***National Cancer Action Team***

**Baseline Assessment of Colorectal Cancer**

**South West London Cancer Network**

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# Executive Summary

Late diagnosis is a major factor contributing to poor survival rates in this country, and while survival rates in South West London are good in comparison to other networks in England, when benchmarked against counterparts in Europe it is clear that there is much more to be done. Last year the SWL cancer network successfully bid for funding for a range of initiatives to support local preventative work within the National Awareness and Earlier Diagnosis Initiative (NAEDI) to increase awareness and promote earlier diagnosis in communities and primary care. One of these initiatives that was funded was the development of this Baseline Assessment. The key findings are set out below. On pages 6 and 7 two matrices ( and ) outline the figures of each PCT and the overall SWLCN figures.

**Croydon**

After Sutton, Croydon has the highest projected proportion of people aged 65 and over. Croydon has the second lowest bowel screening uptake rate. Croydon has the highest male incidence of colorectal cancer in SWL. Contrastingly, female incidence is the lowest in SWL and is significantly lower than the national average. Croydon has the highest one-year survival rate while the male mortality rate is one of the highest in SWL and female mortality is one of the lowest in SWL. The reduction in mortality since 1993-95 has been nearly 20% for males and 27% for females. Following the overall trend in SWL Croydon has an emergency bed day rate that is above the national average by 10%. There were 52.8% of diagnosed cases that were considered to be non-urgent, a rate above the national average. The average 2WW crude referral rate for suspected lower GI cancer in Croydon for 2009 was 137.60 per 100,000 population. However 11.1% of urgent referrals result in a colorectal cancer diagnosis, a higher rate than the national average.

**Kingston**

The population aged 65 and over is at 12.0%, comparable to the other PCTs (except Wandsworth) in SWL. Also similar to the other PCTs in the sector, Kingston’s bowel screening uptake rate is below the national average and well below the 60% target. Male incidence is the lowest in SWL, while female incidence is mid-ranged. The one-year survival rate is one of the highest in SWL at 73.8%, while the male and female mortality rate is the lowest in SWL. However since 1993-95 Kingston has achieved the lowest reduction in male (all ages) mortality at 13.8%, while female all age mortality has decreased by 32.0%, the highest reduction in SWL. Kingston also has the lowest emergency bed day rate at 383 per 100,000 but is still higher than the national average. Kingston had the lowest proportion of diagnosed cases through non-urgent referrals in SWL at 40.7%. The PCT average urgent 2WW suspected lower GI referral rate is 206.90 per 100,000 population. Nearly 10% of urgent referrals result in a cancer diagnosis, a proportion above the national average.

**Richmond & Twickenham**

Besides Wandsworth (which has a relatively young population) Richmond & Twickenham is projected to experience the least increase in the 65 and over population. Richmond & Twickenham record the highest bowel screening uptake in SWL but is still below the national average and target uptake. Male and female incidences are the highest in SWL. One-year survival is at 73.3%, mid-ranked in SWL as is male and female mortality. The male mortality rate has decreased by 29.4% between 1993-95 and 2006-08 while female mortality has decreased by 19.5% for the same period. Analogous to the other PCTs in SWL, Richmond & Twickenham records an emergency bed day rate that is higher than the national average at 393 per 100,000. Fifty-seven percent of diagnosed cases were non-urgent referrals. The average urgent 2WW crude referral rate in Richmond & Twickenham for suspected lower GI cancer for 2009 was 205.55 per 100,000 population. Only 7.6% of urgent referrals result in a cancer diagnosis below the national average of 8.8%.

**Sutton & Merton**

The 65 and over population is comparable to the other PCTs (except Wandsworth) at around 13% of the total population. As with all PCTs in SWL the uptake of bowel screening is below the national average as well as the target of 60%. Male and female incidence is comparable with the other PCTs. Sutton & Merton has the lowest one-year survival rate in SWL at 71.4%. Both male and female mortality rates are comparable to the other PCTs and the national average. Male mortality from colorectal cancer has decreased by 26.6%, and by 14.3% for female mortality since 1993-95. Sutton & Merton record the highest rate for emergency bed days for colorectal cancer at 448 per 100,000. Fifty-seven percent of diagnosed cases were non-urgent referrals. The average 2WW crude referral rate for suspected lower GI cancer in Sutton & Merton for 2009 was 162.77 per 100,000 population. The proportion of urgent referrals resulting in a cancer diagnosis was above the national rate at 9.2%.

**Wandsworth**

Wandsworth is characterised by a young population and as such only 8.2% of the population is currently projected to be aged 65 or over. The uptake of bowel screening in the PCT is low and is the lowest in the sector at 38.6%, over 20% lower than the national target of 60%. Male and female incidence is comparable to other PCTs in the sector. The one-year survival rate is 72.5%, while male and female mortality is the highest in SWL. The decrease in the mortality rate between 1993-95 and 2006-08 is comparable to the other PCTs, at 20.1% for males and 23.9% for females. Again, Wandsworth’s emergency bed day rate is higher than the national average at 415 per 100,000. Wandsworth had a high proportion of diagnosed cases, 61.7%, come through the non-urgent referral route. The PCT average for urgent 2WW referrals for suspected lower GI cancer is 142.48 per 100,000 population. Only 6.1% of referrals result in a cancer diagnosis, a proportion below the national average.

**South West London Cancer Network**

Overall the SWLCN performs well against all other networks in London, coming out best 4 out of 5 times on cancer network specific indicators. However, one indicator, the rate of emergency bed days, is the highest in London, reflecting the high rates in all the PCTs of SWL, particularly Wandsworth, Sutton & Merton and Croydon. One year survival rate (76.9%) for males is significantly higher than the national average and is comparable to the male rate in Norway, Finland and Sweden in the EUROCARE-4 study. The female one-year survival rate is considerably lower at 71.2%. The five-year survival rate (persons) is higher than the national average. The SWLCN has one of the highest proportions of diagnosed cases resulting from non-urgent referrals in the country at 54.3%. The percentage of urgent 2 week wait referrals resulting in a colorectal cancer diagnosis is just above the national average reflecting the mixed rates across the PCTs of SWL. The overall 2WW referral rate per 1,000 population was 1.66.

Figure 1: PCT Matrix of key colorectal cancer figures for South West London.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Croydon | Kingston | Richmond & Twickenham | Sutton & Merton | | Wandsworth |  | |
| Estimated fruit & veg consumption (2003-05) | 27.8% | 33.4% | 37.1% | 30.4% | | 31.1% |  |  |
| Estimated prevalence of binge drinking (2003-05) | 11.0% | 12.3% | 12.3% | 11.4% | 12.3% | 13.9% | Significantly lower national average |  |
| Smoking prevalence (2003-05) | 21.0 - 25.7% | 18.7-24.9% | 16.1 - 23.0% | 18.7 - 23.3% | | 21.0 - 27.7% |  |  |
| % of small areas (LSOA) classed as highest deprivation (2007) | 33% | 5% | 4% | 15% | | 29% | Lowest | Highest |
| 65+ Population as % of PCT population (2010) | 12.9% | 12.0% | 12.1% | 12% (Merton) | 13.5% (Sutton) | 8.2% |  |  |
| 65+ Population increase (2010-2030) | 3.6% | 3.0% | 1.5% | 3.1% (Merton) | 3.9% (Sutton) | 0.4% |  |  |
| Estimated Moderate intensity sport & active recreation (2008-09) | 17.8% | 27.3% | 28.5% | 22.7% (Merton) | 21.1% (Sutton) | 27.0% | Lowest | Highest |
| Bowel screening uptake (up to June 2009) | 44.5% | 48.3% | 49.1% | 46.3% | | 38.6% |  | Below national target (60%) and national average (52.5%) |
| Male Under 75 Incidence (2004-06) | 40.36 | 34.03 | 36.71 | 36.48 | | 37.11 |  |  |
| Female Under 75 Incidence (2004-06) | 20.24 | 30.77 | 30.91 | 25.2 | | 27.89 | Significantly lower national average |  |
| Male Staging (2003-07) | Stage 1: 11.7% Stage 2: 13.7% Stage 4: 14.3% NK: 48.6% | Stage 1: 18.0% Stage 2: 23.7% Stage 4: 17.5% NK: 23.2% | Stage 1: 11.7% Stage 2: 23.1% Stage 4: 25.1% NK: 22.7% | Stage 1: 15.7% Stage 2: 16.9% Stage 4: 22.5% NK: 29.1% | | Stage 1: 17.5% Stage 2: 22.7% Stage 4: 18.6% NK: 20.1% |  |  |
| Female Staging (2003-07) | Stage 1: 10.9% Stage 2: 11.8% Stage 4: 17.3% NK: 49.1% | Stage 1: 15.3% Stage 2: 21.1% Stage 4: 18.7% NK: 23.4% | Stage 1: 19.5% Stage 2: 19.4% Stage 4: 22.0% NK: 17.5% | Stage 1: 12.5% Stage 2: 18.0% Stage 4: 21.1% NK: 33.8% | | Stage 1: 18.1% Stage 2:15.8% Stage 4: 24.8% NK: 25.6% |  |  |
| 1-year survival (2002-07) | 74.5% | 73.8% | 73.3% | 71.4% | | 72.5% | Highest | Lowest |
| 5-year survival (1998-02) | 53.3% | 52.1% | 50.1% | 56.0% | | 44.0% | Highest | Lowest |
| Male Under 75 mortality (2006-08) | 12.51 | 10.14 | 11.75 | 11.93 | | 13.57 |  |  |
| Female Under 75 mortality (2006-08 ) | 8.19 | 6.60 | 8.25 | 8.54 | | 9.42 |  |  |
| Male % Decrease U75 mortality (1995-2008) | 19.2% | 13.8% | 29.4% | 26.6% | | 20.1% | Highest decrease | Lowest decrease |
| Female % Decrease All age mortality (1995-2008) | 27.2% | 32.0% | 19.5% | 14.3% | | 23.9% | Highest decrease | Lowest decrease |
| Emergency Bed Days per 100,000 (2007-08) | 410 | 383 | 393 | 448 | | 415 |  | Higher than national average |
| Average all cancer emergency admission crude rate per 100,000 (2008-09) | 610.41 | 506.50 | 536.97 | 634.87 | | 443.07 |  |  |
| 2WW lower GI cancer referral rate per 100,000 (2009) | 137.60 | 206.90 | 205.55 | 162.77 | | 142.48 |  |  |
| % of cases diagnosed through non-urgent referrals (2010) | 52.8% | 40.7% | 57.1% | 57.1% | | 61.9% | Lowest | Highest |
| % urgent 2 week wait referrals resulting in cancer diagnosis (2010) | 11.10% | 9.80% | 7.60% | 9.20% | | 6.10% | Higher than national average (8.8%) | In lowest quartile |

Figure 2: Matrix of key colorectal cancer figures for the South West London Cancer Network.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | SWLCN | NELCN | NLCN | (N)WLCN | SELCN |
| Male Staging (2003-07) | Stage 1: 16.4% Stage 4: 19.3.% NK: 29.6% |  |  |  |  |  |  |
| Female Staging (2003-07) | Stage 1: 17.1% Stage 4: 20.3% NK: 30.1% |  |  |  |  |  |  |
| Male 1-year prevalence per 100,000 (2006) | 40.0 | 33.0 | 35.2 | 32.7 | 36.0 | Lowest | Highest |
| Female 1-year prevalence per 100,000 (2006) | 24.7 | 21.2 | 21.7 | 22.5 | 22.4 | Lowest | Highest |
| Male One-year survival (2002-07) | 76.9% | 69.7% | 69.2% | 71.2% | 72.7% | Significantly higher than national average | Significantly lower than national average |
| Female One-year survival (2002-07) | 71.2% | 66.7% | 64.7% | 69.2% | 67.8% |  | Significantly lower than national average |
| Five-year survival (Persons) | 52.7% | 45.8% | 46.6% | 46.0% | 46.5% | Higher than national average |  |
| Emergency Bed Days per 100,000 (2007-08) | 404 | 227 | 270 | 321 | 279 |  | Higher than national average |
| % of cases diagnosed through non-urgent referrals (2010) | 54.3% | 49.9% | 43.4% | - | 47.1% | Lowest | Highest |
| % urgent 2 week wait referrals resulting in cancer diagnosis (2010) | 8.9% | 7.7% | 7.3% | - | 7.6% | Higher than national average |  |

# Introduction

Since the Cancer Plan was published in 2000 more people are surviving cancer and the incidence of cancer is increasing as more people live longer. Late diagnosis is a major factor contributing to poor survival rates in this country, and while survival rates in South West London are good in comparison to other networks in England, when benchmarked against counterparts in Europe it is clear that there is much more to be done. Contemporary lifestyles predispose people to cancer and the Cancer Reform Strategy (CRS) (2007) highlighted that with over half of all cancers being potentially preventable services must now begin to think ‘upstream’ and focus on prevention.

The National Awareness and Earlier Diagnosis Initiative (NAEDI) is a collaboration between the National Cancer Action Team and Cancer Research UK and is a key programme emerging from the CRS. Its aim is to make public and healthcare professionals more aware of the signs and symptoms of cancer and encourage those who may have symptoms to seek advice earlier. This workstream offers a good fit with the policy direction of QIPP, NHS Next Stage Review: High Quality for All and World Class Commissioning.

Last year the SWL cancer network successfully bid for funding for a range of initiatives to support local preventative work within NAEDI to increase awareness and promote earlier diagnosis in communities and primary care. These bids included this Baseline Assessment and the Primary Care Audit and Cancer Awareness Measure highlighted within this document.

In order to aid each local early detection initiative a baseline assessment has been undertaken. In collaboration the National Cancer Intelligence Network (NCIN) and the National Cancer Action Team (NCAT) have produced a guide termed: *Local Awareness and Early Diagnosis Baseline Assessments: A Guide for Cancer Networks and Primary Care Trusts.* This baseline assessment follows these guidelines as a framework (National Cancer Intelligence Network 2009a).

Colorectal cancer is one of the most common cancers in the UK (Cancer Research UK). This document provides a summary of currently available information regarding the epidemiology of colorectal cancer. Comparisons are made with national data and international data where possible.

The International Statistical Classification of Diseases and Related Health Problems (10th Revision 2007) for colorectal cancer ranges from C18 to C21.

# Risk Factors

## Diet

Diet is the single most identifiable factor to account for the geographical differences in CRC prevalence. It would seem to be as important in colorectal carcinogenesis as smoking is for lung cancer. Dietary factors, such as fibre content and its source from fruit, vegetables, and grains, protein and fat types and their origin varies enormously (Qasim and O'Morain 2010). In line with World Health Organization (WHO) recommendations, current government advice stipulates that adults and children aged over five years should consume at least five 80g portions of fruit and vegetables a day. Males and females in Britain however consume on average less than three portions of fruit and vegetables a day and just 14% consume the recommended amount (Office of National Statistics 2002).

It is generally believed that 60–80% of colorectal cancer (CRC) in industrialized countries may be linked to dietary preferences (Jedrychowski et al. 2010). A number of correlation studies have established an inverse relationship between consumption of fruit and vegetables and incidence of colorectal cancer (Block et al. 1992, La Vecchia and Tavani 1998, Koushik et al 2007). However a panel of experts recently concluded that the evidence of an inverse relationship between fruit and vegetable consumption and CRC is limited (World Cancer Research Fund 2007). Since then the European Prospective Investigation into Cancer and Nutrition (**van Duijnhoven et al.** 2009) found that there was an inverse relationship with CRC however this was weak. It was stronger for colon cancer. This study also found that smoking played a role in modifying the protective effect fruit and vegetable consumption possibly has on CRC i.e. negating the reduced risk to CRC. It recommends further research into other possible effect modifiers as a possible reason why the inverse relationship between fruit and vegetable consumption and CRC found in many studies is not strong.

Variation in fruit and vegetable consumption has also been linked to deprivation (Cummins et al. 2009) due to a variety of reasons including but not limited, to cost, choice, access and quality. The model based estimates in follow this pattern whereby Richmond & Twickenham has the highest estimated intake at 37.1% (95%CI 33.7% - 40.6%) of adults in the PCT and Croydon the lowest at 27.8% (95%CI 25.7% - 30.1%). The PCTs of Sutton & Merton (30.4% - 95%CI 28.4% - 32.5%), Kingston (33.4% - 95%CI 30.3% - 36.7%) and Wandsworth (31.1% - 95%CI 27.7% - 34.6%) have similar estimated consumption rates.

Figure 3: Model based estimates of fruit and vegetable consumption in adults in South West London, 2003-2005.

**Source: The Information Centre.**

These estimates are model based i.e. they are based on population characteristics extracted from census data for example and are not based on a survey sample. They do not take into consideration local variation, for example the effects of local campaigns. Due to this it is not strictly appropriate to compare between areas and these data should not be used to monitor performance (The Information Centre 2008). Also consideration of the 95% confidence intervals is needed when assessing the data.

Foods containing polyunsaturated fatty acids (PFAs), including docosahexaenoic acid rich in certain fish, lead to inhibition of the arachidonic acid cascade involved in tumorigenesis and cell proliferation, whereas saturated fatty acid consumption increases risk of CRC (Kuriki et al. 2006, Qasim and O'Morain 2010). Numerous studies have reached a consensus that there is a positive association between CRC and red and processed meat intake (Department of Health 1998, WHO/FAO 2003, World Cancer Research Fund 2007, Cross et al. 2010). The Department of Health (1998) recommends a daily intake of red and process meat of no more than 90g per day and that those consuming more than 140g should consider a reduction. The World Cancer Research Fund (2007) recommends a 500g per week limit (~71g per day). Latest estimates from the National Diet Nutrition Survey 2008-09 (Foods standards Agency 2010) shows that men consume an estimated 96g per day while women consume 57g per day.

## Alcohol consumption

Evidence indicates that there is an association between alcohol use and increased risk of colorectal cancer (CRC) (Ferrari et al. 2007, World Cancer Research Fund 2007, Poynter et al. 2009) as well as a dose-response relationship (Cho et al. 2004, Moskal 2007, Huxley et al. 2009). Parkin et al. (2009) describes the following results from Cho et al. (2004); their study found a statistically significant 16% risk increase for people drinking 30–45 g/day of alcohol and a significant 41% risk increase for people drinking 45 g/day or more. A meta-analysis of cohort studies by Moskal (2007) found a 15% increase in risk of colon or rectal cancer for an increase of 100 g alcohol intake per week.

National Statistics from 2008 show that 31% of men in Britain drink more than the recommended 21 units per week, and 8% drink more than 50 units per week, while 20% of women drink more than the recommended 14 units per week, and 5% more than 35 units per week (The Information Centre 2010b).

Figure 4: Model based estimates of binge drinking in Adults in South West London, 2003-2005.

**Source: The Information Centre.**

Estimated binge drinking in South West London () is below the national average (18.0% - 95%CI 17.4% - 18.6%) but comparable to the London average (12.7% - 95%CI 11.4% - 14.0%) if only based on population characteristics. Wandsworth has the highest model estimated binge drinking prevalence amongst adults in SWL at 13.9% (95%CI 12.0% - 16.2%), while the lowest is in Croydon at 11.0% (9.6% - 12.6%), however all estimates for SWL do not show much variance. These estimates are model based i.e. they are based on population characteristics extracted from census data for example and are not based on a survey sample. They do not take into consideration local variation, for example the effects of local campaigns. Due to this it is not strictly appropriate to compare between areas and these data should not be used to monitor performance (The Information Centre 2008). Also consideration of the 95% confidence intervals is needed when assessing the data.

## Smoking

Recent reviews/meta analysis (Botteri et al. 2008, Liang et al. 2009, Chan and Giovannucci 2010) state that there is compelling evidence indicating that smoking is associated with a higher risk of colorectal cancer (CRC). Another study found this as well as a possible indication of a dose-response relationship (Tsoi et al. 2009). Some studies have also shown that the strength of the protective effect of fruit and vegetable consumption depends on smoking status (**van Duijnhoven et al. 2009,** Chaiter et al 2009).The relation between fruit and vegetables and the risk of CRCdiffered according to smoking status in the European Prospective Investigation into Cancer and Nutrition (**van Duijnhoven et al.** 2009)in which an inverse associationfor never and former smokers and a statistically non-significantpositive association for current smokers was observed. Thispattern was even more pronounced for vegetable consumption.The associations between vegetables and CRC risk were largerfor heavy smokers and recent quitters than for mild smokersand long-term quitters. This pattern seems to be consistentwith effect modification by smoking status, which thus suggeststhat smoking may negate the potential beneficial effect of vegetableson CRC risk.

Results from the Health Survey for England (The Information Centre 2006) showed more variation in smoking rates for BME communities compared with the population as a whole. Following age-standardisation, Bangladeshi and Irish men were more likely to smoke than the general male population, while Indian men were found to be less likely to smoke than the general male population. The picture is very different for women as after age-standardisation none of the female BME groups were more likely to smoke than the general female population. Black African, South Asian and Chinese women were found to be less likely to smoke than the general female population. These results were however based on self-reported smoking behaviour which is likely to underestimate smoking prevalence.

Overall, the model estimated smoking prevalence across the 6 boroughs of SWL to be similar () ranging from 19.3% (95%CI 16.1% – 23.0%) in Richmond to 25.4% (95%CI 22.1% – 29.1%) in Sutton (). As with the fruit and vegetable data these rates are also comparable with the London and national averages. These estimates are model based i.e. they are based on population characteristics extracted from census data for example and are not based on a survey sample. They do not take into consideration local variation, for example the effects of local campaigns. Due to this it is not strictly appropriate to compare between areas and these data should not be used to monitor performance (The Information Centre 2008). Also consideration of the 95% confidence intervals is needed when assessing the data.

Figure 5: Model based estimates of smoking in adults in South West London compared with England, 2003-2005.

**Source: The Information Centre 2010.**

Although SW London has followed the national trend with a reduction in the prevalence of smoking this masks significant health inequalities with smoking rates highest in the most deprived populations. In some super output areas in Croydon, Wandsworth and Sutton the prevalence reaches 41% ().

Map 1: Estimates of smoking prevalence in adults (16+) in the SWL sector, 2003-05.

****

**Source: HSfE 2006; map by SWL Public Health Intelligence from Staying Healthy Strategy for South West London 2010-2016**

## Multiple Deprivation

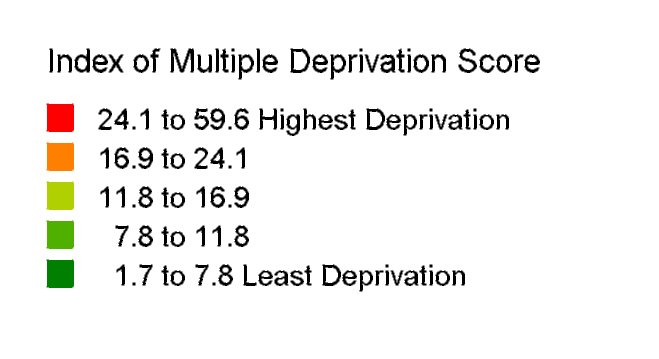
shows the age standardised colorectal cancer incidence across England. The graph shows that there is significant variation between deprivation quintiles for males but not for females. For men, as deprivation increases the incidence of colorectal cancer increases. While the difference between the least and most deprived groups is significant the ratio between both age standardised incidence rates is only 1.1 (National Cancer Intelligence Network 2010a). A study specific to the South Thames region (Pollock and Vickers 1997) also found no significant difference between extreme deprivation groups in 1997 but did find a significantly lower 5-year relative survival rate for those residing in areas of most deprivation compared to those in areas of least deprivation. A possible contributing factor to the lack of variation in incidence between deprivation groups may be due to the fact that those living in deprived areas are less likely to take up the offer of bowel screening (Whynes et al. 2003). As a result, with more affluent groups screened the detection of colorectal cancer may result in a more even incidence rate.

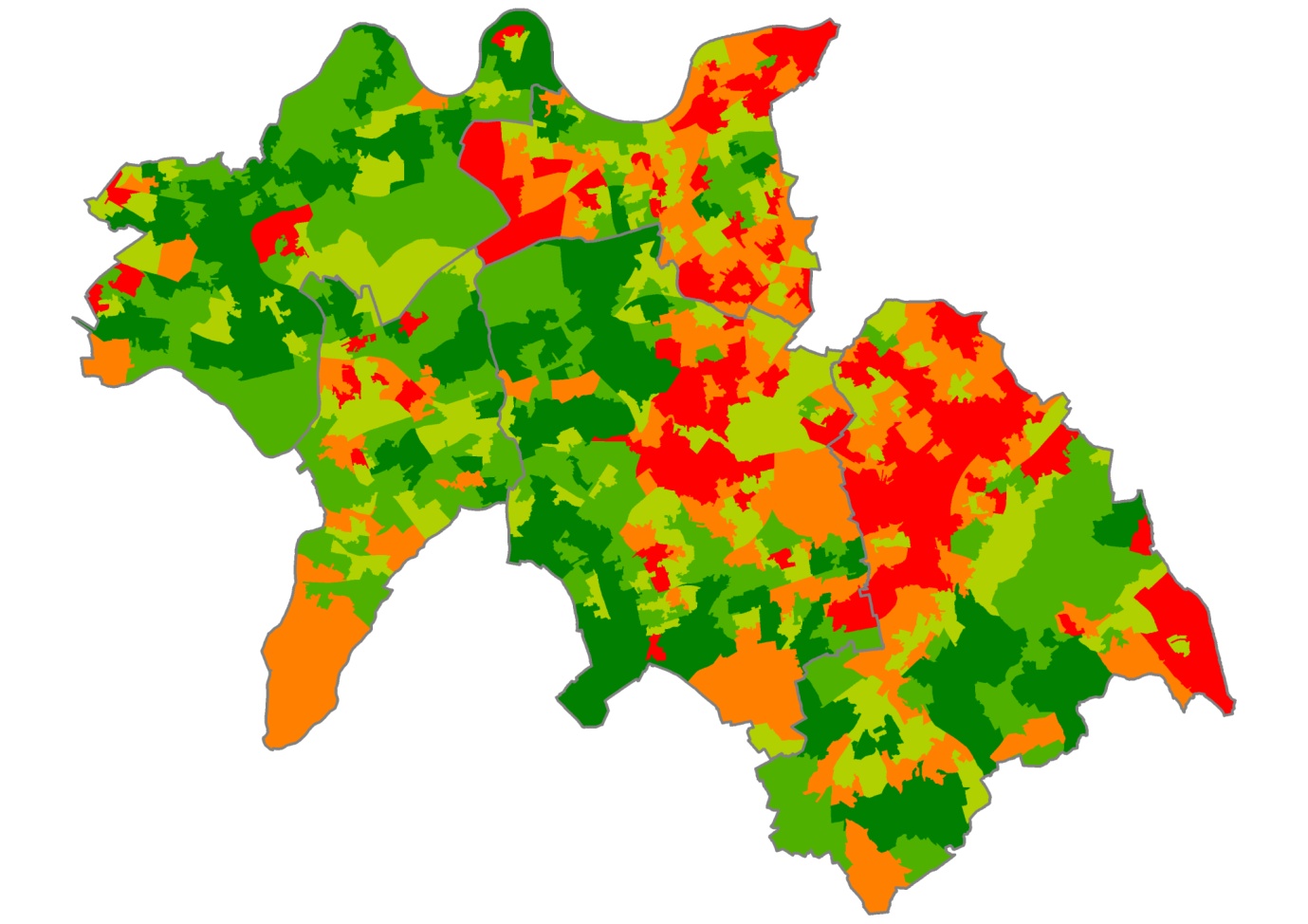
Figure 6: Colorectal cancer incidence by index of multiple deprivation 2000-2004.

**Source: National Cancer Intelligence Network, 2008.**

In SWL the main areas of high deprivation are in Wandsworth (Battersea, Roehampton, Tooting), Sutton & Merton (Morden, Carlshalton) and Croydon (Croydon centre and surrounding area, and

Map 2: Index of multiple deprivation, South West London, 2007 (SWL Scale).





**Source: Department of Local Government and communities, 2007.**

New Addington).

## Age

The biggest single risk factor for colorectal cancer is age. More than 8 out of 10 bowel cancers (84%) in 2007 in the UK were diagnosed in people aged 60 or over (Office of National Statistics 2010).

Figure 7: Projected increase in the proportion (Percent of total population) of 65+ population in South West London, 2010-2030.

**Source: Greater London Authority, Population Projections 2009 Round, London Plan, Borough SYA.**

shows that there is a steady projected increase in the 65 and older population across each borough in SWL except Wandsworth which has a predominantly younger population. However Wandsworth still experiences the highest cancer mortality in SWL. The highest proportion of total population that is 65 and over is found in Sutton, accounting for 13.5% of the projected population in 2010. The lowest proportion is in Wandsworth at 8.2% of the population. The highest increase, from 2010, to 2030, in the 65 and over population is projected to occur in Sutton with an increase of 3.9% followed by Croydon (3.6%) and Kingston (3.0%). By 2030 it is projected that nearly one in five (18.8%) women in Sutton will be 65 or older. Overall, males that are 65 and over account for 10.3% of the projected male population in SWL in 2010, while women account for 12.9%. These proportions are projected to increase to 11.2% and 13.5% respectively by 2020 and to 12.8% and 15.2% by 2030.

## Ethnicity

Ethnicity has an effect on the health and well being of individuals, to a lesser or greater extent depending on the type of cancer. As part of the Cancer Reform Strategy the National Cancer Inequalities Initiative (NCEI) was launched with the aim to reduce inequalities in cancer incidence and survival for several different groups where inequality exists; one such grouping is Black and Minority Ethnic (BME) populations. Historically though the recording of ethnicity for routinely collected cancer data has been incomplete and of poor quality (Department of Health 2007). As a result work on cancer and ethnicity has been limited in the UK, with mortality studies using place of birth information (Grulich et al. 1992, Swerdlow et al. 1995, Wild et al. 2006) while incidence work has only been carried out on the south Asian ethnic population (Winter et al. 1999, dos Santos Silva et al. 2003, Farooq and Coleman 2005).

However as part of the National Cancer Inequalities Initiative, the National Cancer Intelligence Network (NCIN) and Cancer Research UK produced analysis on incidence and survival by major ethnic group for the period 2002-2006, in 2009 (National Cancer Intelligence Network 2009b). It found Asian and Black ethnicities were at a significantly lower risk of getting colorectal cancer compared with White ethnicity; however there was no difference between ethnicities in survival rates. Both the Chinese and Mixed ethnic groups tended to have significantly lower incidence rates of colorectal cancer compared to White ethnicity.

The study found that Asian males had a 50% to 64% less chance of getting colorectal cancer while females were estimated to have a 50% to 66% less chance. For Black and White ethnicity, Black males had a 20% to 45% less chance of getting colorectal cancer while females were estimated to have an 8% to 40% less chance (National Cancer Intelligence Network 2010b). There were no significant differences in age-standardised relative survival between White, Asian and Black ethnic groups at either one or three years after diagnosis.

Croydon has the largest non-white resident ethnicity at 40.9% of the total population of the PCT followed by Sutton & Merton with 23.3% (). Richmond has the lowest at 11.7%. The largest resident BME group across all PCTs is Asian, which comprises of Pakistani, Indian, Bangladeshi and other Asian. Croydon has the largest Black population accounting for 21.2% or one in five of the PCT population. For exact figures see Appendix 1.

Figure 8: Projected (2010) resident ethnic composition of SWL PCTs, for Males and Females of all ages.

**Source: Greater London Authority Ethnic Group Projections 2008 Round, London Plan, Borough.**

## Physical (in)activity

Parkin et al (2009) states that individuals with high levels of physical activity throughout their lives are at lower risk for colon cancer. The evidence was considered ‘sufficient’ in the IARC (2002) evaluation and ‘convincing’ by World Cancer Research Fund (2007) and WHO/FAO (2003). The relationship between physical exercise and risk of rectal cancer is much less certain (IARC 2002, Wei et al. 2004, Friedenreich et al. 2006), although some studies describe an inverse relationship (Slattery et al. 2003).

The latest estimated figures () from the Active People 2008-09 Survey by Sport England shows that more people (aged 16+) in the borough of Richmond partake in moderate intensity sport than other boroughs in SWL. The exact definition is to partake in at least 30 minutes of sport at moderate intensity at least three times a week (Further details on this survey can be found at <http://www.sportengland.org/research/active_people_survey.aspx>). Croydon is estimated to be the least active population at 17.8%. All other boroughs record that over one in five are engaged in this level of activity. A high proportion seen in Wandsworth, possibly higher than expected given the level of deprivation in the borough, will partly be due to the borough having a young population as it is likely that a greater proportion of younger people undertake levels of physical activity at the recommended levels than older people.

The figures are not age standardised and the indicator does not include active recreation such as housework, DIY, activity in ones job or active transport. Also the figures may be prone to respondent bias as the level of physical activity is self-reported.

Figure 9: Estimated proportion of population (aged 16+) to be taking part in moderate intensity sport and active recreation on at least 3 days a week, 2008-09.

**Source: Active People Survey 2008-09, Sport England .**

# Bowel Screening

## Uptake by PCT – up to June 2009

The NHS Bowel Cancer Screening Programme (BCSP) offers screening to men and women aged 60–69 every two years using a guaiac based faecal occult blood test (FOBt). People aged 70 or over can request an FOBt kit. Most people who participate in the NHS BCSP will not see a health professional (NHS Cancer Screening Programmes 2008). They will have a normal test result and will be invited to participate again in two years’ time. Uptake is defined as, “response to an invitation”, therefore only people who have been sent the standard “S1” invitation letter are included in the denominator of the calculation; opt-ins and self-referrals (over 70s) are not included.

shows the bowel screening uptake by PCT since the beginning of the programme until June 2009. The target uptake rate is 60% and the national average is 52.5%. All PCTs in SWL do not reach the target or the level of the national average. The highest uptake rate in SWL was at Richmond & Twickenham at 49.1%, while the lowest was recorded for Wandsworth at 38.6%.

Figure 10: Bowel screening uptake rates by PCT, for ages 60-69 years, since inception to June 2009.

**Source: NHS London Bowel Screening Programme, London Quality Assurance Reference Centre (QARC).**

# Colorectal Cancer Incidence

## Under 75 incidence by PCT 2004-06

shows the under 75 age standardised colorectal cancer incidence in SWL for 2004-06. Incidence rates are highest in Croydon (40.36 per 100,000 95%CI 34.40 – 46.33) for males and Richmond & Twickenham (30.91 95%CI 23.98 – 37.85) for females. Interestingly Croydon has the lowest female (20.24 95%CI 16.20 – 24.29) under 75 colorectal incidence rate, which is significantly lower than the national average (25.95 95%CI 26.60 – 26.30). All other incidence rates (male and female) are comparable to the London and national average, ranging from 34.03 per 100,000 (95%CI 25.60 – 42.46) in Kingston to 40.36 (95%CI 34.40 – 46.33) in Croydon for men and from 20.24 (95%CI 16.20 – 24.29) in Croydon to 30.91 (95%CI 23.98 – 37.85) in Richmond & Twickenham for women.

Figure 11: Directly age standardised (DSR) under 75 years colorectal cancer incidence, 2004-06.

**Source: Clinical and Health Outcomes Knowledge Base, National Centre for Health Outcomes Development (NCHOD).**

## All age incidence by PCT 2004-06

The all age directly standardised incidence follows a similar pattern as the under 75 incidence with Croydon recording the highest incidence () for males (54.81 per 100,000 95%CI 48.25 – 61.36) and Richmond & Twickenham highest for females (42.34 95%CI 34.99 – 49.69). Again Croydon (30.65 95%CI 26.20 – 35.11) has a female incidence rate which is significantly lower than the national average (36.55 95%CI 36.17 – 36.92).

Figure 12: Directly age standardised (DSR) all ages colorectal cancer incidence, 2004-06.

**Source: Clinical and Health Outcomes Knowledge Base, National Centre for Health Outcomes Development (NCHOD).**

All other incidence rates (male and female) are comparable to the London and national average, ranging from 48.43 per 100,000 (95%CI 39.10 – 57.77) in Kingston to 54.81 (95%CI 48.25 – 61.36) in Croydon for men and from 30.65 (95%CI 26.20 – 35.11) in Croydon to 42.34 (95%CI 34.99 – 49.69) in Richmond and Twickenham for women.

## All age incidence by PCT 1993-2006 (3-year rolling average)

The trend over time seen for males () is characterised by an initial increase to a peak followed by a substantial decrease before the rate increases again. The timeline of change varies from PCT to PCT. The male incidence rate in Kingston has substantially decreased since 1999-01 (after the largest increase from 1993-95), from 68.60 per 100,000 to 48.43 in 2006. Croydon has followed a similar pattern with a peak reached 2 years earlier (compared to Kingston) at 56.53. However since 2001-03 the male all age colorectal incidence rate in Croydon has been increasing sharply from a low of 43.09 in 2001-03 to 54.81 in 2004-06. Wandsworth PCT also experienced a rise in incidence followed by a decrease but not a subsequent rise, levelling off at 50.55 in 2004-06. The latest figures (2004-06) show that all SWL PCTs have a 3-year rolling average all age incidence rate below the national average (56.54). However, compared to the London average (48.99) only Kingston has an incidence rate (41.82) below it.

Figure 13: Male directly age standardised (DSR) all ages colorectal cancer incidence, 1993- 2006 3-year rolling average.

**Source: Clinical and Health Outcomes Knowledge Base, National Centre for Health Outcomes Development (NCHOD).**

Female incidence () does not show such a large variation over time compared to male incidence. Only Wandsworth shows an erratic trend, decreasing to a low of 28.63 in 1997-99 before increasing to 38.91 in 2004-06. Richmond & Twickenham has experienced a steady increase since 1997-99, from 36.16 to 42.34 in 2004-06. The same can be said of Kingston increasing from 36.62 in 1997-99 to 41.43 in 2004-06. Contrastingly Croydon has witnessed a steady decline in female incidence rates since 1996-98, decreasing from 39.47 to 30.65 in 2004-06. Differently to males all PCTs (except Croydon) have an incidence rate higher than national average (36.56) as well as the London average (33.59).

Figure 14: Female directly age standardised (DSR) all ages colorectal cancer incidence, 1993-2006 3-year rolling average.

**Source: Clinical and Health Outcomes Knowledge Base, National Centre for Health Outcomes Development (NCHOD).**

# Colorectal Cancer Prevalence 2006

Cancer prevalence refers to the number of people who have previously received a diagnosis of cancer and who are still alive at a given time point. Some of these patients will have been cured and others will not. Therefore prevalence reflects both the incidence of cancer and its associated [survival](http://info.cancerresearchuk.org/cancerstats/incidence/prevalence/ssLINK/news-survival) pattern.

## One-year prevalence by Cancer Network

In 2006 the SWLCN had the highest male age standardised prevalence of colorectal cancer in London at 40.0 per 100,000 population (), however the confidence intervals are wide. In terms of actual numbers the highest prevalence is also in SWL.

Table 1: Male age standardised colorectal cancer prevalence, 2006.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cancer Network | No. of patients | Crude Prevalence | ASP\* | 95% Lower CI | 95% Upper CI |
| SWLCN | 304 | 39.7 | 40.0 | 35.4 | 44.5 |
| WLCN | 276 | 30.1 | 32.7 | 28.8 | 36.6 |
| NLCN | 248 | 33.1 | 35.2 | 30.8 | 39.7 |
| NELCN | 224 | 29.2 | 33.0 | 28.6 | 37.4 |
| SELCN | 251 | 33.0 | 36.0 | 31.4 | 40.5 |
| England | 12,066 | 48.4 | 40.1 | 39.4 | 40.8 |

\*Age standardised prevalence

**Source: National Cancer Intelligence Network (2010c).**

Female prevalence for colorectal is also highest in SWL at 24.7 per 100,000, but again the confidence interval is wide (). In terms of actual burden the greatest numbers are in also SWL.

Table 2: Female age standardised colorectal cancer prevalence, 2006.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cancer Network | No. of patients | Crude Prevalence | ASP\* | 95% Lower CI | 95% Upper CI |
| SWLCN | 257 | 32.0 | 24.7 | 21.4 | 27.9 |
| WLCN | 226 | 24.5 | 22.5 | 19.4 | 25.5 |
| NLCN | 196 | 25.2 | 21.7 | 18.5 | 25.0 |
| NELCN | 192 | 24.7 | 21.2 | 18.0 | 24.4 |
| SELCN | 198 | 25.4 | 22.4 | 19.1 | 25.7 |
| England | 9,340 | 36.2 | 25.0 | 24.4 | 25.5 |

\*Age standardised prevalence

**Source: National Cancer Intelligence Network (2010c).**

# Colorectal Cancer Staging 2003-07

The staging data presented reveals that the availability of information on staging, for a cancer at registration is not always present for analysis. Note that this point refers to the availability of information to the Thames Cancer Registry (TCR) for analysis and differs from stating that staging of tumours is not occurring and that medical notes are insufficient. Specifically where the proportion of cases staged by the TCR is low (e.g. SWLCN at 55%), it will be due to the low ascertainment of information used to construct the TCR stage. This is due to the information not being available at the time of registration. It is possible that further information may be added at a later date. This may come from the initial hospital visited or another hospital subsequently visited, for example, in the process of treatment. The sources of information for the TCR are:

* Medical notes
* Pathology
* Electronic data sent by trust (only occurs at some trusts)

Ultimately if the information (listed above) is not available or it is not immediately apparent in the medical notes, then constructing a TCR stage at diagnosis is not possible. Given the extent of paper medical notes possible for each patient, the TCR cannot invest inordinate amounts of time examining every piece of medical notes for each patient. It must be emphasised that the lack of staging data (as reflected in the SWLCN 2007 average proportion – 55%) is due to processes in the ascertainment of the data. It does not mean that the patients did not have their disease staged by their clinician(s) (Thames Cancer Registry 2010a).

The Thames Cancer Registry staging system is as follows:

Table 3: Thames Cancer Registry four level staging system.

|  |  |
| --- | --- |
| **Stage** | **Description** |
| 1 | Local (tumour confined to organ of origin). |
| 2 | Direct extension (tumour has extended into surrounding tissues and organs). |
| 3 | Nodal involvement (local nodes are involved). |
| 4 | Metastases (distant metastases are present). |

**Source: Thames Cancer Registry (2009).**

## PCT staging

Across the SWLCN, staging of colorectal cancer is distributed more widely across the groups compared to other cancers reported here. Wandsworth PCT shows higher female diagnosis at stage 4 for colorectal cancer and stage 2 for men. The highest proportion for Kingston is at stage 2 for males (23.7%) and at stage 3 for women (21.5%). Richmond & Twickenham show largest proportions at stage 4 for both male (25.1%) and female (22.0%). Similarly Sutton & Merton have most (besides ‘Not Known’) men and women presenting at stage 4 ().

Figure 15: Percentage of colorectal cancer incidence by stage (NK = Not Known) 2003-07 (PCT).

**Male Female**

**Source: Thames Cancer Network (2009).**

Croydon PCT stands out as where the TCR was unable to stage a large proportion of colorectal cancer cases, nearly half for both men and women. In fact Croydon PCT accounts for well over half (58.3%) of all non staged colorectal cancers in the SWLCN area. Consequently the proportion of malignant cancers within each stage group is low for Croydon. The next highest PCT with tumours unable to be staged is Sutton and Merton with 29.1% of male cancers and 33.8% of female cancers not staged.

## SWLCN staging

During 2003-07 there were 3,998 new incidences of colorectal cancer in the SWLCN area. Two thousand and seventy-four of these were male and 1,924 were female. shows male and female colorectal cancer incidence proportions by stage.

Figure 16: Percentage of colorectal cancer incidence by stage (NK = Not Known) 2003-07.

**Male Female**

**Source: Thames Cancer Network (2009).**

The distribution of the proportions of colorectal staging is more evenly distributed across each staging group compared to lung and breast cancer. The highest proportions of colorectal cancers that have been staged are seen at stage 4. Nearly 20% of colorectal cancers in SWLCN were assessed to be stage 4 at the time of diagnosis compared to 22.6% across London and 21.6%. There is very little difference between males and females in the proportions for stage 4. However, for SWL the next highest proportion is recorded at stage 2 for colorectal cancers in men at 18.0%, then stage 1 at 16.4%. For women the next highest proportion (after stage 4) is recorded for stage 1 colorectal cancers at 17.1% followed by stage 2 at 16.2%. Recorded proportions of stage 2 colorectal cancers, for males and females, are higher in SWL (17.2%) compared to London (15.0%) and SEE (14.6%).

The proportion of colorectal cancers that have not been staged are lower compared to lung and breast cancer staging but it is still the largest group. The SWLCN area shows the highest proportion of colorectal cancers not staged for men at 29.6%, with London being highest for women at (30.1%).

# Colorectal Cancer Survival

The Cancer Reform Strategy (Department of Health 2007) emphasizes the importance of diagnosing cancer early by screening, raising public awareness of signs and symptoms of cancer and minimising delays in investigation and referral. The overarching goal of NAEDI is to promote earlier diagnosis of cancer and thereby improve survival rates and reduce cancer mortality. Survival data is provided by the Thames Cancer Registry, which was obtained from the NCIS.

## One-year relative survival by PCT and Cancer Network 2002-07

The Cancer Reform Strategy (Department of Health 2007) acknowledges the lack of data concerning the staging of cancers and suggests that one-year cancer survivals rates are a good proxy for late presentation of cases. The survival analysis was based on a cohort of cancer patients aged between 0 and 99 years, diagnosed between 2002 and 2006, and follow-up was to the end of 2007. The cohort approach was used to estimate the relative survival.

Broken down by PCT, Sutton & Merton PCT (71.4% 95%CI 68.1 – 74.7) has the lowest colorectal cancer one-year (persons) survival rate (). Croydon PCT records the highest survival rate at 74.5% (95%CI 70.9 – 78.2), however the confidence intervals are wide indicating there is not much variation between PCTs.

Figure 17: Persons one-year (2002-07) estimated relative survival rates for colorectal cancer by PCT.

**Source: NCIN/APHO/UKACR from Cancer e-Atlas 2010.**

The NCIN have developed benchmarks of good performance on cancer one-year survival rates. They are based on data from the EUROCARE-4 study (Department of Health 2009). However there is not a benchmark for colorectal cancer, only colon cancer, also benchmarks are not available by gender. However the Thames Cancer Registry follows NCIN advice and compares against similar countries to the UK in the absence of a benchmark. Finland, Norway and Sweden were selected as these countries have similar cancer registration features and access to death certification data as the United Kingdom (Thames Cancer Registry 2010b). The column identified as ‘UK England’ is taken from the Eurocare study which looked at data from 1995 to 1999. The column marked ‘England’ is taken from the NCIS and is included in the TCR 2007 annual report and is calculated from data between 2002 and 2007. Although caution must be employed as these figures have been estimated from two different sources and time periods, it does allow comparison with European countries. It also shows the improvement in survival at the England level.

shows that 76.9% (95%CI 74.8 – 79.1) of males diagnosed with colorectal cancer between 2002 and 2006 were still alive a year later in the SWLCN area. This is the highest survival rate of all London cancer networks, and is significantly higher than all networks except the SELCN. The male relative survival rate in the SWLCN is also significantly higher than the England and London averages. In relation to the EUROCARE-4 countries, the SWLCN one-year survival rate is below all 3 countries; however SWLCN is only slightly below the male one-year survival rate in Norway (77.3% 95%CI 76.7 – 77.8).

Figure 18: Male one-year (2002-07) estimated relative survival rates for colorectal cancer by cancer network with selected EUROCARE-4 study countries.

**Source: Cancer in South East England 2007 Report, Thames Cancer Registry, 2010.**

Female one-year survival rates are less compared to males. The SWLCN female relative survival rate (71.2% 95%CI 68.9 – 73.4) is again higher than all other networks in London. The rate is significantly higher than the England (70.8% 95CI 70.4 – 71.2) average (). The gap between the SWLCN one-year survival rate for women and the EUROCARE-4 countries is larger compared to men, with Norway the closest at 77.1% (95%CI 76.6 – 77.7).

Figure 19: Female one-year (2002-07) estimated relative survival rates for colorectal cancer by cancer network with selected EUROCARE-4 study countries.

**Source: Cancer in South East England 2007 Report, Thames Cancer Registry, 2010.**

Providing comparisons and a benchmark to aim for is valid. The difference in survival rates between the UK and European rates may not only be due to later presentation in the UK but also additional factors such as data quality, tumour-related factors, host factors and healthcare-related factors (Thomson and Forman 2009, Brewster 2010). However comment and research does state that poor survival in the UK compared to other European countries is associated with more advanced stage at presentation ([Imperatori](http://thorax.bmj.com/search?author1=A+Imperatori&sortspec=date&submit=Submit) et al. 2006, Richards 2009, Brewster 2010, Crawford 2010).

## Five-year relative survival PCT and Cancer Network

Sutton & Merton PCT has the highest 5-year relative survival rate at 56.0% (95%CI 51.6 – 60.3) (). Wandsworth has the lowest survival rate at 44.0% (95%CI 38.2 – 49.7), this is significantly lower than the national. Due to small numbers of colorectal cancer incidence occurring at a PCT level, survival rates at PCT level are calculated on a 5-year rolling average as opposed to 3 years at sector level. Also PCT data shown is for a different time period to the sector data below ().

Figure 20: All persons five-year (1998-2002) estimated relative survival rates for colorectal cancer by PCT.

**Source: NCIN/APHO/UKACR from Cancer e-Atlas 2010.**

Five year cohort relative survival estimates for persons have been extracted from the Cancer Information Service (CIS) database by rolling 3 year cohorts (1990-1992, 1991-1993 ... 1999-2001) for cancer networks (CNs). The survival estimates from CIS relates to the June 2008 data submission by Registries to CIS, which contains follow up on death information to the end of 2006.

The SWLCN has the highest 5-year colorectal cancer relative survival in the London area at 52.7% (). It is also slightly higher than the national average at 51.7%. Confidence intervals were not available. The lowest estimated survival rate is in the Kent & Medway CN at 43.4% while the lowest in London is the NELCN at 45.8%.

Figure 21: All persons five-year estimated relative survival rates for colorectal cancer by cancer network.

**Source: National Cancer Information Service, Cancer Commissioning Toolkit.**

# Colorectal Cancer Mortality

## Under 75 mortality by PCT 2006-08

reveals similar male mortality patterns to the pattern of male colorectal cancer incidence with Wandsworth recording the highest rate at 13.57 per 100,000 population (95%CI 8.97 – 18.18) and Kingston the lowest at 10.14 (95%CI 5.57 – 14.70). Wandsworth also records the highest mortality rate for females at 9.42 (95%CI 5.84 – 13.00) as well as Kingston having the lowest rate at 6.60 (95%CI 3.10 – 10.10). For colorectal cancer incidence Kingston records the highest rate. Due to a small number of deaths the confidence intervals are wide, revealing no significant differences between PCTs or regional and national averages.

Figure 22: Directly age standardised (DSR) under 75 years colorectal cancer mortality, 2006-08.

**Source: Clinical and Health Outcomes Knowledge Base, National Centre for Health Outcomes Development (NCHOD).**

## All ages mortality by PCT 1993-2008 (3-year rolling average)

and shows all age colorectal cancer mortality for males and females over time. The male trend overall shows a decrease in mortality with large increases for Kingston and a smaller increase for Croydon at the beginning of the time period. Kingston has experienced a sharp decrease in mortality since 2004-06, from 22.55 per 100,000 to 16.24 in 2006-08. Currently (2006-08) all PCTs in SWL have a mortality rate below the national average for colorectal cancer (22.19). Only Kingston has a rate below the London average (20.12) for males.

Figure 23: Male directly age standardised (DSR) under 75 years colorectal cancer mortality, 1993-2008 3-year rolling average.

**Source: Clinical and Health Outcomes Knowledge Base, National Centre for Health Outcomes Development (NCHOD).**

The pattern for female mortality is less clear () with a number of PCTs showing erratic trends (Richmond & Twickenham, Kingston and Wandsworth). The latest data (2006-08) shows that Kingston (12.34) and Sutton & Merton (15.58) have mortality rates higher than the national average (14.08), while Croydon (17.21) in addition (to Kingston and Sutton & Merton) record a rate above the female London average (16.49). All PCTs record a lower female mortality rate than at the beginning of the time period.

Figure 24: Female directly age standardised (DSR) under 75 years colorectal cancer mortality, 1993-2008 3-year rolling average.

**Source: Clinical and Health Outcomes Knowledge Base, National Centre for Health Outcomes Development (NCHOD).**

All age mortality trend data has not been included as the same trends seen above is revealed.

## All age mortality by PCT 2006-08

As with incidence, male all age colorectal cancer mortality follows a similar pattern as the under 75 mortality rate, with Wandsworth (21.36 95%CI 16.07 – 26.66) recording the highest mortality and Kingston (16.24 95%CI 11.00 – 21.48) the lowest (). The highest all age mortality rate for females is at Sutton & Merton (15.58 95%CI 12.72 – 18.44) but this is only slightly higher than Wandsworth (14.57 95%CI 10.70 – 18.44), which also records the highest under 75 years old mortality for colorectal. The lowest all age female mortality as in Kingston at 12.34 per 100,000 population (95%CI 8.35 – 16.33).

Figure 25: Directly age standardised (DSR) all ages years colorectal cancer mortality, 2006-08.

**Source: Clinical and Health Outcomes Knowledge Base, National Centre for Health Outcomes Development (NCHOD).**

# Emergency Admissions

Emergency admissions are a reflection that patients may not be getting diagnosed or treated at an early stage of their cancer, thus it may be an indicator of late presentation, late diagnosis and entry to treatment not through primary care (National Cancer Intelligence Network 2009a). Over the past eight years, although elective day case episodes (usually for chemotherapy) have risen, inpatient admissions for cancer have also risen by 25% (nationally). Most of this increase relates to emergency cancer inpatient episodes and emergency bed days are rising by 2.5% each year. A number of emergency admissions are due to the side effects of treatment, for example chemotherapy, or radiotherapy, or due to progressive disease (NHS Cancer Commissioning Toolkit 2010).

## All cancer emergency admissions by GP Practice 2008-09

Data in this section include all emergency admissions with an invasive cancer code (ICD-10 C00-C97, excluding C44) present in any diagnostic field and were originally extracted from the national HES database. Data by cancer site was not available. The figures are crude rates expressed per 100,000 persons of emergency in-patient or day-case admissions. As these are crude rates it is not suitable to compare between PCTs. Emergency admissions may occur at any stage of the cancer pathway and will include persons diagnosed with cancer in prior years. This indicator may be expected to be higher in practices with an unusually high fraction of persons of 65+ years of age, due to the higher incidence of cancer at these ages. This must be considered when/if GP practices with high rates are investigated. Where the number of referrals for a GP practice was less than 5, no rate has been released nor has the GP practice been identified.

* + 1. **Croydon**

shows the variation in emergency admissions by GP practice across Croydon PCT. The highest admission rate is 1349.21 per 100,000 population (95%CI 1004.49 – 1774.00) at practice H83029 and is significantly higher than the PCT average (610.41 95%CI 585.49 – 636.12). Six other GP practices record admission rates significantly higher than the PCT average. They are practices H83619, H83031, H83033, H83019, H83050 and H83015.

**Figure 26: Croydon all cancer emergency admissions crude rate per 100,000 population.**

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

The lowest admission rate is 146.88 per 100,000 population (95%CI 53.63 – 319.70) at practice H83041. This rate is also significantly lower than the PCT average. A further three GP practices record cancer admission rates significantly below the PCT average; they are H83051, H83625 and H83025. One GP practice records less than five admissions over 2008-09.

* + 1. **Kingston**

Five GP practices, H84015, H84049, H84607, H84053 and H84033 record an all cancer emergency admission rate that is significantly higher than the PCT average which is calculated at 506.50 per 100,000 population (95%CI 472.50 – 542.27). The highest rate is 1359.91 per 100,000 (95%CI 1090.65 – 1675.48) at practice H84015 ().

**Figure 27: Kingston all cancer emergency admissions crude rate per 100,000 population.**

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

The lowest admission rate is 200.32 per 100,000 population (95%CI 64.56 – 467.48) at practice Y02379. This rate is also significantly lower than the PCT average. A further three GP practices record cancer admission rates significantly below the PCT average; they are H84020, H84025 and H84619. One GP practice records less than five admissions in 2008-09.

* + 1. **Richmond & Twickenham**

Richmond & Twickenham has an average cancer admission rate of 536.97 per 100,000 population (95%CI 505.10 – 570.33) (). Four GP practices record admission rates significantly higher than the PCT average. These practices include; H84060, H84018, H84031 and H84032. The highest admissions rate was 1272.17 per 100,000 population (95%CI 993.53 – 1604.70) at practice H84060.

**Figure 28: Richmond & Twickenham all cancer emergency admissions crude rate per 100,000 population.**

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

The lowest admission rate was 246.36 per 100,000 population (95%CI 127.15 – 430.36) at practice H84625. This rate was significantly lower than the PCT average. Two other GP practices also record an admission rate significantly below the PCT average; they are H84005 and Y01206. Two GP practices recorded less than five admissions.

* + 1. **Sutton & Merton**

shows the variation in cancer emergency admissions by GP practice across Sutton & Merton PCT. The highest admission rate was 1858.19 per 100,000 population (95%CI 1314.79 – 2550.60) at practice H85108 and is significantly higher than the PCT average (634.87 95%CI 609.88 – 660.63). A further seven GP practices record admission rates significantly higher than the PCT average. They are practices H85110, H85683, H85032, H85653, H85038, H85030, and H85037.

**Figure 29: Sutton & Merton all cancer emergency admissions crude rate per 100,000 population.**

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

The lowest admission rate is 88.42 per 100,000 population (95%CI 28.49 – 206.34) at practice H85112. This rate is also significantly lower than the PCT average. Six other GP practices record cancer admission rates significantly below the PCT average; they are, H85022, H85649, H85634, H85027, H85028 and H85686. One GP practice records less than 5 emergency admissions in 2008-09.

* + 1. **Wandsworth**

Wandsworth has an average cancer admission rate of 443.07 per 100,000 population (95%CI 420.53 – 466.51). Six GP practices record admission rates significantly higher than the PCT average (). These practices include; H85006, H85643, H85005, H85067, H85008 and H85045. The highest admissions rate was 840.49 per 100,000 population (95%CI 615.29 – 1121.13) at practice H85006.

**Figure 30: Wandsworth all cancer emergency admissions crude rate per 100,000 population.**

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

Two GP practice recorded no emergency admissions for 2008-09. The lowest rate was 171.56 per 100,000 population (95%CI 98.00 – 278.63) at practice Y01132. This rate was significantly below the PCT average. Four other practices, H85012, H85049, H85680 and H85048 also recorded an emergency admission rate below the PCT average.

## Lower GI cancer emergency bed days PCT and Cancer Network 2007-08

PCTs, supported by cancer networks, should ensure that emergency bed usage is minimised by the provision of individualised patient care, including a specialist out of hours service and effective community support. This indicator, which measures the number of emergency bed days for cancer per head of unified weighted population, is an indicator for local action in the "Vital Signs".

By PCT, figures vary from the lowest at 383 in Kingston to the highest at 448 in Sutton & Merton. This shows that each PCT in SWL has a rate higher than the national average. Compared to all the cancer networks in London the SWLCN records the highest number of emergency bed days per 100,000 weighted population at 404 per 100,000. The SWLCN sector also records the highest emergency bed days for lung and breast cancer. This is also higher than the national average at 374 per 100,000 ().

Figure 31: Lower GI cancer emergency bed days per 100,000 weighted population, 2007-08.

**Source: National Cancer Services Analysis Team (NatCanSAT) from Hospital Episode Statistics (HES).**

# Colorectal Cancer Referrals

## Urgent two week wait (2WW) referrals with suspected lower GI cancer 2009 by GP Practice

Patient level Cancer Waiting Times data (including patient identifiers) was sourced from the Department of Health Cancer Waiting Times Database by the Trent Cancer Registry. Each patient was traced to a GP Practice using the Open Exeter Batch Tracing Service Two Week Wait Referrals were identified for patients with a date first seen on the CWT database in 2009. All records with a ‘Referral Priority Type’ of ‘3’ (Two Week Wait) and a ‘Cancer Referral Type’ of ‘07’ (Suspected Lower GI Cancer) were included. The data included the number of Two Week Wait referrals with a suspicion of lower GI cancer, whether or not cancer was subsequently diagnosed. This indicator may be expected to be higher in practices with an unusually high proportion of persons of 65+ years of age, due to the higher incidence of cancer at these ages. In many cases the number of referrals will be small resulting in large confidence intervals. Where the number of referrals for a GP practice was less than 5, no rate has been released nor has the GP practice been identified.

### Croydon

The average 2WW crude referral rate for suspected lower GI cancer in Croydon for 2009 was 137.60 per 100,000 population (95%CI 125.90 – 150.09) (). Six GP practices, H83035, H83048, H83009, H83016 H83015, and H83024, record a referral rate that is significantly higher than the PCT average. The highest referral rate is 431.03 per 100,000 population (95%CI 246.21 – 700.18) at practice H83035.

Figure 32: Croydon urgent 2WW referrals with suspected lower GI cancer, crude rate per 100,000 population.

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

Nine GP practices recorded no referrals for suspected lower GI cancer in 2009. A further eighteen practices recorded less than five referrals. These practices are not featured in . No GP practice records a referral rate significantly below the PCT average.

### Kingston

Two GP practices in Kingston record a suspected lower GI cancer referral rate that is significantly higher than the PCT average. These two GP practices are H84008 and H84034. The PCT average rate is 206.90 per 100,000 population (95%CI 185.39 – 230.21) (). Two GP practices H84008 and H84034, stand out from the other GPs in Kingston with much higher referral rates at 780.94 per 100,000 population (95%CI 557.85 – 1063.46) and 540.54 per 100,000 (391.15 – 728.13) respectively.

Figure 33: Kingston urgent 2WW referrals with suspected lower GI cancer, crude rate per 100,000 population.

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

The lowest referral rate was 81.39 per 100,000 population (95%CI 46.49 – 132.18) at practice H84020. This is the only GP practice in Kingston recording a rate significantly below the PCT average. One GP practice records no referrals while another two record less than 5 referrals for the whole of 2009.

### Richmond & Twickenham

The average 2WW crude referral rate in Richmond & Twickenham for 2009 was 205.55 per 100,000 population (95%CI 186.02 – 226.58) (). Three GP practices, H84615, H84007 and H84623, record a referral rate that is significantly higher than the PCT average. The highest referral rate is 713.21 per 100,000 population (95%CI 429.20 – 1113.83) at practice H84615.

Figure 34: Richmond & Twickenham urgent 2WW referrals with suspected lower GI cancer, crude rate per 100,000 population.

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

One GP practice, does not record any suspected lower GI cancer referrals for 2009. A further six GP practices record less than 5 referrals in the year. The lowest referral rate was 81.71 per 100,000 population (95%CI 35.18 – 161.01), a rate significantly below the PCT average. Two other GP practices record suspected lower GI cancer referral rates significantly below the PCT average. The two practices are H84005 and H84023.

### Sutton & Merton

The average 2WW crude referral rate in Sutton & Merton for 2009 was 162.77 per 100,000 population (95%CI 150.24 – 176.07) (). Four GP practices, H85076, H85030, H85035 and H85024, record a referral rate that is significantly higher than the PCT average. The highest referral rate is 353.96 per 100,000 population (95%CI 243.61 – 497.11) at practice H85076.

Figure 35: Sutton & Merton urgent 2WW referrals with suspected lower GI cancer, crude rate per 100,000 population.

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

Two GP practices recorded no referrals for suspected lower GI cancer in 2009 and eight GP practices recorded less than five referrals over 2009. The lowest generated rate was 62.71 per 100,000 population (95%CI 22.90 – 136.50) at practice H85693 and was significantly lower than the PCT average. Two other GP practices (H85115 and H85649) recorded referral rates significantly below the PCT average.

### Wandsworth

Three GP practices in Wandsworth record a suspected lower GI cancer referral rate that is significantly higher than the PCT average. These practices are H85052, H85006 and H85003. The PCT average is 142.48 per 100,000 population (95%CI 129.82 – 156.04) (). The highest suspected lower GI cancer referral rate was 348.50 per 100,000 population (95%CI 202.90 – 558.02) at practice H85052.

Figure 36: Wandsworth urgent 2WW referrals with suspected lower GI cancer, crude rate per 100,000 population.

**Source: Practice Profiles, NHS Cancer Commissioning Toolkit.**

Seven GP practice did not record any lower GI cancer referrals for 2009, while a further nine GP practices recorded less than five referrals in the year. The lowest generated referral rate was 45.38 per 100,000 population (95%CI 14.62 – 105.90) at practice H85009. Along with practice H85061 the referral rates recorded were significantly below the PCT average.

## Proportion of colorectal cancer cases diagnosed through non-urgent referral by PCT and Cancer Network 2010

In general, the earlier a cancer is diagnosed, the greater the prospect of a cure. Evidence suggests that later diagnosis of cancer has been a major factor in the poorer survival rates in the UK compared with some other countries in Europe. One of the priorities of the Cancer Reform Strategy for England, is to diagnose more cancers early. The proportion of cases of cancer diagnosed through the urgent two week wait programme (2WW) is an indicator of GPs' recognition of the signs and symptoms of cancer and appropriateness of the referral. There is wide variation across the country in the percentage of cases diagnosed through non urgent referral routes. If relatively high numbers of patients are diagnosed through non urgent referrals, this would merit investigation by the PCT (Cancer Commissioning Toolkit 2010).

Figure 37: Percentage of total colorectal cancer cases diagnosed through non-urgent referral, 2010.

**Source: National Cancer Waiting Times database (CWT-db).**

Wandsworth records the highest proportion of diagnosed colorectal cancer cases through non-urgent referrals at 61.9% (). This is very high relative to the national average at 46.0%. Sutton & Merton, Richmond & Twickenham and Croydon have proportions above 50%. Kingston records the lowest proportion of non-urgent referrals at 40.7%. In terms of cancer networks the SWLCN has one the of the highest proportions of non-urgent referrals in the country at 54.3%. There was no data available for the (N)WLCN.

## Urgent 2 week referrals resulting in lower GI cancer diagnosis (‘The Hit Rate’) by PCT and Cancer Network 2010

This section looks at the percentage of suspected lower GI cancer 2WW referrals that result in an actual diagnosis of lower GI cancer.

The proportion of cases of cancer diagnosed through the two week wait programme (2WW) is an indicator of GPs' recognition of the signs and symptoms of cancer and appropriateness of the referral.

The proportion of urgent 2 week suspected lower GI () cancer referrals resulting in a diagnosis of cancer in the SWLCN (8.9%) is similar to the national average (8.8%). The rate in SWLCN is the highest in London. Within the SWLCN Croydon PCT records the highest percentage of referrals resulting in lower GI cancer at 11.1%, while Wandsworth records the lowest at 6.1% The PCTs of Croydon, Kingston (9.8) and Sutton & Merton (9.2) exceed the national average.

Figure 38: Percentage of urgent lower GI cancer referrals diagnosed with colorectal cancer.

**Source: National Cancer Waiting Times database (CWT-db).**

Although not a Department of Health standard, this metric demonstrates the percentage of two week referrals (TWR) found to have cancer, and may be indicative of the quality of service provided by local organisations. If the benchmarked data show the organisation within the lower quartile (i.e. a smaller proportion of patients referred as TWR are diagnosed with cancer than other organisations) then questions could be asked about the interpretation of the TWR NICE Referral Guidelines by primary care. In addition local secondary care teams could be asked to audit the appropriateness of all TWR referrals received (NHS Cancer Commissioning Toolkit 2010). Only Wandsworth PCT in SWL appears in the lowest quartile, while SWLCN as a whole appears in the inter-quartile range, i.e. the 2 middle quartiles.

# Primary Care Audit 2010

The Cancer Reform Strategy 2007 proposed undertaking a national audit in primary care of newly-diagnosed cancers, to inform decisions about how best to support primary care professionals and ensure the earliest diagnosis. During the period April-June 2010 the SWLCN undertook such an audit. A person’s cancer pathway begins when they recognise and then act on signs and symptoms. A person who has a type of cancer with easily recognisable symptoms will present sooner. For example, breast cancer signs are more recognisable than those of colon cancer. Sometimes, despite recognising symptoms, people are reluctant to present to primary care. The audit covered 39 practices across South West London. Ninety-six cases of colorectal cancer were found accounting for 14% of all cancer incidence found in the audit. An even distribution across the possible stages at diagnoses of colorectal was reported, with 30% (29 cases) of cases staged at ‘organ’, 29% (28) at local spread’ and 28% (27) at ‘distant metastases’. Thirteen percent (12) were classed as ‘Not known’ or ‘Not stated’. Due to small numbers the findings presented here are a mixture of colorectal cancer specific figures as well as data aggregated for all cancers.

Of all the cancer patients found in the audit 46% (299 cases) were 2 week referrals, which is similar to the average (45%) recorded across England for 2009-10. Fourteen percent (89) were emergency cases and 15% (101) were classed as routine. The number of emergency cases appears excessive (compared to other networks); this may be due to occurrences of patients that did not visit the GP but were admitted to hospital via A&E being recorded as emergency cases. The correct definition in relation to GPs is only those patients that visit the GP and are immediately (same day) referred to the acute trust. Consultation with participating GPs and the lead GP for the SWLCN audit confirmed this ambiguity had arisen (SWLCN 2010).

Twelve percent (81) were not referred by the practice. Overall 146 cases (22%) were identified as cases where an avoidable delay had occurred.

The median time for patients noticing and reporting symptoms of colorectal cancer were 16 days, while the median time between reporting symptoms to a GP referral to secondary care was 1 day with the median time from referral to first visit to secondary care being 12 days. Comparisons with other cancers are shown in .

Figure 39: Median times from patients noticing and reporting symptoms to first being seen in secondary care.

**Source: SWLCN Primary Care Audit 2010.**

## Avoidable delays (all cancers)

The audit identified **146** cases of avoidable delays as assessed by the auditing GP. Of these:

* **31%** (45 cases) due to patient delaying first presentation, investigation or hospital referral.
* **11%** (16 cases) could have been referred sooner using 2 week rule.
* **23%** (34 cases) delayed in referral to secondary care, often due to the GP not initially thinking of cancer as a possible diagnosis.
* **9%** (14 cases) delayed due to communication problems between primary and secondary care.
* **18%** (27 cases) delayed after referral to secondary care.
* **7%** (10 cases) delayed due to other causes.

## Colorectal cancer summary

The most common symptoms included rectal bleeding (17 cases, 24% ), change of bowel habit (18 cases, 26%), abdominal pain (15 cases, 21%) and symptoms of anaemia (17 case, 24%). Four patients presented with an abdominal mass. Other less common symptoms were tiredness, vomiting, and bloating.

Thirty-three of the patients (47%) were referred through the 2 week wait rule. Sixteen cases (23%) were referred routinely and 14 cases (20%) were admitted as emergencies. One case of colorectal cancer in an 83 year old female patient with a long standing history of erratic bowel habit- delayed presentation for 1077 days (3 years).

# Cancer Awareness Measure (CAM) Survey in South West London 2010

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This section summarises the findings from research conducted by Ipsos MORI Social Research Institute (2010) and commissioned by the SWLCN on cancer awareness amongst the residents of South West London undertaken between May and August 2010. A total of 5,009 resident people were interviewed across South West London. The majority of South West London residents report having been affected by cancer in some way, either personally or through friends or family having the disease. One in ten residents (12%) has personally had cancer themselves. Specific groups of residents – particularly women, white residents, those aged 45-54 and those from social grades AB – are particularly more likely to have been affected by cancer. Over half of residents (54%) reported having a close family member having had cancer.

Residents mention a range of possible warning signs and symptoms of cancer. One in eight people identified (unprompted) a change in bowel/bladder habits as a possible symptom (the most commonly mentioned was an unusual lump or swelling 59%). Unexplained bleeding featured higher (24%) for unprompted answers, however a change of bowel/bladder habits appeared a more common response when prompted (). In Richmond a fifth (19%) of the population state a change in bowel/bladder habits (unprompted) as a possible warning sign of cancer, while only a tenth does this in Wandsworth. Richmond consistently reports higher proportions of knowledge whereas Wandsworth reports the lowest proportions.

Table 4: Summary of CAM responses (%).

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Warning Signs of Cancer | | SWL | Croydon | Kingston | Merton | Richmond | Sutton | Wandsworth |
| Unprompted | A change in bowel/bladder habits | 12 | 10 | 15 | 10 | 19 | 12 | 9 |
| Unexplained bleeding | 24 | 22 | 25 | 27 | 29 | 23 | 23 |
| Persistent unexplained pain | 20 | 20 | 22 | 21 | 27 | 13 | 20 |
| Unexplained weight-loss | 18 | 20 | 17 | 15 | 22 | 17 | 15 |
| Loss of appetite | 8 | 7 | 8 | 7 | 11 | 7 | 8 |
| Prompted | A change in bowel/bladder habits | 86 | 86 | 85 | 85 | 87 | 90 | 86 |
| Unexplained bleeding | 83 | 81 | 83 | 81 | 87 | 85 | 81 |
| Persistent unexplained pain | 79 | 79 | 79 | 80 | 81 | 79 | 76 |
| Unexplained weight-loss | 83 | 85 | 81 | 80 | 84 | 85 | 80 |
| On noticing a change in bowel/bladder habits, how long to contact Dr. | | | | | | | | |
|  | 1-3 days | 20 | 26 | 15 | 25 | 18 | 14 | 18 |
|  | 4-6 days | 14 | 12 | 15 | 15 | 12 | 16 | 13 |
|  | 1 week | 21 | 19 | 20 | 23 | 20 | 25 | 21 |
|  | 2 weeks | 20 | 17 | 23 | 17 | 21 | 22 | 20 |
|  | 1 month | 13 | 12 | 15 | 12 | 15 | 14 | 13 |
| How much do you agree or disagree, if at all, that each of these can increase the chance of getting cancer?– - Agree | | | | | | | | |
|  | Smoking | 90 | 90 | 93 | 89 | 92 | 93 | 88 |
|  | Eating red or processed meat | 5 | 4 | 6 | 11 | 7 | 1 | 4 |
|  | Drinking alcohol | 41 | 41 | 42 | 49 | 38 | 36 | 39 |
|  | <5 portions of fruit & veg a day | 39 | 37 | 37 | 41 | 45 | 34 | 39 |
|  | Not doing enough exercise | 38 | 33 | 39 | 41 | 39 | 38 | 41 |
| At what age are people first invited for bowel screening? | | | | | | | | |
|  | 60-69 | 36 | 31 | 43 | 33 | 44 | 37 | 33 |
|  | Within 5 years of correct answer | 5 | 4 | 7 | 6 | 3 | 7 | 5 |

The depth of residents’ awareness appears to be quite shallow, with only a relatively small proportion able to identify more than five signs or symptoms of cancer (13%). While prompted awareness of symptoms is significantly higher than unprompted, South West London residents appear to have lower levels of awareness than residents elsewhere in the country. One in five of people would contact a GP practice to make an appointment (20%) within 1-3 days on noticing a change in bowel habits. However one in five would also do so within 2 weeks. Eating red or processed is only seen by 5% or one in twenty of respondents as a possible contributing factor to developing cancer. This varies across PCTs with Merton (11%) and Richmond (7%) significantly higher compared to the sector average. The majority of South West London residents believe that there is an NHS breast cancer screening programme and an NHS cervical cancer screening programme (78% for both), although these figures are lower than for the country as a whole (87% and 84% respectively). In contrast, South West London residents are actually more aware of the NHS bowel cancer screening programme than residents across the country. Regardless, knowledge of this screening programme is much lower than for the other programmes (31%). Awareness of the screening programmes appears to be very much linked to personal experience of cancer and relevance (in terms of gender and age). Just over a third of respondents identified the correct age at which a person is invited for bowel screening.

In almost identical results to residents across the country as a whole, South West London residents clearly believe that breast cancer is the most common form of cancer among women, with over four in five residents believing this to be true (82%). Few residents highlight other cancers, with breast cancer ten times more likely to be mentioned than the next most popular choice. In reality the three most common forms of cancer among women in South West London are breast, colorectal (bowel) and lung cancer.

The results for common cancers among men are slightly more varied, with just under half (48%) thinking that prostate cancer is the most common form, while a quarter of residents (23%) believe that lung cancer is the most common, while one in ten residents (12%) think it is testicular cancer. Only four per cent of residents say they do not know. The three most common forms of cancer among men are prostate, lung and colorectal (bowel) cancer.

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# Conclusion

## GP practice summaries

GP data for the colorectal cancer baseline assessment features all cancer emergency admissions and urgent two week wait referral rates for suspected lower GI cancer.

**Croydon**

Seven GP practices recorded all cancer emergency admission rates significantly higher than the PCT average; they were H83029, H83619, H83031, H83033, H83019, H83050 and H83015. Four GP practices recorded emergency admission rates significantly lower than the PCT average; they were H83041, H83051, H83625 and H83025. Six GP practices, H83035, H83048, H83009, H83016 H83015, and H83024, record an urgent 2WW referral rate for suspected lower GI cancer that is significantly higher than the PCT average. The highest referral rate is 431.03 per 100,000 population at practice H83035. Twenty-seven GP practices recorded zero or less than five referrals in 2009. No GP practice records a referral rate significantly below the PCT average.

**Kingston**

Five GP practices recorded all cancer emergency admission rates significantly higher than the PCT average; they were H84015, H84049, H84607, H84053, and H84033. Four GP practices recorded rates significantly lower than the PCT average; they were Y02379, H84020, H84025, and H84619. Two GP practices in Kingston record a suspected lower GI cancer referral rate that is significantly higher than the PCT average. These two GP practices are: H84008 and H84034. Two GP practices H84008 and H84034, stand out from the other GPs in Kingston with much higher crude referral rates at 780.94 per 100,000 population (95%CI 557.85 – 1063.46) and 540.54 per 100,000 (391.15 – 728.13) respectively. The lowest referral rate was 81.39 per 100,000 population (95%CI 46.49 – 132.18) at practice H84020. This is the only GP practice in Kingston recording a rate significantly below the PCT average.

**Richmond & Twickenham**

Four GP practices recorded all cancer emergency admission rates significantly higher than the PCT average; they were H84060, H84018, H84031 and H84032. Three GP practices recorded emergency rates significantly lower than the PCT average; they were H84625, H84005 and Y01206. Three GP practices, H84615, H84007 and H84623, record a suspected lower GI cancer referral rate that is significantly higher than the PCT average. The highest referral rate is 713.21 per 100,000 population (95%CI 429.20 – 1113.83) at practice H84615. The lowest referral rate was 81.71 per 100,000 population (95%CI 35.18 – 161.01), a rate significantly below the PCT average. Two other GP practices record suspected lower GI cancer referral rates significantly below the PCT average. The two practices are: H84005 and H84023.

**Sutton & Merton**

Eight GP practices recorded all cancer emergency admission rates significantly higher than the PCT average; they were H 85108, H85110, H85683, H85032, H85653, H85038, H85030, and H85037. Seven GP practices also recorded rates significantly lower than the PCT average; they were H85112, H85022, H85649, H85634, H85027, H85028 and H85686. Four GP practices, H85076, H85030, H85035 and H85024, record a urgent 2WW referral rate for suspected lower GI cancer that is significantly higher than the PCT average. The highest referral rate is 353.96 per 100,000 population (95%CI 243.61 – 497.11) at practice H85076. The lowest generated rate was 62.71 per 100,000 population (95%CI 22.90 – 136.50) at practice H85693 and was significantly lower than the PCT average. Two other GP practices (H85115 and H85649) recorded referral rates significantly below the PCT average.

**Wandsworth**

Six GP practices recorded all cancer emergency admission rates significantly higher than the PCT average; they were H85006, H85643, H85005, H85067, H85008 and H85045. Five GP practices recorded admission rates significantly lower than the PCT average; they were Y01132, H85012, H85049, H85048 and H85087. Three GP practices in Wandsworth record a suspected lower GI cancer referral rate that is significantly higher than the PCT average. These practices are H85052, H85006 and H85003. The highest suspected lower GI cancer referral rate was 348.50 per 100,000 population (95%CI 202.90 – 558.02) at practice H85052. The lowest generated referral rate was 45.38 per 100,000 population (95%CI 14.62 – 105.90) at practice H85009. Along with practice H85061 the referral rates recorded for these two practices were significantly below the PCT average.

## PCT summaries

Detailed figures of each PCT are shown in the matrix below ().

**Croydon**

Croydon has the lowest estimated fruit and vegetable consumption in SWL since the estimates are based on population parameters such as deprivation, i.e. Croydon experiences the highest and most widespread deprivation in SWL. After Sutton, Croydon has the highest projected proportion of people aged 65 and over.

Croydon has the second lowest bowel screening uptake rate. Croydon has the highest male incidence of colorectal cancer in SWL, however it is not a statistically significant difference compared to the national and London averages. Contrastingly, female incidence is the lowest in SWL and is significantly lower than the national average. Almost half of male and female cases were not staged by the Thames Cancer Registry (TCR) therefore it is not appropriate to comment on the impact of staging. Croydon does have the highest one-year survival rate while the male mortality rate is one of the highest in SWL and female mortality is one of the lowest in SWL. The reduction in mortality since 1993-95 has been nearly 20% for males and 27% for females. Following the overall trend in SWL Croydon has an emergency bed day rate that is above the national average by 10%. The crude rate for all cancer emergency admissions was 610.41 per 100,000 population. There were 52.8% of diagnosed lower GI cancer cases that were considered to be non-urgent, a rate above the national average. The average 2WW crude referral rate for suspected lower GI cancer in Croydon for 2009 was 137.60 per 100,000 population. Eleven percent of urgent referrals result in a colorectal cancer diagnosis, a higher rate than the national average.

**Kingston**

In Kingston the estimated fruit and vegetable consumption is amongst the highest in SWL while prevalence of binge drinking is estimated to be significantly below the national average. Kingston has a low number of areas considered to be deprived, while the proportion of the population aged 65 and over is at 12.0%, comparable to the other PCTs (except Wandsworth) in SWL.

Also similar to the other PCTs in the sector Kingston’s bowel screening uptake rate is below the national average and well below the 60% target. Male incidence is the lowest in SWL, however the difference is not significantly different, while female incidence is mid-ranged. Staging data for Kingston (as for all other PCTs except Croydon) is more evenly distributed compared to lung and breast cancer cases. Only 23% of cases are not staged by the TCR. The highest proportion is seen at stage 2 (over 20%) for both male and female while 17-18% are diagnosed at stage 4. The one-year survival rate is one of the highest in SWL at 73.8%, while the male and female mortality rate is the lowest in SWL. However since 1993-95 Kingston has achieved the lowest reduction in male (all ages) mortality at 13.8%, while female all age mortality has decreased by 32.0%, the highest reduction in SWL. Kingston also records the lowest emergency bed day rate at 383 per 100,000 but it is still higher than the national average. The crude rate for all cancer emergency admissions was 506.50 per 100,000 population. Kingston had the lowest proportion of diagnosed lower GI cancer cases through non-urgent referrals in SWL at 40.7%. The PCT average urgent 2WW suspected lower GI referral rate is 206.90 per 100,000 population. Nearly 10% of urgent referrals result in a cancer diagnosis, a proportion above the national average.

**Richmond & Twickenham**

As fruit and vegetable estimates are based on population characteristics it is estimated that people in Richmond & Twickenham consume the most in SWL at 37.1%. It is the least deprived PCT in the sector with only 4% of small areas classed as high deprivation. Besides Wandsworth (which has a relatively young population) Richmond & Twickenham is projected to experience the least increase in the 65 and over population, about half of the other PCTs (except Wandsworth) in SWL. This is despite currently having a proportion of 65s and over similar to the other PCTs (except Wandsworth).

Richmond & Twickenham record the highest bowel screening uptake in SWL but is still below the national average and target uptake. Male and female incidence are the highest in SWL, however the confidence intervals are wide. The majority of colorectal cancers in Richmond & Twickenham have been staged at stage 4 for both male (25.1%) and female (22.0%). Only 11.7% of male tumours were diagnosed at stage 1, while female staging fairs better at 19.5% of tumours. Just under 23% of male cases were not staged compared to 17.5% of females. One-year survival is at 73.3%, mid-ranked in SWL as is male and female mortality, while Richmond & Twickenham shows the highest reduction in the all age male mortality rate between 1993-95 and 2006-08 at 29.4%, while the female rate reveals the lowest reduction in SWL for the same period at 19.5%. Analogous to the other PCTs in SWL Richmond & Twickenham record an emergency bed day rate that is higher than the national average. The crude rate for all cancer emergency admissions was 536.97 per 100,000 population. Fifty-seven percent of diagnosed lower GI cancer cases were non-urgent referrals. The average urgent 2WW crude referral rate in Richmond & Twickenham for suspected lower GI cancer for 2009 was 205.55 per 100,000 population. Only 7.6% of urgent referrals result in a cancer diagnosis, below the average of 8.8%. This low figure may indicate poor primary care interpretation of the 2 week referral of NICE Referral Guidelines and may require investigation.

**Sutton & Merton**

The proportion of people in Sutton & Merton is estimated to consume sufficient amounts of fruit and vegetables at comparable rates to the other PCTs in SWL. Binge drinking prevalence is also estimated to be similar to other PCTs at around one in eight adults. The PCT has less deprived areas compared to Croydon and Wandsworth but more than Kingston and Richmond & Twickenham. The 65 and over population is comparable to the other PCTs (except Wandsworth) at around 13% of the total population, while the projected increase over the next 20 years varies between Sutton and Merton, 3.1% and 3.9% respectively.

As with all PCTs in SWL the uptake of bowel screening is below the national average as well as the target of 60%. Male and female incidence is comparable with the other PCTs at 36.5 and 25.2 per 100,000 respectively for under 75 incidence. The majority of tumours were staged at stage 4 but the staging is likely to be skewed since around a third of tumours were not staged due to a lack of information. Sutton & Merton has the lowest one-year survival rate in SWL at 71.4%, 3.1% lower than the highest in Croydon. Both male and female mortality rates are comparable to the other PCTs and the national average. Sutton & Merton record the highest rate for emergency bed days for colorectal cancer at 448 per 100,000, the national average is 374. The crude rate for all cancer emergency admissions was 634.87 per 100,000 population. Fifty-seven percent of diagnosed lower GI cancer cases were non-urgent referrals. The average 2WW crude referral rate for suspected lower GI cancer in Sutton & Merton for 2009 was 162.77 per 100,000 population. The proportion of urgent referrals resulting in a cancer diagnosis was above the national rate at 9.2%.

**Wandsworth**

Wandsworth has a similar estimated proportion of the population, compared to the other SWL PCTs, consuming sufficient amounts of fruit and vegetables at 31.1% of the total population, while the proportion binge drinking is also similar at 13.9% (lower than national average). Twenty-nine percent of small areas in Wandsworth are classed as highly deprived, the second highest proportion after Croydon. Wandsworth is characterised by a young population and as such only 8.2% of the population is currently projected to be aged 65 or over, while this population group is only projected to increase by 0.4% over the next twenty years.

The uptake of bowel screening in the PCT is low and is the lowest in the sector at 38.6%, over 20% lower than the target of 60%. Male and female incidence is comparable to other PCTs in the sector. Most male tumours have been staged at stage 2 while females record a highest proportion at stage 4. Twenty percent of male tumours were not staged by the TCR, while a quarter of females tumours were not. The one-year survival rate is 72.5%, while male and female mortality is the highest in SWL. The decrease in the mortality rate between 1993-95 and 2006-08 is comparable to the other PCTs, at 20.1% for males and 23.9% for females. Again, Wandsworth’s emergency bed day rate is higher than the national average at 415 per 100,000. The crude rate for all cancer emergency admissions was 634.87 per 100,000 population. Wandsworth had a high proportion of diagnosed lower GI cancer cases, 61.7%, come through the non-urgent referral route. The PCT average for urgent 2WW referrals for suspected lower GI cancer is 142.48 per 100,000 population. Only 6.1% of referrals result in a cancer diagnosis, a proportion below the national average. This low figure may indicate poor primary care interpretation of the 2 week referral of NICE Referral Guidelines and may require investigation.

Figure 40: Matrix of key colorectal cancer figures for South West London.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Croydon | Kingston | Richmond & Twickenham | Sutton & Merton | | Wandsworth |  | |
| Estimated fruit & veg consumption (2003-05) | 27.8% | 33.4% | 37.1% | 30.4% | | 31.1% |  |  |
| Estimated prevalence of binge drinking (2003-05) | 11.0% | 12.3% | 12.3% | 11.4% | 12.3% | 13.9% | Significantly lower national average |  |
| Smoking prevalence (2003-05) | 21.0 - 25.7% | 18.7-24.9% | 16.1 - 23.0% | 18.7 - 23.3% | | 21.0 - 27.7% |  |  |
| % of small areas (LSOA) classed as highest deprivation (2007) | 33% | 5% | 4% | 15% | | 29% | Lowest | Highest |
| 65+ Population as % of PCT population (2010) | 12.9% | 12.0% | 12.1% | 12% (Merton) | 13.5% (Sutton) | 8.2% |  |  |
| 65+ Population increase (2010-2030) | 3.6% | 3.0% | 1.5% | 3.1% (Merton) | 3.9% (Sutton) | 0.4% |  |  |
| Estimated Moderate intensity sport & active recreation (2008-09) | 17.8% | 27.3% | 28.5% | 22.7% (Merton) | 21.1% (Sutton) | 27.0% | Lowest | Highest |
| Bowel screening uptake (up to June 2009) | 44.5% | 48.3% | 49.1% | 46.3% | | 38.6% |  | Below national target (60%) and national average (52.5%) |
| Male Under 75 Incidence (2004-06) | 40.36 | 34.03 | 36.71 | 36.48 | | 37.11 |  |  |
| Female Under 75 Incidence (2004-06) | 20.24 | 30.77 | 30.91 | 25.2 | | 27.89 | Significantly lower national average |  |
| Male Staging (2003-07) | Stage 1: 11.7% Stage 2: 13.7% Stage 4: 14.3% NK: 48.6% | Stage 1: 18.0% Stage 2: 23.7% Stage 4: 17.5% NK: 23.2% | Stage 1: 11.7% Stage 2: 23.1% Stage 4: 25.1% NK: 22.7% | Stage 1: 15.7% Stage 2: 16.9% Stage 4: 22.5% NK: 29.1% | | Stage 1: 17.5% Stage 2: 22.7% Stage 4: 18.6% NK: 20.1% |  |  |
| Female Staging (2003-07) | Stage 1: 10.9% Stage 2: 11.8% Stage 4: 17.3% NK: 49.1% | Stage 1: 15.3% Stage 2: 21.1% Stage 4: 18.7% NK: 23.4% | Stage 1: 19.5% Stage 2: 19.4% Stage 4: 22.0% NK: 17.5% | Stage 1: 12.5% Stage 2: 18.0% Stage 4: 21.1% NK: 33.8% | | Stage 1: 18.1% Stage 2:15.8% Stage 4: 24.8% NK: 25.6% |  |  |
| 1-year survival (2002-07) | 74.5% | 73.8% | 73.3% | 71.4% | | 72.5% | Highest | Lowest |
| 5-year survival (1998-02) | 53.3% | 52.1% | 50.1% | 56.0% | | 44.0% | Highest | Lowest |
| Male Under 75 mortality (2006-08) | 12.51 | 10.14 | 11.75 | 11.93 | | 13.57 |  |  |
| Female Under 75 mortality (2006-08 ) | 8.19 | 6.60 | 8.25 | 8.54 | | 9.42 |  |  |
| Male % Decrease U75 mortality (1995-2008) | 19.2% | 13.8% | 29.4% | 26.6% | | 20.1% | Highest decrease | Lowest decrease |
| Female % Decrease All age mortality (1995-2008) | 27.2% | 32.0% | 19.5% | 14.3% | | 23.9% | Highest decrease | Lowest decrease |
| Emergency Bed Days per 100,000 (2007-08) | 410 | 383 | 393 | 448 | | 415 |  | Higher than national average |
| Average all cancer emergency admission crude rate per 100,000 (2008-09) | 610.41 | 506.50 | 536.97 | 634.87 | | 443.07 |  |  |
| 2WW lower GI cancer referral rate per 100,000 (2009) | 137.60 | 206.90 | 205.55 | 162.77 | | 142.48 |  |  |
| % of cases diagnosed through non-urgent referrals (2010) | 52.8% | 40.7% | 57.1% | 57.1% | | 61.9% | Lowest | Highest |
| % urgent 2 week wait referrals resulting in cancer diagnosis (2010) | 11.10% | 9.80% | 7.60% | 9.20% | | 6.10% | Higher than national average (8.8%) | In lowest quartile |

## South West London Cancer Network

Overall the SWLCN performs well against all other networks in London, coming out best 4 out of 5 times on cancer network specific indicators (). One indicator, emergency bed days rate is the highest in London, reflecting the high rates in all the PCTs of SWL, particularly Wandsworth, Sutton & Merton and Croydon. One year survival rate for males is significantly higher than the national average and is comparable to the male rate in Norway, Finland and Sweden in the EUROCARE-4 study. The female one-year survival rate is considerably lower at 71.2%. The five-year survival rate (persons) is higher than the national average. Overall for the SWLCN a large proportion of colorectal cancers are classed as not known, around 30%, meaning the true staging data could reveal higher proportions of cancer diagnosed at stage 1, which would reflect the better survival rates. The SWLCN has one of the highest proportions of diagnosed cases resulting from non-urgent referrals in the country at 54.3%. The percentage of urgent 2 week wait referrals resulting in a colorectal cancer diagnosis is just above the national average reflecting the mixed rates across the PCTs of SWL. The overall 2WW referral rate per 1,000 population was 1.66.

Below is a matrix summarising the key statistics for colorectal cancer in the South West London Cancer Network.

Figure 41: Matrix of key colorectal cancer figures for South West London Cancer Network.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | SWLCN | NELCN | NLCN | (N)WLCN | SELCN |
| Male Staging (2003-07) | Stage 1: 16.4% Stage 4: 19.3.% NK: 29.6% |  |  |  |  |  |  |
| Female Staging (2003-07) | Stage 1: 17.1% Stage 4: 20.3% NK: 30.1% |  |  |  |  |  |  |
| Male 1-year prevalence per 100,000 (2006) | 40.0 | 33.0 | 35.2 | 32.7 | 36.0 | Lowest | Highest |
| Female 1-year prevalence per 100,000 (2006) | 24.7 | 21.2 | 21.7 | 22.5 | 22.4 | Lowest | Highest |
| Male One-year survival (2002-07) | 76.9% | 69.7% | 69.2% | 71.2% | 72.7% | Significantly higher than national average | Significantly lower than national average |
| Female One-year survival (2002-07) | 71.2% | 66.7% | 64.7% | 69.2% | 67.8% |  | Significantly lower than national average |
| Five-year survival (Persons) | 52.7% | 45.8% | 46.6% | 46.0% | 46.5% | Higher than national average |  |
| Emergency Bed Days per 100,000 (2007-08) | 404 | 227 | 270 | 321 | 279 |  | Higher than national average |
| % of cases diagnosed through non-urgent referrals (2010) | 54.3% | 49.9% | 43.4% | - | 47.1% | Lowest | Highest |
| % urgent 2 week wait referrals resulting in cancer diagnosis (2010) | 8.9% | 7.7% | 7.3% | - | 7.6% | Higher than national average |  |

## Recommendations

* Improve bowel screening uptake rates across the sector as all PCTs record rates below the national average (as well as the higher national target of 60%).
* Diagnose colorectal cancer cases earlier, latest figures show one in five cases are diagnosed late at stage 4.
* Improve female one-year survival rate as rate is below European counterparts.
* Investigate the substantial increase in male colorectal cancer mortality in Richmond & Twickenham since 2003-05.
* Investigate emergency admissions for Lower GI cancer in PCTs in the SWL sector, the emergency bed day rate is above the national average in all PCTs.
* Review the proportion of diagnosed colorectal cancer cases referred through a non-urgent route in Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth.
* Investigate the interpretation of the two week referral NICE Referral Guidelines for breast cancer by primary care at Wandsworth and Richmond & Twickenham (Proportion of urgent 2 week referrals resulting in cancer diagnosis is low).
* Local secondary care teams to consider auditing the appropriateness of all breast cancer urgent 2 week referrals received from Wandsworth and Richmond & Twickenham (Proportion of urgent 2 week referrals resulting in cancer diagnosis is low).
* Implement the recommendations of the Primary Care Audit of Cancer.
* Implement social marketing strategy resultant from the results of the CAM survey.

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# Appendix 1: South West London GLA Projected population by ethnicity, 2010.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Croydon | Kingston | Richmond | Sutton & Merton | Wandsworth |
| Persons | All Ethnicities | 341,201 | 154,405 | 185,634 | 382,766 | 293,877 |
| White | 201,514 | 119,818 | 163,737 | 293,535 | 229,791 |
| Black Caribbean | 34,954 | 1,101 | 660 | 11,156 | 11,139 |
| Black African | 23,372 | 2,224 | 1,105 | 11,765 | 10,267 |
| Black Other | 14,072 | 1,353 | 2,076 | 7,639 | 7,268 |
| Chinese | 1,862 | 3,074 | 1,278 | 4,367 | 2,637 |
| Asian | 56,188 | 17,204 | 10,897 | 42,071 | 20,073 |
| Other | 9,239 | 9,632 | 5,881 | 12,232 | 10,231 |
| Male | All Ethnicities | 166,745 | 76,109 | 90,708 | 187,394 | 143,260 |
| White | 99,906 | 59,546 | 80,182 | 144,540 | 113,206 |
| Black Caribbean | 15,195 | 537 | 257 | 4,934 | 4,771 |
| Black African | 11,280 | 1,101 | 499 | 5,528 | 4,710 |
| Black Other | 6,789 | 698 | 1,095 | 3,577 | 3,511 |
| Chinese | 825 | 1,484 | 514 | 2,126 | 1,258 |
| Asian | 28,538 | 8,188 | 5,454 | 21,021 | 11,214 |
| Other | 4,211 | 4,555 | 2,706 | 5,668 | 4,591 |
| Female | All Ethnicities | 174,456 | 78,296 | 94,926 | 195,372 | 150,618 |
| White | 101,608 | 60,272 | 83,555 | 148,995 | 116,585 |
| Black Caribbean | 19,760 | 564 | 403 | 6,222 | 6,368 |
| Black African | 12,092 | 1,123 | 606 | 6,236 | 5,557 |
| Black Other | 7,283 | 655 | 981 | 4,062 | 3,757 |
| Chinese | 1,037 | 1,591 | 764 | 2,241 | 1,563 |
| Asian | 27,649 | 9,016 | 5,443 | 21,050 | 10,869 |
| Other | 5,028 | 5,077 | 3,175 | 6,565 | 5,919 |

**Source: Greater London Authority Ethnic Group Projections 2008 Round, London Plan, Borough.**