

A review of breast screening in Southwark

Southwark's Joint Strategic Needs Assessment

Healthcare Public Health

Public Health Division, Place & Wellbeing

March 2020

GATEWAY INFORMATION

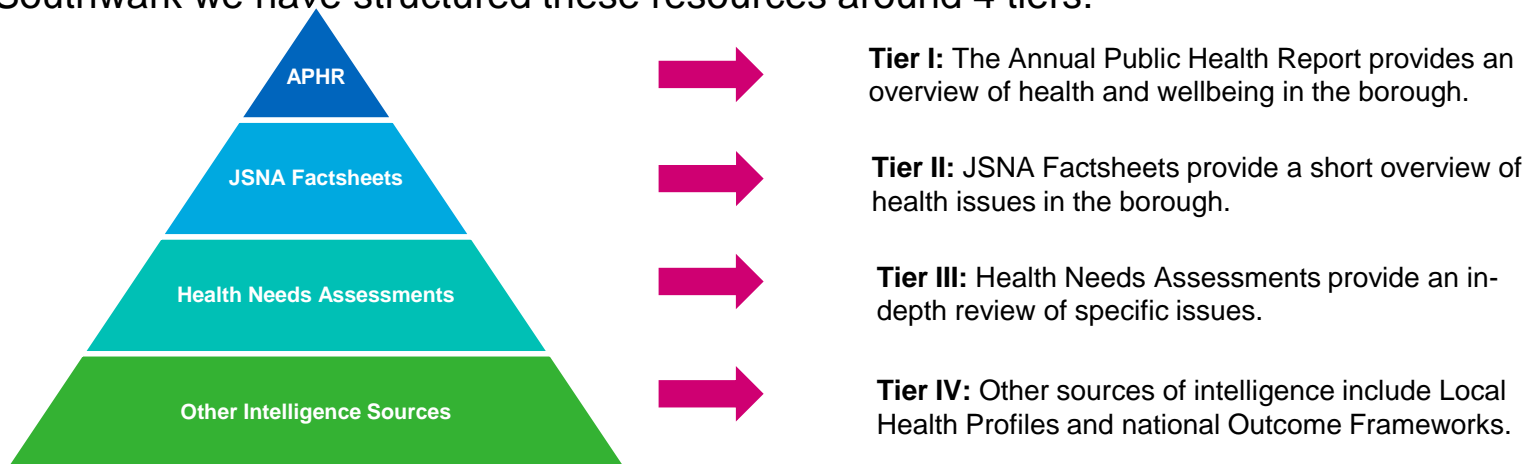
Report title:	A Review of Breast Screening in Southwark
Status:	Public
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Suggested citation:	A Review of Breast Screening in Southwark. Southwark's JSNA. Southwark Council: London. 2020.
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Date of publication:	March 2020

Health Needs Assessments form part of Southwark's Joint Strategic Needs Assessment process

BACKGROUND

The Joint Strategic Needs Assessment (JSNA) is the ongoing process through which we seek to identify the current and future health and wellbeing needs of our local population.

- The purpose of the JSNA is to inform and underpin the Joint Health and Wellbeing Strategy and other local plans that seek to improve the health of our residents.
- The JSNA is built from a range of resources that contribute to our understanding of need. In Southwark we have structured these resources around 4 tiers:



- This document forms part of those resources.
- All our resources are available via: www.southwark.gov.uk/JSNA

This needs assessment aims to identify opportunities to improve breast screening uptake in Southwark

AIMS, OBJECTIVES AND DEFINITIONS

This health needs assessment aims to produce a series of recommendations to improve the performance and uptake of breast screening in Southwark. The objectives of this report are to:

- Describe the current national and local policy around breast screening.
- Describe the epidemiology of breast cancer nationally, regionally and locally.
- Describe trends in screening uptake, variation across GP practices and any inequalities in uptake.
- Review the evidence for how uptake can be increased.
- To elicit stakeholder views on drivers and barriers to improved uptake.
- Consider potential solutions and make recommendations.

Definitions for uptake and coverage for breast screening are provided below. They are highly interdependent. As screening uptake falls, so does coverage.

- **Coverage** is defined as the percentage of woman eligible for breast screening, who have been screened adequately within the last 3 years.
- **Uptake** refers to the percentage of woman invited for screening in the last 12 months, who attended screening within 6 months of invitation.

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Breast cancer is the most common type of cancer in the UK, with over 55,000 new cases diagnosed each year

INTRODUCTION: BREAST CANCER RATES

Around 55,200 cases of breast cancer are diagnosed and 11,400 women die from the disease each year in the UK.

- Breast cancer accounts for 30% of all new cancer cases in females.¹ Around 55,200 cases of breast cancer are diagnosed in the UK every year, making it the single most common type of cancer (as per data from 2014-2016)¹. About 1 in 8 women in the UK are diagnosed with breast cancer during their lifetime.²
- Most breast cancers are diagnosed in those aged 50-54, however both younger and older women require particular attention.
 - The individual risk of developing breast cancer increases with age. However, as total population numbers decline with increasing age, slightly fewer cases in total are identified in older ages.
 - Early-onset breast cancer is more likely to be fatal. Therefore the few cancers that do develop in early age need to be detected and treated quickly, to prevent mortality and extend life.³

References

1. Cancer Research UK, Breast cancer statistics: www.cancerresearchuk.org/
2. NHS website. Breast Cancer Screening: www.nhs.uk/conditions/breast-cancer-screening/
3. McPherson K, Steel C, Dixon JM. ABC of breast diseases: breast cancer—epidemiology, risk factors, and genetics. BMJ: British Medical Journal. 2000 Sep 9;321(7261):624.

The NHS operates screening and surveillance programmes, to reduce mortality from breast cancer

INTRODUCTION: BREAST CANCER DETECTION

Two services aim to detect breast cancer as early as possible, in order to reduce mortality:

1) Universal screening, for all women

- All women aged 50-70 are invited into the NHS Breast Screening Programme (NHSBSP).
- This service is the focus of this particular JSNA.

2) Targeted surveillance, for women with a family history of breast cancer

- In addition to the universal screening offer above, a minority of women are eligible for additional surveillance services. Women aged 20-70 who have a particular profile of family history of breast cancer (among first or second-degree relatives) are eligible.¹ They are referred by their GP to a family history clinic. From there, some women are referred on for genetic testing and counselling, following which some women are offered yearly surveillance with mammogram and/or MRI.²
- As this clinical service is only offered to a minority of the population, and has separate governance mechanisms, it is beyond the scope of this JSNA.

References

1. National Institute for Health and Care Excellence. Clinical Guidance 164 - Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer. 2017
<https://www.nice.org.uk/guidance/cg164/>
2. NHS Cancer Screening Programmes. Protocols for the surveillance of women at higher risk of developing breast cancer. 2013
<https://www.gov.uk/government/publications/breast-screening-higher-risk-women-surveillance-protocols>

The NHS Breast Screening Programme aims to reduce mortality from breast cancer

INTRODUCTION: BREAST SCREENING AIMS

The aim of the NHS Breast Screening Programme (NHSBSP) is to:

- Invite eligible people appropriately, to allow for optimal programme coverage.
- Offer high-quality screening services, by appropriately trained personnel.
- Cause more breast cancers to be diagnosed early, thereby reducing mortality.
- Embed audit and evaluation in the service.¹

Scope	Included	Excluded
Eligible patients¹	<ul style="list-style-type: none">- The target age group is women aged 50-70.- In addition, the South East London Breast Screening Service (which includes Southwark) is participating in a randomized controlled trial (AgeX). Some women are additionally invited for screening if they are aged 47-49 or 71-73, depending on which study arm they have been randomised into.	<ul style="list-style-type: none">- Women not eligible for NHS care.- Symptomatic women.- Women with bilateral mastectomy.

References

1. NHS England. NHS public health functions agreement 2018-19. Service Specification no. 24 Breast Screening Programme. 2018 <https://www.england.nhs.uk/>

Breast screening reduces breast cancer mortality by 40% among those who attend

INTRODUCTION – BREAST SCREENING OUTCOMES

Breast screening is effective at reducing breast cancer mortality, although the programme does produce small harms and it remains unclear if it reduces on all-cause mortality

- During the first 18 years of the NHSBSP operation:
 - the incidence of breast cancer doubled. Half of this is thought to be due to the introduction of screening, with the other half due to shift towards unfavourable risk factors (e.g. obesity).¹
 - breast cancers were increasingly detected at an earlier stage, coinciding with a shift away from surgical treatment towards chemotherapy/radiotherapy treatment.¹
- As of 2005, half of all breast cancers are diagnosed via screening.¹
- 11 Randomised Controlled Trials (RCTs) in Sweden, USA, Canada, Edinburgh and UK have suggested that those invited have 23% lower risk of breast cancer mortality.² (Mortality benefits to attendees may be two times higher, on account of how nonresponders dilute population benefits.)
- Screening may reduce all-cause mortality by 2% among attendees. Empirical studies to date have not been sufficiently powered to demonstrate this.³
- Breast cancer screening also produces harm: Swedish and Canada data found 19% of breast cancers to be overdiagnosed among attendees.⁴ UK studies found false-positive results to produce psychological distress, and for mammography to produce some radiation.⁵ This withstanding, benefits from screening outweigh harms, for women in the UK.^{2, 4}
- Screening is cost-effective, costing approximately £12,000 per year of life saved.⁶

References

1. Advisory Committee on Breast Cancer Screening. Screening for breast cancer in England: past and future. J Med Scr. 2006
2. International Agency for Research on Cancer. Breast Cancer Screening. Vol 15. 2016. World Health Organisation. p 249 & 454.
3. Steele *et al.* Should we use total mortality rather than cancer specific mortality to judge cancer screening? BMJ 2011.
4. Marmot MG, *et al.* The benefits and harms of breast cancer screening: an independent review. Br J Ca. 2013.
5. Bond M *et al.* Psychological consequences of false-positive screening mammograms in the UK. Evid Based Med. 2012.
6. Morton R, *et al.* Economic analysis of the breast cancer screening programme used by the UK NHS. Br Ca. 2017.

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The Breast Screening Programme is commissioned by NHS England and delivered by hospitals

NATIONAL POLICY CONTEXT

NHSBSP was introduced in 1988. NHS England commissions hospitals to provide screening, as per the *Public Health Section 7A agreement*. The service specification¹ details how:

Hospitals (and other NHSBSP providers) are required to:

- Ensure their staff are adequately trained.
- Comply fully and promptly with failsafe procedures.
- Provide specified data for national and local audits and other agreed purposes.

The invitation process should strive to maximise uptake by:

- Inviting eligible women at least once every 3 years, using nationally agreed letters with GP endorsement and a timed appointment specified.
- Ensuring that the process of changing appointment times is straightforward, if requested.
- Sending women who do not attend a second appointment letter with a timed appointment.
- Accommodating women who request to be screened at an alternative screening centre.

After attending, women should:

- Be informed of their test result in writing within 2 weeks of their basic mammography screen.
- In case of abnormalities, be assessed by a clinical nurse specialist and potentially other services, within 3 weeks of the initial screen. Any cancer diagnoses needs to be communicated in person by a clinician, and normal results can be communicated by phone or in person.

References

1. NHS England. NHS Public Health function agreement 2017-2018 Service specification no. 24 – Breast Screening.

National priorities include early detection, but specific recommendation for breast screening have not been made

NATIONAL POLICY CONTEXT – RECENT PRIORITIES

Following enactment of the *Health and Social Care Act in April 2013*:

- Clinical Commissioning Groups (CCGs) commission cancer treatment services, from early diagnosis, through to services for patients living with and after cancer and end-of-life care.
- NHS England commissions specialist services including chemotherapy and radiotherapy, primary care and cancer screening.
- Public Health teams within Local Authorities have responsibility for prevention and population awareness of cancer signs and symptoms, including providing local assurances.

Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020 was published in 2015, aiming to “Radically upgrade prevention and public health” and to “Lead a national drive for earlier and faster diagnosis”. For all cancers it recommended:

- Cancer Alliances be established across the country.
- Target known underserved populations like BAME and socially deprived groups.
- The report did not make more specific recommendations about breast screening.

The NHS Long-term plan’s section on cancer focuses on early diagnosis:

- The plan did not make recommendations about breast screening.
- Sir Michael Richards was asked to lead a review of programmes like breast screening, focusing on increasing uptake, modernisation, and expand diagnostic capacity.
- The plan mentioned potential from a personalised and risk stratified approach to screening.

References

1. Independent Cancer Taskforce. *Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020*. 2015.
2. NHS England. *The NHS Long Term Plan*. 2019 <https://www.longtermplan.nhs.uk/online-version/>

The Breast Screening Programme KPIs are defined by Public Health England

NATIONAL POLICY CONTEXT – KEY PERFORMANCE INDICATORS

Public Health England provides advice on suitable service standards and defining Key Performance Indicators (KPIs), which are monitored by NHS England.

- Standard 1 (coverage): The percentage of women eligible for screening, who have had a test with a recorded result at least once in the previous 36 months.
*Rationale: to ensure that the eligible population has been adequately identified and **invited**.*
Acceptable level $\geq 70\%$
- Standard 2 (uptake): The percentage of women invited for screening, who **attend** for screening within 6 months of their first appointment.
Rationale: to maintain effectiveness in reducing breast cancer mortality.
Acceptable level $\geq 70\%$
- Standard 3 (**round length**): The percentage of eligible women invited for their second screen, whose first appointment is within 36 months of their previous screen.
Rationale: to minimise the incidence of interval cancers.
Acceptable level: $\geq 90\%$
- Standards 4-6 specify the initial screen to be of high **quality**, with appropriate radiation.
- Standards 7-17 discuss what happens to women with **abnormal results**.

References

1. Public Health England. Breast screening: consolidated programme standards. 2017.
<https://www.gov.uk/government/publications/breast-screening-consolidated-programme-standards>

Of all the screening programmes, improving uptake of breast screening is the top priority for London

REGIONAL AND LOCAL POLICY CONTEXT

The *Five Year Cancer Commissioning Strategy for London* noted how the city has the lowest coverage and uptake for cancer screening. It aims to increase the coverage, uptake and equity of screening (particularly breast screening as a priority) by:

- Increasing public awareness and engagement with cancer screening programmes.
- Increasing engagement of primary care and improve reliability of data.
- Improving quality, capacity and patient experience of provider services.
- Facilitating high quality research to further inform strategies.

Specific recommendations include:

- For NHS England to ensure services meet national quality and performance **standards**.
- For NHS England to develop services that meet the **needs** of Londoners.
- For NHS England Primary Care Commissioners to review **contractual levers** to encourage uptake through primary care, and develop **education programmes** in partnership with CCGs and the NHS England/Public Health England Screening team.
- For practices to nominate **leads to champion** screening, and to work with local community groups (facilitated through links with local authority public health teams) to deliver messages to support screening.

References

1. NHS England. Five year cancer commissioning strategy for London 2015

Routine screening at Southwark is delivered at King's College Hospital, with invites sent by Royal Free Hospital

LOCAL POLICY CONTEXT

Southwark Health and Wellbeing Strategy 2015-2020 highlighted increased uptake of screening as a priority area in producing healthier and more resilient communities.

- However, there is no specific borough-wide strategy for tackling high cancer rates and mortality, nor any specified strategy regarding improving cancer screening uptake.

The standard national commissioning and provision arrangements for breast screening of Southwark residents are as follows:

- NHS England (London) commissions:
 - Invitations to be sent by a pan-London screening hub, based at the Royal Free Hospital.
 - Screening services to be performed by King's College Hospital (for South East London).
- In detail, the Royal Free accesses GP records (using the *BS Select* IT system) to identify women eligible for breast screening once per month. (Of note, if that a woman has changed address within Southwark, round length time may sometimes be much shorter than 3 years.)
- All women are invited to attend for mammography at KCH with a postal letter (endorsed by the patient's GP) detailing the patient's first timed appointment. In case of non-attendance, a second letter with a new timed appointment is sent. In case of non-attendance, an open invite to book is sent by post.
- All women receive the same communication content, regardless of age, deprivation, ethnicity, past medical history of breast cancer, mental health, any disabilities or the presence of carers.

References

1. Southwark Council. Southwark Joint Health & Wellbeing Strategy. Improving the health of our population and reducing health inequalities. 2015 to 2020. www.southwark.gov.uk/assets/attach/7208/Southwark-Health-and-Wellbeing-Strategy-2015_final.pdf

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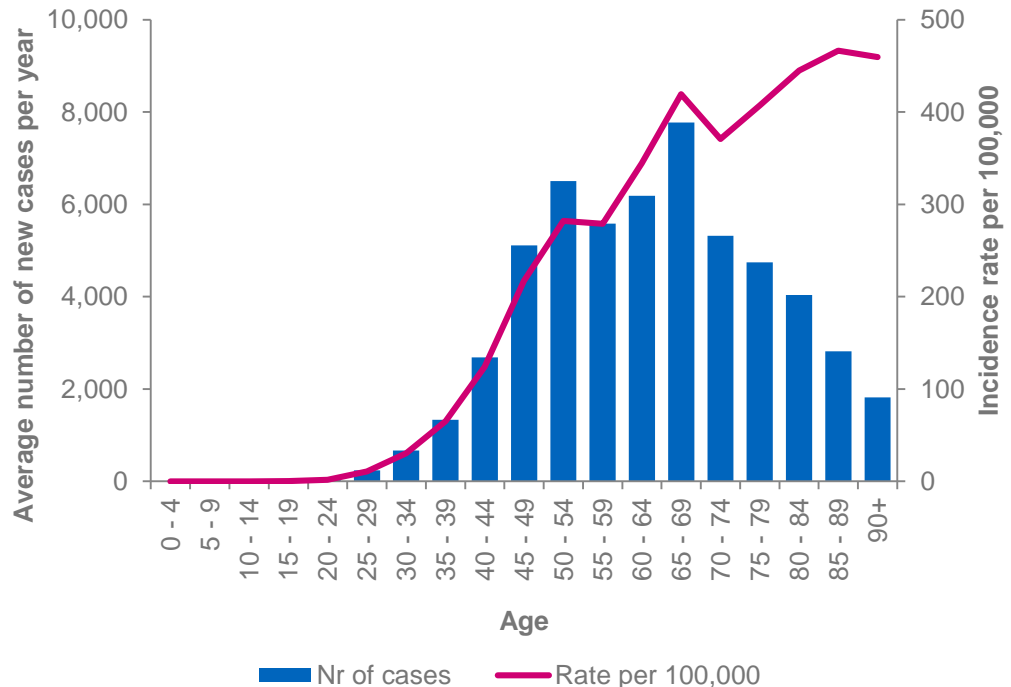
Breast cancer is the most common cancer in the UK, and it mostly affects women aged 50 and above

NATIONAL PICTURE: BREAST CANCER EPIDEMIOLOGY

Most breast cancers are detected in women aged 50-69, but for women who survive into older ages the risk continues to increase.

- The individual risk of developing breast cancer increases with age, being highest in those aged 85 and above.
- However, as there are relatively few women alive at such age, this means that most breast cancer cases are actually diagnosed in women aged 50-69.

Figure 1: Number of cases of breast cancer, and incidence rates, stratified by age in England (2014-2016)



References

1. Cancer Research UK, Breast cancer statistics <https://www.cancerresearchuk.org/>

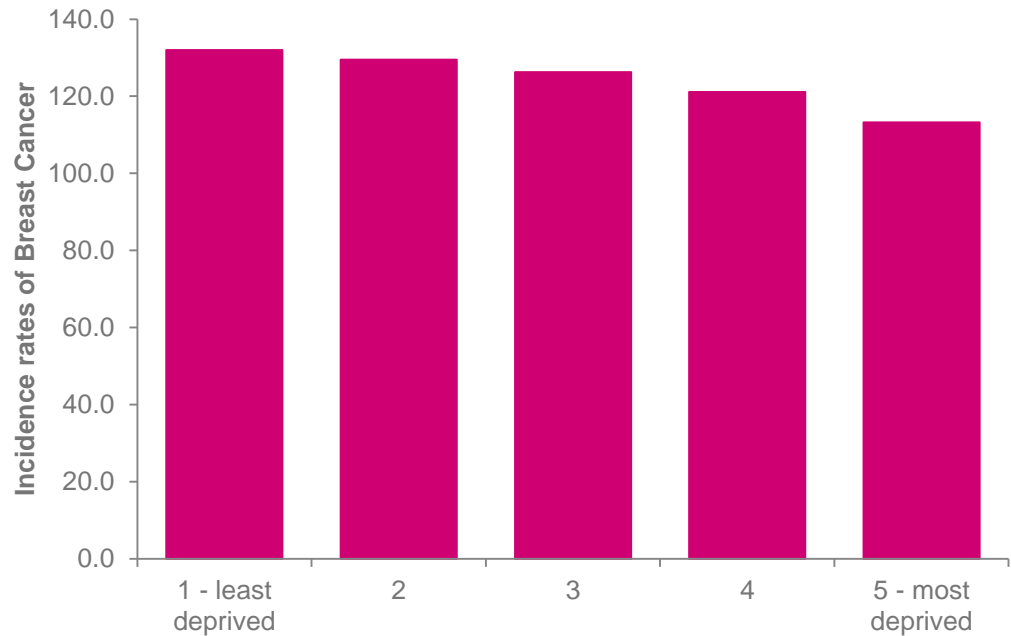
People in more affluent areas are slightly more likely to be diagnosed with breast cancer

NATIONAL PICTURE: BREAST CANCER EPIDEMIOLOGY

Contrary to most gradients in health (where people in deprived areas have more disease), the incidence of breast cancer has a slight trend in the opposite direction.

- People living in the most affluent areas are 14% more likely to be diagnosed with breast cancer when compared to those in most deprived areas.¹
- The causes for this remain unclear, but may reflect a combination of:
 - Greater uptake of screening and slightly more overdiagnosed cases.
 - Greater vigilance and willingness to present for healthcare, once symptoms develop.

Figure 2: Age-standardised incidence rate of breast cancer, stratified by postcode deprivation in England (2006-2010)



References

1. Cancer Research UK and National Cancer Intelligence Network. Cancer by deprivation in England: Incidence, 1996-2010. London: NCIN; 2014.

People in more deprived areas are more likely to die from breast cancer, and less likely to uptake screening

NATIONAL PICTURE: BREAST CANCER EPIDEMIOLOGY

- Women from more deprived areas have 16% lower survival following a diagnosis of breast cancer (figure 3).¹
- In comparison, women from more deprived areas are 9% less likely to be diagnosed with breast cancer.²
- This is likely to be due to lower uptake in screening programmes (figure 4), causing cancers to progress to a later stage before being diagnosed.²

Figure 3: Survival following diagnosis of breast cancer, stratified by deprivation

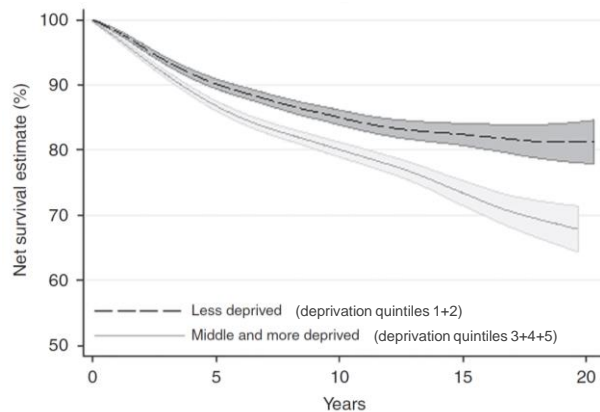
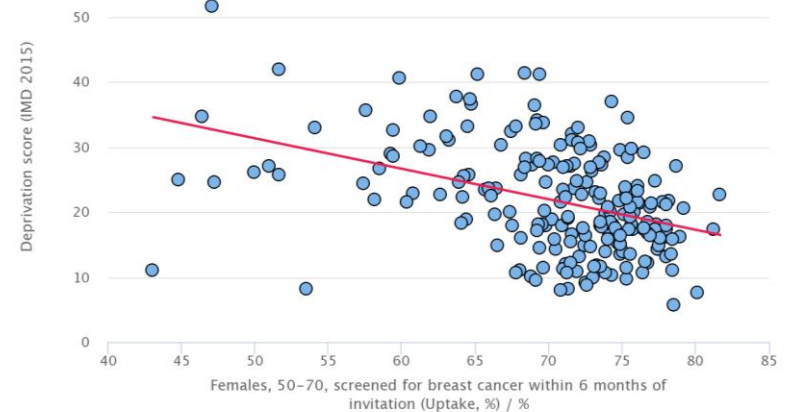


Figure 4: Correlation between deprivation and breast screening uptake, England local authorities



References

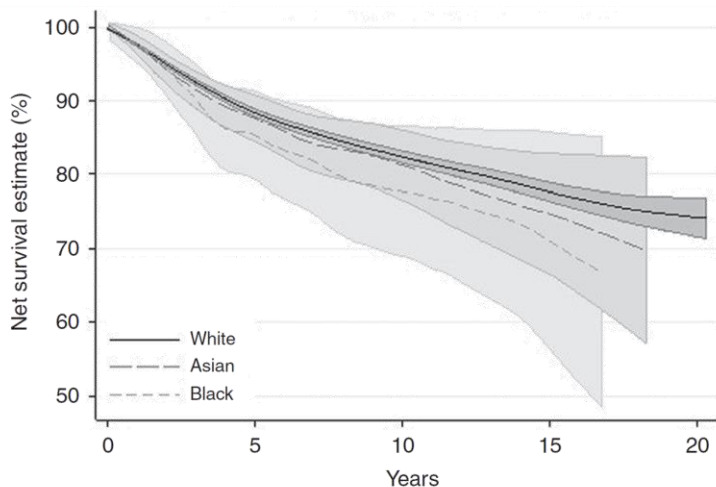
1. Morris M, et al British journal of cancer. 2015 Jul;113(3):548.
2. Cancer Research UK & NCIN. Cancer by deprivation in England: Incidence, 1996-2010. London: NCIN; 2014.
3. National Cancer Registration and Analysis Service, accessed via PHE Fingertips website

Black women are more likely to die from breast cancer, and less likely to uptake screening

NATIONAL PICTURE: BREAST CANCER EPIDEMIOLOGY

- Black women have 12% lower survival following a diagnosis of breast cancer (figure 5), when compared to their white counterparts.³

Figure 5: Survival following diagnosis of breast cancer, stratified by ethnicity



- Multiple studies from London and elsewhere have found black women to have lower screening attendance, both at first and subsequent invite.^{1,2,3,4,5}
- One analysis of first-time invitees in South East London found Black African women be 2x less likely to attend (Odds Ratio 0.54) while Black Caribbean women were not impacted (Odds Ratio 0.95).¹ Altogether, all ethnic minority groups (including Asian, mixed and other) had statistically significant lower uptake rates, when compared to white or Black Caribbean counterparts.¹

1. Jack RH, et al. BMJ open. 2014 Oct 1;4(10):e005586.
2. Renshaw C, et al. BMC Public Health. 2010 Dec;10(1):157.
3. Morris M, et al. British journal of cancer. 2015 Jul;113(3):548.
4. Bansal N, et al. British journal of cancer. 2012 Apr;106(8):1361.
5. PHE. NCIN Data Briefing - Breast Cancer Ethnicity. 2010.

Early diagnosis of breast cancer considerably reduces mortality

NATIONAL PICTURE: STAGE OF DIAGNOSIS

- Earlier diagnosis (i.e. stage I) is associated with much better survival rates when compared to late diagnosis (i.e. stage IV)¹
- Around half of breast cancers are detected by “GP referral, with cancer suspected”, 30% by screening, 9% by routine GP referral and 4% from emergency presentations
- Screen detected cancers are much more likely to be diagnosed in earlier stages.

Figure 6: Survival rates (%) 5-years after diagnosis of breast cancer, by stage of diagnosis (cases in England during 2002-2006)

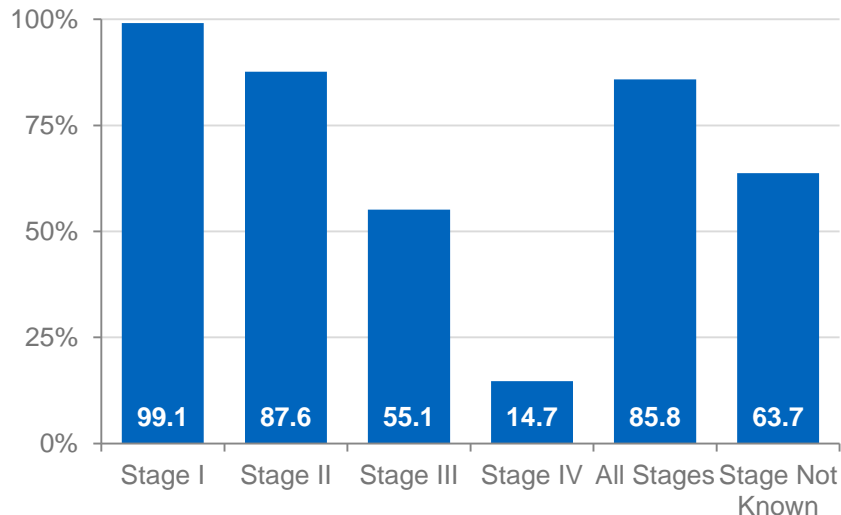
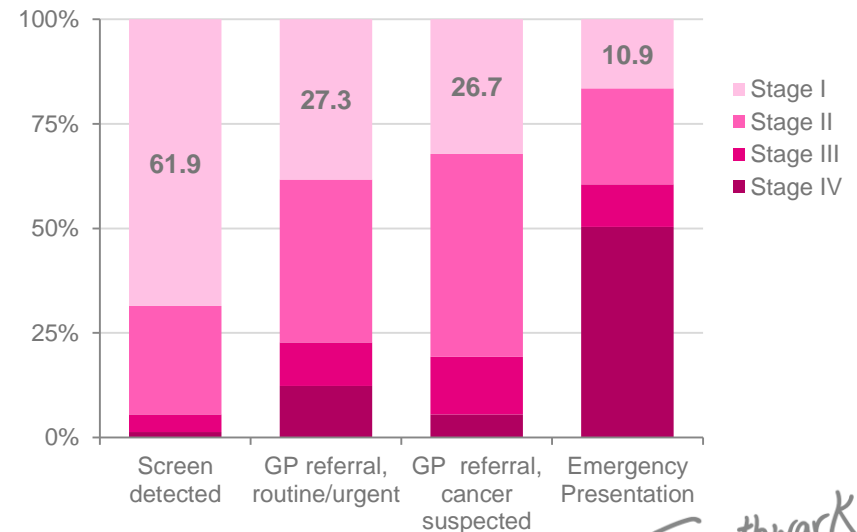


Figure 7: Percentage of Cases by Stage, by Route of Diagnosis, (cases in England 2012-2013)



References

1. The National Cancer Registration Service Eastern Office, via Cancer Research UK

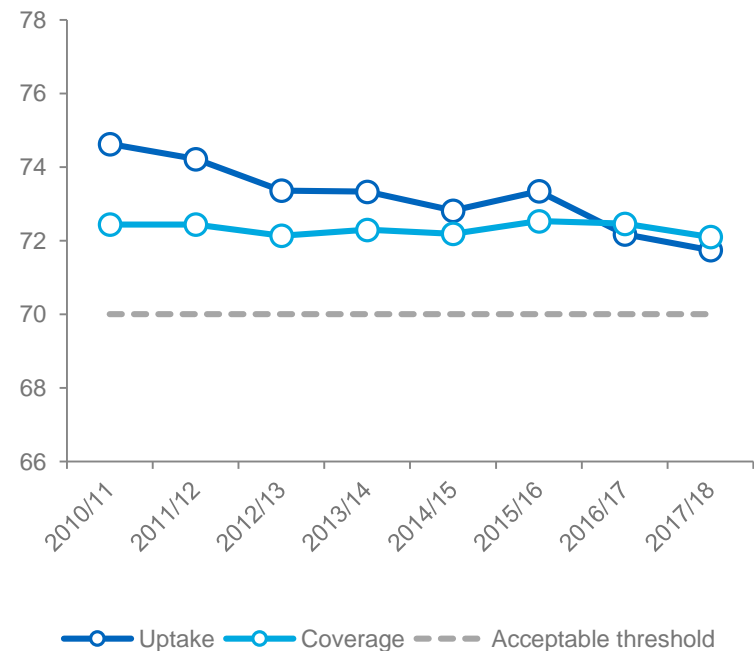
Nationally, screening uptake has declined slightly over the last decade

NATIONAL PICTURE: UPTAKE & COVERAGE

National uptake of breast screening has shown a gradual fall over the last decade.

- In 2010/11 uptake rates were slightly higher than coverage rates. This can be due to multiple reasons (e.g. if outward migration is not captured by GP registrations, then this can artificially deflate coverage rates more than uptake rates).
- By 2016/17 uptake and coverage rates had become comparable to each other. This suggests that women were correctly invited, and that most attendees attended within 6 months of their invite.
- In 2017/18, just over 2.5 million people were invited for breast screening in England, with around 71.7% taking up screening. This meets the national “acceptable” standard (70%) but not the “achievable” standard (80%)

Figure 8: Uptake and coverage of breast screening, among women aged 50-70 in England



References

1. National Cancer Registration and Analysis Service, accessed via PHE Fingertips website on 7 Aug 2019 <https://fingertips.phe.org.uk/profile/cancerservices/>

Lowest uptake rates are in older women, black women, women with disabilities, and those in deprived areas

NATIONAL PICTURE: INEQUALITIES

	Impact on Screening
Age	Younger women are more likely to take up screening than older women. As comprehensive reviews have found screening to be equally effective in both younger and older age groups (within the 50-70 year window) then this suggests more work could be done to increase uptake rates in older populations .
Ethnicity	As detailed on slide 20, black women (and especially Black African women) have both lower breast screening attendance, and lower survival following diagnosis. Around 25% of Southwark's population are Black. This makes the issue of ethnic variation in uptake particularly important for Southwark. ¹
Social Deprivation	People living in more deprived areas , as well as those who rent or do not have a car, have lower uptake of breast screening. ^{2,3,4} As Southwark is more deprived than the average borough in England, this makes the issue of variation by deprivation particularly important for Southwark. ¹
Disability	Women with disabilities are less likely to participate in breast screening (Relative Risk 0.64 compared to those without disabilities). ⁵ This is particularly the case for those with disabilities relating to self-care or vision, or for those with 3 or more disabilities. Women with learning disabilities are also less likely to participate in breast screening (incident rate ratio 0.76 compared to those without learning disabilities). ⁶ Around 13% of people in London are living with a disability which equates to around 40,700 people in Southwark. ¹

In Southwark, many of the above characteristics overlap, so many individuals face multiple disadvantages. For example, Southwark's more deprived wards have a greater proportion of black residents.

1. JSNA Factsheet 2017 Southwark: Protected Characteristics. Accessed 4. online at www.southwark.gov.uk
2. Banks E, et al. Breast Cancer Research. 2001 Feb;4(1):R1.
3. Moser K, et al. BMJ. 2009 Jun 16;338:b2025.
4. Floud S, et al, British Journal of Cancer, 2017 117(11), pp. 1711-1714.
5. Maheswaran R, et al. JECH. 2006 Mar 1;60(3):208-12.
6. Osborn D, et al. PLoS One, 7(8), p. e43841.

Lowest uptake rates are in older women, black women, women with disabilities, and those in deprived areas

NATIONAL PICTURE: INEQUALITIES

	Impact on Screening
Gender	For every male case of breast cancer, there are 140 female cases of breast cancer. ¹ Accordingly, men are deemed as not eligible for breast cancer screening.
Gender reassignment	Breast cancer can occur in both groups of transsexual people, ² however it is not known if these rates differ from the general population. Person with breast tissue are eligible (i.e. female-to-male people who have not have breast removal surgery, and male-to-female people on hormone therapy), in which case people registered as “female” with their GP will be automatically invited, while people registered as “male” need to approach their GP for referral to screening. ³ There is no local data about uptake.
Marital Status	Cross-sectional studies in Wales and Italy have found single people to be 33-45% less likely to uptake screening. ^{4,5} There is no local data about uptake.
Pregnancy and maternity	Not having any children is associated with a greater risk of developing breast cancer. However, the number of children has not been associated with screening uptake. There is no local data about uptake.
Religion or belief	It is not known (in the scientific literature, nor from local data) about whether religion is associated with breast cancer or screening uptake.
Sexual orientation	It is not known (in the scientific literature, nor from local data) about whether sexual orientation is associated with breast cancer or screening uptake.

1. Cancer Research UK, Breast cancer statistics: <https://www.cancerresearchuk.org/about-cancer/breast-cancer/stages-types-grades/types/>
2. Gooren L. et al. Five new cases of breast cancer in transsexual persons. *Andrologia*. 2015
3. Public Health England. Information for trans and non-binary people – NHS Screening Programmes. 2017. www.gov.uk/phe/screening-leaflets
4. Edwards NI, Jones DA. Uptake of breast cancer screening in older women. *Age and ageing*. 2000 Mar 1;29(2):131-5.
5. Damiani et al. Socioeconomic disparities in the uptake of breast and cervical cancer screening in Italy. *BMC Public Health* 2012, 12:99

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Breast cancer is the most common type of cancer in Southwark, mirroring the national picture

THE LOCAL PICTURE: BREAST CANCER RATES

Around 30 women die from breast cancer every year in Southwark.

- Between **140-150 new cases** of breast cancer are diagnosed in Southwark every year, making it the single most common type of cancer in our population (2012-2017 data from the Global Burden of Disease Study, published in collaboration with Public Health England¹).
- After adjustment for the fact that Southwark has a relatively young population, the **standardised incidence rate** in Southwark (142 per 100,000) is slightly lower than for the average in England (173 per 100,000).²
- Following a diagnosis, one-year **survival** rates in Southwark (96.6%) are comparable to the average in England (96.3%).² Data on 5-year survival are not publicly available for Southwark, however 5-year survival for cases diagnosed in London in 2004 (84.5%) had improved slightly from the previous year (83.8%), and remains comparable to the average for England (84.7%).³
- **Age-standardised death rates** from breast cancer (18 per 100,000) are slightly lower in Southwark when compared to the averages for England (21 per 100,000). However, this still results in around 30 breast cancer deaths in Southwark every year.¹
- A quarter of breast cancer is thought to be preventable (via obesity, alcohol and breastfeeding),⁴ leaving **early diagnosis and screening** as the main strategy with which to lower mortality among the vast majority of cases of breast cancer.

References

1. Steel N, et al Changes in health in the countries of the UK and 150 English Local Authority areas 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. The Lancet. 2018 Nov 3;392(10158):1647-61. <http://ihmeuw.org/4u09>
2. Public Health England. Cancer Data Dashboard <https://www.cancerdata.nhs.uk/dashboard/breast.html#?tab=Overview&ccg=08Q>
3. National Cancer Registration & Analysis Service, Public Health England. <https://www.cancerstats.nhs.uk/survival>
4. Cancer Research UK, Breast cancer statistics <https://www.cancerresearchuk.org/>

The incidence of breast cancer in Southwark has increased by 6% since 2001-03

BREAST CANCER: INCIDENCE TRENDS

The age-standardised incidence rate for breast cancer in Southwark has increased by 5.9% since 2001-03.

- The incidence rate in Southwark is consistently below regional and national levels. This has been consistent over time, and has remained so over time.
- Just like in the national picture, local rates of breast cancer are also slowly increasing. This may be due to the increase in risk factors such as obesity.

Figure 9: Age-standardised incidence rate for breast cancer, (3-year average)

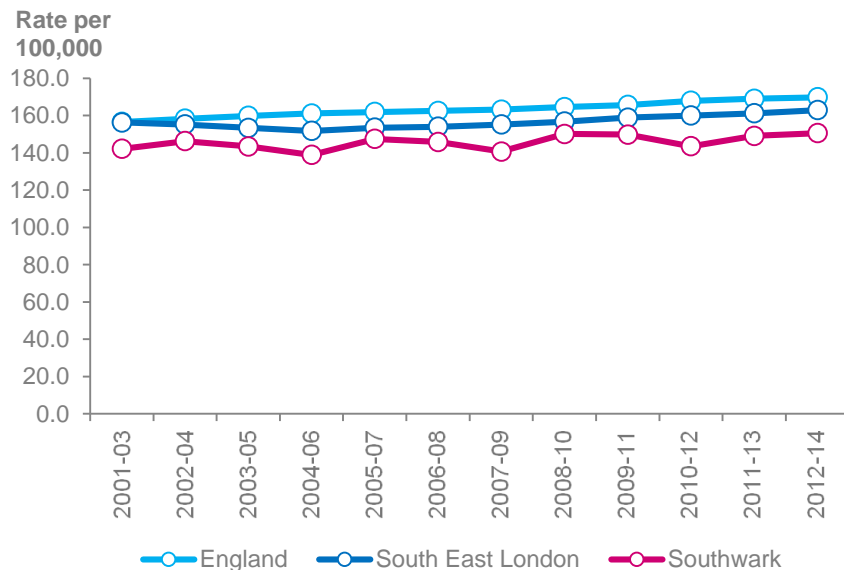
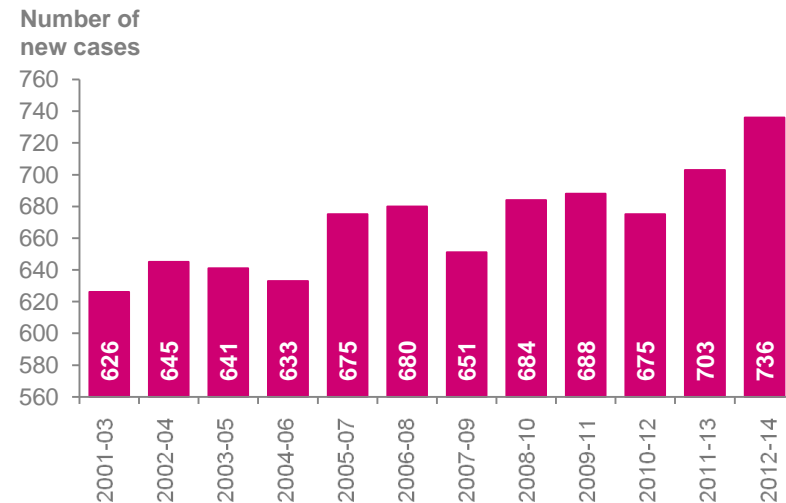


Figure 10: Number of new cases of breast cancer in Southwark, (3-year total)



References

1. National Cancer Registration & Analysis Service (NCRAS)

The incidence rate of breast cancers in Southwark peaks at a younger age than the national average

BREAST CANCER: INCIDENCE BY AGE

The incidence of breast cancer varies greatly by age, with rates significantly higher among older people.

- The incidence of breast cancer is lower than the national average across most age groups, except those in their late 20's and early 40's, though rates in these groups are relatively low.
- The incidence rate of breast cancer in Southwark peaks among those in their late 70's compared to those in their 90's nationally.

Figure 11: Incidence rate for breast cancer by age in 2014-16

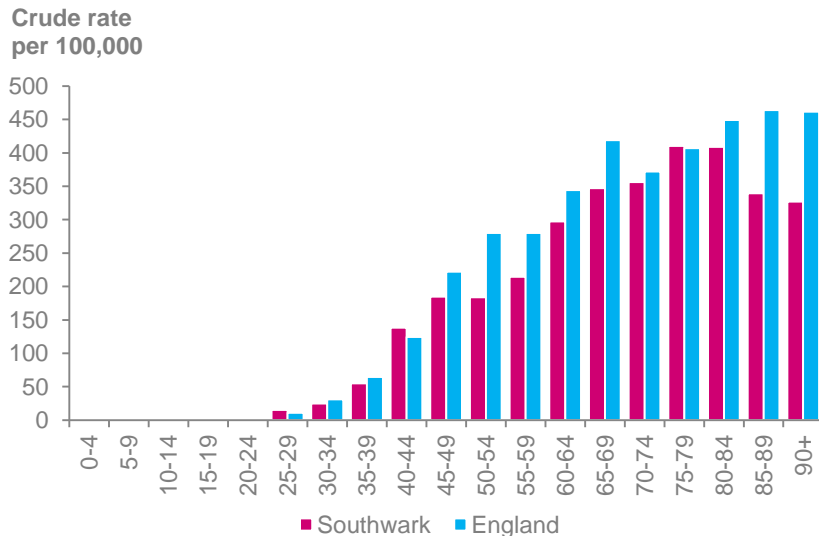
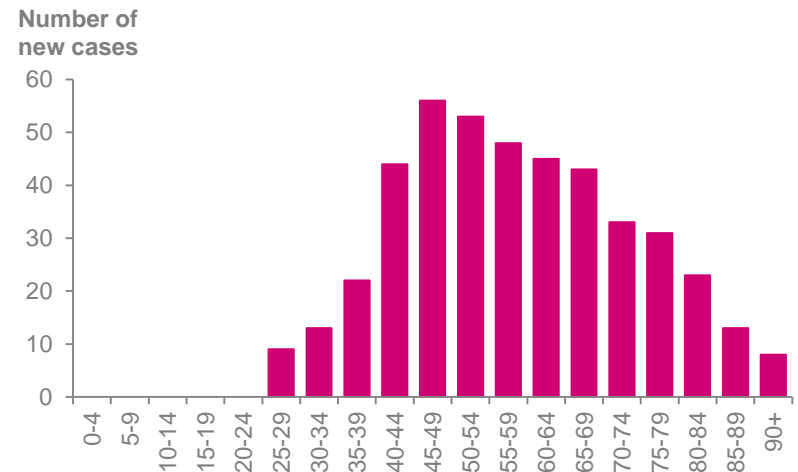


Figure 12: New breast cancers in Southwark by age in 2014-16



References

1. National Cancer Registration & Analysis Service (NCRAS)

Breast cancer rates in Southwark vary by ethnicity, and this may be influenced by differential uptake of screening

BREAST CANCER: INCIDENCE BY ETHNICITY

While breast cancer mortality is substantially greater in black women, breast cancer incidence is slightly greater in white women

- Nationally, age-standardised incidence rates for breast cancer are slightly higher in white women (122 to 126 per 100,000), compared to BAME women (60 to 108).
- Such rates cannot be calculated for smaller areas like Southwark. However, crude case numbers (see table) broadly reflect this pattern.
- Greater incidence in white women is unlikely to cause greater mortality in white women. Wider literature (described on pages 20 and 23) has found black women to have greater mortality than white women.
- Accordingly, white women may not have higher incidence of disease, but instead black women may face barriers to screening and diagnosis.

Incidence and proportion of breast cancer diagnoses, in Southwark 2012-2016, broken down by ethnicity

Ethnicity	Number of new cases	Proportion of all new cases
White	442	60%
Black	205	28%
Asian	12	1.6%
Mixed	11	1.5%
Other	47	6%
Unknown	19	3%
Total	736	100%

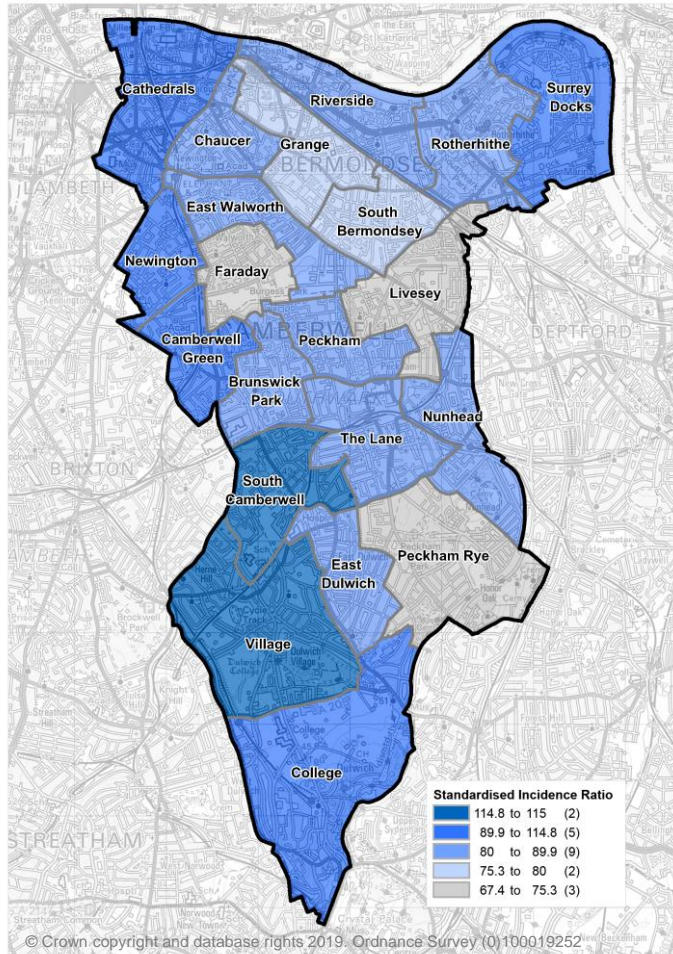
References

1. National Cancer Registration & Analysis Service (NCRAS)

The incidence of breast cancer across the borough is broadly comparable to England

BREAST CANCER: INCIDENCE BY WARD

Figure 13: Standardised incidence ratio for breast cancer, 2011-15



The map opposite illustrates the incidence of breast cancer in 2011-15 across Southwark, with darker areas having the highest incidence.

- Our latest information shows that breast cancer incidence is generally comparable to England, with no ward significantly higher than the national average.
- Data for the period also shows that the incidence of breast cancer is significantly lower than the England in Peckham Rye and Livesey.

References

1. Public Health England, Local Health tool. www.localhealth.org.uk

The premature mortality rate for breast cancer in Southwark has decreased by 26% since 2001-03

BREAST CANCER: PREMATURE MORTALITY

The age-standardised premature mortality rate for breast cancer in Southwark has decreased by 26% since 2001-03, although the difference is not statistically significant.

- There were 53 premature deaths from breast cancer in Southwark in 2014-16. This absolute figure has decreased by 13%, when compared to the 61 deaths seen in 2001-03 (below right).
- Between 2001-2016, Southwark's population demographics have also changed, which is why this decline is more pronounced when looking at age-adjusted mortality rates (below left).
- The premature mortality rate in Southwark is similar to regional and national levels, though figures continue to fluctuate in recent years due to the low number of deaths (below left).

Figure 14: Age-standardised premature mortality rate for breast cancer

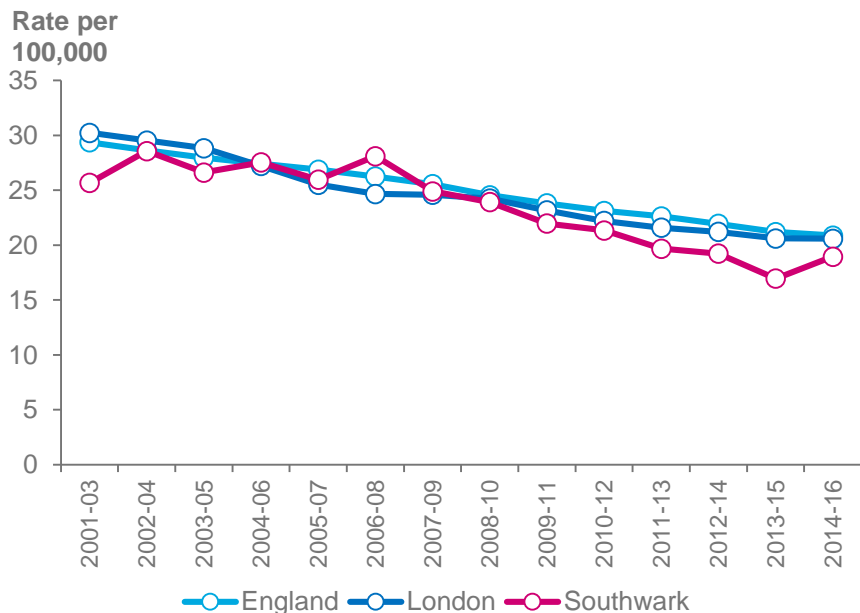
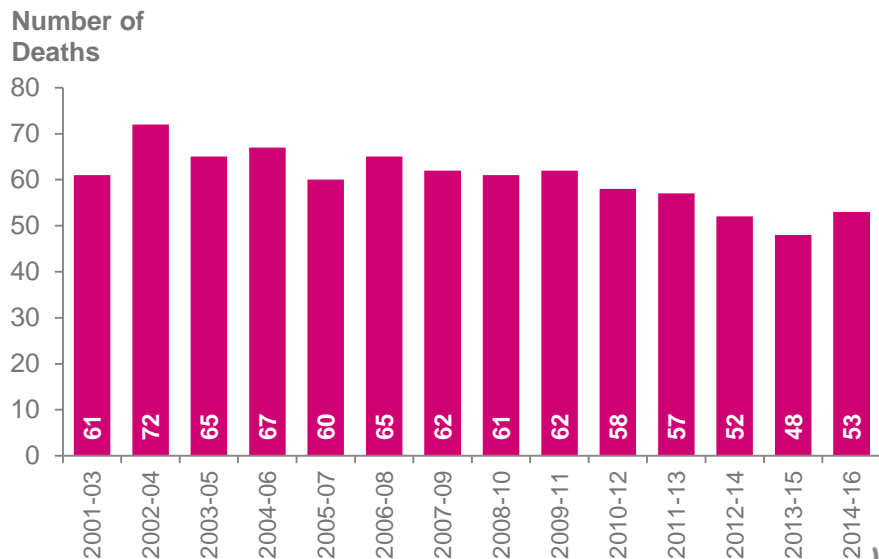


Figure 15: Number of premature deaths from breast cancer in Southwark



References

- National Cancer Registration & Analysis Service (NCRAS)

In Southwark, breast screening uptake is below the nationally acceptable standard

THE LOCAL PICTURE: UPTAKE & COVERAGE

Despite recent increases, uptake rates in Southwark remain below the London average.

- In Southwark neither the coverage nor uptake rates have ever exceeded the national average, the nationally acceptable standard (70%), nor the nationally achievable standard (80%).
- In Southwark, there was an 8 percentage point increase in uptake between 2014-2016, with a small decline thereafter. This may have been due concurrent changes to the content, timing and choice of providers who sent out SMS reminders.³

Figure 16: Uptake (%) of breast screening
(i.e. attendance within 6 months, among those invited)

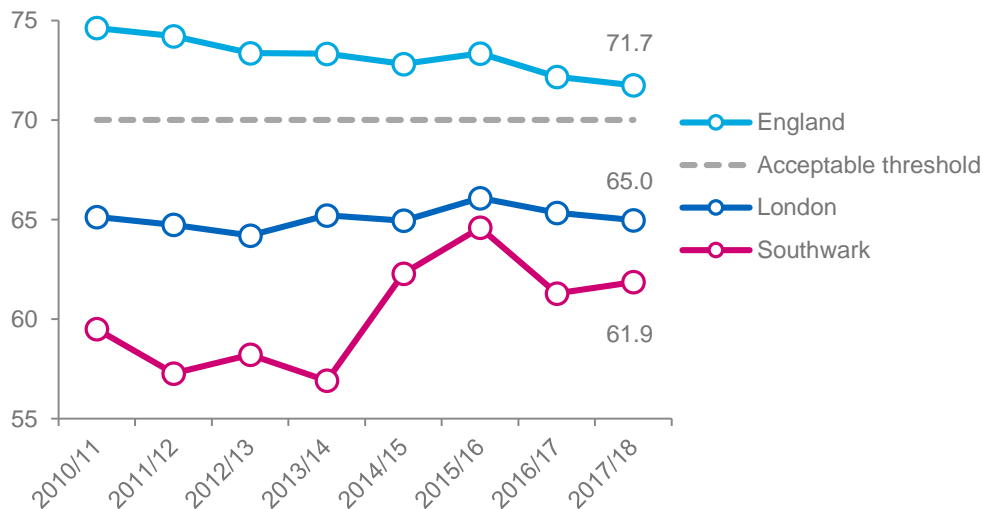
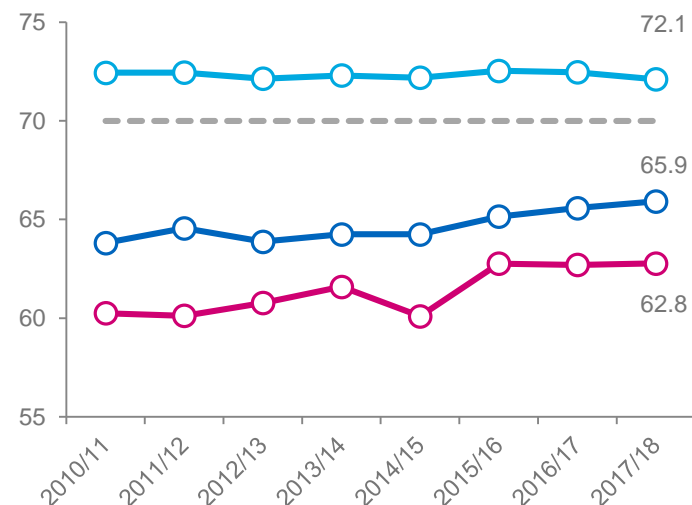


Figure 17: Coverage (%) of breast screening
(i.e. attendance within 36 months, among those eligible)



References

1. Public Health England. Public Health Profiles accessed at <https://fingertips.phe.org.uk>
2. NHS England. Breast Screening Programme England, 2017/18 Report Published 27 November 2018
3. Meeting with J Ruwende, Commissioning Manager for Cancer Screening for NHSE London Region, 10 July 2018.

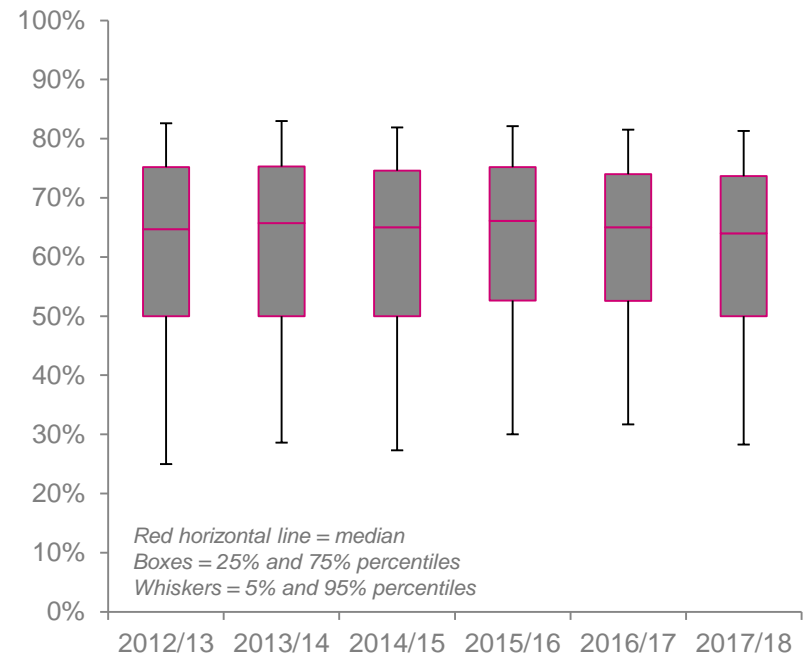
There is large variation in screening uptake across Southwark GPs, with little change over time

THE LOCAL PICTURE: PRACTICE LEVEL UPTAKE

There is great variation in breast screening uptake across GP practices.

- The graph shows great variation in the uptake rates across local GP practices. For 90% of practices (spanning the whiskers), the uptake rate varies from 25% (worst performing practices) to 83% (best performing practices).
- There has been little change in this over time.
- The uptake rate for the median practice remains below the nationally acceptable standard (70%).
- Just over a quarter of GP practices have uptake rates above the nationally acceptable standard (70%).
- Just over 5% of best performing GP practices have uptake rates above the nationally achievable standard (80%).

Figure 18: Breast screening uptake rates (%) in Southwark, grouped by GP practices



References

1. Public Health England. Public Health Profiles accessed at <https://fingertips.phe.org.uk>

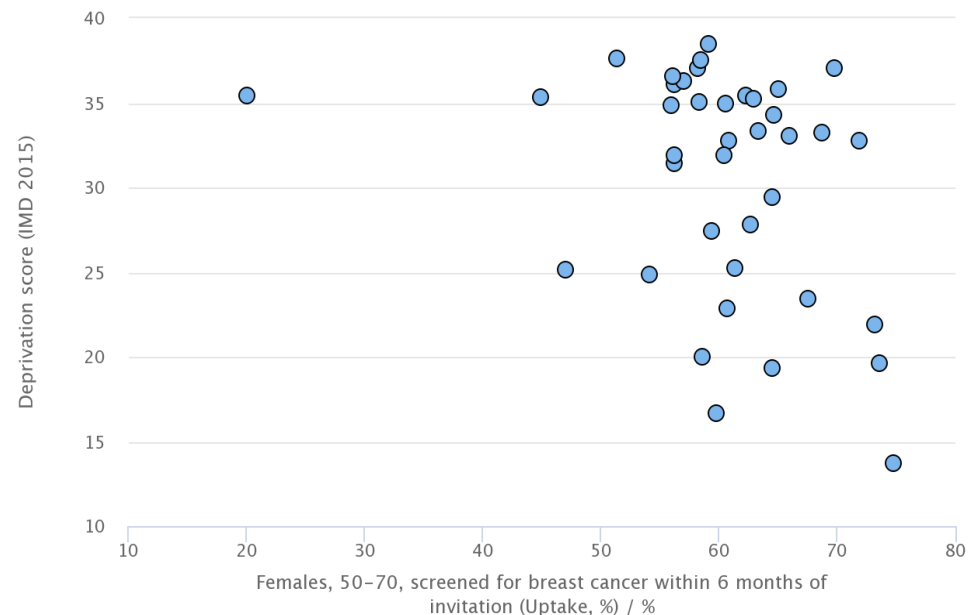
GP practices in the more deprived areas of Southwark may have lower uptake of breast cancer screening

THE LOCAL PICTURE: DEPRIVATION AND UPTAKE

There is variation in screening uptake in Southwark, and this may be related to level of deprivation.

- National data shows a strong correlation, with people living in deprived areas having lower uptake of breast screening (see slide 19)
- Local data (Figure 13, right):
 - Does not show as strong a correlation between deprivation and uptake rates.
 - Instead there is marked variation in uptake rates for practices in deprived and affluent areas alike. Uptake rates span from 45% to 75% across most of the deprivation spectrum.

Figure 19: Correlation between deprivation and breast screening uptake, among Southwark GP practices



References

1. Public Health England. Public Health Profiles accessed at <https://fingertips.phe.org.uk>
2. The National Cancer Registration and Analysis Service accessed online at www.cancerstats.nhs.uk

Most women have their second screen within 3 years, thereby meeting the national round length target

THE LOCAL PICTURE: ROUND LENGTH

Data from 2018-2019 shows that Southwark is meeting the national round length target.

- The national standard is for 90% of women to have their second screen within 3 years of their previous screen (i.e. round length).
- Round length data is not publicly available, as this is monitored by NHS England. NHS England (London) have provided assurance that in Southwark, recent Round Length Time between 2018-2019 has met the national acceptable standard.¹ This is supported by local data from the service provider, however this information is not publicly accessible.²

References

1. Meeting with Nyamajiyah H. Commissioning Manager – Breast Screening Programme London. 2 July 2019
2. Kirby G. Monthly Performance Report, South East London Breast Screening Services. July 2019.

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Non-white ethnicity and deprivation are both associated with lower screening uptake and shorter survival

BARRIERS TO UPTAKE: IMPLICATIONS

Survival rates from breast cancer are lower among non-white women, as well as in more deprived areas, and this may be partly explained by lower uptake of screening services.

- Women in more deprived areas have lower survival rates, following a diagnosis of breast cancer.¹ This may be due to lower uptake of services like screening in more deprived areas.^{3,9}
- Women from Black and Asian Minority Ethnic groups (BAME) are found with more severe disease at the point of diagnosis, with lower survival rates when compared to their white counterparts.^{4,5,6} This may be due to various factors, including:
 - In London, BAME women are consistently less likely to uptake screening.^{5,8} This may allow subclinical disease to progress towards a later stage before being diagnosed.⁶
 - BAME women are diagnosed with a median age of 50, while the median age for white women is 62.⁴ Studies of Japanese migrants into Hawaii showed disease rates to resemble those of host populations within 1-2 generations, indicating that environmental factors are more important than genetic factors in explaining these ethnic differences.²
- Different rates remain after statistically adjusting for deprivation and ethnicity, suggesting that both of these two play an independent role, and need to be considered separately.^{1,6,7,8}

References

1. Morris M, et al. British journal of cancer. 2015;113(3):548.
2. McPherson K, et al. BMJ. 2000;321(7261):624.
3. Banks E, et al. Breast Cancer Research. 2001;4(1):R1.
4. Public Health England. NCIN Data Briefing - Breast Cancer Ethnicity. 2010.

5. Renshaw C, et al. BMC Public Health. 2010;10(1):157.
6. Davies EA, et al. Journal of Public Health. 2013;35(4):607-15.
7. Bansal N, et al. British journal of cancer. 2012;106(8):1361.
8. Jack RH, et al. BMJ open. 2014;4(10):e005586.
9. Maheswaran R, et al. JECH. 2006;60(3):208-12.

Some Southwark women are automatically enrolled in the AgeX trial, coordinated by Oxford University

OVERCOMING BARRIERS TO UPTAKE: CURRENT INITIATIVES

In addition to the service as agreed by the national specification, the following national study is underway which may become embedded as routine practice in the future.

Additional national research studies

- All Southwark women are included in the AgeX trial, coordinated by Oxford University.¹ This is inviting some Southwark women aged 47-49 or 71-73 to also participate in screening, to evaluate if screening in such extended age groups is also effective. This is the largest randomized controlled trial in the world for any condition, with approximately 4 million women having participated by 2019.
- Recent reports by PHE, as well as an independent government review, have both recommended that the AgeX trial should continue and not be impacted by other service improvements (such as changes to the IT systems underpinning the call/recall system).^{2,3}
- The AgeX trial is expected to follow-up women for mortality until 2025, with results available in the late 2020s. As interim findings may not approximate the final outcome of interest (breast cancer mortality), the study team may choose to not publish interim findings.

References

1. Moser K, Sellars S, Wheaton M, Cooke J, Duncan A, Maxwell A, Mitchell M, Wilson M, Beral V, Peto R, Richards M, Patnick J. Extending the age range for breast screening in England: pilot study to assess the feasibility and acceptability of randomization. *J Med Screen* 2011; 18 :96-102.
2. Public Health England. External Review of the AgeX Trial. 2017
3. The Independent Breast Screening Review 2018. House of Commons.

The service in London is making greater use of SMS reminders

OVERCOMING BARRIERS TO UPTAKE: CURRENT INITIATIVES

The pan-London service will shortly include more SMS communications, and targeted information for women with disabilities.

Additional pan-London initiatives

- All women receive one letter and two SMSes *prior to* their first invitation letter.
- Women who do not attend their second timed appointment will shortly receive an SMS reminder with a weblink to book themselves a suitable time, as part of a pan-London initiative. This is currently undergoing procurement during the 2019/20 financial year and is likely to become business as usual.
- A pan-London website is available for women with disabilities, to help select an appropriate mammography venue.

One local pilot of phoning women has demonstrated large success in increasing uptake

OVERCOMING BARRIERS TO UPTAKE: CURRENT INITIATIVES

For 100 nonresponders contacted by phone, 19 have subsequently booked and attended screening, surpassing original expectations.

Additional South East London initiatives

- A fixed-term initiative with iPlato is currently underway (June – Dec 2019).
- Up to 16,000 women who have not attended (following two timed appointments and a subsequent SMS reminder) will be contacted by phone.
- Preliminary data was analysed on 1 Nov 2019, at which point 3187 women had been contacted. Initial findings suggest that around 19% of women will book and subsequently attended for mammography screening.
- In the absence of a control group, it is not clear whether some of these women might have taken up screening later on anyway, even if they would not have received the phone call.
- Nonetheless, these outcomes are still is many times higher than were originally anticipated.
- The pilot has costed approximately £100 per one additional woman to attend screening. If this service is not affordable to use on everybody, then targeted use on higher risk subgroups (e.g. BAME women and/or deprived areas) could be considered in the future.
- Similar services have recently been piloted by Barnet CCG, as well as Community Links.

References

1. Personal communication with T Bush, Junior Project Manager at iPlato Healthcare Ltd. 6 Nov 2019

Many evidence based approaches are implemented in Southwark, except for culturally-personalised reminders

OVERCOMING BARRIERS TO UPTAKE: EVIDENCE REVIEW

A recent systematic review (commissioned by the National Screening Committee) assessed *Interventions to improve participation in cancer screening services*.¹ It found 71 eligible studies of which 58 found positive results. These suggest that:

- The current process of inviting women in England, London and Southwark has **implemented much of the existing evidence** base (e.g. pre-screening notifications, GP endorsement, fixed time appointments, reminder letters, second reminder via SMS).
- However, two studies suggested that **culturo-ethnically sensitive reminders** may potentially increase uptake further, if adopted in areas like Southwark. Namely:
 - 1) Bell *et al.* targeted 369 women in three Cardiff general practices with a low historic uptake (33%) and a high proportion of ethnic minority women. Women received a multilingual leaflet, plus offer of transport to the screening centre, and language support. Following this multifaceted intervention, uptake rates increased to 51%.²
 - 2) Eilbert *et al.* began with a baseline uptake rate of 45% in Tower Hamlets in 2005. After three years of an enhanced programme including multiple interventions, including language- and culture-sensitive letters and reminders, uptake rose to 63%.³
- Neither study used a control group and the intervention was not randomly allocated. Hence it is not entirely clear whether uptake rates could have naturally increased, even in the absence of the intervention.

References

1. Duffy SW, et al. Journal of medical screening. 017:127
2. Bell TS, et al. Ethn Health 1999; 4: 277–284.
3. Eilbert KW, et al Br J Cancer 2009; 101(Suppl. 2)

There is evidence that calling women who have not attended can substantially boost uptake

OVERCOMING BARRIERS TO UPTAKE: EVIDENCE REVIEW

- Two RCTs and two non-randomised pilots evaluated the benefit of using **telephone reminders**, after a woman does not attend her *first* fixed-time appointment. All showed substantial increases in uptake (between 4% and 31%). There are no published evaluations of using telephone reminders once women have not attended their *second* timed appointment (a cohort that might plausibly be ever harder to reach), as was done in the South East London iPlato pilot.
- Smaller increases were seen when using **SMS** reminders in similar cohorts (between 3% to 15%).

References

1. Duffy SW, et al. Journal of medical screening. 2017;24(3):127-45
2. Personal communication with CC Le, Programme Manager at iPlato Healthcare Ltd. 15 Aug 2019

A national review recommends for NHSE to consider financial incentives, to improve breast screening uptake

OVERCOMING BARRIERS TO UPTAKE: NATIONAL RECOMMENDATIONS

The Richards' Review of Cancer Screening recommends for NHSE to take central leadership, and for local systems to invest in improving breast screening uptake.

- In 2019, Prof Sir Michael Richards reviewed cancer screening programmes, focusing on uptake, modernization and diagnostic capacity. The report made 22 recommendations. Further to recommendation that have already been implemented at Southwark, the report recommends that:
 - NHSE should to take a central **leadership and accountability** role, obtaining functions and people from PHE for this purpose, and publishing annual audit data (including equality data on under-served groups). Southwark Council should work with NHSE(London), to help provide local expertise on ensuring that changes are joined up and meet local needs.
 - NHSX is asked to accelerate the roll out of screening **IT infrastructure** such as the “*Next test due date*” system (due to be implemented across London over the next few years).
 - To increase **uptake**, by considering social media pilots, improving access for trans people and to those with disabilities, collaboration with faith and community groups, and financial incentives (e.g. pay per activity, or for targeted activity like extended opening times).
 - Round length should be capped to 34 months, with timely communications and **assessment** where subsequently required.
 - A dedicated **capital fund** be established, to replace outdated equipment where appropriate.
 - Sharing data for **research** should be simplified.

References

1. Richards M. Report of the Independent Review of National Cancer Screening Programmes in England. Oct 2019 <https://www.england.nhs.uk/publication/terms-of-reference-review-national-cancer-screening-programmes-england/>

Collaboration with GPs, and stratified approaches, may improve uptake

OVERCOMING BARRIERS TO UPTAKE: STAKEHOLDER VIEWS

Following an interview with the *Commissioning Manager for Cancer Screening for NHSE London Region*, the following four recommendations were made to increase uptake:

1. Target efforts at those **GPs practices** (or communities) with **lowest uptake**. e.g. Site visits by Macmillan GPs or repurposing the existing visits that are currently made by the KCL Bowel Cancer Health Promotion Strategist.
2. GP patient lists are sometimes **out of date**, thereby inflating denominators. To set up a working group tasked with proposing solutions that can address this.
3. Consider a systematic **MECC approach** optimising the use of other population health screening programmes. Either all women aged 45-52 could be informed that they may shortly receive their first breast screening invite, and/or existing flags for nonresponders could be more proactively followed up in such settings opportunistically.
4. Implementation of the recommendations from the Mike Richards' Review (2019) which includes "*opportunities for the use of artificial intelligence and **stratification** in screening*" to consider a joint project with academic partners to integrate data from the GP record (or NHS Health Check data) about risk factors for breast cancer, from which to generate a prediction of who is most likely to develop disease (or alternatively decline screening) and target them with more intensive reminders in case of non attendance (e.g. phone calls).

Collaboration and incentives with GPs, in primary care networks, may increase uptake in those first screened

OVERCOMING BARRIERS TO UPTAKE: STAKEHOLDER VIEWS

Following an interview with the *Joint Screening and Immunisation Lead at NHS London and Public Health England*, the following five recommendations were made to increase uptake:

1. Encourage **GPs** to be more effective in encouraging uptake, as per “*Cancer Screening Good Practice Guide for General Practice*”, e.g. appointment of a **named prevention lead** to facilitate entry of “DNA” flags into patient records, and systematic processes for following them up (incl. proactive phone calls and/or opportunistic prompts), plus posters in practice waiting areas.
2. Investigate whether existing CCG PMS/APMS **contract** monitors and rewards the above activity, and if not, whether this could be included. An existing “*Guidance on incentive schemes on Bowel Cancer Screening*” may give ideas about this content.
3. To consider financing/delivery mechanisms via **primary care networks**, whose upcoming service specification may financially reward early diagnosis and uptake of screening services. By Nov 2019, NHSE/PHE had received 50 expressions of interest across London about developing innovative PCN pilot services.
4. To target new interventions at women for their **first screen** (aged 50-53) to increase first-time and ongoing participation to age 70. To consider approaching key **academic experts** who work in the local area (e.g. Prof Peter Sareni at KCL and Jo Waller at UCL) to develop and test new services.
5. To raise awareness on how the national **cancer alliance funding allocation formula** is linked to the *62 day cancer wait* time. As wait times are longer in SEL, the SEL Cancer Alliance receives very little funding. This problem structurally worsens inequalities.

Collaboration with GPs, and personalised messaging, may improve uptake

OVERCOMING BARRIERS TO UPTAKE: STAKEHOLDER VIEWS

Following an interview with the Programme Manager at *KCH South East London Breast Screening Programme*, the following three recommendations were made, to increase uptake:

1. To work closer with **GP practices with lowest uptake**, such as single-doctor practices.
2. To seek access and use of detailed patient records, to further **personalise** the invite and reminder process, e.g. by considering the invitee's age, deprivation, ethnicity, past medical history of breast cancer, mental health, any disabilities, or the presence of carers.
3. To consider a comparison of the demographic profiles between typical responders (collected by KCH) and all those eligible (potentially available at Southwark Council), to further **describe any inequalities** in service uptake.

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Uptake in Southwark does not meet national standards, requiring a coordinated and multifaceted solution

KEY FINDINGS

Breast screening uptake in Southwark does not meet the national standards, and those most at risk of dying from breast cancer are least likely to be screened.

- Several underserved groups for breast screening are known to have a higher mortality of breast cancer, and targeted work is need to improve uptake in these groups. Underserved groups include certain minority ethnic groups, those living in the most deprived areas, and those with disabilities.
- Both the 5 year Cancer Commissioning Strategy for London 2015-2020, and Southwark's Health and Wellbeing Strategy 2015-2020, advocate the need for improvement in screening uptake. However there remains an absence of a co-ordinated, borough-specific strategy, with ongoing initiatives operating in isolation from one another as well as the existing evidence base.
- A number of initiatives are already in place which aim to improve coverage, including multiple pan-London initiatives that are evidence based as well as an iPlato SMS and phone call pilot in South East London.
- However several challenges, such as targeting underserved groups as well as collecting data on protected characteristics, still require focused attention.

The following opportunities to improve breast screening in Southwark have been identified (1 of 2)

Recommendation	Details	Suggested Owner
GOVERNANCE		
Develop a strategic approach	From the results of this review, develop a co-ordinated action plan to improve breast screening uptake across Southwark (or South East London), including feeding back to higher geographical areas about the structural inequality that is aggravated by the current STP funding allocation formula.	SEL STP or CCG, NHSE(London), Public Health
SERVICE DELIVERY		
Sharing best practice across geographies	Share practice notes with colleagues at Tower Hamlets, Barnet and Cardiff who have explored and piloted similar approaches towards improving uptake.	Public Health, NHSE(London)
Ensure software alerts are used	Southwark General Practices to be made aware of and encouraged to switch on an EMIS protocol that allows data on nonresponders to be pushed to clinical windows, during opportunistic visits.	GP federations, CCG, Public Health, EMIS
Targeted reminders for underserved groups	Following the successful iPlato pilot (ending Dec 2019), to scope potential sources of continued funding (e.g. NHSE(London)). If funding is limited, a high-need subgroup of nonresponders could be targeted instead (e.g. people with disabilities, those in deprived areas, or BAME women).	SEL STP or CCG, NHSE(London), iPlato.
Integrated communications across the screening services	Explore the development of an integrated communications and invitation system across Breast Screening, Cervical Screening and Health Check services, including: - pre-invitation information, - flagging of non-responders across services, - providing residents with the opportunity of feeding back, if they no longer live near the GP practice they are formally registered with.	NHSE(London), Public Health, Service providers, Invitation providers.

The following opportunities to improve breast screening in Southwark have been identified (2 of 2)

Recommendation	Details	Suggested Owner
INTELLIGENCE		
Request and analyse GP data, to better understand predictors of uptake in Southwark	Examining service user characteristics most strongly associated with low breast screening uptake across Southwark, using practice level data. This can be used in conjunction with an upcoming NHSE Health Equity Audit, to better understand potential inequalities in uptake across protected characteristics.	Public Health , GP Federations, NHS England
COMMUNITY ENGAGEMENT		
Work with community leaders	Community engagement work with faith leaders and people of influence in BAME communities, to promote and improve understanding of breast screening.	Public Health
GP PRACTICE EDUCATION & AWARENESS		
Sharing best practice within Southwark	Collaborative work focused on identifying practices with lower coverage in Southwark and directing resources and training towards them, using learning from practices with highest coverage. This may include: <ul style="list-style-type: none"> - Site visits by Macmillan GPs, Cancer Research UK primary care facilitators, and/or Cancer Health Promotion Strategists. - Asking GPs to appoint a named prevention lead to manage how “DNA” flags are followed up, plus posters in practice waiting areas. - Exploring contractual and/or financial incentives, e.g. with emerging PCNs. 	CCG , NHSE(London), GP federations, Public Health
Identify ways to raise awareness and educate providers	Identify events, such as protected learning time events and general practice forums, to promote awareness and ways to improve screening uptake, particularly among people with protected characteristics.	CCG , Public Health

Find out more at
southwark.gov.uk/JSNA

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