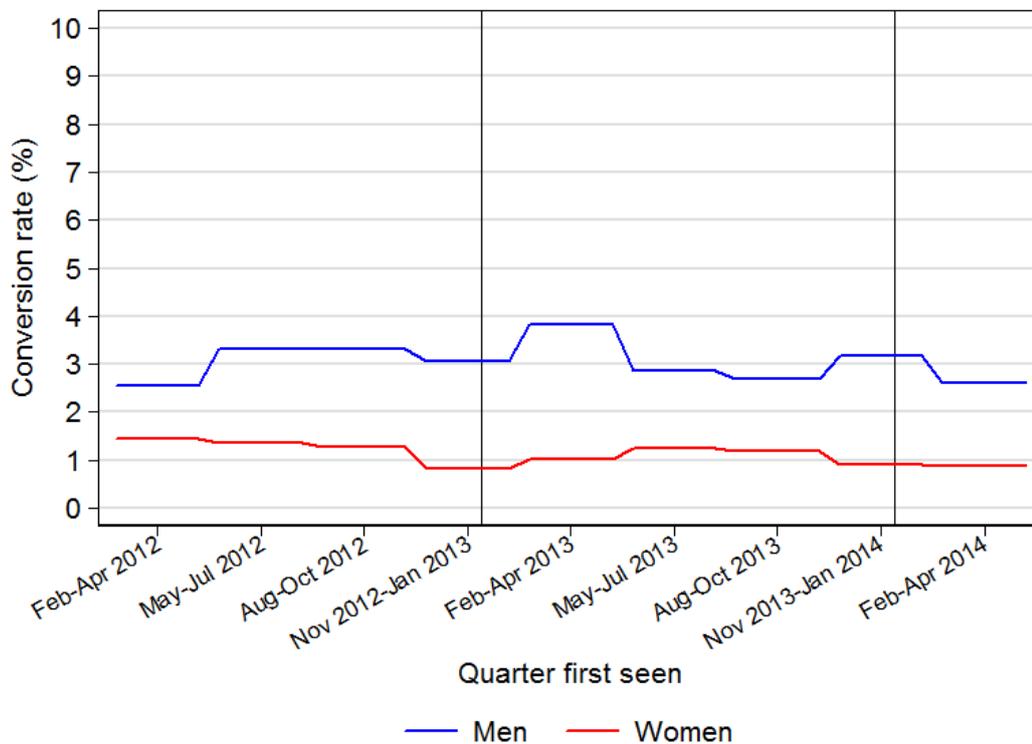
Due to small numbers, it was not possible to consider breakdowns of the stomach cancer conversion rate by sex.

From February to April 2013 to February to April 2014, there was a statistically significant decrease of 2.1 percentage points in the upper GI cancer conversion rate for men, from 6.2% to 4.1% (Table C3). Although, Figure C3 suggests this may reflect a longer term decreasing trend and a higher than usual upper GI cancer conversion rate in February and March 2013.

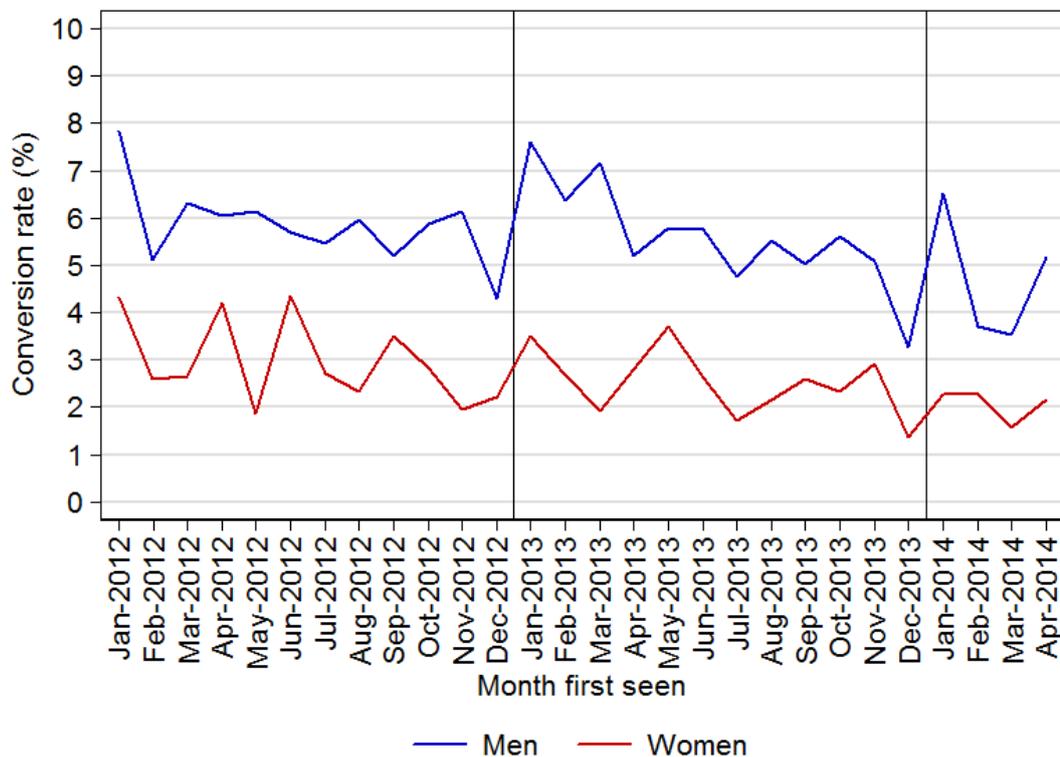
**Table C3: Oesophageal and upper GI cancer conversion rates for urgent GP referrals for suspected upper GI cancers, with change, from February to April 2013 and February to April 2014, regional pilot area, by sex**

Cancer type	Sex	February to April					
		2013		2014		% -point change	P-value
		Conv. rate (%)	95% CI	Conv. rate (%)	95% CI		
Oesophageal cancer	Men	3.8	(2.9, 5.1)	2.6	(2.0, 3.4)	-1.2	0.053
	Women	1.0	(0.6, 1.6)	0.9	(0.6, 1.3)	-0.1	0.667
Upper GI cancer	Men	6.2	(5.0, 7.7)	4.1	(3.3, 5.1)	-2.1	0.008
	Women	2.5	(1.8, 3.3)	2.0	(1.5, 2.6)	-0.5	0.300

**Figure C3a: Quarterly oesophageal cancer conversion rates for urgent GP referrals for suspected upper GI cancers, from February 2012 to April 2014, regional pilot area, by sex**



**Figure C3c: Monthly upper GI cancer conversion rates for urgent GP referrals for suspected upper GI cancers, from January 2012 to April 2014, regional pilot area, by sex**



## Cancer diagnoses recorded in the Cancer Waiting Times database

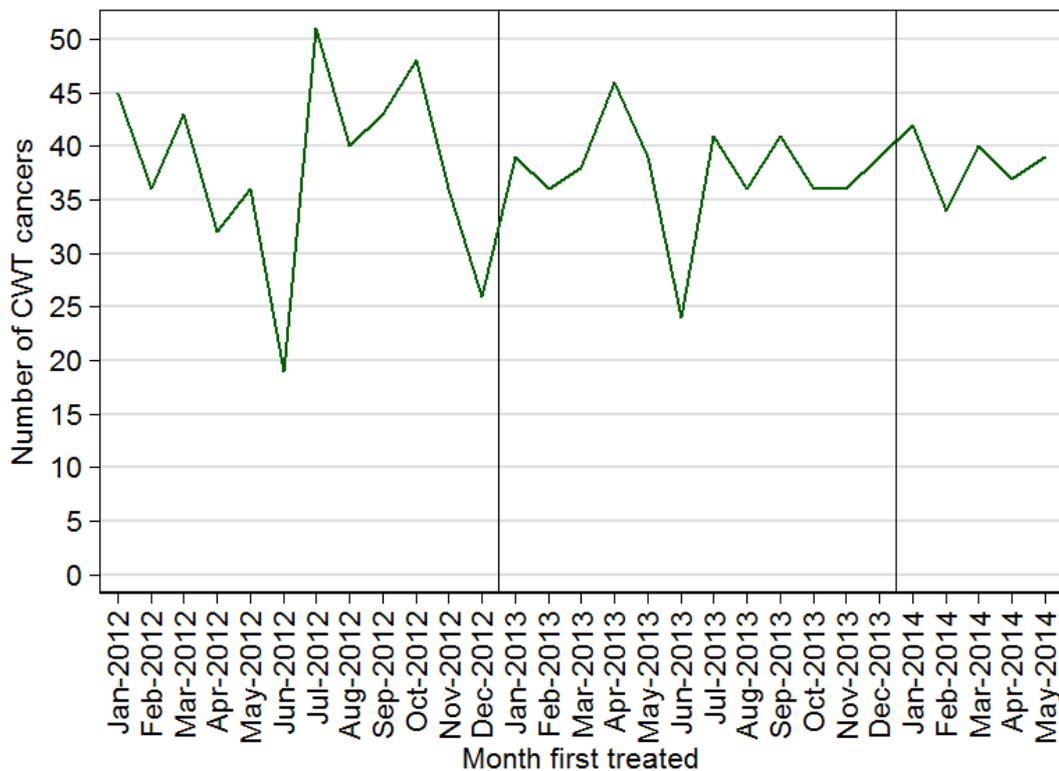
### Total results

For the regional pilot area, table CC1 shows that there were small decreases in the number of the oesophageal (6%), stomach (10%) and upper GI (4%) cancer diagnoses recorded in the CWT data, for March to May 2014 compared to the same months in 2013, but there were relatively small numbers of cases and these changes were not statistically significant. Similarly, for the control area, the changes were not significant.

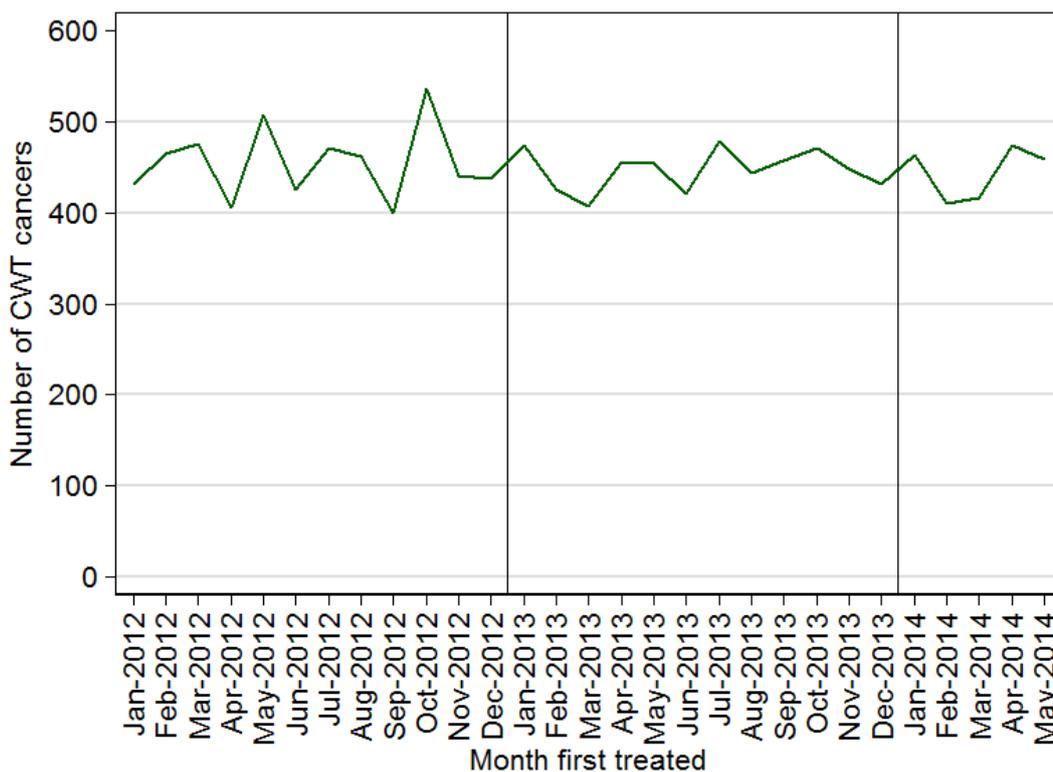
**Table CC1: Number of oesophageal, stomach and upper GI cancer diagnoses recorded in the Cancer Waiting Times database, with percentage change in number of cancers, from March to May 2013 and March to May 2014**

Cancer type	Overall	March to May			
		CWT cancers		% Change in number	P-value
		2013	2014		
Oesophageal cancer	Regional pilot area	123	116	-5.7	0.651
	Control area	1,317	1,350	2.5	0.523
Stomach cancer	Regional pilot area	77	69	-10.4	0.508
	Control area	706	695	-1.6	0.769
Upper GI cancer	Regional pilot area	317	305	-3.8	0.630
	Control area	3,819	3,826	0.2	0.936

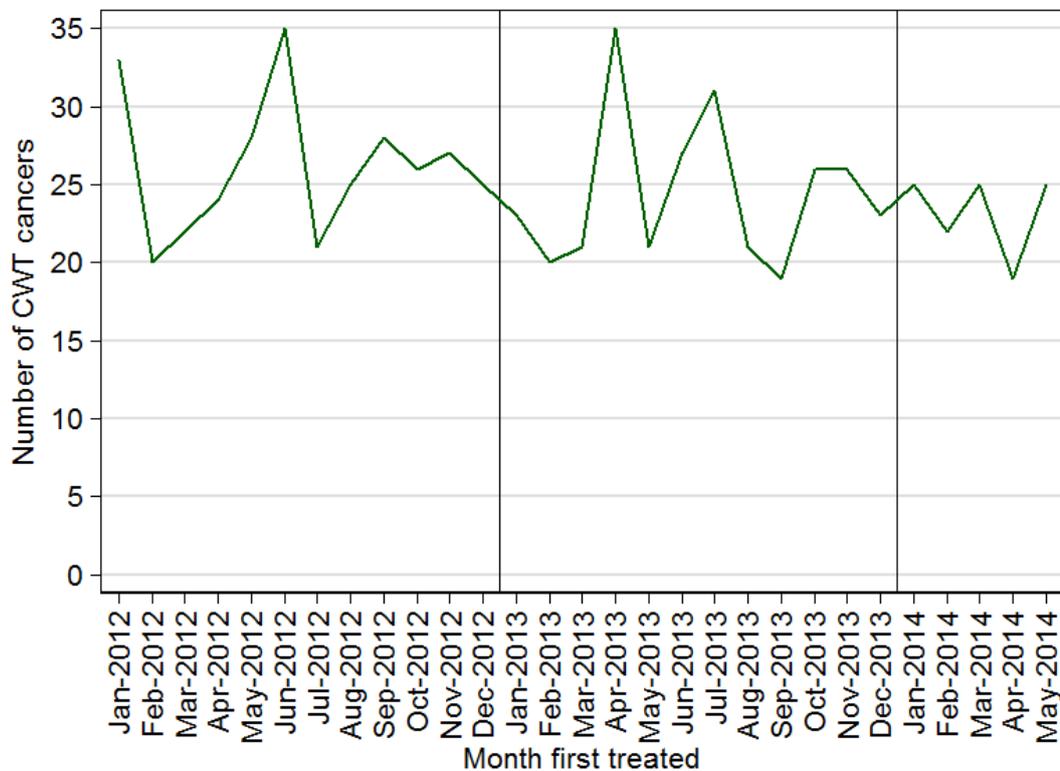
**Figure CC1ai: Monthly number of oesophageal cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, regional pilot area**



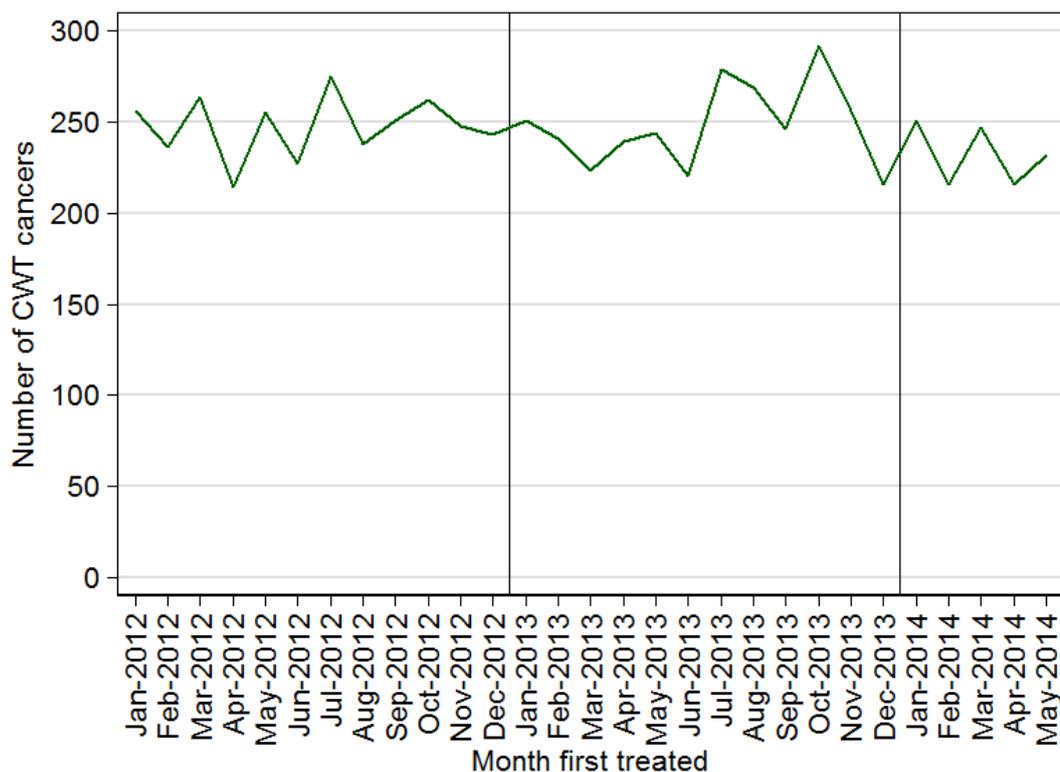
**Figure CC1aii: Monthly number of oesophageal cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, control area**



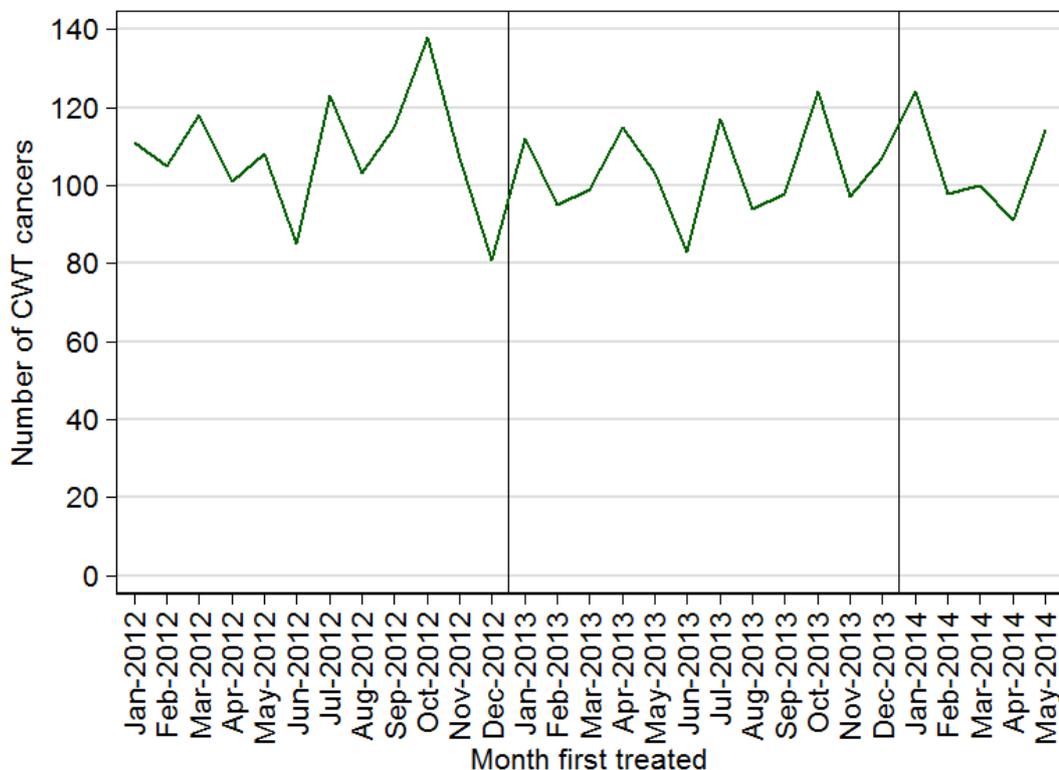
**Figure CC1bi: Monthly number of stomach cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, regional pilot area**



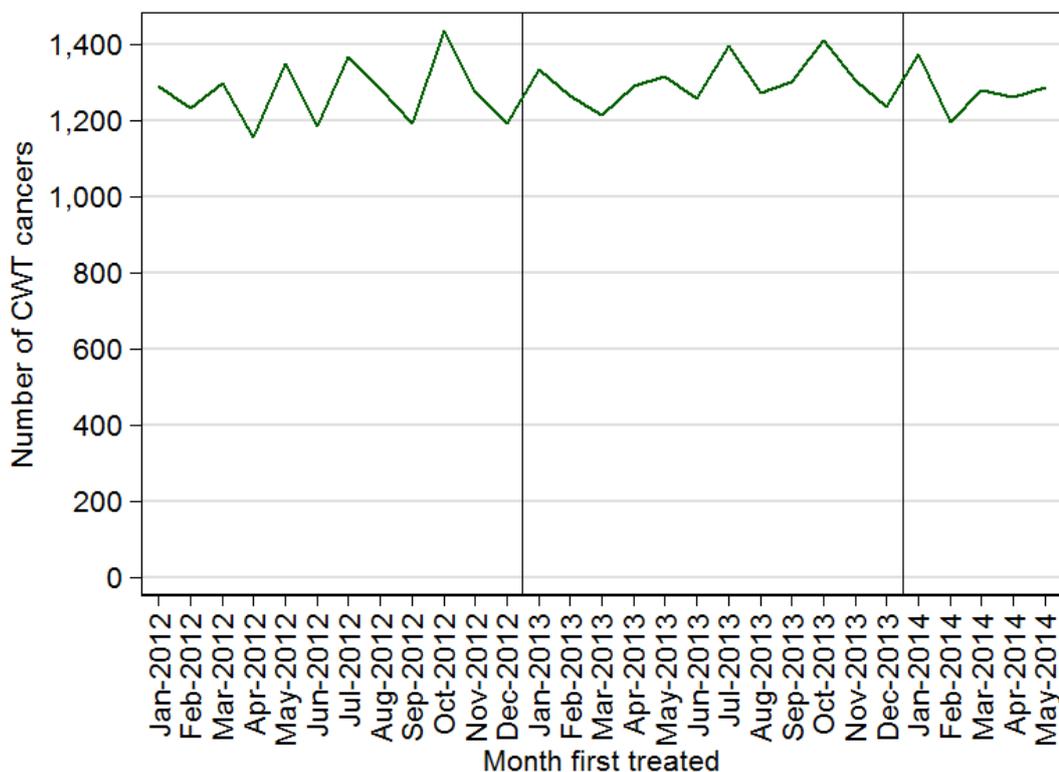
**Figure CC1bii: Monthly number of stomach cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, control area**



**Figure CC1ci: Monthly number of upper GI cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, regional pilot area**



**Figure CC1cii: Monthly number of upper GI cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, control area**



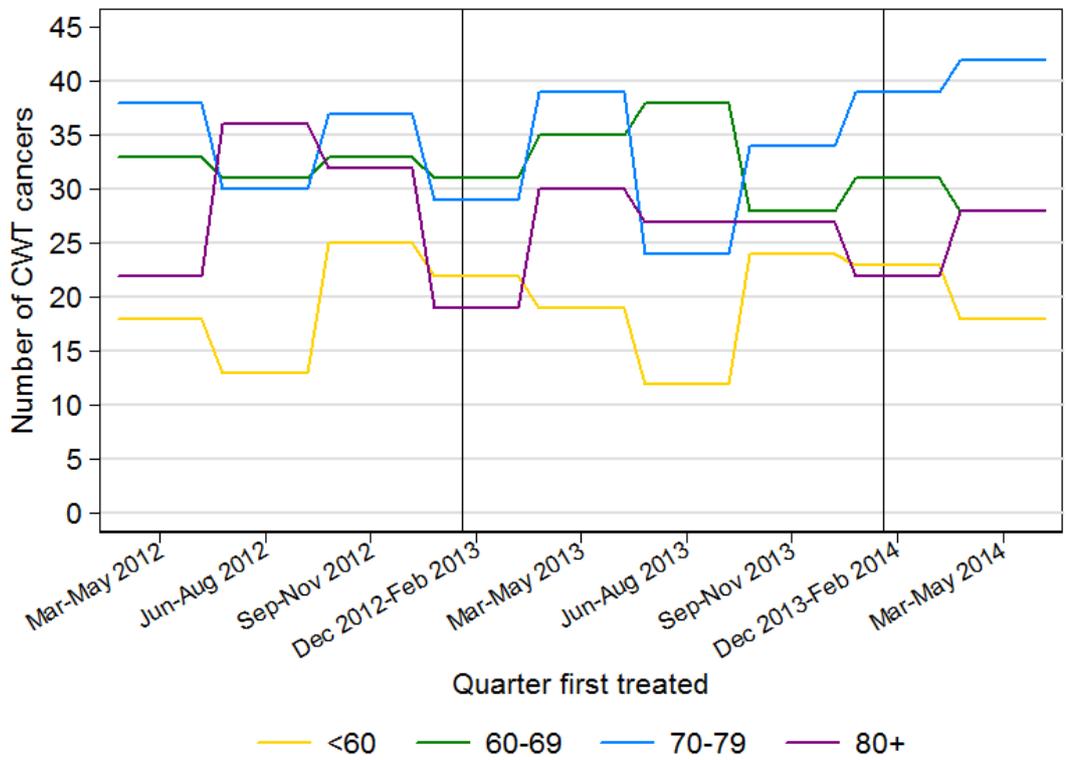
## Age results

By age, there were only a small number of oesophageal, stomach and upper GI cancer diagnoses in the three-month periods considered, with a large amount of natural variation (Figures CC2a-CC2c). Although there were some large percentage changes in the numbers of cancers, these were based on relatively small numbers, and there were no statistically significant changes, for any age-group, from March to May 2013 to March to May 2014 (Table CC2).

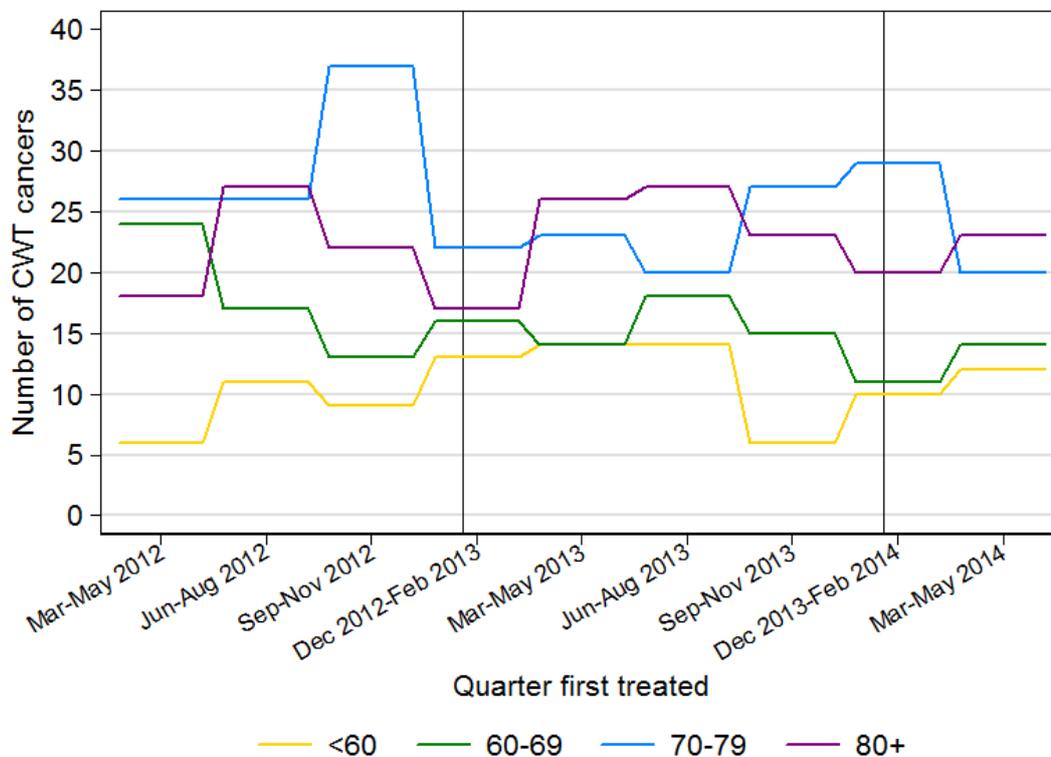
**Table CC2: Number of oesophageal, stomach and upper GI cancer diagnoses recorded in the Cancer Waiting Times database, with percentage change in number of cancers, from March to May 2013 and March to May 2014, regional pilot area, by age**

Cancer type	Age group	March to May			
		CWT cancers		% Change in number	P-value
		2013	2014		
Oesophageal cancer	<60	19	18	-5.3	0.869
	60-69	35	28	-20.0	0.377
	70-79	39	42	7.7	0.739
	80+	30	28	-6.7	0.793
Stomach cancer	<60	14	12	-14.3	0.695
	60-69	14	14	0.0	1.000
	70-79	23	20	-13.0	0.647
	80+	26	23	-11.5	0.668
Upper GI cancer	<60	51	49	-3.9	0.841
	60-69	81	69	-14.8	0.327
	70-79	103	104	1.0	0.945
	80+	82	83	1.2	0.938

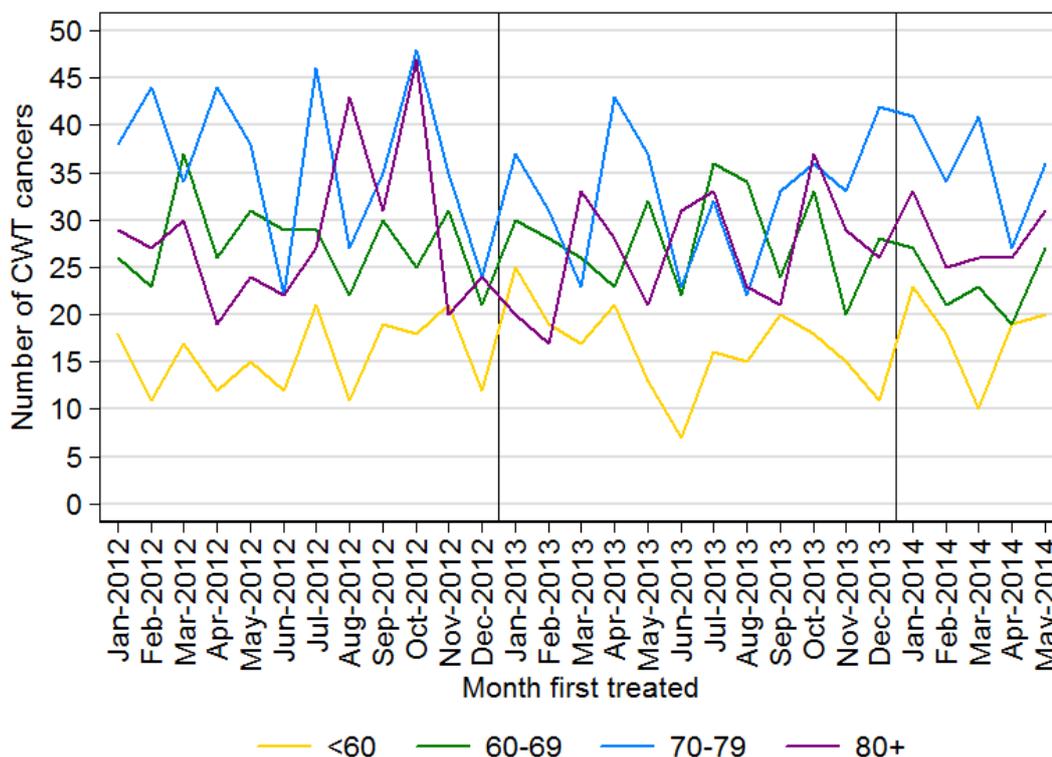
**Figure CC2a: Quarterly number of oesophageal cancer diagnoses recorded in the Cancer Waiting Times database, from March to May 2012 to March to May 2014, regional pilot area, by age**



**Figure CC2b: Quarterly number of stomach cancer diagnoses recorded in the Cancer Waiting Times database, from March to May 2012 to March to May 2014, regional pilot area, by age**



**Figure CC2c: Monthly number of upper GI cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, regional pilot area, by age**



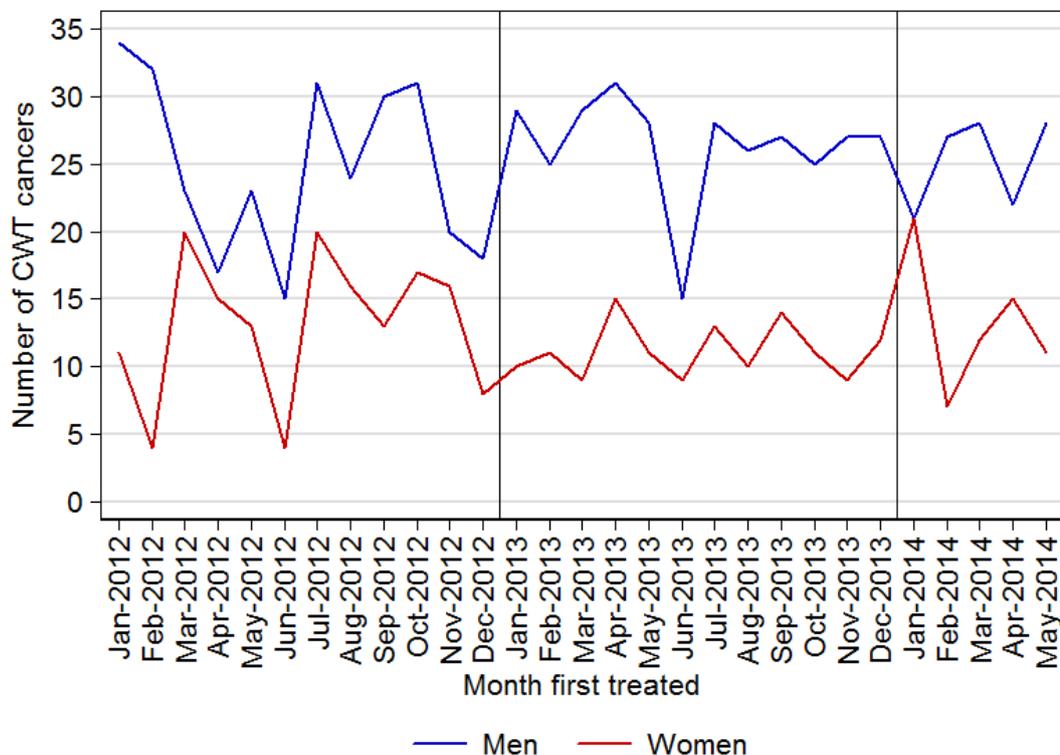
## Sex Results

By sex, there were no significant changes in the number of oesophageal, stomach or upper GI cancer diagnoses recorded in the CWT database, for March to May 2014 compared to the same months in 2013.

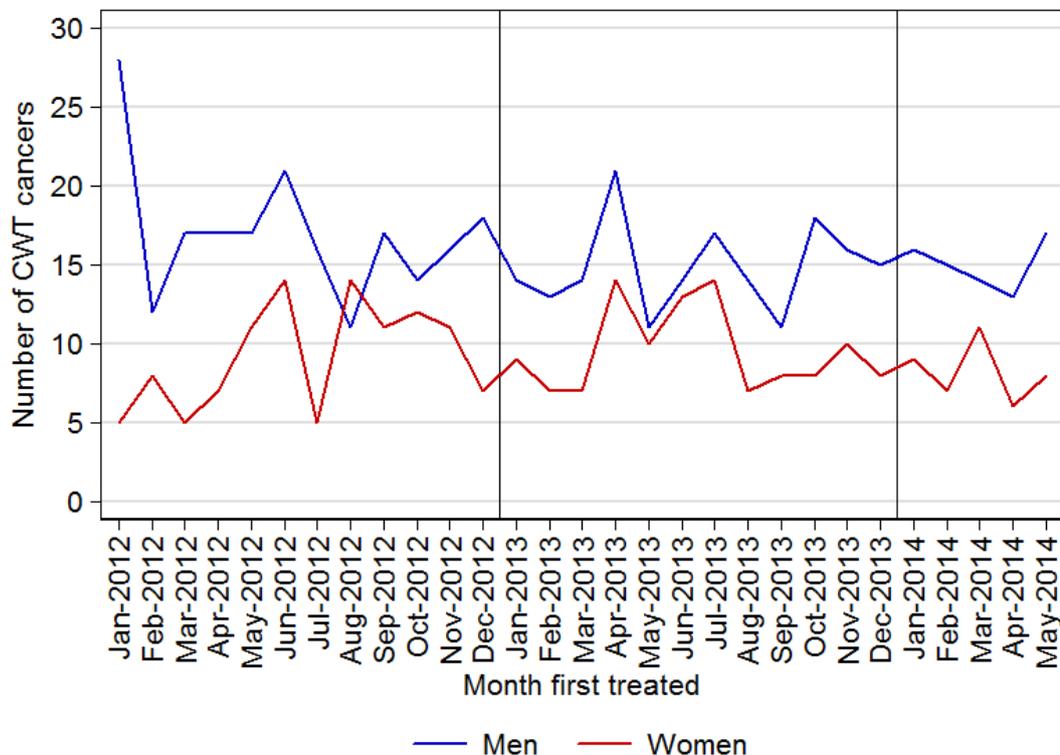
**Table CC3: Number of oesophageal, stomach and upper GI cancer diagnoses recorded in the Cancer Waiting Times database, with percentage change in number of cancers, from March to May 2013 and March to May 2014, regional pilot area, by sex**

Cancer type	Age group	March to May			
		CWT cancers		% Change in number	P-value
		2013	2014		
Oesophageal cancer	Men	88	78	-11.4	0.438
	Women	35	38	8.6	0.725
Stomach cancer	Men	46	44	-4.3	0.833
	Women	31	25	-19.4	0.422
Upper GI cancer	Men	202	179	-11.4	0.239
	Women	115	126	9.6	0.479

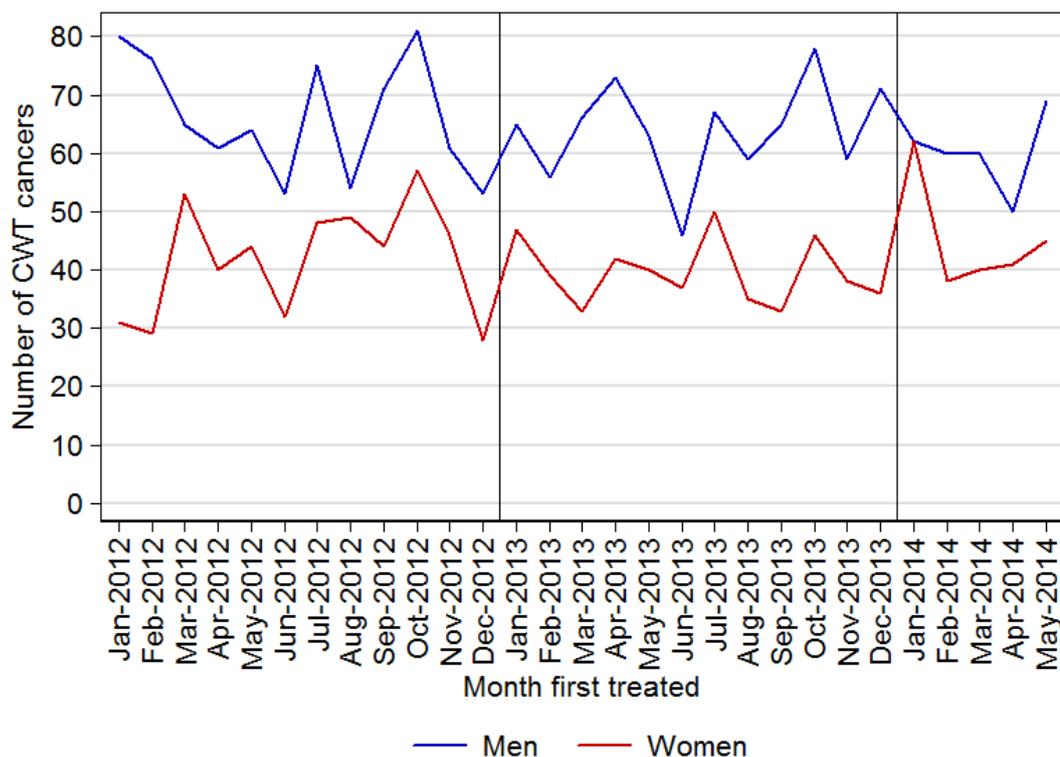
**Figure CC3a: Monthly number of oesophageal cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, regional pilot area, by sex**



**Figure CC3b: Monthly number of stomach cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, regional pilot area, by sex**



**Figure CC3c: Monthly number of upper GI cancer diagnoses recorded in the Cancer Waiting Times database, from January 2012 to May 2014, regional pilot area, by sex**



## Detection rate

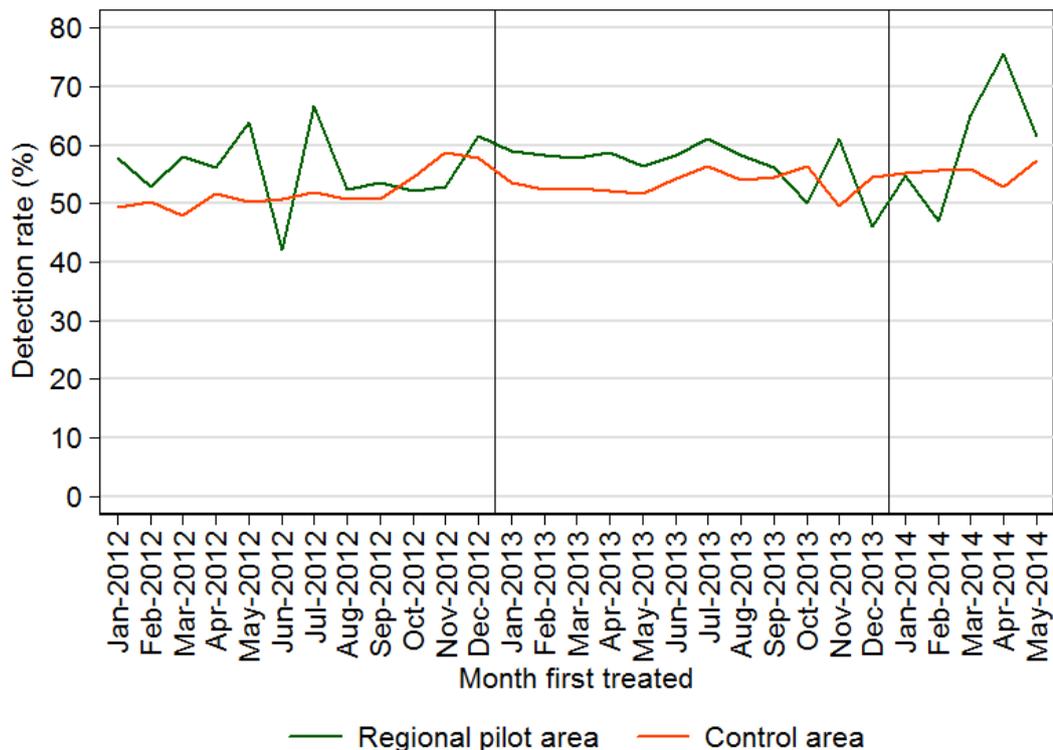
### Total results

Compared to the control area, there was more variability in the monthly oesophageal, stomach and upper GI cancer detection rates for the regional pilot area, due to its smaller size (Figures D1a-D1c). For March to May 2014, compared to the same months in 2013, there were increases in the detection rates in the regional pilot area: for oesophageal cancer, a 9.5 percentage point increase; for stomach cancer, a 3.5 percentage point increase; for upper GI cancer, a 3.3 percentage point increase, however, none of these changes were statistically significant.

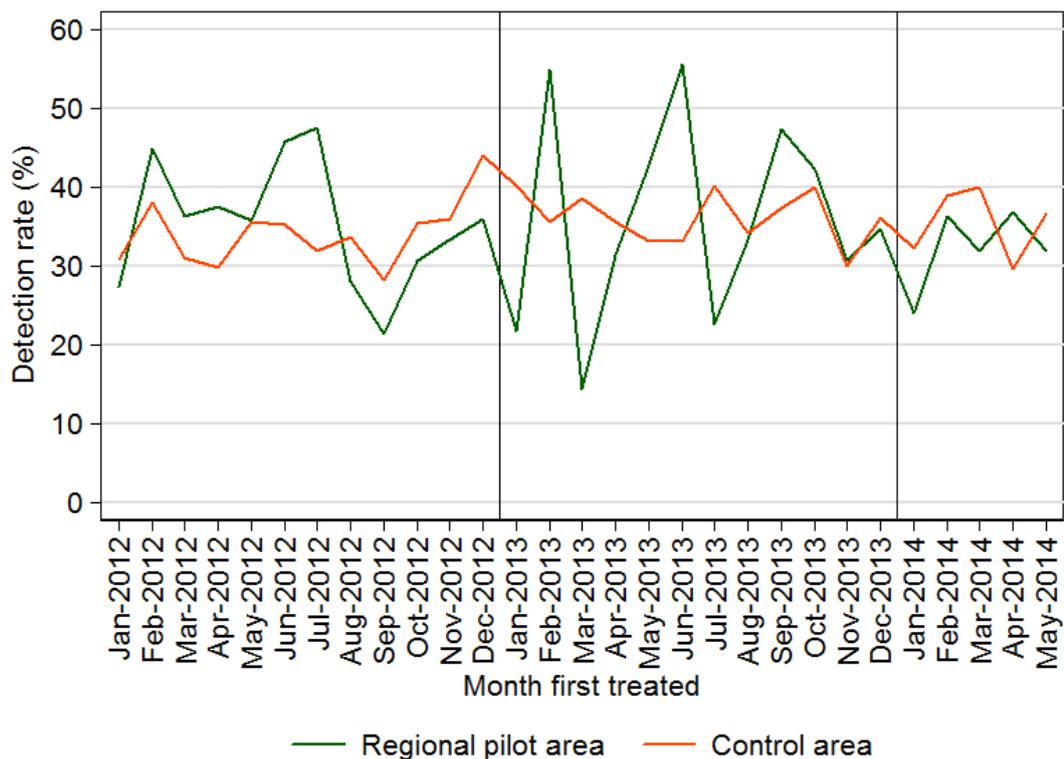
**Table D1: Detection rate for oesophageal, stomach and upper GI cancer diagnoses, with change, from March to May 2013 and March to May 2014**

Cancer type	Overall	March to May					
		2013		2014		% -point change	P-value
		Det. rate (%)	95% CI	Det. rate (%)	95% CI		
Oesophageal cancer	Regional pilot area	57.7	(48.9, 66.1)	67.2	(58.3, 75.1)	9.5	0.129
	Control area	52.2	(49.5, 54.9)	55.3	(52.7, 58.0)	3.2	0.101
Stomach cancer	Regional pilot area	29.9	(20.8, 40.8)	33.3	(23.4, 45.1)	3.5	0.653
	Control area	35.7	(32.2, 39.3)	35.7	(32.2, 39.3)	-0.0	0.997
Upper GI cancer	Regional pilot area	41.3	(36.0, 46.8)	44.6	(39.1, 50.2)	3.3	0.411
	Control area	37.3	(35.7, 38.8)	38.4	(36.9, 39.9)	1.1	0.307

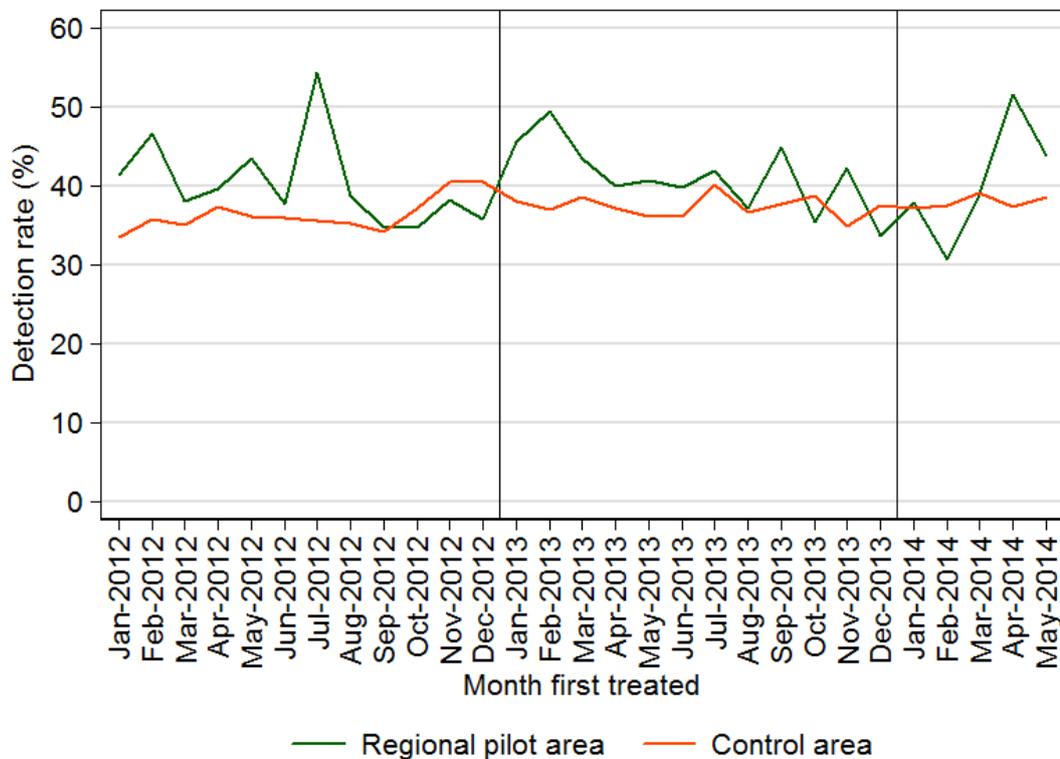
**Figure D1a: Monthly detection rate for oesophageal cancer diagnoses, from January 2012 to May 2014**



**Figure D1b: Monthly detection rate for stomach cancer diagnoses, from January 2012 to May 2014**



**Figure D1c: Monthly detection rate for upper GI cancer diagnoses, from January 2012 to May 2014**



## Age results

Figures D2a-D2c show that, by age, there was considerable quarterly and monthly variation in the oesophageal, stomach and upper GI cancer detection rates.

From March to May 2013 to March to May 2014, there were statistically significant increases in the detection rates, for all three cancer types, for those aged 60 to 69 (Table D2). For oesophageal cancer, the detection rate increased by 40 percentage points, from 46% to 86%. For stomach cancer, the detection rate increased by 50 percentage points, from 21% to 71%. For upper GI cancer, the detection rate increased by 29 percentage points, from 35% to 64%.

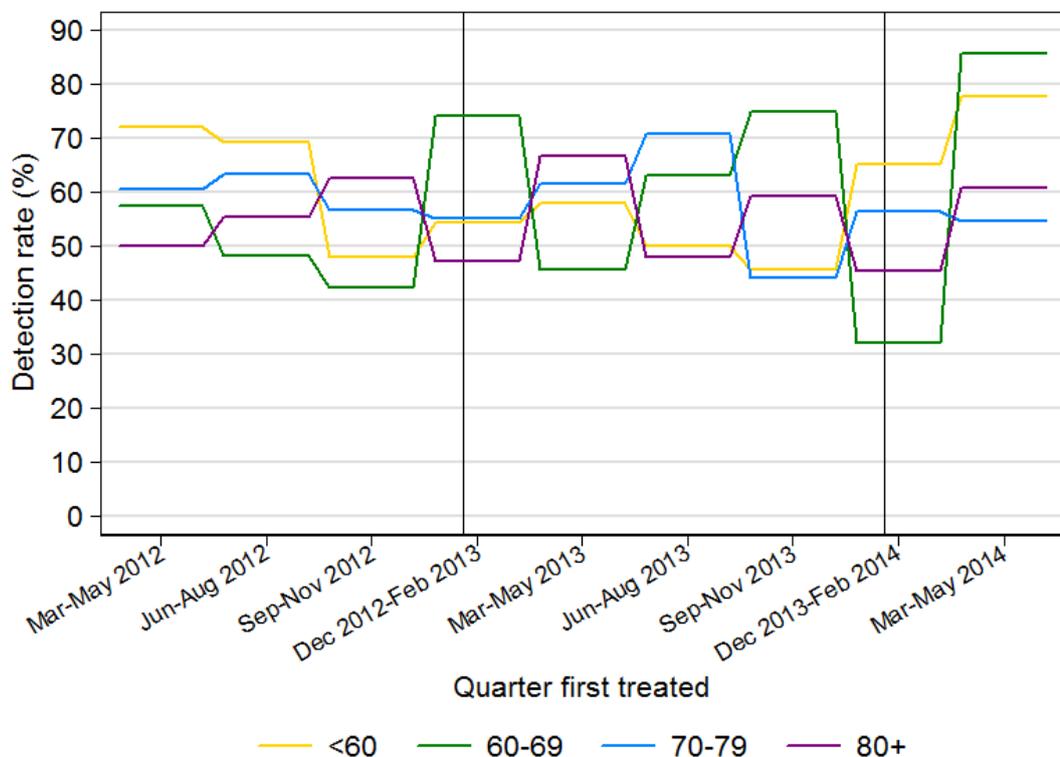
While these changes do appear large, it is important to consider these in light of the evident existing variation over time. For oesophageal and upper GI cancers, some of this apparent change may also be explained by large, but not significant, percentage changes in the number of CWT-Db recorded cancers seen for this age-group (Table CC2). Although these considerations are important, given the scale of the changes they may not account for all the observed increase.

Changes were not statistically significant for any other age-groups.

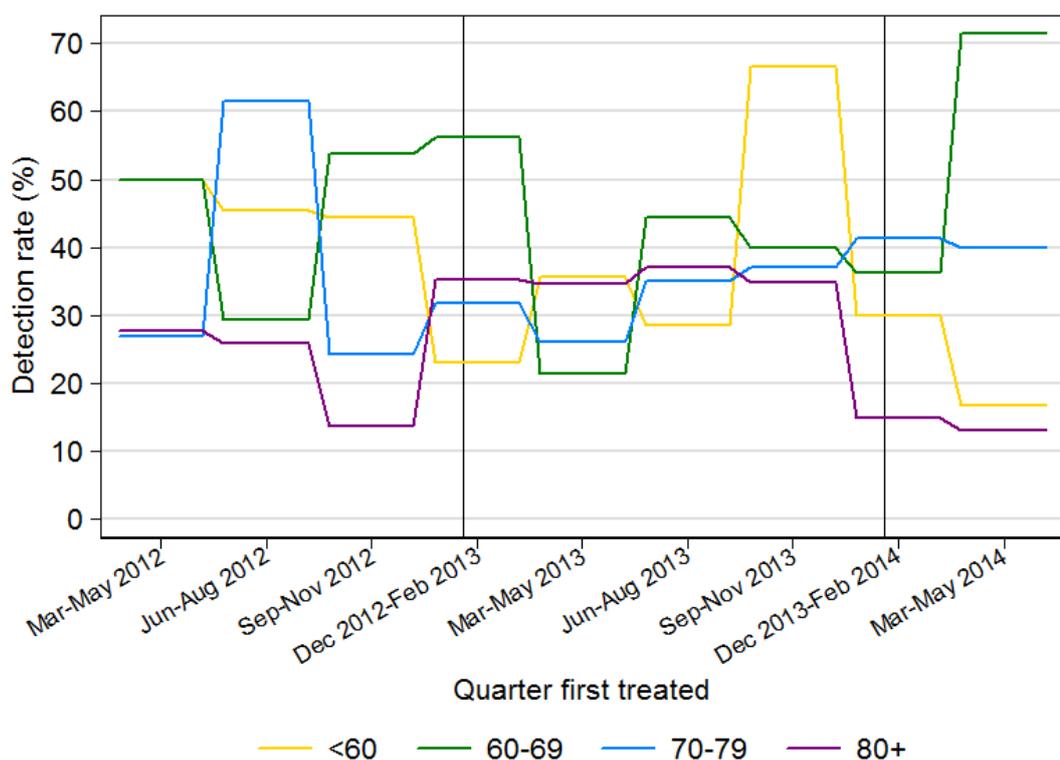
**Table D2: Detection rate for oesophageal, stomach and upper GI cancer diagnoses, with change, from March to May 2013 and March to May 2014, regional pilot area, by age**

Cancer type	Age group	March to May					
		2013		2014		% -point change	P-value
		Det. rate (%)	95% CI	Det. rate (%)	95% CI		
Oesophageal cancer	<60	57.9	(36.3, 76.9)	77.8	(54.8, 91.0)	19.9	0.197
	60-69	45.7	(30.5, 61.8)	85.7	(68.5, 94.3)	40.0	0.001
	70-79	61.5	(45.9, 75.1)	54.8	(39.9, 68.8)	-6.8	0.537
	80+	66.7	(48.8, 80.8)	60.7	(42.4, 76.4)	-6.0	0.637
Stomach cancer	<60	35.7	(16.3, 61.2)	16.7	(4.7, 44.8)	-19.0	0.275
	60-69	21.4	(7.6, 47.6)	71.4	(45.4, 88.3)	50.0	0.008
	70-79	26.1	(12.5, 46.5)	40.0	(21.9, 61.3)	13.9	0.331
	80+	34.6	(19.4, 53.8)	13.0	(4.5, 32.1)	-21.6	0.080
Upper GI cancer	<60	39.2	(27.0, 52.9)	40.8	(28.2, 54.8)	1.6	0.870
	60-69	34.6	(25.1, 45.4)	63.8	(52.0, 74.1)	29.2	<0.001
	70-79	47.6	(38.2, 57.1)	43.3	(34.2, 52.9)	-4.3	0.534
	80+	41.5	(31.4, 52.3)	32.5	(23.4, 43.2)	-8.9	0.235

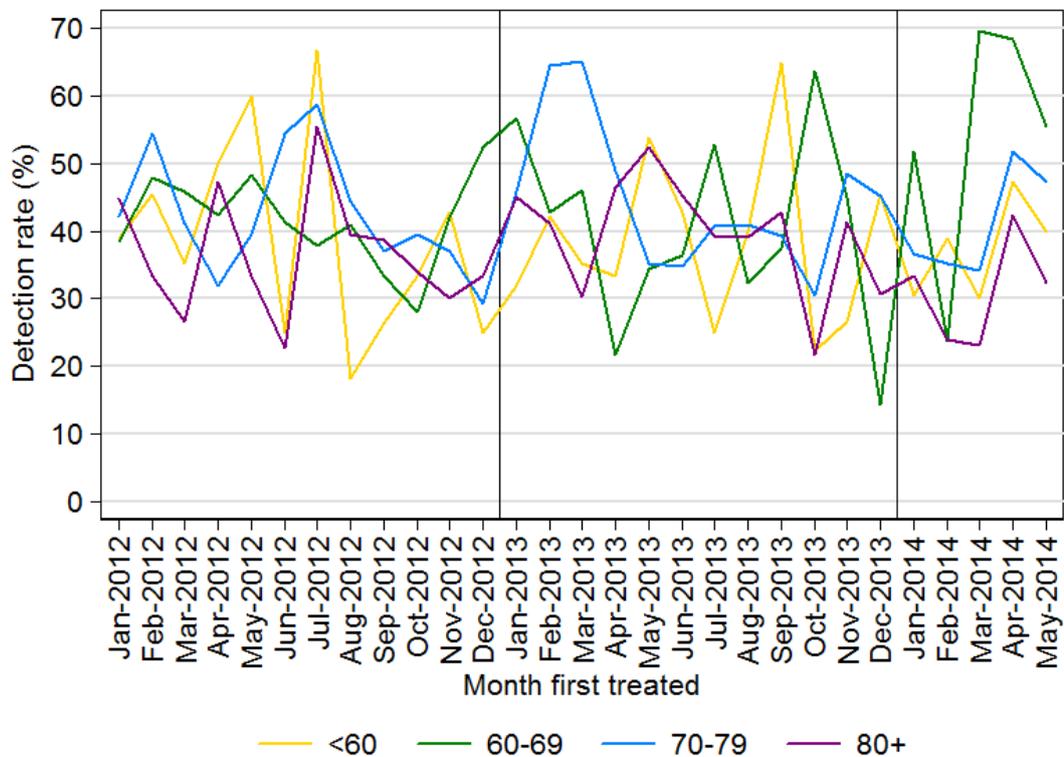
**Figure D2a: Quarterly detection rate for oesophageal cancer diagnoses, from March to May 2012 to March to May 2014, regional pilot area, by age**



**Figure D2b: Quarterly detection rate for stomach cancer diagnoses, from January 2012 to May 2014, regional pilot area, by age**



**Figure D2c: Monthly detection rate for upper GI cancer diagnoses, from January 2012 to May 2014, regional pilot area, by age**



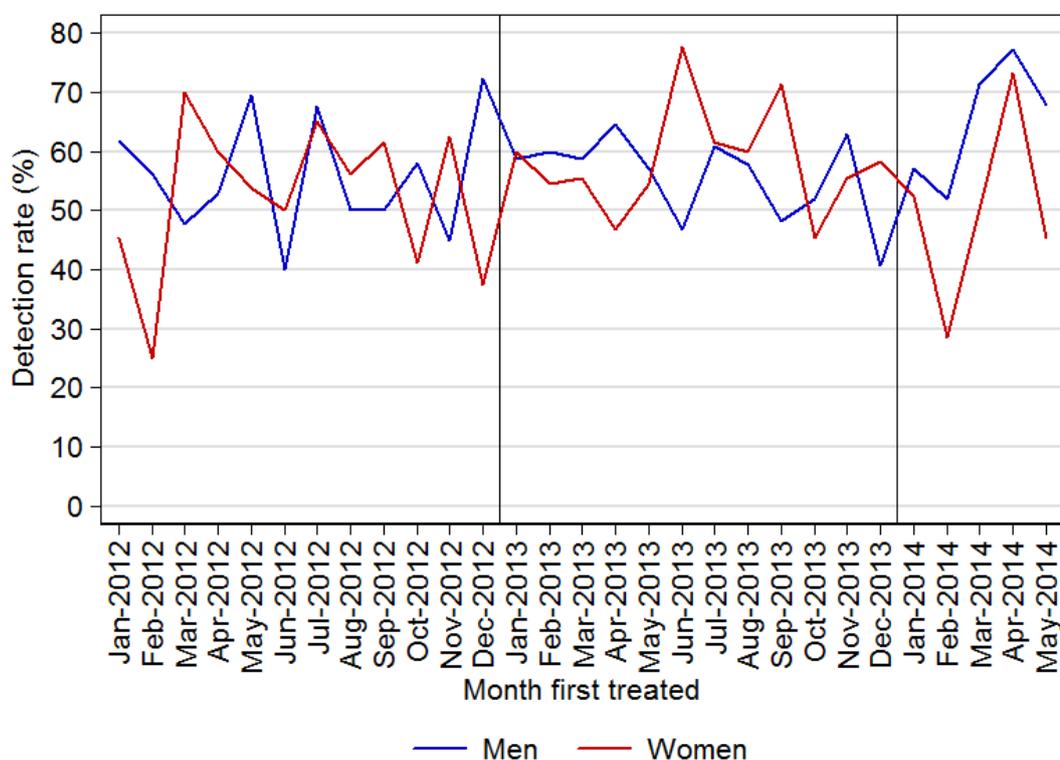
## Sex Results

For March to May 2014, compared to the same months in 2013, there were no statistically significant changes in detection rate for oesophageal, stomach or upper GI cancers, for either men or women.

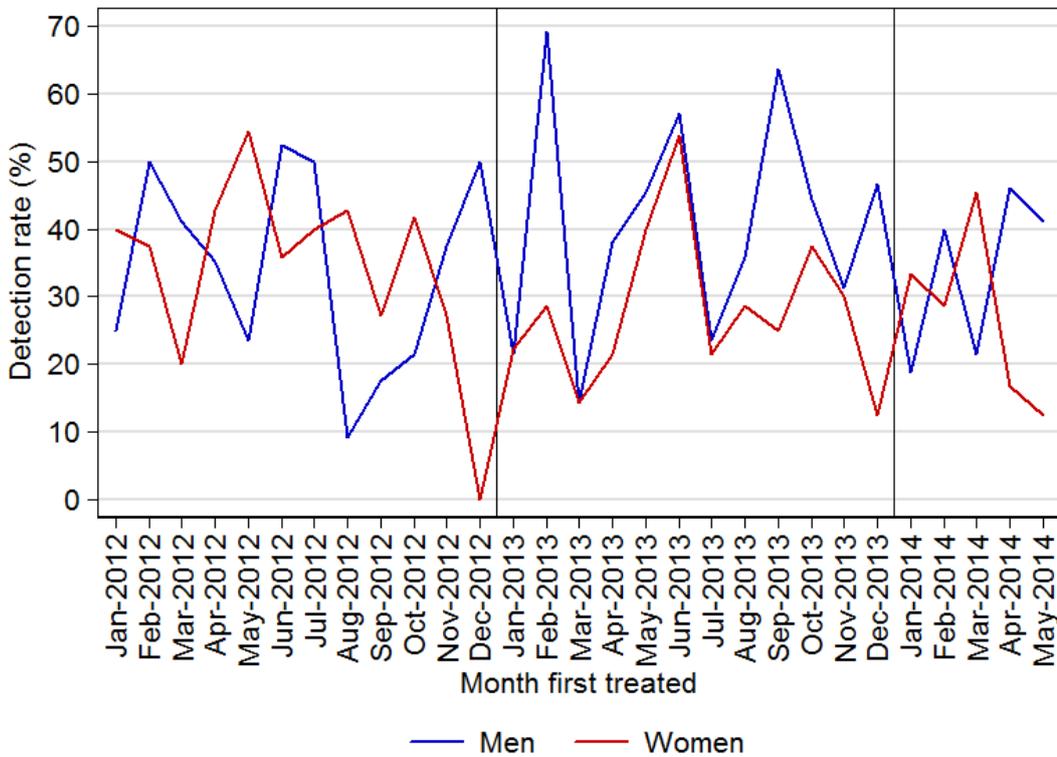
**Table D3: Detection rates for oesophageal, stomach and upper GI cancer diagnoses, with change, from March to May 2013 and March to May 2014, regional pilot area, by sex**

Cancer type	Sex	March to May					
		2013		2014		% -point change	P-value
		Det. rate (%)	95% CI	Det. rate (%)	95% CI		
Oesophageal cancer	Men	60.2	(49.8, 69.8)	71.8	(61.0, 80.6)	11.6	0.117
	Women	51.4	(35.6, 67.0)	57.9	(42.2, 72.1)	6.5	0.579
Stomach cancer	Men	32.6	(20.9, 47.0)	36.4	(23.8, 51.1)	3.8	0.708
	Women	25.8	(13.7, 43.2)	28.0	(14.3, 47.6)	2.2	0.854
Upper GI cancer	Men	43.1	(36.4, 50.0)	50.8	(43.6, 58.1)	7.8	0.129
	Women	38.3	(29.9, 47.4)	35.7	(27.9, 44.4)	-2.5	0.682

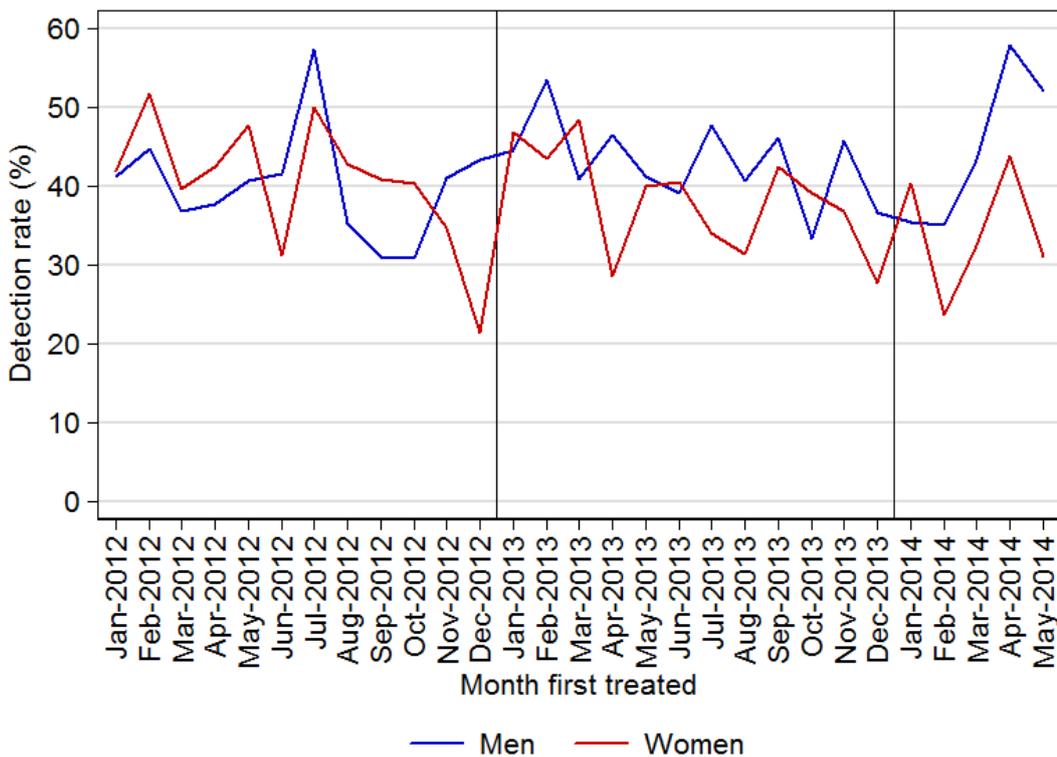
**Figure D3a: Monthly detection rates for oesophageal cancer diagnoses, from January 2012 to May 2014, regional pilot area, by sex**



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