

Lewisham Local Authority Cancer JSNA

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Alexander Allen, Public Health Registrar
ALEX.ALLEN@LEWISHAM.GOV.UK



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Executive Summary and Key Messages

- Cancer is the single most common cause of death in Lewisham, both in the young and old.
- Lewisham has significantly higher mortality in under 75s, and this increase is primarily due to an increase in lung and bowel cancer deaths.
- Despite a higher than average incidence of prostate cancer, Lewisham's mortality rates are similar to our neighbours. This may in part due to Lewisham's higher proportion of prostate cancer diagnosed at early stages.
- Lewisham still lags behind the England average for screening coverage for breast and bowel cancer, although there is an upward trend, and significant gains have been made over the last few years.
- Lewisham has a much higher 2 week wait referral rate than the London average, and a lower conversion of these referrals into a diagnosis of cancer. This difference is primarily driven by referrals for suspected breast and skin cancer.
- Approximately one fifth of the difference in life expectancy between the highest and lowest quintile is due to cancer, with lung cancer being the most common single type of cancer responsible for this difference.
- There is some evidence that those of black African ethnicity are less likely to attend screening or be referred via the 2 week wait pathway. Why this occurs and how we can reach these communities will be key to improving Lewisham's cancer outcomes.

Introduction

Cancer is an ever-growing health issue in the UK, with almost 300,000 diagnoses and 130,000 deaths per year.¹ Ageing populations mean that it is predicted that almost 50% of people currently under the age of 65 will receive a diagnosis of cancer within their lifetime². While national level trends are well documented and analysed, Lewisham faces specific challenges due to the differences in demographic factors such as age structure, ethnicity and deprivation levels. This Joint Strategic Needs Assessment (JSNA) aims to collate local level data from a variety of sources and provide an overall picture of cancer in Lewisham across the entire pathway, and use suitable benchmarks to put Lewisham performance in context with similar boroughs. This will identify gaps both in terms of our knowledge and in our services that will inform recommendations that should be made to improve the our cancer outcomes and the quality of service we provide

What we know

Fact and Figures

Prevalence

The prevalence of cancer in Lewisham (the proportion living with a diagnosis of cancer) is 1.5%. In 2015, cancer caused 29.2% of all deaths in Lewisham, making it the highest single cause of mortality in Lewisham, ahead of circulatory disease (22.4%) and respiratory disease (17.2%). Cancer is a significant cause of death in both older populations (27.8% of over 65 year olds), and the younger population (34.4% of deaths in under 65 year olds). The most common causes of cancer mortality are lung (23%), bowel cancer (10%), prostate (8%) and breast (7%).

Comparing trends in these data is difficult, as changes to the number of people living with cancer could be due to better diagnosis, changing risk factor profiles (e.g. aging population) or improved survival times. Changes in the proportion of deaths caused by cancer could be due to increased cancer mortality rates, but could also be caused by a reduction in deaths from other causes.

Incidence

Table 1. Age standardised rate of cancer registration for any age, per 100,000 population - 2014

	Male	Female	Combined
Lewisham	710.3	503.2	606.8
London	662.1	528.0	595.1
England	670.3	546.6	608.5

Source: PHE Fingertips

¹ <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases>

² Ahmad A.S., Ormiston-Smith N. & Sasieni P.D. (2015). [Trends in the lifetime risk of developing cancer in Great Britain: comparison of risk for those born from 1930 to 1960. \(link is external\)](#), British Journal of Cancer.

When comparing the entire population in terms of the number of new cancer registrations, Lewisham has a rate similar to that of England and London. When this is stratified by gender, Lewisham actually has significantly higher rate of cancer registrations in men and significantly lower cancer registrations in women.

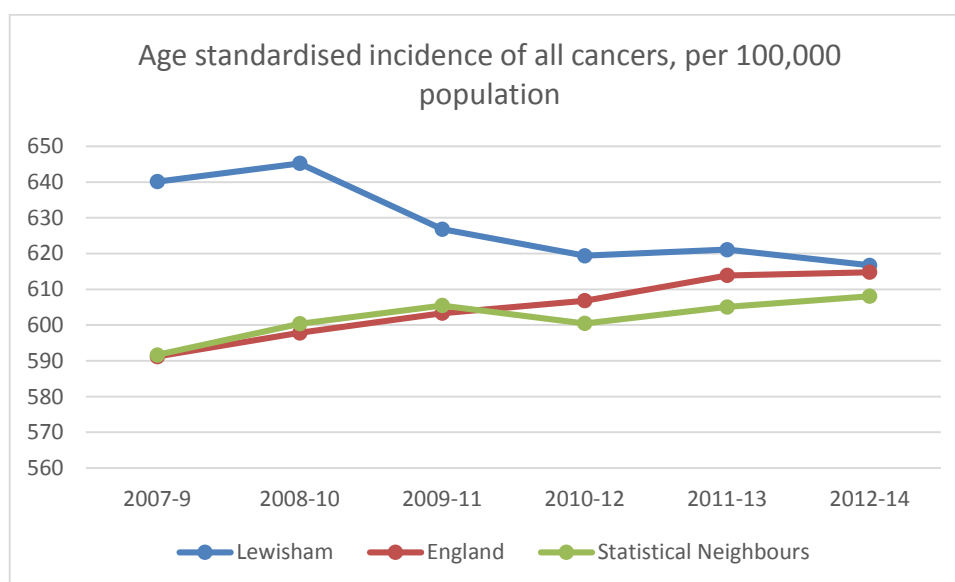
Table 2. Age standardised incidence by type of cancer, per 100,000 population, 2012-2014

	Breast (female only)	Colorectal	Lung	Cervical	Prostate
Lewisham	149.5	72.5	87.7	7.6	223.1
London	172.3	65.5	78.5	8.0	191.0
England	169.9	72.9	79.8	9.5	181.4

Source: PHE Fingertips

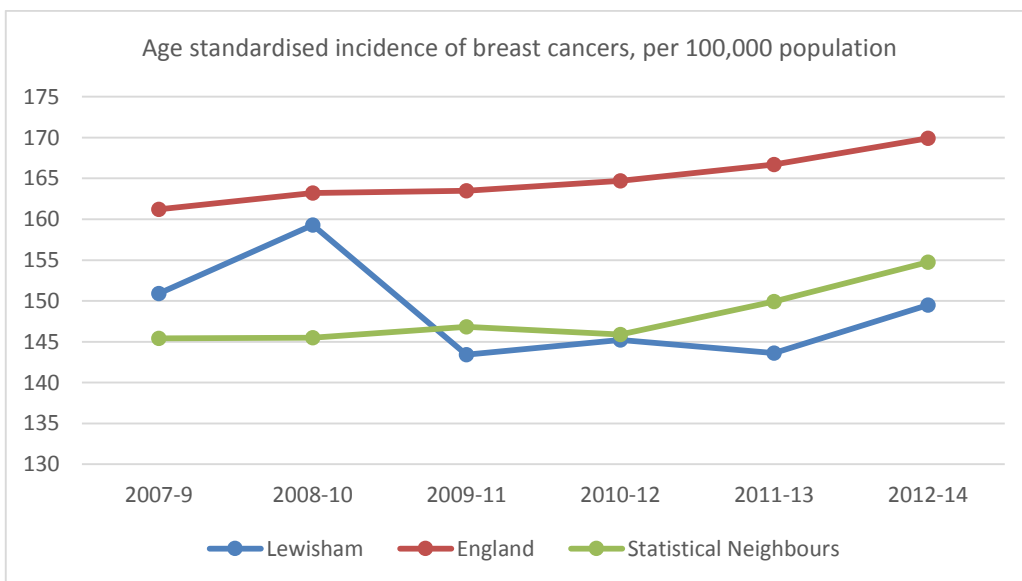
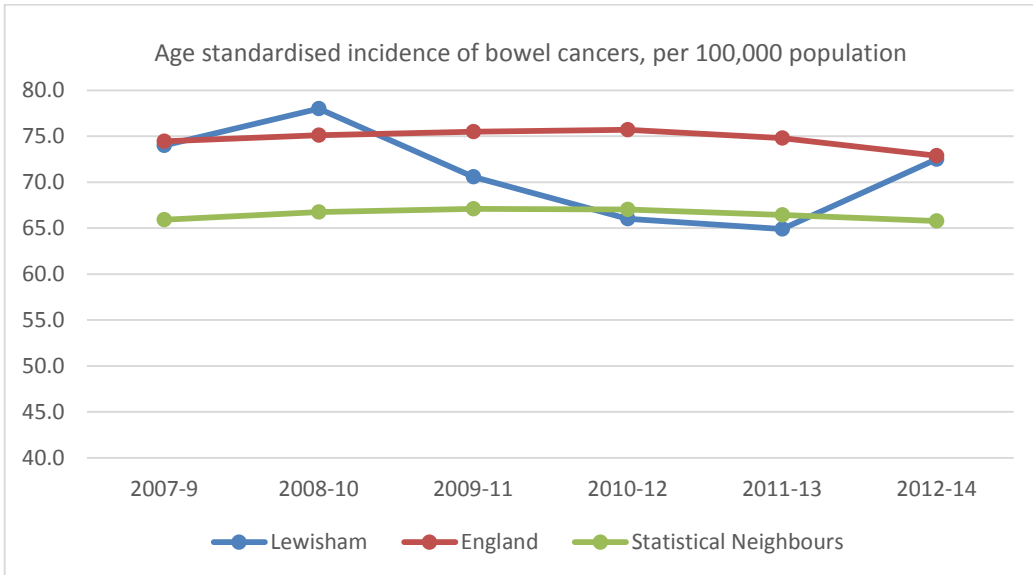
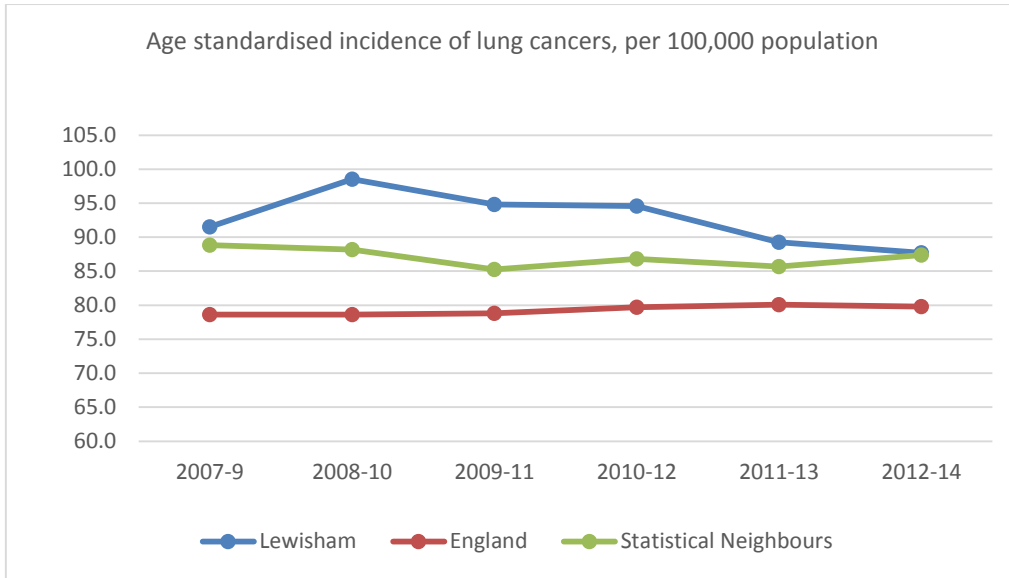
When this is broken down by type of cancer, we see that prostate cancer has by far the higher incidence. Lewisham has significantly higher incidence of lung, prostate and colorectal cancer than the London or England average, while having a significantly lower rate of cervical cancer and breast cancer incidence. This may reflect the makeup of our population, as the incidence of prostate cancer is known to be higher in black ethnic groups. For reference, in 2 boroughs with similarly large black populations, Lambeth and Southwark, the incidence was 197.6 per 100,000 population in Southwark and 248.2 per 100,000 population in Lambeth. Also of note is that the mortality rates also differ by gender, with men having a much higher incidence for both lung cancer (97.7 vs 45.9), likely reflecting historical smoking habits.

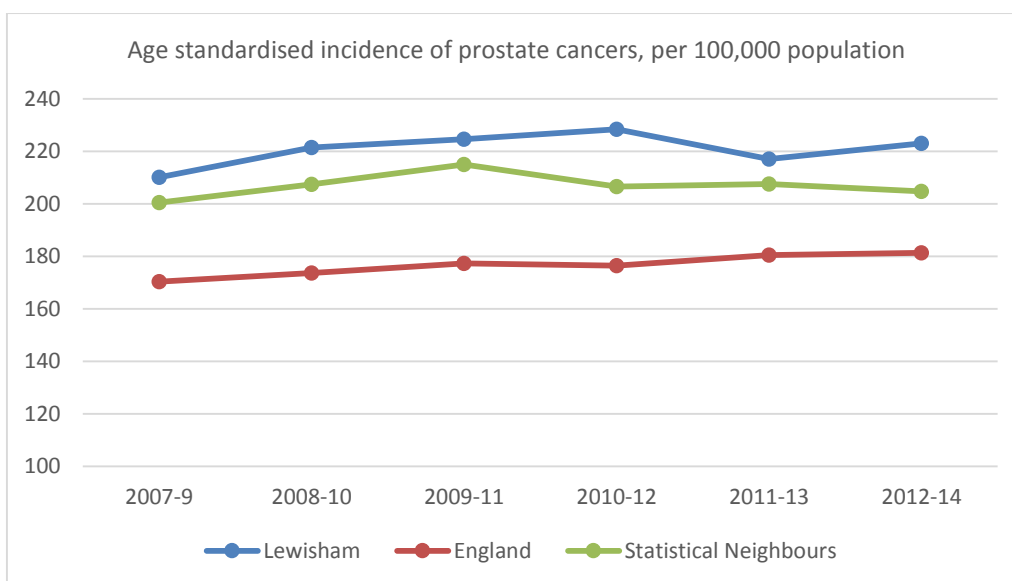
Trends



Source: PHE Fingertips

Lewisham's overall incidence of cancer has been decreasing over recent years, going from above the England average to matching it.





Lewisham incidence of breast cancer is significantly lower than the England average, however the incidence of prostate cancer is significantly higher, than both the England average and the average of Lewisham’s statistical neighbours. This may be due to Lewisham having a relatively high proportion of residents of black ethnicity.

Mortality

Table 3. Age standardised rates of mortality for all cancers, per 100,000 population, 2012-2014

	Male	Female	Combined
Lewisham	345.6	232.1	288.8
Lambeth	331.0	232.9	282.0
Southwark	356.7	230.3	293.5
England	332.3	231.4	282.4

Source: CancerData

Table 4.. Age standardised mortality for all cancers, per 100,000 population, 2013-2015

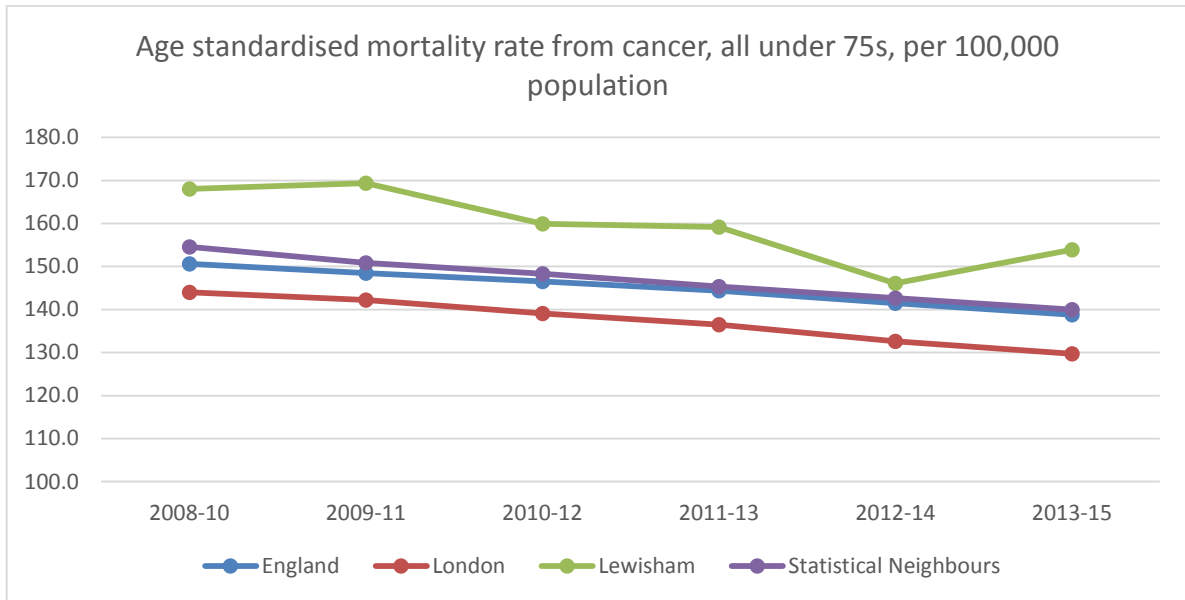
	Under 75 male	Under 75 female	Combined
Lewisham	187.5	124.0	153.9
London	147.7	113.8	129.7
Statistical Neighbours	162.5	124.2	140.0
England	154.8	123.9	138.8

Source: CancerData

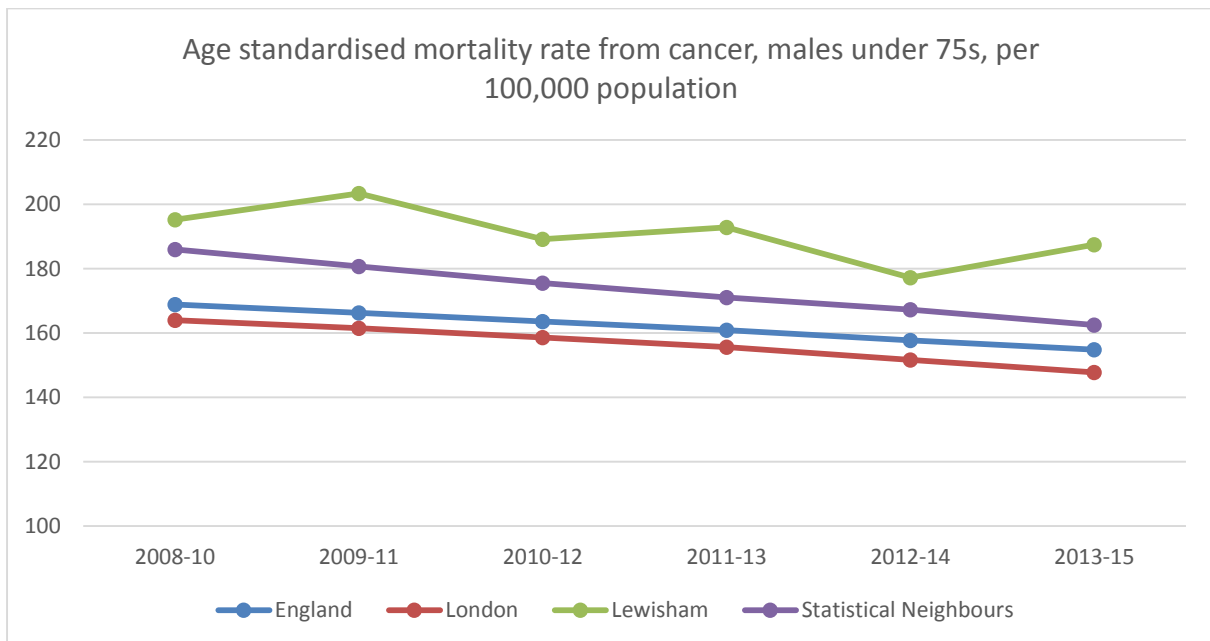
Looking at the mortality we see that, like incidence, there is a large gap between male and female rates, however in this case, both the male and combined mortality rates are significantly higher than the London or England averages. Given that the incidence is similar to the London average, the

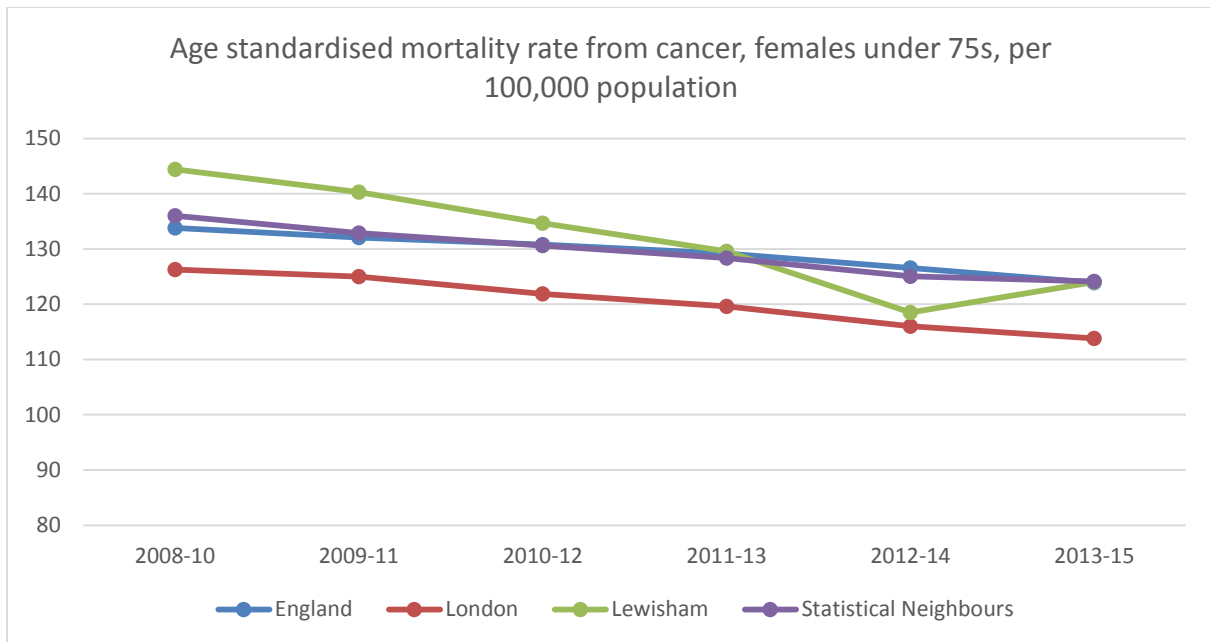
increased mortality rates may indicate that our population are presenting with more severe or later stage cancer, possibly indicating issues with screening, early diagnosis or treatment.

Trends – all cancers



Source: PHE Fingertips





Source: PHE Fingertips

Lewisham’s mortality rates for all cancers have generally been decreasing, as have the rates across London and the country. Of note it appears that the male mortality rates are decreasing more slowly than the female rates in Lewisham, leaving Lewisham with a significantly higher mortality rate in under 75 year old men than London, its neighbours, and England.

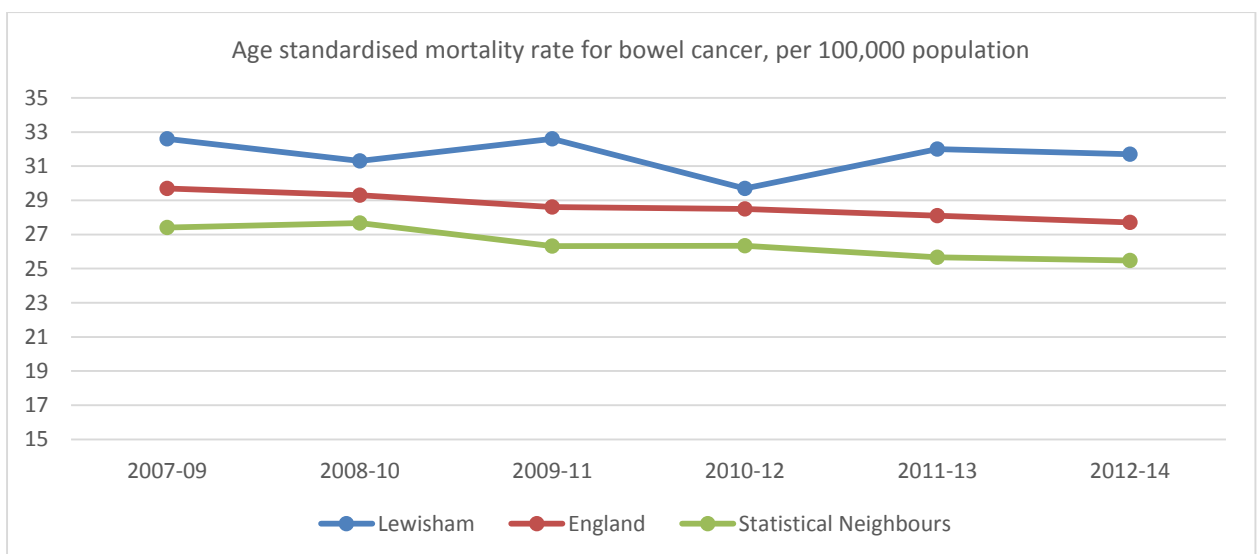
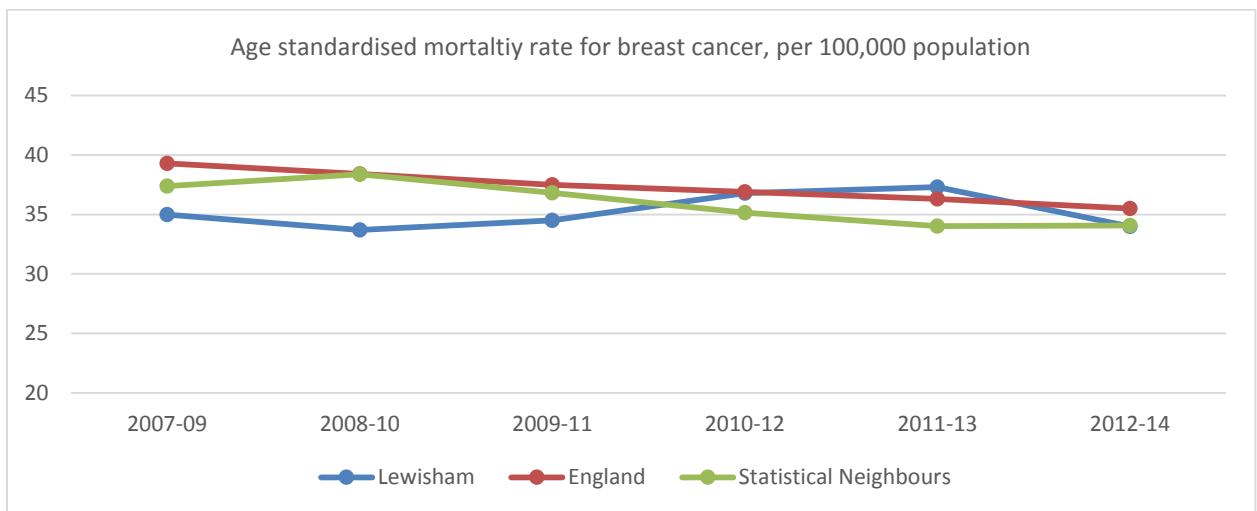
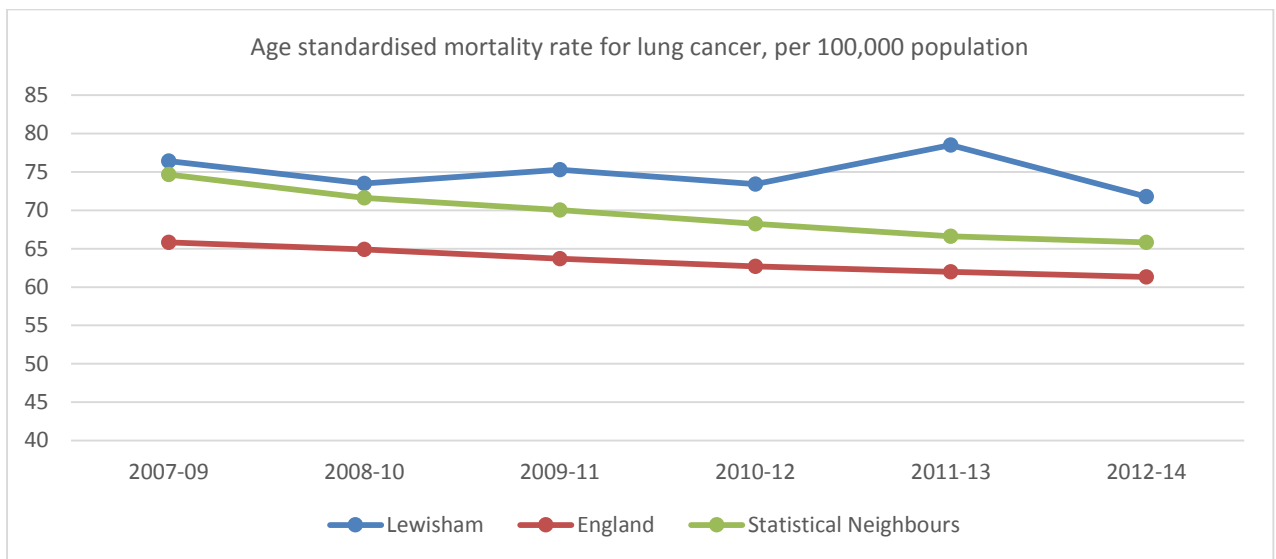
Table 5. Age standardised mortality rates by cancer type, per 100,000 – 2012-14

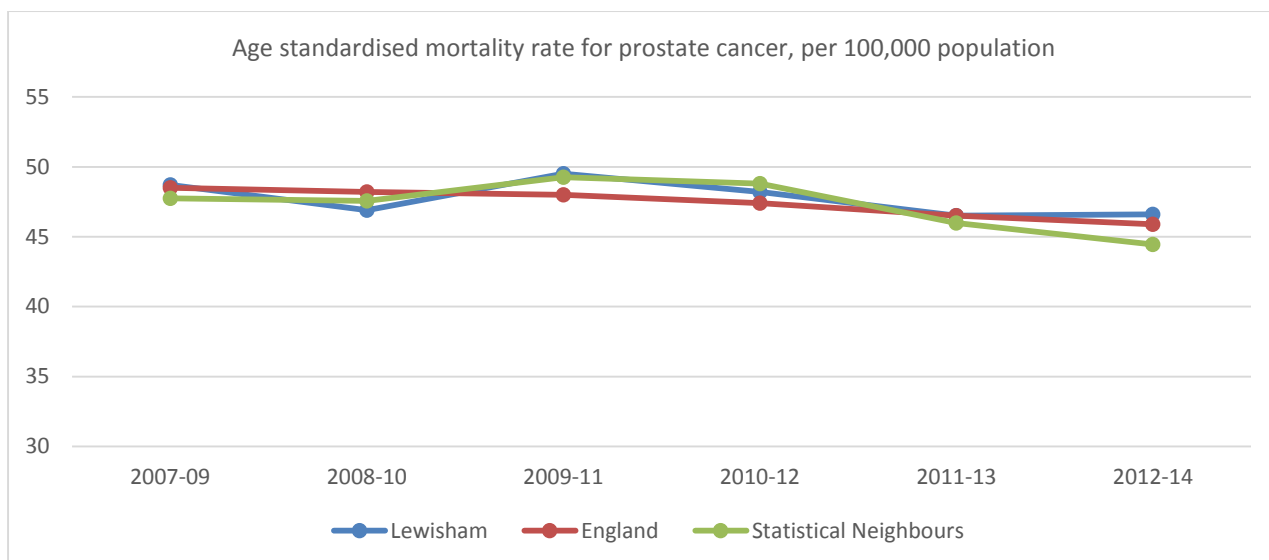
	Lung	Breast	Colorectal	Prostate
Lewisham	71.8	34.0	31.7	46.6
England	61.3	35.5	27.7	45.9
Lambeth	67.7	31.5	25.6	60.6
Southwark	72.8	33.3	29.5	38.6

Source: CancerData

Lewisham has a higher mortality rate for lung cancer compared to England, but is similar to its neighbouring boroughs. Of note, despite Lewisham’s higher incidence of prostate cancer, the mortality rate from prostate cancer is similar to that of the England average, and considerably lower than the neighbouring borough of Southwark. A possible interpretation of this result is that prostate cancers in Lewisham are detected and treated promptly, and therefore the increased incidence does not result in increased mortality. Another possible interpretation is that because of the slow growing nature of prostate cancer, many of these cancers are detected in elderly patients. These patients may then go on to die from another condition, and are classified as dying ‘with’ rather than ‘from’ prostate cancer.

Trends – by cancer type





Overall, for Lewisham the age standardised mortality rates for the most common cancers have decreased, although the rate of decrease has been slower than that of England, and that of neighbouring boroughs. In particular Lewisham’s bowel cancer mortality rate is significantly higher than the comparison benchmarks.

Screening

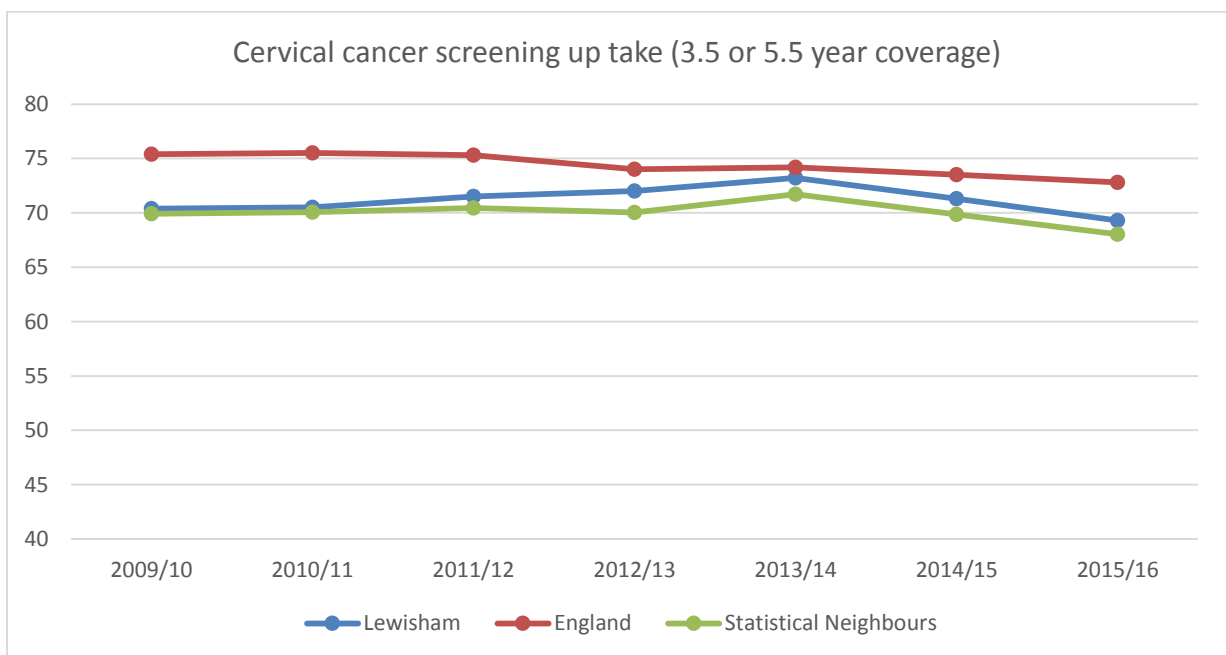
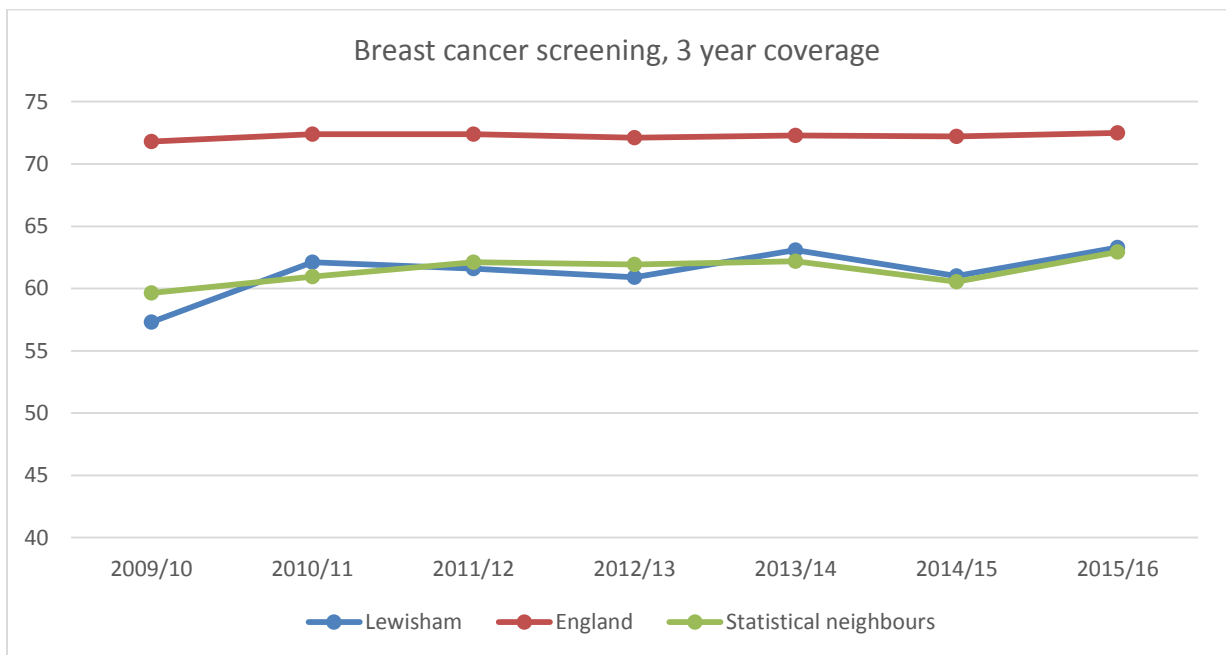
Table 6. Screening up take rate (% coverage in last 3 years for breast 2.5 for bowl, 3.5-5.5 years for cervical cancer), 2015/16

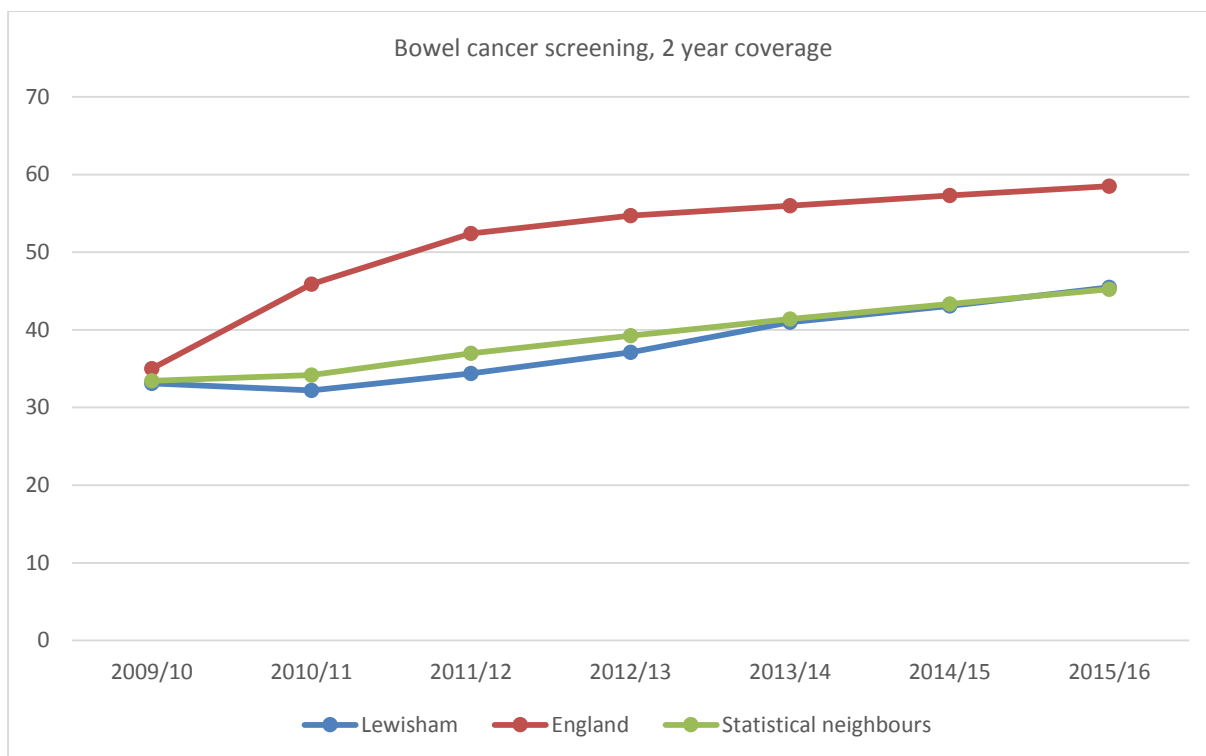
Cancer (age range)	Lewisham uptake	Statistical Neighbours	London uptake	England Uptake
Breast (50-70)	63.3%	62.9%	65.1%	72.5%
Cervical (25-64)	69.3%	68.0%	66.8%	72.8%
Bowel (60-69)	45.5%	45.2%	49.0%	58.5%

Source: PHE Fingertips

Lewisham’s screening rates from 2015/16 are similar to those of London overall but significantly worse than average England screening uptake rates, and generally worse than our neighbouring boroughs (as seen by comparison of the STP foot print).

Trends





Source: PHE Fingertips

Lewisham’s breast screening coverage has been increasing over the years, but still remains below the England average. Both Lewisham and England’s bowel screening uptake has increased but Lewisham’s uptake has been increasing at a slower rate over the last 5 years, leading to a significant difference in uptake. Cervical screening uptake has remained relatively steady in Lewisham but has seen a recent decline in line with has been seen in England as a whole.

Route to diagnosis

The most common routes to diagnosis are via screening programs, GP referrals (either urgent 2 week wait referrals for those with suspicious symptoms as outlined in the NICE guidelines, or a routine referral when cancer is not the suspected diagnosis), hospital inpatient or outpatient visits and via emergency presentation at an A&E department. Research has shown that patients with a diagnosis made when they present as an emergency, generally have higher stage cancers, and poorer outcomes. Those that are diagnosed at screening or by GP referral are diagnosed earlier and have higher rates of survival.³ When all cancers are combined, the proportion being diagnosed on emergency admission in Lewisham is 20.5%, in line with the England average of 20.3%. A more detailed breakdown by cancer type is shown below.

In the tables below, emergency diagnoses refer to all diagnosis after admission from A&E, admitted after a GP emergency referral, or admitted as an emergency from an outpatient clinic. A managed

³ http://www.ncin.org.uk/publications/data_briefings/routes_to_diagnosis

diagnosis refers to all diagnosis made after a two week wait referral, a normal GP referral, or a non-emergency referral or diagnosis from an outpatient clinic.

Colorectal cancer			
	Screen	Managed	Emergency
Lewisham	4%	53%	25%
Statistical Neighbours	4%	49%	30%
England	7%	49%	26%

Lung cancer		
	Managed	Emergency
Lewisham	42%	40%
Statistical Neighbours	41%	41%
England	47%	37%

Breast cancer			
	Screen	Managed	Emergency
Lewisham	22%	63%	4%
Statistical Neighbours	24%	62%	6%
England	29%	59%	4%

Prostate cancer		
	Managed	Emergency
Lewisham	80%	7%
Statistical Neighbours	71%	10%
England	74%	9%

Source: NCRAS – Routes

Lewisham compares well with its statistical neighbours, generally having a lower proportion of cancers diagnosed at the A&E department, particularly in colorectal and prostate cancer, however is still significantly below the England average for lung cancer. Lewisham also has a significantly lower proportion of cancers diagnosed via the screening route than the England average, likely reflecting the comparatively low screening uptake that Lewisham has for these cancers.

Table 7. Number of two week wait referrals, per 100,000 population. 2015/16

	All	Breast cancer	Lower Gastro-intestinal	Lung cancer	Skin
Lewisham	3522	817	430	107.7	714
London	2539	485	463	98.6	482
England	2975	541	453	103.3	572

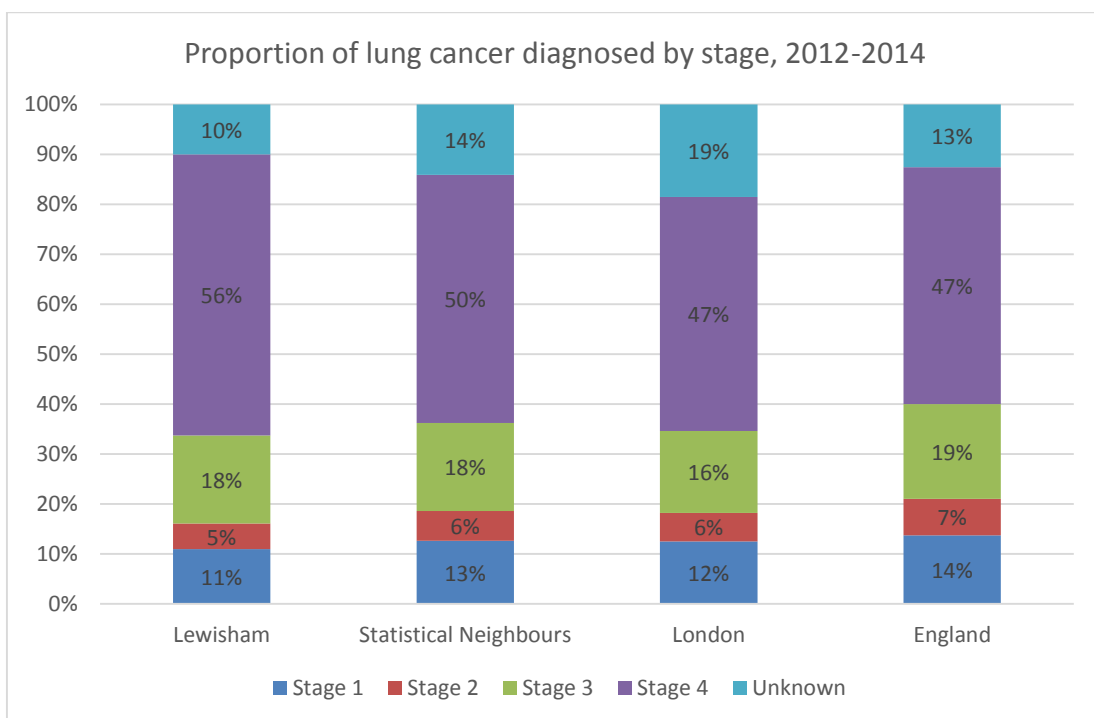
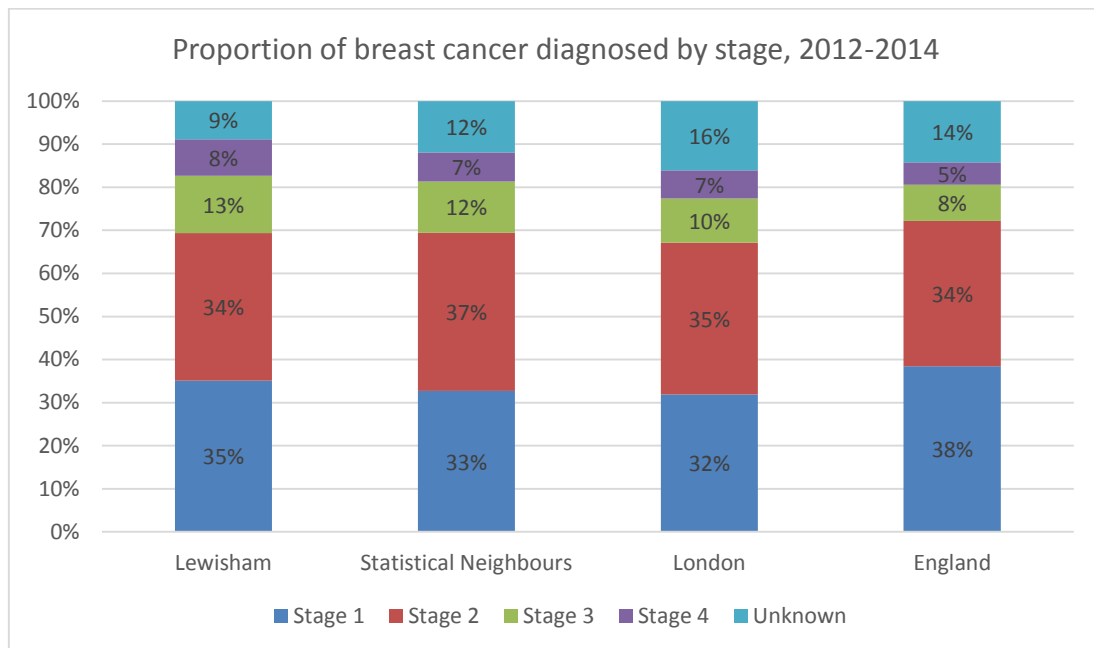
Source: PHE Fingertips

Lewisham refers considerably more patients and has a lower conversion percent of referrals being diagnosed with cancer, 4.2% compared to 5.5% in London and 7.8% in England. When this is broken down by the higher mortality cancers, we can see that most of the disparity is caused by an increased number of referrals for suspected breast and skin cancer.

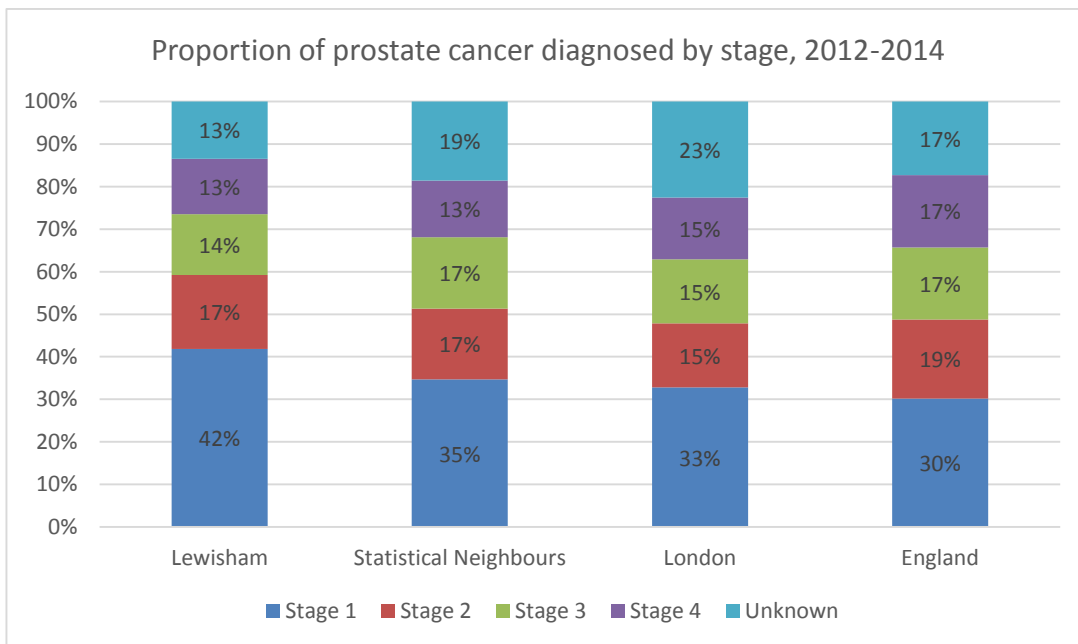
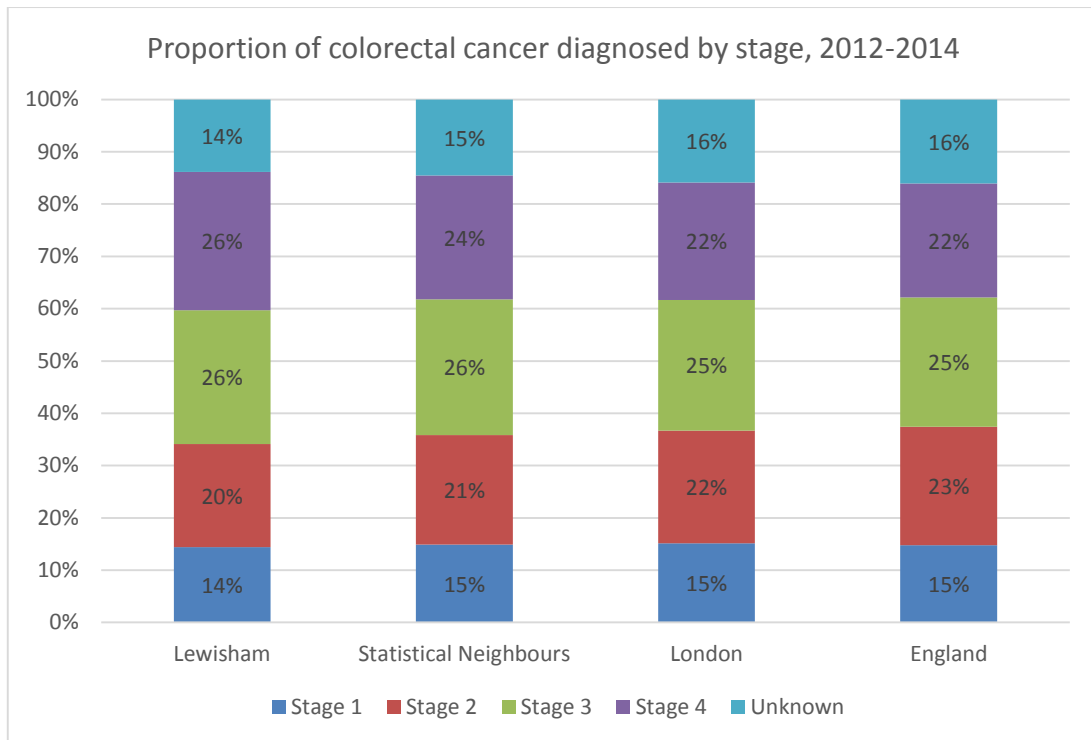
Staging by cancer type

Cancer stages refer to the extent to which the cancer has spread. Each cancer type will have different criteria that defines each stage, but in general, for stage 1 and 2 the cancer is still restricted to the organ and local lymph nodes, and are easy to treat and sometimes curable. In stage 3 and 4 the cancer will have spread far from the initial organ, and in some cases metastasised. These cancers are harder to treat and often incurable. This underlines the importance of early diagnosis; to detect cancer at an

early stage, when they are at their most amenable to treatment. Patient diagnosed with stage 1 or 2 cancers are three times more likely to survive to 10 years than those diagnosed with stage 3 or 4 ⁴



⁴ <http://www.ons.gov.uk/ons/rel/cancer-unit/a-cancer-survival-index-for-clinicalcommissioning-groups/adults-diagnosed-1997-2012-and-followed-up-to-2013/index.html>



Source: NCRAS

Lewisham is significantly better than England, London and its neighbours at diagnosing prostate cancer at an earlier stage, possibly partially explaining our normal mortality rates yet increased incidence rates of prostate cancer. Lewisham diagnoses Lung and Bowel cancer at stage 4 more often compared to London or England, also possibly explaining the increased mortality rate of those two cancers in Lewisham.

Survival

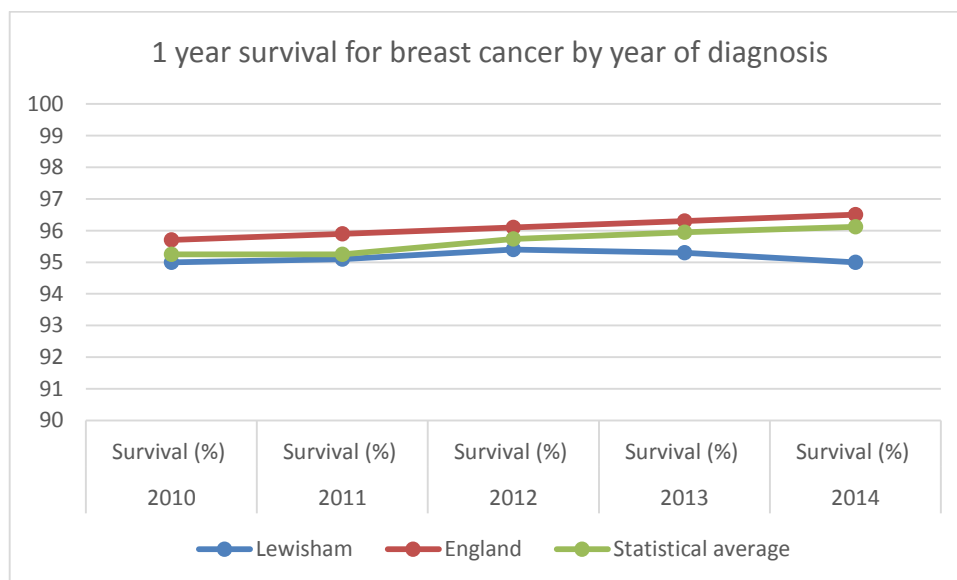
The 1 year survival rates provide an effective surrogate measure of how well diagnosed and treated the more later stage and higher mortalities cancers are, while 5 year survival rates are a more effective measure of how longer term treatment and management of cancer is handled.

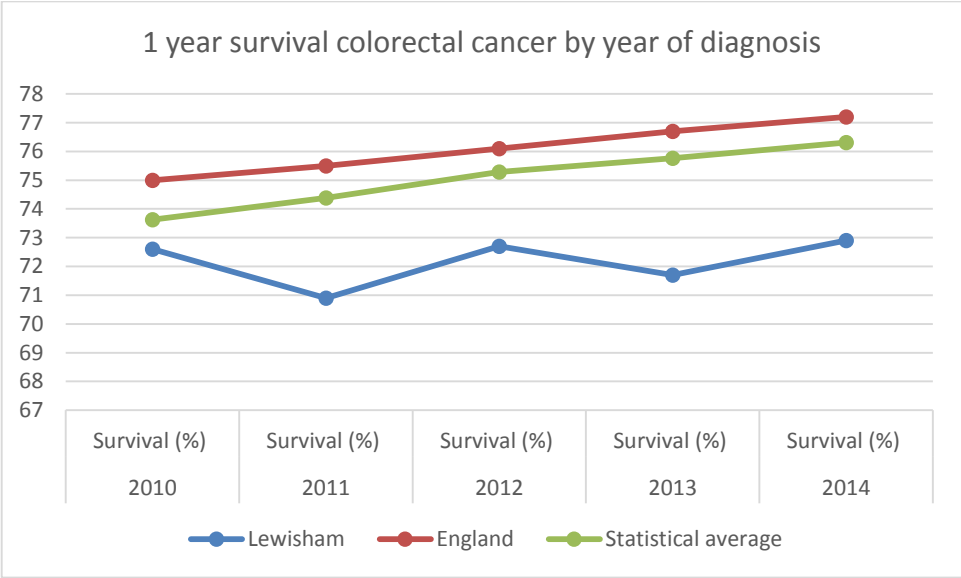
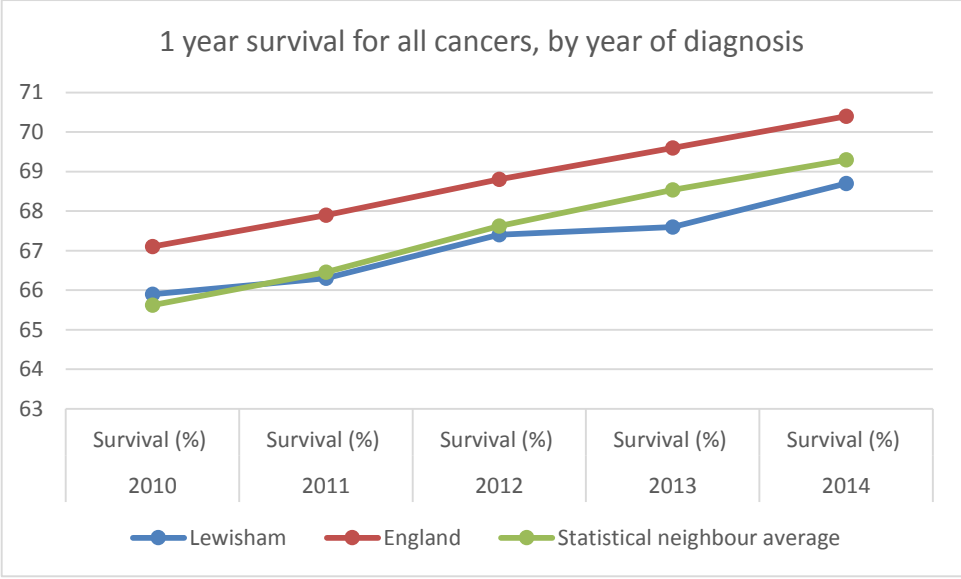
Table 8. 1 year survival percent, from year of diagnosis, 2014

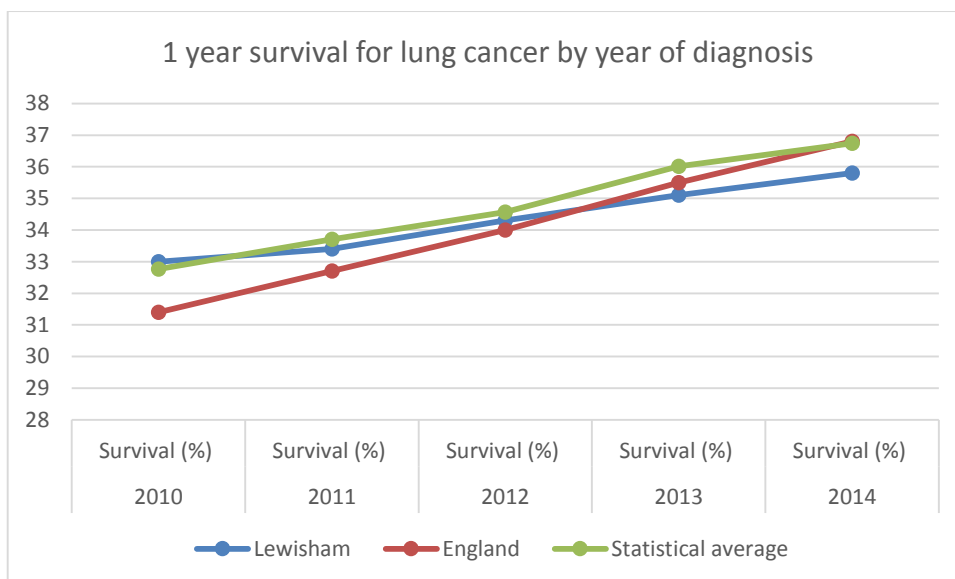
	All	Breast cancer	Colorectal	Lung cancer
Lewisham	68.7	95	72.9	35.8
Lambeth	70.1	96.1	78.9	37.4
Southwark	70.3	96.9	75.3	42.1
England	70.4	96.5	77.2	36.8

Source: Office of National Statistics

Trends







Source: Office of National Statistics

Lewisham is significantly below England and its neighbours in terms of one year survival rates for both breast and colorectal cancer specifically, and when all cancers are considered together. The trend for 1 year survival for all cancers combined has been trending up, but for breast cancer there has been a recent decline. It is worth noting that while the difference between Lewisham and England 1 year survival rates for all cancers are statistically significant, the absolute difference is small, in the range of 1-2%. Lewisham's lower performance for both breast and bowel cancer may be due to Lewisham's lower coverage of screening for these cancers, leading to later diagnosis, more advanced cancers on diagnosis and therefore lowered survival.

End of life care

When given the choice, most people would prefer to die in their home, and have their palliative care conducted in the community, where they are more comfortable and their friends and family better can visit and care for them.

Table 9. Proportion of cancer patient that die in place of usual residence. 2015

	% of Cancer Patients Dying in Usual Place of Residence
Lewisham	27.3
London	35.4
England	44.4

Source: PHE Fingertips

Lewisham has a significantly lower proportion of cancer patients dying at home than both England and London, but is comparable to our statistical neighbours. This could reflect a lack of capacity in the community palliative care services in Lewisham, a higher proportion of cancer patients not having a suitable home life situation (in terms of carers or accommodation) for community care, or reflect patient choice, with more patients preferring to stay in hospital.

Targets and Performance

There are no national targets for 1 or 5 year survival, or mortality rates.

The national screening targets for screening uptake are 80% for cervical cancer, 70% for breast cancer, and 60% for bowel cancer. As seen above, Lewisham is not currently hitting the national targets, although the overall uptake has been increasing for breast and bowel screening.

The CCG commissioning strategy for 2013-2018 aims to reduce the rate of under 75 cancer mortality by 20% by 2018. Since 2013, the under 75 mortality has been decreasing, and as of 2015 had decreased by 5%.

Local Views

In 2009, the Healthy Cancer Collaboration undertook a programme to promote early presentation and diagnosis of breast lung and bowel cancer symptoms in New Cross, Evelyn and Bellingham wards, by improving public awareness and GP engagement, making use of volunteer peer mentors. As part of this a survey of the general public was conducted to find out why they did not see their GP with early signs and symptoms of cancer. Common responses included: fear of what they might find out, lack of awareness about cancer, embarrassed about wasting GP's time, being unable to get an appointment, unable to describe symptoms to GPs due to language barriers, cultural issues or anxiety. The programme aimed to remedy these problems and recruited over 20 volunteers and were involved in over 80 events with over 7,500 Lewisham residents being reached. After 6 months there was a fivefold increase in cancer referrals leading to a quadrupling of cancers being diagnosed within two weeks. Key factors in the success included effective partnerships with the voluntary and charity sector and the local health services. In particular an effort was made to reach out to minority communities and over 70 local minority volunteer groups were contacted.

The National Cancer Patient Experience Survey, carried out annually across the UK, asks patients 50 questions across the entire spectrum of cancer care from screening through to end of life care. Lewisham scored 8.5 on a scale of 0 (very poor) to 10 (very good) in regard to overall cancer care, a score in line with that obtained from the entire country (8.7). 89% of patients were given a named Clinical Nurse Specialist, and 82% said they were treated with respect and dignity while they were in hospital. Almost three quarters of patients felt that they were definitely involved as much as they wanted to be in decisions about their care and treatment. One theme that emerged from the survey where Lewisham does less well (consistently scoring under the national average) is in support outside of the clinical setting. Only 35 % of patients felt they were given enough support from social services during treatment (compared to the national score of 54%) and only 31% felt they were given enough support afterwards (compared to the national score of 45%). This shows that there may be a gap in the integration between health and social care in Lewisham and that more should be done to support cancer patients outside of hospital.

National and Local Strategies

What we know works:

Cancer prevention: More than half of cancers could be prevented by changes in peoples' behaviours. The main modifiable risk factors are smoking and tobacco use (for lung cancer) low fruit and vegetable intake and high intake of red and processed meat (for bowel cancer), exposure to UVB radiation (for skin cancer) and obesity and increased alcohol consumption (various cancers of the gastro-intestinal system)⁵. Other important means of cancer prevention include vaccines: Human Papilloma Virus (HPV) for all girls between 13-15 year old for cervical cancer, and Hepatitis B vaccines for babies whose mother are infected reduces risk of liver cancer.

Early detection and treatment: The earlier cancer is detected and treated the better the prognosis. It is estimated that up to 10,000 deaths per year from cancer could be prevented with earlier diagnosis and treatment.⁶ The major strategies that improve early detections are increased uptake of screening programs (for breast, cervical and bowel cancer), increased public awareness of common symptoms of cancer and swift referral from primary care to specialist assessment if cancer is suspected (the two week wait).

Evidence based high quality treatment and care: This includes access to cost effective chemotherapy and surgery as defined by the National Institute for Health and Clinical Excellence (NICE), as well as lifestyle modifications for cancer survivors aimed at reducing reoccurrence, and finally compassionate and effective palliative care for those who are approaching the end of life.

National Strategies

Improving Outcomes: A Strategy for Cancer - Fourth annual report.⁷ This strategy, initially written in 2011, was created by the Department of Health and Public Health England and sets out the national strategy to improve survival and patient experiences of dealing with cancer. The focus is on early diagnosis and improved access. This involved the opening of bowel screening centres, public awareness campaigns, supporting GPs in make appropriate and prompt referrals, and running of Cancer Patient Experience Survey's.

One of the flagship goals was to halve the 5 year cancer survival gap between England and the top performing countries in Europe. In terms of lives saved this would mean a total of 5,000 per year. The aim was to achieve this goal for patients diagnosed 2011-2015, although of course the final data for this goal won't be collected until 2020, the current best estimate is that over 12,000 patients are surviving with cancer for 5 years or longer, compared to those diagnosed in 2006-2010.

Achieving World-Class Cancer Outcomes,⁸ published in 2015 and produced by the Independent Cancer Taskforce. This strategy report follows on from the National Cancer Strategy above, picking six key priorities and targets that will deliver improved outcomes. These include a focus on prevention

⁵ Parkin DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. Summary and conclusions. Br J Cancer 2011;105 (S2):S77-S81.

⁶ Richards, M. (2009). The size of the prize for earlier diagnosis of cancer in England British Journal of Cancer, 101

⁷ <https://www.gov.uk/government/publications/the-national-cancer-strategy-4th-annual-report>

⁸ <https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf>

with an aim to reduce smoking prevalence to less than 13% by 2020, an ambition to have 95% of patients referred for testing to have a definitive diagnosis (or exclusion of cancer) within four weeks. There is also a strong drive to improve patient experience, including access to all test results online and access to a key worker to coordinate care and improved follow up care to improve the quality of life of patients after treatment has ended.

Be Clear on Cancer – This campaign ⁹, led by Public Health England in partnership with NHS England, is a public awareness engagement campaign aimed at increasing public awareness of the early signs and symptoms of selected cancers. It carries out numerous campaigns both locally and nationally. The most recent campaign focused on lung cancer. Evaluations of the various campaigns have shown that they increase public awareness of the early symptoms of the cancer, reduce diagnosis of cancer at presentation to A&E and increase the number of urgent referrals from GPs for cancers of the type which the campaign was focused.

The Five Year Forward View- Written by Simon Stevens ¹⁰, Chief Executive of NHS England, this strategy was updated in March 2017 and sets out the aims with regard to cancer for the next two years. These include an expanded screening programme for cancer, and in particular a new bowel cancer screening test that will be available to 4 million people from April 2018, with the expectation that this will be more acceptable to more people, leading to a fifth of bowel cancers being caught earlier. Introduction of HPV testing at cervical screening is also expected to prevent around 600 cervical cancers per year. A new cancer wait standard will be introduced in 2020, to give patients a definitive diagnosis within 28 days, and diagnostic capacity will be extended to ensure all patients meet the 62 day target of referral to treatment. Radiotherapy programmes will be updated across the country, with over 50 new machines across 34 hospitals. The headline goal will be for 5,000 extra people to survive cancer per year.

Local strategies

Be Clear On Cancer – Lewisham pilot

In 2014, Lewisham (along with 5 other boroughs high populations of black men) was involved in a pilot under the Be Clear on Cancer campaign focused on increased awareness of prostate cancer in black men. One in four black men will be diagnosed with prostate cancer compared to one in eight of all men ¹¹ The campaign aimed at black men over 45, as well as their wives/partners and friends and family, using targeted outdoor advertising at roadside locations, train stations and barber shops. The campaign also worked with black radio stations and held community events to raise awareness.

The Lewisham Health and Wellbeing Strategy outlines the nine key health and wellbeing challenges in Lewisham, of which one is increasing the number of people who survive colorectal, breast and lung cancer who survive for 1 and 5 years from diagnosis. Many of the other priorities also have strong links to improving cancer outcomes, including reducing uptake and number of people smoking, reducing alcohol harm and improving immunisation uptake. Lewisham Clinical Commissioning Group strategy from 2013-2018 aims to reduce under 75 cancer mortality rates by 20% by 2018. It plans to do this by improving early diagnosis and uptake of screening programs.

⁹ <https://www.nhs.uk/be-clear-on-cancer>

¹⁰ <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>

¹¹ Prostate Cancer UK 2014 <http://prostatecanceruk.org/we-can-help/african-caribbean-communities>

Current Activity and Services

Prevention

Lewisham Local Authority provide a Stop Smoking service that provides one-to-one sessions to help people quit, along with access to nicotine replacement therapy and Champix. More information can be obtained from <http://www.smokefreelewisham.co.uk/Home.aspx>

Lewisham Local Authority also provide community alcohol services such as the Lewisham Primary Care Recovery Service (PCRS). It includes screening, detoxifications, group and peer support, and onward referral to more specialised services if needed. The Prevention and Inclusion team also work to reduce alcohol harm, by providing information, education and training to groups, and run public awareness campaigns to help the general public recognise a drug or alcohol problem. More information can be found here: <https://www.lewisham.gov.uk/myservices/socialcare/health/Drugs-and-alcohol/where-to-go/Pages/Community-alcohol-services.aspx>

Lewisham local authority provide several services to assist residents in maintaining a healthy weight. Shape Up is available to anyone with a BMI over 28, when assessed at an NHS Health Check¹². It features group session on topics including how to limit weight gain, achieve moderate weight loss, eating a balanced diet and becoming more physically active. Also available to those with a BMI over 28, by referral only, is Weight Watchers, providing 12 weekly meeting and 16 weeks access to the Weight Watchers online tools. Community dieticians are also available to provide specialist weight management clinics for those with a BMI of over 35, and who have been referred by their GP. For more information please see https://www.lewisham.gov.uk/myservices/socialcare/health/screening/nhs_health_checks/lewisham-lifestyle-hub/Pages/Lewisham-lifestyle-hub-weight-management.aspx

The Public Health team at Lewisham Local Authority also have run training sessions for pharmacists, aiming to improve their knowledge and understating of the early symptoms and signs of cancer, so they can alert patients and encourage father referral. So far 34 pharmacists have been trained, with further plans to extend the programme.

Human Papilloma Virus vaccination to immunise against selected strains of HPV has been shown to reduce the change of cervical cancer by over 70%.¹³ Vaccination is offered to all girls between the ages of 11-13. It given as two injections taken 6 months apart, provided directly at schools via the school nurses. Lewisham's uptake of the vaccine has dipped slightly over the few years to 75.8% of pupils receiving both doses below the London average of 80.7% and below the national target of 90%.¹⁴

Screening

Cervical cancer screening is provided to all women aged 25 to 64, every three years up till age 49, then every five years till age 64. Invitations are sent by post. The test is normally conducted at your GP by the practice nurse and involves a small sample of cervical tissue being taken and sent for testing. For more information please go to <https://www.gov.uk/guidance/cervical-screening-programme-overview>

¹² <http://www.healthcheck.nhs.uk/>

¹³ NHS Choices <http://www.nhs.uk/conditions/vaccinations/pages/hpv-human-papillomavirus-vaccine.aspx>

¹⁴ <https://www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2015-to-2016-by-local-authority-and-area-team>

Breast cancer screening is provided to all women aged 47-73 every three years. The screening programme is managed by King College Hospital in Denmark Hill, but mobile units also operate to provide the service closer to home. Invitation to screening are issued by post every three years. The screening test involves an examination and mammogram (x-ray). Further information can be found here: <http://www.selbreastscreening.org.uk/userhome.aspx>

Bowel cancer screening is offered to all men and women aged 60 to 74 every 2 years. The test can be carried out in the privacy of your home, and involves the use of a Faecal Occult Blood Test, which tests bowel motions for tiny amounts of blood that are not detected to the eye. A sample kit is sent out to your home. For more information please go to <https://www.lewishamandgreenwich.nhs.uk/bowel-cancer-screening>

Treatment

Lewisham and Greenwich Trust has a multi-disciplinary service that provides an acute oncology service, breast and lung chemotherapy at Lewisham. Many of the team also work at St Thomas and Guys, providing links with specialist tertiary services. Lewisham hospital also has dietetic clinics to help cancer patients manage their nutrition and appetite. Macmillan also work closely in the hospital, providing a Palliative Care team, both in the hospital and in the community, and also a welfare benefits advice service for patients with financial concerns due to their diagnosis.

More information is available here: <https://www.lewishamandgreenwich.nhs.uk/cancer-services-in-lewisham>

What this is telling us?

Overview

Lewisham overall cancer mortality rates are in line with those expected in the UK, however this figure masks a significant increase in the mortality figures for under 75 males. This is due to an increase in mortality from bowel and lung cancer. The reasons behind this are likely to be multi-faceted. There is a greater than average prevalence of smoking (20.2% versus 17.8% for London) that will constitute a strong component of increased incidence and mortality of lung cancer. There is also a known link between smoking and lower-social economic status, and Lewisham has a high level of deprivation, being within the 20% of most deprived Local Authorities (Index of Multiple Deprivation 2015). In addition, there is evidence in the literature that ethnic minorities often present later than average, with higher stage cancer, and Lewisham has a substantial BAME population.

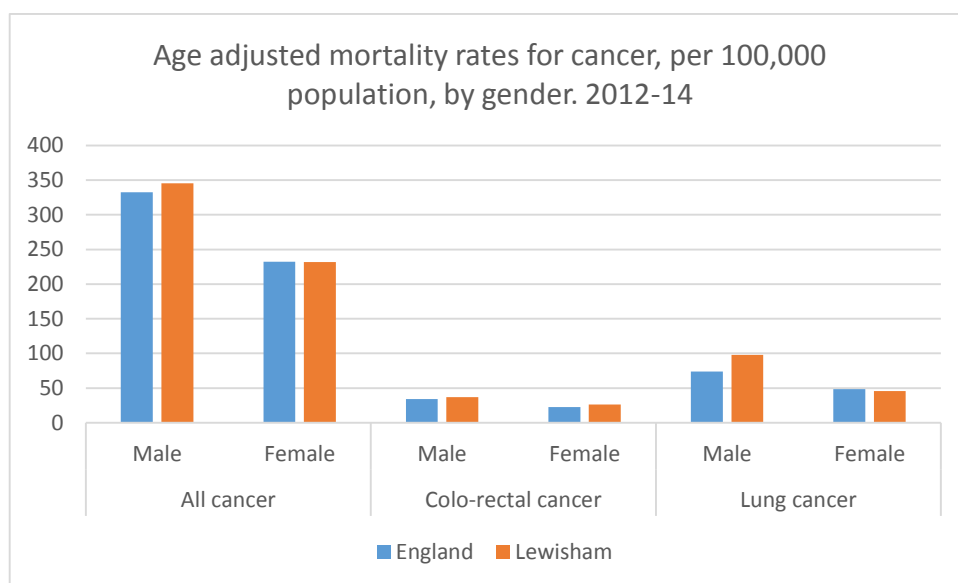
On the upside, despite a higher incidence of prostate cancer, likely driven by the large black population, the mortality rate on prostate cancer remains similar to that of England. This is likely helped by the early diagnosis of prostate cancer, as seen by the higher proportions of prostate cancer diagnosed at stage 1 or 2.

What are the key inequalities?

Gender

When compared to the England life expectancy, Lewisham men have a lower life expectancy. 30% of this difference is due to cancer, and the majority of this is caused by increased mortality due to lung cancer. This is likely to be due to smoking. While smoking prevalence has fallen for both genders rapidly over the last two decades and are now similar between men and women, historically men were much more likely to smoke.¹⁵ As lung cancer can take many years to present, men's increased mortality may reflect this lag between smoking prevalence and lung cancer.

Lewisham men also have an increased mortality due to bowel cancer compared to Lewisham women. The reasons for this are less clear cut, and may also reflect lifestyle factors, such as historical smoking, alcohol consumption and diet. It may also reflect differences in screening attendance with women being more likely than men to attend screening. This would lead to earlier diagnosis and better outcomes.

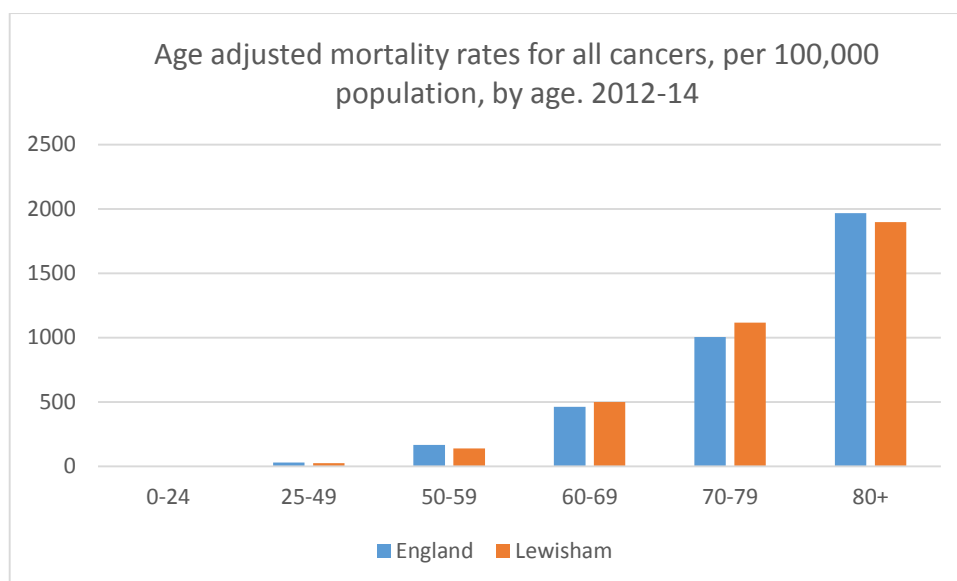


Source: CancerData

Age

Lewisham appears to have a lower mortality rate for all cancers for over 80s than the England average, however a higher mortality rate in the 60-69 and 70-79 age brackets.

¹⁵ <http://content.digital.nhs.uk/catalogue/PUB20781/stat-smok-eng-2016-rep.pdf>



Source: CancerData

Deprivation

When comparing the most deprived wards of Lewisham to the least deprived the difference in life expectancy is about 6 years, of which approximately 20% of that is thought to be due to cancer, with around 60% of this cancer mortality difference in men being due to lung cancer (i.e. 12% of the total difference in life expectancy), and 45% of women (around 10% of total difference in life expectancy).¹⁶

Ethnicity

While data about ethnicity is often difficult to come by, and incompletely recorded, there is evidence from the literature that may be applicable to Lewisham. The National Cancer Patient Experience Survey does break down the response by ethnicity, but only at the national level, however these results may be somewhat generalisable and can provide a guide as to what inequalities may exist in Lewisham based on ethnicity.¹⁷ On a national level, black ethnicities, on average, rated their overall care as significantly lower than white ethnicities, with an average score of 8.29 vs 8.73. While black ethnicities scored slightly lower across many of the sections of the survey, the most stark differences were firstly having diagnosis and treatment options explained in a manner that could be understood, with over a 10% difference between black and white scores, and secondly social support during and after treatment, with around a 15% difference between black and white scores on this questions. As mentioned earlier, on the local level Lewisham also scored lower than average in these questions, and as the borough has a large population, it would be reasonable to suggest that these low scores may be driven by a significant inequality in the social support black ethnicities receive.

¹⁶ Source: PHE Segment Report

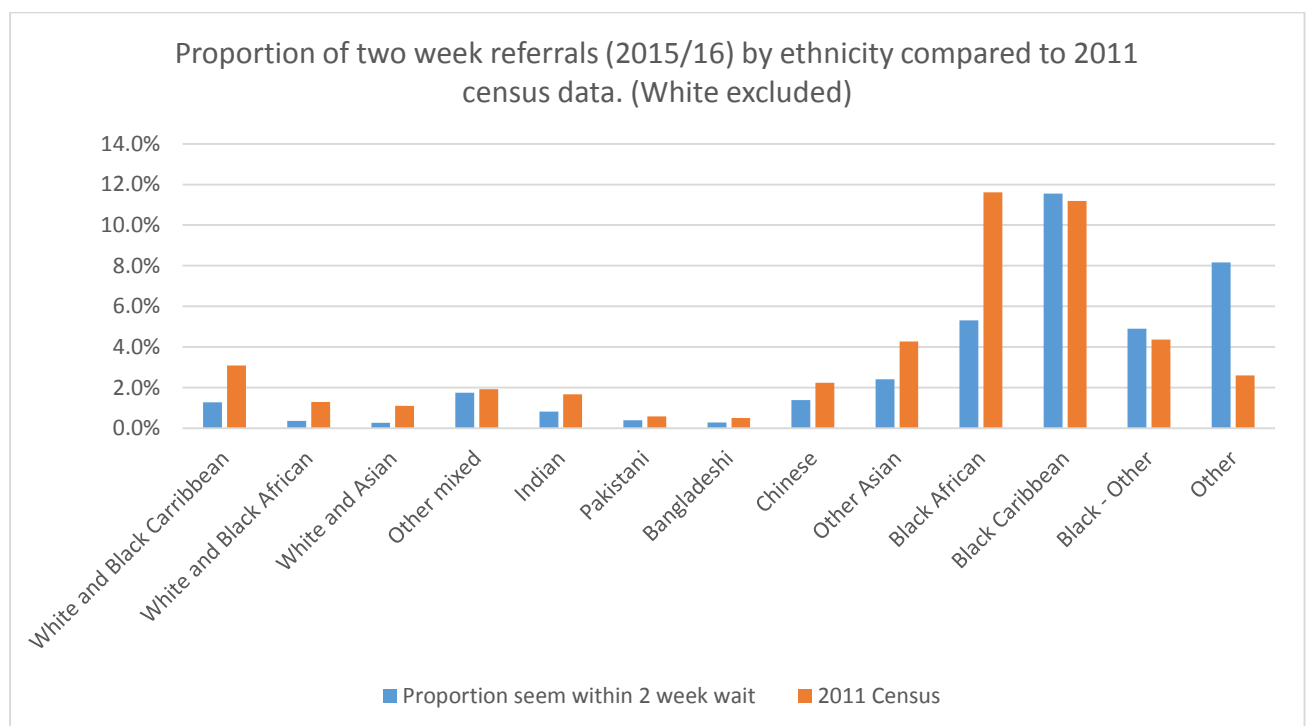
¹⁷ <http://www.ncpes.co.uk/index.php/reports/national-reports>

For breast cancer, there is evidence that black women are less likely to attend screenings¹⁸ and less likely to be diagnosed via the screening route,¹⁹ and therefore are more likely to be diagnosed with higher stage cancers, with the expected poorer outcomes in terms of mortality and survival rates.

Data on ethnicity is gathered by Lewisham CCG on the Two Week Wait and some screening programmes. These can be compared to the 2011 census results to see if any ethnic group is over or under-represented.

For the Two Week Wait data, this shows that white British residents make up a higher proportion of 2 week referrals compared to their expected population (50.2% vs 41.5%). In particular Black Africans are underrepresented compared with their census data (5.3% vs 11.6%). This data cannot tell us why there is this disparity, it could be due to lack of awareness of cancer symptoms, not wanting to or being unable to access an GP, or being less likely to attend follow up appointments.

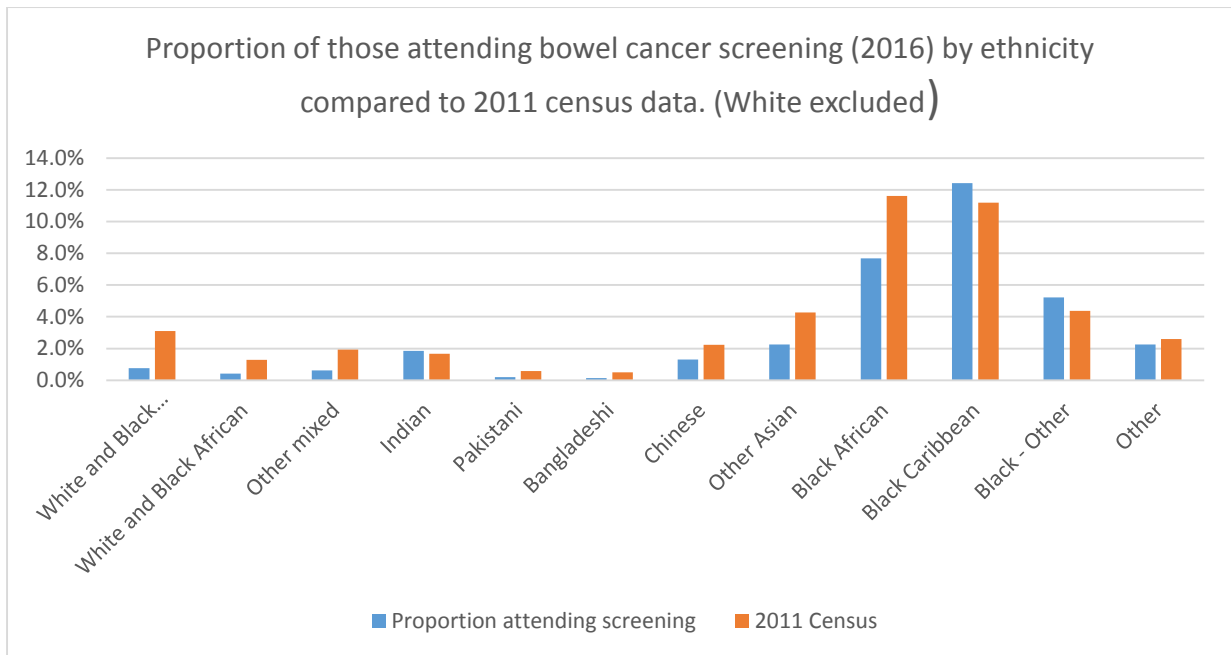
Other ethnicities are graphed below, with white ethnicities excluded, to allow an easier comparison.



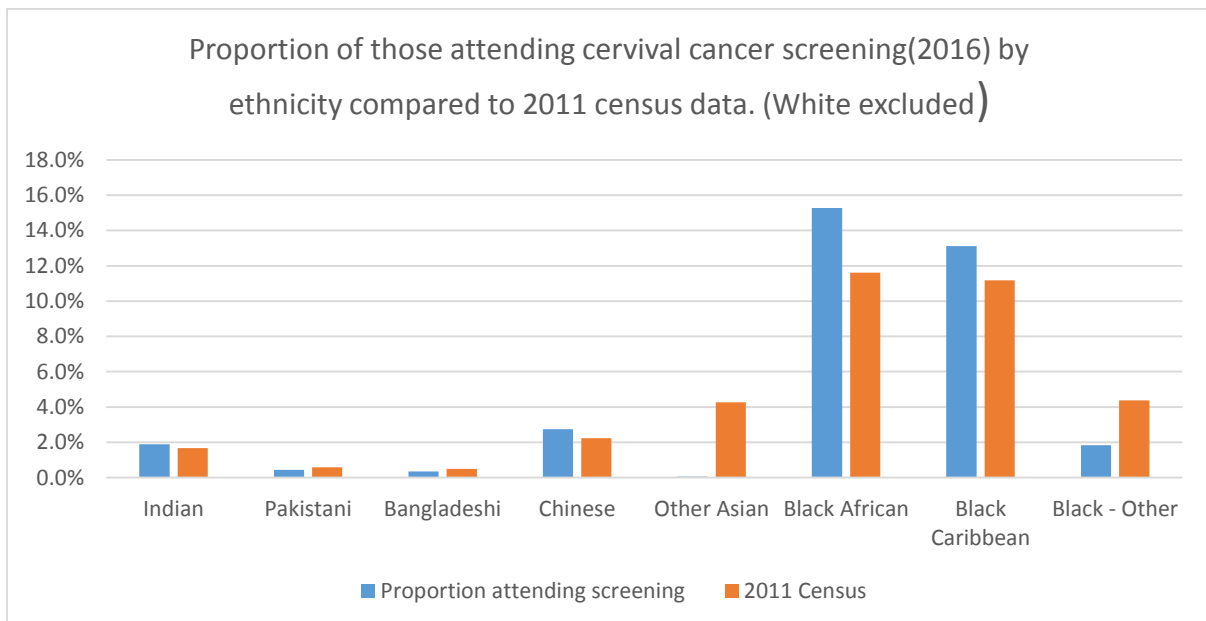
For screening CCG data for ethnicity exists for the bowel and cervical screening programmes, although the categories of ethnicity are not exactly the same as the data used in the census, some comparisons can still be made.

¹⁸ Jack RH, Møller H, Robson T, et al. Breast cancer screening uptake among women from different ethnic groups in London: a population-based cohort study. *BMJ Open*

¹⁹ http://www.ncin.org.uk/publications/data_briefings/breast_cancer_ethnicity



Again black African ethnicity appear underrepresented compared to their 2011 census population levels. Whether this is due to not being registered with a GP, not being invited or not attending screening is unknown.



Source: Lewisham CCG data

For cervical screening, there were no ethnic groups that were underrepresented, although again the ethnic categories for the cervical screening were not directly comparable to the census categories, most notably the mixed categories were not well defined and therefore some of those of mixed ethnicity may have been miscategorised.

Not knowing the reasons for the low referral and screening uptake in specific ethnic groups represents an important gap in our knowledge and given Lewisham highly diverse population could potentially represent a large amount in the difference in Lewisham cancer outcomes compared to those of England. Further and more detailed information would allow a more focused analysis of the issues facing these communities and allow targeted interventions to improve uptake of

An important caveat of all these comparisons is that the census data is now 5-6 years out of date, so there is the possibility that Lewisham's population structure could have changed in that time period.

What are the key gaps in knowledge or services?

We have incomplete data on the role of ethnicity for incidence, mortality and survival at a local level, which given the extremely diverse population of Lewisham, is a significant knowledge gap. This could also represent a gap in services if the public awareness and screening campaigns are less effective at reaching these minorities, and we would need to consider how we can target or reconfigure services to reduce inequalities and ensure widespread engagement and access.

Lewisham has a higher than average mortality and lower than average one year survival for both bowel and lung cancer. While the data suggest this difference seems to be driven by men under the age of 75, and that higher levels of deprivation are a factor in lung cancer mortality we have little data what gap in our services are directly causing this mortality and survival gap. There is therefore the potential for work to be done to investigate what are the major causes of these outcomes, whether they are for example, due to diagnosis, referrals or treatment, and this can be used to target our resources most efficiently.

Similarly, while there is some evidence that some ethnic minorities are less likely to attend screening and be referred via the 2 week wait pathway, we do not know why this occurs, and therefore how we can rectify this. Is it a lack of knowledge in the community, cultural stigma or lack of access? Again knowing how best to direct our resources is vital to improving this population's cancer outcomes.

Is what we are doing working?

As the data shows, overall Lewisham's overall mortality from all cancers has been decreasing. The screening coverage has been increasing and the survival times have been improving. In addition Lewisham does particularly well at diagnosing and treating prostate cancer at the early stages leading to good mortality rates for this cancer despite a higher incidence when compared to the rest of the country.

What is on the horizon?

The Sustainability and Transformation Plans (STP) ²⁰ are overarching strategies devised by collaboration between multiple CCGs, Local Authorities and NHS trusts. The six boroughs in the South

²⁰

<http://www.ourhealthiersel.nhs.uk/Downloads/Strategy%20documents/South%20East%20London%20STP%20October%202016.pdf>

East London STP footprint are Lewisham, Southwark, Lambeth, Bexley, Bromley and Greenwich. They aim to increase the efficiency of the organisations while maintaining or improving services by taking advantage of shared resources and assets, and reducing the amount of overlap in services. To support this work, the South East London Cancer Alliance has been formed and consists of clinicians, public health, voluntary and community sector groups (Macmillan and Cancer Research UK) and patient representatives.

The STP plan involves the development of Local Care Networks (LCNs), organisations made up of GPs, pharmacists, the voluntary sector, social care, community nurses, and many other community based providers, covering between 50,000 and 150,000 people and tailored to the community they serve. By pooling resources across the boroughs into these LCNs, they hope to improve the efficiency of services, while also expanding the scope of service that are offered in the community, thereby improving patient experiences.

Specifically for cancer the STP suggests 19 interventions, including:

- A focus on increasing screening uptake, with a central 'hub' coordinating.
- Professional development for primary care staff, including the implementation of the Cancer Decision Support Tool across all boroughs which will assist and standardise identifying patients that are at risk of cancer, and support early detection.
- Pooling resources and expertise to provide specialist services more effectively, including an acute oncology service, more chemotherapy treatment options in the community (such as GP practices or at home).
- The use of the Cancer Recovery Package, a combination of multiple interventions that aim to integrate primary, secondary and social care to support patients at home.
- Better management of patients after cancer treatment, including access to physical health support intervention, psychological interventions and social care. In addition greater will be made to support patients to return to work or study. Support for carers will also be a key factor in managing the discharge and care planning for cancer patients.

What should we be doing next?

Filling gaps in knowledge

As mentioned above, there are two major gaps in our knowledge that would provide important information for improving the future outcomes in cancer patients. The first is investigating what is causing our increased burden in mortality in our under 75 year old male population. The data indicates this is due to bowel and lung cancer, but does not provide information on the causes, whether it be lack of knowledge, late presentation, not engaging with treatment, or not attending screening. The second area would be a deeper dive into the issues surrounding ethnicity. At a national level we know that black ethnicities feel less support by social care out of hospital, and at a local level it appears that some black ethnic groups are less likely to attend screening. Finding out why this occurs, whether it be due to lack of outreach to their communities, or any other cultural or social barriers is vital to ensuring that we can reach these communities more effectively.

Improving public awareness. Focusing campaigns particularly on areas where the data indicates Lewisham is weaker, such as the increased mortality of under 75s particularly men, and the late presentation of bowel and lung cancers, again particularly in men. Better public awareness of

screening campaigns and of the early symptoms of common cancers may also result in better uptake of screening, and fewer cancer diagnosed on emergency presentation. Given the financial constraints of local government this will mean tapping into the national PHE campaigns such as Be Clear on Cancer, and mobilising our voluntary sector. By making use of the third sector this will give us greater reach into communities that are otherwise hard to reach with conventional public awareness campaigns.

An effort should also be made to improve vaccine uptake in the 11-13 year age group, as once a sufficiently large number of girls are vaccinated, the cervical cancers caused by these strains are almost completely eliminated, and these viruses are the cause of approximately 70% of cervical cancers. This will require engagement of school staff and nurses, and a campaign to inform parents of the importance of the vaccine. It will also require 'catch-up' rounds of vaccinations to ensure that those who miss a round of vaccination still have a chance to receive it later.

The lessons learnt from the Health Communities Cancer program should be, where possible, expanded across the borough. Key points include: the recruitment and retention of volunteers through training and support to ensure they remain motivated, gain relevant skills and are shown their work is a valuable contribution, effective working with partners in the voluntary sector particularly minority groups, and tailoring the message and delivery of the message to the audience, ensuring that a range of age, gender and ethnicity are represented on the volunteer team.

Improving early diagnosis. Ensuring all staff have access to Make Every Contact Count (MECC) training in smoking cessation, alcohol harm reduction and weight management. These sessions train staff in brief intervention, a method of discussing, educating and signposting people to help in short conversations. These interventions are designed to be applicable in a wide variety of situations and contexts, such as at the end of a GP consultation, by teachers to parents or even amongst colleagues and friends. They have been shown to be effective in reducing alcohol consumption²¹, weight management²² and smoking cessation, and is recommended by NICE.²³

Continue to increase uptake of screening. For bowel cancer screening letters will be sent out from each invitee's personal GP, which has been shown to increase uptake of screening by 13% when compared to generic invitations. In addition GP surgeries will receive financial rewards for improving or maintaining screening coverage, incentivising surgeries to be more pro-active in encouraging patients to attend screening.

Increased training opportunities for healthcare professionals. This could involve more education for GPs on the current situation of cancer in Lewisham and the new NICE two week wait guidelines, and the other referral pathways. This should increase the conversion rate of two week referrals.

Training aimed at clarifying who should be offered Prostate Specific Antigen (PSA) testing in primary care, given Lewisham's high incidence and large black population should also be carried out, aiming to reduce the number of inappropriate referrals and subsequent invasive tests

Following on from the work in training pharmacists in the early signs and symptoms of the cancer, this programme could be extended to more pharmacies, but also to other healthcare professionals, such as social workers and mental healthcare workers.

²¹ http://www.cochrane.org/CD004148/ADDICTN_effectiveness-of-brief-interventions-in-primary-care-populations

²² www.hse.ie/eng/health/child/healthyeating/weightmanagement.pdf

²³ <https://www.nice.org.uk/guidance/ph1/chapter/1-recommendations>

The Suitability and Transformation Plan and Integration of care

As the planning and the implementation of the STP continues to evolve, Lewisham must take an active role in ensuring that the cancer services in the borough are maintained, and that the merger and integration of services takes into account the local needs.

For Lewisham, this will require a particular focus on social care. The most recent results of the National Cancer Patient Experience survey showed that Lewisham patients felt less supported outside the hospital by social services and the that this may be due to black ethnicities feeling particularly unsupported. The STP's plan to implement the Cancer Recovery Package, a combination of interventions aimed at integrating health and social care, must therefore take into account the local needs of the population. Planning how this Recovery Package must be accessible and acceptable to black ethnicities, and how, for example any cultural and social barriers can be overcome must therefore be paramount.