

Devon  
Skin Cancer  
Prevention  
Strategy  
2011-14

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## Foreword

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Skin cancer rates have increased rapidly in the last 30 years. The South West has the highest incidence and mortality rates in the country, and Devon's rates are statistically higher than the national average.

This strategy sets out a local multi-agency response to this major public health challenge. If skin cancer rates are to be reversed, co-ordinated and sustained action will need to be taken across schools, local authorities, acute trusts, leisure providers, events organisers, voluntary sector organisations, and other partners.

Awareness raising is important, but it must lead to sustained behaviour change in order to make a lasting impact on rates. Education, policy work, environmental changes and early diagnosis all have their part to play. Interventions must be targeted and evidenced-based in order to lead to a long-term shift in societal attitudes and behaviours around sun safety.

Partnership working is at the centre of the strategy. The recommendations span from prevention, implementing whole population interventions in a range of settings (for example community, schools and workplaces) to the early diagnosis of skin cancer in acute settings.

I would like to thank everyone who has contributed to the development of this strategy.

*Virginia Pearson*

**Dr Virginia Pearson**  
**JOINT EXECUTIVE DIRECTOR OF PUBLIC HEALTH**  
**NHS DEVON/DEVON COUNTY COUNCIL**

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## Executive Summary

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This strategy outlines Devon's approach to tackling rising rates of skin cancer, in both young and old. It covers both prevention and early diagnosis, which are both crucial in saving lives and ensuring that treatment is as rapid and straightforward as possible.

Nationally, rates of skin cancer have quadrupled in the last 30 years, largely due to changing lifestyles. Overall, risk of skin cancer increases with age, but rates of malignant melanoma (the most deadly type) are disproportionately high in 15-34 year olds, and it is now the second most common cancer in that age group. Skin cancer is almost entirely preventable: safe sun precautions include avoiding burning, not using sunbeds, seeking shade during the hottest parts of the day, covering up with clothing and sunglasses, and wearing at least SPF 15 suncream. It is important to check moles regularly and report any changes to the GP – the quicker that skin cancer can be treated the less likely it is to be fatal or result in disfiguring surgery.

Locally, we have the fourth highest incidence rate of malignant melanoma in the country, at 24.4 per 100,000 direct age-standardised compared to 15.6 nationally. Contributing factors include the high number of sunshine hours, high percentage population of white ethnicity, and a high percentage of the population aged over 75. The highest incidence rates are found in West Devon, South Hams and Teignbridge but every area except Torridge has statistically significantly higher rates than the national average. Financially, diagnosing and treating malignant melanoma currently costs NHS Devon £536,000 per year, and non-melanoma costs £2,373,000.

NICE guidance has recently been released on 'Skin cancer prevention; information, resources and environmental changes', and this paper incorporates the evidenced-based findings throughout, including recommendations on how to make interventions cost-effective. The recommendations are for commissioners, organisers and planners of mass media primary prevention campaigns, staff working in charities, non-governmental organisations, health promotion, local authorities (such as environmental health or health and safety officers), the education sector, other workplaces, and for local health practitioners such as GPs, health visitors, pharmacists, school nurses, skin cancer nurse specialists and dermatologists. They recommend continuing to deliver low-cost, information related prevention activities, including one-to-one and group-based advice, targeting at risk groups, ensuring messages give a range of options to help people protect their skin, ensuring messages are tailored to the target audience, and planning shade into the design of any new buildings.

The strategy also acknowledges that a lot of work is already happening locally; this strategy leads on from peninsula-wide workshops, led by social marketing company Forster and funded by the Peninsula Cancer Network, which brought together professionals from the acute trusts to local authorities, in order to discuss a partnership approach. The results of these workshops can be found in a comprehensive report 'Embedding the strategic commissioning of skin cancer prevention and awareness', and which we have drawn on in this strategy.

The strategy recommends that social marketing principles are followed at every stage of commissioning, planning and delivering interventions. Social marketing ensures that an individual's attitudes, beliefs and preferences are fully taken into account. No intervention should be undertaken that is not evidenced-based and measurable. Raising awareness is important but must ultimately lead to behaviour

change to be effective. The behavioural outcome is the measure of success or failure.

The initial priority target groups are teenagers and people over 50 years of age. Teenagers have the lowest skin protection rate of any age group and have the perception that a tan is attractive and gives them confidence. Interventions must appeal to their appearance and not just their health. It is unrealistic to ask them not to tan at all, but alternatives such as fake tan can be encouraged. The focus in people over 50 is on early diagnosis; the message is to check moles regularly and see the GP if they notice any changes. Barriers to overcome include fear of a cancer diagnosis, and a reluctance to 'waste' the GP's time.

As well as focused interventions, the recommendation is for ongoing awareness raising to take place, especially at peak times such as the summer holidays, as skin cancer prevention is everyone's business. The multi-agency action plan allows for both opportunistic and planned awareness raising to take place through as many available channels as possible. The action plan also includes work to take place across NHS Devon, the acute trusts, local authorities including environmental health, trading standards and schools and colleges.

This strategy is only the beginning; there is a huge amount of work that can and should be done on skin cancer prevention in Devon. Partners are working together, momentum is building and we must now continue to work together on this pressing local priority.

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## 1. Introduction

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- 1.1 Skin cancer is the most common form of cancer in the United Kingdom. For both non-melanoma and melanoma skin cancers, the incidence and mortality rates in NHS Devon are statistically significantly higher than those in the rest of England, and rates are increasing year on year.
- 1.2 Action to help raise awareness and prevent skin cancers in Devon has taken place over a number of years. However, this activity has often been reactive and lacked co-ordination across Devon. Recent research undertaken by the South West Public Health Observatory and the Peninsula Cancer Network, has provided the ideal opportunity to examine the work currently taking place in Devon among partners, and to publish a collective strategy and action plan to focus activity for the coming years.
- 1.3 Skin cancer costs the NHS £108 million a year, but the societal cost is much more, estimated to be £132 million a year. The majority of skin cancers can be prevented by adopting protective behaviours.
- 1.4 While it is usually the NHS that treats the people who are diagnosed with skin cancer, co-ordinated prevention work needs to be undertaken across a broad spectrum of organisations, to catalyse behaviour change at the level of the individual. Local authorities have a key role to play through their channels of education, environmental health, employment, planning and outdoor activities work.
- 1.5 This strategy will lead to a detailed action plan that specifies who is best placed to lead the implementation of each recommendation, as well as identifying key partners. The strategy should inform priority actions within local health improvement plans produced at district level.

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## 2. Aims and objectives

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- 2.1 The overall aim of this strategy is to reduce skin cancer incidence and mortality rates in Devon by improving both primary and secondary prevention. The strategy aims to move skin cancer prevention higher up on both public and partnership agendas.
- 2.2 Primary prevention is understood to mean the reduction of skin cancer incidence and secondary prevention is understood to mean early identification and treatment of skin cancer, or preventing skin cancer patients from contracting the disease again.
- 2.3 Clinical treatment of skin cancer is not part of the remit of this strategy.
- 2.4 As a result of the strategy, a skin cancer prevention action plan will be developed by all stakeholders to move the work forward.
- 2.5 The strategy will be evidence-based and the action plan will be appropriately evaluated and monitored.
- 2.6 The strategy will build on, and link to, the Cancer Reform Strategy and the latest cancer strategy: 'Improving Outcomes: A Strategy for Cancer'.

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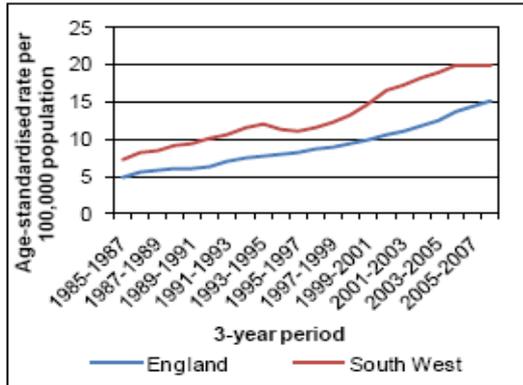
### 3. National and regional picture of skin cancer

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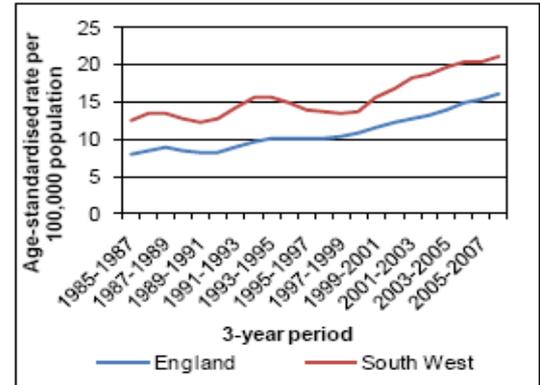
- 3.1 Skin cancer accounts for one-third of all new cancers in the United Kingdom. Three types of skin cancer are responsible for more than 95% of all cases: basal cell carcinoma, squamous cell carcinoma and malignant melanoma. The first two of these are sometimes grouped together as non-melanoma skin cancers, which are very common and usually treated easily. Malignant melanoma is less common but is responsible for approximately 75% of skin-cancer-related deaths.<sup>(1)</sup>
- 3.2 More than 84,550 cases of non-melanoma were registered in the United Kingdom in 2007, but it is estimated that the actual number is at least 100,000 cases each year. About 10,670 cases of malignant melanoma were diagnosed in the United Kingdom in 2007.<sup>(2)</sup>
- 3.3 Malignant melanoma incidence rates have more than quadrupled over the last 30 years, and rates have risen faster than any other common cancer in the last 25 years. Figure 1 shows the rate of increase in melanoma incidence in England and the South West from 1985 to 2008 for males and females. Among males, it has increased from around 2.5 per 100,000 in 1975 to 14.3 in 2006. The rate among females has increased from 3.9 to 15.4 per 100,000 during the same period (Cancer Research UK 2010b). Although incidence rates for malignant melanoma are higher among females, more men die from it; the death rate in men is 2.7 per 100,000 compared to 1.9 per 100,000 in women (age-standardised mortality rates).<sup>(3)</sup> Like most cancers, it is more common as age increases, but malignant melanoma is disproportionately high in younger people. Malignant melanoma is the second most common cancer in young adults (age 15-34).<sup>(2)</sup> Figure 2 shows the rates of malignant melanoma in the South West by age bracket.
- 3.4 The upward trend of skin cancer incidence is predicted to continue. This is due partly to the ageing of the population and partly to changes in behaviour that lead to increased exposure to ultraviolet radiation (UVR).<sup>(4)</sup> Research has shown that the incidence of skin cancer is rising in adults of working age, particularly those in the 30–39 age bracket, but also in teenagers and young adults.<sup>(5)</sup> However, incidence rates in older people still account for the majority of malignant melanoma (see Figure 2).<sup>(6)</sup> If current trends continue, it is estimated that there will be around 15,500 cases of malignant melanoma diagnosed per year within the next 15 years.<sup>(2)</sup>

**Figure 1: Malignant melanoma incidence rates**

*Malignant melanoma – 3-year average age-standardised incidence rates for males, 1985–2008*

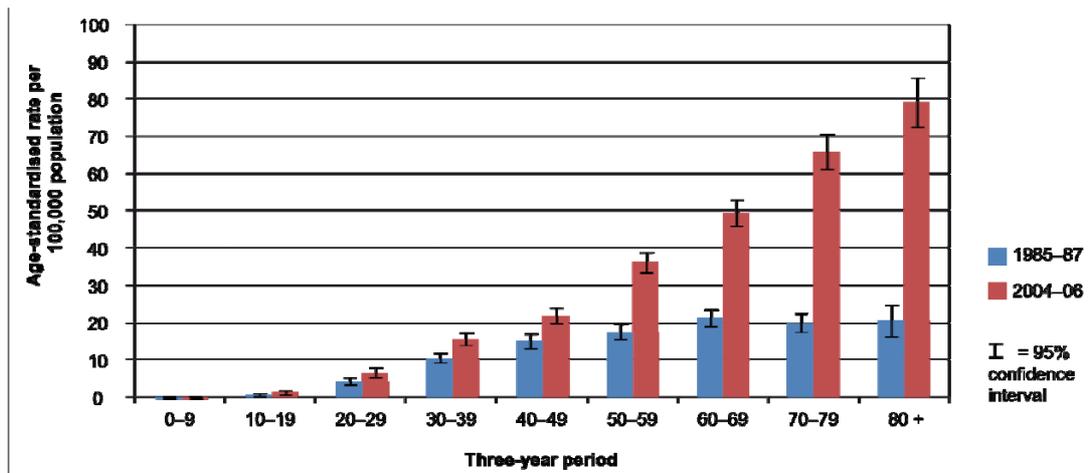


*Malignant melanoma – 3-year average age-standardised incidence rates for females, 1985–2008*



Source: UK Cancer Intelligence Service (UKCIS)

**Figure 2: Malignant melanoma incidence (age-standardised rates per 100,000) by age band in the South West Region, 1985-87 compared with 2004-06**

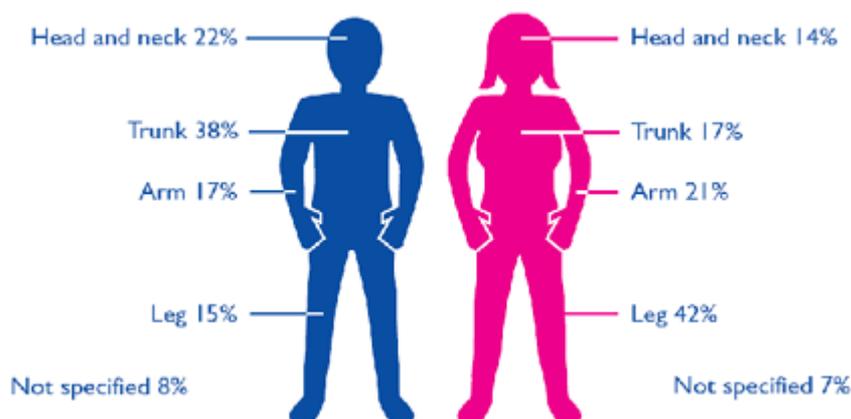


Source: National Cancer Intelligence Network (NCIN) as directly age-standardised rates

3.5 Recent NICE guidance<sup>(7)</sup> identifies a range of factors that can increase the risk of someone developing skin cancer including:

- age and gender – the number of cases of malignant melanoma increases with age and is more common in women. Skin damage (sunburn) at any age is associated with an increased risk of developing skin cancer later in life. The percentage distribution of malignant melanoma is different for males and females, as shown in Figure 3.

**Figure 3: Percentage distribution of malignant melanoma on parts of the body**



Source: Cancer Research UK

- ethnicity – although incidence rates are lower among people with darker skin, it is often diagnosed late, which can increase the risk of death
- occupation – a range of outdoor workers and people involved in outdoor sports are particularly at risk for example, construction workers, cricketers and golfers, farmers, gardeners, military personnel and postal workers
- personal and family history – of skin cancer, lowered immunity or a transplant
- physical characteristics – some people are more likely than others to develop skin cancer, such as those with fair skin that burns easily, those with lots of moles or freckles and those with red or fair hair or light coloured eyes. Skin type can be measured on the Fitzpatrick scale (see Appendix 3) and used as a starting point for assessing personal risk
- regional variation – London and the North have the lowest incidence, while the highest incidence is in the South West of England
- socioeconomic status – malignant melanoma is associated with affluence. There is a 60–70% lower incidence among people from deprived areas compared with their more affluent peers. However, people from more affluent areas are more likely to survive the condition. In addition, it should be noted that sunbed outlets are particularly prevalent in areas of socioeconomic deprivation – and that this could affect the rate among lower socioeconomic groups in the future

- 3.6 Another risk factor to consider is that being exposed to high levels of arsenic is known to lead to an increased likelihood of skin cancer. Devon, and in particular West Devon, historically have had high levels of background arsenic. The Health Protection Agency currently do not have enough evidence to establish risk levels in Devon, but the British Geographical Society is currently undertaking research in Devon, so it is an area to consider as more evidence emerges.
- 3.7 Skin cancer typically accounts for 30% of a consultant dermatologist's workload and one-third of all the plastic surgery on the NHS.<sup>(8)</sup> The cost of skin cancer in England in 2005 was estimated to be over £190 million. Of this, the NHS spent approximately £70 million but very little was spent on prevention.<sup>(7)</sup>
- 3.8 The leading cause of skin cancer is exposure to ultraviolet radiation. This can occur artificially through the use of sun lamps and tanning beds, but the main risk factor is overexposure to sunlight, particularly in people with sensitive skin types.<sup>(9)</sup>
- 3.9 Skin cancer is a largely preventable disease and both primary and secondary prevention is possible. Reduction of exposure to ultraviolet radiation is a key element of primary prevention. Early diagnosis and awareness is very important and there is currently scope for improvement. A recent survey found 44% of people were unable to recognise key signs of skin cancer, such as irregularly shaped or coloured moles or moles which are getting bigger. The majority of respondents (85%) thought that skin cancer accounted for less than 10% of all cancers in the United Kingdom (the actual figure is around 33%). Only 34% of people reported checking their moles at least once a month and 25% never check them.<sup>(10)</sup>

### **Benefits of sunshine**

- 3.10 It is important to strike a balance between avoiding the harmful effects of overexposure, and gaining the benefits associated with time outside in the sun, namely increased physical activity and effective vitamin D synthesis. Vitamin D may protect against a range of diseases, including bowel cancer. Following concerns raised about conflicting public health messages regarding exposure to the sun, Cancer Research UK released a vitamin D consensus statement, in partnership with six other leading health organisations. In summary:

'The time required to make sufficient vitamin D varies according to a number of environmental, physical and personal factors, but is typically short and less than the amount of time needed for skin to redden and burn. Enjoying the sun safely, while taking care not to burn, can help to provide the benefits of vitamin D without unduly raising the risk of skin cancer. The best estimates suggest that for most people, everyday casual exposure to sunlight is enough to produce vitamin D in the summer months when it comes to sun exposure, little and often is best.'<sup>(11)</sup>

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#### 4. Local picture of skin cancer in Devon

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4.1 There are links between skin cancer rates and sunshine hours, age, ethnicity, and deprivation:

- **Devon has 1501 hours of sunshine per year compared to the national average of 1420**
- **97% of Devon's population are white, compared to the national average of 88%**
- **11.9% of Devon's population are aged over 75, compared to the national average of 8.4%**
- Devon's average score on the Index of Multiple Deprivation is 17.5 compared to the national average of 21.6. However, Plymouth scores at 26.3 and Torbay at 26.2, yet they have the 1<sup>st</sup> and 2<sup>nd</sup> highest incidence rates of malignant melanoma in the country, so locally it is difficult to make a causal link between affluence and incidence rates. ***Nationally, an individual is more likely to get skin cancer if they are affluent, but more likely to die from it if they are from a deprived background.***

4.2 Devon has significantly higher rates of incidence and mortality for all kinds of skin cancer than the national average.

- skin cancer accounts for approximately **one in 200 deaths** in Devon
- between 2006 and 2008 there were on average **246 cases of malignant melanoma** per year and **40 related deaths**
- **malignant melanoma incidence rates** are 24.4 compared to 15.6 nationally and 20.6 in the South West (2006-08 pooled direct age-standardised rates per 100,000). Every area in Devon except for Torridge has statistically significantly higher incidence rates than the national average. **The highest rates are in the South Hams (28.9) Teignbridge (27.6) and West Devon (26.3)**
- numbers of deaths from malignant melanoma at local authority level are too small to make any meaningful interpretation, but Devon as a whole has a higher rate than England, locally 3.2 compared to 2.6 nationally (2006-08 pooled direct age-standardised rates per 100,000)
- between 2004 and 2006 there were on average **2065 cases of non-melanoma** skin cancer per year and **nine related deaths**
- **non-melanoma incidence rates** are 167.02 compared to 93.01 nationally and 158.86 in the South West (2004-06 pooled direct age-standardised rates per 100,000). **The highest rate is in East Devon (188.2) but every area has statistically significantly higher rates than the national average**

- numbers of deaths from non-melanoma at local authority level are too small to make any meaningful interpretation, but Devon as a whole has a higher rate than England, locally 0.55 compared to 0.48 nationally (2004-06 pooled direct age-standardised rates per 100,000)
- in Devon, the **malignant melanoma incidence rates for men and women are not significantly different** (21.38 for men compared to 22.23 for women per 100,000 direct age-standardised rates in 2004-06). This is slightly different to the national figures where the rates for women (14.62) are 9% higher than the rates for men (13.37). For **non-melanoma skin cancers** the local picture is similar to the national one: in Devon the rates for men are 200.42 compared to 136.41 in women (this is **47% higher for men than women**, compared to 48% nationally). For more national data on age and gender, see Appendix 1
- numbers of deaths from skin cancer are relatively low compared to 'big killers' such as lung cancer or heart disease. However, thousands of people have to undergo **life changing and disfiguring surgery** as a result of skin cancer, and these consequences should not be underestimated. The perception needs to be broken down that skin cancer is not a 'serious' cancer with serious consequences. **Using the NICE guidance estimates for the cost of diagnosing and treating skin cancer, malignant melanoma currently costs NHS Devon approximately £536,000 per year, and non-melanoma costs £2,373,000**

For tables and charts of Devon skin cancer statistics, refer to Appendix 2.

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## 5. Summary of national policy and guidance

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- 5.1 There are no current national or regional targets specifically related to skin cancer prevention, although the South West Strategic Health Authority has identified it as one of their key priorities. There are some national policy documents, which are relevant.
- 5.2 In 2005, the Chartered Institute of Environmental Health produced 'Saving our Skins Toolkit: Raising Awareness of the Risk of Skin Cancer'.<sup>(12)</sup> It aims to help professionals working in local authorities, primary care trusts, cancer networks and their partner agencies to develop strategies and campaign programmes to tackle the increasing incidence of skin cancer.
- 5.3 Identifying the importance of cancer prevention, the NHS Cancer Reform Strategy states Primary care trusts and cancer networks should give high priority to raising public awareness of cancer risk factors.<sup>(13)</sup>
- 5.4 The NHS Cancer Plan identified reducing exposure to ultraviolet radiation as key to preventing skin cancer.<sup>(14)</sup> This involves staying in the shade, avoiding exposure to the sun in the middle of the day, wearing protective clothing, using high sun-protection-factor (SPF 15+) products, and taking care to protect children and babies.<sup>(15)</sup> Reducing ultraviolet radiation exposure related to sunbed use is also important.<sup>(4)</sup>
- 5.5 SunSmart is a national campaign to promote behaviour change in order to prevent skin cancer and raise awareness of the early signs of the disease. It was commissioned by the United Kingdom Health Departments in 2003 and is managed by Cancer Research UK. The campaign emphasises evaluation and evidence-based practice and takes a strategic approach to targeting messages to key groups such as children and young adults, new parents and outdoor workers. The SunSmart campaign has an independent advisory board comprised of a number of prominent academics, health professionals and organisations with an interest in skin cancer prevention. The Advisory Board provides guidance on a range of strategic issues relating to the campaign.
- 5.6 Sunbeds are a growing source of ultraviolet radiation exposure in the population and are more common in areas of socio-economic deprivation. There is evidence that exposure to sunbed use in tanning salons can be addictive.<sup>(16)</sup> The World Health Organisation classifies sunbeds in the category of 'definitely' carcinogenic and harmful to human health, alongside asbestos and smoking. The National Cancer Action Team and the Department of Health commissioned Cancer Research UK to undertake a study into sunbed use in under 18s.<sup>(17)</sup> Parliament has now passed a law to protect children under 18 from using sunbeds. The Sunbeds (Regulation) Act From April 2011, all sunbed salons in England and Wales will be prohibited from allowing under 18s to use sunbeds.
- 5.7 The National Institute for Health and Clinical Excellence (NICE) has produced guidance on cancer prevention for the NHS and local authorities.<sup>(7)</sup> The recommendations can be found in Appendix 4.

5.8 The South West Public Health Observatory is currently leading a project designed to increase awareness of skin cancer in the South West and nationally. The project has three main elements:

- production of Skin Cancer Profiles to provide needs assessment data for commissioners, to enable local figures to be compared to national and regional ones, and to enable local target setting. A web-based Skin Cancer Hub has been implemented to make these profiles available alongside other relevant resources and examples of best practice
- in collaboration with the University of the West of England, design and production of a social marketing intervention
- production of skin cancer prevention toolkits for cancer networks, primary care trusts, local authorities, acute trusts, voluntary organisations, schools, strategic health authorities, and regional departments of health

The research initially identified five priority audiences with an additional sixth one added by local stakeholders:

- mothers of young children and childcare providers
- parents of school-aged children
- teenagers
- outdoor workers
- sports and leisure participants and spectators
- older people (early diagnosis)

5.9 The Peninsula Cancer Network obtained funding from the National Cancer Action Team to take forward the social marketing work undertaken by the South West Public Health Observatory and University of the West of England to the next stage by engaging with key stakeholders throughout the peninsula. This work was driven by the Peninsula Cancer Network working collaboratively with Forster, a social marketing company. This will be covered in more detail later in the strategy.

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## 6. Evidence of effectiveness of interventions

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6.1 The Skin Cancer 2012 Expert Group agreed that campaigns like SunSmart are likely to lead to increased awareness and may promote earlier detection of skin cancer (which influences prognosis and treatment complexity), and proposed sustained action be taken to prevent and/or encourage earlier diagnosis of skin cancer through several routes.<sup>(4)</sup> However, the long lag-time between ultraviolet radiation exposure and detection of most forms of skin cancer means the ultimate effectiveness of sun-protection campaigns on cancer rates is still uncertain.<sup>(18)</sup> For example, there can be a lead time of over 30 years between exposure to intense burning sunlight and onset of malignant melanoma.<sup>(15)</sup> The key findings from the Office of National

Statistics trends analysis of the SunSmart campaign over five years show that there has been a significant trend towards increased awareness of the importance of protecting children, checking moles and going to the doctor about moles, as well as avoiding getting sunburnt. No significant trends in attitudes towards the benefits or risks of the sun were observed, although significantly more people reported using shade, covering up and avoiding sunbeds to protect themselves from skin cancer. Overall, reported awareness levels are low, as are the proportions of people reporting SunSmart behaviour, so there is still work to be done.<sup>(19)</sup>

- 6.2 The NICE guidance outlines six recommendations to consider when identifying and developing interventions.<sup>(7)</sup> These recommendations are considered to be cost-effective.

<b>Recommendation 1</b>	Information provision: Delivery
<b>Recommendation 2</b>	Information provision: Developing national campaigns
<b>Recommendation 3</b>	Information provision: Message content
<b>Recommendation 4</b>	Information provision: Tailoring the message
<b>Recommendation 5</b>	Protecting children, young people and outdoor workers
<b>Recommendation 6</b>	Providing shade

The full recommendations can be found in Appendix 4.

- 6.3 There is evidence that teenagers are susceptible to appearance-based interventions. Some studies have examined the relation between appearance concern and responses to an intervention targeting tanning and sunscreen use among young adults.<sup>(20)</sup> The interventions produced increases in safe sun attitudes, intentions, and behaviour.
- 6.4 There is currently no evidence to support a national population-based screening programme for melanoma.<sup>(4)</sup>

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## 7. What is happening locally?

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### Devon

- 7.1 The Peninsula Cancer Network identified that local skin cancer prevention work has been undertaken but acknowledges that the scope of this work varies and historically activity is seasonal and tactically driven. It identified a clear absence of strategic plans and sustained interventions with very limited formal evaluation of interventions. Some examples of work within Devon undertaken by the NHS and partners include:
- sun awareness public relation campaigns at specific events such as the Devon County Show and Devon Youth Games

- mole checking event with the RNLI lifeguards at Exmouth beach
  - beach “Mole Patrols” developed and implemented by LINK Devon and dermatology departments
  - the development of the Devon Heatwave Plan 2010
- 7.2 As stated earlier, the Peninsula Cancer Network obtained funding from the National Cancer Action Team to support the development of a co-ordinated approach to the commissioning of skin cancer prevention and early diagnosis. Using social marketing techniques, the project focused on understanding the behavioural motivators and barriers of the different segments of ‘at risk’ people, thereby ensuring future strategy developed at a local level could build on this insight.
- 7.3 The Peninsula Cancer Network commissioned the social marketing agency Forster to deliver the work and, recognising the importance of stakeholder engagement in successful preventative strategies, brought together senior NHS commissioners, consultant dermatologists and local authority partners to consider and agree strategic priorities and commissioning intent (4<sup>th</sup> and 10<sup>th</sup> March 2010). A project report which includes a toolkit has been published entitled ‘Embedding the strategic commissioning of Skin Cancer Awareness and Prevention’.<sup>(22)</sup>
- 7.4 The discussion and planning workshops and the report found that the focus of work should be on embedding awareness and prevention into commissioning processes and policy. Key critical success factors identified by participants included:
- senior management buy-in
  - partnership working
  - co-ordination across the network
  - pooling of resources
  - message development – to be based on insight

#### **Examples from the rest of the region**

- 7.5 NHS Dorset commissioned “Brilliant Futures” to develop a social marketing intervention to reduce sunbed use in under 18s. After initial research, they piloted an appearance-based intervention using ultraviolet scanners to demonstrate sun damage, and providing a positive alternative by demonstrating effective fake tan application. The project was shown to be effective in changing short-term knowledge and attitudes. As a result of this project, a recommendation has been made for a longer-term intervention in partnership with Weymouth College and development of a Healthy Schools Plus support pack to the sun awareness module. The work was supported by linking material to Heat Magazine’s “Dazzle Don’t Frazzle” national campaign.
- 7.6 SunSafe is an NHS-based campaign working to raise awareness of sun safety in Cornwall. SunSafe began in Cornwall in May 2008; it adopts a pro-

active health promotion programme including mobile clinics, roaming van, indoor and outdoor displays, a dedicated website and personnel.

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## 8. Social marketing: a new approach for Devon

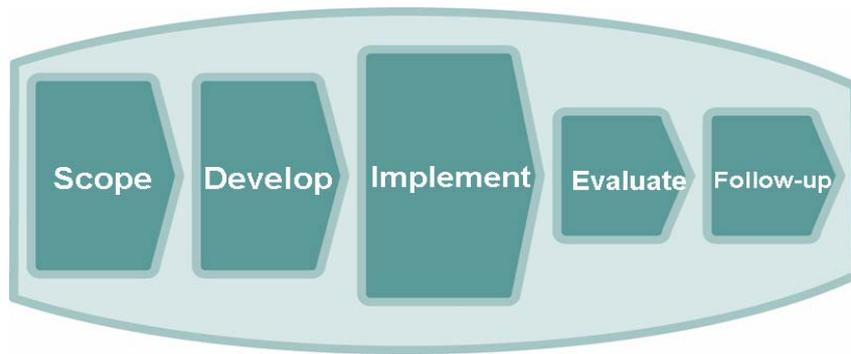
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- 8.1 Social marketing is the systematic application of marketing concepts and techniques to achieve behaviour change. It provides an effective framework for achieving changes in behaviour that benefit the individual and/or community.



Source: National Social Marketing Centre

- 8.2 Social marketing puts the audience at the centre. The planning and delivery of effective interventions demands an understanding of the audience. It is through the understanding of knowledge, attitudes and behaviour of the individuals and groups of people that barriers and motivators are identified; it is then possible to focus on 'the exchange' - removing barriers and amplifying motivators.
- 8.3 The National Social Marketing Centre recommends a social marketing approach. Forster, the agency commissioned by the Peninsula Cancer Network, led on the scoping phase. This strategy continues to apply the principles of this planning to inform and enhance development of effective policy and is committed to adhering to the process in a systematic way when focusing on targeted behavioural goals.



Source: National Social Marketing Centre

### **Targeting resources**

8.4 The findings from the research conducted by the South West Public Health Organisation, as well as the insight development work that took place at the workshops, identified the need to provide different interventions to specific target groups. Based on the population and incidences of skin cancer within Devon, the strategy will focus in the first instance on two priority groups. This does not mean that other population groups will not potentially benefit from the interventions, particularly in relation to raising awareness, but the focus of the interventions will be on the target groups. The two target groups chosen are:

- teenagers
- over 50s (early diagnosis)

### **Focus on behaviour**

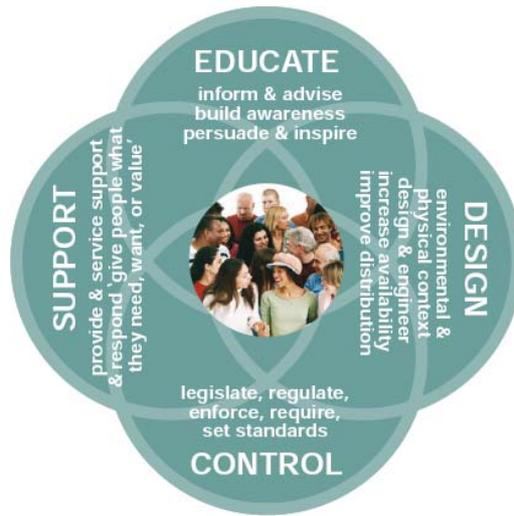
8.5 The strategy must focus on behavioural change rather than just raising awareness. To achieve behaviour change, whether in preventing exposure or seeking professional help, it is important to understand the audience's key beliefs, perceptions, barriers and motivations, many of which overlap. For example:

- the perception that skin cancer is something that happens to other people
- the perception that burning is not serious
- the perception that sunbeds are less harmful than the sun because you are in 'control' of your tan
- the perception that it is necessary to burn in order to get a tan
- the belief that tanned skin is more attractive than pale skin
- the barrier that suncream is too expensive/messy/difficult to remember to use

- the barrier that the United Kingdom is a country that has relatively little sun, compared to Australia and the United States, therefore when it is sunny people may have the attitude of 'making the most of it' and may forget to take care

### Methods mix

- 8.6 The strategy adopts a methods mix, applying the four primary elements for influencing behaviour as recommended by the National Social Marketing Centre.



Source: National Social Marketing Centre

### Commitment to evaluation

- 8.7 This strategy acknowledges the challenges of measuring the impacts of the action plan. Impacts on skin cancer rates will not be measurable in the short-term. Interventions must be sustainable and not simply 'quick-fix'. However, evaluation and monitoring must be as rigorous as possible for each intervention undertaken, even if the long-term outcomes are difficult to assess. Evaluation may be undertaken on both a local or peninsula-wide level, in partnership with key stakeholders, the Peninsula Cancer Network and the South West Public Health Observatory.
- 8.8 Appendix 5 shows the social marketing process followed in putting together the strategy and action plan.

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## 9. Teenagers

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- 9.1 Teenagers and young adults across all social classes are at particularly high risk from overexposure to ultraviolet radiation. Insight informs us that young men, and particularly young women, perceive a direct association between having a tan and being physically attractive, which links directly to self esteem in teenagers. Changing perceptions towards the attractiveness of a tan is extremely difficult and outside the scope of this strategy. The focus will be on encouraging teenagers to 'love their skin', to avoid burning at all costs, and to seek safe alternatives such as using fake tan.
- 9.2 A study of sunbed use undertaken by Cancer Research UK identified that 6% of 11-17 year olds have used a sunbed and a further 14.9% said that they had not done so yet but may do in the future.<sup>(17)</sup> In the age group 15-17 years, 11.2% stated they had used a sunbed, with girls (17.5%) more likely to use them than boys (3.5%). The research also found that sunbed use is higher in children from lower socio-economic groups. Using a sunbed before the age of 35 can increase the risk of skin cancer by 75%, and using a sunbed just once a month can increase the risk by 50%. Sunbed use in the South West is lower than the national average, at 4.0%. However, the new Sunbed Regulation Act will provoke a large amount of publicity nationwide, and provides an important opportunity to capitalise on.
- 9.3 Devon has approximately 91,384 young people aged 15-24.

Fifty-four percent of the young people live in Exeter, East Devon and Teignbridge. Of this, 50% live in Exeter (22,377) with nearly an equal split between East Devon (13,589) and Teignbridge (13,662). Table 5 details population figures by local authority.

**Table 5: Number of teenagers by local authority**

Local Authority	Aged 15-19	Aged 20-24
East Devon	7,435	6,154
Exeter	9,368	13,009
Mid Devon	4,752	3,907
North Devon	5,995	4,973
South Hams	5,296	4,226
Teignbridge	7,716	5,906
Torridge	4,039	2,944
West Devon	3,264	2,400
Devon	47,865	43,519

Source: Family Health Services Authority

- 9.4 By targeting teenagers now, there will be an expected reduction in skin cancer rates in future years, both in younger age groups, where melanoma rates are disproportionately high, and in older age groups, where incidence of all skin cancers is highest. Evidence shows that a history of sunburn doubles the risk of melanoma and also increases the risk of non-melanoma skin cancer, so it is important to prevent this from an early age.

## **Insight**

- 9.5 The following insights should be considered when developing actions:
- teenagers have the lowest skin protection rate of any age group
  - knowledge of potential dangers of excessive sun exposure does not result in sun protection-related behaviours
  - there is the perception is that a tan is 'sexy' increasing perceived attractiveness and raising self-esteem
  - they believe it is 'worth' getting sunburnt in order to get a tan and that less protection is needed as a tan progresses
  - the emphasis of immediate interventions should be on obtaining a tan safely as changing perceptions of the acceptability of tanning will require considerable resources to be invested over time
  - they are most likely to respond to appearance-based appeals, including indicators of premature ageing or wrinkling
  - it is important that interventions are not perceived as boring and difficult rather than making behaviour change fun, easy and popular
  - individuals behave differently while on holiday

## **Behavioural goals**

- 9.6 The strategy aims to achieve the following behavioural goals:
- teenagers avoid burning by adopting safe sun habits
  - teenagers who want to tan begin to choose safer alternatives such as using fake tan
  - teenagers recognise and act according to their individual skin type
  - under 18s cease to use sunbeds under new legislation

## **Strategic approach**

- 9.7 The strategic approach of the strategy includes:
- adopting a partnership approach to ensure skin cancer prevention is embedded in local policy and practice
  - identifying opportunities to raise awareness at key trigger points using insights and key messages
  - using a mix of interventions which cover "Educate, Design, Support, Control" as recommended by the National Social Marketing Centre

- 9.8 When agreeing on actions, the initial emphasis should be on low-cost, high-impact interventions that can be easily integrated into the existing working practices of the organisation(s). Interventions should be evidence-based, measurable, and long-term and sustainable, rather than short-term and reactive.

### **Message development**

- 9.9 According to NICE guidance, the format and content of messages should be developed and piloted with the target audience.<sup>(7)</sup> This will take time, but potential tactics and messages for teenagers based on insight are:

- focus on tanning alternatives – preferably use fake tanning products, never burn, limit sun exposure
- dispel myths, for example that sunbeds help prepare your skin for tanning in the sun; that burning is a necessary stage in getting a tan
- focus on appearance-based messages rather than simply health-based: show pictures of young people with sun-aged skin, use ultraviolet radiation technology to show damage
- where possible, use real examples rather than computer-generated images, to avoid disbelief from teenagers
- show the disfiguring impact of skin cancer surgery
- give real life examples of young people who have skin cancer
- emphasise that melanoma rates are disproportionately higher in younger people

### **Measuring impact**

- 9.10 The agreed multi-agency action plan will identify key outcome measures.

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## 10. Over 50s (early diagnosis)

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- 10.1 Over 95% of skin cancer is cured if treated early enough. Spotting the signs and symptoms of skin cancer early and seeking the appropriate medical advice will help save lives in Devon. A clear cancer pathway already exists within Devon with urgent GP referrals being seen within two weeks by a hospital specialist, and routine referrals being seen within the national 18 week target. People spotting the signs and symptoms early is the critical factor.
- 10.2 The incidence of malignant melanoma is highest amongst older people. A recent survey found that 44% of people were unable to recognise key signs of skin cancer, only 34% of them reported checking their moles at least once a month, and 25% never check them. A key challenge is to increase the number of people, particularly older people, who are able to recognise the key signs of skin cancer and check their moles regularly.

## **Demand management**

- 10.3 This strategy acknowledges that work is currently being undertaken to review NICE guidance on skin cancer management.<sup>(23)</sup> When prevention work is undertaken, it will impact on the numbers of patients presenting at their GPs, so it is essential that the GPs are suitably trained. It is important that preventive work is viewed as the first stage in the care pathway.
- 10.4 The guidance recognises that 24% of primary care consultations in England and Wales are related to the diagnosis and management of skin conditions, including skin lesions (1.7%). The burden of skin lesion management in dermatology out-patient services is also great, with 35–45% of specialist referrals relating to the diagnosis and management of skin lesions. This figure is as high as 60% in some areas. Furthermore, approximately 88% of two-week wait urgent referrals for suspected skin cancer turn out to be non-malignant, highlighting a need for better training in primary care on the recognition of skin cancer. The epidemiology of basal cell carcinoma, especially the predictions for the next two decades, means that there will be a requirement for better trained healthcare professionals to diagnose and manage basal cell carcinomas.

## **Insight**

- 10.5 The following insights should be considered when developing actions:
- seeking medical advice for bodily changes is the exception, rather than the norm
  - the way in which bodily changes are interpreted is influenced by personal, social and cultural factors, as well as the nature of the change itself
  - individuals diagnosed with cancer often do not realise the seriousness or significance of their bodily changes prior to consultation/diagnosis
  - fear of a cancer diagnosis can delay help-seeking behaviour
  - seeking professional help is not straightforward: there are many factors across a number of levels which can influence an individual seeking help, such as attitudes, beliefs and social context
  - knowledge of symptoms and risk alone are not sufficient to ensure help-seeking behaviour

## **Behavioural goal**

- 10.6 The strategy aims to achieve the following behavioural goals:
- over 50s to check their skin regularly and to seek appropriate medical advice and treatment if they notice any abnormal or new skin changes

## **Strategic approach**

10.7 The strategic approach of the strategy includes:

- adopt a partnership approach to ensure that the care pathway is streamlined and extends from prevention through to diagnosis and treatment
- identify opportunities to raise awareness at key trigger points using insights and key messages
- use a mix of interventions which cover “Educate, Design, Support, Control” as recommended by the National Social Marketing Centre

10.8 When agreeing on actions, the initial emphasis should be on low-cost, high-impact interventions that can be easily integrated into the existing working practices of the organisation(s). Interventions should be evidence-based, measurable, and long-term and sustainable, rather than short-term and reactive.

### **10.9 Message development:**

According to the draft NICE guidance, the format and content of messages should be developed and piloted with the target audience.<sup>(7)</sup> This will take time, but potential tactics, messages and trigger points for older people based on insight are:

- occurrence of an interpersonal crisis which may call to attention any bodily changes and prompt action
- symptoms will interfere with social and personal relations if they do not seek help
- sanctioning - family, friends agree to help-seeking
- symptoms will interfere with vocational or physical activity if they do not seek help
- temporalising of symptoms – ‘I’ll go to the doctor in two weeks if it hasn’t gone or if it has got worse’

One example of an intervention which tapped into these triggers and messages is the “Skin Cancer Kills” campaign by the Merseyside and Cheshire Cancer Network and Cancer Research UK, an awareness campaign targeting older men through eye-catching posters at bus-stops, working men’s clubs and sports club, as well as ‘hit squads’ giving out information to men in the area. Evaluation shows that the campaign:

- has increased prompted awareness of specific melanoma symptoms
- has raised awareness of the importance of early detection

- has encouraged men in the target group to check skin more frequently and visit their GP with any concerns
- provides a body of evidence and a strong awareness campaign framework that can be used as a model for similar local campaigns

#### 10.10 Measuring impact

Key performance indicators will be developed in collaboration with key stakeholders including the Peninsula Cancer Network and neighbouring primary care trusts once the final action plan has been agreed.

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### 11. Increasing public awareness

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11.1 Raising awareness throughout the year is an essential element to keeping skin cancer on the agenda with the general public and partners. The South West Public Health Observatory report provides evidence that many messages around skin cancer awareness and prevention are not well-recognised and understood.

11.2 Forster recommends that message development and awareness activity is commissioned regionally to maximise reach, cost-effectiveness, clarity and consistency. However, at this time, there are no plans regionally or locally to commission an awareness raising activity.

11.3 Therefore NHS Devon together with local partners is committed to:

- ensuring all message development is done using the insights developed and outlined in this strategy
- delivering health promotion activity to employees, utilising all internal communication channels, including work place promotion during peak times
- co-ordinating public relations activity with partner press offices and skin cancer co-ordinators during peak times, building on the heatwave plan
- adhering to branding guidelines if adopting a partner or national brand

11.4 Peak times to plan activity around are the run up to the holidays, Easter, summer and winter.

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### 12. Action plan

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12.1 The discussion and planning workshops highlighted the importance of sign-up across all agencies; those with a duty to protect the public and employees and providers of acute and preventative services. It was agreed that a multi-agency strategy will be produced for sign-up by the stakeholders. It was agreed that an action plan would be developed focusing on the identified target audiences. It was also agreed that a steering group would be established to support the development and delivery of an action plan. The action plan will be renewed and updated on an annual basis.

## Skin Cancer Prevention Strategy Action Plan 2011-12

	<b>Behavioural/Strategic Goal</b>	<b>Action</b>	<b>Lead &amp; Partner Organisations</b>	<b>Resources</b>	<b>Measurements</b>	<b>Timeline</b>
<b>1. Strategic</b>						
1.1	Establish skin cancer as a priority in a range of strategic plans	Include skin cancer as a key priority in the 2011/12 JSNA, set out specific actions in the Joint Health and Wellbeing Strategy and Local Health Improvement plans	NHS Devon Devon County Council	Mainstream	Specific actions in relevant plans	May 2011
<b>2. Sunbeds</b>						
2.1	Prevent use of sunbeds by under 18s in line with new legislation	Investigate a programme of underage test-purchasing	Trading Standards Exeter CC and Teignbridge DC Environmental Health	Mainstream	Number of test-purchases undertaken Test outcomes	Ongoing from April 2011
2.2		Monitor number of sunbed salons	Local Authorities (Environmental Health)	Mainstream	Number of private sunbed salons by location Number of LA owned sunbeds	Ongoing

2.3		Raise awareness with salons and ensure compliance with new sunbed legislation	Local Authorities (Environmental Health)	Mainstream	Number of salons receiving mail shots by location Number of salons receiving visits by location Number of salons providing safety information in accordance with national guidance	Ongoing from Dec 2010
2.4		Raise awareness with beauticians by providing information pack and salon visits	Devon Environmental Health Officers Health and Safety Subgroup	Mainstream	Number of salons receiving information pack	October to December 2011
3. Outdoor/Physical Activity						
3.1	Encourage teenagers to practice safe sun behaviour at all outdoor events and recreational activities	Embed sun safety into event policy, practice and promotion	Licensing Group NHS Devon	Mainstream	Number of events and activities providing information and encouraging participants to practice safe sun behaviours	May 2011
3.2		Embed sun safety into all promotional material developed for Devon Games to Inspire,	Active Devon NHS Devon	Mainstream	Number of events and activities providing information and encouraging	Ongoing Devon games to Inspire – 18 <sup>th</sup> June 2011

		Ability Games, Street Games, Sports Governing Bodies			participants to practice safe sun behaviours	Ability Games – 7 <sup>th</sup> July 2011
4. Schools/Colleges/Other Youth						
4.1	Encourage teenagers to practice safe sun behaviour	Implement UV scanner intervention and awareness campaign with Exeter College beauty students	Exeter College NHS Devon	£1500	Self-reported change in knowledge, attitudes and behaviour, as detailed in project plan	April-June 2011
4.2		Embed sun safety into Healthy Schools programme	Devon Learning and Development Partnership NHS Devon	Mainstream	Number of schools with safe sun initiatives	April-July 2011
4.3		Embed sun safety into PEDPASS strategy	Devon Learning and Development Partnership	Mainstream	Sun safety identified within PEDPASS as priority	Ongoing
4.4		Schedule regular sun awareness Youth Bytes	Exeter College NHS Devon	Mainstream	Number of hits Conversion rate Click through	April-June 2011
5. Early Diagnosis (over 50s)						
5.1	Improve early diagnosis and treatment in primary care	Train GPs at locality level in operating on low-risk basal cell carcinomas in primary care in accordance with NICE guidelines. North Devon training	Acute Trusts Network Site Specific Group for Skin NHS Devon	Via Primary Care contracting – similar to GPwSI contract model  Commissioned by	Number of GPs trained in accordance with guidance	GP training in May 2011

		sessions on treatment of premalignant lesions, including recognition of squamous cell carcinomas		PCT		
5.2	Ensure that primary and secondary care are prepared to cope with the potential increase in skin cancer diagnoses	Redesign pathways - C2Cs to work on developing referral and treatment pathways of basal cell carcinomas, squamous cell carcinomas and melanoma/skin lesions	NHS Devon	Mainstream	Pathway developed to deal with service delivery in primary and secondary care as appropriate and reduction in total service demand	Ongoing
5.3	Encourage over 50s to practice safe sun behaviour, to check their moles regularly and to see their GP if they notice anything suspicious	Implement community pharmacy awareness campaign in South Hams, West Devon and Teignbridge, joint with Torbay Care Trust	Local Pharmaceutical Committee NHS Devon Torbay Care Trust	£4000	Number of patient interactions Number of patients intending to change behaviour/see GP Number of informal referrals to GP	May-July 2011
5.4		Run workplace health sessions on skin cancer prevention and spotting symptoms early	Devon County Council Wellbeing @ Work NHS Devon	Mainstream	Number of conversations with employees on skin cancer Self-reported change in attitudes/ knowledge	June 2011

6. Health Protection						
6.1	Examine risk of skin cancer through arsenic in drinking water	Establish toxicity levels of arsenic in drinking water and background levels in environment (especially West Devon), risks of skin cancer, decide any action needed	Health Protection Agency (Pete Smith)	Mainstream	Results of research	Ongoing
6.2	Investigate quality of UV products	Test summer products	Trading Standards	Mainstream	Results of research	Ongoing
7. General Awareness Raising						
7.1	Raise awareness of the importance of skin cancer prevention and early diagnosis across a range of stakeholders and target audiences	Undertake opportunistic and planned awareness raising through consistent safe sun messages and material, utilising all available channels	NHS Devon	Mainstream	See communications plan Number of press releases Column inches Broadcasting coverage Number of articles published	Ongoing

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Himp/Skin Cancer (Sarah Bird)/Skin Cancer Prevention Strategy 2011-2014/Devon Skin Cancer Strategy 2011-2014  
Board Version April 2011

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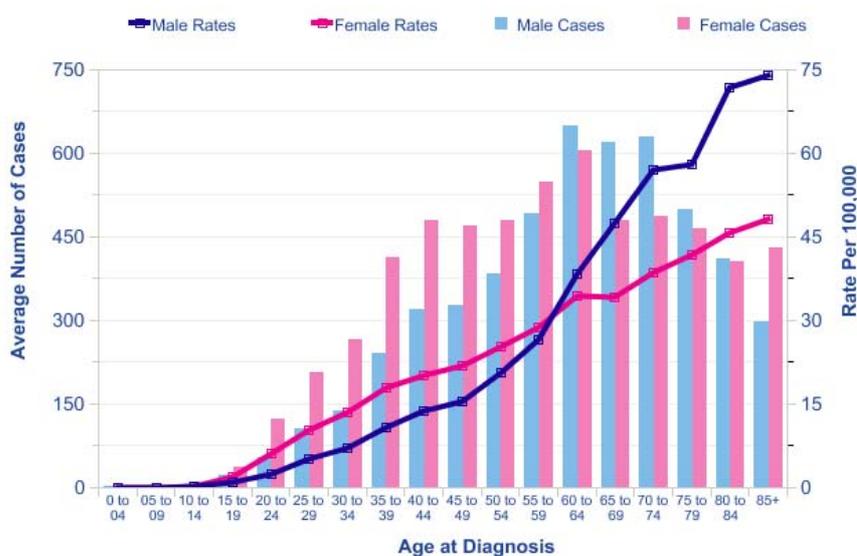
## National Data by Age and Gender (Source: Cancer Research UK)

**Table 2: Incidence of malignant melanoma, average number of new cases and age specific rates per 100,000 of the population, UK, 2006-08**

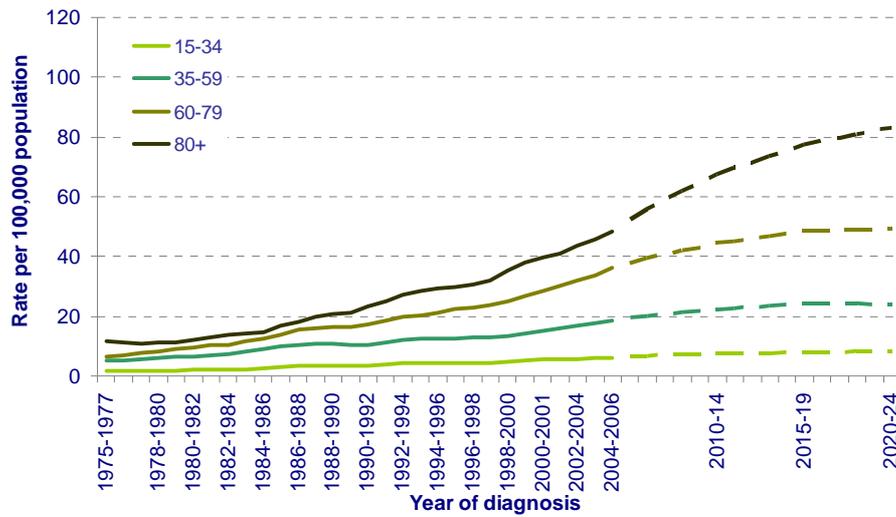
Age	Total Cases		Rate per 100,000	
	Male	Female	Male	Female
00-04	*	*	*	*
05-09	*	*	*	*
10-14	*	*	*	*
15-19	21	37	1.0	1.9
20-24	53	123	2.5	6.1
25-29	105	206	5.2	10.4
30-34	138	266	7.1	13.5
35-39	242	412	10.8	18.1
40-44	319	481	13.7	20.3
45-49	327	471	15.6	21.9
50-54	384	481	20.8	25.4
55-59	491	548	26.5	28.7
60-64	648	606	38.4	34.3
65-69	620	481	47.6	34.1
70-74	630	486	57.1	38.5
75-79	499	464	58.0	41.7
80-84	410	405	71.8	45.8
85+	297	429	74.0	48.2
All Ages	5,189	5,901	17.3	19.0

\* Suppressed (less than five cases per annum)

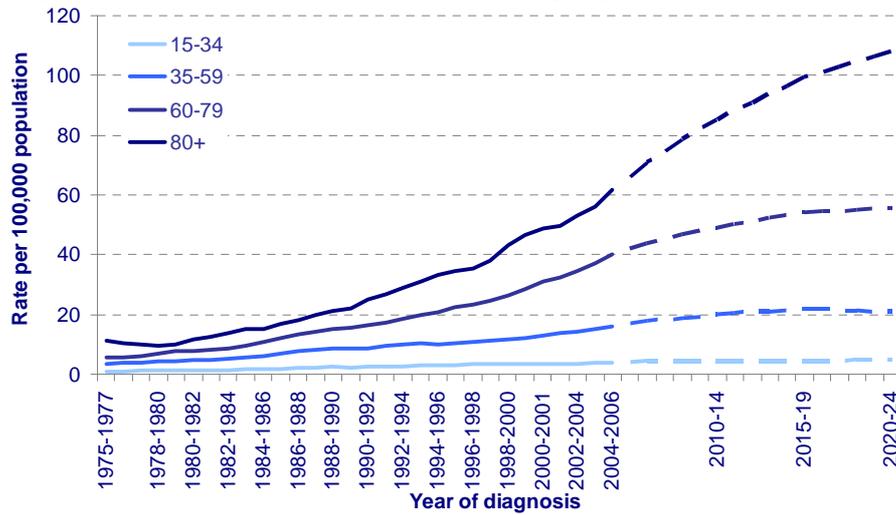
**Figure 4: Incidence of malignant melanoma, average number of new cases and age specific rates per 100,000 of the population, UK, 2006-08**



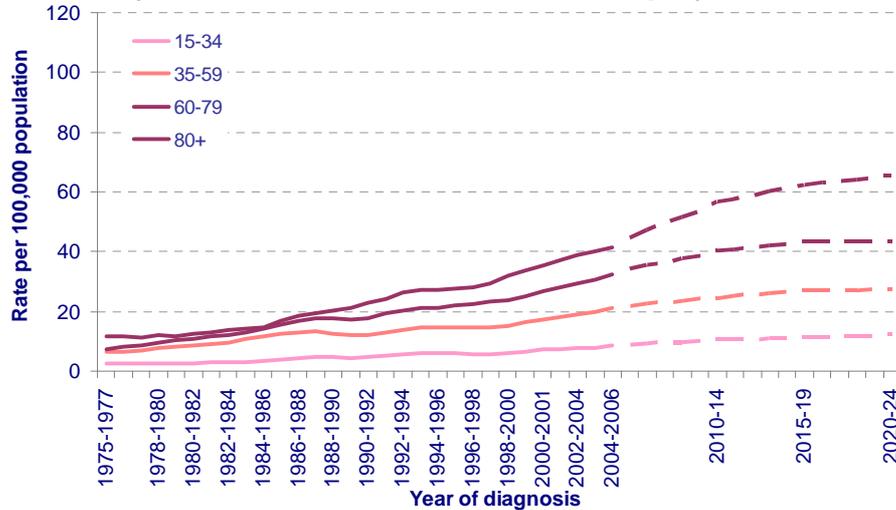
**Figure 5: Age specific incidence rates of malignant melanoma in persons, adults only, Great Britain, from 1975-2006 and projected to 2024**



**Figure 6: Age specific incidence rates of malignant melanoma in males, adults only, Great Britain, from 1975-2006 and projected to 2024**

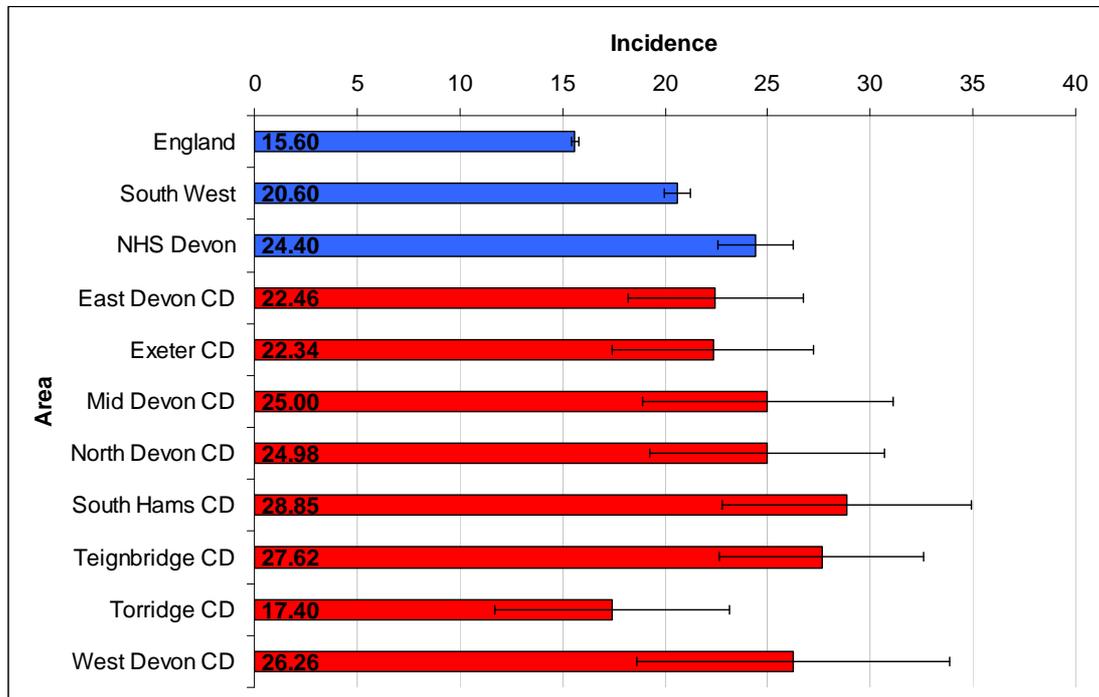


**Figure 7: Age specific incidence rates of malignant melanoma in females, adults only, Great Britain, from 1975-2006 and projected to 2024**

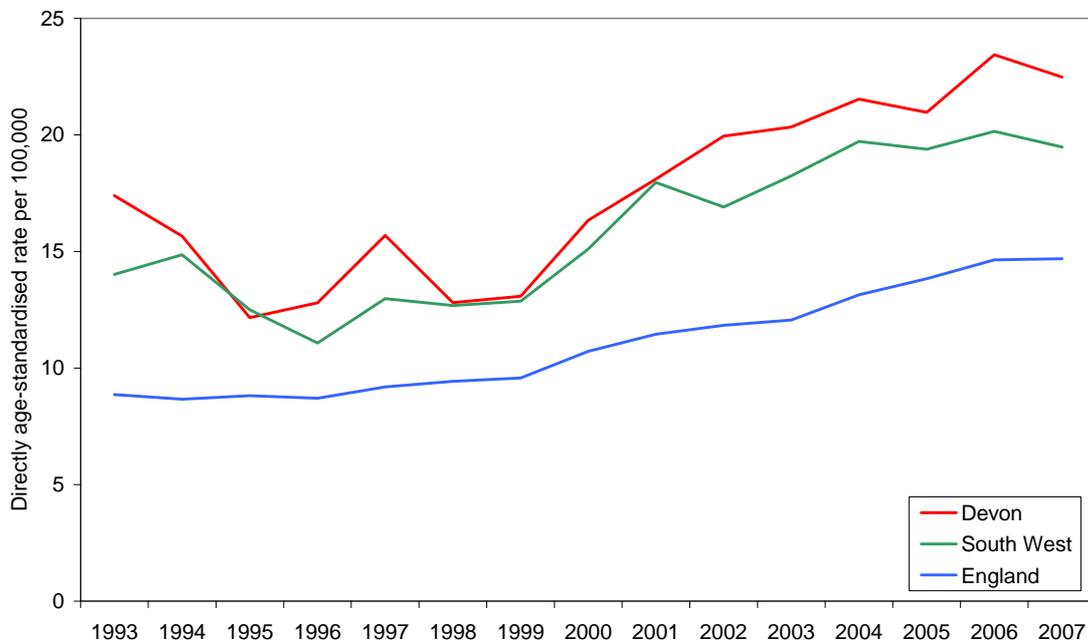


Local Data

**Figure 8: Incidence of malignant melanoma (direct age-standardised rates per 100,000), 2006-08**



**Figure 9: Incidence of malignant melanoma, (direct age-standardised rate per 100,000), 1993-2007**



**Figure 10: Incidence of malignant melanoma (direct age-standardised rates per 100,000), 2006-08, Devon in England**

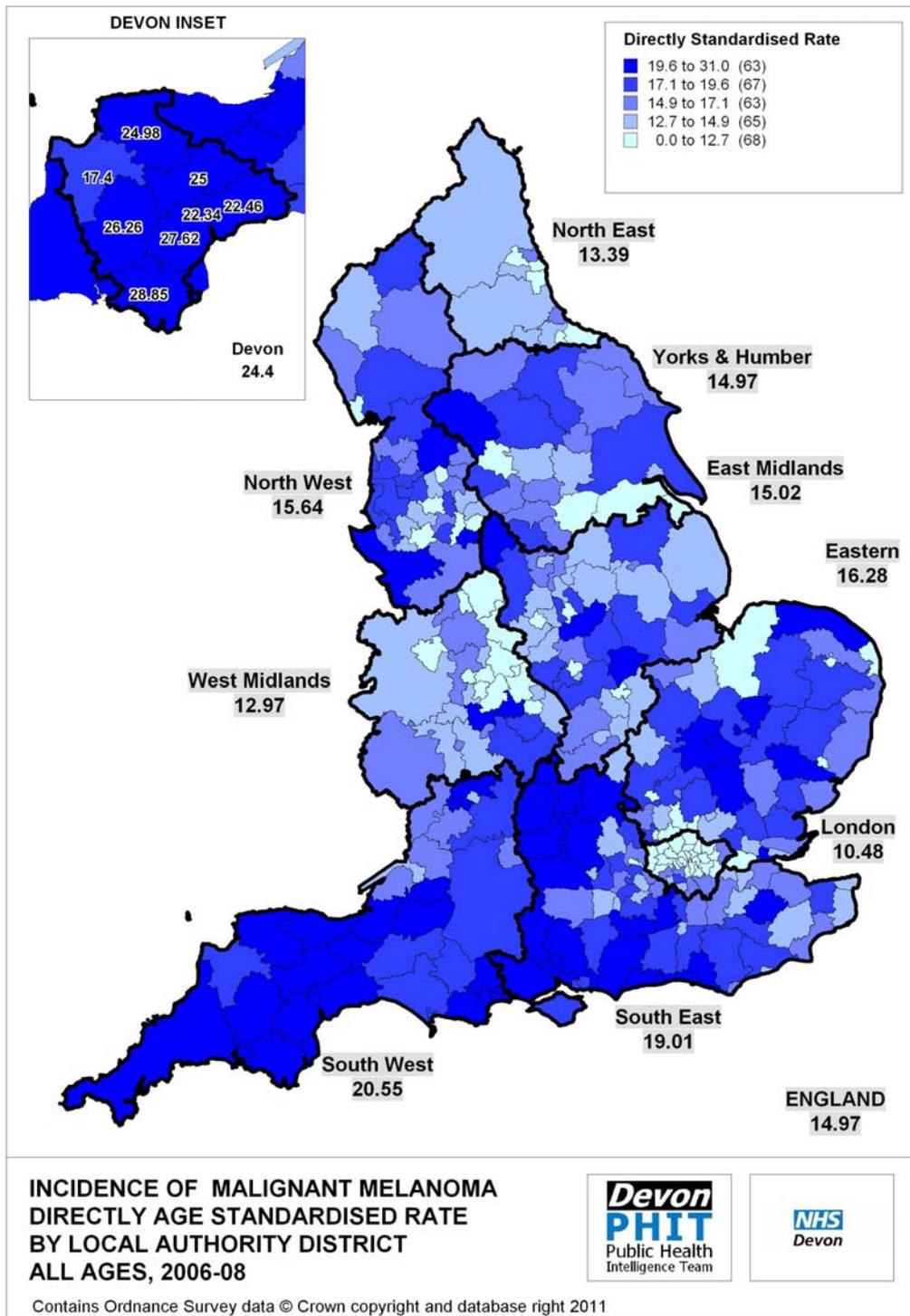
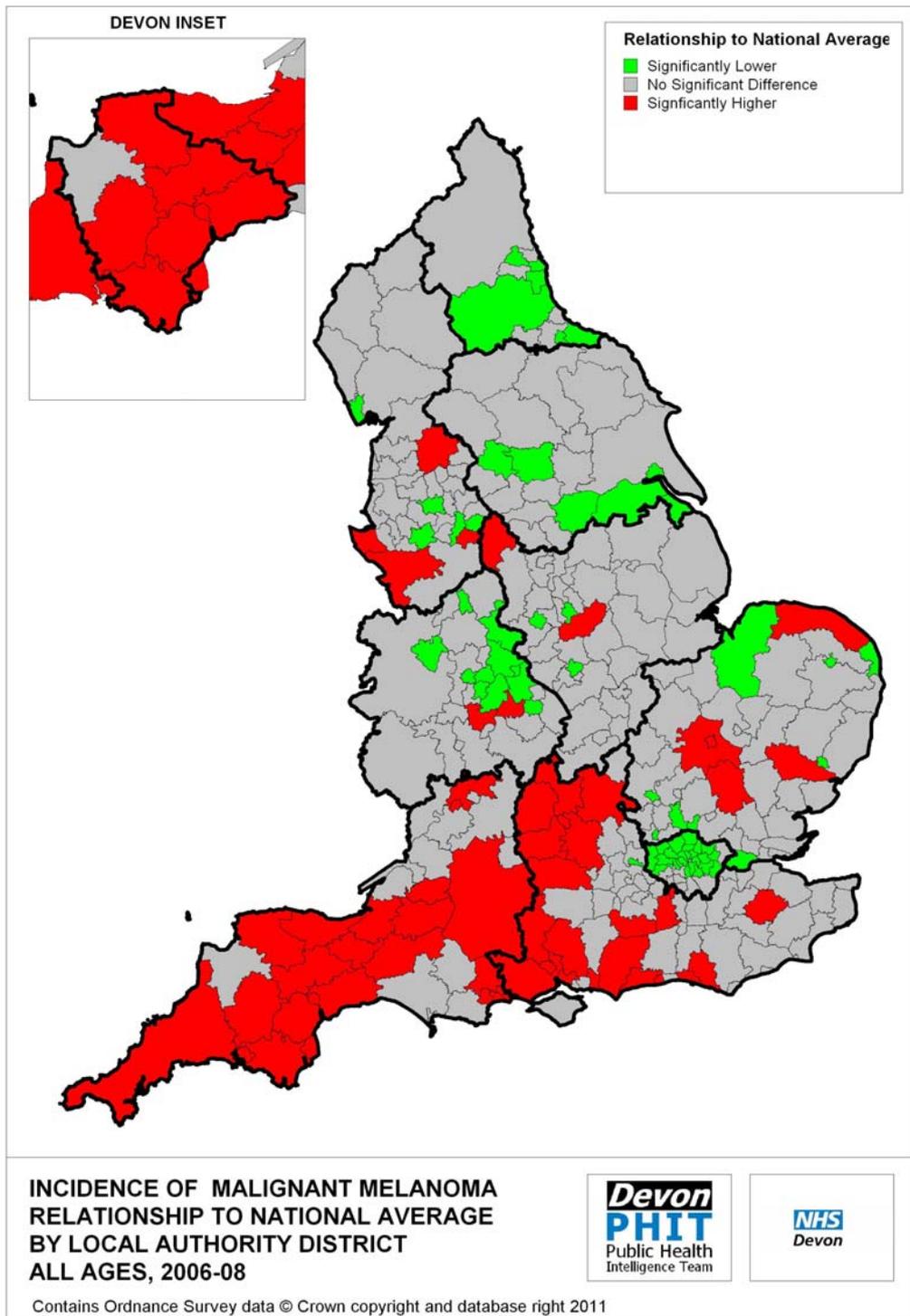
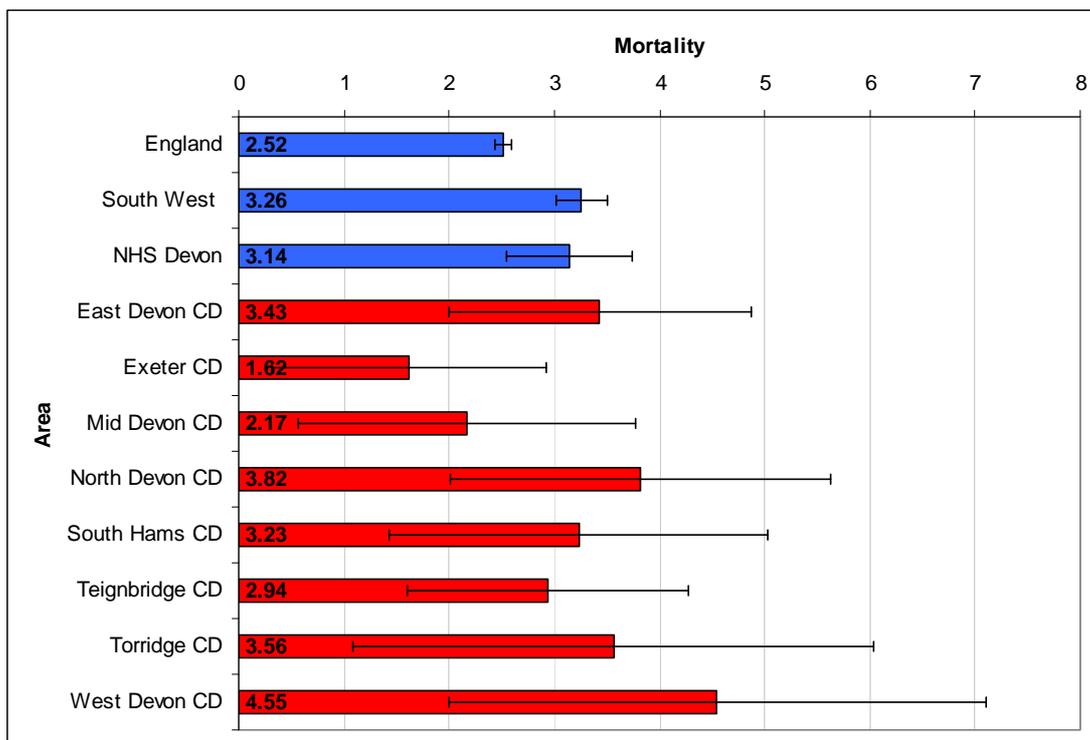


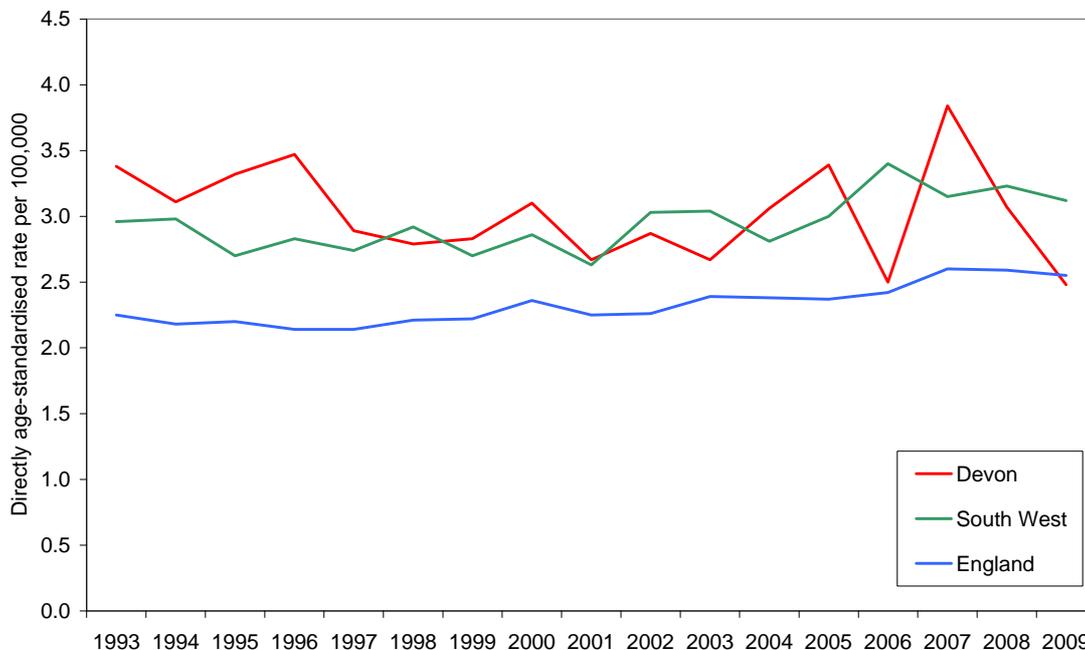
Figure 11: Incidence of malignant melanoma (direct age-standardised rates per 100,000), 2006-08, relationship to national average



**Figure 12: Mortality from malignant melanoma (direct age-standardised rates per 100,000), 2006-08**



**Figure 13: Mortality from malignant melanoma (direct age-standardised rates per 100,000), 1993-2009**

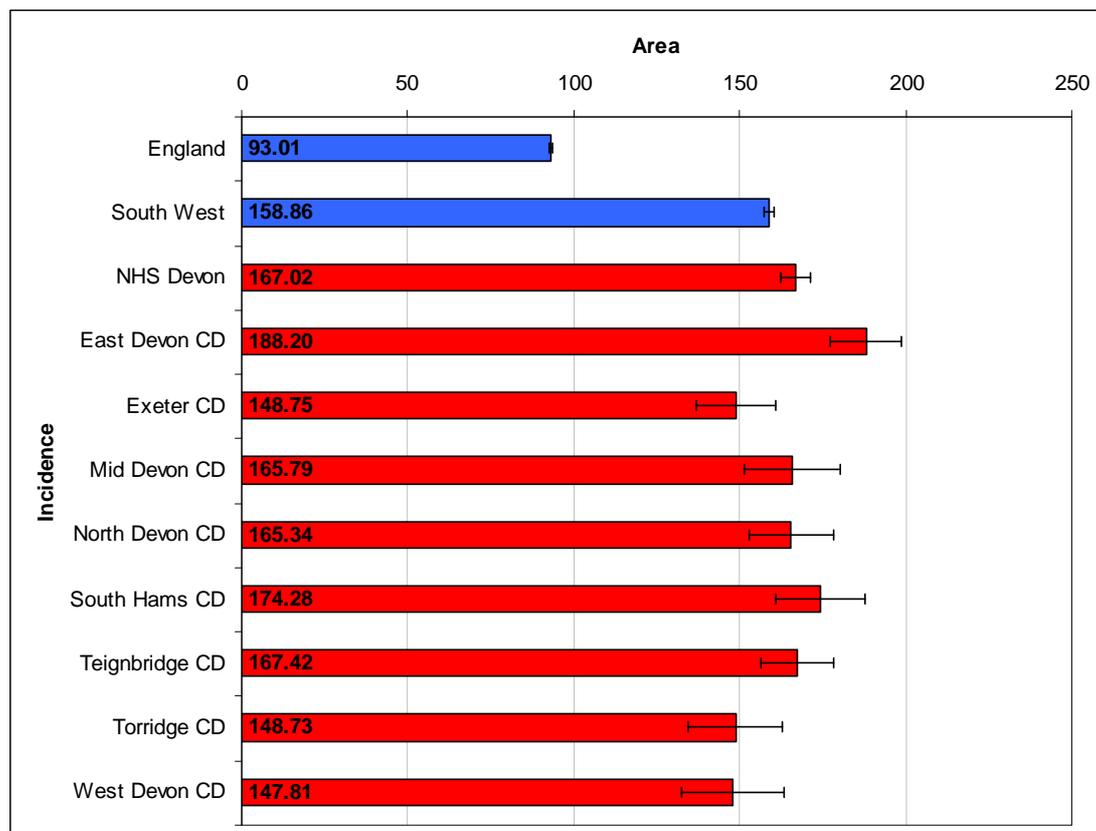


**Table 3: Observed cases of malignant melanoma per year (based on 2006-08 pooled data)**

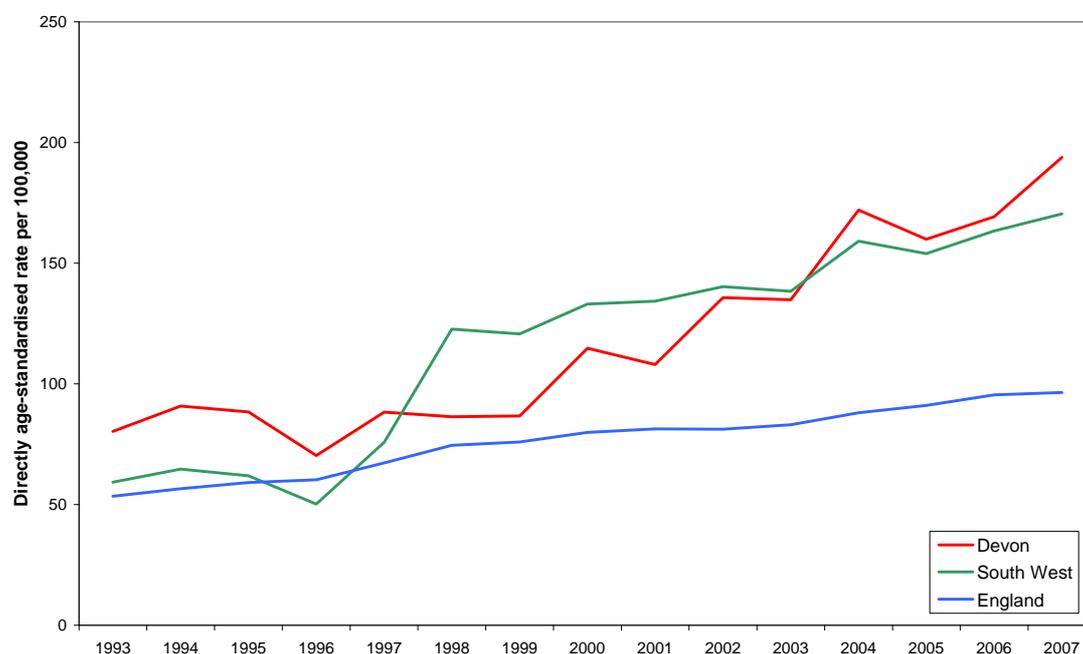
Area	Incidence of malignant melanoma	Mortality from malignant melanoma
England	9,094	1,657
South West	1,355	245
NHS Devon	246	40
East Devon CD	49	9
Exeter CD	29	*
Mid Devon CD	25	*
North Devon CD	29	6
South Hams CD	33	*
Teignbridge CD	48	7
Torrige CD	14	*
West Devon CD	19	*

\* Suppressed (less than five cases per annum)

**Figure 14: Incidence of skin cancer other than malignant melanoma (direct age-standardised rates per 100,000), 2004-06**



**Figure 15: Incidence of skin cancer other than malignant melanoma (direct age-standardised rates per 100,000) 1993-2007**

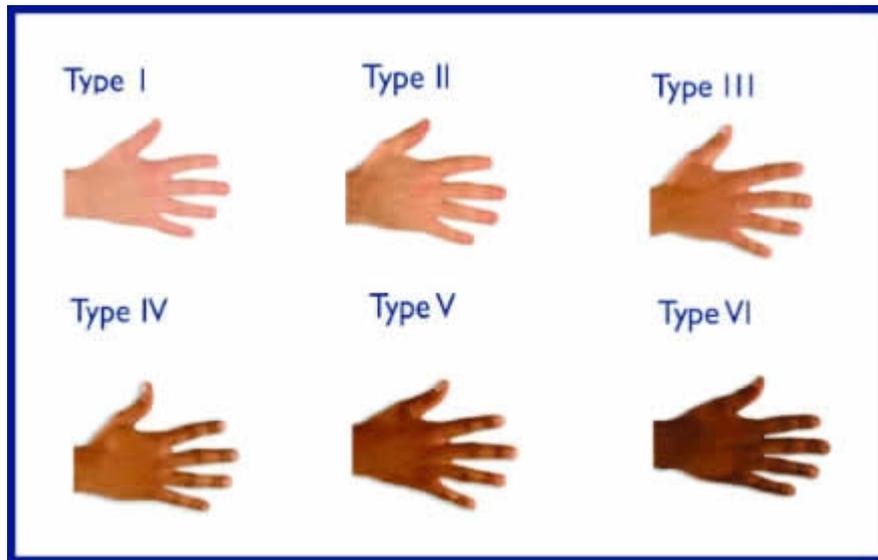


**Table 4: Observed cases of skin cancer other than malignant melanoma per year (based on 2004-06 pooled data)**

Area	Incidence of other skin cancers	Mortality from other skin cancers
England	63,744	421
South West	12,465	58
NHS Devon	2,065	9
East Devon CD	508	*
Exeter CD	223	*
Mid Devon CD	187	*
North Devon CD	249	*
South Hams CD	246	*
Teignbridge CD	360	*
Torridge CD	162	*
West Devon CD	128	*

\* Suppressed (less than five cases per annum)

## The Fitzpatrick Skin Type Scale



Source: Cancer Research UK

Type	Description
Type I	Often burns, rarely tans. Tends to have freckles, red or fair hair, and blue or green eyes.
Type II	Usually burns, sometimes tans. Tends to have light hair, and blue or brown eyes.
Type III	Sometimes burns, usually tans. Tends to have brown hair and eyes.
Type IV	Rarely burns, often tans. Tends to have dark brown eyes and hair.
Type V	Naturally black-brown skin. Often has dark brown eyes and hair.
Type VI	Naturally black-brown skin. Usually has black brown eyes and hair.

## NICE Guidance PH32

### Skin cancer prevention: information, resources and environmental changes

**NICE provides the following recommendations for preventing skin cancer.**

***Recommendations 1 - 4: who should take action?***

- Commissioners, organisers and planners of national mass-media primary prevention campaigns for skin cancer. This includes directors of public health, NHS commissioners and those working in charities and non-governmental organisations (NGOs).
- Local practitioners involved in skin cancer primary prevention activities. This includes staff working in:
  - charities and NGOs
  - health promotion
  - local authorities (such as environmental health or health and safety officers)
  - the education sector (such as Head Teachers, Healthy Schools Co-ordinators or personal, social, health and economic (PSHE Co-ordinators)
  - other workplaces
- Local practitioners who provide skin-related health information (for example, GPs, health visitors, pharmacists and school nurses or specialists such as cancer nurse specialists or dermatologists).

<b>Recommendation 1: Information Provision: Delivery</b>
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**What action should they take?**

- Commissioners, organisers and planners of national, mass-media skin cancer prevention campaigns should:
  - continue to develop, deliver and sustain these campaigns to raise awareness of the risk of UV exposure and ways of protecting against it

- try to integrate campaign messages within existing national health promotion programmes or services to keep costs as low as possible (Sure Start is an example of an initiative where they could be integrated)
- evaluate the impact using a range of knowledge, attitudes, awareness and behavioural measures. (For recommendations on the principles of evaluation see –Behaviour change at population, community and individual levels’ [NICE public health guidance 6].)
- Local practitioners should continue to deliver low cost, information-related prevention activities to raise awareness of the risks of UV exposure and ways of protecting against it. This may include one-to-one and group-based advice as well as local media campaigns. (A low cost option could involve integrating skin cancer prevention messages into existing local health promotion campaigns and activities. Examples include employee wellbeing initiatives or activities related to the Healthy Child Programme and Sure Start.)
- Ensure national and local messages are repeated over time and regularly revised to keep the audience’s attention. They should also be timed appropriately (for example, they should be promoted in the Spring and Summer) and reinforced each year

<p><b>Recommendation 2: Information Provision: Developing national campaigns and local activities</b></p>
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**What action should they take?**

- Use local, regional and national epidemiological data and demographic and risk assessments to identify which groups, behaviours or activities need to be targeted. This could include profiles from public health observatories (such as those available from the South West Public Health Observatory’s skin cancer hub). It could also include data from joint strategic need or local risk assessments. Groups who may be at higher risk of skin cancer include:
  - those with fair skin: people with skin types I and II burn rapidly (those with skin types III and IV are at risk in strong sunshine and during prolonged UV exposure, those with skin types V and VI are at risk during prolonged UV exposure)
  - children (babies are at greatest risk of burning and should be kept out of direct sunlight)
  - young people
  - outdoor workers
  - those who are immuno-suppressed
  - those with a personal or family history of skin cancer

- those with a lot of moles (more than 50)
- those who put themselves at risk of overexposure to UV by sunbathing or by using indoor tanning devices such as sunbeds and sunlamps
- Ensure national and local prevention activities are based on evidence that details the needs of groups at risk – and the barriers they face in changing their behaviour.
- Establish clear, measurable objectives for national and local prevention activities.
- Ensure the need to tackle health inequalities is taken into account when developing national and local prevention activities. Consider cultural, religious and group norms in relation to sun exposure and delivery preferences (in terms of message format, medium and languages used).
- Develop and pilot the format and content of national campaigns with the target audience. Where feasible, do the same for local activities.

### **Recommendation 3: Information Provision: Message Content**

#### **What action should they take?**

- Ensure messages include a simple explanation of how UV exposure can damage the skin and how environmental factors can affect the level of sun exposure. (Factors include: geographical location, cloud cover, seasonal variations, UV forecasts or solar UV index and the availability of shade.)
- Ensure messages explain how someone can assess their own level of risk (for example, if they have pale skin, red hair, freckles or lots of moles then they should take extra care). They should also stress the importance of checking the skin regularly for any changes (such as changes to any moles) and where to go for further advice if changes are detected.
- Ensure messages give a balanced picture of both the risks of overexposure and the benefits of being out in the sun. (The risks include skin cancer, the benefits include boosting vitamin D levels and increasing the likelihood of and ears). Re-apply at least every 2 hours and immediately after being in water, even if the sunscreen is 'water resistant'. Also re-apply after towel drying. If applied adequately, SPF 15 should be sufficient.

### **Recommendation 4: Information Provision: Tailoring the Message**

#### **What action should they take?**

- Ensure messages are simple, succinct and tailored for the target group. For example, they should be tailored for those with different skin types, those who work outdoors, those taking winter and summer holidays in the sun and the parents of children and young people.

- Ensure messages take account of cognitive ability (in particular, in relation to children). They should also encourage people to be sensible in the sun. For example, they could appeal to carer or parental concerns for their child, or tap into general concerns about the ageing effects of the sun.
- Ensure messages address the social and practical barriers to using sun protection. This includes:
  - acknowledging the common perception that a sun-tanned appearance is attractive
  - acknowledging that sunshine is a good source of vitamin D
  - acknowledging that sunshine encourages people to be physically active
  - stressing how easy it is for people to apply sunscreen and that 'protective', loose fitting and light clothing can be attractive and comfortable to wear
  - acknowledging that people mistakenly believe that the health risks of overexposure are minimal, and that malignant melanoma and squamous cell carcinoma are not serious conditions
- Phrase messages in such a way that they enhance people's belief in their ability to change – and encourage them to make those changes. Use positive statements such as: 'Using sunscreen with high UVA protection (as indicated by UVA stars and the UVA circle logo) increases the chances of keeping skin healthy and young looking'. Note: negative messages are not so effective. These include, for example, 'Not using sunscreen increases the risk of skin cancer and sun exposure prematurely ages the skin'.
- Ensure messages are delivered in a way that meets the target audience's preferences (for example by radio, text messaging or leaflets).

<b>Recommendation 5: Protecting Children, Young People and Outdoor Workers</b>
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**Who should take action?**

- Employers and managers in leisure or educational settings (examples of the latter include head teachers, healthy schools co-ordinators and PSHE lead teachers).
- Other employers, managers and practitioners in contact with employees who work outdoors (such as workplace health practitioners and health and safety officers).

**What action should they take?**

- Assess if there is a risk of harmful exposure to the sun. Where this is the case, develop, implement and monitor a specially tailored policy to ensure people are protected as much as possible.

- Ensure policies aim to prevent children and young people from getting sunburnt by encouraging them to seek shade whenever possible. When it is not possible, they should be encouraged to wear hats, other clothing and sunscreen to protect themselves. Policies should also encourage parents to provide their children with sunscreen. Guidelines should be provided on how to help children apply it (and how children can help each other to apply it).
- Ensure policies encourage outdoor workers to wear clothing to avoid getting sunburnt (including a hat that shades the face and back of the neck, where possible). They should also be encouraged to stay in the shade when possible, especially during breaks and in the middle of the day (11am to 3pm). When it is not possible to stay in the shade or wear protective clothing (for example, because of work requirements) they should be encouraged to wear a sunscreen with UVA and UVB (at least SPF 15) protection. For more details see recommendation 4. (Further information on the development of education, leisure or workplace-based policies can be obtained from the SunSmart and Health and Safety Executive websites.)
- Assess the training needs of staff responsible for policy-making in outdoor, educational or leisure environments. Ensure they have the necessary skills and information to give their colleagues advice on sun protection issues. For example, teachers and others working in education may need training in the risk factors, the types of behaviours to avoid and how to encourage children and young people to apply their own sunscreen. Employers and managers may need training in how to carry out risk assessments in relation to sun exposure during the working day.

<b>Recommendation 6: Providing Shade</b>
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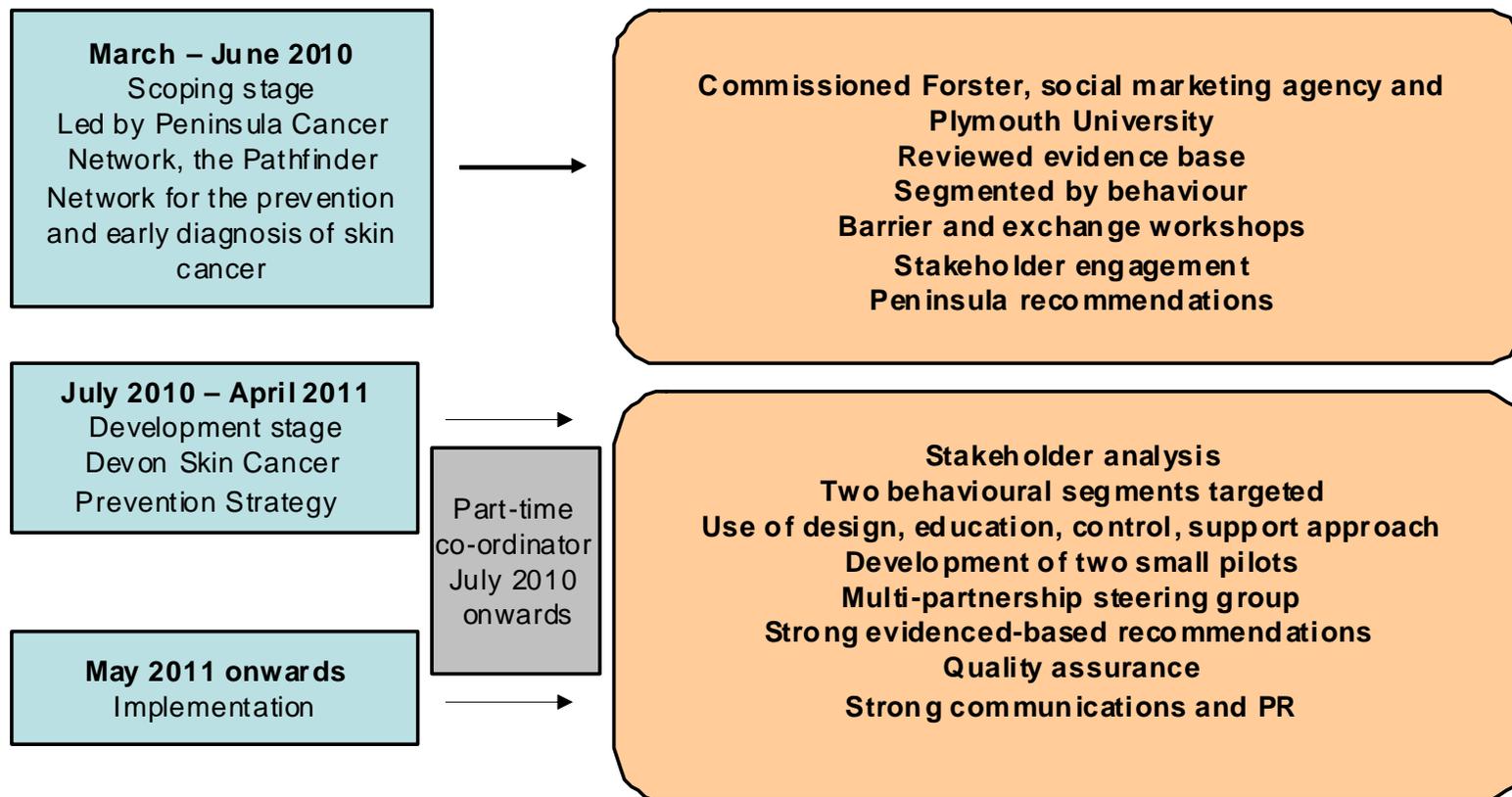
**Who should take action?**

Architects, designers, developers, planners and employers.

**What action should they take?**

- When designing and constructing new buildings, consider providing areas of shade created either artificially or naturally (for example, by trees).

## Skin Cancer Prevention in Devon – Social Marketing Process



## Key Messages

**Never burn**

Burning can double your risk of skin cancer

**Know your skin**

People with fair skin that burns easily, lots of freckles, moles, a history of sunburn and family/personal history of skin cancer are more at risk of skin cancer and need take extra care

**Seek shade**

In the UK, the sun is strongest between 11am and 3pm. Abroad, the sun is strongest when your shadow is shorter than your height – seek shade during this time.

**Cover up**

Protect your skin with clothing such as sunglasses, hat and t-shirt

**Sunscreen – know how to use it**

- Use at least SPF15
- Use a 'broad-spectrum' (UVA and UVB protection) sunscreen with a 4\* rating
- Reapply regularly and generously
- Most sunscreens expire after 1-2 years so make sure yours is in date
- Cheaper sunscreens can be just as effective as the expensive ones
- Don't rely on sunscreen as your only form of protection
- No sunscreen gives 100% protection so don't be tempted to stay out longer

**Never binge-tan**

Intense intermittent exposure or 'binge-tanning', whether on Devon beaches or on holiday abroad, increases your risk of malignant melanoma, the most serious form of skin cancer.