1. Overview: the importance of early diagnosis

Around 31,700 people are diagnosed with cancer in Scotland every year. And while cancer death rates in Scotland have fallen by a fifth over the last twenty years, incidence remains high: one in two people in the UK will be diagnosed with some form of cancer during their lifetime.

Cancer Research UK welcomes the Committee’s ongoing focus on a preventative health agenda. Four in ten cancers diagnosed in the UK are attributable to preventable risk factors. These cancers could be prevented by actions like not smoking, keeping a healthy bodyweight, cutting back on alcohol, eating a healthy balanced diet, keeping active and enjoying the sun safely.

Nevertheless, the biggest risk factor for cancer is age, with incidence rates increasing with age for most cancers. Early diagnosis of cancer is vital if Scotland is to improve its survival outcomes. When cancer is diagnosed at an early stage, more treatment options are available. We know patients are three times more likely to survive cancer if they are diagnosed in stages 1 and 2, as opposed to stages 3 and 4.

Therefore, focus and investment on earlier detection of cancer, in addition to cancer prevention, must remain a core part of The Scottish Government’s strategies to reduce Scotland’s cancer burden.

2. About the DCE programme and Cancer Research UK’s involvement

Detect Cancer Early (DCE) was launched in February 2012 with the aim of improving overall five year survival for people in Scotland diagnosed with cancer. The programme’s activity covers three broad areas:

i. Public awareness and behaviour influencing, including working to raise the public’s awareness of the national cancer screening programmes, and the early signs and symptoms of cancer to encourage them to seek help earlier

ii. Primary Care cancer symptom management and referral, including working with GPs to promote referral or investigation at the earliest reasonable opportunity for patients who may be showing suspected signs of cancer

iii. Managing Demand for Cancer Screening and Diagnostics, including ensuring there is sufficient capacity in the screening programmes and diagnostic departments to meet the expected increase in those choosing to take part.

Primary cancer prevention is not one of the aims of the DCE programme. However, DCE has aimed to improve uptake across the three cancer screening programmes. Cancer screening saves thousands of lives each year, and can detect cancers at an early stage. Cervical and bowel cancer screening can also detect abnormal changes before they can turn into cancer, and therefore can contribute to the prevention of cervical and bowel cancer.
With other initiatives in place to tackle primary cancer prevention, Cancer Research UK supports the DCE programme’s aims and investment to improve cancer survival by driving early diagnosis of cancer.

As set out in the Scottish Government’s cancer strategy, Beating Cancer: Ambition and Action (“Beating Cancer”), Cancer Research UK is working in partnership with the Scottish Government to develop and expand our health professional engagement facilitator programme (‘Facilitator Programme’) across Scotland. The Facilitator Programme aims to support further improvements in early diagnosis, cancer prevention and the interface between primary and secondary care.

**Box 1. About Cancer Research UK’s Facilitator Programme**

The Facilitator Programme works with local and national health services to improve the prevention and earlier diagnosis of cancer. Facilitators work with health professionals (including public health) and health services to drive improvement in cancer outcomes by:

- Working with local partners to assess where there is the greatest need for improvement locally (for example, a particular geography or an aspect of the cancer pathway)
- Influencing uptake of best practice in a range of ways including providing training
- Facilitating local solution-finding and implementation
- Gathering local intelligence and insights for new opportunities to support improvement
- Working as a long-term partner of local professionals and organisations

It has been operational in parts of the UK since 2013, with its first pilot in Scotland in NHS Greater Glasgow and Clyde commencing in 2014. **The Facilitator Programme now works in partnership with 6 Health Board areas.**

<table>
<thead>
<tr>
<th>Team</th>
<th>Boards covered</th>
<th>Staffing</th>
<th>n. GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>North and East Scotland</td>
<td>NHS Lothian, NHS Grampian, NHS Tayside</td>
<td>2 (1 Manager, 1 Facilitator)</td>
<td>183</td>
</tr>
<tr>
<td>West Scotland</td>
<td>NHS Greater Glasgow &amp; Clyde, NHS Lanarkshire, NHS Forth Valley</td>
<td>4 (1 Manager, 3 Facilitators)</td>
<td>372</td>
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</tbody>
</table>

We have also supported and advised the programme in various ways including: providing policy advice; supporting data analysis; generating and sharing evidence; hosting a UK-wide learning day for similar programmes across the nations; and working as a lead partner in the Scottish Government’s “wee c” campaign, which aims to reduce fear around the disease and boost survival rates.
3. DCE and early diagnosis: progress and outcomes

Early diagnosis is critical to improving cancer outcomes. For example, when bowel cancer is diagnosed at stage 1, around 90% of patients survive ten years, compared to just 5% for those diagnosed at stage 4. The focus of the DCE programme has been breast, colorectal and lung cancers.

Below, we examine progress against each of the programme’s three broad workstreams.

i. Public awareness and behaviour influencing

The DCE programme has initiated marketing campaigns aimed at increasing public awareness of the symptoms of breast, bowel and lung cancer, and increasing uptake of screening for bowel cancer.

The campaigns consisted of TV, radio, digital media, outdoor posters, PR and field activity. A summary of the results of the evaluation of the DCE social marketing campaign, ‘Cancer. Don’t get scared get checked’ has been published. Results are summarized in Box 2 below.

<table>
<thead>
<tr>
<th>Box 2. Results of ‘Cancer. Don’t get scared, get checked’ evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ‘Spontaneous awareness of the ‘getting checked early’ message amongst women increased from 57% before the campaign to 64% post campaign and from 54% to 67% amongst those aged 55-64yrs.</td>
</tr>
<tr>
<td>• Those claiming to self-examine increased from 65% to 70%.</td>
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<tr>
<td>• Of those who had seen TV advertising about cancer, 18% recalled specific aspects of the campaign (significantly more than the recall on the ‘Be clear on Cancer’ campaign from NHS England, which ran at the same time).</td>
</tr>
<tr>
<td>• Prompted recognition of the campaign across all aspects (radio, TV and posters) reached 85%, which is very high.</td>
</tr>
<tr>
<td>• The main message take out from those who have seen the campaign is ‘get checked’ at a high level of 81%.</td>
</tr>
<tr>
<td>• Just under half of the audience feel more confident about approaching their GP as a result of seeing the campaign, particularly 40-64s and those in income groups DE.</td>
</tr>
<tr>
<td>• Over half of the audience stated the advertising would make them get checked earlier if they had signs/symptoms.</td>
</tr>
</tbody>
</table>

Research commissioned by Cancer Research UK and published in 2017, ‘Where next for cancer services in Scotland,’ includes some qualitative findings on the views of clinicians and key national stakeholders on awareness raising with regards to cancer.

The reluctance of many patients to act on their symptoms at an early stage was considered one of the main barriers to achieving early diagnosis. One national stakeholder commented:

“I think there’s a significant amount more that we could be doing to raise awareness - without alarming the public and that’s always the difficulty - of what might be symptoms of cancer and encouraging them to go to their GPs to get early investigation”. (National interviewee)

This was felt to be particularly significant for lung cancer:
“...one of the challenges for lung cancer especially is that the demographic for lung cancer ...is a socio-economically deprived population, typically elderly and typically male and those are the people who are probably least responsive to public health campaigns”. (Oncologist)

Characteristics such as old age, ‘Scottish stoicism’, not wanting to ‘worry the doctor’ and social deprivation were seen as contributing to unwillingness to visit the GP with symptoms and hence to late diagnosis of cancer. One respondent in a remote part of Scotland felt that reluctance to visit the GP was widespread in such areas and that this kind of stoicism masked the needs of the population and contributed to poorer services. In addition, some fatalistic attitudes (“the ‘big C’ attitude”) were seen by some as accounting for a lack of response to campaigns, particularly amongst older people.

A campaign called the ‘wee c’ was launched in August 2015 aimed at overcoming some of the extreme fear and fatalism which discourages people from presenting with potential signs and symptoms (see Box 3).viii

**Box 3. The Wee C Campaign**
A new strand of activity was introduced into the DCE programme in 2015 – the ‘wee c’. In partnership with Cancer Research UK, the ‘wee c’ aims to change perceptions and attitudes to cancer in Scotland in a bid to reduce fear around the disease and encourage earlier presentation. This was accompanied by a generic symptom awareness raising campaign #getchecked.

These findings around the difficulty of raising awareness in hard to reach groups are also reflected in Beating Cancer. As such, the Scottish Government has committed to continuing the DCE programme, with a focus on trying to reach people who are most likely to present at a later stage of disease. Cancer Research UK welcomes this move.

While some progress has been made on public awareness and attitudes through the DCE programme, it is clear that more needs to be done to help educate people about the signs and symptoms of cancers. Encouraging people to seek help if something changes for them is also crucial.

- **Recommendation:** The DCE programme should publish a clear evaluation of public awareness campaigns to understand their impact. As outlined in Beating Cancer, DCE should publish plans on how it will reach deprived, harder to reach communities where early detection of cancer remains poor.

- **Recommendation:** The programme should continue to target DCE social marketing campaigns to C2DE individuals who are most likely to present with later stage disease and less likely to participate in screening.

- **Recommendation:** DCE must continue to raise the public’s awareness of cancer signs and symptoms and the national cancer screening programmes, as well as generally encouraging help seeking with the NHS. To do so, the Scottish Government should ensure that evidence-based public health campaigns within the DCE programme continue to be invested in and evaluated.

**ii. Primary Care cancer symptom management and referral**

Most patients who are diagnosed with cancer will have visited their GP, and the DCE programme aims to work with GPs to promote referral or investigation at the earliest reasonable opportunity for
patients who may be showing a suspicion of cancer. This should happen alongside making the most efficient use of NHS resources and avoiding adverse impact on access to key diagnostics tests.

This workstream has involved activity including:
- Review of Scottish Referral Guidelines for Suspected Cancer, including the development of a website and app
- Two year General Medical Services contract initiative for bowel screening
- Primary care education sessions
- Partnership with CRUK’s Facilitator Programme

Box 4 outlines the role that Cancer Research UK’s Facilitator Programme has helped to play in this area.

Box 4. Cancer Research UK’s Facilitator Programme: Recognition and Referral workstream

Much of the team’s work is focused around supporting GPs recognition of cancer symptoms, effective use of existing referral systems, and referral pathway review to improve earlier diagnosis of cancer. Within the 3 month period July – September 2017, around 35% of the team’s engagements related to this topic. This includes discussions around cancer referral data, safety netting, audits and significant event analysis as well as recognition of symptoms and use of referral guidelines.

Case Study
- The Facilitator Programme in Grampian developed a Cancer Referral Dictation Checklist for some tumour sites to support GPs who dictate referral forms for other staff to type up. This ensures that they have included all the necessary information in primary care with the aim of reducing delays within the GP Practice setting.

Direct access to key investigative tests for suspected cancer is an area that could be explored further in Scotland.

If a patient presents with symptoms, GPs will usually refer them to a secondary care specialist who will then order the investigative test. The specialist will discuss the result with the patient before referring them back to the GP if the test is negative. In many cases, the GP knows which test to order. The potential exists therefore to save both time, and a considerable number of outpatient appointments, if GPs could refer directly for these tests. ix

Another area that should be explored further in Scotland is availability of data. There is a currently a significant deficit in the availability of data that could inform further analysis and improvement in this area. The NHS in England benefits from key data sets that can identify routes to referral and diagnosis and valuable GP practice level information that could help drive improvement. In England, the National Cancer Registration and Analysis Service (NCRAS) publishes ‘Routes to Diagnosis’ data, allowing the route a patient follows to the point of diagnosis to be categorised, in order to examine demographic, organisational, service and personal reasons for delayed diagnosis. Two types of data are presented; the percentage of total cancers that are diagnosed by each Route, and the net
survival for each Route. Data are presented by sex, age group and deprivation quintile as well as by ethnicity for incidence, providing valuable data that can help drive improvements in survival.

Anecdotal local evidence has shown significant variation in referral processes and practice, as well as subsequent reporting from secondary care. These can result in delays in a patient progressing through the pathway.

- **Recommendation:** The Scottish Government should explore best practice pathways for referral of patients with vague or non-specific symptoms, and consider whether national guidance should be updated to ensure consistent pathways and processes for referral and reporting.

- **Recommendation:** The Scottish Government should use the opportunity of the Scottish Cancer Registry and Intelligence Service (SCRIS) to enhance the quantity and availability of GP practice level data as described above.

**iii. Managing Demand for Cancer Screening and Diagnostics**

**Screening**

DCE aims to ensure that there is sufficient diagnostic capacity to service all patients progressing through the system.

Cancer screening is intended for healthy people without symptoms and aims to diagnose cancer at an early stage when the chances of successful treatment are higher. However screening has harms as well as benefits.

We know that cancer screening saves thousands of lives each year, and the benefits of screening include the potential to detect cancer at an early stage. If cancer is picked up early, treatments are more likely to work and more people survive.

Some screening programmes can also prevent cancer. The cervical screening programme can detect abnormal changes before they can turn into cancer. Treating these early changes can prevent cancer from developing.

Screening does have associated risks, however. It can miss cancers. How often this happens varies for different types of screening test. It’s therefore important to communicate to the public that they should see their GP about any unusual changes, even if they have been through a screening programme.

Screening can also involve further testing, which can cause anxiety for some patients. Sometimes, the tests themselves can have risks or side effects, like bleeding, pain, or infections.

Screening also has the potential to overdiagnose patients, by picking up cancers that would not grow at all, or be very slow growing. As a result, some people can get a diagnosis of cancer, and undergo unnecessary treatment. This is a particular problem with breast screening.

Given the harms and benefits of screening, it is vital that everyone is given clear, evidence-based information so they can come to a decision about whether or not to accept their screening invitation. Further opportunities around screening are described in Section 5- Early Detection and Inequalities.
Diagnostics

As part of the drive to meet DCE’s objectives, marketing activity used only a small portion (<3%) of the Detect Cancer early fund, with the remainder used for investments in diagnostic services.\textsuperscript{xii} These funds were distributed to NHS Boards as they were judged to be in the best position to determine priorities for addressing pressure areas.\textsuperscript{xiv}

Diagnostic capacity is crucial to maximising early diagnosis as well as being able to rule out cancer. In 2009, the Scottish Government set a national standard that patients shouldn’t be waiting more than 6 weeks to have one of 8 key diagnostic tests and investigations\textsuperscript{xv}. This target is not being met. In 2015, around 67,200 patients waited longer than 6 weeks for a diagnostic test; some of these might be testing possible cancer symptoms.\textsuperscript{xvi} These indicators act as a barometer for the service in general, showing that diagnostic services do not have sufficient capacity to meet demand.

A respondent with a leading network role, quoted in “Where next for cancer services in Scotland”, described how the process of funding in this area worked:

“...there’s certainly a government focus on earlier diagnosis that has filtered down – it’s come with money – it has filtered down through the health boards, through the service, into primary care, into the general public; I do feel it has been well researched in terms of trying to identify the barriers to people coming along earlier on. And we now have to wait for the full evaluation of the impact of that...” (Regional clinical lead)\textsuperscript{xvii}

A stakeholder with a national remit took the view that a lot of work had been done to scope diagnostic services before launching the DCE programme, and that Health Boards could cope with the increased pressure that increased referral might result in. Nevertheless, it was always recognised that the ability to cope with additional pressures arising from DCE initiatives should not be ‘taken for granted’.

“...before we do anything to raise further awareness or look at other cancers, we need to be very carefully mapping out what’s already there and what might need to be done to expand service capacity”. (National interviewee)

“while it’s useful to have a policy such as DCE, it...there’s no point in having that policy if there are not resources in place to deliver it”. (Clinical director)

Addressing diagnostic capacity will be crucial to improving early diagnosis of cancer in Scotland. This needs to take into account both equipment and workforce. And while Beating Cancer commits to a £2m per annum Diagnostics Fund and 2,000 additional scopes, the strategy does not have as clear commitments on addressing workforce capacity.

- **Recommendation**: The Scottish Government must address the immediate shortages in the diagnostic workforce and take a more strategic approach to current and future workforce planning based on best-practice and clinical need. This includes radiologists, radiographers, endoscopists and pathologists. Short term solutions could include upskilling some workers, international recruitment, as well as introducing incentives for skilled staff to remain in the NHS after retirement, or trained staff to return to practice.
Box 6. Case study: Scotland’s radiology workforce

In June 2017, only 86.9% of patients urgently referred with suspected cancer began treatment within the 62 day target time, significantly below the target of 95%\(^1\). This is, in part, due to delays in diagnostic services such as radiology.

The Royal College of Radiologists 2016 census revealed a 10% current vacancy rate of consultants across Scotland with almost 1 in 5 (19%) of the current workforce expected to retire over the next 5 years.

The Scottish Government announced in September additional funding to increase the number of radiology training places by at least 50 trainees over the next 5 years to help address the long-term shortages in radiology.

However, it takes at least 5 years to become a consultant so more must be done to in the short term to address the current workforce shortages.
4. Evaluation of the DCE programme

Box 7 below outlines the objectives of the DCE programme.

**Box 7. DCE Objectives**

‘To increase the proportion of people with stage 1 disease at diagnosis (as a proxy indicator of survival outcome) and to use performance against a HEAT Target as a lever for a whole systems approach to improvement.

To improve informed consent and participation in national cancer screening programmes to help detect cancer earlier and improve survival rates.

To raise the public’s awareness of the national cancer screening programmes and also the early signs and symptoms of cancer to encourage them to seek help earlier.

To work with GPs to promote referral or investigation at the earliest reasonable opportunity for patients who may be showing a suspicion of cancer whilst making the most efficient use of NHS resources and avoiding adverse impact on access.

To ensure there is sufficient capacity in the screening programmes to meet the expected increase in those choosing to take part.

To ensure that imaging, diagnostic departments and treatment centres are prepared for an increase in the number of patients with early disease requiring treatment.

To strengthen data collection and performance reporting within NHS Scotland to ensure progress continues to be made on improving cancer diagnosis, treatment, referral and survival.

To facilitate further evaluation of the impact of public awareness campaigns on the stage of cancer at presentation and to contribute to research that establishes evidence for the link between late presentation and survival deficit.’

The first objective listed above is a Local Delivery Plan (LDP) standard, defined originally as a HEAT target, which states that the percentage of people diagnosed at stage 1 for breast, colorectal and lung cancer (combined) is to increase by 25%. This target was not achieved: there was a 9.2% increase in the percentage of people diagnosed at stage 1 for breast, colorectal and lung cancer (combined) between the baseline (calendar years 2010 & 2011 combined) and Year 5 (calendar years 2015 & 2016 combined).

Formal evaluation of the programme is currently being undertaken by the University of Edinburgh, however the latest staging data available reports the following:

- **For lung cancer**, there has been an increase in the proportion of lung cancer patients diagnosed at an early stage (stage I and II) since 2011-12, with a particular increase in those diagnosed at stage I.
For bowel cancer, there has been a decrease in the proportion diagnosed early (stage I and II). In particular, this is driven by a decrease in the proportion diagnosed at stage I, with little change in the proportion diagnosed at stage II.

For breast cancer, there is not a clear interpretation of the change in the proportion diagnosed early over time because there has been a steady increase in the completeness of staging data (a reduction in those recorded with an unknown stage) since the baseline.

Stage data completeness, and proportion of patients diagnosed by stage (excluding those with an unknown stage):xx

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<tbody>
<tr>
<td>All 3 cancers combined</td>
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<tr>
<td>Lung</td>
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Table footnotes:
- Stage completeness is the percentage of cases with a stage at diagnosis recorded in the data.
- Percentages provided for the proportion diagnosed at stage I, II, III and IV exclude cases with an unknown stage from the denominator.

Lung, bowel and breast by deprivation: For the two-year period 1 January 2015 to 31 December 2016, of those patients diagnosed with breast, colorectal and lung cancer in the most deprived areas of Scotland (deprivation category 1), the highest proportion were diagnosed at the most advanced stage of disease; stage 4 (29.4%). For those patients living in the least deprived areas (deprivation category 5), the highest proportion were diagnosed at stage 2 (28.6%).xxi
Overall, the data suggests that in the four years the DCE programme has been running there has been significant improvement in the early detection of lung cancer, a potentially static performance in breast cancers, while early detection of colorectal cancer has been falling, in spite of increased screening uptake. This is a concerning finding, and one in need of further investigation. Developing a better understanding of the causes of these trends will be vital in helping to increase the earlier detection of these cancers.

Cancer Research UK’s report, ‘Where next for cancer services in Scotland’, also includes some qualitative findings on the views of clinicians about the DCE programme.xii

In general, it found that DCE received qualified support from clinicians. A ‘downside’ of the programme, from many perspectives, is the difficulty of demonstrating the impact of the programme on survival outcomes to politicians and the public, and a few respondents were sceptical about the impact of DCE in the absence of any data.

“...my general feeling is that this is a very difficult thing to do and I’m not convinced that we have necessarily achieved anything clearly demonstrable in terms of catching cancers earlier as part of the programme”. (Clinical lead)

Most respondents had something to say about the limitations of the programme and the intractability of the problem. This was a fairly typical comment:

“I think there are genuine efforts being made to engage with GPs and to make the public aware of the importance of early diagnosis ... I remain uncertain how effective that is going to be and I think we’ve just got to wait and see. I’m not sure that there are any other obvious things that you can be doing to actually improve the rates of early diagnosis... most of the things that could be done are either in progress or being looked at”. (Oncologist)

At Cancer Research UK we support the work of the Detect Cancer Early programme. Significant investment has been made in diagnostic services as a result of the programme and it’s important this funding stream is protected. However, we acknowledge that more needs to be done to help drive early detection of cancer in Scotland - some of which falls outwith the scope of the programme (see earlier sections).

5. Early detection of cancer and health inequalities

Cancer incidence is generally higher in the most deprived areas of Scotland. However, this is not the case for all types of cancer.

In 2016, of people in the 45-74 year age group, those in Scotland’s most deprived areas are more than twice as likely to die of cancer than those in the least deprived (577.4 deaths per 100,000 population compared to 242.4 per 100,000 population, in 2016).xiii

As has been the case previously, of the most common types of cancer, the absolute gap between most and least deprived areas was largest for lung cancer (2015 rates were 128.9 and 33.9 per 100,000 population in the most and least deprived areas respectively).

Screening uptake decreases with increasing deprivation, as uptake figures for the following three cancer types show:
• **Breast screening:** In Scotland there is a considerable difference in breast screening uptake between the most deprived and the least deprived communities. In the most deprived areas of Scotland uptake was only 61.4% compared to 73.8% in the least deprived.

• **Cervical screening:** In women aged 25 – 64 years, the combined percentage uptake (to 31 March 2017) fell with increasing deprivation from 78.3% in the least deprived category, to 67.4% in the most deprived category. Uptake rates for the HPV vaccination were also lower in most deprived communities.

• **Bowel screening:** There is over a 20% difference in uptake of bowel screening from the least deprived to most deprived. Higher positivity percentages have been observed in areas with large concentrations of deprivation. The new FIT test will make the test easier and pilots have been shown to increase uptake by 7-14% especially in men and the most deprived communities, which suggests it will help reduce uptake inequalities.

In increased screening uptake can help drive early diagnosis, and therefore reduce mortality rates.

• **Recommendation:** The Scottish Government should deliver on its commitment in Beating Cancer to invest up to £5 million by the end of this Parliament in new activity targeted to improve outcomes by addressing health inequalities in screening. This includes supporting the development of an NHSScotland network to develop innovative strategies and share learning on inequalities in screening.

• **Recommendation:** The Scottish Government should aim to maximise the potential of the new FIT test in the bowel screening programme, by investing in a comprehensive awareness campaign about the benefits of the new test.

6. **Cancer Prevention**

Four in ten cancers diagnosed in the UK are attributable to preventable risk factors. In recent years the importance of addressing rates of cancer through tackling these factors has been increasingly recognised, but so far without the scale of action needed.

We support the Committee’s ongoing focus on prevention, as an effective strategy for addressing ill health.

Smoking rates have declined in a long-term downward trend. In contrast, rates of obesity remain high and have seen little change since the start of the millennium. But in Scotland prevalence of the most important risk factors still lag behind the rest of the UK.

The emphasis must remain on tackling these key risk factors. But consideration should also be given to the opportunities to improve the public health system at the national and local levels.

• **Tobacco recommendations:** We need a revised and strengthened tobacco strategy. A new strategy should engage experts in agreeing key priorities and setting new targets for achieving the Scottish Government’s “endgame” target of <5% prevalence by 2034. It should also:
  o Include actions that are fully realisable and evaluated.
  o Maintain the tobacco control budget at current levels across the 5 year lifetime of any new strategy.
• Be published alongside the Scottish Government’s evaluation of the Scottish Tobacco Retailer Register to inform policy development.

• **Obesity recommendations:** Being overweight or obese is the single biggest risk factor for cancer after smoking in Scotland, and is linked to 13 types of cancer.
  - We were pleased to see that the Scottish Government’s consultation on a diet and obesity strategy contains a range of population wide measures to tackle obesity in Scotland.
  - In particular, we are calling for the final strategy to include regulations to restrict multi-buy price promotions on foods high in fat, sugar and salt.

7. **Recommendations**

**Early Diagnosis**

- The DCE programme should publish a clear evaluation of public awareness campaigns to understand their impact. As outlined in Beating Cancer, DCE should publish plans on how it will reach deprived, harder to reach communities where early detection of cancer remains poor.

- The programme should continue to target DCE social marketing campaigns to C2DE individuals who are most likely to present with later stage disease and less likely to participate in screening.

- DCE must continue to raise the public’s awareness of cancer signs and symptoms and the national cancer screening programmes, as well as generally encouraging help seeking with the NHS. To do so, the Scottish Government should ensure that evidence-based public health campaigns within the DCE programme continue to be invested in and evaluated.

- The Scottish Government should explore best practice pathways for referral of patients with vague or non-specific symptoms, and consider whether national guidance should be updated to ensure consistent pathways and processes for referral and reporting.

- The Scottish Government should use the opportunity of the Scottish Cancer Registry and Intelligence Service (SCRIS) to enhance the quantity and availability of GP practice level data as described above.

- The Scottish Government must address the immediate shortages in the diagnostic workforce and take a more strategic approach to current and future workforce planning based on best-practice and clinical need. This includes radiologists, radiographers, endoscopists and pathologists. Short term solutions could include upskilling some workers, international recruitment, as well as introducing incentives for skilled staff to remain in the NHS after retirement, or trained staff to return to practice.

- The Scottish Government should deliver on its commitment in Beating Cancer to invest up to £5 million by the end of this Parliament in new activity targeted to improve outcomes by addressing health inequalities in screening. This includes supporting the development of an NHSScotland network to develop innovative strategies and share learning on inequalities in screening.

- The Scottish Government should aim to maximise the potential of the new FIT test in the bowel screening programme, by investing in a comprehensive awareness campaign about the benefits of the new test.
**Prevention**

- We need a revised and strengthened tobacco strategy. A new strategy should engage experts in agreeing key priorities and setting new targets for achieving the Scottish Government’s “endgame” target of <5% prevalence by 2034. It should also:
  - Include actions that are fully realisable and evaluated.
  - Maintain the tobacco control budget at current levels across the 5 year lifetime of any new strategy.
  - Be published alongside the Scottish Government’s evaluation of the Scottish Tobacco Retailer Register to inform policy development.

- Being overweight or obese is the single biggest risk factor for cancer after smoking in Scotland, and is linked to 13 types of cancer.
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  - In particular, we are calling for the final strategy to include regulations to restrict multi-buy price promotions on foods high in fat, sugar and salt.

References:

15. 8 Key Diagnostic Tests and Investigations which are classified as: all endoscopy tests (Upper endoscopy, lower endoscopy, colonoscopy, cystoscopy) and all radiology tests (CT scan, MRI scan, barium studies, non-obstetric ultrasound)
Cancer Research UK. Where next for cancer services in Scotland.

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http://www.gov.scot/About/Performance/scotPerforms/NHSScotlandperformance/DCE-LDP


Cancer Research UK. Where next for cancer services in Scotland: An evaluation of priorities to improve outcomes.


https://www.isdscotland.org/Health-Topics/Cancer/Publications/2016-04-19/brstscreen_depcat3yr.xls