# Scrutiny Review of Breast Cancer Screening in Haringey

## Scoping Report & Terms of Reference

**November 2009**

**Draft for discussion**

## 1. Introduction

1.1 Breast Screening Services in Haringey are provided through the North London Breast Screening Service (NLBSS). This is a specialist service which is commissioned by a consortium of 6 Primary Care Trusts (PCTs) in north London (Barnet, Brent Enfield, Haringey, Harrow and West Hertfordshire). The lead commissioning authority is Enfield PCT and performance is managed by a local (Enfield and Haringey) Committee.

1.2 A number of serious untoward incidents occurred at the NLBSS in 2006, which gave rise to significant safety concerns. Following a visit from the national compliance team, the decision was taken to close the service in December 2006. Although the service reopened in May 2007, a screening backlog continues at the service: the current screening round (the interval at which women are screened) is approximately 47 months instead of the national standard of 36 months.

1.3 The uptake of breast cancer screening invitations and the overall coverage of breast screening amongst the target population are also of concern in Haringey. In 2007/8, just 59% women invited to breast screening in Haringey attended, which is significantly below the national average (75%).[1] Similarly, the breast screening coverage[2] was 52% in Haringey, which is significantly below the average coverage in London (64%) and England as a whole (76%), and the third lowest nationally.[1]

1.4 Against this backdrop, in June 2009, Haringey Overview and Scrutiny Committee commissioned a panel of local councillors to conduct an in-depth review of how the uptake of breast screening services could be improved. The following report provides a detailed scoping of issues pertaining to breast cancer and associated screening services. The report also provides an overview of the national and local policy framework for the review including national, regional and local background data. The proposed terms of reference and the planned methods through which the review may be conducted are also presented.

1.5 This scoping report is intended to inform discussions around the nature of the review and more specifically, the terms of reference which will guide the work of the panel. Once agreed by the review panel, the scoping report will be sent to the Overview & Scrutiny Committee for approval. It is anticipated that the review will commence in November 2009 with a final report going to Overview & Scrutiny Committee in March 2010.

## 2. Breast Cancer Background

What is breast cancer?

2.1 Breast cancer is the irregular development of cells within the breast which may lead to the development of a tumour. There are two types of breast cancer; *ductal carcinoma* which is contained in ducts within the breast and *invasive* breast cancer, where the cancer has spread to broader breast tissue. If left

[1] National breast screening data 2007/8 www.cancerscreeeing.nhs.uk
[2] The number of eligible women who have screened within a three year period.

untreated, breast cancer can also spread (metastasis) through the blood stream to other parts of the body.

How common is breast cancer?

2.2 Breast cancer accounts for 31% of all female cancers and is the most common cause of cancer among women in the UK. Men may also develop breast cancer, but these account for less than 1% of all breast cancer cases. In 2006, there were 45,822 new cases of breast cancer diagnosed of which 45,508 (99%) were among women and 314 (1%) among men. The approximate lifetime risk of women developing cancer is 1 in 9 whilst for men this is 1 in 1,014.[3]

2.3 The incidence of breast cancer is a measure of the likely risk that a person will develop this condition over a specified period of time (generally a one year period). In 2006, the age standardised incidence of breast cancer was 122 per 100,000 of the female population. The incidence of breast cancer among women has risen considerably since 1977 (recorded at 75 cases per 100,000) which has been largely due to the introduction of the national breast screening programme (in 1988).[4]

2.4 Prevalence is a measure of how many people there are living with a particular condition, that is, those who are surviving after diagnosis and treatment. It is estimated that there are currently 5550,000 women in the UK surviving with breast cancer. This equates to 2% of the female population or 12% of the adult female population over 65.[5]

What are the risk factors associated with breast cancer?

2.5 There are a number of risk factors which are associated with breast cancer. The most significant factors associated with breast cancer are **sex** and age. Although both men and women can develop breast cancer, women are 100 times more likely to develop breast cancer than men.

2.6 **Age** is also strongly associated with breast cancer in women where the relative risk increases with age, where it is noted that 81% of breast cancers occur in women after the age of 50. Although the lifetime risk of a women developing breast cancer is approximately 1 in 9, the table below demonstrates the significance of age in the likelihood of women developing breast cancer.

| **Age range** | **Breast cancer risk** |
|---|---|
| Up to 25 | 1 in 15,000 |
| Up to 40 | 1 in 200 |
| Up to 50 | 1 in 50 |
| Up to 60 | 1 in 23 |
| Up to 70 | 1 in 15 |
| Up to 80 | 1 in 11 |
| Up to 85 | 1 in 10 |

[3] UK Breast cancer incidence statistics. Research UK (data from 2001-2005) June 2009
[4] CancerStats Breast Cancer UK Cancer Research UK May 2009
[5] 'ibid'

2.7 **Childbearing** (parity) is also known to influence to the risk of a woman developing breast cancer. Not only is childbearing associated with a reduced risk, the higher number of full-term pregnancies a woman has undergone provides also provides further protection from developing breast cancer. Research has shown that women who have had children have a 30% lower risk than women who have no children (nulliparous).[6] Furthermore, the younger a woman is when she begins child bearing the lower the risk of developing breast cancer: the relative risk increases by 3% for every year of delay in childbearing.[7]

2.8 Following on from childbearing, women who **breast feed** their children are also known to receive greater protection from developing breast cancer. Women who breast feed reduce their risk of breast cancer and the longer a women breast feeds the greater the protection: risk is reduced by 4% for every 12 months of breast feeding[8].

2.9 A woman's **menstrual cycle** and the level of associated hormones within the body are also known to influence the risk of breast cancer. Increased risk of breast cancer is associated with the earlier age at which a woman has her first menstrual cycle (menarche). Conversely, those women who menopause at a later age also experience an increased risk of developing breast cancer: women who have the menopause at 55 rather than 45 have a 30% higher risk of breast cancer (equivalent to 3% per annum).[9]

2.10 The level of some **hormones**, whether produced naturally (endogenously) or taken as medication (exogenously), may also present an increased risk of developing breast cancer in women. Whilst naturally produced oestrogen and testosterone may increase the risk of breast cancer, taken medication such as **oral contraception** (OC) and **hormone replacement therapy** (HRT) are also associated with an increased risk of developing breast cancer: those women on HRT have an increased risk of 66% in developing breast cancer whilst those women who are taking the OC have an increased risk of 24%. It should be noted however that the relative risk is reduced to zero five years after a woman has stopped taking HRT and 10 years after taking the OC.[10], [11]

2.11 A woman's **family history** (genes) may also determine the relative risk of developing breast cancer. A woman with a first degree relative (such as a mother or sister or daughter) who has had breast cancer is twice as likely to develop the same condition as those with no such family history.[12]

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[6] Evertz et al Age at first birth, parity and risk of breast cancer: meta-analysis of 8 studies from the Nordic countries International Journal of Cancer 1990 (46) 597-603.

[7] Breast cancer and breast feeding: collaborative reanalysis of individual data from 47 epidemiological studies and 50,302m women with breast cancer The Lancet 2002 360 p187-95

[8] Breast cancer and breast feeding: collaborative reanalysis of individual data from 47 epidemiological studies and 50302m women with breast cancer Lancet 2002 360 p187-95

[9] Breast cancer and HRT collaborative reanalysis of 51 epidemiological studies. Collaborative group on hormonal factors in breast cancer The Lancet 1997 (350)1047-59.

[10] Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data of 53,297 women with breast cancer and 100,239 women without cancer from 54 epidemiological studies.

[11] Breast cancer and HRT in the million women study The Lancet (2003) 363 419-427

[12] Family breast cancer: collaborative reanalysis of individual data from 52 epidemiological studies The Lancet 2001 (358) pp1389-99

2.12 There are a number of lifestyle factors which are associated with breast cancer. Post-menopausal women who are **overweight** or **obese** have an increased risk of between 10-30% of developing breast cancer; it is estimated that 7% of breast cancer cases in post menopausal women are due to being overweight.[13] Conversely, there would appear to be a reduced risk of breast cancer in pre-menopausal women that are obese (approximately 20%).

2.13 There is also an increased risk associated with **alcohol consumption**, indeed, international reviews would appear to suggest that this link is causal (as this may increase the level of hormones within the body).[14] Research would seem to infer that even low to moderate alcohol consumption can increase cancer risk, and that 11% of the total annual incidence of breast cancers may be attributable to alcohol consumption.

2.14 From a preventative viewpoint, **increased physical activity** is associated with a significant reduction in the risk of developing breast cancer (as this may reduce the level of hormones in the body). High levels of physical activity (10 hours walking or 3.5 hours running per week) have been associated with a reduced risk of developing breast cancer in women by between 20-40%.[15]

2.15 Internationally, it is noted that breast cancer occurs more frequently in **affluent** western populations which would infer that there are certain lifestyle factors associated with increased risk (perhaps some of those factors listed above). Here it is noted that there are higher rates of breast cancer in more Europe and North America than in less developed countries in Africa and Asia. Similarly, affluence would appear to influence the risk associated with more localised populations, where research has indicated that women from more affluent areas may experience up to 20% increased risk of developing breast cancer than those in more deprived areas.[16]

2.16 There are also a number of studies, mainly conducted within the USA, which suggest that there are possible associations between lesbian women and breast cancer. Evidence from this research has indicated that there were significant differences in the breast cancer risk factors exhibited among lesbian women than heterosexual women,[17] which has subsequently produced a higher level of overall risk in them developing breast cancer.[18]

Breast Cancer Mortality

2.17 In 2007, 12,082 people died from breast cancer of which 11,990 were women and 92 were men. Mortality from breast cancer has fallen dramatically since

[13] Reeves et al, Cancer incidence and mortality in relation to Body Mass Index in the Million Women Study: cohort study BMJ 2007 (335) 1134

[14] Baan et al Carcinogenicity of alcoholic beverages International Agency for Research on Cancer 2007

[15] Lahmann et al Physical activity and breast cancer risk: the European Prospective Investigation into Cancer and Nutrition. Cancer Epidemiol Biomarkers Prev. 2007 Jan;16(1):36-42. 2006

[16] Cancer incidence by deprivation 1995-2004) National Cancer Intelligence Network 2008

[17] Roberts et al, Differences in Risk Factors for Breast Cancer: Lesbian and Heterosexual Women Journal of the Gay & Lesbian Medical Association Vol. 2 No. 3 (1998) pp93-101

[18] Dibble et al Comparing breast cancer risk between lesbians and their heterosexual sisters, Women's Health Issues, Volume 14, Issue 2, pp 60-68

1989; the age standardised death rate has fallen from 42 per 100,000 (in 1989) to 27 per 100,000 (which equates to a 36% fall.[19] The reduction in breast cancer mortality is largely attributable to earlier detection of breast cancer (through the national breast cancer screening programme) and improved treatment options.

Treatment of breast cancer

2.18 The exact nature of the treatment for breast cancer will depend on the stage of development at which the cancer has been detected, the age of the patient an the size of the tumour. A combination of surgery and radiotherapy is the most common approach to the treatment of breast cancer, though most will have some form of surgery (i.e. either a lumpectomy, mastectomy).

2.19 There are two main types of treatment for breast cancer: those that are **breast specific** where the cancer is contained within the breast (usually surgery and radiotherapy) and **whole body**, where the cancer has spread to other parts of the body (usually chemotherapy or hormone treatment).

Breast Cancer Survival

2.20 The stage at which breast cancer is diagnosed can have a significant impact on the treatment options and subsequent survival rates of those women diagnosed with this condition. Generally, earlier detection leads to longer survival rates.

2.21 As a result of the introduction of the National Breast Screening Programme (NBSP), there has been a significant improvement in 1 year, 5 year, 10 year and 20 year survival rates for breast cancer. In 1971-1975 the five year survival rate for breast cancer among women was 52%, yet by 2001-2003 this had risen to 80%.[20] Similarly it is recorded that the 10 year survival rates have increased from 41% to 72% in the period 1991-2003.[21]

2.22 Social deprivation is known to be associated with breast cancer survival rates. It has been recorded that women in areas of social deprivation are more likely to first present at a more advanced stage of breast cancer development than those living in more affluent areas[22], more likely to present with another health condition (co morbidity)[23] and have a lower survival rate.[24]

Prevention of breast cancer

2.23 As has been noted earlier, there are some factors which are associated with breast cancer that are behaviour related (i.e. alcohol consumption, exercise, breast feeding). In this context, encouraging **behaviour change** may reduce the risk of developing breast cancer. Internationally it has been acknowledged

[19] CancerStats Breast Canver UK Cancer Research UK 2009
[20] CancerStats Breast Canver UK Cancer Research UK 2009
[21] Office for National Statistics Breast Cancer Survival in E & W 1991-2003
[22] Macleod et al Socioeconomic deprivation and stage of disease at presentation in women with breast cancer Annals of Oncology 2000 11 (1) p105-107.
[23] Macleod et al Primary and secondary care management of women with early breast cancer from affluent and deprived areas: retrospective review of hospital and GP records BMJ 2000 320 (7247) p1442-5)
[24] Coleman et al Trends in socioeconomic inequalities in cancer survival in England and Wales up to 2001 British Journal of Cancer 2004 90 (7) p1367-73

that that increasing the uptake of exercise and reducing levels of obesity can reduce breast cancer.[25]

2.24 **Prophylactic surgery** is also performed for those women who have a very high risk of developing breast cancer, that is, where there is strong family history of breast cancer. It is estimated that in this context, such surgery can reduce the risk by approximately 90%.

2.25 **Education and awareness** initiatives are also important tools in developing a broader understanding of breast cancer issues such as the importance of breast care and attendance at breast screening services and also how to access services if a problem is identified. In addition to a number of national campaigns, there are a number of national charities which operate awareness and education programmes for breast cancer (i.e. Breakthrough Cancer, Breast Cancer Campaign).

2.26 Although **screening** cannot prevent breast cancer, it is perhaps the most effective tool in the diagnosis and treatment of cancer. An effective screening programme can provide a number of significant benefits for women including early diagnosis, improved treatment options, better health outcomes and improved survival rates.

## 3.0 Breast Cancer Screening

What is breast screening?

3.1 Breast cancer screening (mammography) involves a low dose radiation scan to identify abnormal cell development or growths (tumours). Generally two scans are undertaken, both from above (craniocaudal) and from the side (mediolateral) of the breast as this increases the chances of detecting smaller cancers. Breast screening is effective in reducing mortality by approximately 35% in 50-69 year olds, this equates to 1 life is saved for every 500 women screened.[26]

3.2 The introduction of breast cancer screening was designed to detect cancers at an early stage, which would subsequently lead to an improved prognosis and survival rate of women diagnosed with this condition. The importance of breast screening in this context is underlined by that the fact that 40% of breast cancers detected by screening would not have been detected by other methods (i.e. by hand).

The National Breast Screening Programme

3.3 The National Breast Screening Programme (NBSP) was first established in 1988 and was the first such coordinated screening programme in the world. Within the NBSP, women aged between 50 and 70 years are routinely invited for a breast cancer screen every three years. Invitations are issued by a local breast

[25] World Cancer Research Fund: Food nutrition, physical activity and the prevention of cancer: a global perspective 2009

[26] International Agency for Research on Cancer (IARC), 7th Handbook on Cancer Prevention, Lyons 2003

screening unit to local women on General Practice basis (i.e. invitations issued practice by practice).

3.4 Women aged below 50 years are not included within the NBSP as breast cancer can be difficult to detect in pre-menopausal women. Those women believed to be at risk but who are outside the current screening age range can still be referred for breast screening through their GP. It is planned to extend the NBSP to women between the ages of 47 and 73 years by 2012, which will involve an additional 400,000 women in the screening process.

3.5 There are 82 breast screening units in the UK (7 of which are in London). Local breast screening units are coordinated by a national service and breast screening practice is overseen by both regional and national quality assurance network. The NBSS costs approximately £75 million to administer each year, which equates to £37.50 per woman invited or £45.50 per woman screened.

3.6 Breast screening pathway

Breast screening is a cyclical programme where all eligible women (currently aged 50-70 years) are invited to a free breast screen every three years. A radiographer will take x-rays of the breast and examine these for potential abnormalities (usually two specialists will do this). Those women identified as having an abnormal mammogram will undergo a further second assessment. If the abnormality is confirmed as malignant it will be treated (as set out above), if it is normal, the woman will be returned to the recall system and invited for screening again in 3 years time.

Breast Screening Uptake

3.7 The uptake for breast screening is defined as 'the proportion of eligible women who have been invited for screening for whom a screening result is recorded'. Currently the national minimum standard for breast screening uptake is 70% though the national target is higher at 80%.

3.8 National data from that NBSP for 2007-8 reveals that 2.25 million women were invited for a breast screen of which 1.713 million women attended, which produced an uptake of 73%. Nationally, the uptake of breast cancer screening has remained broadly static for the past 5 years (Figure 1). The proportion of women who take up their breast screening invitation in London and within the North London Breast Screening Service (in which Haringey is located) is significantly below national rate at 61% and 59% respectively (Figure 1). Like national trend data, the uptake of breast cancer screening for the London region and within the North London Breast Screening Service has also remained broadly unchanged since 2002/3 (Figure 1).

3.9 There are wide variations in screening uptake among individual breast screening units and within individual Primary Care Trust areas. In some high performing breast screening units such as Barnsley and Rotherham, 81% of women invited for a breast screen have a corresponding screening result. In the London region the average uptake for 2007/8 was 61%. There is also a wide variation in screening uptake among London breast screening units: in Barking & Havering the uptake is 73% whilst in Central North East London uptake is just 52% (Figure 2).

Breast screening coverage

3.10 The breast screening coverage refers to the proportion of eligible women who have recorded a test at least once in the previous three years. The national benchmark for breast screening coverage is 70%. Data from the NBSP for 2007/8 indicates that the breast screening coverage for women aged 53-70 in England was 75.9%, for London 63.6% and in Haringey 52.4% (see table below).

| Region | Population | Women screened | Coverage (%) |
|---|---|---|---|
| **England** | 5,115,011 | 3,883,130 | 75.9 |
| **London** | 599,309 | 381,077 | 63.6 |
| **Haringey** | 18,586 | 9,742 | 52.4 |

3.11 Regionally, in 2007/8, all but one area reported a breast screening coverage of greater than 70%: the one exception being in London where the breast screening coverage was 65%. The level of breast screening coverage also varied widely across local primary care organisation level (Figure 3). At the primary care organisation level, 121 out of 152 areas reported a coverage above 70% (35 of which were above 80%). Just fourteen primary care organisations had coverage below 70%.

3.12 Whilst the average breast screening coverage for the London region was 65%, there were wide variations in coverage among primary care organisations. Thus while in Havering the coverage was 78.2% this fell to 42.3% in Barnet (Figure 4). In Haringey, the coverage was 52.4%, making this the third lowest in the country. The proportion of women aged 53-70 in London who have never screened is 19%, which is far higher than the national average (11%).

Screening round length

3.13 The screening round length is the interval between the date of a women previous screening mammogram and the date of her next first appointment. The round length is measured by the percentage of eligible women whose first appointment is within 36 months of their previous screen. The national minimum standard is 90% or above and the target is 100%.

3.14 It is important that the minimum round length is met, because if women are screened within the 36 month interval the incidence of “interval cancers” (i.e. those developing cancer between screening appointments) is very low. This risk of developing cancer rises as the interval increases.

3.15 Following a number of serious untoward incidents (SUI) at the North London Breast Screening Service and a visit by the regional quality insurance service, the decision was taken to close the service in December 2006. Although the service reopened in May 2007, a breast screening backlog continues at the NLBSS. The current screening round length is below the national minimum standard at approximately 47 months.

What factors affect the uptake of breast screening?

3.16 There are clearly many factors which may influence the take up of invitations to breast screen and in the UK at least, however, there are few definitive large scale studies to guide such assessments. There are however number of smaller

scale studies which have identified a number of factors which are associated with the take up breast screening services.

3.17 There are a number of studies which have provided a link between **social deprivation** and the take up of breast screening invitations. There have been a number of studies which have highlighted that the women resident in areas of social deprivation are less likely to attend breast screening services than women from more affluent areas.[27],[28],[29]

3.18 A number of studies have also made associations between **ethnic origin** and attendance at invitations for breast screening. Research conducted in Brent & Harrow concluded that that poor knowledge, underlying health and cultural beliefs, attitudes and language were central to low attendance by BME groups.[30] Other studies among non attendees of breast screening services found that some BME groups did not perceive themselves to be at risk or were more anxious about attending.[31] There is insufficient research evidence however to conclude that there is a direct link between BME status and breast screening uptake as lower levels of attendance may be the result of other factors (i.e. socioeconomic group differences or inaccurate registers).

3.19 The **location of the breast screening unit** was also found to influence the uptake of invitations to breast screening services. One study found that the distance that women have to travel had a significant impact on the uptake for screening services,[32] whilst another study concluded that after a breast screening service was moved, attendance fell by 2% for each kilometre further women were from the unit.[33]

3.20 **Personal attitudes** have also been shown to influence a woman's decision whether to attend for breast screening. A study in Lambeth, Southwark & Lewisham found that a positive personal attitude and the perceived personal importance of screening were strongly associated with attendance for breast screening services. Conversely, the study found that some of the most common reasons women gave for non-attendance included the avoidance of anxiety, pain and embarrassment.[34]

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[27] Gatrell 1998 Uptake of screening in breast cancer in South Lancashire Public Health 112 (5) 297-301

[28] Maheswaran et al 2006 Socioeconomic deprivation, travel distance, location of service and uptake of breast screening services in North Derbyshire Journal of Epidemiology and Community Health 60 (3) 208-12

[29] Banks et al 2002 Comparison of various characteristics of women who do and do not attend breast cancer screening, Breast Cancer Research 4 R1

[30] Barriers to effective uptake of cancer screening among BME ethnic groups, International Journal of Palliative Nursing 2005 Nov 11 (11) 564-571)

[31] Barter-Godfrey & Takert 2005 Women and health: views of women aged 50—64 living Lambeth, Southwark & Lewisham, London South Bank University

[32] Maheswaran et al 2006 Socioeconomic deprivation, travel distance, location of service and uptake of breast screening services in North Derbyshire Journal of epidemiology and community health 60 (3) 208-12

[33] Maxwell 2000 Relocation of a static screening unit: a study of factors affecting attendance Journal of Medical Screening (7) 114-115

[34] Barter Godfrey and Taket 2005 'op cit'

3.21 For the most vulnerable women in the community responding to invitations to breast screening appointment may be problematic. Lower levels of breast screening have been reported among women with a **learning disability**,[35] despite that this group are now living longer and fuller lives and living to an age where screening is appropriate. Similarly, it is noted that there is evidence to suggest that there is lower attendance among women with severe **mental health** problems.[36]

3.22 There may be a number of **structural factors** associated with the organisation of the screening service which may influence the uptake of screening. A well organised breast screening programme may positively influence uptake, which might include:

- Adequate population registers
- Effective call and recall system
- Good quality control
- Reliable and safe procedure[37]

3.23 Attendance for invitations to a breast screen is clearly affected by a broad range many social, cultural and economic factors, of which just a few have been highlighted above. It is clear that the decision to attend for breast screening is undoubtedly complex and in many cases personal to the individual making this decision.

Interventions to improve breast screening uptake

3.24 There is evidence to suggest that there are a number of possible interventions which have had a positive impact in developing breast screening uptake among women. Although **GPs** are not directly involved in the breast screening process, there is evidence to suggest that planned interventions by GPs can improve screening uptake. Improved uptake has been recorded where GPs have written or made a call to non-attendees at breast screening services,[38] furthermore, such GP interventions were found to override factors associated with poor attendance such as social deprivation and ethnicity.[39]

3.25 Issuing **reminder letters** to non-attendees was found to be effective in improving the uptake of breast screening services; in a review of 28 studies, it was concluded that the issuing of reminder letters consistently increased uptake.[40] Furthermore, those reminders which offered another fixed appointment were also found to improve breast screening uptake further still.[41]

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[35] Cancer Reform Strategy 2007

[36] Werneke etal Uptake of screening for breast cancer in patients with mental health problems Journal of Epidemiology and Community Health 2006;60:600-605

[37] London Quality Assurance Reference Centre 2002

[38] Bankhead et al Improving attendance for breast screening among recent non-attenders: a randomised controlled trial of two interventions in primary care. Journal of Medical Screening 2001;8(2):99-105

[39] Majeed, et al, Do GPs influence the uptake of breast screening: a general practice based study Journal of Medical Screening 1995 4 (1) 19-29. 2005

[40] Sin & Leger. Interventions to increase breast screening uptake: do they make any difference? Journal of Medical Screening 1999; 6(4): 170-181.

[41] M J Stead Improving uptake in non-attenders of breast screening: selective use of second appointment J Med Screen 1998;**5**:69-72

3.26 The role of the **media** undoubtedly influences a woman's decision to attend an invitation for screening: a case in point being a recent celebrity death from cervical cancer from which it has been concluded, has induced a significant rise in screening uptake in some areas of the UK.[42] Other more specific local advertising campaigns have also been found to be helpful in promoting screening, reassuring attendees and improving uptake.[43]

Future considerations for breast cancer/ screening

3.27 In term of the future considerations for breast cancer and breast screening services, there are a number of generalised points that should be noted. These are summarised below.

- Although death rates from breast cancer are falling, the number of women diagnosed with cancer is likely to increase as a result of the expansion of the breast screening programme (to 47-73 years age spectrum) and the ageing distribution of the population.

- Although breast cancer is a significant cause of mortality among women, breast cancer is becoming a disease that the majority of women live with rather than die from: that is the prevalence of breast cancer is increasing. This has important implications for the provision of physical, therapeutic and emotional support service for those that are surviving breast cancer.

- There is a nationally shortage of both radiologist and radiographers which may impact on the effective operation of local breast screening services.[44] Increasing the scope and capacity of screening services will depend on successful training, recruitment and retention of such highly trained staff.

## 4.0 National and regional policy framework

4.1 National cancer policy and priorities were outlined in the **NHS Cancer Plan** in 2000. A number of key policy streams were highlighted within this document including improvements to cancer prevention, screening and treatment services. Of particular relevance within this report were measures to extend breast screening to women aged 50-70 years (now largely implemented) and a reorganisation of screening support staff to improve access to key staff groups (i.e. radiographers).

4.2 The NHS Cancer Plan has largely been superseded by the **Cancer Reform Strategy** which was published in 2007. This strategy identified a number of new developments and issues for the development of breast screening services which are highlighted below:

- Screening age for women is to be extended to 47-73 years, with all women guaranteed to receive their first screen before the age of 50. Service extension to be completed by 2012.

- Mammograms at all breast screening services will all be digitised by 2012.

[42] Jade Goody effect increases cervical screening rates Nursing Times March 2009
[43] Cohen, L et al (2000) Promoting breast screening in Glasgow, Health Bulletin, 58(2). 127-32
[44] Behind the Screen GLA Health Committee Report 2008

- The imminent eligibility of the baby boom generation for screening will result in increased uptake within the NBSP. This may require additional local investment to maintain the screening round length at 36 months.

- The NBSP will assume responsibility for the management and surveillance of women at high risk of familial breast cancer.

- There will be a need for local commissioners to be mindful of health inequalities and inequities in service provision, and the need to develop programmes in response.

- The need to continue to raise awareness of breast cancer and the availability of screening services, to those women outside the screening programme, especially those aged over 70 years.[45]

Greater London Assembly

4.3 The Greater London Assembly conducted a detailed investigation of breast screening services across the capital, focussing on how London's low uptake for this service can be improved (entitled *Behind the Screens)*.[46] This highlighted 4 main problems:

- Lack of knowledge as to why women attend, demographics of non attendees – this means that services are unable to target non-attendees
- Low levels of awareness of breast cancer screening, breast cancer symptoms and risks in London
- Women in London have a poor experience of breast screening services
- Waiting times for radiotherapy in 1/3 of London's trust exceed national waiting times limit.

4.4 The GLA report makes a number of recommendations to improve services across London:

- More information about non attendees needs to be collated and analysed
- Women over screening age should continue to be reminded of importance of breast screening
- A 3 year London wide media campaign to raise awareness should be developed
- GPs need to take a bigger role in promoting breast screening to their patients
- London wide call and recall system for breast screening needs to be developed as part of the Healthcare for London modernisation work.

## 5. Local policy context

5.1 Developing the uptake of health screening services is noted within key strategy documents for Haringey. From this documentation, it is possible to identify a number of areas where the review may potentially contribute to help support local policy objectives and achieve local targets.

[45] Cancer Reform Strategy Department of Health 2007
[46] Behind the Screens: breast screening uptake and radiotherapy waiting times in London 2008

Sustainable Community Strategy (2007-2016)

5.2 The Sustainable Community Strategy (SCS) is the overarching plan of the Haringey Strategic Partnership which details how the Council and its partners will tackle broad community wide issues. The SCS is based on a wide community consultation process and provides a ten year vision for Haringey. Key priorities embedded within the SCS include the need for helping people to become healthier with a better quality of life, reducing health inequalities and the provision of high quality services for those in need.

5.3 There is an explicit commitment within the SCS plan for 2009-2011 to "increase the uptake of cervical and breast screening including amongst non-English speaking communities. It is anticipated that the scrutiny review will contribute to this process.

Local Area Agreement (2007-2010)

5.4 The Local Area Agreement (LAA) sets out a range of targets for the Council and its partners in delivering the key priorities and objectives of the SCS. There are 80 indicators in Haringey which are made up of statutory (n=16), national (n=35) and local (n=16) targets.

5.5 The following table provides an overview of national indicators which may be of relevance to the review of breast screening services.

| Indicator | LAA target | Detail |
|---|---|---|
| NI 119 | Yes | Self-reported measure of people's overall health and wellbeing |
| NI 120 | No | All-age all cause mortality rate |
| NI 122 | No | Mortality from all cancers at ages under 75 |
| Local | Yes | Prevalence of breastfeeding at 6-8 weeks from birth |

Comprehensive Area Assessment (2009)

5.6 Comprehensive Area Assessment (CAA) is the new process in which local public services are assessed. The emphasis of assessments within the CAA process is on broad public perceptions of the quality of life in an area rather than on the nature and quality of services provided. As part of the assessment process, the local strategic partnership is required to submit an annual self assessment of its performance against agreed local priorities.

5.7 It is envisaged that there will be two-way relationship between the CAA and overview and scrutiny, where local in-depth scrutiny reviews may provide evidence for the completion of the local self assessments, while the CAA may assist local scrutiny committees identify and prioritise issues to investigate. The current self-assessment has highlighted that one of the key challenges for Haringey is A key priority from the CAA self evaluation 2009-2011 is to increase the uptake of breast screen screening.

## 6. Terms of reference

5.1 The terms of reference fulfil a number of functions for the review through: providing purpose and structure to the review process; helping to develop a

common understanding of the scope of the review among stakeholders, and; creating a framework around which future decisions are made. The terms of reference are also critical in establishing the questions that the review will seek to address and that appropriate methods to be used to collect the necessary data.

Aim of the review

6.2 It is proposed that the overarching aim of the review will be:

*'To identify how the uptake and coverage of breast screening services may be improved among women resident in Haringey.'*

Objectives of the review

6.3 It is proposed that the review addresses the following objectives:

1. Describe the nature and level breast screening services available to women living in Haringey.

2. To identify the barriers to improved take up and coverage of breast screening services in Haringey and possible interventions to overcome these.

3. To identify how local partners may work together better to improve services, raise awareness and increase uptake of breast cancer screening in Haringey

4. Consider the effectiveness of local breast screening services in relation to meeting local strategic and policy objectives (i.e. well being agenda, health inequalities).

5. Examine how the uptake and coverage of breast screening services impact on local equalities issues and to assess how access can be improved to minority and other community groups.

6. Evaluate policy and performance data from other screening services and other Primary Care Trusts to identify good practice and improved ways of working to further promote the uptake and coverage of breast screening services in Haringey.

7. Assess whether breast screening services achieve value for money through ascertaining whether: costs are commensurate with performance, outcomes and delivery and compare well against other boroughs.

8. Ensure that the scrutiny review process generates relevant evidence that will contribute to ongoing assessments made within the Comprehensive Area Assessment.

## 7. Review methods

Review Panel

7.1 A review panel of four backbench Members will be convened to conduct the scrutiny review. Members of the review panel have been confirmed as Cllr Winskill (Chair), Cllr Alexander, Cllr Bull, Cllr Beynon and two Labour vacancies.

Panel Meetings

7.2 The review will use a range of investigative methods to ensure that Members have access to the necessary evidence to assist them in their assessment of breast screening services in Haringey. A series of panel meetings will be held to approve the aims of the review, to receive oral and written evidence, oversee project progression and formulate conclusions and recommendations. Panel meetings will occur at approximately four week intervals (or as agreed by the panel).

7.3 It is proposed that approximately 3 or 4 panel meetings will be held from November 2009 through to January 2010. It is anticipated that panel meetings will focus on particular themes or topics to inform the data gathering process. It is suggested that evidence sessions be held to consider the following issues:

- What services are currently provided and what plans are there to improve and develop services?
- What can be learnt from the experience of other breast screening services or other Primary Care Trusts to improve the uptake and coverage of breast screening services?
- What can be learnt from the experiences of local women and other local stakeholders to improve the uptake and coverage of breast screening services?

7.4 A number of key informants have been identified and to participate within the review including officers from NHS Haringey, representatives from NLBSS and other relevant stakeholder groups. A plan of the proposed meeting structure, including possible informants to the review process, is contained in **Figure 5** During the course of the review members aim to hear from:

| Stakeholder | Issues to be covered |
|---|---|
| NLBSS | Issues with current configuration of breast screening services, measuring the effectiveness of service, benchmarking data, comparative performance with other screening services, quality assurance data & future plans for the service. |
| NHS Haringey | Current and future commissioning plans for the service, future investment, coordination of services (NLBSS, NHS Haringey and Primary Care Services) how local preventative initiatives will link to the work of the NLBSS and other regional work-streams. |
| North Central London Cancer Network<br>London Quality Assurance Reference Centre | Identify regional developments in breast cancer screening services |
| Other NHS Trusts / breast screening services | Identify best practice, innovative ways of working from other breast screening services or other NHS Trusts. |

Assessing internal and external data sources

7.5 A range of information from a variety sources will be used to help meet the review objectives. It is anticipated that relevant services (NHS Haringey and NLBSS) will provide financial, operational and evaluative data to assist panel members in their deliberations of breast screening services issues.

7.6 The review will aim to draw on external research, policies and other service data where this is felt to assist to review process. Analysis of national, regional and local performance data will be undertaken to inform the review. Comparative data from other NHS trusts may also be used to help panel members identify good practice, benchmark local breast screening service provision and identify local priorities for service improvement.

Panel Visits

7.7 It is proposed that panel members undertake a number of planned visits to gain a practical insight in to the provision of breast screening services in the locality. The NLBSS have suggested that it might be helpful for the panel to visit Chase Farm Hospital to understand central operations from this site. The Panel may also wish to visit one of the mobile breast screening units (through which most local women are screened) or, undertake a visit to another breast screening service in London.

Background briefing reports

7.8 It is proposed that background briefing reports on relevant meeting topics will be prepared and circulated to the panel before each meeting. It is hoped that this these themed reports will assist the panel in their deliberations on particular aspects for the review. It is planned that background briefing reports will coincide with planned evidence sessions and focus on the following themes:

- Obstacles to breast screening uptake in inner city areas
- Best practice from other breast screening services or other NHS Trusts
- Evidence of what women would like from a breast screening service.

Community / Public Involvement

7.9 Community and public involvement is an integral part of the scrutiny process through helping to maintain local accountability. All scrutiny meetings are held in public at which, at the discretion of the Chair, local residents and community groups may also participate. To facilitate local community participation, it is proposed that a number of the planned panel meetings are held at different community venues across the borough.

7.10 Whilst it is noted that there has already been some consultation with local women about the nature of breast screening services, the panel may also wish to consult local women's group representatives for their perspectives on how services could be improved. The local women have indicated a willingness to participate in the review process. This will provide a further opportunity for local community group representatives and local residents to discuss breast screening issues with the panel (or representatives).

Independent Expert Advice

7.11 The Panel may wish to consider if their work would be assisted by the provision of independent expert advice which could "add value" to the review through:

- Giving evidence to the Panel

- Impartially evaluating current practice, providing advice on successful approaches and strategies that are being employed elsewhere
- Suggesting possible lines of inquiry
- Commenting on the final report and, in particular, the feasibility of draft recommendations.

## 8.0 Equalities

8.1 The scoping report has identified a number of equalities issues which will be important to explore and assess further within the work of which the scrutiny review. From the evidence presented in this report it is apparent that there may be a number of variations in the incidence of breast cancer, the take up of an invitation to screen and the outcomes of treatment which may impact unequally on equalities groups. For instance:

- Increased incidence of breast cancer among more affluent populations
- Lower take up of breast screening services among:
  - ✓ women in areas of social deprivation
  - ✓ among black and other minority ethnic groups
  - ✓ women who have a mental health problem or a learning disability
- Higher risk factors associated with lesbian women

8.2 The scrutiny review therefore will be particularly keen to assess if such variations are exhibited locally and to assess how the local partnership of services is addressing such inequities where they exist (i.e. service monitoring, service commissioning, service delivery).

**Figure 1 – Uptake of breast cancer screening 2002/3 to 2007/8.**

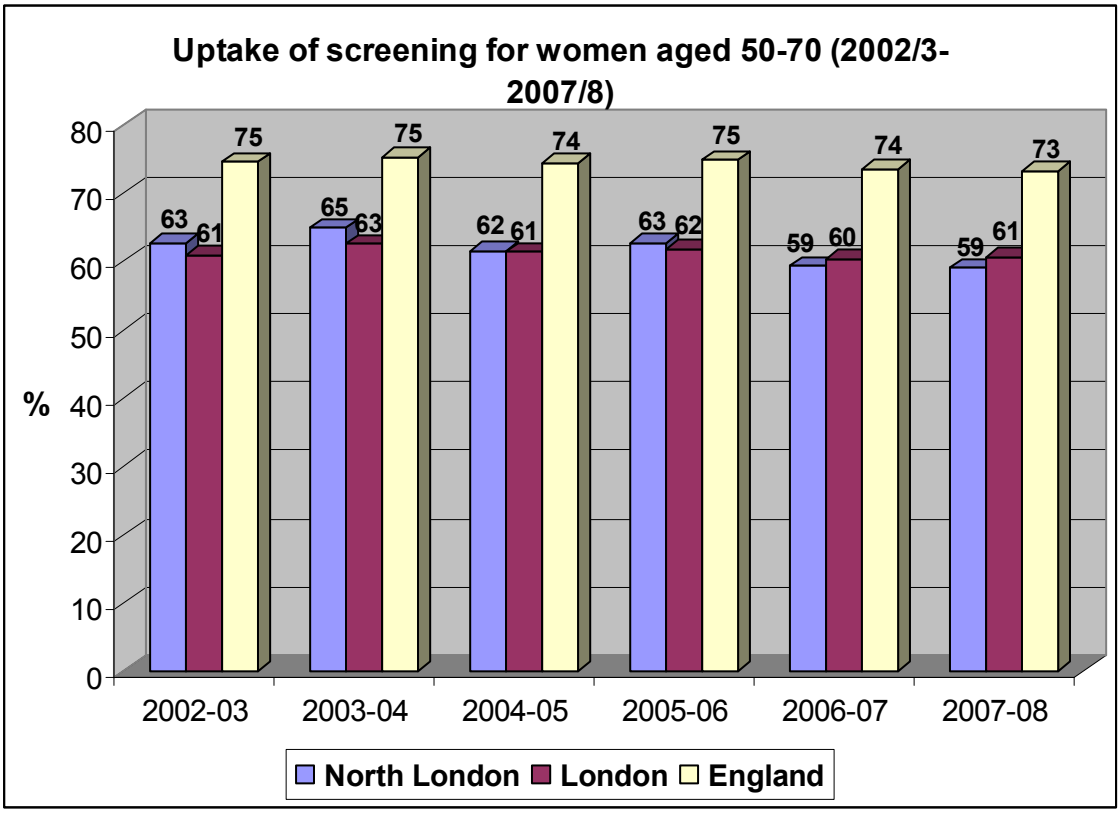


**Figure 2 – Screening uptake in London Breast Screening units in 2007/8.**

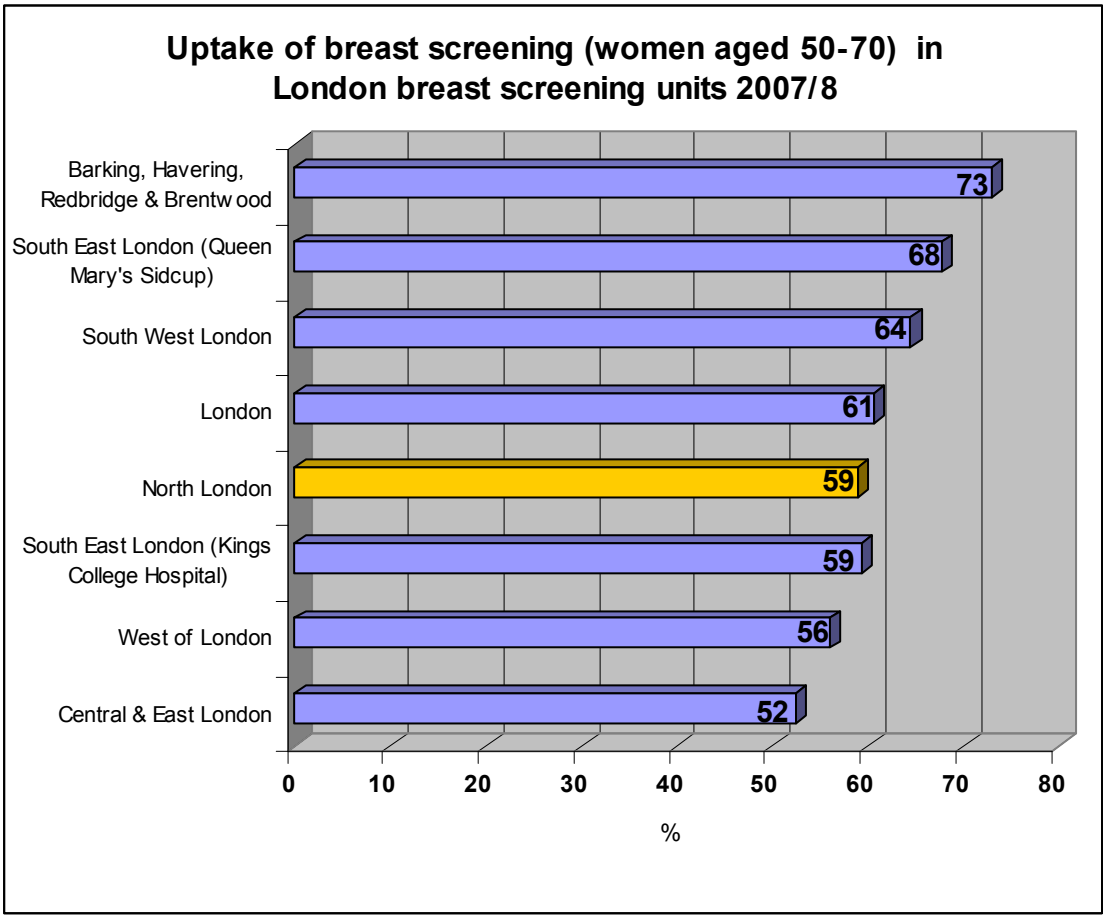

**Figure 3 – National breast screening coverage (women aged 53-64 2007/8).**

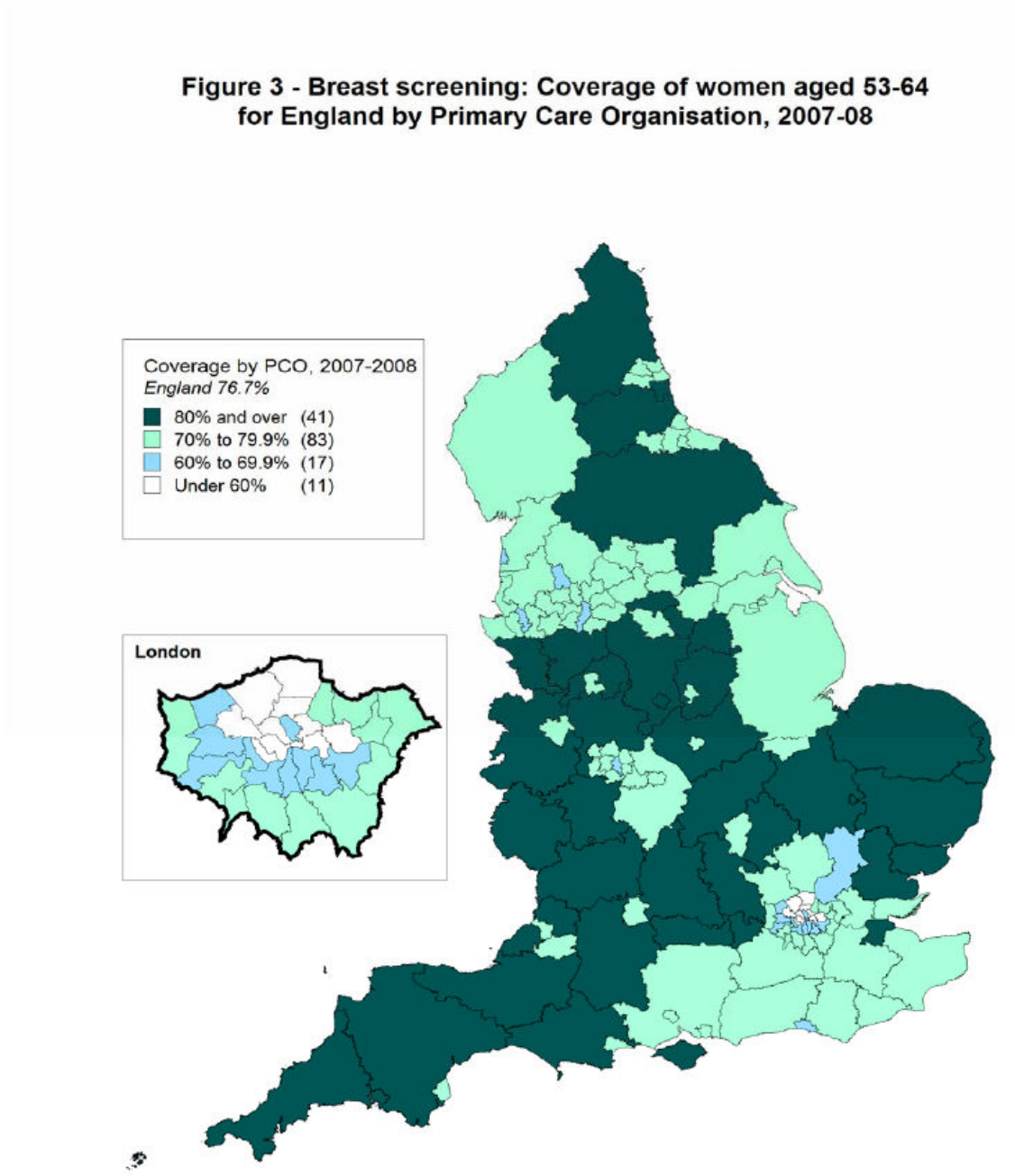

**Figure 4 – Breast Screening Coverage in London PCT areas.**

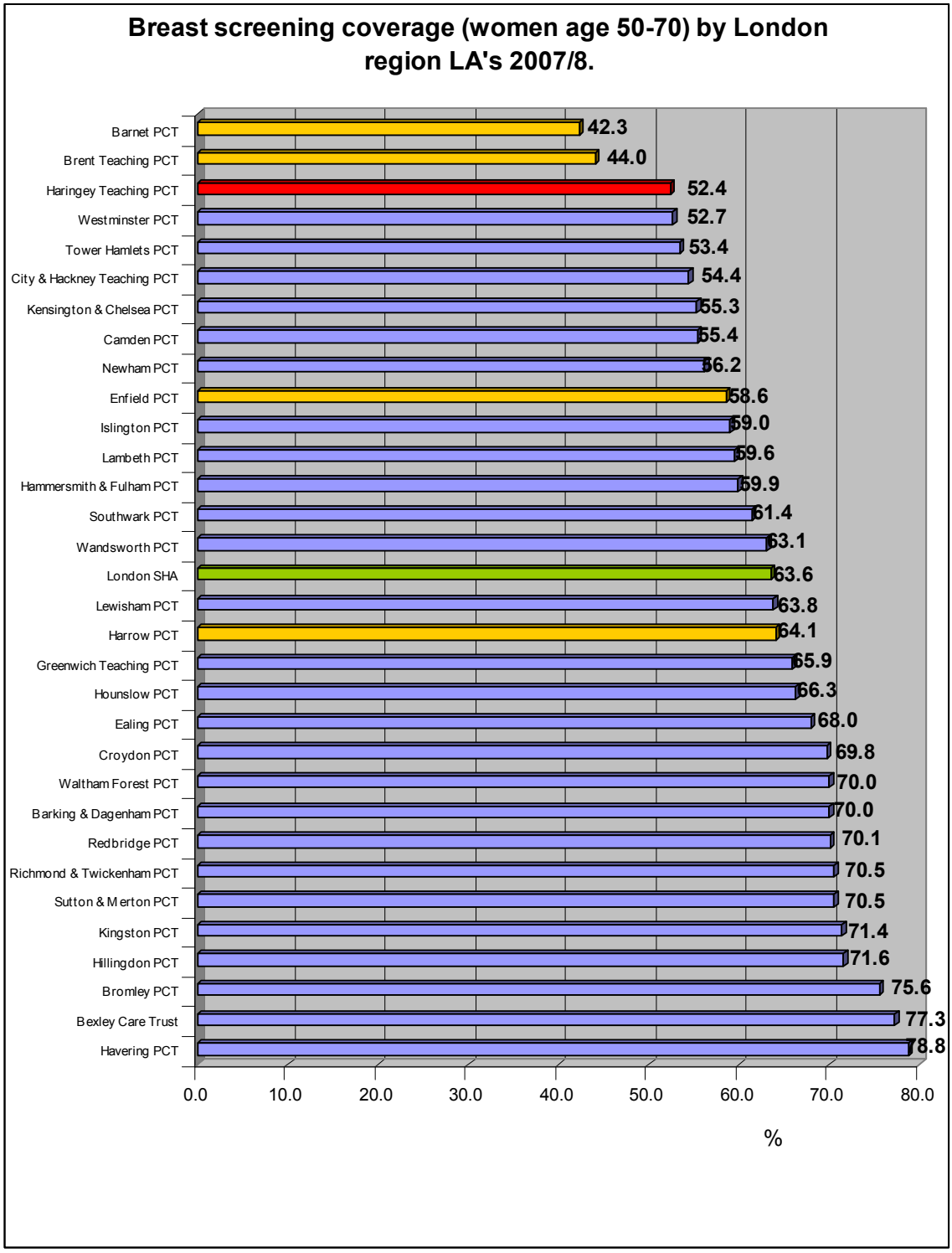

**Figure 5 - Proposed work plan for scrutiny review**

| | Aims | Possible participants |
|---|---|---|
| **Meeting 1**<br><br>**2nd December 2009** | ▪ Approve scoping report<br>▪ What services are currently commissioned in Haringey?<br>▪ What plans are there to improve and develop services?<br>▪ How can improved breast screening services contribute to other strategies and policies? | ▪ Tamara Djuretic, NHS Haringey |
| **Meeting 2**<br>**TBC December 2009** | ▪ How are breast screening services provided in Haringey?<br>▪ Regional developments in Breast Screening Services? | ▪ Debbie Brazil, NLBSS<br>▪ Clinical Director, NLBSS<br>▪ London QARC<br>▪ NCL Cancer Network |
| **Meeting 3**<br><br>**TBC January2009** | ▪ What can be learnt from the experience of other breast screening services?<br>▪ What can be learnt from other Primary Care Trusts? | ▪ Independent adviser<br>▪ Other BSSs<br>▪ Other PCTs |
| **Meeting 4**<br><br>**TBC January 2009** | ▪ What can be learnt from the experiences of local women?<br>▪ How can partners/ other stakeholders to improve the uptake and coverage of breast screening services? | ▪ Independent expert adviser<br>▪ Women's Group Representatives<br>▪ Equalities Officer<br>▪ Other local stakeholders |
| **TBC January 2009** | ▪ Formulation of conclusions and recommendations | |