Behind the Screen: Breast screening uptake and radiotherapy waiting times in London

March 2008
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Breast screening uptake and radiotherapy waiting times in London
March 2008
Health and Public Services Committee

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Executive summary

One out of nine UK women will be diagnosed with breast cancer in their lifetime. It is now the most common cancer in the UK, accounting for almost one in three of all female cancers.

The Committee is concerned at reports last year that UK breast cancer survival rates are far lower than in other Northern and Central European countries despite the significant amount of investment and focus given to cancer by the government in the 2000 Cancer Plan and more recently in the 2007 Cancer Reform Strategy.

Two reasons given for the UK’s higher mortality rates are the late diagnosis of cancer and a lack of capacity in the radiotherapy service. The first part of this report examines the late diagnosis of cancer, linked to low uptake of breast screening programmes and low awareness of breast cancer symptoms and risk. The second section will explore current problems with the radiotherapy service in London.

Saving an estimated 1,400 lives a year the national breast screening programme offers mammogram appointments to women aged 50 to 70 years of age every three years. However London’s uptake rates, at 62 percent are significantly lower than the national average of 75 percent.

The Committee’s investigation highlighted three key reasons for London’s low uptake rates:

- There is a lack of knowledge about the reasons why women do not attend and the characteristics of non attenders, which reduces the ability of the service to respond to changing needs.
- There are low levels of awareness of the screening programme and breast cancer symptoms and risks amongst particular groups of women in London.
- London women’s poor experiences of the screening programme.

The Committee makes a number of recommendations to address these issues, recognising that there is no single magic bullet to improve London’s uptake rates and it will require a multi-strand approach. The Committee recommends the following action:

- Better information about non attenders needs to be gathered systematically across London.
- Women over the screening age range should be reminded every three years that they are still entitled to screening appointments.
• A three year London-wide media campaign to raise awareness needs to be evaluated by the Department of Health.
• GPs need to take a bigger role in promoting the screening programme and risks and symptoms of breast cancer to their patients.
• A London-wide call and recall service that offers appointments to all London women across London needs to be established as part of Healthcare for London modernisation work.

In the final part of this report the Committee sets out its examination of the radiotherapy service in London. There has been a national problem of under capacity planning of the service in the past, which has led to delays in patient pathways and longer than recommended waiting times. Waiting times in a third of London’s trusts exceed national waiting time targets. The Committee heard that London-specific factors exacerbating national problems include problems retaining staff due to the cost of living, varying workloads and commissioning relationships between PCTs and acute trusts and the fragmented management of the radiotherapy service. The Committee recommends that a pan-London coordination of the service should be established to enable a long term equipment and workforce strategy for the whole of London to be devised. This will improve the sharing of best practice and explore the possibility of a devolved radiotherapy service in London involving a large number of small radiotherapy units professionally supported by larger cancer centres.
Summary of recommendations

**Recommendation 1:** All London PCTs should carry out health equity audits of their populations in relation to breast cancer screening and radiotherapy by December 2012.

**Recommendation 2:** The Department of Health to require all Screening Programmes to send letters to women over the screening age range every three years reminding them that they are still entitled to screening appointments.

**Recommendation 3:** The Department of Health to assess the practicalities of implementing a three-year rolling media campaign in London targeting key at risk groups by March 2009.

**Recommendation 4:** By 2009 NHS London to sponsor a London PCT to pilot an incentive scheme to encourage local GPs to promote the NHS breast cancer screening programme, using an electronic flagging and letter system. The findings of the study should be shared with other PCTs and NHS London.

**Recommendation 5:** The establishment of a London-wide call and re-call service which offers appointments, including outside working hours, across London to all London women should be included in the modernisation work planned under the Healthcare for London Framework.

**Recommendation 6:** As part of the modernisation work proposed under the Healthcare for London Framework NHS London must lead London’s five cancer networks to establish a pan-London coordination of radiotherapy treatment services inline with the Cancer Reform Strategy.
1 Why the Committee carried out the investigation

Take a moment to think of the nine most important women in your life; your mother, your sister, your daughter, your grandmother, your partner; or even you. One of these women will develop breast cancer at some point in their lives.

1.1 Breast cancer is now the most common cancer in the UK. In London 4,235 people were diagnosed with breast cancer in 2005 and 1,185 people died from the disease.

1.2 It is the most common cancer for women, accounting for almost one in three of all female cancer cases. One in every nine women will be diagnosed with the disease during their lifetime, and more than 44,000 women are diagnosed with breast cancer in the UK each year. Although around 300 men are diagnosed nationally with breast cancer each year the Committee has focussed on the incidence of female breast cancer because of the significantly greater risk to women.

1.3 Breast cancer survival rates in England lag far behind those in other Northern and Central European countries. The survival rate for breast cancer patients five years after diagnosis is 78 percent in England compared to 93 percent in Iceland. Two reasons given for the UK’s poor results are late diagnosis of cancer and a lack of capacity in the radiotherapy service. Our review looks in more detail at these issues in the London context.

Late diagnosis

1.4 Late diagnosis of breast cancer is linked to low uptake of screening programmes and low awareness of breast cancer symptoms. Evidence shows that screening helps save lives by detecting breast cancer in its early stages when it is easier to treat. The Cancer Reform Strategy estimates that the NHS Breast Screening Programme saves an estimated 1,400 lives per year. Pressures on the NHS Breast Screening Programme (NHSBSP) are set to increase as the population ages and grows and more women become eligible for the screening programme.

1.5 The Committee decided to examine uptake rates as an indicator of the success of the invitation based national screening programme operating in London.

1.6 The government’s minimum standard for uptake is 70 percent. However London has the lowest uptake of breast cancer screening in the country, a fact widely recognised within the screening service. A rolling programme of referrals seeks to invite all women aged 50-64 to a screening. In London in 2005-06 just 62 percent attended their appointments, compared to a national average of just over 75 percent. Breast cancer screening coverage is particularly poor in inner London, as shown in the table below.
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1.7 Breast screening uptake by London’s six screening programmes is illustrated in the map below.

**Uptake by women aged 53-64 by London Screening Programme at 31 March, 2006**

1.8 Screening is an important step in early diagnosis of breast cancer. However, whilst 20 percent of breast cancer incidences reported each year are detected via the screening programme the vast majority of women diagnosed with breast cancer are self or GP referred.

**Problems with the radiotherapy service**

1.9 There is a national problem of radiotherapy capacity. National guidelines recommend that breast cancer patients should generally start radiotherapy treatment within four weeks of surgery. Long waiting times for radiotherapy can lead to major stress for patients and according to some research, can also increase the chances of the cancer recurring.

1.10 In 2006 the average waiting time for radiotherapy was longer than four weeks in more than a third of the 17 acute trusts in London for which information is available.

1.11 A recent National Radiotherapy Advisory Group report highlights that under capacity of the radiotherapy service and long waiting times are linked to a...
lack of radiotherapy equipment and a lack of qualified radiologists, and other relevant staff. London specific issues that may be exacerbating nationwide under capacity, include the high cost of living and the fragmentation of service delivery in London.

**Incidence of breast cancer**

1.12 The incidence of breast cancer varies according to demographics:

- Breast cancer risk is strongly related to age, with more than 80 percent of cases occurring in women aged 50 and above. The risk increases as women get older.
- Women are much more likely to be diagnosed than men, although a small number of male cases (around 300 nationally) are diagnosed each year.
- There is currently poor understanding of how ethnicity affects the development of breast cancer. A small study in Hackney has found that black women may develop breast cancer at an earlier age than white women of the same age.
- The incidence of breast cancer is higher in more affluent areas, which may be linked to lifestyle factors, such as affluent women tending to have children later. However, survival rates are lower in more deprived areas, which may be partly linked to their lower uptake of breast screening.

**Committee focus**

1.13 The Committee’s review has focused on the following key questions:

- Why is uptake of breast cancer screening so low in the capital? What could be done to boost screening rates?
- Awareness: What more should be done to increase awareness of the screening programme, and of the symptoms and treatments associated with breast cancer?
- Radiotherapy: Why is there such variation in radiotherapy waiting times across the capital? What could be done to reduce waiting times for radiotherapy?
- Inequalities: Are there any inequalities in terms of accessing breast cancer screening and radiotherapy treatment? What could be done about these inequalities?

1.14 These issues are examined in more detail in the following chapters.
2 Background and context

2.1 Tackling cancer is a national priority for the National Health Service (NHS). Government priorities are set out in the National Service Framework for Cancer - the NHS Cancer Plan. This plan, published in 2000 aims to increase the number of people who survive cancer, and improve the patient’s overall experience of the service. As well as providing extra investment in staff and equipment, this plan includes a number of new targets including a maximum one-month wait from diagnosis to initial treatment for patients with breast cancer.

2.2 The Cancer Reform Strategy (CRS), published in December 2007 builds on the work of the NHS Cancer Plan and takes into account new systems of commissioning and financial management operating in the NHS since 2000. It sets out proposed action in ten separate areas: six areas of action to improve cancer outcomes and four areas of action to ensure delivery. Priorities include diagnosing more cancers early, coordinating the collection of better quality cancer data and supporting the role of commissioning as a driver of improvement in cancer outcomes.
3 The NHS Breast Screening Programme in London

3.1 The NHS Breast Screening Programme (NHSBSP) is a nationally coordinated and monitored programme. This year is its twentieth anniversary. It aims to offer all women aged 50 to 64 years the opportunity to have a mammogram. This was extended in April 2001 to include women aged up to 70 years old. Recent proposals in the Cancer Reform Strategy includes the extension of the programme to women aged 47 to 73, starting in 2008 with coverage completed by 2012, and a guarantee that women will have their first screening before the age of 50. This will mean an extra 400,000 women a year will be invited to use the service.

3.2 There are a number of organisations responsible for the successful running of the NHSBSP in London; between April 2005 and March 2006, some 250,000 women were invited to a screening.

London Screening Programmes

3.3 There are six Breast Screening Programmes operating in London, with a screening population of approximately 800,000 between them. London PCTs commission breast-screening services from the programmes in a consortium approach with a lead PCT. The commissioning group within each breast screening programme is responsible for monitoring and performance managing the service, including indicators such as uptake rates. The London Quality Assurance Research Centre (QARC) monitors the breast screening programme running in London against nationally set targets and standards.

3.4 The programme invites groups of eligible women in batches according to the GP surgery they are registered with, using GP registration lists provided by PCTs.

3.5 The six services operating in London and its borders are:

- Barking, Havering & Brentwood Breast Screening Service;
- Central & East London Breast Screening Service;
- North London Breast Screening Service;
- South East London Breast Screening Service;
- South West London Breast Screening Service;
- West of London Breast Screening Service.
3.6 The call/re-call components of the breast screening programme inviting women to attend mammogram appointments is managed by thirteen call/recall offices in London and three fringe offices in Surrey, Essex and Hertfordshire. They are usually located within a Family Health Service directive, hosted by a PCT.

**Cancer Networks**

3.7 The Cancer Plan 2000 identified cancer networks as the appropriate model for service providers to evaluate the running of cancer services, implement the Cancer Plan and meet its targets and ensure improvement. The five London cancer networks bring together health service commissioners and providers such as PCTs and NHS hospital trusts, the voluntary sector and local authorities and work closely with patients to try and increase satisfaction with the service.
4 How does the programme work?

1 Invitation Letters
- Using the data held by GP surgeries the Screening Programme call/recall centres send women a letter inviting them to a mammogram appointment on a certain date, time and location.
- The letter includes a number to call if women would like to change their appointment time.
- As part of informed consent requirements the national information leaflet Breast Screening - the Facts is sent along with the invitation letter.

2a Did not attend (DNA)
- She will be sent a second appointment.
- If she does not attend her second appointment she will be invited again in three years time.
- If a woman does not attend her second appointment her GP surgery is told that she did not attend.

2b Acceptance of Invite
- Screening will take place at a specialised screening unit, which can be hospital based, mobile, or permanently based in another convenient location such as a shopping centre.
- A screening appointment takes about half an hour.
- The woman is asked about any symptoms or history of breast disease. Then a mammogram, a low dose X-ray, is taken of the woman’s breast.

3 Screening Results
Results abnormal or technical problem:
- She will be recalled to an assessment clinic where further tests will be carried out, which may include: clinical examination, further mammograms, ultrasound or core biopsy.
- Breast care nurses should be available at the assessment clinic to give advice to women and answer any questions they have during or following diagnosis.

Results normal:
- She will be sent her next routine appointment invitation in three years time.

4 Treatment
- If a woman is found to have a breast cancer she is referred to a consultant surgeon to discuss the treatment options available to her.
- Treatment usually involves some form of surgery either a lumpectomy, which involves removal of the lump and a small amount of surrounding tissue, or a mastectomy where the whole breast is removed.
- Surgery is then often followed by radiotherapy, chemotherapy or hormone therapy or a combination of these.
5 Data concerns

5.1 The Committee heard there are two key data issues that may be affecting the accuracy of uptake rates and the efficiency of the programme in London. These are a lack of information on the characteristics of women who do not attend their appointments and inaccurate GP patient lists.

Lack of data on characteristics of non-attendees

5.2 We have heard widespread concerns about the lack of available data on the characteristics of non-attendees. Until the NHS knows who is not attending and why it will not be able to take measures to increase uptake. QARC told the Committee

“The best data that we have to look at women who do not attend is the general population data and you can look at the uptake rates within a geographical area but then you have to make assumptions about those women who have not attended or may not have attended. So we do not have the data on women who do not attend”.35

5.3 Some research into the characteristics of non-attendees has been carried out in the past but it has been patchy and localised and lessons have not been shared across London.36 Small studies have highlighted that ethnicity and levels of social deprivation in the population of women being screened appear to have an impact on uptake levels.37 A Breast Cancer Care study found 45 percent of BAME women aged 50 to 70 had never undertaken screening compared with nine percent of the population surveyed.38

5.4 Access to screening by learning-disabled women is significantly lower than the national average at 17 percent for those in family care and 52 percent for those in formal care.39

5.5 Early findings from a small study by Westminster and Kensington and Chelsea PCT indicates that private screening rates may be significantly affecting the accuracy of current uptake rates at some London surgeries. The study examined uptake rates at a surgery in the area and after taking into account patients who had undertaken private breast screening or had self-referred uptake rates were adjusted from 48 percent to 72 percent.

Further research a priority

5.6 The Committee was told that further research to ascertain a full and comprehensive picture of what is contributing to the low London-wide uptake rates needs to be carried out:

“there needs to be some fundamental, basic research done to look at the non-attenders and what it is that is making them decide not to come for
screening and that may be related to cultural, religious, health beliefs; all sorts of complex things which need to be unravelled and I do not think that that basic work has been done yet”.

5.7 The lack of data hampers the ability of the screening service, PCTs and NHS London to target local and pan-London schemes to improve uptake. Improved data collection and analysis will enable better informed commissioning of services based on identified need and improve the effectiveness of attempts to tackle London’s low uptake rates.

5.8 PCT health equity audits are a valuable source of information about some of the characteristics of women not attending screening and barriers to screening in the area, although ethnicity of non attenders will still be difficult to assess. These may be used to tailor in-depth research into particular local issues and allow comparison between PCT populations in London as long as consistent methodologies are used. This will in turn assist the development of measures to increase uptake rates amongst these local communities.

**Recommendation 1:**

All London PCTs should carry out health equity audits of their populations in relation to breast cancer screening and radiotherapy by December 2012.

**Inaccurate GP lists**

5.9 London has a highly mobile population making it difficult for London GPs to maintain the accuracy of their lists. A small study of six GP surgeries in London found that nearly 40 percent of patients that had moved took longer than six months to re-register with a new GP. About 13 percent took longer than one year and seven percent took over three years to re-register. Women not registered with a GP fall outside of the screening programme’s invitation system. A Breakthrough Breast Cancer study in London and the West Midlands found one in four women had not received their screening invitation letter, which they believed was most likely due to the mobile nature of the population in these areas.

5.10 ‘Ghost patients’ or women who do not update their details with their GP and were sent an invitation letter to their old address will be included and so worsen uptake rates.
Measures needed to improve accuracy of PCT and GP databases

5.11 Improving the way in which patient information is shared as well as ‘cleaning’ GPs lists will improve the accuracy of data used in compiling uptake rates. Access to the NHS Spine portal by breast screening units could improve the speed at which GP lists could be updated.

5.12 But data ‘cleaning’ is not easy. We heard of two particular concerns, related to London’s population characteristics and resources, which need to be heeded before undertaking any cleaning of GP surgery lists. The Royal College of GPs noted that certain features of London’s population may lead to patients being incorrectly removed from lists:

“Lots of people in London do move regularly and also if language is a barrier people may not return the forms and may find themselves not registered at their GP practice. The additional practice checks are supposed to prevent this from happening. There are sometimes people who are still in their practice’s catchment area and do have to re-register.”

5.13 Sufficient resources for list cleaning would need to be identified to ensure it is carried out to a high quality and is made an ongoing priority with PCTs and GPs. To make a long-term impact it needs to be a regular ongoing process.

5.14 There are limits to the impact of list cleaning or improving access to central NHS databases as these will not necessarily increase the number of women screened unless they include an exercise to update the details of those women who have moved. It also will not address the issue of women not registered with a GP not being invited.
6  Why is uptake of breast cancer screening so low in the capital?

6.1 At its meeting in November, the Committee heard that services in London, adhering to a national programme and rigorously quality assessed by QARC, are as good as those in the rest of the country. However, the meeting also heard that London’s screening uptake rates are significantly lower than the national average.

6.2 This section will examine the “multifaceted and complex” reasons for London’s low uptake rates. Our investigation highlights the two key areas contributing to London’s low uptake rates:

- London women’s awareness, attitudes and understanding of breast screening programmes and breast cancer symptoms; and
- Women’s experiences of the London service.

Awareness, attitudes and understanding

6.3 Whilst breast screening programmes are an important method of detecting cancer, self awareness and understanding of what clinical signs to look for also have an important role to play. Eighty percent of patients attending breast assessment clinics have been referred by GPs because the patient or the GP have noticed signs or symptoms of breast cancer.

6.4 According to a 2007 study conducted in south east London, attitudes that women have towards breast cancer and whether they consider breast screening personally relevant and important to them is the strongest predictor of attendance/non-attendance at screening appointments.

Key at risk groups

6.5 Two key risk groups of having lower levels of awareness of the screening programme and breast cancer symptoms and risks are BAME and older women.

BAME women

6.6 The message that early detection increases the chance of survival needs to be more effectively disseminated to combat fears and misconceptions held by some BAME women. The head of London QARC told the Committee that women not born in the UK “may not be used to the concept of screening and, therefore, not understand what it is about and what it is trying to do for them and... the benefits that they might receive from it”.

6.7 A number of studies have indicated there are distinct attitudes towards breast cancer and lower levels of awareness of the screening programme amongst many groups of BAME women.
6.8 The 2005 Same Difference study by Breast Cancer Care found that BAME women taking part in the survey were more likely to be missing key information about breast awareness such as what symptoms to check for and how to check for them.\textsuperscript{56} Other studies have indicated that BAME women were less likely to believe they were personally at risk of breast cancer than other women.\textsuperscript{57} A study carried out in south east London found that BAME women were least likely to find screening reassuring.\textsuperscript{58}

6.9 South Asian and Arab women who took part in a small 2004 Breast Cancer Care study indicated greater levels of pessimism than White British women who took part.\textsuperscript{59}

6.10 Recent research indicates that black women may be more likely to develop breast cancer younger than white women, at an age prior to the national breast screening programme’s initial age of invitation of 50 years.\textsuperscript{60} An awareness of the risks and symptoms of breast cancer is therefore crucial for black women. Additionally the age range at which the screening programme is offered, both now and with the extension proposed by the Cancer Reform Strategy, may not meet the requirements of black women. \textit{Large scale research needs to be undertaken by the NHS and cancer charities into the link between ethnicity and breast cancer incidence.}

\textbf{Older women}

6.11 The Committee heard that misconceptions about the age related risks of breast cancer are widespread, possibly reinforced by how the screening programme is run.

6.12 The risk of breast cancer increases as a woman ages.\textsuperscript{61} However women over 70 years stop receiving invitation letters although they are entitled to request further appointments. A study by Breast Cancer Care found that 20 percent of London women over 50 years of age incorrectly believed that screening stops at 70 years of age because they are no longer at risk at this age.\textsuperscript{62} A Breakthrough Breast Cancer study found that over half of all UK women over 70 were unaware that they could continue to get free screening by making their own appointments.\textsuperscript{63}

6.13 The participants in the Committee’s focus group were very concerned that invitation letters ceased at age 70 and doubted that most women would be proactive about getting screened without a regular reminder letter prompting them to go:
“How many people wait for the letter and when it does not come, do not bother to do anything about it. I do not think it should be cut off at 70. I think it should go on.” 64

**Recommendation 2:**
The Department of Health to require all Screening Programmes to send letters to women over the screening age range every three years reminding them that they are still entitled to screening appointments.

**Improving awareness**

6.14 Influencing the attitudes held by some women will be a key way to increase uptake rates in London. This is recognised by the Cancer Reform Strategy. A number of channels should be used to raise women’s awareness of the importance and quality of breast screening, the importance of early diagnosis and the increased risk of breast cancer as you get older will need to be a part of this approach.

6.15 Research by breast cancer charities found that the main sources of information on breast cancer signs and symptoms for women are their local GP/health professionals, friends and family and the media. 65

6.16 Our review has found that initiatives for raising awareness of breast cancer symptoms and the screening programme should include the following; media awareness campaigns, community outreach work, and a greater focus on GPs and their staff.

**Media awareness campaigns**

6.17 Many contributors to our review spoke of the need for a rolling programme of national and pan-London TV, tube and bus advertisement campaigns, rather than what appears to be a piecemeal approach to articulating the value of early screening. We would welcome the views of the Department of Health as to whether given current resource levels a reinvigorated media campaign could be financed in the next financial year. We believe that this should be specifically targeted at key at risk groups. For example; the Clinical Director of the South East London Screening Service told the Committee that he would like the messages about breast cancer, currently portrayed by the media to emphasise the risk of breast cancer to older women:

“if there is any way of controlling the message that the media give out about breast cancer, they could perhaps change their emphasis from young women with breast cancer, which makes headlines, to actually emphasising the risk which is more in the older age group.” 66
6.18 We welcome the targeted localised approaches such as outreach work by health care professionals using community networks, which reach socially deprived and BAME groups. Breast Cancer Care told the Committee that it has worked with Afro-Caribbean and Turkish-speaking community groups in London to develop audio plays exploring current attitudes towards the disease in those communities in an attempt to improve awareness and dispel any myths.67

6.19 Breast care nurses also have an important role to play in community outreach work, providing information about the screening service. Many women told the Committee about the importance of breast care nurses in their cancer journey, as a source of advice and information. The Committee is concerned to hear reports that the security of these specialist positions is not always ensured which has caused anxiety within some patient and survivor networks.68

6.20 Breast Cancer Care told the Committee that it provides information leaflets free of charge to breast cancer units and GPs however there were reports they were not always made available to women:

“We produce it free and hospitals only have to spend postage and packing. We sometimes get feedback from people who have been in the clinic and have seen one of our leaflets there and it has the sticker saying do not remove...We get quite surprised by that because we know they are free”.69

6.21 In London these information packs especially need to be available in a variety of languages and formats and culturally and religiously sensitive to the diverse London population they are targeting.

6.22 A lack of funding for a concerted long-term campaign will limit the effectiveness of any awareness campaign. In the past momentum has been lost from smaller initiatives when funding has run out.70

6.23 The Committee welcomes NHS London’s interest in developing a London-wide awareness campaign in conjunction with London’s PCTs.71 Given the renewed emphasis the government has given to raising the awareness of cancer through its Cancer Reform Strategy we would welcome an assessment from the Department of Health of the content and practicalities of a three year rolling media campaign in London targeting key at risk groups.72
Recommendation 3:
The Department of Health to assess the practicalities of implementing a three-year rolling media campaign in London targeting key at risk groups by March 2009.

Role of GP and GP surgery staff

6.24 A large number of stakeholders highlighted the importance of GPs and their staff as a link between the screening service and women in London.

6.25 The attitude of GPs and their staff towards breast screening and breast awareness can be very influential on women, especially those who have not attended screening before. They are a trusted source of information about breast cancer symptoms and breast awareness\(^73\) and can have a role in promoting the breast screening programme and encouraging women to take up their appointments.\(^74\) GP surgeries are notified when their patients are invited to screening appointments and when they do not attend.\(^75\)

6.26 ‘Gatekeeper’ staff need to be educated on the entitlements to breast screening services of particular groups, such as refugees and asylum seekers.\(^76\) Breast cancer charities, experienced in awareness campaigns and working with GPs, could be funded to devise a training programme for GP surgery staff.

6.27 Studies have indicated that time consuming approaches, such as home visits by GPs, are not necessarily effective in increasing uptake.\(^77\) A trial in Islington, where GP surgeries were paid to encourage women to attend by writing to the patients before and after screening, phoning them as well as having community group sessions and videos in waiting rooms did not increase screening significantly.\(^78\)

6.28 Simpler cost effective measures by GPs could be more appropriate. The Royal College of GPs suggested that GPs should send a single letter to their patients about a month prior to routine screening appointment letters being sent out, encouraging them to attend. Additionally a flagging system on the GP computer system could be used to raise non-attendance at screening with women when they visit the surgery.\(^79\)

6.29 However the lack of incentives or interest of some GPs to carry out breast cancer promotional or awareness work makes it difficult to encourage them to prioritise this issue. Westminster and Kensington and Chelsea PCT told us:

“*There are no incentives at the moment for GPs to do any work on breast screening; it is not a target that they are paid for, it is a target the PCTs are...*
monitored on, but not the GPs. So it makes it very hard for us to do work with them unless you do get some motivated GPs but they have so many other calls on their time”.

6.30 GPs could be encouraged to take on a greater role in monitoring uptake rates and promoting breast awareness and the screening programme with their female patients by including this work in the Quality and Outcomes Framework or other incentive schemes.

Recommendation 4:
By 2009 NHS London to sponsor a London PCT to pilot an incentive scheme to encourage local GPs to promote the NHS breast cancer screening programme, using an electronic flagging and letter system. The findings of the study should be shared with other PCTs and NHS London.

London women’s experience of screening

6.31 Evidence suggests that if women attend one screening appointment they are more likely to take up following invitations. In London 57.2 percent of women attend their first appointment in comparison to 81.5 percent of women attending subsequent screens. The Committee has identified a number of important steps to ensuring a satisfactory screening experience; from receiving the letter of invitation, to the time and location, to the experience of the appointment itself.

The invitation letter

6.32 The importance of the screening process and the perception of the way it will be handled begins with the invitation letter. One focus group participant told the Committee that they almost missed their appointment because of the lack of identifying information on the letter’s envelope:

“I nearly did not attend the appointment because the letter that arrived I threw in the bin because it looked like it was junk mail, quite honestly. If it had not been for a friend - we were due to go at the same time - I would never have attended”.

6.33 Identifying details on the envelope such the breast screening programme name and details or a NHS logo would begin the process of identifying the screening appointment as a significant event that the NHS is taking seriously.

6.34 Both the screening appointment letter and the national information leaflet Breast Screening- the Facts sent with it is in English. The information leaflet
is available in nineteen languages and large print on request from PCT health promotion clinics. Details of the translation services available may be provided in the letter but it depends on the call/recall centre co-ordinating the invitation process. The Committee is concerned that with over 300 languages and dialects spoken in London some women may not be attending their appointments because they do not understand the invitation or the accompanying information.

Inconvenient screening times and locations for London women

6.35 Research commissioned by the All Party Parliamentary Group on Breast Cancer found that one in six women interviewed found screening appointment times given to them inconvenient and do not rearrange them.\(^83\) This issue was also highlighted in our focus group as a possible reason for low uptake rates. Focus group participants told us that the current screening hours offered during working hours made it complicated for them to attend their appointments:

“If you are working in London, it is difficult to get time off to attend your local mobile unit, so maybe if you could give a preference perhaps...so that you could be seen when you want to be seen”.\(^84\)

6.36 Some focus group participants told us that the location of screening sites had not been convenient for public transport:

“Well, for me it was off-putting, yes, because it meant going to some remote little hut on this vast... hospital site, which was nowhere near a bus stop. It is hardly encouraging. It is not made easy”.\(^85\)

6.37 Screening appointments are offered to women at units in the same area as the GP surgery they are registered with. Traditionally invitation letters will include a specified time and location for the appointment. The number for the call/recall centre they are linked with is provided if women want to change their appointment time. The Committee’s focus group agreed that appointments offered at a location of their choice, either close to their place of work or closer to their home would be a welcome option:

“It would be nice to be offered different locations. I have to trek half way across London. It would be much nicer to be able to choose something locally”.\(^86\)

6.38 The Committee was told that increasing the number of screening units in London would not necessarily improve uptake rates. Ensuring current units
are accessible is more important. For example static units situated outside hospitals, in shopping precincts, have been popular with some women:

“The attraction of that is that it completely takes the screening experience out of any hospital, clinical, healthcare setting. It is in an environment which women are used to being in; it is part of normal, healthy living, if you like.”

The importance of satisfactory first appointments

6.39 We were told that the attitude and professionalism of healthcare ‘gatekeepers’ involved in the screening programme affected women’s experiences of the screening process. Describing her visit to a screening unit one woman told the committee:

“the reception was not welcoming. There was no one behind the desk, but two women were chatting nearby. Were they staff or patients? I didn’t know whether to interrupt in order to introduce myself, who to address myself to, or where to go… I had to stand there waiting until they had finished their conversation. This is plain discourtesy, but it also deters one from wanting to repeat the experience.”

6.40 The screening staff may well be the first human contact that the woman will have in what will undoubtedly be a significant clinical appointment. For most women the event will be unremarkable; perhaps inconvenient and possibly uncomfortable. For some it will be the first step on a long journey of treatment. It is vital that this is dealt with the utmost professionalism and is made as comfortable an experience as possible. Given the importance of advice shared between friends and family a bad experience at the first screening appointment could through word of mouth put off many women from attending.
7 Pan-London management service?

7.1 The effectiveness of PCT led commissioning for breast screening services varies across London by PCT. QARC told the Committee the current commissioning structure and performance is impeding the progress of local and pan-London schemes addressing low uptake:

“London-wide initiatives, such as pooling resources for extended hours phone coverage, [are] very difficult to organise. There is currently no incentive to work collaboratively and the funding structure actually creates barriers to resource sharing.”

7.2 Attempts to address the problems of Pan-London service managed at a PCT level are currently taking place. The Committee hopes that the recent formation of the London Commissioning Group, responsible for steering London-wide commissioning in line with the Healthcare for London Framework, will improve the quality of commissioning in London and encourage further joint working on matters of London-wide importance.

7.3 Additionally QARC told the Committee that a number of modernisation initiatives for the breast screening service in London have been proposed to address the problems with coverage and uptake in London. These included proposals for the centralisation of administrative functions of the screening service and the development of a London-wide call/recall centre to increase accessibility for women.

7.4 Currently the call/recall components of the breast screening programme inviting women to attend mammogram appointments is managed by thirteen call/recall offices in London and three fringe offices in Surrey, Essex and Hertfordshire. In contrast a single call/recall centre, with a single phone number, that offers appointments to all women in London would provide greater flexibility of locations across London and of times, including outside working hours. Women could ask for appointments near their place of work rather than near their GPs.

7.5 The key organisations involved in the running of the NHS Breast Screening Programme in London are aware of issues raised by the Committee relating to data collection, data accuracy and the way the service is organised in London. However it is not clear whether it is a lack of funds, political will or the lack of a Londonwide NHS body prior to mid-2006 that has so far prevented the rapid implementation of measures to address these problems.
The Committee believes that NHS London should use the opportunity offered by the Healthcare for London Framework to ensure that these identified problems are addressed. The Committee calls on London’s PCTs and NHS London to identify funding streams to ensure these initiatives are taken forward.

**Recommendation 5:**

The establishment of a Londonwide call and re-call service which offers appointments, including outside working hours, across London to all London women should be included in the modernisation work planned under the Healthcare for London Framework.
8 Radiotherapy waiting times

Current guidelines

8.1 Radiotherapy treatment is a cheap, effective and vital element of care for a large number of patients, not just breast cancer patients. The demands on radiotherapy treatment are expected to continue to grow as the number of cancer patients and the proportion eligible for radiotherapy treatment rises steeply across the country.92

8.2 Radiotherapy is the use of high energy x-rays to destroy cancer cells and is given as a course of daily treatments for between three to seven weeks. Breast cancer patients most often receive it as a follow on treatment, after surgery or chemotherapy, to destroy any remaining cancer cells in the breast area.93

8.3 National NICE guidelines recommend radiotherapy treatment be given within four weeks of the “identification of need” which is usually identified as being after initial treatment rather than at initial diagnosis of breast cancer.94 However radiotherapy cannot be given immediately after breast surgery as women need to recover from the effects of the surgery first. Most women will have recovered within four weeks of surgery.95 However if there is a delay between breast cancer surgery and radiotherapy treatment of over eight weeks the risk of a relapse is increased by 60 percent.96

8.4 Under current national targets the first cancer treatment should occur within 31 days of diagnosis. Radiotherapy is not usually subject to this target as it is most commonly given as a secondary treatment.

“it has basically been excluded from the way that targets are written at the moment. One of the things that we have argued for is that all radiotherapy should be given within 31 days of the decision to treat. That would be a huge undertaking to actually deliver that, but that is what we believe would be best for patients”.97

8.5 The Committee welcomes the government’s pledge in the Cancer Reform Strategy to extend the 31-day target for cancer treatment to radiotherapy as a second or third treatment. If PCTs are to meet this requirement by December 201098 they must work through their cancer networks to ensure appropriate local investment in workforce and equipment. The Committee however believes that this should be made an immediate priority.

Current waiting times

8.6 For a number of years concerns have been raised about radiotherapy service capacity and waiting times for treatment. The most recent data collected by the Royal College of Radiologists from radiotherapy units indicates that in
the UK over half of curable patients, at 53 percent, are waiting longer than
the four week recommended guideline for treatment.99

8.7 Data provided by radiotherapy units in 2006 to market research company Dr
Foster indicates that the average waiting time for radiotherapy was longer
than four weeks in more than a third of the seventeen acute trusts in London
for which information is available.100 The survey excluded patients who had
chosen to delay their treatment.

8.8 The time taken between a decision to treat and when a first treatment is
given is routinely collected within the NHS. However it is not collected
routinely for second or third treatments such as radiotherapy.101 The
Committee welcomes plans to introduce the London-wide routine collection
of radiotherapy data, including waiting times.102 The availability of this data
will allow a unit’s performance to be assessed against national and London-
wide performance standards.

“[the data] will then be available in the public domain, for everyone to see.
That, I think, will become a great driver to improve quality because you will
be able to see that your hospital is good or bad and that the hospital down
the road is better.”103

National problems and solutions- NRAG report

8.9 The Cancer Reform Strategy recognised a recent National Radiotherapy
Advisory Group (NRAG) report that discussed the national under-capacity of
the radiotherapy service contributing to lengthy waiting times for patients.104
Crucially, the NRAG report found that the projected need for radiotherapy
had been underestimated in the 2000 Cancer Plan. Investment in, retention
of and training of the radiotherapy workforce and the efficiency of and
investment in equipment has been inadequate nationally.105

8.10 The Committee heard that radiotherapy workforce retention of staff at
different levels of experience is a problem across units due to stressful
working environments and pay band structures. This is especially so for
radiographer positions with drop-out rates for the demanding three-year
degree course at about 35 percent and an 11 percent vacancy rate for
radiographer positions nationally.106

8.11 Maintenance regimes can also increase waiting times unnecessarily. The
Committee heard that the maintenance of radiotherapy machines could be
made more efficient by using a continuity system where radiotherapy teams
rotate across the unit’s machines leaving one spare to receive maintenance
work. This should be standard practice across the trusts.
London specific causes for long waiting times

8.12 The Committee found that there are a number of London-specific factors that may be exacerbating national radiotherapy capacity problems, leading to long waiting times in London. These include problems retaining staff, the commissioning relationship between PCTs and acute trusts with radiotherapy departments, and the fragmentation of London’s radiotherapy service.

8.13 The Committee heard that London’s radiotherapy units are finding it even harder than other units across the country to retain staff because of the high cost of living in London. Encouragingly NHS London told the Committee that London radiographer vacancy rates have seen an improvement over recent months with only one vacancy on each site except for Imperial College Healthcare NHS Trust that has a vacancy rate closer to the national rate at ten percent. This is in part because of changes to rates of pay and scales introduced under the Agenda for Change modernisation project.

8.14 The varying workloads, capacity and access to equipment across hospitals in London means that some trusts are struggling more than others to reach the recommended four week guidelines. The Committee was told that the relationship that commissioners have with radiotherapy providers can be crucial to ensuring a good service:

“How services are provided, depends on how the provider interacts with the commissioner and how much investment they get. So some people do well and other departments go downhill and I think that has been a problem”.

8.15 Although the Cancer Reform Strategy pledges an extra £200 million in new equipment and staff for the national radiotherapy service PCT commissioners and service providers in London will need to prioritise the reduction of waiting times and ensure it is carried out in an efficient cost-effective manner.

A pan-London co-ordinated service?

8.16 The Committee is concerned at the way radiotherapy services are currently organised and delivered in London. Not all acute trusts in London offer radiotherapy and this can lead to delays because inter-trust pathways are not always effective. Travel times in London can be long and difficult even for relatively short distances and if a patient’s local trust does not offer radiotherapy they may have to undertake long journeys.

8.17 NHS London believes a strategic pan-London partnership approach between London’s Cancer Networks is the best way to improve services across London. The Committee was told that the five London Cancer Networks have agreed
to work together on a pan-London basis “to look at the radiotherapy services across London because they do have quite a big impact on each other and a single service cannot be seen in isolation”.113

8.18 A pan-London coordinated service would also be able to develop a long-term equipment and workforce investment programme in line with the NRAG report and the Cancer Reform Strategy.114 It will improve the sharing of best practice between radiology units across London, which will be increasingly important as treatment become more complex in the future.

8.19 The Committee believes that London’s five cancer networks, bringing together PCTs and Acute Trusts, are the appropriate bodies to provide a strategic co-ordination of the service. NHS London, responsible for implementing the proposals of the Cancer Reform Strategy must take the lead in encouraging the five cancer networks to do this and ensure pan-London consistency is achieved.

8.20 The Committee welcomes the Healthcare for London’s proposals for centralised centres of excellence. A devolved London radiotherapy service, involving a large number of small radiotherapy units professionally supported by larger cancer centres115 could work in such a system. Increasing the number of radiotherapy units could provide greater accessibility to radiotherapy services for London’s population, reduce travel times and reduce the risk of inter-trust pathway breakdowns.

**Recommendation 6:**

As part of the modernisation work proposed under the Healthcare for London Framework NHS London must lead London’s five cancer networks to establish a pan-London coordination of radiotherapy treatment services inline with the Cancer Reform Strategy.
9 Conclusion

9.1 Our review has investigated the reasons why London’s uptake rate for breast cancer screening falls so far below the national average. We have set out a number of recommendations, the implementation of which we believe would improve London’s uptake rate. In particular, through gaining a better understanding of why some women do not respond positively to a letter offering them a screening, through increasing public awareness of the risks of breast cancer and the benefit that early diagnosis brings, and through providing a Londonwide call and re-call service that could more easily tailor the appointment service to meet women’s needs.

9.2 We have also reviewed the existing evidence as to why waiting times for radiotherapy treatment in a third of London’s trusts exceeds national waiting time targets. Our support for a Londonwide mechanism for coordinating radiotherapy treatment could ensure effective sharing of resources to support those parts of London under most pressure and to meet the future challenges of a growing and ageing population.

9.3 We would like to thank all those individuals and organisations that have contributed and in particular to those cancer survivors who shared their experiences with us in the hope that our work could materially benefit the thousands of London women who will be diagnosed with breast cancer in the next few years.
Endnotes


3 Email correspondence, 22 February, Thames Cancer Registry.


5 Left in the dark, 2003, Breakthrough Breast Cancer.

6 http://info.cancerresearchuk.org/cancerstats/types/breast/incidence/


8 Lancet Oncology, September 2007; Survival of Cancer Patients in Europe, Eurocare: http://www.eurocare.it/


10 Screening for Breast Cancer in England: Past and Future; NHS Breast Screening programme no. 61; Screening Saves Lives, 2007, Breakthrough Breast Cancer

11 Cancer Reform Strategy, p 44.

12 Uptake refers to the percentage of women who attend screening within six months of their first offered appointment. Women who are GP or self-referred for screening are not included in these figures. Coverage is the proportion of women resident and eligible for screening who have had a test with a recorded result at least once in the previous three years and includes those who are GP or self referred. QARC written submission, Part 1, p 4.

Uptake data from Breast screening programme, England 2005-06, 2007, The Information Centre for Health and Social Care: www.ic.nhs.uk covers women from 50 to 64 years of age because coverage of women to 70 years will not be fully reached until 2008-09.


Organised by Breast Screening Programme. The six Breast Screening Programmes within London also incorporate some non-London neighbouring boroughs.


Breast Cancer Care written submission, p 1.


Your Guide to Breast Cancer Services, 2006, Breast Cancer Care. The longest recorded waits for radiotherapy were at Charing Cross and Kingston Hospitals which both recorded waiting times of up to 93 days, around three times longer than the recommended waiting time of four weeks.

Radiotherapy: developing a world class service for England, National Radiotherapy Advisory Group, 07.


The Cancer Research UK study in Hackney of 293 women found that on average the black women surveyed had developed breast cancer 21 years younger than the white women surveyed. Black women ‘develop breast
cancer earlier’, The Times, 17 January 2008 at: http://women.timesonline.co.uk/tol/life_and_style/women/article3200528.ece

26 Cancer Atlas of the UK and Ireland, 2005, Office for National Statistics; Same difference- Breast Awareness is for everyone, 2005, Breast Cancer Care; Breast Cancer Risk Factors, www.cancerresearch.org


30 QARC written submission, Part 1, p 3.

31 QARC written submission, Part 1, p 3.

32 QARC written submission, Part 1, p 3.

33 Three bordering PCTs and their populations are included in the London screening programmes. These are South West Essex, Surrey and West Herfordshire PCTs. QARC written submission, Part 1, p 3.


37 QARC written submission, Part 1, p 6.


39 Breakthrough Breast Care written submission, p10.
Michael Michell, Clinical Director - South East London Screening Service, and radiologist lead for the London Quality Assurance Reference Centre. Also representing the Royal College of Radiologists, Transcript of Meeting on 28 November 2007, p 6.


QARC written submission, Part 1, p 7; Southwark PCT written submission.


Breakthrough Breast Cancer written submission, p 3

List cleaning involves the PCT verifying the accuracy of patient lists held by GP surgeries. PCTs write to patients asking them to return a form confirming they are still at the address given by the GP. If the form isn’t returned the PCT checks if the patient has been seen by the practice in the past three years. If not and after the GP practice has a final chance to check whether the patient is still at that address then six months later the patient will be removed from the list.

The NHS Spine portal is part of the NHS Care Records Service and is being developed to allow each patient’s Summary Care Record to be stored on it. This will mean that wherever a patient seeks care from the NHS in England, those treating them will have secure access to summary information to assist with diagnosis and care.

Royal College of GPs written submission, p 1.

Email correspondence from Royal College of GPs, 31 January 2008.

QARC written submission, Part 1, p 6.


QARC written submission, Part 1, p 5.

Barter-Godfrey and Taket, “Understanding women’s breast screening behaviour: A study carried out in South East London, with women aged 50-64 years”, Health Education Journal 66 (4) 2007 355-346. The study was carried out in the inner London boroughs of Southwark, Lambeth and Lewisham.

The Cancer Reform Strategy also highlights the link between social deprivation and lack of awareness of cancer and the benefits of early detection.

Kathie Binysh, Transcript of Meeting on 28 November 2007, p 2.

Same Difference, 2005, Breast Cancer Care.

Barter-Godfrey and Taket, “Understanding women’s breast screening behaviour: A study carried out in South East London, with women aged 50-64 years”, Health Education Journal 66 (4) 2007 355-346. The study was carried out in the inner London boroughs of Southwark, Lambeth and Lewisham.

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Black women ‘develop breast cancer earlier’, The Times, 17 January 2008 at: http://women.timesonline.co.uk/tol/life_and_style/women/article3200528.ece

80 over 50 study, 2003, Breast Cancer Care.

80 over 50 study, 2003, Breast Cancer Care.

Breakthrough Breast Cancer written submission, p 5.

V Reilly Collins, Transcript of Focus Group, 30 October 2007, p 14.

Same Difference, 2005, Breast Cancer Care.

The Cancer Reform Strategy pledges to establish a National Awareness and Early Diagnosis Initiative led by the National Cancer Director to co-ordinate and support local interventions to increase awareness of cancer symptoms and risk.


Correspondence from Royal College of GPs, 9 January 2007, p 2.

Correspondence from the Royal College of GPs, 9 January 2007, p 2.


Breakthrough Breast Cancer written submission, pp 3-4.

D Slade, Transcript of Focus Group, 30 October 2007, p 3.

The hospital radiotherapy units with average waits over four weeks were Charing Cross, Kingston, Central Middlesex, Northwick Park, Royal Free, St Mary’s, Whipps Cross University. The longest recorded waits for radiotherapy were at Charing Cross and Kingston Hospitals which both recorded waiting
times of up to 93 days, around three times longer than the recommended waiting time of four weeks. In Your Guide to Breast Cancer Services, 2006, Breast Cancer Care.

101 QARC written submission, Part 2, p 2.

102 QARC written submission, Part 2, p 2.

103 Michael Williams, Transcript of Meeting on 28 November 2007, p 24.


105 Michael Williams, Transcript of Meeting on 28 November 2007, p 20.

106 Michael Williams, Transcript of Meeting on 28 November 2007, p 20.

107 Created in October 2007 by merging the Hammersmith Hospitals NHS Trust and St Mary’s NHS Trust and integrating with Imperial College London Faculty of Medicine.

108 Email correspondence, Kathie Binysh, 18 January 2008.

109 Barking, Havering and Redbridge Hospitals NHS Trust written submission; City & Hackney Teaching PCT written submission.

110 Michael Williams, Transcript of Meeting on 28 November 2007, p 18.


112 City and Hackney PCT written submission.

113 Kathie Binysh, Transcript of Meeting on 28 November 2007, p 19.


## Appendix 1: Glossary

<table>
<thead>
<tr>
<th>Term/abbreviation</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Agenda for Change</td>
<td>The single pay system operating in the NHS since late 2004 that applies to directly employed NHS staff with the exception of doctors, dentists and some very senior managers.</td>
</tr>
<tr>
<td>BAME</td>
<td>Black, Asian and Minority Ethnic. Refers to those in Mixed, Asian or Asian British, Black or Black British, Chinese and Other ethnic groups.</td>
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<tr>
<td>Cancer Plan</td>
<td>The government’s strategy for investment in and reform of cancer services in England with the aim of increasing the number of people who survive cancer, and improving the patient’s overall experience of the service. Published in July 2000.</td>
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<tr>
<td>Cancer Reform Strategy</td>
<td>Sets out the government’s plans for the development of cancer services in England over the next five years. Published in December 2007.</td>
</tr>
<tr>
<td>Coverage</td>
<td>Coverage is the proportion of women resident and eligible for breast screening who have had a test with a recorded result at least once in the previous three years and includes those who are GP or self referred.</td>
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<tr>
<td>Mammogram</td>
<td>A low dose x-ray. Each breast is placed in turn on the x-ray machine and gently but firmly compressed with a clear plate. The compression lasts a few seconds.</td>
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<tr>
<td>NHS London</td>
<td>The Strategic Health Authority for London.</td>
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<td>NRAG</td>
<td>National Radiotherapy Advisory Group</td>
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<td>Term</td>
<td>Definition</td>
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<td>QARC</td>
<td>The London Quality Assurance Research Centre. It monitors the breast-screening programme running in London against nationally set targets and standards. It does this by visiting each screening programme every three years and monitoring data from each programme. The QA team includes representatives from each profession contributing to the screening programme.</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trust. The body responsible for commissioning health services in a local area. The PCT also provides some services.</td>
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<tr>
<td>Radiotherapy</td>
<td>The use of high energy x-rays to destroy cancer cells, given as a course of daily treatments for between three to seven weeks.</td>
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<tr>
<td>Uptake</td>
<td>Uptake refers to the percentage of women who attend screening within six months of their first offered appointment under the national screening programme. Women who are GP or self-referred for screening are not included in these figures.</td>
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Appendix 2: How we conducted this investigation

Call for written evidence

Information was gathered in a number of ways:

- writing to key stakeholders to obtain written views and information;
- letters from the Chair to local media requesting the views of members of the public;
- including an item on the Assembly home page to encourage people to send us their views.

The following organisations responded to our call for written evidence in September 2007:

- Barking, Havering & Redbridge Hospital NHS Trust
- Barnet & Chase Farm Hospitals NHS Trust
- Barnet PCT
- Bexley PCT
- Breakthrough Breast Cancer
- Breast Cancer Care
- Cancer Research UK
- Central and East London Breast Screening Service
- City & Hackney Teaching PCT
- Clerkenwell Medical Centre
- Ealing Hospital NHS Trust
- Guy’s and St Thomas’ NHS Foundation Trust
- Havering PCT
- Kingston Hospital
- London Quality Assurance Reference Centre
- Mayday Healthcare NHS Trust
- NHS Cancer Screening Programmes
- North East London Cancer Network
- Redbridge PCT
- Richmond and Twickenham PCT
- Royal College of General Practitioners
- Royal College of Radiologists
- South East London Breast Screening Programme
- Southwark PCT
- The Royal Marsden NHS Foundation Trust

Additionally nine London women responded to the Committee’s call for written views and information.
Focus group with patients and survivors
The Chair and Deputy Chair hosted a small focus group with breast cancer patients and survivors to gather from them in-depth personal accounts of their experiences of screening and radiotherapy treatment in London, including:

- problems or barriers accessing screening services
- delays or problems accessing radiotherapy treatment
- good experiences of screening and radiotherapy treatment services.

A copy of the transcript of the focus group is available online at: http://www.london.gov.uk/assembly/health_ps/2007/healthpsnov28/item04a.pdf

Additional survivor and patient experiences were gathered via an online survey which was publicised on the Assembly website and made available on the website of breast cancer charity Breast Cancer Care.

Public meeting
A public meeting was held on 28 November 2007 to discuss the issues arising from the call for written evidence and the focus group. The following people attended the meeting to answer Committee member questions:

- Kathie Binysh, Director, London Quality Assurance Research Centre and Medical Director, West London Cancer Network. Also representing NHS London;
- Michael Michell, Clinical Director - South East London Screening Service, and radiologist lead for the London Quality Assurance Reference Centre. Also representing the Royal College of Radiologists;
- Michael Williams, Vice President and Dean of Faculty of Clinical Oncology, Royal College of Radiologists;
- Nikki Cannon, Screening Co-ordinator, Westminster and Kensington and Chelsea Primary Care Trusts;
- Maggie Alexander, Director of Policy and Campaigns, Breakthrough Breast Cancer.

A copy of the transcript of meeting is available online at: http://www.london.gov.uk/assembly/health_ps/2007/healthpsnov28/minutes/transcript.pdf

Further information
For further information on this investigation or how it was conducted please contact Sarah Hurcombe, Assistant Scrutiny Manager, on 020 7983 6542 or email: Sarah.Hurcombe@london.gov.uk
Appendix 3: Principles of London Assembly scrutiny

An aim for action
An Assembly scrutiny is not an end in itself. It aims for action to achieve improvement.

Independence
An Assembly scrutiny is conducted with objectivity; nothing should be done that could impair the independence of the process.

Holding the Mayor to account
The Assembly rigorously examines all aspects of the Mayor’s strategies.

Inclusiveness
An Assembly scrutiny consults widely, having regard to issues of timeliness and cost.

Constructiveness
The Assembly conducts its scrutinies and investigations in a positive manner, recognising the need to work with stakeholders and the Mayor to achieve improvement.

Value for money
When conducting a scrutiny the Assembly is conscious of the need to spend public money effectively.
Appendix 4: Orders and translations

How to order
For further information on this report or to order a copy, please contact Sarah Hurcombe, Assistant Scrutiny Manager, on 020 7983 6542 or email: Sarah.Hurcombe@london.gov.uk

See it for free on our website
You can also view a copy of the report on the GLA website: http://www.london.gov.uk/assembly/reports

Large print, Braille or translations
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