

7.22 Cancer

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As of the end of 2012, around 3,612 people including 1,552 males and 2,060 females in Barking and Dagenham were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 7,000 by 2030 based on current 20-year prevalence and indicative future estimates by PHE-Local Cancer Intelligence (LCI) and Macmillan Cancer Support (MCS).

Cancer prevalence is a count of people still alive who have been diagnosed with cancer in the past. Figure 7.22.1 shows the recorded prevalence of all cancer, all ages by QOF in Barking and Dagenham from 2009/10 to 2014/15, compared to England. The figure shows a very lower rate for B&D CCG (almost half) compared to the national average.

Figure 7.22.1 Recorded prevalence of all cancer, all ages by QOF, Barking and Dagenham and England, 2009/10 to 2014/15

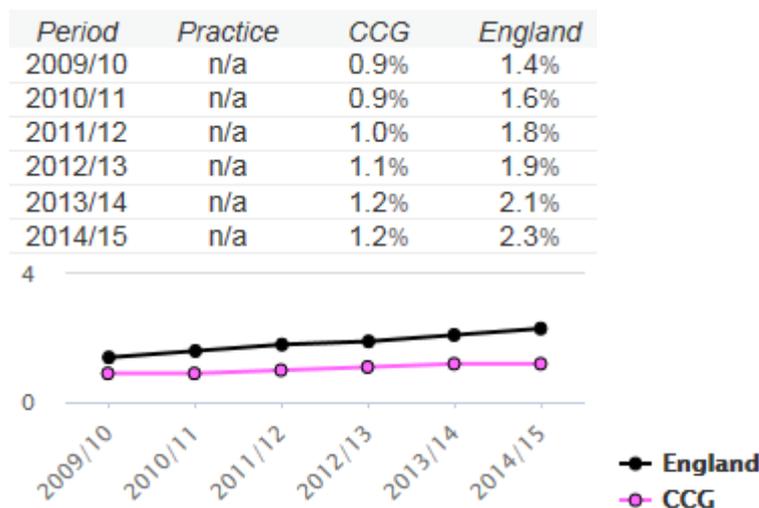
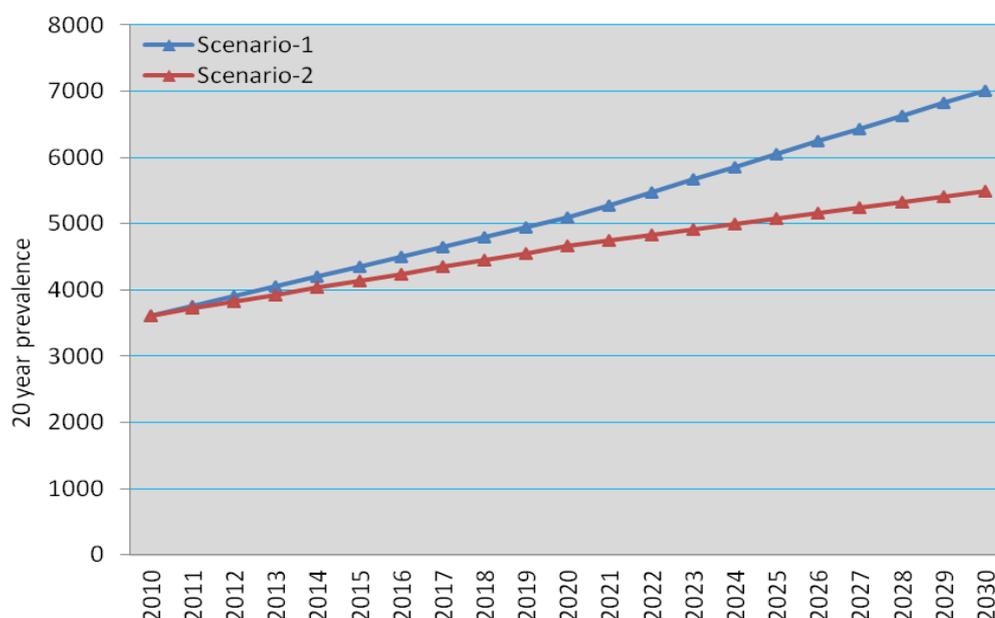


Figure 7.22.2 shows projected 20-year cancer prevalence for Barking and Dagenham CCG, the number of people living in LBBDD who received a cancer diagnosis between 1991 and 2010 and were still alive at the end of 2010 (the latest data available). Cancer prevalence reflects trends in cancer incidence, mortality and survival, as well as advances in cancer treatment and detection, and the ageing of the population. The number of people living with and beyond cancer is increasing and is set to rise further, if existing trends continue. Figure 7.22.2 shows two possible future scenarios:

Scenario 1: assumes people will continue to get and survive cancer at increasing rates in line with recent trends (except for prostate cancer), and the general population will continue to grow and age.

Scenario 2: assumes people will continue to get cancer at the rate they do today, and that survival rates will remain as they are. The estimates are therefore driven by a growing and ageing population only.

Figure 7.22.2 20-year prevalence and indicative future estimates by scenario: all cancers, NHS Barking and Dagenham CCG



Source: PHE-LCI and MCS

The overall number of cancer deaths each year in the UK has remained fairly static over recent years, while cancer mortality rates are decreasing as a result of improvements in early diagnosis, treatments and cancer services. Cancer is the most common cause of death in England and Wales – approximately 29% of all deaths in 2013 were from cancer.

In the past five years there has been an emphasis on diagnosing cancer early at a stage when treatment is likely to be effective. The National Awareness and Early Diagnosis Initiative ¹ has driven the activity linked to improving awareness and early diagnosis.

When NHS Five Year Forward² was published in 2014 it set out a vision which calls for action on three fronts: better prevention; swifter diagnosis; and better treatment, care and aftercare for all those diagnosed with cancer.

A new multi-agency cancer strategy published in 2015³. It includes cancer specialist doctors and clinicians, patients groups and charity leaders, including Macmillan Cancer Support, Public Health England, local councils, and the Royal College of GPs.

¹ <http://www.cancerresearchuk.org/health-professional/early-diagnosis-activities/national-awareness-and-early-diagnosis-initiative-naedi> (Accessed 2 July 2015)

² <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

³ Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020', [Online] Available from: https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf [Last accessed: 15th of August 2016]

The strategy considers prevention, first contact with services, diagnosis, treatment, support for those living with and beyond cancer, and end-of-life care, as well as how all these services will need to develop and innovate in future.

In addition to the strategy the following have been put in place:

- A major early-diagnosis programme, working jointly with Cancer Research UK and Macmillan Cancer Support, testing seven new approaches to identifying cancer more quickly. Initiatives will 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.
- An improvement to the monitoring of cancer survival at a local level. NHS England will include a one-year cancer survival indicator in the assurance system used to ensure Clinical Commissioning Groups are delivering. This puts cancer survival at the front and centre for every single CCG across the country.

The four major cancers contributing to early death both locally and nationally are lung, bowel, breast, and prostate cancers. Lung and Bowel cancers are largely preventable through lifestyle modification. The single most important risk factor for all cancers is smoking; however obesity, diet and alcohol are also important risk factors. The proportion of breast cancers which is preventable is much less than for bowel and lung cancer, and for prostate cancer, there is limited evidence for preventative measures.

Early diagnosis and screening

There are three national cancer screening programmes; breast, cervical, and bowel cancer screening. There is no organised screening programme for prostate cancer but an informed choice programme for prostate cancer risk management has been introduced. The purpose of the screening programmes is to identify people who are at high risk of developing disease but may otherwise be unaware of it because they are currently not experiencing any symptoms. The screening test identifies those who need further testing to determine whether they have cancer. The aim of the NHS Cancer Screening Programmes is to reduce deaths from cancer, and increase survival rates by detecting early changes for which treatment will improve outcomes.

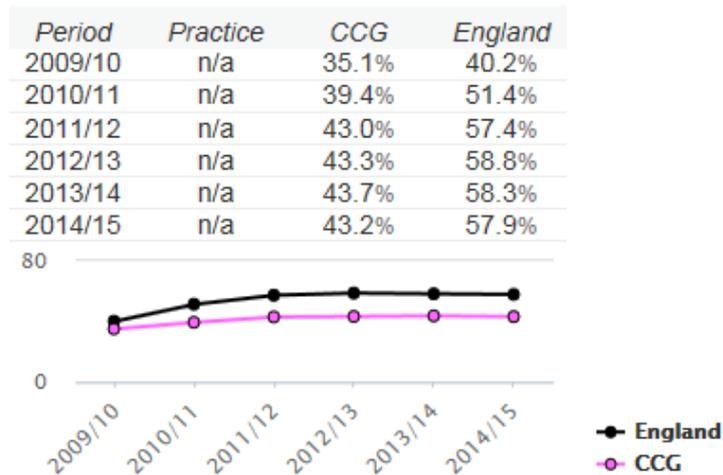
A number of initiatives have taken place both locally and nationally to address early awareness and detection including:

- An RCGP Accredited education programme for local GPs on early awareness and detection of cancers
- Bowel cancer community engagement
- National 'Be Clear on Cancer' campaigns for lung and bowel cancers, and 'Know 4 Sure' campaign on four common symptoms of cancer.

Bowel screening

The rate of uptake for bowel screening has gradually improved over the last few years, increasing from 35.1% in 2009/10 to 43.2% in 2014/15. Figure 7.22.3 shows the local uptake rate is still much lower than the national target of 57.9% and is also low in comparison to other London boroughs (7th lowest).

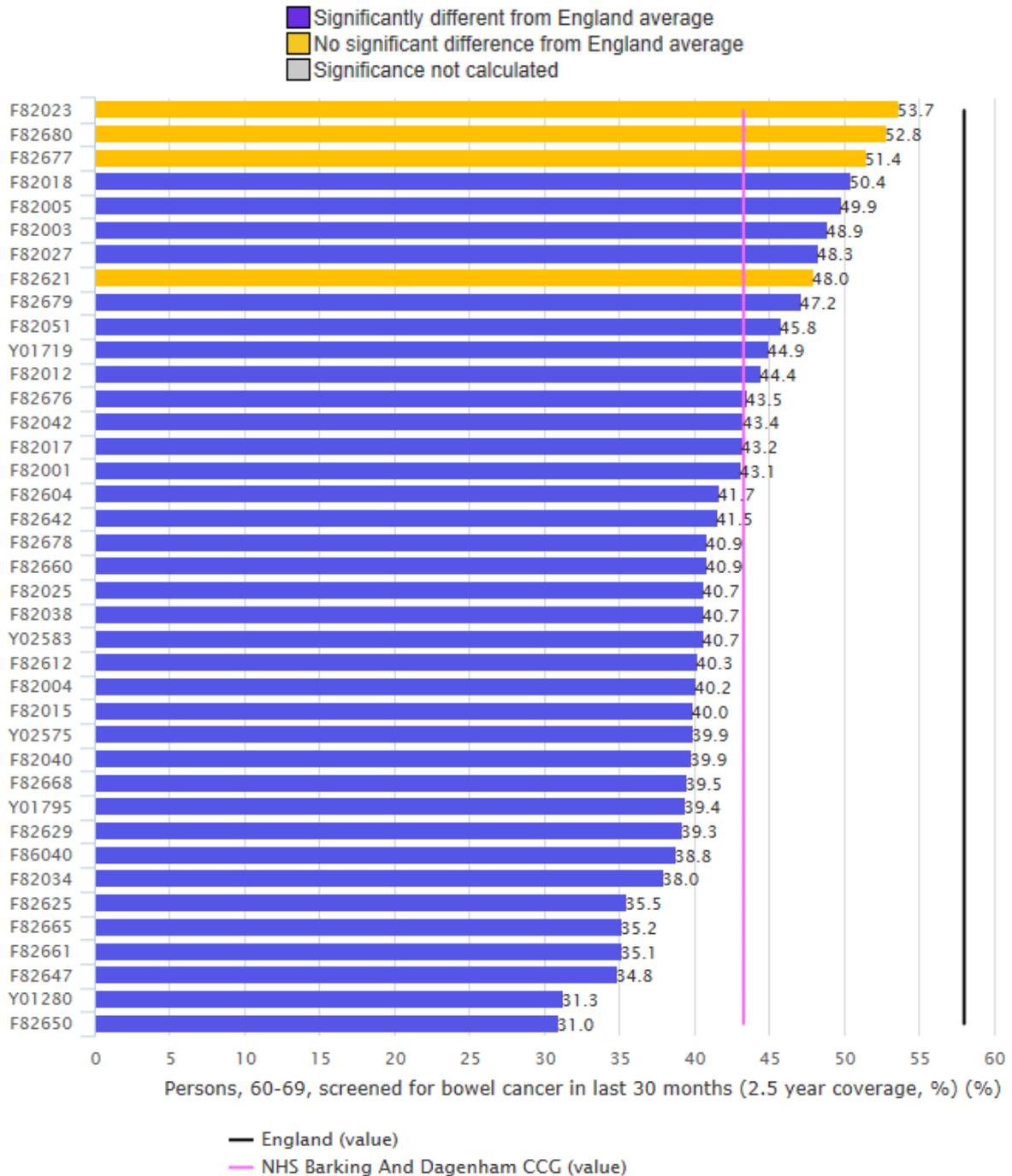
Figure 7.22.3 Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage), B&D CCG and England, 2009/10-2014/15



Source: PHE, National GP Profile

Figure 7.22.4 shows that there are not any practices in Barking and Dagenham that was higher than the national average, although four practices were statistically similar.

Figure 7.22.4 Percentage of 60-69 years old screened for bowel cancer in last 30 months by practice, Barking and Dagenham, 2014/15



Source: PHE, National GP Profile

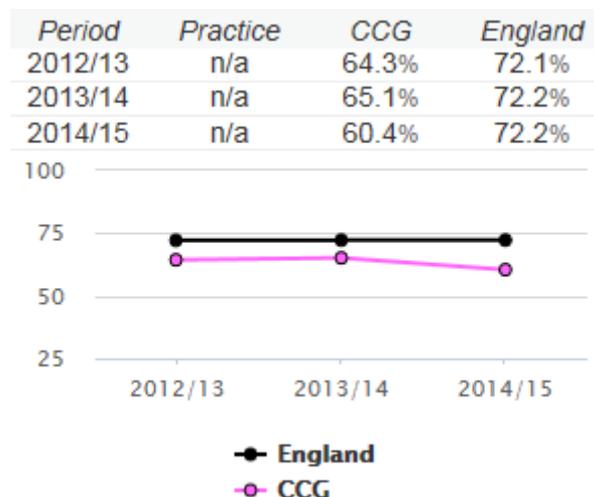
Bowel screening currently covers people aged 60 to 69 years but this is being expanded to include people aged up to 75 years. Age extension will start in outer north east London once all the necessary arrangements are in place with the provider (Homerton University Hospital Trust). Nationally, flexible sigmoidoscopy

scanning will start to be offered to all people aged 55 years of age. Flexible sigmoidoscopy uses a thin tube called an endoscope inserted into the rectum. It is a one off test which aims to detect bowel polyps and cancers early before any symptoms develop.

Breast screening

Proportion of eligible women, 50-70 in Barking and Dagenham CCG, who were successfully screened for breast cancer in the last 36 months (3 year coverage), was slightly increased between 2012/13 and 2013/14 from 64.3% to 65.1%, but latest data from 2014/15 shows (Figure 7.22.5) that there has been a reduction, declining to 60.4%. This is lower than the level for England of 72.2%⁴. According to the research, there is generally lower uptake of breast screening in more deprived areas⁵.

Figure 7.22.5 Females, 50-70, screened for breast cancer in last 36 months (3 year coverage), B&D CCG and England, 2012/13 – 2014/15



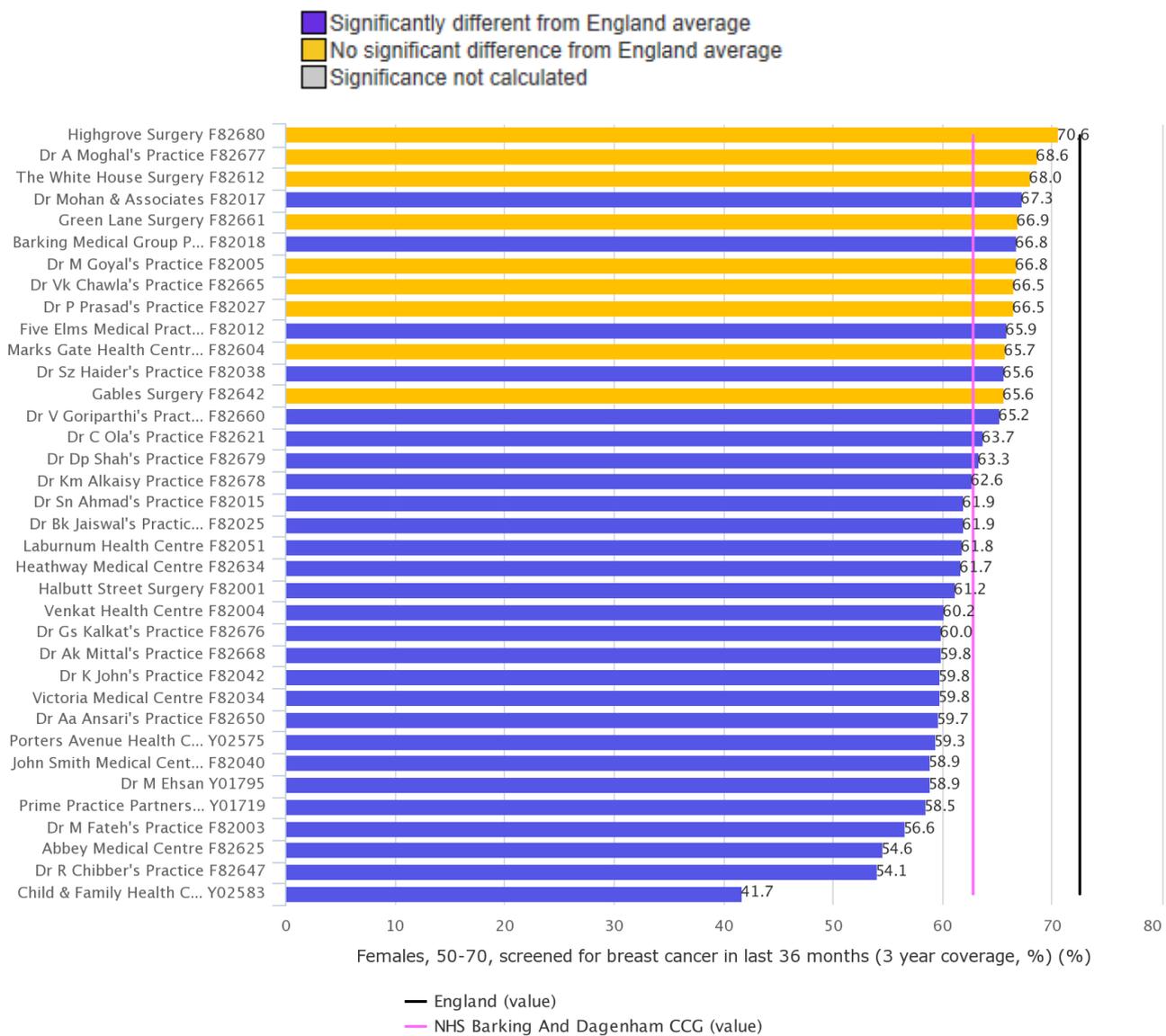
Source: PHE, National GP Profile

Figure 7.22.6 illustrates the recorded percentage of females aged between 50 and 70 years who have been adequately screened in the last three years, by all GP practices in Barking and Dagenham, compared to B&D CCG and England in 2014/15. Figure 7.22.6 shows that there are not any practices in Barking and Dagenham with significantly higher screening rate the national average and 27 practices significantly lower than the national average; the reminder of practices were statistically similar.

⁴ PHE, National GP Profile, 2015, [Online] Available form: <http://fingertips.phe.org.uk/profile/general-practice/data> [Last accessed 7 July 2016]

⁵ Ruth, H.J. et.al. 2014, 'Breast cancer screening uptake among women from different ethnic groups in London: a population-based cohort study' BMJ Open [online] available from: <http://bmjopen.bmj.com/content/4/10/e005586.full> [accessed 6 July 2015]

Figure 7.22.6 Females 50-70 years adequately screened for breast cancer in the previous 36 months, GP Practices in Barking and Dagenham, compared to B&D CCG and England, 2014/15



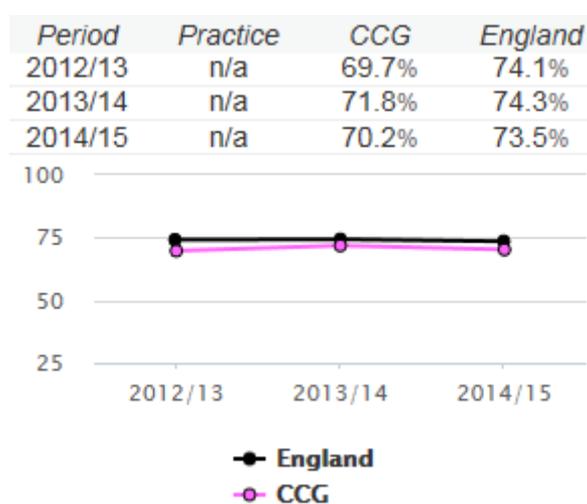
Source: PHE, National GP Profile

Cervical screening

Figure 7.22.7 shows from 2012/13 to 2013/14 There has been 2.1% increase in the rate of female 25-64 years old who attended a cervical screening and have been adequately screened (within the target period of 3.5 or 5.5 years), but 2014/15 data shows 1.6% decline compared to the previous year.

Figure 7.22.7 shows the screening rate in Barking and Dagenham is 3.3% lower than the national average of 73.5% in 2014/15. The national standard is 80% and the minimum standard is 70% so there is still opportunity for improvement.

Figure 7.22.7 Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %), B&D CCG and England, 2012/13 – 2014/15

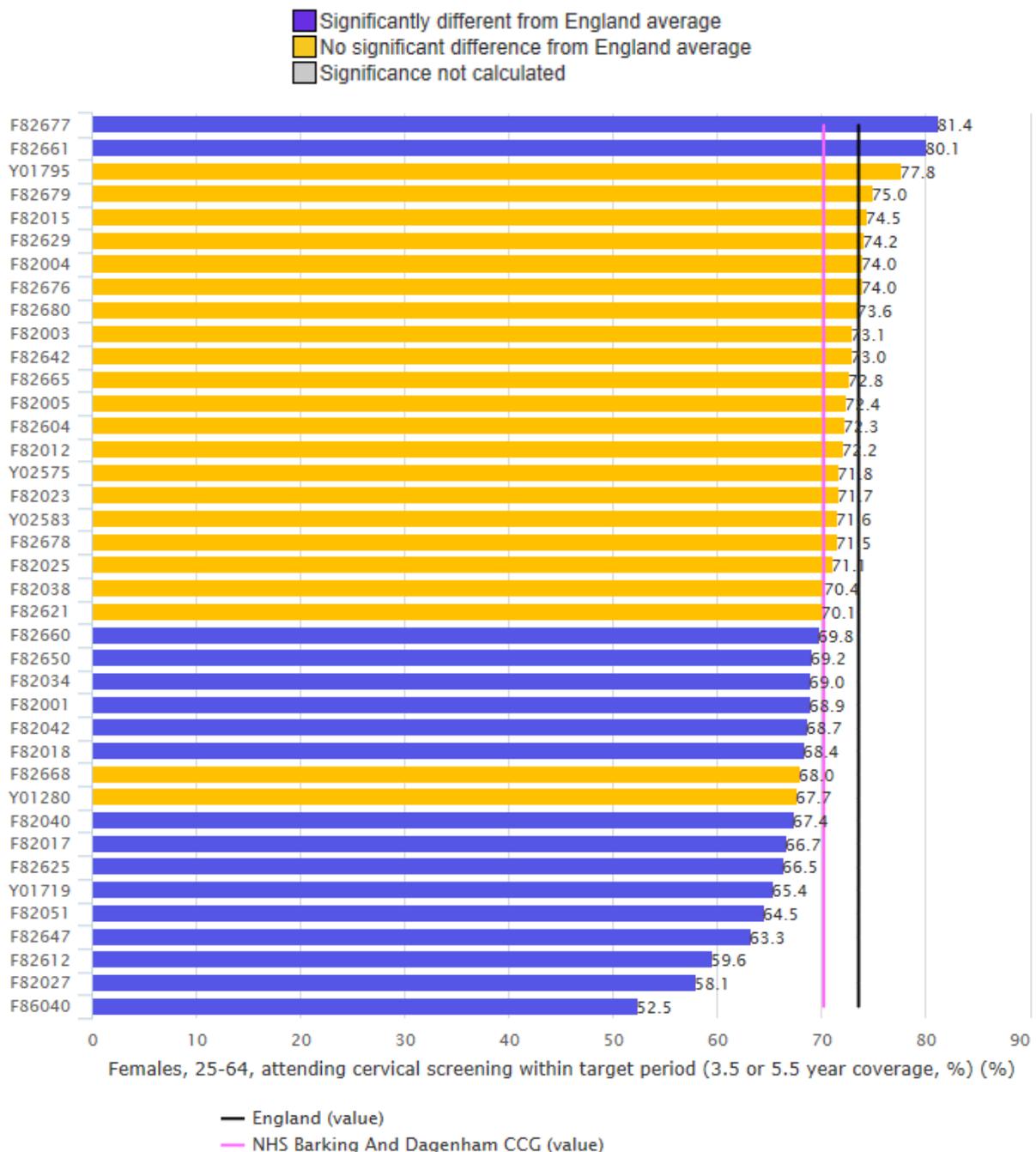


Source: PHE, National GP Profile

Figure 7.22.8 also shows the percentage of women aged 25-64 with a record of cervical screening in the last 5 years (prior to the end of 2014/15), by practices, CCG and England average.

The figure shows there is one practice in Barking and Dagenham with significantly higher percentage of screening than the national average and twelve practices with significantly lower coverage. There is no significant difference between the reminders of the practices and the national average.

Figure 7.22.8 Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage), GP Practices in Barking and Dagenham, compared to B&D CCG and England, 2014/15



Achieving earlier diagnosis of cancer

A report by the cancer intelligence network⁶ found that nationally 23% of newly diagnosed cancer patients came through as emergency presentations on 2007 or

⁶ NCIN, 2016, "Routes to diagnosis – NCIN Data Briefing [Online] Available from: http://www.ncin.org.uk/publications/data_briefings/routes_to_diagnosis.aspx [Last accessed: 8 July 2016]

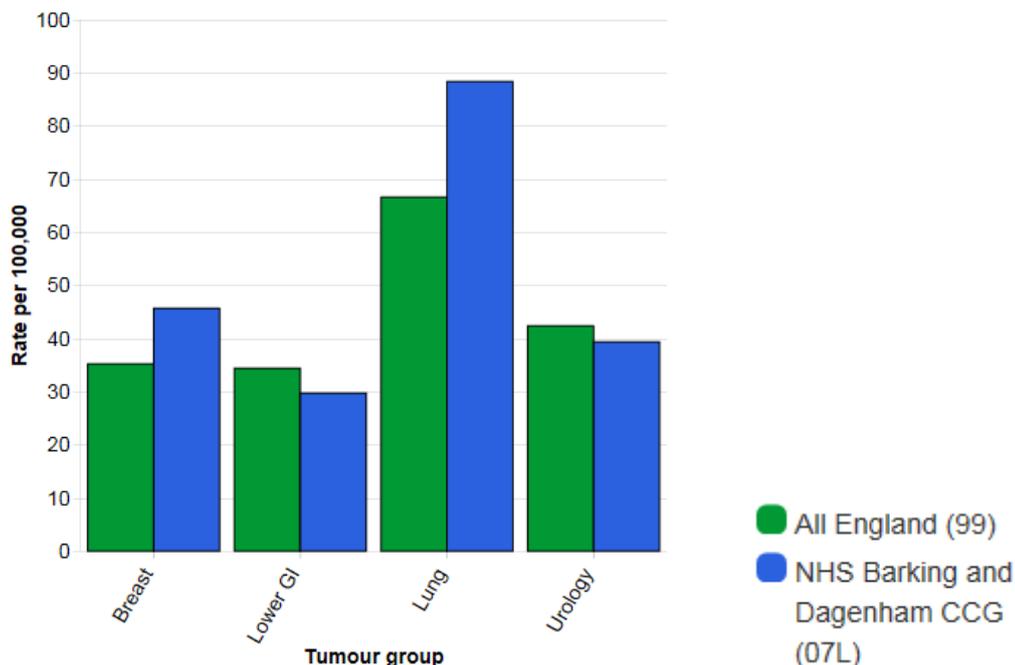
before. Emergency presentations include accident and emergency presentation, emergency GP referral, emergency consultant outpatient referral or transfer. For almost all cancer types, one-year survival rates were much lower for patients presenting as emergencies than for those presenting via other routes. The reason for this is that if people present as an emergency it is likely that the cancer has progressed to stages 3 or 4 which are later stages and more difficult to treat.

The proportion of emergency presentations varied widely between cancer types (e.g. melanoma 3%; brain and central nervous system 58%) and by age. Patients aged under 25 and patients over 75 were the most likely to present as emergencies. A socio-economic gradient was also observed, with more affluent patients being less likely to present as emergencies.

Cancer mortality

Cancer contributes significantly to the health inequalities gap. Based on information provided by PHE- LCI, in Barking and Dagenham there were 356 cancer deaths in 2013, This is equivalent to 337 cancer deaths per 100,000 people, which is 19% higher than the England rate of 284 per 100,000 people and the highest rate between all London CCGs⁷. Figure 7.22.9 compares age-standardised mortality rate per 100,000 populations by tumour group, between LBBD and England in 2013.

Figure 7.22.9 all age group, age-standardised mortality rate per 100,000 by tumour group, LBBD and England, 2013



Source: LCI-PHE and MCS

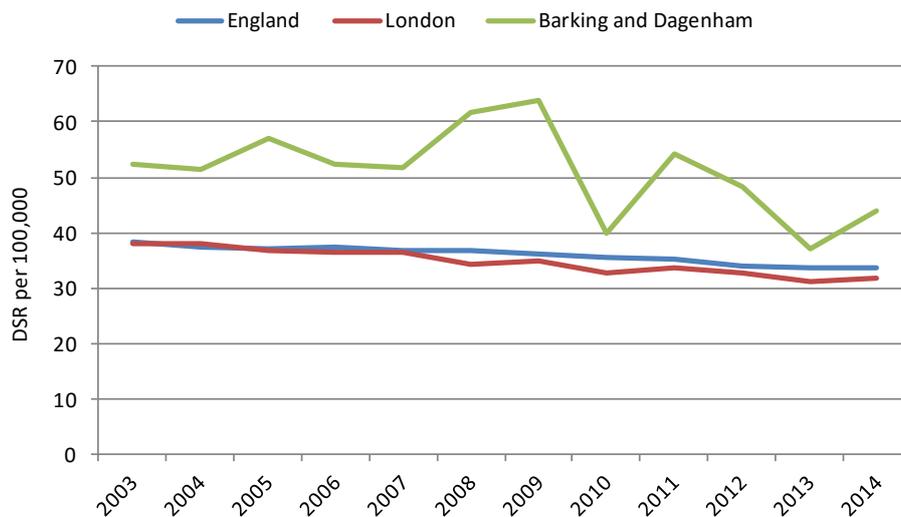
Figure 7.22.9 shows that the mortality rate for breast and lung cancer in Barking and Dagenham is higher than the national average. Lung Cancer is the cause of 6% of all deaths in the UK and is the most common cause of cancer death, causing 22% of

⁷ Local Cancer Intelligence Networks (PHE) and Macmillan Cancer Support, 2016, "Cancer Mortality in NHS Barking and Dagenham CCG" [online] available from: <http://lci.cancertoolkit.co.uk/Mortality> [Last accessed: 8 July 2016]

deaths from cancer⁸. It is the most common cause of cancer death in Barking and Dagenham, a mortality rate of 91.2 per 100,000 populations, is 50.3% higher than the England rate of 62. Smoking causes more than 8 out of 10 lung cancer cases and smoking prevalence remains higher in Barking and Dagenham than in England as a whole.

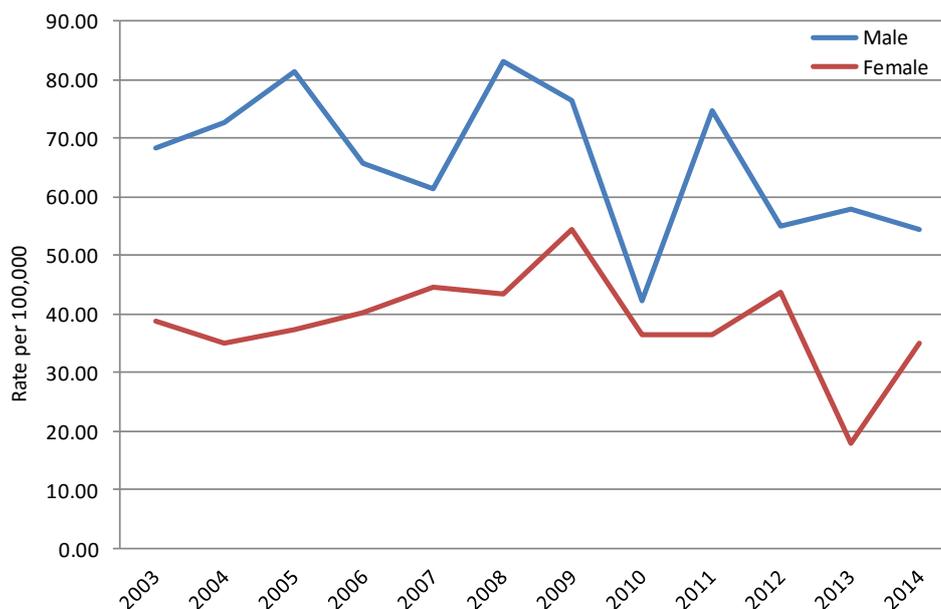
Figures 7.22.10 show the rate of premature deaths from lung cancer for those younger than 75 years old in LBB, London and England and Figure 7.22.11 shows the rate of premature deaths from lung cancer for those younger than 75 years old by gender in LBB; from 2003 – 2014.

Figure 7.22.10 Lung cancer mortality, <75 years, LBB, London and England, 2003-2014



Source: HSCIC

Figure 7.22.11 Lung cancer mortality, <75 years, by gender, LBB 2004-2013

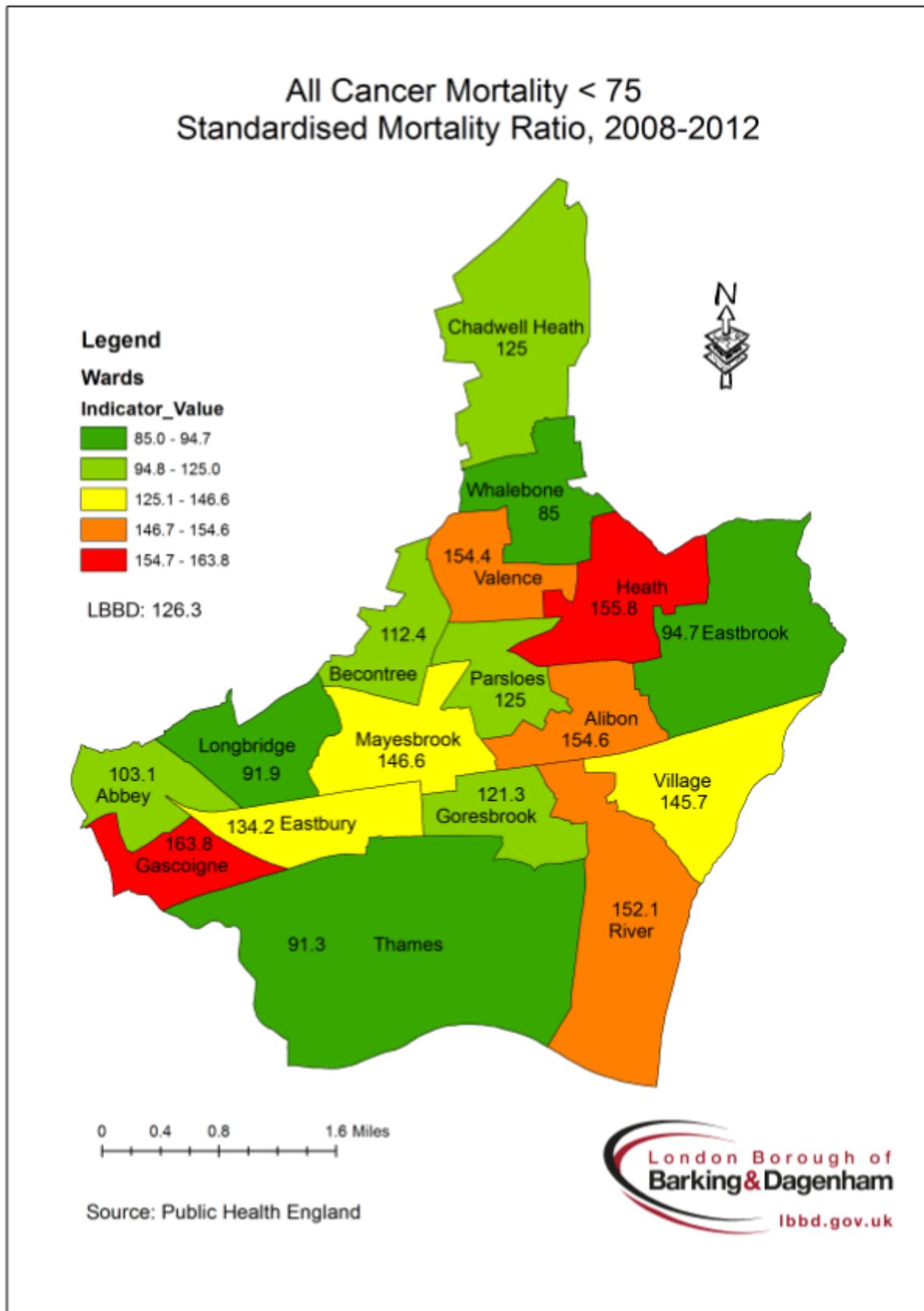


⁸ Cancer Research UK, 2015. 'Cancer mortality statistics', [online] available from: <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/lung/mortality/uk-lung-cancer-mortality-statistics> [accessed 10th July 2015]

Source: HSCIC

Figure 7.22.13 also shows the cancer mortality rate by LBBB wards.

Figure 7.22.13 All Cancer Mortality, <75 years, Standardised Mortality Ratio, LBBD by ward level, 2008-12⁹

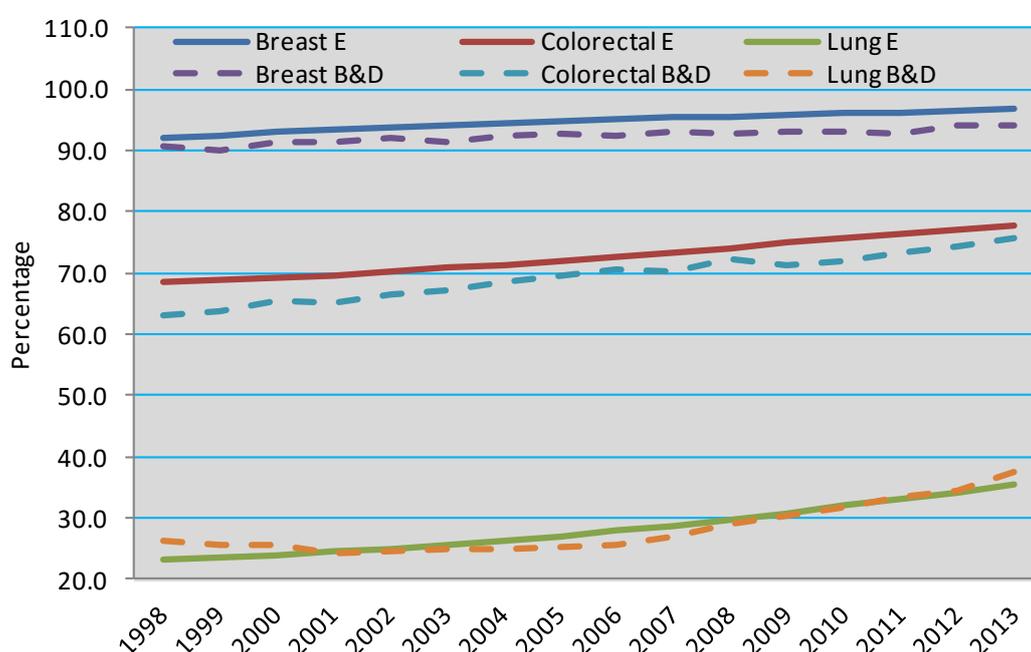


Cancer survival

One year cancer survival is a good indicator of whether cancer is being diagnosed early and whether access to optimal treatment is available. On average, one year cancer survival in England lags behind the best in Europe, so there is still room for improvement in this area.

One year survival rates for the three major cancers – breast, colorectal and lung have improved in recent years in Barking and Dagenham and England, with one year survival is presented in Figure 7.22.14. The trend shows a steady improvement since 1998 for both breast and colorectal cancer but for lung cancer the improvement started from 2006-07¹⁰.

Figure 7.22.14 One-year survival index (%) for 3 major cancers (breast, colorectal and lung), by calendar year of diagnosis: all adults (aged 15-99 years), CCG, England, 1998-2013

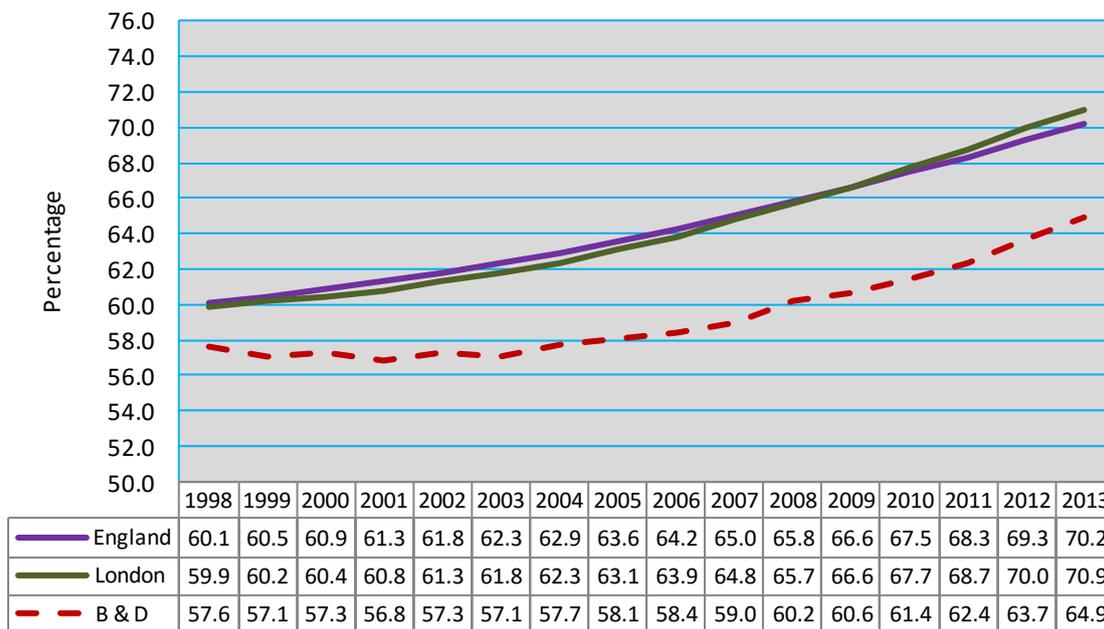


This improvement is also reflected in the all cancers combined one year survival (Figure 7.22.15), although the improvement has come later and more slowly, from 58% in 2005 to 65% in 2013. The one year survival rate for B&D for all cancers in 2013 was the second lowest in London after Newham, much lower than London rate of 70.9% and England rate of 70.2%. The highest rate between all London boroughs was for Barnet and Harrow with 74.5% survival.

⁹ PHE, Local Health Indicators, 2016 “Deaths under 75, all cancer – 2008-2012 inclusive”, [Online] available from: http://www.localhealth.org.uk/#z=542681,187467,8319,5429;v=map4;l=en;sly=ward_2013_DR;sid=10;i=t2.obese_child_year_6 [Last accessed: 11 Jul. 16]

¹⁰ ONS, February 2016. ‘Table 01 to 09: 1-year cancer survival by clinical commissioning groups in England, with precision estimates-Table-8’ [online] available from: <http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/table01to091yearcancersurvivalbyclinicalcommissioninggroupsinenglandwithprecisionestimates> [accessed 11 July 2016]

Figure 7.22.15 One-year survival index (%) for all cancers, by calendar year of diagnosis: all adults (aged 15-99 years), CCG, England, 1998-2013



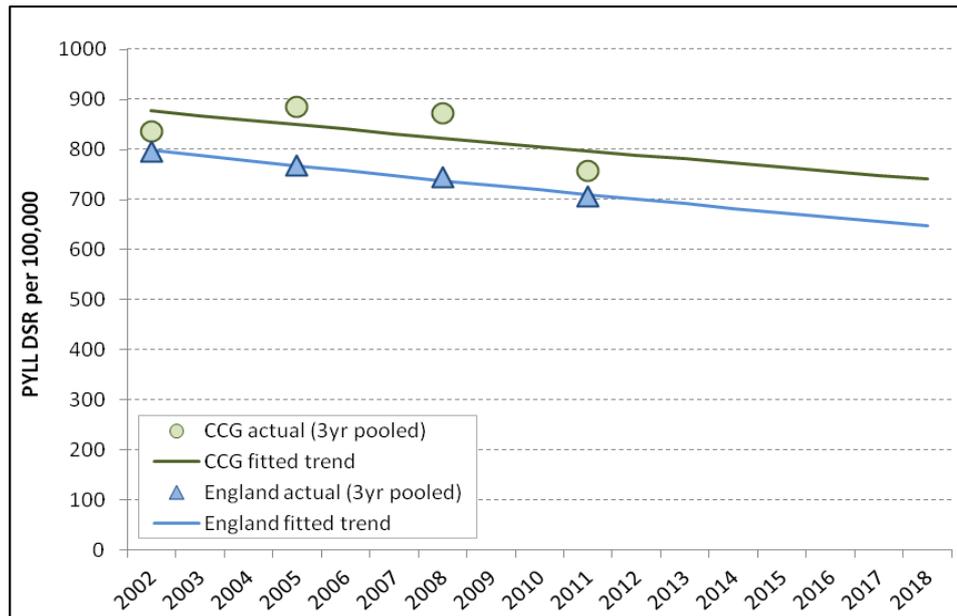
Source: ONS ¹¹

¹¹ ONS, February 2016. 'Table 01 to 09: 1-year cancer survival by clinical commissioning groups in England, with precision estimates-Table-1' [online] available from: <http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/table01to091yearcancersurvivalbyclinicalcommissioninggroupsinenglandwithprecisionestimates> [accessed 11 July 2016]

Potential years of life lost (PYLL)

PYLL from causes considered amenable to healthcare is one of the key outcome measures that NHS England has asked CCGs with NHS England Area teams to include in five year strategic plans (2014/15 to 2018/19). Figure 7.22.12 is an illustration of potential years of life lost in Barking of Dagenham (2002-2018) from amenable cancers.¹²

Figure 7.22.12 NHS Barking and Dagenham CCG (resident population), amendable Cancers - Potential years of life lost due to cancer DSR



Source: PHE, 2014.

¹² PHE, August 2014. 'Potential Years of Life Lost tool' [online] available from: <http://www.yhpho.org.uk/default.aspx?RID=203686> [Accessed 11 July 2016]

Recommendations for Commissioners

A focus on interventions to reduce mortality from lung and bowel cancers will have the biggest impact on cancer mortality and survival for the borough compared to other types of cancer. Lung cancer is currently addressed through smoking cessation which is the single most effective strategy for tackling the problem. The number of people who successfully stop smoking needs to increase dramatically to reduce lung cancer mortality.

Bowel cancer requires a combination of approaches including lifestyle interventions such as increased physical activity and healthy eating, and also secondary prevention which is aimed at promoting early awareness of symptoms and diagnosis. Promoting the value of the cancer screening programmes should be a local priority to improve the levels of early diagnosis and survival rates.

Programme budgeting data show that secondary care is prioritised over primary care interventions. Commissioners should aim to achieve a good balance by looking at ONS cluster group comparators that have managed to improve outcomes by investing more into primary care.

Screening uptake rates and referral practices in primary care are sub-optimal and highly variable across the borough. The use of urgent referral pathways is not consistent. Primary care commissioning needs to use the levers available to improve uniformity and encourage best practice.

Cancer Strategy for England 2015-2020¹³

Recommendation 1: NHS England, working with the other Arms Length Bodies, should develop a cancer dashboard of metrics at the CCG and provider level, to be reported and reviewed regularly by Cancer Alliances. The following metrics should be included as a minimum:

CCG Dashboard:

Proportion of patients referred by a GP with symptoms receiving a definitive cancer diagnosis or cancer excluded within 2 and 4 weeks, with a target of 50% at 2 weeks and 95% at 4 weeks by 2020

Proportion of diagnoses through emergency presentation

Proportion of cancers diagnosed at stage 1 or 2, with a target of 62% by 2020 for cancers staged, and an increase in the proportion of cancers staged

Screening uptake, with an ambition of 75% for FIT in the bowel screening programme by 2020

¹³ Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020', [Online] Available from: https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf [Last accessed: 15th of August 2016]

One-year survival

Proportion of patients meeting cancer waiting times targets: target of 96% meeting 31 day target and 85% meeting 62 day target