CROYDON PUBLIC HEALTH INTELLIGENCE TEAM PHIT

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# CROYDON'S CANCER STRATEGY: DATA ANALYSIS AND ASSESSMENT OF CURRENT PREVENTION/ EARLY DETECTION & DIAGNOSIS SERVICES

**Public Health January 2015**

## EXECUTIVE SUMMARY

This report provides further data analysis to support the development of Croydon CCG's cancer strategy. It also provides an assessment of current prevention and early detection and diagnosis services to strengthen the CCG's understanding of these parts of the cancer pathway. It provides a number of recommendations for further lines of enquiry that should be taken forward by the Project Group responsible for delivering the strategy, and also highlights a number of service improvement recommendations that should be considered when implementing new programmes of work to improve prevention, earlier detection and earlier diagnosis of cancer.

The report suggests that there are specific population groups that are more at risk of having worse outcomes from the 4 priority cancers. These groups vary for each of the 4 priority cancer, though some important commonalities can also be seen. Younger population groups are likely to be unaware of the symptoms of cancer, for example, whilst older people (with symptoms) are less likely to visit their GP to discuss their concerns. Ethnic minority groups and those living in deprived parts of the borough are least likely to attend breast or bowel screening programmes. Those aged 75 or over have significantly poorer survival rates for all cancers than younger age-groups. For lung and colorectal cancer, a drop off in survival rates by age is seen in the 65-74 age groups.

It is important that Croydon CCG work in a targeted way with these groups to improve access to professional support earlier in the patient pathway. Whilst detection rates of cancer are improving locally, Croydon still does not perform well on the overall numbers of cancers being detected at Stage 1 or Stage 2. Breast and bowel screening coverage remain below the national minimum standard. Emergency presentations for 3 of the 4 cancers (not breast) are higher than the London and England averages. Further, there remain visible inequalities across the Borough- with those in more deprived areas being more likely to have unhealthy behaviours that are risk factors for developing cancer; being less likely to take up screening opportunities and talk to their GPs about their concerns; and presenting as emergencies in A&E or other urgent care settings. Working through social marketing campaigns and targeted GP training and support offers the opportunity locally to start reversing these trends. Defining how local commissioners can hold NHS England and Public Health England to account for improvements to the effectiveness of the breast and bowel screening programmes is also an important step that needs to be taken to improve local provision.

## REPORT RECOMMENDATIONS

**This report recommends that the following groups of Croydon's population should be given priority focus in order to improve prevention, earlier detection of and outcomes from breast, bowel, lung and colorectal cancer in Croydon[1]:**

| BREAST CANCER | COLORECTAL CANCER<br><br>Those with low awareness: |
|---|---|

[1] Based on both previous research and data analysis (2010-13), and more recent data analysis (2014) completed locally

| | |
|---|---|
| **Those least likely to check their breast are aged 16-29 and 70+**<br><br>**Those least likely to visit their GP with symptoms are aged 60+**<br><br>**Low screening uptake:**<br>• **Ethnic minority groups (including Tamil, Asian and Polish populations), those who have newly arrived to the country, Deprived regions**<br>• **Update targeting based on NHSE work**<br><br>**Those with poorest outcomes**<br>• **50-64 (incidence highest)**<br>• **70+ (mortality greatest)**<br>• **White British (incidence highest)**<br>• **Affluent women (incidence highest)**<br>• **Asian and Black women (lower risk of breast cancer but present later)**<br><br>**Areas with high prevalence of smoking, obesity and alcohol use** | • **Men, Under 30s, Lower social grades, Non-white ethnic groups**<br><br>**Those who would delay seeing GP:**<br>• **24% of over 60s would wait a week or more or never see their doctor**<br><br>**Low screening uptake:**<br>• **Ethnic minority groups (including Tamil, Asian and Polish populations), those who have newly arrived to the country, Deprived regions**<br>• **Update targeting based on NHSE work**<br><br>**Outcomes are poorest:**<br>• **Deprived regions, White British/white Irish, Aged 60+**<br><br>**Areas where diet poor, obesity, excessive alcohol consumption and smoking prevalence are high** |
| **LUNG CANCER**<br><br>**Those with worst outcomes**<br>• **Most deprived areas of Croydon: Waddon, New Addington, Fieldway, Broad Green, Thornton Heath, South Norwood and Woodside**<br>• **Older men**<br>• **White British/white Irish**<br><br>**Those least likely to contact doctor**<br>• **Higher social grades, white ethnicity**<br><br>**Areas with high smoking rates: big focus on New Addington, Fieldway and wards in the north of the borough** | **PROSTATE CANCER**<br><br>**Younger men (under 55) to raise awareness of symptoms before onset of cancer likely**<br><br>**Older men (55+) who may not be accessing their GP early enough**<br><br>**Those with the poorest outcomes**<br>• **higher mortality for black African and black Caribbean men in Croydon**<br><br>**Those who are presenting as emergencies**<br>• **More research required to understand this cohort**<br><br>**Areas with high prevalence of smoking, obesity and alcohol use** |

**Data gaps/ further lines of enquiry**

- Endorsement and support should be given locally to NHS England for their plans to complete further analysis on which ethnic groups are taking up screening programmes, to enable Croydon CCG to plan a targeted campaign to increase screening among groups who are least likely to take it up.

- Further analysis to understand the patterns of detection and conversion rates for cancer over time would be helpful, to unpick why detection rates through the Two Week Wait referral route are improving and how good practice by particularly high performing surgeries can be shared.

- Further investigation to understand the disparity between the lower number of new cases of cancer diagnosis, low screening coverage for breast and bowel cancer, low Two Week Wait referral rates, and the higher number of emergency admissions for cancer in the northern GP networks in Croydon (East Croydon, Mayday and Thornton Heath) would be valuable. This investigation should try to determine whether opportunities to diagnose cancer at an earlier stage are being missed along the patient pathway.

- Further analysis is required to understand the characteristics of those being diagnosed with cancer in A&E, to help understand why opportunities to diagnose cancer earlier have been missed.

**Service Improvement recommendations**

- This report has only considered service improvements for cancer prevention and screening services, and opportunities to improve early detection of cancer in GP surgeries. Work needs to be completed by the CCG to develop a series of recommendations for service improvements for other parts of the cancer pathway.

- There are a number of recommendations for improvements that should be made to the stop smoking, weight management and alcohol misuse services in Croydon, which are summarised in this document. Strengthening these services offers a vital opportunity to prevent future cases of cancer in Croydon, and will also improve the quality of life in survivors of cancer. Croydon CCG has a role to play to ensure these recommendations are implemented, working in partnership with the public health team and the Council.

- The CCG has a role in ensuring that its front-line staff groups are able to offer brief intervention (such as Making Every Contact Count) to discourage the behaviours that are risk factors for cancer and also to talk to and signpost people who think they might already be at risk/ have symptoms of cancer.

- Further, in line with this nationally led work that recognises the important contribution that the voluntary and community sector can make to helping individuals to detect their cancer early, the CCG and Council should consider how they might work in partnership with voluntary sector partners to educate the public about the warning signs of cancer, and signpost/ support those who have risk factors for cancer to the appropriate lifestyle services, or their GP.

- Croydon CCG should ensure it reviews learning from the new national programme that is testing innovative ways[2] of diagnosing cancer more quickly when evidence is made available (by 2016/17).

- Croydon CCG should review the viability of taking forward learning from the local pilot work that took place between 2010-2013 to improve earlier diagnosis of cancers (see final section of this

[2] Approaches include offering patients the option to self-refer for diagnostic tests; lowering referral thresholds for GPs; and multi-disciplinary diagnostic centres where patients can have several tests in the same place on the same day.

report) in order to inform the development of an action plan to support the cancer strategy. There is a lot of local work to build on to encourage awareness raising of the signs and symptoms of cancer. Work needs to continue locally, based on learning from the 2010-2013 work streams, to raise awareness of signs/symptoms of the most common cancers, and consider the most sustainable approaches to doing this. Social marketing techniques should be central to designing any information and awareness raising work that takes place.

- The lowest uptake for screening is among minority ethnic groups and those who have recently moved to the country[3]. These population groups will need tailored reminders and different support to ensure they are able to access screening programmes. It is recommended that GP networks identify the local areas where there are concentrations of Tamil, Asian and Polish populations to find out what the screening uptake is like among these groups, and identify what the specific population needs of these groups are that, if met, would support them to attend screening services. Information on these groups by GP network is available from the Public Health team.

- The recommendations from the June 2014 "Bowel Screening: Good Practice Guidance for General Practices in SWL" suggest the following needs to be taken forward to increase bowel screening coverage. These recommendations also apply to breast screening:

    - Regularly update practice staff about the benefits of the programme
    - Ensure that the practice list is up to date and investigate/ remove those who have not been seen in the surgery in over 3-5 years
    - Ensure telephone numbers (and addresses) of patients are up to date so that when texts are used to remind patients about screening the numbers are correct
    - When the surgery is notified of the results letter sent to their patients, these should be scanned into the electronic records and coded using a breast or bowel screening template
    - Perform monthly searches on all those who have been identified as not responding to screening, send a letter from the surgery supporting the benefits of taking part in the screening programme
    - Perform annual search/ audit on the eligible population to identify how many have been screened and the outcomes of the screening episode e.g. normal, abnormal or not completed
    - Send letters from the surgery to those reaching the minimum age thresholds from screening and inform them that they will soon be sent a letter inviting them to take part in the screening programme and offer them support and advice if needed

- There are more detailed recommendations in the document about improving uptake of bowel screening that should be reviewed and discussed at GP network meetings to agree how to disseminate across local GP practices. This review should be supported by the Health Improvement Specialists for Breast and Bowel Screening in SW London.

- It would be helpful if there is a network champion for each of Croydon's 6 networks who will be responsible for disseminating information about the screening programmes and working with local practices to ensure they are implementing the recommendations above. This champion

[3] NB it has been acknowledged by NHSE that understanding screening coverage by ethnic group would be helpful. NHSE are looking into the feasibility of obtaining this information as of Dec 2014

should try to identify a named lead within each GP practice with whom they can liaise and share good practice and learning on an ongoing basis.

- Further work is also needed to clarify the roles and responsibilities of NHS England, Public Health England, the SWL network, Health and Well-Being Boards and local CCGs in delivering improvements to the breast and bowel screening programmes. Roles and responsibilities could helpfully be mapped to ensure there is clarity about whom and how Croydon's local commissioners can hold national bodies to account. The Health and Well-Being Board might helpfully hold national bodies to account when they are failing to deliver in their roles.

- There will also be an important role for the proposed local Health Protection Forum in supporting this agenda. This forum will have responsibility for reviewing current and emerging health protection issues, including screening, and agreeing roles and responsibilities of each participating organisation to address these issues. The Director of Public Health will report to the Health and Well-Being Board on the progress of this forum. This forum could be a helpful mechanism through which to assess how well the current arrangements for breast and bowel screening are working, and at which suggestions for improvements can be made.

**SECTION 1: CANCER IN CROYDON – AN OVERVIEW**

**Croydon's population**

The Office of National Statistics (ONS) suggests there are approximately 372,800 people resident in Croydon (mid-2013). This is projected to increase to 400,000 by 2021, with the greatest increases seen in the age groups 5-14, 30-39 and 55+ years.

In the 2011 census, 47.3% of the population described themselves as White: English / Welsh / Scottish / Northern Irish / British. This compares to 79.8% for the whole of England. The level of diversity is increasing. Just under 45% come from Black, Asian and Minority Ethnic (BAME) communities; a significant increase from the 2001 census. Distribution of BAME communities varies in Croydon, with 83% living in West Thornton ward in the North, compared to 20% in Coulsdon East ward in the South. There are approximately 2,100 emigrants and 3,500 immigrants per year. The most common areas that immigrants arrive from are: South Asia, Eastern Europe and Central and Western Africa. It is anticipated that by 2026 the majority of residents of Croydon will be from BME background.

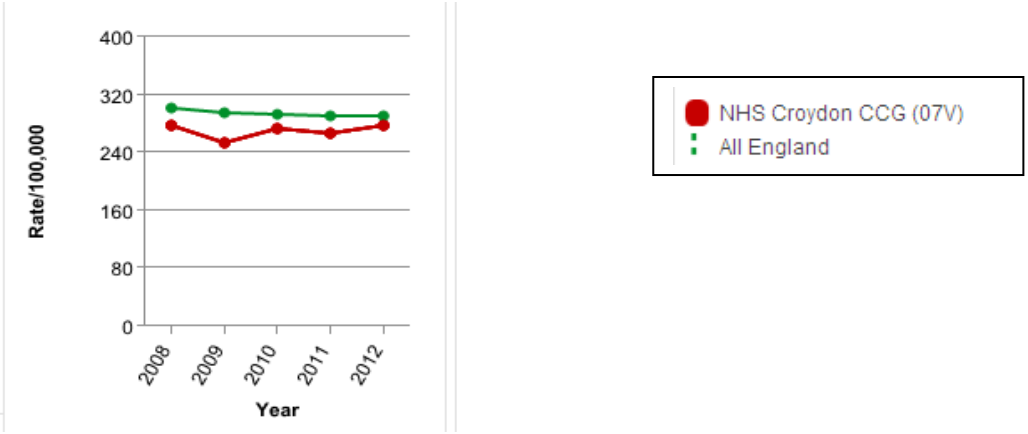
The pattern of socio-economic deprivation in Croydon is complex, with areas of affluence sitting alongside areas of significant disadvantage. Croydon is the 19th (out of 32) most deprived boroughs in London. 63,482 residents (17.2%) fall within the 20% most deprived areas of the country and 16,000 fall within the 10% most deprived areas. Within Croydon, the 5 wards which rank highest on the Index of Multiple Deprivation (IMD) are Fieldway, New Addington, Broad Green, Selhurst and South Norwood.

Cancer is the second biggest killer in Croydon (responsible for 26% of deaths locally), after circulatory disease (responsible for 33% deaths). Preventing and treating cancer effectively is an essential part of Croydon CCG's strategy for keeping Croydon's populations healthy and safe.

**Profile of Diagnosed Cancer in Croydon**

In 2013, cancer[4] was the leading cause of death in England (responsible for 29% of all registered deaths), followed by circulatory diseases such as stroke and heart disease (28% registered deaths)[5]. Cancer is the leading cause of death for men in England and the second leading cause of death for females. In London and in Croydon, cancer is the second leading cause of death. Croydon and London have slightly lower mortality rates for cancer than England. Deaths from cancers in Croydon make up 15.5% of excess deaths in men and 19.6% of excess deaths in women when comparing mortality between the most and least deprived parts of Croydon[6].

Overall, cancer mortality is decreasing in the UK, as more and more people survive the disease (owing to better detection and treatment of the disease). This decrease has been slowing in the last decade, and between 2008 and 2012, the mortality rate for all cancers in England dropped by 3.7%. The picture in Croydon is slightly less clear over time, and the overall mortality rate for cancer in Croydon has decreased by only 0.07% between 2008 and 2012, though the mortality rate in Croydon did not exceed that of the national average over the past 5 years up to 2012.




**Mortality rate, all cancers, rate per 100,000 population**

Despite improvements in mortality, cancer is still the leading cause of premature (under 75) mortality in England, London and Croydon, despite improvements to overall cancer mortality. 42% of England's premature deaths are from cancer.

However, as mentioned above, survival rates from cancer are improving, and one year survival from cancer has been steadily improving for the past 15 years. Croydon's overall one-year survival index[7] for all cancers is currently 68%, the same as the England average of 68% (2011 data)[8]. In 1996, the one year survival index from all cancers in Croydon was 60.6%, and for England was 59.2%.

[4] Definition includes lung cancer, breast cancer, prostate cancer, colorectal cancer, and cancers of the stomach and oesophagus

[5] http://www.ons.gov.uk/ons/rel/vsob1/death-reg-sum-tables/2013/info-deaths-2013.html

[6] http://www.croydon.gov.uk/contents/documents/meetings/Health_Wellbeing/1160006/2012-10-12/hwbb20121031strategy.pdf

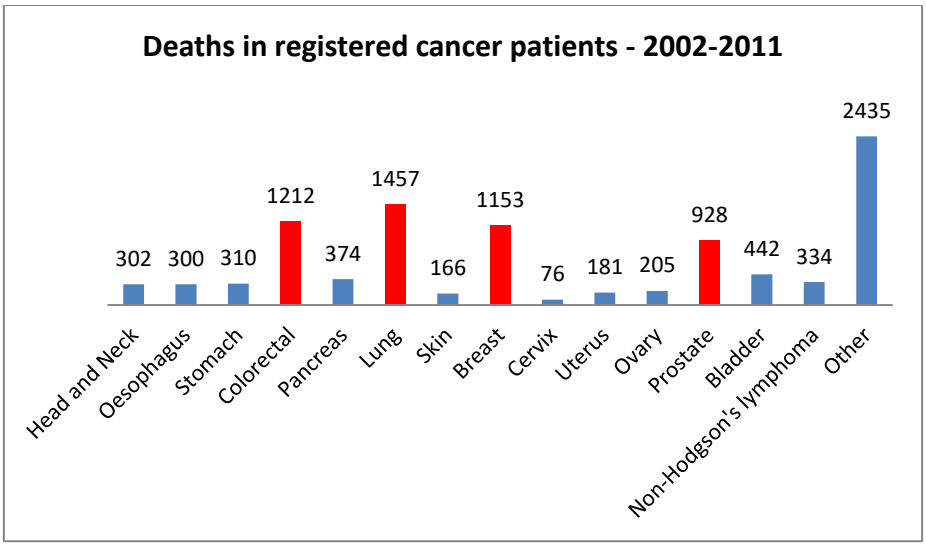
[7] An estimate of a person's survival from the cancer of interest one year after cancer diagnosis, after adjustment for other causes of death

[8] http://lci.cancertoolkit.co.uk/HeadLines

The number of new cases of cancer being diagnosed in Croydon dropped by a significant number in 2012 compared to 2011. However, the number of cancers newly identified as an emergency presentation in Croydon is not decreasing[9].

A number of challenges remain, owing to a complex interplay of demographic, behavioural and health service factors. This report outlines the key messages for Croydon to help inform the development of a targeted cancer strategy that focuses ample attention on prevention and early detection of cancers.

This cancer strategy focuses specifically on 4 types of cancer- breast, colorectal, lung and prostate cancers. Breast, colorectal, lung and prostate cancers account for 53% of all newly diagnosed cancers in England[10], and together account for almost half (46%) of all cancer deaths[11]. In Croydon, deaths in registered cancer patients are highest for these 4 cancers (see below).




Furthermore, there are some worrying trends when comparing mortality rates over time for these cancers in Croydon to the rates for England and London as a whole. For example, whilst the mortality rates for lower GI (colorectal) and urology (prostate) cancers have decreased in Croydon from 2008 to 2012; the rates for lung cancer and breast cancer increased over that period. Whilst the longer-term trend shows that mortality from breast and lung cancer has dropped significantly since 2001, and that during the 201-2007 period there were fluctuations in the numbers dying each year from each type of cancer, it suggests that there is still work to be done to ensure that the downward trends do indeed continue. Indeed, this needs assessment also shows that there are improvements needed to the patient pathways for each of the 4 cancers in order to ensure the best outcomes from these cancers for Croydon's residents.

**Who is at risk of developing cancer in Croydon?**

Research suggests that up to half of all cancers in the UK could be avoided if people made changes to their lifestyle, such as stopping smoking, moderating alcohol intake, maintaining a healthy bodyweight and avoiding excessive sun exposure. Tackling cancer must begin with a focus on preventing and reducing the risks of developing the disease- for the 4 priority cancers referred to in

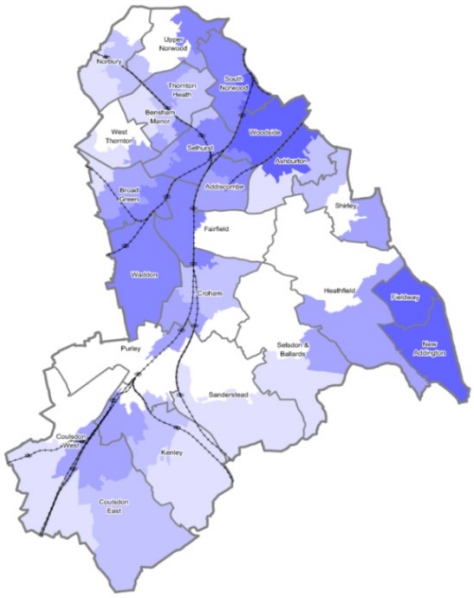
[9] https://www.cancertoolkit.co.uk/Charts/Incidence/ByCCG
[10] Cancer and equality groups: key metrics – 2014 report
[11] http://www.cancerresearchuk.org/cancer-info/cancerstats/mortality/cancerdeaths/uk-cancer-mortality-statistics-for-common-cancers

this needs assessment, the major risk factors for the development of each of them are outlined in turn below.

**Risk Factor – Smoking**

Smoking is the main cause of preventable death and illness in Croydon. Nationally tobacco kills over 80,000 people every year; more people each year than obesity, alcohol, road accidents and illegal drug use put together. Almost 1 in 5 adult deaths in the UK are attributable to smoking.[12] The rate of smoking related deaths was 270 per 100,000 in 2012, better than the average for England. This represents 398 deaths per year.

For every death caused by smoking, approximately 20 smokers are suffering from a smoking related disease[13],[14]. Smoking is responsible for 5 % of all hospital admissions nationally[15] amongst adults 35yrs +. Amongst these, heart disease and cancers are the commonest causes. Smoking is responsible for **29% of cancer deaths[16] overall but over 80% of deaths from lung and trachea.** Smoking is also responsible for **87% of COPD cases** – 36% of deaths from respiratory disease and 86% of COPD deaths. Half of all smokers will be killed by a smoking related illness and on average lose 16 years of life[17].



Approximately one in five adults in Croydon smokes. This varies across the borough- prevalence is highest in the wards of Addiscombe & Broad Green (East Croydon locality) Ashburton (Woodside & Shirley locality), Bensham Manor (Mayday locality), and Coulsdon East (Purley locality).

The prevalence of smoking is higher in people from routine and manual occupational groups, 29.4% of people in these groups currently smoke. It is also higher among people with mental health problems. c25% of men and 16% of women smoke. Some ethnic groups are more likely to smoke than others.

**GP recorded smoking prevalence, ages 16 and over (age-sex standardised), map of Croydon middle super output areas, as at 31 Mar 2012**

[12] Statistics on smoking: England, 2012 The NHS Information Centre for Health and Social Care, 2012
[13] U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010
[14] Cigarette smoking-attributable morbidity – United States, 2000. MMWR Weekly Report. 5 Sep. 2003
[15] Statistics on smoking: England, 2012 The NHS Information Centre for Health and Social Care, 2012
[16] Healthy lives healthy people: A tobacco Control Plan for England
[17] Peto et al 96 British Med Bulletin

Generally very few adults start smoking. Two thirds of smokers say they began before they were 18, the legal age for buying cigarettes. 9 out of 10 say they started before the age of 19. By the age of 20, 80% of smokers say they regret they ever started[18].

**Risk Factor- Healthy Weight & Physical Activity**

The evidence linking **poor diet** and **obesity** to cancer has become much stronger. Recent research has found an association between fruit and vegetable consumption and all-cause, cancer and cardiovascular mortality in England, adjusting for age, sex, social class, education, BMI, alcohol consumption and physical activity[19]. It is estimated that, in the UK, current levels of overweight and obesity could lead to around 19,000 cases of cancer each year. In Croydon, 22.3% (788) of children are classified as obese, worse than the average for England. 24.3% of Croydon's adults are classified as obese. Croydon's geographical maps of obesity show that higher rates of child and adult obesity can be seen in the less affluent areas of the borough. The prevalence of obesity is also highest amongst black ethnic groups. Further, only 27.8% of people eat the recommended 5+ portions of fruit and vegetables each day.

An analysis combining the results of 31 studies on **physical activity** and breast cancer found that the women who did the most activity had a 12% lower risk of developing breast cancer compared with the least active women. The analysis also showed that the more activity a woman does, the more she can reduce her risk of breast cancer. For example, for every 2 hours a week a woman spends doing moderate to vigorous activity, the risk of breast cancer falls by 5%. Research has also shown that being physically active after the menopause can reduce breast cancer risk by 10%, no matter what a woman's fitness, weight or waist circumference. 56.8% of Croydon's adults are physically active, compared to the national average of 56%. However, in context, Croydon ranks in the bottom 10% of local authorities for physical activity (2011/12 data).

**Risk Factor - Alcohol Misuse**

Excessive alcohol consumption is strongly linked to an increased risk of several cancers. 12.8% of the population drink alcohol at a level of increasing risk (hazardous) to their health, a further 5.0% drink at an even higher risk (harmful). These compare well to the regional averages (15.8%, 7.6% respectively). There have been approximately 1,726 hospital stays for alcohol related harm. GP data shows alcohol dependence is highest in Waddon & Addiscombe (East Croydon locality), Woodside & Ashburton (Woodside & Shirley locality) and Bensham Manor (Mayday locality).

Approximately 20% of men in every age group in Croydon up until the age of 65 are drinking at a harmful or high risk. About a third of people drinking at increasing and high risk levels are ages over 50. Rates of both overall alcohol misuse and dependence are 2-3 times higher in Croydon's White British registered population than for other ethnic groups[20]. Rates of GP diagnosed alcohol dependence are over 2.5 times higher in people living in the most deprived quintile compared to those living in the least deprived quintile.

**Population differences – national evidence base**

There are a number of considerations to make when deciding how to try and minimise the numbers of people living with and dying from cancer. There are, for example, a number of population factors that are worth bearing in mind. In short, these are:

[18] BMJ. 2002 Mar 9;324(7337):608. Effectiveness of smoking cessation initiatives. Efforts must take into account smokers' disillusionment with smoking and their delusions about stopping.
Jarvis MJ, McIntyre D, Bates C, Foulds J.

[19] http://jech.bmj.com/content/early/2014/03/03/jech-2013-203500

[20] Croydon General Practice data, as at March 2012

**Ethnicity** (based on recent analysis by Cancer Research[21] –incidence and survival rates from the 4 cancers for Asian, Black and Chinese/ Mixed ethnic groups in comparison to White populations):

| Population Group | Incidence | Survival |
|---|---|---|
| **Asian** | At significantly lower risk of developing the 4 priority cancers than White populations. | • Asian women aged 15-64 years had significantly reduced survival from breast cancer than women from the White ethnic group at 3 years but not at one year; nor for those aged 65-99 years or for all ages.<br>• Significantly improved outcomes for lung cancer at both one and three years than Whites for all ages<br>• No significant differences between the survival of the Asians and Whites for colorectal cancer. |
| **Black** | Black men significantly more likely to have a diagnosis of prostate cancer than White males. | • Black women aged 15-64 years also had significantly poorer survival from breast cancer at both one and three years than White women. There were no significant differences for those aged 65-99 years nor for all ages.<br>• Black males with lung cancer aged over 65-99 had much better survival than White males at both one and three years (13% compared with 8% at 3 years) |
| **Chinese/ Mixed** | Chinese & Mixed ethnic groups tended to have significantly lower incidence rates than Whites for each of the 4 cancers. | • Numbers too low for comparative analysis |

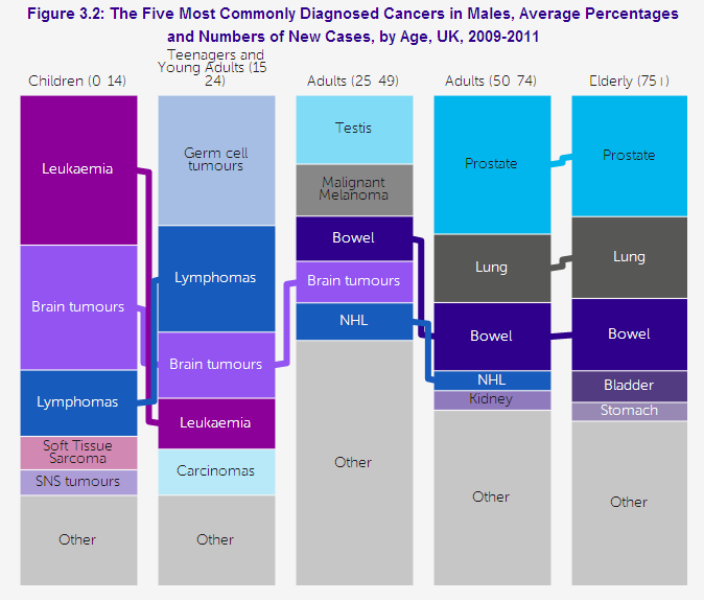
**Gender:**

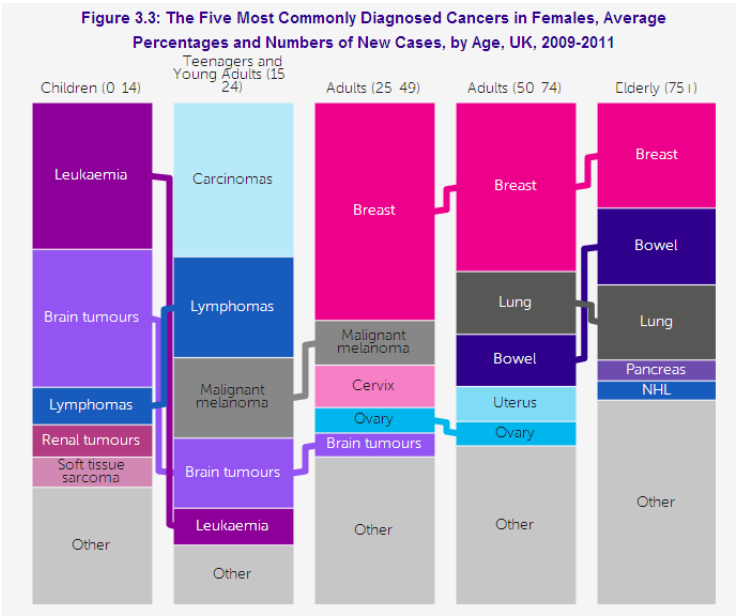
- In general men are at significantly greater risk of all of the common cancers that occur in both sexes than women, with the exception of breast cancer[22]. Based on 2010 data, men are 14% more likely to develop cancer, and are 37% more likely to die from cancer, than women (owing to differences in life expectancy between sexes, and the fact that men are more likely to develop fatal cancers than women).
- Prostate cancer is the most common cancer found in men, but most men die from lung cancer.
- In men, lung, prostate and bowel cancers account for c53% of all male cancers and c47% all cancer deaths in men.

**Age:**

- Cancer is primarily a disease of older people, with incidence rates increasing with age for most cancers. More than a third of cancers in the UK (in 2009-2011) were diagnosed in people aged 75 and over[23]
- The five most common cancers in males and females vary considerably by age group[24]:

[21] http://publications.cancerresearchuk.org/downloads/Product/CS_REPORT_INCSURV_ETHNIC.pdf
[22] http://publications.cancerresearchuk.org/downloads/Product/CS_REPORT_EXCESSBURDEN.pdf
[23] http://www.cancerresearchuk.org/cancer-info/cancerstats/incidence/age/
[24] http://www.cancerresearchuk.org/cancer-info/cancerstats/incidence/age/




- Men age 65 and over are significantly more likely to die from all common cancers (inc breast and sex specific cancers) than women in that age group; and whilst men aged 15-64 are still more likely to die from all common cancers than women, the difference is far less marked[25].
- It has been suggested that younger males (under 65 years old) may have higher overall cancer mortality than women because of their excess rate of lung cancer specifically. However, when mortality ratios are calculated excluding breast and sex-specific cancers, men aged 15–64 have an overall mortality rate that is 58% higher than in women for cancers which may affect the sexes equally. Thus, the less marked difference between sexes in younger years for all common cancers is likely to result from the high number of cancer deaths that occur in younger women for breast cancer and genital organs cancers (36% of cancer deaths in those aged 15–64; and 49% in those aged 35–44). In contrast, there are relatively few deaths from a sex-specific cause for males in younger age groups (5% deaths in ages 15–64 are for male-specific cancers).

[25] http://publications.cancerresearchuk.org/downloads/Product/CS_REPORT_EXCESSBURDEN.pdf

**Deprivation:**

- Differences in overall cancer incidence and mortality by deprivation have not improved over time, with some individual sites even showing a widening of the deprivation gap. The enduring impact of socio-economic inequality is substantial: for all cancers combined, excluding non-melanoma skin cancer, if all socio-economic groups had the rates of the least deprived, around 19,200 deaths from cancer could be prevented each year in England (based on figures from 2007-2011)[26].
- The majority of cancers show increasing incidence and mortality with increasing socio-economic deprivation, although three common cancers – breast, prostate and malignant melanoma – show the reverse trend for cancer incidence
- In the most recent period, 2006-2010, the incidence of female breast cancer was highest in the least deprived quintile. However, the more deprived had a statistically significantly higher mortality, with an estimated 350 yearly excess deaths in the period 2007-2011.
- Lung cancer had by far the largest number of excess cases (11,700 persons per year) and deaths (9,900 persons per year), in the most recent periods.
- The deprivation gap was significantly different for incidence and mortality of colorectal cancer (and 6 other cancers) between males and females- it was larger in males.

**Geographical differences in risk factors for cancer across Croydon**

Based on the information above, the following snapshots of risk factors by GP network help show where there are clusters of risk within the borough:

| | |
|---|---|
| **Mayday**<br>• 77% Black, Asian and Minority Ethnic groups<br>• High prevalence of obesity<br>• High numbers in Stop Smoking services | **Thornton Heath**<br>• 68% Black, Asian and Minority Ethnic groups<br>• Deprived area with high unemployment<br>• High prevalence of smoking and severe mental illness |
| **East Croydon**<br>• 57% Black, Asian and Minority Ethnic groups<br>• Deprived area with high crime rate<br>• High prevalence of adult obesity, smoking, severe mental illness, and drug and alcohol use (binge drinking) | **Woodside / Shirley**<br>• Demographics similar to Croydon average<br>• 51% Black, Asian and Minority Ethnic groups<br>• High prevalence of smoking, adult obesity, and long-term conditions<br>• High diagnosis rates for adult obesity |
| **Purley**<br>• High proportion aged over 55<br>• 31% Black, Asian and Minority Ethnic groups<br>• Affluent area<br>• High prevalence of long-term conditions including cancer | **New Addington / Selsdon**<br>• 29% Black, Asian and Minority Ethnic groups<br>• High prevalence of smoking, adult obesity, circulatory diseases, cancer, COPD<br>• Good support for stopping smoking<br>• High levels of smoking during pregnancy |

## SECTION 2: THE 4 PRIORITY CANCERS IN MORE DEPTH (BREAST, BOWEL, LUNG AND COLORECTAL)

**Executive Summary Picture**

[26] http://www.ncin.org.uk/about_ncin/cancer_by_deprivation_in_england

This section provides more information on each pf the 4 priority cancers considered in this strategy- breast, colorectal, lung and prostate. A summary of information in this needs assessment on each of the priority cancers is set out below:

| | |
|---|---|
| **Breast cancer** is the most common cancer in women in the UK. Breast cancer affects women in Croydon from age 35 and upwards, with most cases presenting in women in their mid 60s. The *National screening* programme calls women aged 47 to 73 for screening every three years. Uptake in Croydon, whilst improving, has always been below the 70% target and it tends to be women in the most advantaged areas that attend their appointment. Of those women who are screened for breast cancer in Croydon, the % of women whose breast cancer is detected at the screening stage of the pathway is in line with the England average (28%) and higher than the London average of 25%. However, the percentage of breast cancers detected at an early stage (Stage 1 or 2) is 53.6% compared to the national average of 69.8%. Emergency presentations[27] for breast cancer are in line with the national and London averages, and emergency admissions for breast cancer have been decreasing steadily over time. 1 year survival from breast cancer following diagnosis is slightly lower in Croydon than in London and England. | **Bowel cancer** largely affects people age 60 and over. It is much more commonly diagnosed in men than women. In Croydon, cases have been found in men from the age of 40 and women from the age of 50.[28] It is also more commonly diagnosed in White British/ White other than Asian or Black populations. The *National bowel cancer screening* programme was introduced in Croydon in July 2007. Bowel screening coverage is currently 51.2% in Croydon, which is slightly higher than the London average of 49.5%, and lower than the England average of 58.8%. The percentage of bowel cancers detected at an early stage (Stage 1 or 2) is 29.7% compared to 37.2% (national average). The number of emergency presentations for bowel cancer is higher in Croydon than London or England. Whilst emergency admissions for bowel screening have been decreasing, there were a comparatively high number of emergency admissions for colorectal cancers for both men and women aged u60 years old, compared to the incidence rates in those age groups for both sexes. Mortality from bowel cancer in Croydon is lower than in London and England; and a slightly higher percentage of people in Croydon survive bowel cancer for 1 year or more than in London or England. The socio-economic gradient in survival is getting wider for women, which might reflect differential access to bowel screening. |
| **Prostate cancer** tends to affect men from age 50 and up and data for Croydon shows visits to GPs for prostate cancer begin in the mid-50s.[29] Men from Black ethnic groups are the most affected nationally and locally. The incidence (new cases) of prostate cancer is lower in Croydon compared to England, having been higher than the London average less than 5 years ago. There is no screening programme for prostate cancer, but rather a risk management programme that aims to inform men who are concerned about prostate cancer of the advantages and disadvantages of a PSA test and treatment for prostate cancer. The number of emergency presentations for prostate cancer is higher than the national and London averages. Data suggests hospital admissions for prostate cancer are rising. Admissions are higher in those from less deprived quintiles, and over time admission rates in the more deprived quintiles have decreased more quickly than in the least deprived quintiles. Mortality from prostate cancer in Croydon is | **Lung cancer** is mostly caused by smoking. 1 in 5 people in Croydon smoke, though the number of smokers is going down, and numbers achieving the 4 week smoking quit target is increasing. Lung cancer continues to affect more men than women in Croydon (in line with the national picture), though the gap is decreasing (owing to an increase in the number of women who smoke). It is also most common in White British and White Irish population groups (these population groups also have high smoking rates). Lung cancer is most common among the most deprived communities in Croydon, with the lowest rates seen in the most affluent groups. The percentage of lung cancers detected at an early stage (Stage 1 or 2) is 12% compared to 19.6% (national average). The number of emergency presentations for lung cancer is higher than the national and London averages. Mortality rates from lung cancer in Croydon remain nearly double than for each of the other 3 priority cancers considered in this strategy. Mortality rates are also beginning to increase in the under75 population; and the socio-economic gradient in survival is getting wider for women over time. However, more |

[27] An emergency route via A&E, emergency GP referral, emergency transfer, emergency consultant outpatient referral, emergency admission or attendance
[28] Data from Croydon general practices, March 2010
[29] Data from Croydon general practices, 30 September 2009

| | |
|---|---|
| also slightly lower than in London and England. | people in Croydon survive lung cancer for 1 year following diagnosis, than in London or England. |

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**Comparative incidence, mortality, survival, and trends for the 4 priority cancers in Croydon**

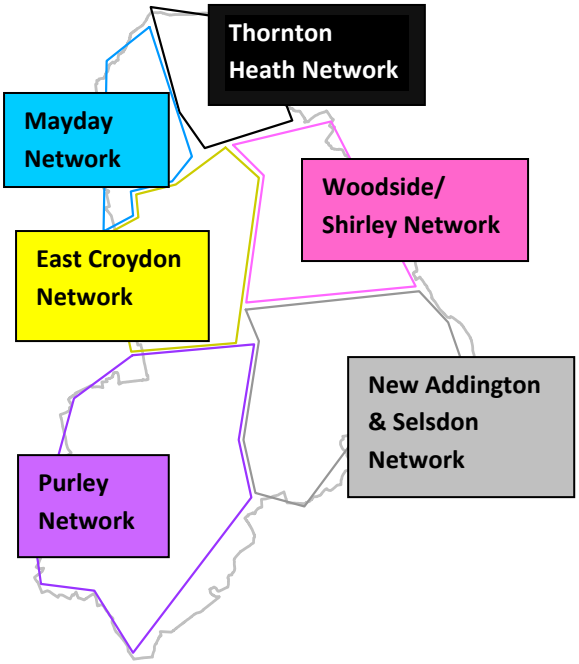
| | Breast | Prostate (urology) | Colorectal (lower GI/ bowel) | Lung |
|---|---|---|---|---|
| **WHO GETS CANCER IN CROYDON?** | | | | |
| **No of new cases of cancer per year (2012)** | *192* | *278* | *189* | *172* |
| **Incidence (ASR) per 100, 000 population (2012)** | *120.3* | *116.2* | *76.3* | *72.8* |
| **Is incidence significantly higher for Croydon than London or England averages?** | No- Lower than England (164.1) | No- Lower than England (130.3) | No- Similar to England (79.9) | No- Lower than England (84.8) |
| **Socioeconomic gradient in incidence** | No clear gradient across quintiles | No clear gradient across quintiles | Slightly more common in least deprived than most deprived quintile | Clear gradient; Much more common in most deprived than least deprived quintile |
| **Trend in incidence (2008-2012)** | No clear changing trend over time – relatively constant | No clear changing trend over time – relatively constant | No clear changing trend over time – relatively constant | No clear changing trend over time – relatively constant |
| **Diagnosis by ethnicity (2012)** | More commonly diagnosed in White British/ White other than Asian or Black populations | Highest diagnosis rate in Black population, followed by White British/ White other, and Mixed populations. Lowest in Asian and other ethnic groups | More commonly diagnosed in White British/ White other than Asian or Black populations | Most common in White British and White Irish population groups (these population groups also have high smoking rates) |
| **Diagnosis by age (2007- 2012)** | Diagnosis rates significantly higher in the over 50s | No diagnosis in the under 50s from 2007-12 | Significantly higher diagnosis in the over 75s | Not available. |
| **Diagnosis by gender (non-gender specific cancers) (2012)** | N/A | N/A | More common in men than women | More common in men than women |
| **WHO DIES FROM CANCER IN CROYDON?** | | | | |
| **No of deaths due to cancer in 2012** | 54 | 77 | 73 | 160 |
| **Mortality (ASR) per 100, 000 population (2012)** | 35.3 | 36.6 | 29.6 | 67 |
| **Is mortality significantly higher for Croydon than the London or England averages?** | No- slightly higher than London (34.8); slightly lower than England (36.4) | No- slightly lower than London (38.1) and lower than England (43) | No- lower than London (31.9) and England (36) | No- slightly higher than London (66.1) and similar to England (67) |
| **Socio-economic gradient in mortality** *(NB bowel, prostate and lung cancer use 2002-7 data for the analysis)* | No stark differences, but slightly lower mortality rates recorded in more deprived quintiles (2007-11 data) | No statistically significant differences between deprivation quintiles in terms of mortality (2002-7 data) | Although the highest rate of death is in the most deprived quintile, the mortality rates by IMD quintile do not reveal any significant inequalities (2002-7 data) | Mortality rate is 2 times greater in the most deprived quintile compared to the least deprived quintile (2002-7 data) |

| | Breast | Prostate (urology) | Colorectal (lower GI/ bowel) | Lung |
|---|---|---|---|---|
| **Trend in mortality (2008-2012)** | Less clear pattern in u75s, but higher in 2012 than in 2008.<br><br>Decreasing in the over 75s since 2010 | Less clear pattern in u75s, but lower in 2012 than in 2008.<br><br>Decreasing in the over 75s since 2010 | Relatively stable rate in the u75s<br><br>Decreasing in the over 75s since 2010 | Slowly increasing in the u75s.<br><br>Increasing in the over 75s since 2010. |
| **WHO SURVIVES FROM CANCER IN CROYDON?[30]** | | | | |
| **1 year relative survival estimate (2008-10)** | 96.3% | 96% | 78.3% | 38.4% |
| **Is one year relative survival estimate significantly higher for Croydon than the London or England averages? (2008-10)** | No<br><br>London: 96.9%<br>England: 97% | No<br><br>London- 96.2%<br>England- 96% | Slightly<br><br>London- 76.9%<br>England- 77% | Yes<br><br>London- 35.3%<br>England- 33% |
| **WHO SURVIVES FROM CANCER IN ENGLAND?** | | | | |
| **Socio-economic gradient in one-year survival –** National figures (2006 data) | Survival in most affluent (%): 97.8<br><br>Deprivation gap (%): -2.6 | Survival in most affluent (%): 97<br><br>Deprivation gap (%): -2.9 | Survival in most affluent (%): m= 79.6/ f= 78.8<br><br>Deprivation gap (%): m= -7.3/ f= -10 (The gradient for females has worsened since 1996) | Survival in most affluent (%): m=27.4/ f=30.9<br><br>Deprivation gap (%): m= -1.6/ f= -3.1 (The gradient for females has worsened since 1996) |
| **5 year survival (%) (no DPs) (2010-11)[31]** - No data available at the local level. England data | 87% | 85% | 59% | 10% |
| **10 year survival (%) (2010-11) (no DPs)** - No data available at the local level. England data | 78% | 84% | 57% | 5% |
| **Longer-term survival by sex:**<br>**5 year survival (2005-9)**<br>**10 year survival (2010-11)** | N/A | N/A | <br>Men: 58%/ Women: 58%<br>Men: 56%/ Women: 57% | <br>Men: 8%/ Women: 12%<br>Men: 4%/ Women: 7% |

[30] Survival has a number of determinants of which age and stage at diagnosis are two of the most important. Age is considered in the table above. Stage of diagnosis is considered in the next section of this report.

[31] http://publications.cancerresearchuk.org/downloads/Product/CS_REPORT_EXCESSBURDEN.pdf

Data analysis in the section below, broken down by the 6 GP networks in Croydon, is presented in coloured maps. For reference, the 6 networks and the significance of colours are as follows:




In the maps below, the circles represent GP practices, and the coloured boundaries represent each network.

Each GP practice has been ranked against others in the borough to give a comparative picture of performance. If the percentile rank is less than 50, the GP practice is shown in **GREEN**. This means that performance is better than average compared to other practices.

If the percentile rank is greater than 50, the practice is marked in **YELLOW** and the practice is below average for the indicator.

If the percentile rank is above 80, the practice is shown in **RED** and the practice is in the bottom 20% of practices for the indicator.

## THE PATIENT PATHWAY FOR CANCER – WHAT DOES THE DATA TELL US?

### Uptake of Screening Programmes

Screening offers a significant opportunity to detect and treat breast and bowel cancer early. **Breast screening** coverage in Croydon over time has remained below the national average but since 2007/8 has been approximately in line with the national target of 70% for minimum screening coverage[32].

| | Eligible population | No of women screened | Coverage (less than 3 years since last test:%) |
|---|---|---|---|
| **England** | 5,568,097 | 4,249,943 | 76.3 |
| **London** | 671,244 | 460,214 | 68.6 |
| **Croydon** | 33,617 | 23,285 | 69.3 |

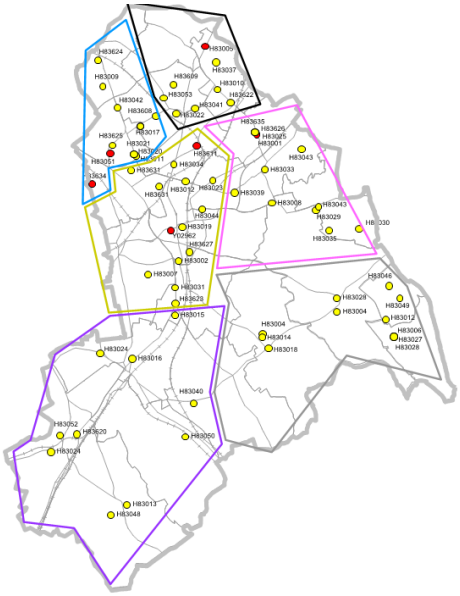
NHS Breast Screening Programme: coverage of women aged 53-70 by Upper Tier Local Authority, at 31 March 2013

Across the 6 South West London CCGs, Croydon, Kingston, Merton and Richmond all have similar coverage rates. Sutton has a significantly higher coverage rate (exceeding the minimum standard for coverage but not meeting the national target of 80%), and Wandsworth has a significantly lower rate.

There are local variations in breast screening coverage in Croydon. The Mayday, Thornton Health and East Croydon GP Networks have coverage rates of 60% or less, significantly below the national minimum coverage standard of 70% (and even further below the target coverage rate of 80%). The

[32] https://www.cancertoolkit.co.uk/Pages/Report.aspx?report=34

highest screening coverage is in the Purley Network; however the coverage rate is still only 68.2%, significantly lower than national target of 80%.



**Source: April 2013, General practice profiles for cancer, NCIN**

**Interpreting the data:**

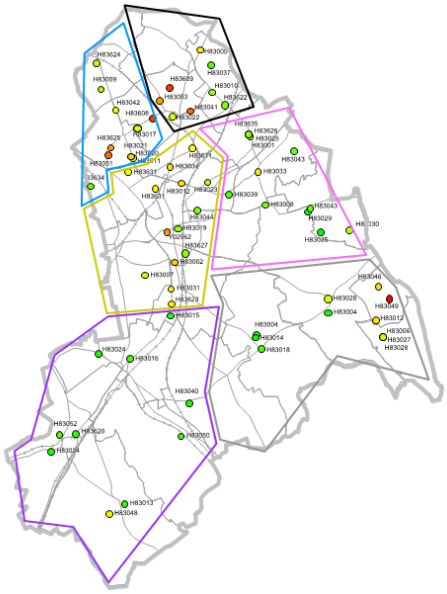
| | |
|---|---|
| G | Meets the target |
| A | Below the target |
| R | Well below the target |

Those performing worst against the screening target are in the Borth of the Borough.

Of those women who are screened for breast cancer in Croydon, the % of women whose breast cancer is detected at the screening stage of the pathway is in line with the England average (28%) and higher than the London average of 25%.

**Bowel screening** coverage in Croydon is 51.2%, slightly higher than the London average of 49.5%, and lower than the England average of 58.8%. Roll out of the original NHS Bowel Cancer Screening Programme using faecal occult blood (FOB) home testing kits began in 2006, and full roll-out (all screening centres open and inviting the original target group of men and women aged 60-69) across England was completed in January 2010. The programme is one of the first national bowel cancer screening programmes in the world, and the first cancer screening programme in England to invite men as well as women. The national minimum standard for cost effectiveness of the programme is 60%.

There are a number of similar local variations in bowel screening as with breast screening coverage in Croydon. The Mayday, Thornton Health and East Croydon GP Networks have lowest coverage rates for breast bowel and breast cancer screening coverage. The highest bowel screening coverage, as for breast, is in the Purley Network, which has coverage in line with the national average.



**Source: April 2013, General practice profiles for cancer, NCIN**

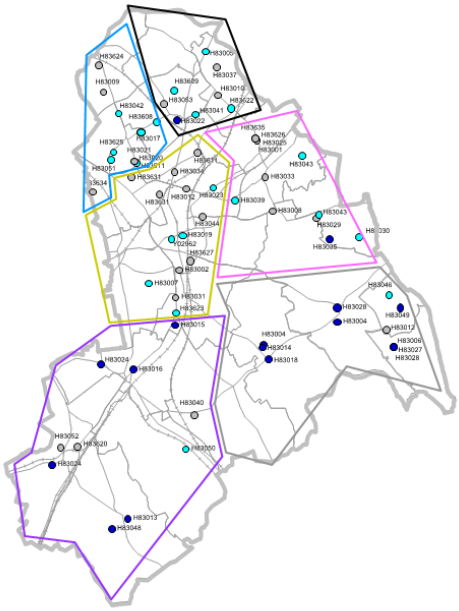
**Interpreting the data:**

| | |
|---|---|
| G | Meets the target |
| A | Below the target |
| R | Well below the target |

The clustering of poorer performance appears in the North and the Borough and New Addington ward.

**Total TWW (urgent) referrals (rate per 1000), 2012/13 data – ALL CANCERS**

Those patients urgently referred with suspected cancer should experience a maximum waiting time of two weeks to see a specialist, supporting early diagnosis of cancer. This maximum waiting time requirement was introduced in Quarter 4 2009/10, when 92% of patients (nationally) were seen within 2 weeks of referral. The operational standard for this measure is 93%. 96.1% of patients in Croydon (PCT) see a specialist within two weeks. This is similar to the English average (95.7%).



| | |
|---|---|
| | Higher than Croydon average |
| | Similar to Croydon average |
| | Lower than Croydon average |

The average TWW referral rate per 1000 Croydon population is 18.3. This is higher than London (17 per 1000) but lower than England (21.7 per 1000). Across Croydon, there are variations by network- Mayday has the lowest TWW referrals (13.7 per 1000) followed by East Croydon (16 per 1000) whilst North Addington and Selsdon has the highest rate (23.2 per1000). However, within this network, Selsdon practices have a TWW referral rate of 28 per 1000, whilst New Addington has a rate of 16.8 per 1000.

In Croydon, the most up to date data from Q1 2014/15 shows that 97.9% patients with suspected breast cancer are referred within 2 weeks[33]. There has been marginal variation from this figure since Q1 2013/14. Within Croydon, the lowest TWW referral rate for suspected breast Cancer is

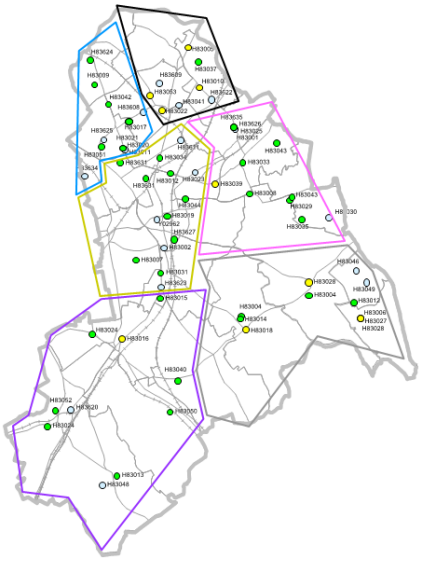
[33] https://www.cancertoolkit.co.uk/Charts/CancerReferrals/TimeTrendCRByCCG

concentrated in Mayday network (followed by the East Croydon network), whilst the highest TWW referral rate is found in the Purley and New Addington and Selsdon networks (2012/13 data).

Two week referral rates for suspected colorectal cancer have dropped slightly (from 95.2% Q1 3013/14 – 92.5% Q1 2014/15); the lowest TWW referral rates in Croydon are seen in the East Croydon network (followed by the Thornton Heath network), whilst the highest are seen in New Addington and Selsdon network, and the Purley network (2012/13 data).

For suspected lung cancer, two week referral rates have increased significantly over the same time period (from 87.5% to 96.2%); and for suspected prostate cancer have increased slightly (from 94.2% in Q1 2013/14 – 96.5% in Q1 2014/15).

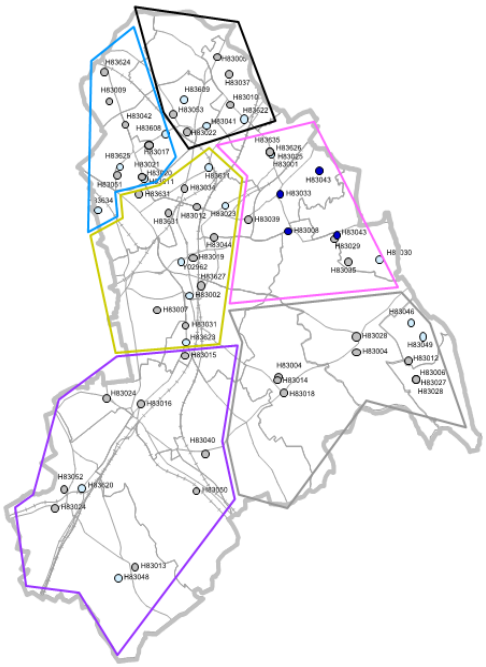
**Detection rate 2012/13 – ALL CANCERS**



The percentage of new cancer cases treated that were referred through the TWW route is higher in Croydon than in London and England, and 5 out of the 6 networks perform above the national target rate of 43.9%. The only network that does not perform above the target is Thornton Heath, where the detection rate through the TWW route is only 41.0%. The networks in both Woodside and Shirley and East Croydon have detection rates of c54% (highest in the Borough). The picture has improved since 2010.

**Conversion rate 2012/13 – ALL CANCERS**

The average conversion rate from suspected cancer (TWW urgent referral from GP) to cancer diagnosis in Croydon is 9.1%, which is higher than the London average but lower than the England average. There is significant variation between the networks in Croydon- the conversion rate in the Thornton Heath network is 6.7% whilst in the Woodside and Shirley network is 10.5%.



**Comment on early diagnosis**

There is evidence to show that the stage at which an individual is diagnosed with cancer is strongly associated with outcomes. Those who are diagnosed in later stages are less likely to have good outcomes. In Croydon, the % of individuals who are diagnosed at stage 1 and 2 of disease progression for all cancers is 31.6%. Nationally, 41.6% of cancers are diagnosed at stage 1 and 2, and in London the average is 36.1%[34]. This comparatively worse picture raises cause for concern.

However, Croydon is not an outlier for all cancers in comparison to the other 5 South West London CCGs, suggesting sub-regional variation in delivery of an effective cancer pathway. The average across the 6 South West London Boroughs of Kingston, Richmond, Wandsworth, Croydon, Merton and Sutton is 30.6%, and in fact the range among these 6 CCGs is 15.2% (with the lowest detection in stages 1 and 2 at 21.4% in Kingston)[35].

Locally, the % of 3 of the priority cancers detected at an early stage (stage 1 and 2) is lower than the national average. The percentage of breast cancers detected at an early stage is 53.6% compared to the national average of 69.8%; of lung cancer is 12% compared to 19.6%; for colorectal cancers is 29.7% compared to 37.2%;. This data is not available for prostate cancer.

**Waits for Treatment**

84.0% of cancer patients in Croydon receive their first treatment within 62 days of an urgent GP referral. This is lower than the English average (87.3%). The operational standard in England is 85%. The speed that patients receive their first treatment can have a positive impact on their likely clinical outcome.

98.7% of cancer patients in Croydon receive their first treatment within 31 days of a decision to treat. This is similar to the English average (98.4%). The operational standard in England is 96%.[36]The speed that patients receive their first treatment can have a positive impact on their likely clinical outcome.

99.0% of patients in Croydon wait no more than 6 weeks for a diagnostic test for cancer. This is lower than the English average (99.1%).Quick access to diagnostic tests is crucial for the early diagnosis of cancer. The Government has previously invested in giving GPs direct access to four key diagnostic tests for cancer, and Government and local bodies should work together to ensure GPs have access and are using them where appropriate.

**Hospital admissions**

Nationally, 20.6% of cancer patients were newly diagnosed when they presented at A&E[37]. For almost all cancer types, one-year survival rates were much lower for patients presenting as emergencies than for those presenting via other routes. In Croydon, 22.2% of cancers first presented as an emergency.

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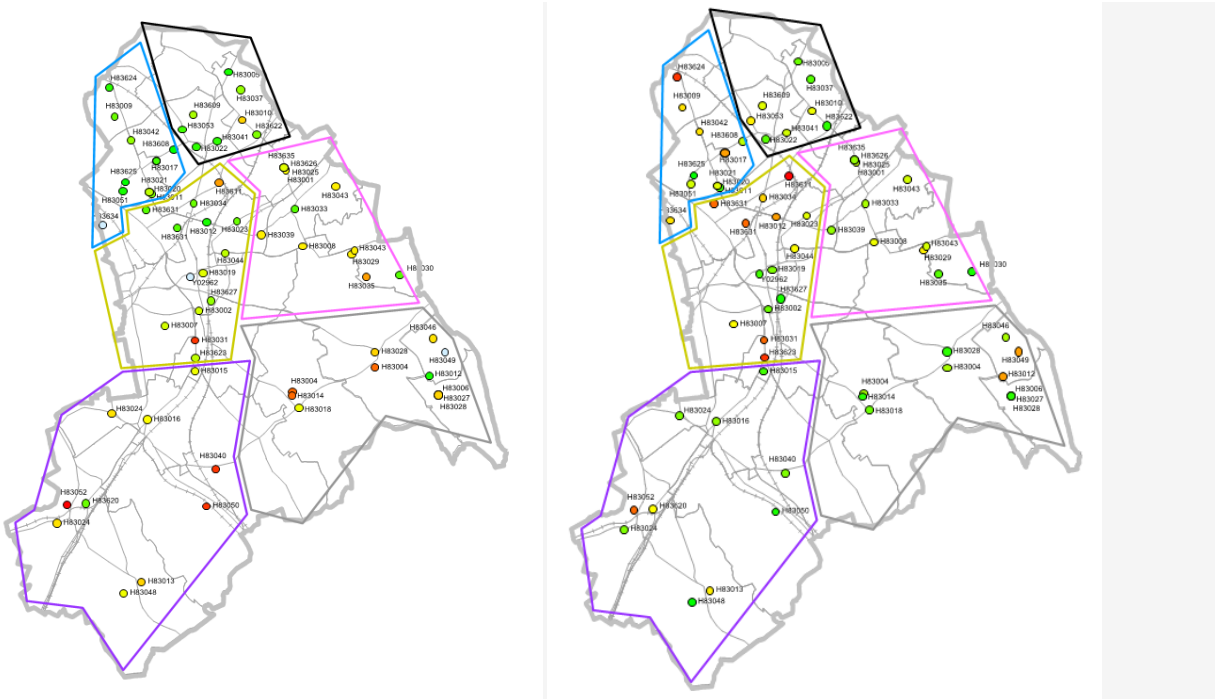
[34] https://indicators.ic.nhs.uk/webview/index.jsp?v=2&submode=ddi&study=http%3A%2F%2F172.16.9.26%3A80%2Fobj%2FfStudy%2FP01693&mode=documentation&top=yes

[35] NB. It is worth noting that the above figures should be treated with some caution. The proportion of cancers assigned a complete stage continues to vary greatly by CCG, ranging from 24% to 83%.[35] In Croydon, the percentage of all cases of cancer for which a valid stage is recorded is 46.9% which is lower than the England average of 59%. However, this means that a number of cancer diagnoses in Croydon (and elsewhere in England) are not being assigned a complete stage – and in fact the % of cancers diagnosed at stages 1 and 2 may in practice be notably higher than presented in current datasets.

[36] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-1=NHS Croydon CCG&location-1=07V

[37] https://www.cancertoolkit.co.uk/Charts/Incidence/ByCCG

Interestingly, the highest rate of emergency admissions for cancer can be found in the north of the borough, in the East Croydon and Mayday networks. When considered alongside the new cases of cancer being diagnosed in Croydon (see below), it could be the case that GPs in the northern networks are not diagnosing cases of cancer early on (particularly when considering that the screening coverage for breast and bowel cancers in lower in these networks, and that the TWW referral rates are also comparatively low in these networks), rather than that there are actually fewer new cases of cancer in these networks. An alternative interpretation if this data is that even if there are fewer cases in the north of the Borough, and GPs are diagnosing a comparable number of cancer cancers to those in the south of Croydon, characteristics of the populations getting cancer in the north of Croydon make them more likely to present at an emergency site rather than any earlier in the pathway. Either way, further investigation to understand this disparity would be valuable.



| New ca practic | Emergency Admissions for Cancer (AS rate per 1000), 2012/13-2013/14 |
|---|---|

Overall, 24.7% of patients in NHS Croydon CCG are diagnosed with cancer through emergency routes. This is similar to the English average (23.7%). Higher numbers of patients diagnosed through emergency routes may indicate late diagnosis and may correlate closely with poor survival[38].

Emergency presentations[39] for breast cancer are in line with the national and London averages (3.9 per 100,000, or 5% presentations). Emergency presentations for colorectal is higher than the national and London averages (representing 30% local presentations, compared to 25% and 28% respectively); for lung is higher than the national and London averages (representing 46% local

[38] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-1=NHS Croydon CCG&location-1=07V

[39] An emergency route via A&E, emergency GP referral, emergency transfer, emergency consultant outpatient referral, emergency admission or attendance

presentations, compared to 38% and 41% respectively); and for prostate is also higher than the national and London averages (representing 16% local presentations, compared to 9% and 11% respectively). Further analysis is required to understand the characteristics of those being diagnosed with cancer in A&E, to help understand why opportunities to diagnose cancer earlier have been missed.

The table below summarises additional key findings from admissions data for each of the 4 priority cancers.

| | |
|---|---|
| **BREAST**<br>Emergency admissions for breast cancer have been decreasing rapidly since 2004/5. However, the number of all admissions for breast cancer increased between 2010 and 2012. Admissions and Emergency admissions are highest in women in their 60s, which is in line with the highest number of women diagnosed with breast cancer in this age group. There is no clear pattern of admissions or emergency admissions by deprivation quintile. | **COLORECTAL**<br>Admissions, including emergency admissions, for colorectal cancer have decreased since 2004/5. Admissions and emergency admissions are higher in men than women, in proportion to the higher incidence rate in men. There were a comparatively high number of emergency admissions for colorectal cancers for both men and women aged u60 years old, compared to the incidence rates in those age groups for both sexes. There is no clear pattern of emergency admissions by deprivation quintile. |
| **LUNG**<br>Emergency admissions for lung cancer have decreased steadily since 2004/5. Emergency admissions are higher in men than women, with a higher than expected rate based on incidence by sex. The difference is greatest between men and women aged 70-74 years old. There is a clear picture of emergency admissions for lung cancer in relation to deprivation. Emergency admissions are highest in the most deprived regions of Croydon with rates in Fieldway, Waddon, Kenley and Thornton Health being the greatest. | **PROSTATE**<br>All admissions for prostate cancer have been decreasing more slowly than for the other cancers since 2004/5, but went up slightly in 2011/12. Admissions are highest for men in their 70s; and are also highest for black men. Admissions are higher in those from less deprived quintiles, and over time admission rates in the more deprived quintiles has decreased more quickly than in the least deprived quintiles. |

**SECTION 3A: LEARNING FROM THE ANALYSIS - Who should the cancer strategy target?**

| | |
|---|---|
| **BREAST CANCER**<br><br>**Those least likely to check their breast are aged 16-29 and 70+**<br><br>**Those least likely to visit their GP with symptoms are aged 60+**<br><br>**Low screening uptake:**<br>• **Ethnic minority groups (including Tamil, Asian and Polish populations),** | **COLORECTAL CANCER**<br><br>**Those with low awareness:**<br>• **Men, Under 30s, Lower social grades, Non-white ethnic groups**<br><br>**Those who would delay seeing GP:**<br>• **24% of over 60s would wait a week or more or never see their doctor**<br><br>**Low screening uptake:** |

| | |
|---|---|
| **those who have newly arrived to the country, Deprived regions**<br>• **Update targeting based on NHSE work**<br><br>**Those with poorest outcomes**<br>• **50-64 (incidence highest)**<br>• **70+ (mortality greatest)**<br>• **White British (incidence highest)**<br>• **Affluent women (incidence highest)**<br>• **Asian and Black women (lower risk of breast cancer but present later)**<br><br>**Areas with high prevalence of smoking, obesity and alcohol use** | • **Ethnic minority groups (including Tamil, Asian and Polish populations), those who have newly arrived to the country, Deprived regions**<br>• **Update targeting based on NHSE work**<br><br>**Outcomes are poorest:**<br>• **Deprived regions, White British/white Irish, Aged 60+**<br><br>**Areas where diet poor, obesity, excessive alcohol consumption and smoking prevalence are high** |
| **LUNG CANCER**<br><br>**Those with worst outcomes**<br>• **Most deprived areas of Croydon: Waddon, New Addington, Fieldway, Broad Green, Thornton Heath, South Norwood and Woodside**<br>• **Older men**<br>• **White British/white Irish**<br><br>**Those least likely to contact doctor**<br>• **Higher social grades, white ethnicity**<br><br>**Areas with high smoking rates: big focus on New Addington, Fieldway and wards in the north of the borough** | **PROSTATE CANCER**<br><br>**Younger men (under 55) to raise awareness of symptoms before onset of cancer likely**<br><br>**Older men (55+) who may not be accessing their GP early enough**<br><br>**Those with the poorest outcomes**<br>• **higher mortality for black African and black Caribbean men in Croydon**<br><br>**Those who are presenting as emergencies**<br>• **More research required to understand this cohort**<br><br>**Areas with high prevalence of smoking, obesity and alcohol use** |

**SECTION 3B- LEARNING FROM THE ANALYSIS – PREVENTION AND EARLY DETECTION OF CANCER**

## 1. STRENGTHENING SERVICES THAT CAN HELP PREVENT CANCER

As mentioned above, research suggests that up to half of all cancers in the UK could be avoided if people made changes to their lifestyle, such as stopping smoking, moderating alcohol intake, and maintaining a healthy bodyweight. An earlier section in this report has summarized the main risk factors for cancer in Croydon, and given a sense of the size of each of these risks. This section of the report covers the current provision of prevention and early detection services in Croydon and provides recommendations as to how to strengthen these parts of the cancer pathway (for each priority cancer where appropriate).

**What are we doing about smoking in Croydon?**

**Smoking Cessation Support**

Croydon public health team commissions a smoking cessation service that supports people to give up smoking through pharmacies, GP surgeries, the hospital and a community based service. The support includes individual or group support, either face to face or over the phone from a trained advisor. Nicotine replacement therapy and other medications are provided which help increase the chance of quitting successfully. Support continues for up to 12 weeks and payment is only made if the client successfully quits (payment by results). Croydon public health team also commission and support a number of health promotion campaigns on smoking from the Stop Smoking providers throughout the year, including Stoptober, New Year Stop Smoking campaign, and National No Smoking Day.

**Future plans for the service**

The Stop Smoking service is performing well against the nationally set target of 4 week quits. The percentage of successful 4 week quitters in Croydon is 2012/13 was 61.24% against the national average of 52%[40]. However, there is a limit to how much success can be attributed to people who quit smoking for 4 weeks; for example, a number may begin smoking again after 4 weeks (relapse rates after 4-week can be high, up to 75%), and the target does not encourage focus on particularly hard to reach groups within which smoking rates are higher than average. Croydon is trying to move away from the national 4-week quit measure to a 12-week measure. Delivery of a 12-week model will reduce the relapse rate substantially and provide an even more cost-effective way of preventing premature deaths.

Further, Croydon's current smoking cessation programmes prioritises groups at increased risk of harm from smoking including those living in deprived areas, pregnant smokers, young people, those with mental health problems and long term conditions. Further work is being done to work in a more focused and longer term manner with these groups to support smoking quits among the populations who need the support most.

The public health team have recently introduced COPD screening into the Stop Smoking assessment model, and have begun work with the local COPD Strategy Group to ensure that opportunities to identify various forms lung ill-health early are picked up as early as possible.

**Recommendations for service improvements**

- Croydon's Stop Smoking Service is determined by provider appetite. This leads to service provision based on the capacity of providers rather than on population need. Currently, there is no active Stop Smoking provider in Waddon, for example, which has a higher smoking prevalence than many other wards in the Borough (though there is a number of Stop Smoking providers active just outside the ward boundaries). Mapping 'ideal' provision based on population need and comparing this to the current Stop Smoking provision would provide a helpful basis on which to begin targeted work with providers to stimulate the market in areas of higher need. To optimise the effectiveness of this mapping exercise, it would be advisable to map the current and ideal service provision of all the cancer prevention activities (stop smoking; weight management; physical activity; and alcohol services) in order to inform future service planning based on a clear view of population needs and service provision and gaps.

- The public health team are also accelerating work on broader Tobacco Control, and will be developing a Tobacco Control Strategy in 2015 (considering issues such as taking action on illicit tobacco, local regulation of tobacco products, advice to businesses, targeted social media work

[40] https://www.cancertoolkit.co.uk/Charts/SmokingCessation/SingleYear

with under 18s, work to reduce the attractiveness of tobacco products, and information and advice about Shisha, e cigarettes and oral tobacco). Croydon CCG will need to be a key partner developing and delivering this strategy.

**HEALTHY WEIGHT & PHYSICAL ACTIVITY**

**What are we doing about healthy weight in Croydon?**

Croydon has a Healthy Weight Healthy Lives Strategy (2009-2014), which emphasises cross-agency, multi-factoral approaches to reducing overweight and obesity in Croydon.

The public health team is leading Croydon Heart Town (the 5 year collaboration with British Heart Foundation). The programme includes a Community Grants Programme to fund community programmes that will increase physical activity, increase access to healthy food.

Alongside other healthy schools initiatives being rolled out by the public health team, Croydon has been awarded status as one of the 2 Flagship Food Boroughs in London. Using the School Food Plan as a critical foundation, the Flagships will demonstrate the transformational impact on health and attainment achievable through improving food across the whole environment, using schools as a catalyst to drive this change.

The Croydon Eat Well project has begun, involving a Public Health dietician working alongside the Food Safety Team to assist food businesses to make a number of changes to their cooking practices and menus to offer healthier food and snacks.

A community weight management service has been procured for both children (4-12yrs) and adults (18yrs plus) from April 2014. These services are both multi-component with nutritional advice, physical activity and behaviour change theory at the core. Neither service has an upper limit of Body Mass Index for referral. Healthy weight services for children will be targeted to the areas of the borough with the highest rates of child obesity. It is the intention that the adult and child weight management services be integrated to existing care pathways to increase referral rates.

**Future plans for the service**

The public health team is refreshing its Healthy Weight action plan for the prevention and management of child and adult obesity, and take the recommendations from the 2013/14 Healthy Weight JSNA forward for implementation.

To strengthen the healthy weight agenda in schools there will be a roll-out of a healthy lifestyles commissioned programme which will be delivered in targeted schools in areas of high rates of child obesity.

Included in the commissioning plans for 2014 to 2016 is a workforce training programme to deliver skills and knowledge to school nurses, early year practitioners, the wider school workforce and the Third Sector. This is in recognition of the gap in knowledge regarding the sensitive issue of how to raise the subject of obesity in children, particularly with parents.

The contract managing of weight management services will be the responsibility of the Integrated Commissioning Unit. This joint service between the Local Authority and the Clinical Commissioning Group presents an opportunity to integrate a framework for reducing child obesity into the

performance outcomes of the wider health workforce, including health visitors and school nurses from 2015.

Exercise on referral has been a referral route for individuals who are overweight or obese, and this service is being reviewed to implement a multi-component physical activity programme that will be based on behaviour change theory.

There is currently limited investment in active travel in Croydon but options for improving on this position are being reviewed by the public health team.

**Recommendations for service improvements**

- There is currently a gap to focus efforts specifically on adults with mental health issues and obesity. The Adult Obesity Needs Assessment (2010) found higher levels of obesity within this group, which should be further reviewed.

- In summer 2015 there is to be a PHE led mapping of Tier 2 and Tier 3 weight management services in the UK, which will provide guidance to Croydon about gaps in current service provision and advice on how to address these gaps.

- The JSNA 2013/14 chapter on Healthy Weight recommended that Croydon Council should clarify the funding responsibility for the commissioning of child and adult weight management services (including maternal) to ensure that there is a full pathway in Croydon.

- Locally, we need to think creatively about opportunities for children to be physically active, and Play Streets could be an option to consider. Play Streets is a ground-breaking approach which a number of London boroughs have adopted to allow local resident-led street play sessions. Typically the road is closed for up to three hours, in order to facilitate supervised children's play without the potential danger and inconvenience of through traffic. These offer an opportunity for children in more disadvantaged areas of the borough to increase their physical activity, particularly as the north of the borough lacks open space.

**ALCOHOL MISUSE– PREVENTION AND SCREENING**

**What are we doing about alcohol misuse in Croydon?**

Croydon is one of the 20 places in the country to be awarded status as a Local Action Alcohol Area, and has been working with the Home Office and Public Health England to reduce alcohol related harm and violence, and to diversify the night-time economy in the borough. This programme of work involves offering brief intervention and advice across 6 settings – GP surgeries, pharmacies, probation services, voluntary sector bases, acute and mental health hospitals. Screening in this way is an evidence based method of identifying people before their drinking becomes problematic or they become alcohol dependent.

The programme is also working with partners to implement the Cardiff Model for Violence Prevention which aims to prevent violence and reduce the burden on emergency services. The first step for Croydon is to secure a system for data collection and analysis within emergency settings that will help services to understand where and when violent attacks are happening in Croydon.

The programme also involves a communications and engagement strategy, which will look at web based tools and other innovative communication channels in partnership with the voluntary sector, pharmacists and GPs.

**Future plans for the service**

Croydon is planning to continue delivering on the Local Action Alcohol Area objectives when the external support formally stops in April 2015.

Alcohol is very readily available across Croydon, owing to the high number of licensed premises in the Borough. Croydon's licensing department is looking into the feasibility of introducing a local voluntary scheme where off licenses would take the decision not to sell cheap beer and cider products above a certain alcohol content or alcohol by volume.

**Recommendations for service improvements**

- There is considerable work happening to tackle different alcohol-related issues in Croydon. However, Croydon does not have a Borough wide strategic approach to encourage sensible drinking culture and reduce alcohol related harm.

- There is extremely low identification of alcohol problems in primary care. Out of the c18% adults thought to drink at increasing/ higher risk levels, only 1% of Croydon's total registered population is recorded as having alcohol misuse problems[41]. This may indicate that primary care practitioners are not routinely screening or enquiring about alcohol consumption, which could enable identification of potential problems at an early stage[42]. In line with NICE guidance, as far as possible screening should be standard practice with all patients, in addition to targeting population groups who are deemed vulnerable.

- Screening should be taking place by GPs, practice nurses, pharmacists, health care assistants in primary care, as well as other key practitioners such as social workers, school nurses, and targeted youth workers. There is an opportunity through implementation of the Cardiff Model to consider the variety of urgent and emergency settings in which data collection of violent crime could take place – the model doesn't need to confine itself to data collection in A&E.

- There is also no standardised programme of alcohol education in Croydon schools. There is also an intelligence gap around Croydon young people's views and behaviour about alcohol.

**HOLISTIC APPROACH TO ILL-HEALTH PREVENTION**

The Healthy Living Hub based in Croydon central library, is a walk-in public facing space where the public can talk to an advisor about stop smoking services and active lifestyles. There are occasional visiting professionals who attend to talk about other health issues, for example MacMillan nurses.

The public health team is also scoping an integrated lifestyles/ behaviour change service that brings together stop smoking, weight management, physical activity and drug and alcohol services with a view to provide multi-faceted support for individuals who may want to address more than 1 lifestyle

[41] Croydon GP data as at 31 March 2012
[42] JSNA 2013/14 – a rapid assessment of population needs in Croydon

behaviour/ for whom working holistically with these people will bring about more effective lasting results with bigger return on investment.

- Through this sort of approach to ill-health prevention, it might be possible to consider implementation of approaches such as Making Every Contact Count, comprising conversations between professionals and the public based on behaviour change methodology. Through such as approach, it would be possible to offer brief intervention to discourage the behaviours that are risk factors for cancer, and also to talk to and signpost people who think they might already be at risk/ have symptoms of cancer.

## 1. EARLY DIAGNOSIS OF CANCER IN CROYDON

**Patient awareness 1**

In 2010, IPSOS Mori was commissioned to conduct research on attitudes and understanding of cancer in SW London and reported that awareness of the warning signs and symptoms of cancer appear in general to be lower among South West London residents than across the country, based on research they completed with the local population. The research also found that the group of residents for which cancer awareness is particularly low across the board in SW London included ethnic minority residents, especially black residents, those from the lowest social grades and those aged 18-24.

Local research also found that most of those patients who would wait a week (93%) or two weeks (96%) to be seen by a GP to discuss their symptoms also agreed with the statement 'early detection is critical to curing cancer' so awareness of the importance of seeking medical attention is not at the centre of this issue. 'Difficultly making an appointment', 'worry about what the doctor might find' and 'too busy to make an appointment' and 'worry about wasting the doctor's time'.

- Understanding the barriers for population groups to accessing their GP to discuss their concerns about cancer will be invaluable to increasing opportunities for earlier conversations about cancer and appropriate signposting/ detection at the earliest stage.

In 2010/11, based on this and other research and evidence, the public health team and Croydon PCT completed work to improve early detection of colorectal, breast and lung cancer in Croydon. The scope of the work was to create a social marketing campaign targeted at appropriate areas and populations (i.e. the "push"), and equip GPs with the knowledge to 'pull' the right patients into the system to facilitate early diagnosis.

The social marketing work involved various strands, including:

- Lung cancer: Public information campaign on the significance of a persistent cough, delivered through peer educators, Stop Smoking Advisors (able to offer brief advice), billboard advertising in targeted areas, and direct mail outs to targeted households and community facilities
- Community members were also trained as peer supporters for breast and bowel cancer.
- Community champions to raise awareness of cancer in community venues
- Bowel cancer stand in targeted location

The work recommended that social marketing and population segmentation to improve dissemination of messaging be used to ensure that the population groups most at risk of cancer are engaged and supported.

**Patient awareness 2**

Croydon began a "*Get to know cancer*" awareness raising programme in 2012, which involved ensuring local dissemination of a London wide campaign on cancer detection; a pop up shop in a centrally located shopping centre; recruitment of 1000 cancer activists; and a charity partnership. Over 38 days, 1319 people visited the shop and 279 nurse consultations were recorded. 5500 leaflets were distributed on healthy living and cancer symptoms and 5200 'Get to know cancer campaign' leaflets. The visitors of the shop were largely white and female but the ethnic split broadly reflected Croydon's demography. Most visitors were aged between 45 and 64. 42% visitors were advised to see their GP in Croydon following a 1:1 consultation and over a third of visitors said they would visit their GP as a result of visiting the shop. The majority of visitors spoke to the nurses for between 6 – 15 minutes. Findings from a small sample of people interviewed who visited the Croydon shop suggest that attitudes towards cancer are changing, with people aware that there is life after cancer and this is supported by findings from the visitor feedback questionnaires. Whether these are a result of the shop or were previously held views was not possible to demonstrate.

This was an innovative initiative to raising awareness to improve early diagnosis. Community cancer awareness initiatives exist in the UK but none are based in shop-space for an extended period. The limitation of the pilot was issues around sustainability- the input and resource required to maintain this approach was substantial.

- There is a lot of local work to build on to encourage awareness raising of the signs and symptoms of cancer. Work needs to continue locally, based on learning from the 2010-2013 work streams, to raise awareness of signs/symptoms of the most common cancers, and consider the most sustainable approaches to doing this.

**Work with primary care- GP awareness and urgent referrals**

The 2010/11 work was targeted at those practices with the highest mortality rate (age standardised per 100,000 (between 27.1 and 49.2)) for breast, lung and bowel cancers, with high emergency admission rates, and the lowest 2 week referral rates (i.e. the "pull"). GPs were invited in small groups in similar geographical areas to GP workshops with secondary care consultants. The training provided information on each of the 3 priority cancers and also provided data tailored to the practice population to give an insight into cancer outcomes amongst their patients. An education pack was given to each practice for ongoing reference.

Further education initiatives included training Practice nurses, GPs and health care assistants to identify those individuals who may be at risk of colorectal cancer so that they could prompt a discussion at routine appointments about their bowel habits.

**Work with Primary care- other staff groups**

SWL Cancer Network ran a 12 week pilot project (January to March 2012) investigating earlier diagnosis of lung cancers using a small cohort of pharmacies (18) within 2 wards with a cancer Standardised Mortality Rate over 100, high deprivation, high smoking rates, poor awareness of lung cancer, access issues, and low life expectancy who are currently offering a Stop Smoking service. The pilot offered customers direct referrals for chest x-rays and examined whether this was an acceptable and effective vehicle for customer, pharmacist and primary/secondary and whether it resulted in earlier diagnosis of lung cancer against the baseline population.

The pilot showed very positive and promising results in regard to acceptability (across primary and secondary care, as well as patients), and the viability and efficiency of the referral process- with 29

referrals being generated and additional 27 via the use of mystery shoppers (who did not proceed to a chest x-ray). The diagnosis of the 29 genuine referrals, whilst not identifying a lung cancer, did identify 5 cases of moderate/severe COPD and also identified lung problems in a younger than expected age group- the average age of referrals was 51. Mystery shoppers also identified that it was far easier to engage with pharmacists on the subject of lung cancer than their GPs and were impressed with the speed of the referral process.

The pilot's short lifespan did not allow for enough time to thoroughly embed the process in staff behaviour and inability to follow up patients who DNA'd (of which there were 8). The SW London network proposed testing this framework in a wider setting, and utilising the existing participating pharmacies as a way of identifying service improvement.

- Discussing the viability of taking forward learning from the local pilot work listed above should take place as part of the development of the Cancer Strategy.

**Learning from elsewhere**

The **Promoting Early Presentation (PEP) intervention**[43] aims to equip older women who are no longer routinely invited for screening with the knowledge and motivation to present promptly to primary care in the event they suffer from the symptoms of breast cancer. PEP has to date been subject to randomised control trial and to piloting across 4 breast screening sites. The results of the RCT (published in 2011) showed that at one year, the intervention increased the proportion of women who were breast cancer aware six-fold. After 2 years of receiving the PEP intervention, 21% of women remained breast aware, compared with just 6% who received the current standard care. When delivered in the 4 pilot sites, PEP was reduced to a 5 minute brief intervention immediately following mammogram. The preliminary findings demonstrate similar success to that achieved through the RCT.

In partnership with Prostate Cancer UK, PH England ran a local **Be Clear on Cancer pilot** in London to raise awareness of the increased risk of prostate cancer amongst black men aged 45+. The pilot ran between 20 October and 23 November 2014 in six London Boroughs: Hackney, Haringey, and Newham in north-east London, and Lambeth, Lewisham and Southwark in south-east London. The key message of the campaign was: '1 in 4 black men will get prostate cancer. Prostate cancer often has no obvious symptoms. If you are a black man over 45 and want to discuss your personal risk of prostate cancer, visit your GP.' Evaluation results of the pilot are awaited, and should be reviewed locally when the results are published[44].

- In line with this nationally led work, which recognises the important contribution that the voluntary and community sector can make to helping individuals to detect their cancer early, the CCG should consider how it might work in partnership with voluntary sector partners to educate the public about the warning signs of cancer, and signpost/ support those who have risk factors for cancer to the appropriate lifestyle services, or their GP.

NHS England has recently (January 2015) announced a new independent taskforce who will develop a **5-year action plan for cancer services**, and also launched a new programme to test 7 innovative

[43] http://www.kcl.ac.uk/innovation/groups/earlypres/Research/Promoting-Early-Presentation-in-Cancer.aspx
[44] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384661/IOSC_fourth_annual_report_FINAL.pdf

ways[45] of diagnosing cancer more quickly at more than 60 sites across the country, in partnership with Cancer Research UK and Macmillan Cancer Support. Evidence from these pilots will be evaluated in order to inform service changes from 2016/17.

- Croydon CCG should ensure learning from this work is considered for local implementation.

## 2. EARLY DETECTION & DIAGNOSIS: CANCER SCREENING IN CROYDON

Improving cancer screening coverage and uptake is critical to increasing earlier detection and diagnosis of cancer in Croydon. The involvement of primary care to promote screening is central to achieving improvements in this area.

**Breast Screening – Current Provision**

Currently, there is only 1 screening location for Croydon residents, at Edridge Road. Discussions have taken place regarding the re-establishment of a site for screening within the Croydon Outlet Village on Croydon High Street. This began operation in early 2014 however the service has decided that due to the poor facilities that an alternative site would be sought. Discussions have taken place at Centrale which would see a screening site for a minimum of 5 years with an opportunity to be within the new Croydon development.

The St Georges / South West London Breast Screening Service failed to meet round length and screen to assessment waiting times in 2012/13 and Q1 and 2 of 2013/14. The trust developed and implemented a service improvement plan in February 2014, supported by London QA and NHSEL. Performance improved significantly as a result.

The breast screening programme is currently offered to women aged between 50 and 70 years of age. There is a national randomised controlled trial underway to extend the programme to women aged from 47 to 73. Age extension has been introduced in following London breast screening services: South East (Kings), Barking Havering Redbridge (BHRUT), West London (Imperial) and North London (Barnet and Chase Farm). NHS England will be working with St George's hospital to implement the age extension in SW London during 2015/16.

**Bowel Screening- Current Provision**

Between January and November 2013, bowel screening uptake declined from 47% to 38% across London. The decline was evident in all boroughs. The decline could be partially attributable to the cohort effect as similarly low uptake rates were seen when the same group of individuals was invited two years ago. However, in Q4, uptake improved by 5% across London, bring rates to 2012/13 levels[46].

The SW London Bowel Screening Programme will shortly start offering bowel scope screening tests for men around the time of their 55th birthday, in a phased roll-out. The current national plan is to make bowel scope screening available to all 55 year olds in England by 2016.

**Recommendations for service improvements in screening programmes**

[45] Approaches include offering patients the option to self-refer for diagnostic tests; lowering referral thresholds for GPs; and multi-disciplinary diagnostic centres where patients can have several tests in the same place on the same day.

[46] London Cancer Screening Commissioning update- 2013/14 Annual Review

- The lowest uptake for screening is among minority ethnic groups and those who have recently moved to the country[47]. These population groups will need tailored reminders and different support to ensure they are able to access screening programmes. It is recommended that GP networks identify the local areas where there are concentrations of Tamil, Asian and Polish populations to find out what the screening uptake is like among these groups, and identify what the specific population needs of these groups are that, if met, would support them to attend screening services.

- NHS England has incentivised all providers to implement the following evidence-based interventions: Pre-appointment text reminders (estimated 6% improvement in uptake); Second-timed appointment (estimated 3% improvement in uptake); and Pre-invitation letters (estimated 3-4% improvement in uptake[48]). The recommendations from the June 2014 "Bowel Screening: Good Practice Guidance for General Practices in SW London" echo these national recommendations, and suggest the following needs to be taken forward to increase bowel screening coverage. These recommendations also apply to breast screening:

    - Regularly update practice staff about the benefits of the programme
    - Ensure that the practice list is up to date and investigate/ remove those who have not been seen in the surgery in over 3-5 years
    - Ensure telephone numbers (and addresses) of patients are up to date so that when texts are used to remind patients about screening the numbers are correct
    - When the surgery is notified of the results letter sent to their patients, these should be scanned into the electronic records and coded using a breast or bowel screening template
    - Preform monthly searches on all those who have been identified as not responding to screening, send a letter from the surgery supporting the benefits of taking part in the screening programme
    - Perform annual search/ audit on the eligible population to identify how many have been screened and the outcomes of the screening episode e.g. normal, abnormal or not completed
    - Send letters from the surgery to those reaching the minimum age thresholds from screening and inform them that they will soon be sent a letter inviting them to take part in the screening programme and offer them support and advice if needed

- There are more detailed recommendations in the document about improving uptake of bowel screening that should be reviewed and discussed at GP network meetings to agree how to disseminate across local GP practices. This review should be supported by the Health Improvement Specialists for Breast and Bowel Screening in SW London.

- It would be helpful if there is a network champion for each of Croydon's 6 networks who will be responsible for disseminating information about the screening programmes and working with local practices to ensure they are implementing the recommendations above. This champion should try to identify a named lead within each GP practice with whom they can liaise and share good practice and learning on an ongoing basis.

[47] NB it has been acknowledged by NHSE that understanding screening coverage by ethnic group would be helpful. NHSE are looking into the feasibility of obtaining this information as of Dec 2014

[48] London Cancer Screening Commissioning update- 2013/14 Annual Review

It is NHS England's intention to consider the reconfiguration of breast screening services across London to potentially create a London wide model that allows women flexible access to different sites, centralised administration etc. NHSE's current intention is to work with local areas to decide upon a model that works, to give a year's notice from April 2015 and undertake a London wide procurement of the agreed new model, with a start date for the new service of April 2016.

Having incentivised all breast screening providers to improve uptake through the implementation of second-timed appointments, texting and pre-invitation letters, NHSE expect that these interventions are included as part of the service offer and covered by the tariff price in 15/16.

NHSE will also be working with CCGs to agree that commissioning responsibility for women with a moderate risk will be included in the new model of service to be commissioned, although this is still to be confirmed. This work will also include reviewing the 62 day cancer waits (screening pathways) to ensure these are robust and fit for purpose given a number of Trusts have struggled with this target in 2014/15.

- Further work is also needed to clarify the roles and responsibilities of NHS England, Public Health England, the SWL network, Health and Well-Being Boards and local CCGs in delivering improvements to the breast and bowel screening programmes. Roles and responsibilities could helpfully be mapped to ensure there is clarity about whom and how Croydon's local commissioners can hold national bodies to account. The Health and Well-Being Board might helpfully hold national bodies to account when they are failing to deliver in their roles.