Cancers

Background

6.1. About a third of people in England will develop cancer at some stage in their life and one in four will die from cancer. Cancers disproportionately affect people from deprived backgrounds who are more likely to get cancer and more likely to die from it.

6.2. The Cancer Plan, published in 2000, set out ambitious targets to improve cancer treatment. Despite significant improvements, a persistent gap in cancer outcomes remains between the UK and the best in Europe. The Cancer Reform Strategy 2007 set out plans for further improvements with particular attention to prevention, early diagnosis and the interface between primary and secondary care. Evidence shows that smoking and poor diet, the two largest preventable causes of cancer, are disproportionately concentrated in deprived areas and awareness of cancer symptoms and access to services also tends to be poorer in those areas.

Cancers in Southwark

6.3. Deaths from cancer in Southwark have reduced markedly in recent years as has the gap in the rates between Southwark and those for London and England as the figure below shows.

Figure 6.1: Cancer mortality rate adults < 75 years 1996/8-2005/7 Southwark, London and England.

Source: Floor targets interactive 2009
6.4. For the years 2005-7, only the gap between Southwark and London is statistically significant at the following figure shows.

Fig 6.2: Mortality from all cancers <75 years. Directly aged standardised (3 year average 2005-2007).

6.5. Nevertheless, cancers accounted for 27.4% of deaths in Southwark’s population in 2007. Of these deaths, the percentage attributable to individual cancers is shown in Table 6.1

Table 6.1: Breakdown of types cancers causing mortality in Southwark

<table>
<thead>
<tr>
<th>Locus of cancer</th>
<th>% of cancer deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>lung &amp; bronchus</td>
<td>26.6%</td>
</tr>
<tr>
<td>colorectal</td>
<td>8.0%</td>
</tr>
<tr>
<td>ill defined</td>
<td>7.5%</td>
</tr>
<tr>
<td>breast</td>
<td>6.5%</td>
</tr>
<tr>
<td>oesophagus</td>
<td>6.3%</td>
</tr>
<tr>
<td>prostate</td>
<td>5.1%</td>
</tr>
<tr>
<td>head and neck</td>
<td>3.9%</td>
</tr>
<tr>
<td>pancreas</td>
<td>3.9%</td>
</tr>
<tr>
<td>stomach</td>
<td>3.4%</td>
</tr>
<tr>
<td>non-Hodgkin’s lymphomas</td>
<td>3.1%</td>
</tr>
<tr>
<td>bladder</td>
<td>2.7%</td>
</tr>
<tr>
<td>ovaries</td>
<td>1.4%</td>
</tr>
<tr>
<td>cervical</td>
<td>0.7%</td>
</tr>
<tr>
<td>others</td>
<td>20.9%</td>
</tr>
<tr>
<td>total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: [http://hna.csl.nhs.uk](http://hna.csl.nhs.uk) 2009
6.6. It can be seen that lung cancer was by far the most common cause of cancer mortality accounting for over 1 in 4 of all cancer deaths. Whilst considerable progress has been made in recent years in tobacco control, most notably through the ban on smoking in public places, the full effects of these changes will not be realised for many years. Furthermore, a significant minority of people continue to smoke in Southwark, 32.2% of men and 13.6% of women according to the Health Survey for England boost 2006, with dire and predictable health consequences (half will die of smoking related disease).

6.7. The table below allows consideration of the incidence, mortality (both per 100,000) and relative survival (%) of specific cancer in Southwark, London and England across all ages.


<table>
<thead>
<tr>
<th>Cancer</th>
<th>Indicator</th>
<th>Southwark rate (Lower Confidence interval CI, Upper CI)</th>
<th>London rate (LCI, UCI)</th>
<th>England rate (LCI, UCI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>Incidence</td>
<td>60.6 (54.4,66.7)</td>
<td>48.0 (47.7,48.3)</td>
<td>48.1 (47.7,48.3)</td>
</tr>
<tr>
<td></td>
<td>Mortality</td>
<td>50.3 (44.7,56.0)</td>
<td>40.3 (39.5,41.2)</td>
<td>40.1 (39.8,40.4)</td>
</tr>
<tr>
<td></td>
<td>5 year survival</td>
<td>6.3 (4.3,8.3)</td>
<td>8.4 (7.9,8.9)</td>
<td>7.5 (7.4,7.7)</td>
</tr>
<tr>
<td></td>
<td>1 year survival</td>
<td>25.4 (21.6,29.3)</td>
<td>29.8 (29.0,30.6)</td>
<td>28.2 (28.0,8.5)</td>
</tr>
<tr>
<td>Colorectal</td>
<td>Incidence</td>
<td>43.5 (38.2,48.7)</td>
<td>39.7 (38.9,40.6)</td>
<td>44.6 (44.3,44.9)</td>
</tr>
<tr>
<td></td>
<td>Mortality</td>
<td>19.9 (16.4,23.4)</td>
<td>16.6 (16.0,17.1)</td>
<td>18.0 (17.9,18.2)</td>
</tr>
<tr>
<td></td>
<td>5 year survival</td>
<td>47.3 (41.4,53.3)</td>
<td>47.8 (46.8,48.9)</td>
<td>52.1 (51.7,52.4)</td>
</tr>
<tr>
<td></td>
<td>1 year survival</td>
<td>67.3 (62.0,72.7)</td>
<td>69.0 (68.0,69.9)</td>
<td>72.4 (72.2,72.7)</td>
</tr>
<tr>
<td>Breast (f)</td>
<td>Incidence</td>
<td>111.4 (99.6,123.2)</td>
<td>112.9 (110.9,114.9)</td>
<td>123.8 (123.0,124.5)</td>
</tr>
<tr>
<td></td>
<td>Mortality</td>
<td>27.3 (21.7,32.9)</td>
<td>27.8 (26.8,28.7)</td>
<td>28.1 (27.7,28.4)</td>
</tr>
<tr>
<td>Prostate (m)</td>
<td>Incidence</td>
<td>101.1 (89.2,113.1)</td>
<td>97.3 (95.3,99.3)</td>
<td>100.2 (99.5,100.8)</td>
</tr>
<tr>
<td></td>
<td>Mortality</td>
<td>13.0 (9.0,17.0)</td>
<td>24.8 (23.9,25.8)</td>
<td>25.7 (25.4,26.0)</td>
</tr>
<tr>
<td>Cervix (f)</td>
<td>Incidence</td>
<td>11.3 (7.8,14.9)</td>
<td>6.9 (6.4,7.4)</td>
<td>8.1 (7.9,8.3)</td>
</tr>
<tr>
<td></td>
<td>Mortality</td>
<td>3.2 (1.3,5.1)</td>
<td>2.4 (2.1,2.7)</td>
<td>2.5 (2.4,2.6)</td>
</tr>
</tbody>
</table>

Source: NCIS 2009

6.8. It can be seen that incidence and mortality from lung cancer in Southwark were significantly higher than London as well as England as a whole. In addition, the incidence of cervical cancer was significantly above that for London. Prostate cancer mortality was significantly lower than that for London and England.

6.9. Looking within the borough, significant variation in cancer mortality across wards is evident as can be seen in the figure below.
6.10. Although ratios at the ward level are subject to considerable natural variation, as can be seen in consideration of the 95% confidence intervals, at the extremes they do not overlap indicating significant variation. Whilst Surrey Docks has an SMR of 60 (meaning that cancer mortality is 40% lower than expected if mortality was consistent with that across England), Rotherhithe has an SMR of over 140 (meaning that its cancer mortality is more than 40% higher than expected).

6.11. In summary, despite reducing cancer mortality in Southwark and a narrowing gap between Southwark and England, cancer continues to account for more than one quarter of all deaths in 2007. Lung cancer is the driver of the excess mortality in Southwark with rates in Southwark significantly above London and England as a whole. Prostate cancer mortality on the other hand is significantly lower in Southwark than London and England. Across Southwark’s wards there are statistically significant differences in cancer mortality ratios with wards with the highest ratios more than double those in the wards with the lowest ratios.

**Intervention & management**

6.12. Intervention and management relevant to cancer ranges from prevention activities, in particular tobacco control and smoking cessation but also healthy eating and physical activity promotion, screening, including programmes for breast, cervix and colorectal cancers, diagnosis and referral, and treatment.
**Screening**

**Breast Screening**

6.13. The graph below shows that the breast screening coverage in Southwark has remained just above 62% in recent years and is slowly increasing; this is slightly higher than Lambeth but slightly lower than Lewisham and London as a whole.

**Fig 6.4: Breast Screening Programme coverage rates 1996-2001**

![Breast Screening Programme coverage rates 1996-2001](image)

The figures for 1996 - 2002 are based on a screening age range of 50-64 however in 2003 it was agreed that coverage was best assessed using the 53-64 age group as women may be called at any time between their 50th and 53rd birthdays.

6.14. Coverage is considerably lower than England as a whole and the national requirement of 70%. It should be recognised however that screening uptake is particularly challenging in the capital as a result of population diversity and mobility.

6.15. Whilst there is no clear and consistent data on screening uptake by ethnicity, local surveys have shown differences in attitudes towards screening by ethnic group. Uptake amongst recent immigrants is particularly challenging due to language and cultural barriers.

6.16. Southwark’s population is highly mobile which means that many people are not consistently registered with a GP who has their current address. This results in many people not receiving invitations for breast and cervical screening. Geographical mapping of variation in screening uptake has been undertaken and shows a significant association of low uptake with deprived post codes.

6.17. In cancer screening the age range for being invited for Breast Screening has been extended from 50 - 65 years to 50 - 70 years and is due to be further expanded by 2012 to regularly invite women aged 47 – 73. The National Health Service Breast Screening Programme is increasingly moving
towards digital mammography. Digital mammography has greater sensitivity than film based mammography and is logistically more straightforward to operate than film based mammography. However, because of the cost, digitalisation is likely to lead to a rationalisation of screening sites – but this is likely to be offset by extended opening hours to include early mornings, evenings and weekends.

**Action to improve screening**

6.18. The PCT is working with local GP practices to send letters to their patients prior to invitation for breast screening and following non-attendance for screening to emphasise the importance of screening, this activity has produced a 5% increase in uptake of screening invitations in South Lambeth where this pilot project has been undertaken.

6.19. Following feedback from GPs, the current invitation process and letter was reviewed with a view to making it more ‘friendly and understandable’ especially for women with low levels of literacy. This included reviewing the process of making appointments with South East London Breast Screening Programme (SELBSP) to establish if there is a more satisfactory approach of making an appointment. New invitation letter was drafted and followed up with SELBSP.

6.20. The screening service has developed a leaflet in the top 10 most commonly used languages in Southwark to accompany letters inviting women for cervical screening to ensure that women who do not speak English as their first language understand what the letter is that they have been sent.

**Fig 6.5: Trends in screening for Cervical Cancer**

![Graph showing trends in cervical cancer screening](source: KC53 Statistical Returns (2009))
6.20. The graph above shows that cervical screening coverage in Southwark has remained just above 70% in recent years which is slightly below neighbouring boroughs Lewisham and Lambeth and is considerably below the national target of 80% and the England coverage of 79%. However, in the last quarter (to March 09) the coverage has increased by 1% in Southwark which is thought to be the result of media attention to the death of the celebrity Jade Goody from cervical cancer. The likely persistence of this effect is as yet unknown.

6.21. Uptake is challenging for the same reasons as outlined in consideration of breast screening uptake. In addition for cervical screening, uptake by age is marked (see graph below) with poor uptake among women under 35 years both nationally and locally.

Fig 6.6: Cervical screening coverage by age groups in Lambeth, Southwark and Lewisham March 2007 (except England data)

![Graph showing cervical screening coverage by age groups in Lambeth, Southwark, Lewisham, and England]

Source: KC53 Statistical Returns

6.22. In cervical cancer screening a new technology, Liquid Based Cytology, has been introduced which reduces the proportion of smear tests which need to be repeated from 10% to around 2%. There are also proposals to reduce the waiting time between being tested and receiving results to under 2 weeks by 2010.

6.23. We are currently developing a network of community based services for women who are not registered with a GP or unable to reach their GP during office hours to attend for cervical screening. We anticipate that this will make services more accessible to some of the more mobile groups of our population who are less likely to attend for screening.

6.24. We have implemented Direct Referral to Colposcopy from the laboratories which identify women’s need for further investigation following an abnormal smear test result. This helps to reduce waiting times for Colposcopy.
Screening for Colorectal Cancer
6.25. The national colorectal screening programme was rolled out in Southwark in 2008. Whilst the programme is still very much in an introductory phase, uptake is proving to be challenging (32.8% for 2008 as compared to a London average of 40.3% and an England average of 52.5%).
6.26. A health promotion programme will be developed to encourage uptake of this programme. A Health Promotion Specialist who works across SE London has been recruited in August 2009 to develop a strategy to improve bowel screening uptake.

Diagnosis and referral
Treatment Waiting Times
6.27. National Targets for waiting times for cancer treatment were introduced in 2005 and are now consistently met. These include:
- A maximum waiting time of 14 days from urgent GP referral to first outpatient appointment
- A maximum waiting time of one month from diagnosis to treatment for all cancers.
- A maximum waiting time of two months from urgent referral to treatment for all cancers.

6.28. Additional targets have been introduced and met for first treatment after referral from a NHS screening programme (62 days) and for subsequent drug treatment (less than 31 days). A further new target is not being met however, namely that all symptomatic breast referrals be seen within 2 weeks although the numbers are very small.

Hospital Admissions
6.28. The figures below present inpatient and outpatient activity attributable to cancer in Southwark.

Fig 6.7: Southwark PCT total elective cancer admissions per 1000 population 2008/2009
6.29. The figure above shows that in Southwark the level of hospital admissions relating to cancers are lower than for London and England.

Fig 6.7: Southwark PCT emergency cancer admissions 2008/2009

Source: NHS Comparators 2009

6.30. Emergency admissions on the other hand are higher than London and England. Emergency admissions may be the result of late diagnosis and/or complications following treatment, particularly chemotherapy.

6.31. Whilst it is clearly desirable to avoid emergency admissions wherever possible, inpatient activity might appear low either because of the provision of alternative outpatient services or because of under utilisation. The figures below indicate that outpatient activity for medical and clinical oncology is also relatively low in Southwark suggesting under utilisation.

Fig 6.8: Southwark PCT clinical oncology outpatient attendances 2008/2009

Source: NHS Comparators 2009
6.32. In consideration of admissions within the borough, some variation is observed as the following figure shows.

Fig 6.10: Inpatient admissions and total episodes by ward (April 2007-Aug 2009) unadjusted and adjusted for deprivation.

Source: Dr Foster 2009
6.33. The figures indicate that Southwark wards have lower levels of hospital admissions relating to cancers than would be expected. The exceptions are the Lane, where admissions are inline with expectations, and East Dulwich, a more affluent population where utilisation is higher than expected.

**Treatment**

6.34. Southwark is compliant with all the treatment standards outlined by NICE in the improving outcomes guidance (IOGs).

**Recommendations**

- There is a continuing need to focus on smoking as a major risk factor for cancer especially smoking in conjunction with diet.
- Uptake of services such as emergency admissions need to be better understood so as to ensure the best and most effective treatment is accessed in a timely way.
- Screening rates need significant further improvement especially cervical screening rates.