

SECTION 5 - Prevention, Awareness and Early Detection

Introduction

Evidence suggests that over half of all cancers could be prevented if people made changes to their lifestyle. Action to increase awareness of risk factors and to encourage people to live healthier lives is therefore critical to reducing cancer incidence.

The early detection of cancer is critical to its successful treatment. At present around 45% of patients are diagnosed at a stage when cancer can be successfully treated. The United Kingdom has been behind other countries in Western Europe in terms of survival rates for cancer. In 2007 EUROCARE (the European Cancer Registry) found that cancers in the UK were more likely to be diagnosed at a later stage when compared to other European countries⁴. Outcomes in the UK could be improved and differences between the UK and Europe reduced if the issues of early presentation and diagnosis can be addressed. Actions to improve awareness of early signs and symptoms and to encourage people to go to their doctors early should therefore improve cancer survival in Northern Ireland, bringing our outcomes in line with the rest of Europe.

The standards below are aimed at improving survival through improved prevention, awareness and early detection.

While a lot of work has been ongoing to reduce smoking and to encourage people to exercise, more targeted work around obesity prevention is needed. Malignant melanoma rates have increased three-fold while other skin cancers are also increasing, albeit at a lesser rate.

Some work is already underway to enhance cancer screening programmes within Northern Ireland and so is not included here. This work includes: extending the age at which breast screening is available; the introduction of HPV vaccine to help prevent cervical cancer; and planning for the implementation of bowel cancer screening.

⁴ F, Berrino et al (2007) Survival for eight major cancers and all cancers combined for European adults diagnosed in 1995—99: results of the EUROCARE-4 study. The Lancet Oncology, [Volume 8, Issue 9](#), Pages 773 - 783, September 2007

Overarching standard 5:

Health and social care should work in cooperation with voluntary, education, youth and community organisations to prevent the recruitment of young people to smoking.

Rationale:

More than one in four (29%) of all UK cancer deaths are caused by smoking. Smoking causes 90% of lung cancers in men and up to 86% of cases in women in developed countries. Smoking is also linked to an increased risk of a range of other cancers including: oesophageal; larynx; pharynx; oral cavity; pancreas; bladder; stomach; liver; kidney; cervix; and myeloid leukaemia.

Its effects of smoking are related to the amount of tobacco smoked daily and the duration of smoking. If smoking levels could be reduced to 5% by 2025 350 lives would be saved each year.

Stopping young people from starting to smoke is crucial to reducing smoking levels, as evidence suggests that 82% of adult smokers started in their early teens (Tobacco Action Plan). The Young People Behaviour and Attitudes Surveys in 2000 and 2003, have shown that rates of boys smoking every day has remained constant (25.2% and 23.9% respectively) whilst the proportion of girls who smoke every day has increased (24.9% and 30.6% respectively).

Current interventions have not been shown to stop recruitment to smoking by young people. There is some evidence that 'The Smoke Busters' programme delays the age of onset. National Institute for Health and Clinical Excellence (NICE) guidance on smoking and young people is expected in July 2008 and this standard may need revised at that time.

Evidence:

Cancer Research UK – Tobacco and cancer risk

<http://info.cancerresearchuk.org/cancerstats/causes/lifestyle/tobacco/?a=5441>

A 5 year Tobacco Action Plan was produced in 2003, detailing a comprehensive programme of action to reduce the harm caused by tobacco use <http://www.dhsspsni.gov.uk/publications/2003/tobaccoplan.pdf>.

The prevention of recruitment of young people to smoking was identified as a key area of action in the Tobacco Action Plan.

DHSSPS (2005) Fit Futures <http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

‘Preventing the uptake of smoking by children and young people – review of effectiveness’, NICE rapid review, June 2008
<http://www.nice.org.uk/nicemedia/pdf/PH14reviewofeffectiveness.pdf>

Responsibility for delivery / implementation

HSC Board
 Public Health Agency
 HSC Trusts
 Primary Care, including GPs and pharmacy
 Voluntary Agencies

Quality Dimension

Equitable

Tobacco education should be accessible to all young people in a range of media settings.

Patient Centred

Lifeskills development programmes for young people should include input on tobacco as well as drugs, alcohol and solvents.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of 12, 14 and 16 year old boys and girls who smoke	Establish baseline data from Young People Behaviour and Attitude Survey (2007) in 12, 14 and 16 year olds	5% decrease on 2007 baseline for boys (rate has been constant)	March 2012
	Survey repeated 3 yearly* * subject to available resource	Maintain at 2007 baseline for girls (rate has been increasing therefore initial target to halt rise)	March 2012

Overarching standard 6:

All relevant health and social care professionals should identify people who smoke, make them aware of the dangers of smoking, advise them to stop and provide information and signposting to specialist cessation services.

Rationale:

Smoking is one of the recognised risk factors for many types of cancer (see previous standard on preventing young people from starting to smoke). Its effects are related to the amount of tobacco smoked daily and the duration of smoking.

Evidence:

Cancer Research UK – Tobacco and cancer risk

<http://info.cancerresearchuk.org/cancerstats/causes/lifestyle/tobacco/?a=5441>

A 5 year Tobacco Action Plan was produced in 2003, detailing a comprehensive programme of action to reduce the harm caused by tobacco use <http://www.dhsspsni.gov.uk/publications/2003/tobaccoplan.pdf>

National Institute for Health and Clinical Excellence (NICE) produced guidance on brief interventions and referral for smoking cessation in primary care and other settings in March 2006, which represents best practice

<http://guidance.nice.org.uk/PH1>

NICE guidance on ‘Smoking Cessation Services, in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities, February 2008

<http://www.nice.org.uk/Guidance/PH10>

DHSSPS (2005) Fit Futures <http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

Responsibility for delivery / implementation

HSC Board

Public Health Agency

HSC Trusts

Primary Care, including GPs and pharmacy

Quality Dimension

Patient Centred

People who are ready to stop smoking should be able to access specialist smoking cessation services in a choice of settings.

Effective, Efficient

Brief Intervention Training for Health and Social Care Staff will ensure clients receive consistent and timely advice on smoking cessation.

Equitable, Effective

Specialist smoking cessation services will be delivered to regional quality standards ensuing equitable service provision.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of people attending specialist smoking cessation services	Elite Monitoring System	Maintain 2007/08 baseline levels	March 2010
		4% increase in uptake	March 2011
		4% increase in uptake	March 2012
Percentage of clients quitting at 4 and 52 weeks	Elite Monitoring System	Maintain 2007/08 baseline levels	March 2010
		2% increase in number of quitters (4% increase in uptake of services)	March 2011
		2% increase in number of quitters (4% increase in uptake of services)	March 2012

Overarching standard 7:

All relevant health and social care professionals should identify inactive* individuals and, where appropriate, provide them with advice and support to accumulate a minimum of 30 minutes of moderate activity** on 5 days of the week or more.

*inactive refers to all people who do not meet the recommended level of physical activity

**walking briskly, walking downstairs, dancing, biking, swimming, gardening, housework e.g. washing floors

(<http://www.paho.org/English/HPP/HPN/whd2002-factsheet2.pdf>)

Rationale:

National Institute for Health and Clinical Excellence (NICE) has fully endorsed the importance of physical activity as a means of promoting good health and preventing disease. Evidence is growing to show the benefits of exercise in helping to prevent cancer.

Evidence:

WHO (2004) Global Strategy on Diet, Physical Activity and Health

http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

National Institute for Health and Clinical Excellence (NICE). Public Health Intervention Guidance No.2 (2006) Four commonly used methods to increase physical activity: Brief intervention in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.

http://www.nice.org.uk/nicemedia/pdf/word/PH002_physical_activity.doc

DHSSPS (2005) Fit Futures <http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

Friedenreich, C., et al. (2006) Physical activity and risk of colon and rectal cancers: the European prospective investigation into cancer and nutrition. *Cancer Epidemiol Biomarkers Prev.* 15(12): p. 2398-407

<http://cebp.aacrjournals.org/cgi/content/full/15/12/2398>

Wei, E.K., et al. (2004) Comparison of risk factors for colon and rectal cancer. *Int J Cancer.* 108(3): p. 433-42 <http://www3.interscience.wiley.com/cgi-bin/fulltext/106560115/HTMLSTART>

Responsibility for delivery / implementation			
HSC Board Public Health Agency HSC Trusts Primary Care, including GPs and pharmacy			
Quality Dimension			
Effective, Efficient Appropriate physical activity brief intervention training should be provided for Health and Social Care Staff to ensure clients receive consistent and timely advice			
Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of people being asked and advised about their physical activity	Audit	Establish baseline Performance level to be determined once baseline established	March 2010
Percentage of people advised who achieve the recommended level of physical activity	Audit	Establish baseline Performance level to be determined once baseline established	March 2010

Overarching standard 8:

People should be provided with healthy eating support and advice, appropriate to their needs, in a range of settings.

Rationale:

Reducing fat, salt and processed and red meat in the diet and eating more fruit and vegetables reduces the risk of a large number of cancers including: breast; lung; prostate; bladder; oral; stomach, oesophageal. Eating fibre also helps to protect against bowel cancer.

Evidence:

WHO (2004) Global Strategy on Diet, Physical Activity and Health

http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

DHSSPS (2005) Fit Futures <http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

Scientific Advisory Committee on Nutrition recommendations on healthy eating for the general population

http://www.sacn.gov.uk/reports_position_statements/reports/the_nutritional_wellbeing_of_the_british_population.html

Cancer Research UK – Diet, alcohol and cancer in the UK

<http://info.cancerresearchuk.org/cancerstats/causes/lifestyle/diet/>

Responsibility for delivery / implementation

HSC Board

Public Health Agency

HSC Trusts

Primary Care, including GPs and pharmacy

Quality Dimension**Effective**

All stakeholders should promote a consistent nutrition message by using the Eat Well – getting the balance right plate model.

Effective

Training and education should be available for child carers / group care workers.

Equitable

Support and advice to develop skills for healthy eating in a range of settings should be available.

Patient centred

Schools / hospitals / residential care and nursing homes should be supported in the implementation of nutrition standards.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of nutrition advisers using the Eat Well / Getting the Balance Right Plate model	Audit to establish baseline	Establish baseline 15% increase on baseline	March 2010
Percentage of people eating the recommended 5 pieces of fruit or vegetables a day	Health and Social Wellbeing Survey Repeated 5 yearly	10% increase on 2005/06 baseline	March 2011

Overarching standard 9:

Health and social care should work with early years' settings, schools, workplaces and communities in the promotion and support of breastfeeding, healthy eating and physical activity to prevent obesity.

Rationale:

Being overweight or obese increases the risk of several cancers including breast, uterus, kidney and colon.

Evidence:

The DHSSPS established a task force on childhood obesity which published 'Fit Futures' – a framework for action in 2006 <http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

National Institute for Health and Clinical Excellence (NICE) have produced 'Evidence based guidance on the prevention, identification and management of overweight and obesity in adults and children' <http://www.nice.org.uk/CG43>

Lahmann, P.H., et al. (2004) Body size and breast cancer risk: Findings from the European prospective investigation into cancer and nutrition (EPIC). Int J Cancer. 111(5): p. 762-71 <http://www3.interscience.wiley.com/cgi-bin/fulltext/108565443/HTMLSTART>

Key, T.J., et al., (2004) Diet, nutrition and the prevention of cancer. Public Health Nutr. 7(1A): p. 187-200
<http://journals.cambridge.org/action/displayFulltext?type=6&fid=630396&jid=&volumeId=&issueId=1a&aid=569892&bodyId=&membershipNumber=&societyETOCSession=&fulltextType=RA&fileId=S1368980004000205>

Moore, L.L., et al., (2004) BMI and waist circumference as predictors of lifetime colon cancer risk in Framingham Study adults. Int J Obes Relat Metab Disord, 2004. 28(4): p. 559-67
<http://www.nature.com/ijo/journal/v28/n4/full/0802606a.html>

Scottish Intercollegiate Guidelines Network (SIGN) Management of Obesity in Children and Young People No 69 April 2003

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts
Primary Care, including GPs and pharmacy

Quality Dimension

Effective

Training should be facilitated for early year’s providers to assist them in implementing physical activity and nutrition programmes.

Patient Centred

DHSSPS should develop childcare standards which include the need to provide opportunities for daily physical activity and a requirement to meet nutrition standards.

Health and Social Care should work with employers to provide opportunities for staff to eat a healthy diet and be physically active.

The public should be provided with information and support on how to eat healthily and engage in health enhancing physical activity for the prevention of obesity.

Equitable

Health and Social Care staff will work with partners to ensure that schools have and implement policies which help children and young people to maintain a healthy weight, eat a healthy diet and be physically active.

Performance Indicator:	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of people who have a BMI of above 25	Health and Social Wellbeing Survey 2005/06 Survey repeated 5 yearly	2% decrease on 2005/06 baseline	March 2011
Percentage of P1 children who have been identified as being overweight and obese	Child Health System	Establish baseline Performance level to be determined once baseline established	March 2010

Overarching standard 10:

Primary care professionals should identify people who consume hazardous / harmful amounts of alcohol, make them aware of the dangers, advise them to reduce or stop and provide information and signposting to specialist services if appropriate.

Rationale:

Excessive alcohol consumption is associated with many diseases such as cancers (oesophagus, liver etc), cirrhosis of the liver, pancreatitis. There are also direct effects of alcohol and an increased association with injuries and violence. Excessive alcohol consumption can affect the cardiovascular system, and is associated with high blood pressure, abnormal heart rhythms, cardiomyopathy and haemorrhagic stroke.

Evidence:

Scottish Intercollegiate Guidelines Network (SIGN) (2003) The Management of harmful drinking and alcohol dependence in Primary Care

<http://www.sign.ac.uk/pdf/sign74.pdf>

New Strategic Direction for Alcohol and Drugs (2006-2011) Consultation Document

[http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_\(2006-2011\).pdf](http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_(2006-2011).pdf)

Responsibility for delivery / implementation

HSC Board

Public Health Agency

HSC Trusts

Primary Care, including GPs and pharmacy

Quality Dimension**Effective, Efficient**

Brief Intervention Training for Health and Social Care Staff will ensure clients receive consistent and timely advice on alcohol consumption.

Performance Indicator:	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of people who receive Brief Intervention in Primary Care to reduce alcohol related risk	Cardiovascular DES	Establish baseline Performance level to be determined once baseline established	March 2010

Overarching standard 11:

The public should be made aware of the dangers of *UV exposure* (through sun or use of sunbeds) and steps they can take to reduce their risk of skin cancer.

Rationale:

Skin cancer is the most common cancer in the UK and the number of people who get it is increasing. Skin cancer is caused by exposure to UV rays either from the sun or through use of sunbeds. The greater the exposure, the higher the risk. Most skin cancers could be prevented by protecting the skin from UV exposure.

Prevention remains the single most effective way to save lives and reduce costs to the health service.

The Health and Safety Executive provides guidance for controlling health risks from the use of UV tanning equipment. Since the publication of the guidance there has been a large growth in the sunbed industry. Work is underway nationally to review options for regulation of the sunbed industry.

Evidence:

Koh HK, Geller AC, Miller DR, Grossbart TA, Lew RA. (1996) Prevention and early detection strategies for melanoma and skin cancer: Current status. Arch Dermatol 1996; 132: 436-442 <http://archderm.ama-assn.org/cgi/content/summary/132/4/436>

Health and Safety Executive Reducing health risks from the use of ultraviolet (UV) tanning equipment. Revised Apr 09
<http://www.hse.gov.uk/pubns/indg209.pdf>

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts
Primary Care

Quality Dimension

Timely, effective & patient centred – Increased awareness and reduced exposure will help reduce the incidence of skin cancers.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Public awareness of the risks of exposure to UV light through the sun and sunbeds and ways of protecting the skin from UV exposure	Survey	Establish baseline of public awareness Performance level to be determined once baseline established	March 2011

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 12:

The public should be made aware of the early signs and symptoms of cancer so they know when they need to go to their doctor for advice.

Rationale:

The UK has among the lowest one year cancer survival rates in Europe. Late diagnosis is the main reason for poor survival from cancer in the UK. When cancers are found earlier they are nearly always easier to treat.

Evidence:

Northern Ireland Cancer Registry Survival of Cancer Patients in Northern Ireland: 1993-2004 (2007) <http://www.qub.ac.uk/research-centres/nicr/FileStore/PDF/Survival/Filetoupload,81422,en.pdf>

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts
Primary Care

Quality Dimension

Timely, effective, efficient & patient centred – Earlier detection can improve survival and reduce the burden of cancer on patients and the service.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Public awareness of early signs & symptoms	Survey	Undertake baseline survey of knowledge and awareness of signs and symptoms and barriers to going to see a GP when worried Baseline will inform development of appropriately targeted awareness campaign with agreed performance levels	March 2011

Overarching standard 13:

All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed.

Rationale:

Using evidence based referral guidance for suspect cancer ensures that people are referred appropriately. NICKaN has produced Referral Guidance for Suspect Cancer which is based on National Institute for Health and Clinical Excellence (NICE) Referral Guidelines for Suspected Cancer 2005.

NICE recommends that referrals for suspect cancer are forwarded within one working day.

“Cancer in Primary Care, A Guide to Good Practice” identified a number of things that help to ensure prompt referral.

Evidence:

National Institute for Health and Clinical Excellence (NICE) (2005) Referral Guidelines for Suspected Cancer <http://guidance.nice.org.uk/CG27>

NHS Modernisation Agency (2004) Cancer in Primary Care, A Guide to Good Practice
<http://www.library.nhs.uk/HealthManagement/ViewResource.aspx?resID=315991>

NICKaN (2007) Referral Guidance for Suspect Cancer
<http://www.cancerni.net/files/file/ReferralGuidanceMay2007.pdf>

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts
Primary Care

Quality Dimension**Safe & Timely**

Use of NICKaN Referral Guidance for Suspect Cancer will ensure the early recognition of symptoms and signs relating to a possible cancer diagnosis.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of referrals made in accordance with regional referral guidelines for suspected cancer	Trust data management systems	75% 90% 95%	March 2011 March 2012 March 2013

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 14:

All year 9 girls should be routinely offered the HPV immunisation to protect against future risk of cervical cancer.

Rationale:

There is a known link between cervical cancer and infection with human papilloma virus (HPV). HPV causes 99% of invasive cervical cancers, with HPV types 16 and 18 being responsible for 70% of all invasive cases. Cervical cancer is the second most common cancer in women worldwide. The virus is spread through sexual activity. New HPV vaccines offer tremendous potential for improving public health as they prevent up to 70% of cervical cancers. The Joint Committee on Vaccination and Immunisation (JCVI) provides independent expert advice to the four UK Health Departments within the UK all issues to do with vaccines and immunisation. On October 17th 2007 the JCVI considered the evidence produced by the Health Protection Agency on the likely effectiveness and cost effectiveness of HPV vaccination in the UK. This evidence led the Committee to confirm the previous recommendation to Ministers for a universal vaccination of girls aged 12 to 13 years. In addition it indicates that a time-limited “catch up” vaccination of girls aged 13-17 years would be cost effective, and would be delivered most efficiently through schools.

Evidence:

Joint Committee on Vaccination and Immunisation (JCVI) statement on human papillomavirus vaccines to protect against cervical cancer

http://www.advisorybodies.doh.gov.uk/jcvi/HPV_JCVI_report_18_07_2008.pdf

Immunisation against infectious disease – The Green Book, Chapter 18a (Updated November 2008)

http://www.dh.gov.uk/en/PublicHealth/Healthprotection/Immunisation/Greenbook/DH_4097254

Help Protect Yourself NI website: <http://www.helpprotectyourself.info/>

Chief Professional letters: (HSS MD 15,16,24,25,45/2008)

http://www.dhsspsni.gov.uk/index/phealth/professional/cmo_communications/phealth-urgentcomms-2008.htm

Responsibility for delivery / implementation

HSC Board

Public Health Agency

HSC Trusts

Primary Care, including GPs and pharmacy

Quality Dimension

All girls aged 12 to 18 will be immunised against HPV which will reduce any future risk of developing cervical cancer

HPV vaccine protects against 70% of cervical cancers.

Performance Indicator:	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of year 9 girls receiving the second dose of HPV vaccination	CDSC surveillance database	90%	March 2010
Development of a catch up programme to immunise all girls currently aged 12 to 18 against HPV		Implement programme	March 2011

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 15:

All women who are eligible to participate in the Cervical Screening Programme should be invited for screening within the recommended timescales and be provided with the appropriate information and support to allow them to make an informed decision to attend.

Rationale:

The Cervical Screening Programme aims to reduce the number of women who develop and die from cervical cancer. It does this by screening all women at risk, so that conditions which might otherwise develop into cancer can be identified early and treated. All women between the ages of 20 and 64 are eligible for a cervical screening test every 3 to 5 years.

The effectiveness of the programme can be judged by coverage which is the percentage of women in the target age group who have been screened in the last 5 years. Many women who are currently diagnosed with cervical cancer in Northern Ireland, have either never had a screening test, or had their last test more than 5 years ago. Current coverage in Northern Ireland is 73.39% (at end March 2008). We would like to increase coverage to the national standard of 75% by 2011.

Evidence:

NHS Cancer Screening Programmes Quality Assurance Guidelines for the Cervical Screening Programme (1996)

P Sasieni, J Adams & J Cuzick (2003) Benefit of cervical screening at different ages: evidence from the UK audit of screening histories. British Journal of Cancer, July 2003 <http://www.nature.com/bjc/journal/v89/n1/full/6600974a.html>

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts
Primary care

Quality Dimension**Safe, Efficient, Equitable and Patient Centred**

A coverage rate that meets the national standard will help to ensure that the programme is cost-effective, accessible and can be properly quality assured.

Performance Indicator:	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of women in the target age group who have been screened within the recommended timescales.	NI Quality Assurance Reference Centre (KC53)	75%	March 2011

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 16:

All women who are eligible for the Breast Screening Programme should be invited for screening at within the recommended timescales and be provided with the appropriate information and support to allow them to make an informed decision to attend.

Rationale:

The effectiveness of the breast screening programme can be judged by its coverage. Coverage describes the percentage of women in the target age group who have had a screening *mammogram* within the recommended timescales. Coverage is influenced by the uptake (i.e. the proportion of eligible women invited for screening in any year who have a mammogram, and by the programme round length).¹

Coverage is an important indicator of the quality of communication with women about the programme and of its accessibility.

A round length that meets the national minimum standard of 70% is required to allow proper monitoring and quality assurance of the programme. This is because the various national quality assurance standards are based on a 36 month round length.

Evidence:

Department of Health (1996). Breast Cancer Screening. Report to the Health Ministers of England, Wales, Scotland & Northern Ireland by a working group chaired by Professor Sir Patrick Forrest. HMSO: London, 1986

<http://www.cancerscreening.nhs.uk/breastscreen/publications/forrest-report.html>

National Health Service Breast Screening Programme (2005). Consolidated Guidance on Standards for the NHS Breast Screening Programme. NHSBSP Publication No 60 (Version 2). NHS Cancer Screening Programmes: Sheffield, 2005.

<http://www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp60v2.pdf>

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts
Breast screening units
Primary care

Quality Dimension**Safe, Efficient, Equitable and Patient Centred**

A coverage rate that meets the national standard will help to ensure that the programme is cost-effective, accessible and can be properly quality assured.

Performance Indicator:	Data source	Anticipated Performance Level	Date to be achieved by
Percentage coverage achieved by each breast screening unit	Quality Assurance Reference Centre (QARC)	Establish baseline based on 2008/09 data	March 2010
		70%	March 2012

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 17:

All men and women who are eligible to participate in the Bowel Cancer Screening Programme should be invited for screening within the recommended timescales and be provided with the appropriate information and support to allow them to make an informed decision to take part.

Rationale:

Evidence shows that screening men and women for bowel cancer using the FOB test (guaiac faecal occult blood test) can reduce the number of deaths from bowel cancer by 16% in those invited for screening.

The Northern Ireland Bowel Cancer Screening Programme began in April 2010. It aims to reduce the number of men and women who develop and die from bowel cancer by inviting all men and women between the ages of 60 and 69 to complete a home screening test every 2 years. This means that conditions which might otherwise develop into cancer can be identified early and treated.

The effectiveness of the programme can be judged in part by examining 'coverage'. This is the percentage of men and women aged 60-69 who have been screened over a two year period.

Evidence:

DRAFT Quality Assurance Standards for the Bowel Cancer Screening Programme, Bowel Cancer Screening Project, January 2009

Hardcastle JD, Chamberlain JO, Robinson MHE, Moss SM, Amar SS, Balfour TW et al. Randomised controlled trial of faecal occult blood screening for colorectal cancer. *Lancet* 1996, 348; 1472-1477

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(96\)03386-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(96)03386-7/fulltext)

Kronborg O, Fenger C, Olsen J, Jorgensen OD, Sondergaard O. Randomised study of screening for colorectal cancer with faecal occult blood test. *Lancet* 1996, 348; 1467-1471

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(96\)03430-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(96)03430-7/fulltext)

Mandel JS, Bond JH, Church JR, Snover DC, Bradley GM, Schuman LM, et al. Reducing mortality from colorectal cancer by screening for faecal occult blood. *New England Journal of Medicine*, 1993, 328; 1365-1371

<http://content.nejm.org/cgi/content/full/328/19/1365>

Responsibility for delivery / implementation			
HSC Board Public Health Agency HSC Trusts Primary care			
Quality Dimension			
Safe, Efficient, Equitable and Patient Centred A high coverage rate will help to ensure that the programme is effective, accessible and can be properly quality assured.			
Performance Indicator:	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of men and women aged 60-69 who have been screened within the recommended timescales	NI Quality Assurance Reference Centre	Establish baseline Provisional performance level of 60%, dependant on baseline	March 2012 March 2014

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 18:

All people with a family history of cancers that have a *genetic component* should be appropriately referred to the Northern Ireland Regional Cancer Genetics Service (NICGS) for testing and support.

Rationale:

5-10% of cancer of the breast, ovary and colon are due to *inherited predisposition*. The Northern Ireland Regional Cancer Genetics Service (NICGS) assesses the risk of cancer based on family history and genetic testing. NICGS then work with relevant specialists to recommend screening for family members where needed. NICGS have developed referral guidance for this service. The guidance states which people have a greater risk of an inherited form of cancer and how they should be referred.

Evidence:

NI regional cancer genetics service referral guidance

<http://www.cancerni.net/files/Cancer%20Genetics%20Referral%20Guidance%20for%20GPs.doc>

Department of Health (1995) A policy framework for commissioning cancer services: Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales Calman Hine Report

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4071083

DHSSPS (2007) Regional Cancer Framework: A Cancer Control Programme for Northern Ireland

http://www.dhsspsni.gov.uk/eeu_cancer_control_programme_eqia.pdf

Responsibility for delivery / implementation

Primary care including GPs

Northern Ireland Regional Genetics Centre

Quality Dimension**Timely, Efficient, Effective & Patient-Centred**

Genetic referral and testing helps to identify and support people who have a greater risk of cancer. Use of regional referral guidance ensures that patients who need to be seen are seen quickly.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of referrals which comply with NICGS guidance	NICGS data system	50% 60% 75%	March 2011 March 2012 March 2013

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 19:

All patients referred to the Northern Ireland Regional Cancer Genetics Service (NICGS) should have timely access to a genetics counsellor.

Rationale:

5-10% of cancer of the breast, ovary and colon are due to inherited predisposition. The NICGS assesses the risk of cancer based on reported family history and molecular genetic testing. NICGS then work with relevant specialists to recommend screening strategies for family members where appropriate.

Genetic counselling and screening can identify individuals with a significantly increased risk of cancer and use established protocols for the management of these individuals to reduce their mortality rate from these diseases.

The current practice in the UK is for all referrals to the cancer genetics service should be seen by a Genetic Counsellor. Genetic counsellors take people's family history and assess their risk of cancer. High risk patients are then referred on to be seen by a Consultant Geneticist and other relevant specialists.

Due to the limited number of Genetic Counsellors within the NICGS some low risk patients currently wait in excess of 2 years to have their family history reported and risk of cancer assessed. High risk patients are being seen by a consultant who must then take their family history which is not a good use of a Consultant resource.

Evidence:

DHSSPS (1996) Cancer Services - Investing for the Future (The Campbell Report)

[http://www.cancerni.net/files/ph_cancer_services_-_investing_for_the_future_\(the_campbell_report\).pdf](http://www.cancerni.net/files/ph_cancer_services_-_investing_for_the_future_(the_campbell_report).pdf)

DHSSPS (2003) Review of Clinical Genetic Services in Northern Ireland

http://www.dhsspsni.gov.uk/clinical_genetics_rev_sept03.pdf

Responsibility for delivery / implementation

HSC Board

Public Health Agency

Primary care

Northern Ireland Regional Cancer Genetics Service

Quality Dimension**Timely, equitable, effective & efficient**

The standard will ensure that all patients are seen within the guaranteed maximum waiting time. Access to Genetic Counsellors will reduce inappropriate referrals to the Consultant Geneticists and screening services. Patients who come through to the NICGS and who are deemed to be at low risk can be removed from long term screening resulting in cost savings to screening services.

Patient-Centred

The NICGS can provide advice and counselling to individuals about the risks of developing cancer. Access to Genetic Counsellors provides quick reassurance for those at low risk and can ensure timely access to appropriate screening advice and other support or interventions for individuals or families who are deemed to have a “medium” or “high” risk of developing cancer.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of patients referred to the NICGS who are assessed for risk of cancer by a Genetic Counsellor within one year	NIGCS data system/PAS	100%	March 2011
Percentage of patients referred to the NICGS seen within 13 weeks to be assessed for risk of cancer by a Genetic Counsellor		98%	March 2012

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.