2. CANCER AND CANCER SCREENING

INTRODUCTION

The incidence of cancer and premature mortality from cancer are higher in Islington compared to the rest of England. Although death rates are reducing, this reduction is not occurring quickly enough. The Government has set national health inequalities targets to reduce mortality rates by 2010 from cancer by at least 20% in people under 75 years old from the 1995-97 baseline, with a reduction in the inequalities gap of at least 6% between Spearhead Local Authorities and the population as a whole. Islington is unlikely to reach this target.

Premature mortality from cancer can be reduced through population-based cancer screening programmes. Currently three national cancer screening programmes are offered to eligible populations in Islington: the breast (NHSBSP), cervical (NHSCSP) and colorectal (NHSCRSP) cancer screening programmes. These programmes aim to detect early stage cancer or pre-malignant disease. There is potential for improving health outcomes by improving screening coverage; if screening coverage were to increase, then more cancers would be detected at an earlier stage. Effective treatment at an earlier stage in the disease process greatly improves prognosis and reduces the risk of premature mortality from cancer.

Islington residents are not taking full advantage of cancer screening services. The uptake and coverage is low compared to other boroughs and there are social inequalities in uptake.

WHO ARE THE KEY GROUPS AFFECTED?

Participation in cancer screening programmes is socially patterned. Table 2.1 summarises the research evidence concerning inequalities in awareness, acceptance, uptake, and coverage of the cancer screening programmes by socio-economic status, age, ethnicity, gender, disability and religion (1).
<table>
<thead>
<tr>
<th></th>
<th>Breast Cancer Screening</th>
<th>Cervical Cancer Screening</th>
<th>Bowel Cancer Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-economic deprivation</td>
<td>Coverage lower in more deprived groups. Less well educated women are more likely to believe that age does not matter in the risk of getting breast cancer. Awareness of cancer risks and cancer symptoms poorer in more deprived groups.</td>
<td>Coverage lower in more deprived groups. Awareness of cancer risks and cancer symptoms poorer in more deprived groups.</td>
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</tr>
<tr>
<td>Ethnicity</td>
<td>Lower acceptance of screening within BME groups than the average which is independent of socio-economic status.</td>
<td>Lower acceptance of screening within BME groups than the average which is independent of socio-economic status.</td>
<td>Lower acceptance of screening within BME groups than the average, which is independent of socio-economic status. Specifically - lower perceived efficacy of screening, higher perceived psychological costs, higher perceived barriers and lower levels of encouragement from children or a partner.</td>
</tr>
<tr>
<td>Age</td>
<td>Older people - Poor awareness of age as a risk factor for breast cancer.</td>
<td></td>
<td>Older age group has higher uptake of bowel screening</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>Women more likely to take up screening than men</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>Uptake is lower amongst disabled people. Access to mobile screening units is difficult for physically disabled women, compared to static units</td>
<td>Uptake is lower amongst disabled people.</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>Uptake is lower amongst Muslim women and may be due to fear of a male carrying out the mammogram</td>
<td></td>
<td>Uptake is lower for Muslim men and women.</td>
</tr>
</tbody>
</table>

THE ISLINGTON PICTURE

Premature mortality
Premature mortality from cancer is 15% higher in Islington than the England average (25% higher in men and 2% higher in women). In 2008, 165 people died prematurely from cancer in Islington compared to 140 premature deaths from circulatory diseases. Many of these premature deaths were potentially preventable.

Figure 2.1: Trend in premature mortality from cancer (1993-1995 to 2006-2008)

Source: ONS annual mortality files; analysed by NCHOD

Breast cancer
Breast cancer is the commonest cancer in the United Kingdom, the commonest cancer in women and accounts for almost one third of all cancer cases. In London, 4,328 women were diagnosed with breast cancer in 2007 and 1,123 people died from the disease in 2008. In Islington, this equated to 98 new cases of breast cancer in 2007 and 26 deaths in 2008.

Late diagnosis of breast cancer is a significant factor in why breast cancer survival in England lags behind other European countries. Late diagnosis is linked to low uptake of screening and low awareness of breast cancer symptoms.
**Cervical cancer**

Cervical cancer is the second most common cancer in women worldwide. In London, on average, 275 women were diagnosed with cervical cancer each year between 2005 and 2007, and 87 die per annum from cervical cancer (2006–2008). In Islington, there were on average, seven new cases of cervical cancer per year (2005–2007) and two deaths in 2008.

The main cause of cervical cancer is infection with high-risk types of human papillomavirus (HPV). This has obvious implications for primary prevention (vaccination) and secondary prevention (screening) of this disease. Precancerous changes or very early stage disease are usually asymptomatic and can be detected on a cervical smear. Improving screening coverage, especially in the 25–35 year old age group where participation in screening programmes has been declining in recent years, offers a great opportunity to reduce mortality.

**Colorectal cancer**

Colorectal (bowel) cancer is the second most common cause of cancer death in the United Kingdom, accounting for 10% of all cancer deaths. In London, approximately 3,105 new cases of colorectal cancer were diagnosed each year between 2005 and 2007, and 1,384 people died from the disease each year between 2006 and 2008. In Islington, on average, there were 62 new cases of bowel cancer per annum between 2005 and 2007, and 27 deaths each year between 2006 and 2008. Late diagnosis is significant: currently around 20% of patients first present at A&E departments after experiencing mild symptoms for weeks or months.

About 55% of patients are not diagnosed until the disease has spread to lymph nodes or elsewhere. Overall, five-year survival is only around 50%, but only 7% for those presenting with lymph node disease. Diagnosing bowel cancer early through population screening is likely to greatly improve these poor health outcomes.

In 2007, the bowel screening programme was rolled out across Islington. Uptake is currently lower than the 60% national expected figure, at around 38% of the eligible population who have been sent test kits. Since roll out there have been 13 bowel cancers detected through the screening programme in Islington. If the 60% bowel screening coverage could be achieved and assuming incidence remained unchanged, the proportion of screen detected cancers, and hence earlier stage cancers, would almost double.
Table 2.2 summarises the picture of breast, cervical and bowel cancer incidence, mortality, survival and trends in Islington compared to that for England and London as a whole. Islington’s rates for incidence, mortality and five-year survival across the three cancers were not significantly different to that of the North London Cancer Network, London or England, though numbers were too small to statistically analyse survival data for cervical cancer.

Table 2.2: Breast, cervical, bowel cancer: comparative incidence, mortality, survival, and trends

<table>
<thead>
<tr>
<th></th>
<th>Breast Cancer</th>
<th>Cervical Cancer</th>
<th>Colorectal Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence (ASR) per 100,000 population (CIs 95%) for NHSI (2005 – 2007)</strong></td>
<td>121.77 (106.8 to 135.5)</td>
<td>8.27 (4.63 to 11.9)</td>
<td>40.79 (34.8 to 46.8)</td>
</tr>
<tr>
<td><strong>No of new cases of cancer per year for NHSI (2005 – 2007)</strong></td>
<td>98</td>
<td>7</td>
<td>62</td>
</tr>
<tr>
<td><strong>Is incidence significantly higher for NHSI than London average?</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Socioeconomic gradient in incidence</strong></td>
<td>Higher in more affluent group – positive gradient</td>
<td>Higher in more deprived group – negative gradient</td>
<td>No gradient</td>
</tr>
<tr>
<td><strong>Trend in incidence (1985 – 2007)</strong></td>
<td>Increasing</td>
<td>Decreasing</td>
<td>No change</td>
</tr>
<tr>
<td><strong>No of deaths in Islington due to cancer per year (2006 – 2008)</strong></td>
<td>26 per annum</td>
<td>2 per annum</td>
<td>27 per annum</td>
</tr>
<tr>
<td><strong>Mortality (ASR) per 100,000 population (CIs 95%) for NHSI (2006 – 2008)</strong></td>
<td>29.39 (22.6 to 36.1)</td>
<td>2.51 (0.55 to 4.5)</td>
<td>16.78 (13.0 to 20.5)</td>
</tr>
<tr>
<td><strong>Is mortality significantly higher for NHSI than the London average?</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Socio-economic gradient in mortality</strong></td>
<td>Higher in more deprived group – negative gradient</td>
<td>Higher in more deprived group – negative gradient</td>
<td>For rectal cancer, males higher in more deprived group – negative gradient</td>
</tr>
<tr>
<td><strong>Trend in mortality (1993 – 2008)</strong></td>
<td>Decreasing</td>
<td>Decreasing</td>
<td>Decreasing</td>
</tr>
<tr>
<td><strong>5 year survival (North London Cancer Network) (CIs 95%) (1998 - 2002)</strong></td>
<td>78.7 (77.0 to 80.3)</td>
<td>69.9 (63.7 to 76.0)</td>
<td>46.5 (44.2 to 48.8)</td>
</tr>
<tr>
<td><strong>Socio-economic gradient in five-year survival</strong></td>
<td>Lower in more deprived group – negative gradient</td>
<td>Lower in more deprived group – negative gradient</td>
<td>For rectal cancer, lower in more deprived group for males and females – negative gradient</td>
</tr>
</tbody>
</table>

Source: Thames Cancer Registry, The Information Centre for Health and Social Care
THE FUTURE

Between 2006 and 2020, Islington’s population is projected to grow, including the numbers of ethnic minorities, and those who are socio-economically disadvantaged and in poor health. Because population growth will occur in the younger and middle-aged groups, numbers of people eligible to participate in the cervical, breast and bowel screening programmes will increase. The older population, who can request screening if desired, will not increase greatly so that increased demand from this section of the population is unlikely.

CANCER SCREENING SERVICES CURRENTLY PROVIDED IN ISINGTON

The NHS Breast Screening Programme

There are six breast screening programmes operating in London. London PCTs commission breast screening services from the programmes via a consortium approach (Camden, Islington, City & Hackney, Newham, Waltham Forest, Tower Hamlets PCTs) with a lead commissioning PCT (Tower Hamlets) overseeing the development of the service specification, service level agreement and procurement with Central and East London Breast Screening Service (CELBSS), the provider of breast screening services to Islington residents.

Women aged 50 to 70 are routinely invited for screening every three years. The programme will shortly be extended to include women aged 47 to 73. Basic screening by mammography can take place either at a static breast screening unit (St Bartholomew’s Hospital) or on a mobile breast screening unit (currently at The Whittington Hospital). CELBSS currently provides services through mobile analogue vans that are located in suitable locations in each borough. Digital mammography will be introduced as the screening test by 2010.

The breast screening programme in Islington achieved coverage of 60.28% in 2007/08, ranking it 20th in London.
The NHS Cervical Screening Programme
NHS Islington oversees the commissioning of the following services which make up the cervical screening care pathway:

- **Call/recall programme**, provided by NHS Islington.
- The screening test: sample taking is provided by GP practices in Islington, family planning/sexual health clinics, and genitourinary medicine clinics. The family planning and genitourinary services are provided by NHS Camden.
- Cytopathology/histopathology services report cervical smears and biopsy results.
- Colposcopy services are provided by the Whittington Hospital, UCLH and the Royal Free Hospital.

Women aged 25 to 49 years are screened at three yearly intervals and those aged 50 to 64 at five yearly intervals. The invitation system is delivered through the call/recall services. A GP or nurse at a primary care or community clinic usually carries out the liquid based cytology (LBC) smear. Women with negative tests are invited for re-screening at the standard three to five year interval, while those with borderline or mildly dyskaryotic smears are monitored at a reduced screening interval.

The cervical screening programme in Islington achieved 72.7% coverage in 2008/09, ranking it 20th out of 31 London PCTs. This was lower than the national coverage target of 80%.

The NHS Bowel Cancer Screening Programme
This programme is commissioned and organised at national level. It comprises five programme hubs and 90-100 local screening centres, each serving populations of up to two million people. One week after initial invitation letters, men and women aged 60 to 69 years of age are sent a faecal occult blood test (FOBt) kit through the post. Call/recall is delivered by the programme hub, which for London is at Northwick Park Hospital. Uptake of screening is currently around 38% of the eligible population who have been sent test kits.
NATIONAL DRIVERS FOR SERVICE PROVISION

Cancer screening services should be provided in line with the national standards set out by the Quality Assurance Reference Centre (QARC). Quality Assurance is a fundamental part of the NHS Cancer Screening Programmes. The aim of quality assurance is to maintain minimum standards and to improve the performance of all aspects of cancer screening in order to ensure that the population have access to a high quality screening service wherever they live. This is carried out through regular monitoring and visiting of services, encouraging the adoption and transfer of good practice and identifying and investigating problems as they arise.

The Department of Health published the Cancer Reform Strategy in 2008 (2), which builds on the progress made since the publication of the NHS Cancer Plan in 2000 and sets a clear direction for cancer services for the next five years. A number of objectives relevant to screening were outlined, including:

**Prevention**
- Primary prevention of cancer: smoking, diet, physical activity, obesity, sunlight.
- Primary prevention of cancer: HPV vaccination.

**Diagnosing cancer early**
- Raise public awareness of the causes, signs and symptoms of cancer.

**Breast Screening**
- Improve coverage and reduce inequalities.
- Extending the age range for breast screening to provide nine screening rounds between 47 and 73 years.
- Promotion of self-referral for screening every three years for women over 70 years of age.
- Incorporating the responsibility for the management of surveillance for women at high familial risk of breast cancer, into the NHSBSP.
- Increasing the uptake of screening in poor communities, BME groups, among disabled women, among Muslim women.
Bowel Screening
• Improve coverage and reduce inequalities.
• Extending the range for bowel screening from 2010 to invite men and women aged 50 to 59 and 70 to 75 years to take part.
• Increasing the uptake of screening in men, poor communities, BME groups, and among Muslim men and women.

Cervical Screening
• Improving coverage and reduce inequalities.
• All women to receive their screening test result within 2 weeks of it being taken.
• Action to tackle the falling participation of younger women aged 25 to 35 years.
• Increasing the uptake of screening in poor communities, BME groups, disabled women.

In addition to implementing national guidance and standards, Islington reviews the evidence for the effectiveness and cost-effectiveness of the cancer screening programmes, what works for increasing coverage and uptake and what works for reducing inequity in coverage and uptake, to ensure investment is made in the most appropriate interventions.

PROGRESS SINCE LAST YEAR

In 2008, the JSNA made several recommendations to increase the uptake of screening. These included quality measures targeting commissioning and primary care, increased use of social marketing techniques, use of equity audit and improved data collection and linkage. A social marketing campaign to promote the uptake of bowel screening across the sector is currently underway, and a Local Incentive Scheme is in development. There is a door-knocking outreach programme on social housing estates, and equity audits are underway for all three cancer screening programmes. Analysis of screening data for all three programmes by practice has been undertaken.
OPPORTUNITIES FOR DEVELOPMENT

The areas for development within NHS Islington for 2010/11 include:

- Provision of modern responsive breast screening digital mammography unit and breast screening service.
- Improving public awareness, health promotion, social marketing.
- Improving the quality of primary care and primary care based promotion.
- Determining through General and Personal Medical Services GP Contract commissioning routes, the means to maximise screening.

RECOMMENDATIONS

We envisage that, by 2020, Islington residents will be aware of the risks, causes and symptoms of common cancers so that they will adopt behaviours that minimise or eliminate risks. Eligible women and men will be aware of cancer screening opportunities and will take advantage of these programmes. Any Islington resident will be able to contact screening services to make a convenient appointment at any screening unit in London.

We will continue to build on the work that we started since the 2008 JSNA including:

- Health promotion by continuing to use social marketing to improve awareness and increase participation in screening programmes, targeting outreach at communities with low participation in cancer screening.
- Improving the quality of cancer screening services: by improved commissioning, improved access, appropriateness and acceptability, and by incentivising GPs to increase screening uptake.
- Recommendations for improved outcome measures, audit methods and targets: there should be a focus on equity audit, improved data collection and linkage, and an improved evidence base including the use of social marketing.

REFERENCE LIST