Agenda Item No: 5

UPDATE ON ACTIONS TO ADDRESS LOW UPTAKE OF BREAST AND CERVICAL SCREENING IN CAMBRIDGESHIRE

To:	**HEALTH COMMITTEE**
Meeting Date:	**10 March 2016**
From:	**Dr Liz Robin, Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	***Key decision:*** **No**
Purpose:	**To describe the outcome of work undertaken by a Task & Finish Group set up to address low uptake of breast and cervical screening in Cambridgeshire. The report details the recommendations arising out of the work of the groups and initial actions that have been identified for implementation.**
Recommendation:	**The Committee is asked** **a) to receive this report; and** **b) tocomment on the actions taken to date by NHS England, supported by the County Council Public Health team, through the Task and Finish Group.**

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1. BACKGROUND

1.1 The purpose of this report is to provide an update further to the report in September 2015, on the outcome of work by a Task & Finish group set up by NHS England to identify issues leading to low uptake of screening in Cambridgeshire, to outline the main recommendations of that group and the initial work that is under way to implement action to address the recommendations.

1.2 Breast cancer screening using mammography has had an average uptake nationally of about 75%, and is estimated to have detected 5000 cancers each year nationally. Screening leads to early detection and treatment of cancer and better outcomes for those women. In Cambridgeshire uptake of screening had dropped from approximately 77% in 2011 to 71.7% in 2013/14, but increased to 75.3% in the year to31 March 2015 almost equal to the national average of 75.4%.

1.3 Cervical cancer screening detects pre-cancer changes that with treatment can prevent the development of cancer. Nationally screening rates have been reducing gradually for some years with a much faster decline in Cambridgeshire where uptake rates are below the national average – uptake in Cambridgeshire in 12 months to 31 March 2015, uptake was 72.7% compared to 74.4% nationally. These recent figures show that uptake in Cambridgeshire is static while it has reduced again nationally by 0.3%.

1.4 The section below summarises the recommendations of the group and afull report that has been produced by the Public Health England (PHE) Screening and Immunisation team working within NHS England on this work is available.

1.5 The Task & Finish group was established by the Screening and ImmunisationTeam, based in NHS England and the local authority team. The Health and Social Care Act 2012 gave the local leadership for improving and protecting the public's health to local government, and provided specific roles for NHS England and Public Heath England for the commissioning and system leadership of the national screening and immunisation programmes. NHS England commissions these services. Specialist public health staff employed by PHE are embedded in NHS England to provide accountability and leadership for the commissioning of the programmes and to provide system leadership. It is that specialist team that has led this work in Cambridgeshire.

1.6 The Task & Finish group had membership from NHS England, PHE, Cambridgeshire County Council Public Health team, the Clinical Commissioning Group (CCG) Cancer lead,representatives of Healthwatch, and staff representing the screening service providers. Healthwatch representatives undertook wider public consultation and reported back to the group. The Screening and Immunisation team undertook the GP survey.

2. OUTCOME OF THE WORK OF THE TASK & FINISH GROUP

2.1 Committee members asked for a report on the GP practice survey that was undertaken. Unfortunately the survey had a very poor return rate and the responses did not come up with any issues that had not already been identified - see below:

- 28 practices were targeted
- 9 (31%) responded

<u>General issues identified in GP survey that affects uptake</u>

- Lack of awareness of the importance and benefits of screening
- Culturally influenced health beliefs which results in a lack of cultural acceptance
- Complacency, apathy and indifference
- Busy lifestyles resulting in screening not being considered a priority
- Patients not taking responsibility for their own health and wellbeing.
- The undignified and unpleasant procedure involved with screening
- Transient nature of some migrant communities and the student and academic staff populations means that patient held information is not always up to date.
- Anecdotal evidence suggests some migrant communities returning home to have their screening done on a yearly basis.

Other key findings include:

- Responding practices confirmed good public access links to, and suitable car parking facilities at their premises.
- Inconsistent and non-systematic approach to following up patients once practices have been informed of non-attendance.
- For service users living with a learning disability, practices monitor screening uptake at the time of their yearly annual health check.
- Posters and leaflets are reportedly available on request.
- Proactive promotion of screening is not undertaken systematically, some believe that this should be done by commissioners.
- Due to the transient nature of some communities, it is unclear whether the Prior Notification List is always accurately and thoroughly validated to ensure it is accurate and reflects the true numbers eligible for screening.
- Reminder letters were sent by the practices with higher uptake
- 100% response rate to wanting to be notified in advance of the Breast screening van's scheduled visit to area and to promoting van presence when it arrives.
- Practices report that they update patients' records if they are informed that the patient has been privately screened.

2.2 These findings have informed the recommendations and plans for future actions

2.3 The key recommendations that arose from the work of the Task & Finish group are:

Themes	Recommendations
Community Engagement and screening awareness campaigns	1. Undertake a 1:1 patient engagement or run focus groups targeted at certain communities to better understand levels of engagement with screening programmes and the reasons underpinning this. 2. The outcome of the focus group or 1:1 would inform the programme of work/initiatives and interventions to be adopted to improve participation. 3. Incorporate opportunity to educate and raise awareness about cervical screening into HPV vaccination delivery. For example, leaflets could be handed out along with HPV consent forms for parents and young girls to read. However, due regard will need to be given for the cost benefit implication of this approach and as such, this would be run as a pilot targeted at areas of low uptake in the first instance. 4. Health promotion buses to incorporate cancer screening into their promotional activity. 5. Alignment of local campaigns with national campaigns and cancer awareness week. 6. Community pharmacies to support the delivery of local campaigns for Cervical and breast screening in February 2016. 7. Display of screening posters in public toilets 8. Encouraging and engaging with organisations to promote Health and Wellbeing in the workplace. 9. Screening publicity on council's website to raise awareness. 10. Engagement with colleagues and universities via the student representative groups.
Primary care-focused initiative	11. Breast van schedule to be circulated to practices in advance of the van visit to enable better publicity to patients at practice level and to allow practices to encourage their eligible patients to attend. 12. A cleansing exercise of the practices' clinical systems to be undertaken to ensure that practices hold accurate patient records and that patients who have moved out of area are effectively deducted. To support this, it is recommended that a Did Not Attend (DNA) data analysis exercise to be undertaken for a pilot practice, 1:1 contact made with the patients who have not attended screening to understand why as well as validate their continued residence in the area. The

Themes	Recommendations
	outcome of this exercise will inform plans to roll out to other practices and help understand resource implications - both human and financial - for undertaking a wider roll out. 13. The Group will draw learning from a small pilot in Peterborough which will look at sending letters from practices to patients who have DNA their Bowel screening appointments and see if this would encourage patients to attend. 14. Training and update to be undertaken with practices to ensure the regular and systematic validation and submission of the Prior Notification Lists for cervical screening, which will ensure the invites go out to the eligible women.
Integrated and collaborative initiatives	15. An integrated and opportunistic approach to delivering screening which will see eligible individuals offered screening in any care setting to enable those hard to reach women to be able access cervical screening service. 16. Breast Screening unit to undertake GP engagement through existing training and educational structures designed by CCGs for GPs. It was agreed that the Lab could also tap into these GP educational/training days to update on protocols and changes to pathway for cervical screening.

2.4 On 26 November a first meeting was held to commence planning for implementation of the recommendations.

Recommendation	Planned actions
1. Undertake a 1:1 patient engagement or run focus groups targeted at certain communities to better understand levels of engagement with screening programmes and the reasons underpinning this. 2. The outcome of the focus group or 1:1 would inform the programme of work/initiatives and interventions to be adopted to improve participation. 3. Incorporate opportunity to educate and raise awareness about cervical screening into HPV vaccination delivery. For example, leaflets	The group will work with GP leads to identify practices to undertake patient surveys. Ideally practices with low uptake now and/ or with high proportion of patients from backgrounds associated with poor access to services This is still under discussion. Those having HPV vaccine are aged 12 or 13 years and will not become eligible for cervical screening until age 25, so promotion of screening at this age may not be appropriate but information in the pack sent to parents could contain

Recommendation	Planned actions
could be handed out along with HPV consent forms for parents and young girls to read. However, due regard will need to be given for the cost benefit implication of this approach and as such, this would be run as a pilot targeted at areas of low uptake in the first instance.	information aimed at promoting cervical screening uptake by the mothers.
4. Health promotion buses to incorporate cancer screening into their promotional activity.	Initial positive discussion but we need to better understand the use of the bus and how it can help in this work.
5. Alignment of local campaigns with national campaigns and cancer awareness week. 6. Community pharmacies to support the delivery of local campaigns for Cervical and breast screening in February 2016.	This is in hand – we will hold a pharmacy campaign in February 2016 for screening which will commence at the end of Cervical Cancer Prevention Week from 24 – 30 January 2016 and linked to World Cancer Day on 4 February. Appropriate literature being sought to support pharmacy awareness campaign. Support to be sought from District Councils for this campaign.
7. Display of screening posters in public toilets	Advice will be sought from the health improvement team who are engaged in workplace health initiatives as to how we can engage with workplaces to promote cancer screening
8. Encouraging and engaging with organisations to promote Health and Wellbeing in the workplace.	This is agreed, although it is not clear that this is the best website to display this information, Discussions suggest that the best action is to have some information on the Council website with links to other reliable sources of information such as PHE, NHSEngland, NHS Choice and the various cancer charities
9. Screening publicity on council's website to raise awareness.	We are aware that each year information packs are sent out to incoming students at Cambridge University that includes a considerable amount of health information. However, the majority of students will not be eligible for screening as they are too young so we will be discussing how we can get information to mature students.
10. Engagement with colleagues and universities via the student representative groups.	
11. Breast van schedule to be circulated to practices in advance of the van visit to enable better publicity to patients at practice level	This is already in hand. As the route of the breast screening vans is planned, the breast screening service will send advance notice to practices to enable them to discuss with their patient opportunistically and to display

Recommendation	Planned actions
and to allow practices to encourage their eligible patients to attend.	information in their waiting rooms. The service will assist with poster information. This is an ongoing activity, and relevant to public health interventions such as other screening programmes and immunisations.
12. A cleansing exercise of the practices' clinical systems to be undertaken to ensure that practices hold accurate patient records and that patients who have moved out of area are effectively deducted. To support this, it is recommended that a Did Not Attend (DNA) data analysis exercise to be undertaken for a pilot practice, 1:1 contact made with the patients who have not attended screening to understand why aswell as validate their continued residence in the area. The outcome of this exercise will inform plans to roll out to other practices and help understand resource implications - both human and financial - for undertaking a wider roll out.	The more detailed work with individual practices will be planned in as part of action 1 above. With support from Cancer Research UK, and Jo's Trust, training will be delivered to practice champions and appropriate PH Promotion staff within the community so that they are better equipped to promote information and sign post on cancer screening issues.
13. The Group will draw learning from a small pilot in Peterborough which will look at sending letters from practices to patients who have DNA their Bowel screening appointments and see if this would encourage patients to attend.	There has been evidence produced some years ago that letters sent to patients and signed by their own GP are more effective in encouraging patients to take up preventive interventions. This evidence dates form the time when GPs operated personal lists. Now the call recall services do this on behalf of the screening programme, this pilot will help to understand if invitation letters endorsed by their GP will make a difference.
14. Training and update to be undertaken with practices to ensure the regular and systematic validation and submission of the Prior Notification Lists for cervical screening, which will ensure the invites go out to the eligible women.	This is already in hand. Training is delivered by clinical and administrative staff in the screening programme.
15. An integrated and opportunistic approach to delivering screening which will see eligible individuals offered screening in any care	This needs to be explored further by NHS England who commission screening services. At present cervical screening is commissioned ass part of the GP contract and every eligible woman gets invited to

Recommendation	Planned actions
setting to enable those hard to reach women to be able access cervical screening service. 16. Breast Screening unit to undertake GP engagement through existing training and educational structures designed by CCGs for GPs. It was agreed that the Lab could also tap into these GP educational/training days to update on protocols and changes to pathway.	attend cervical screening at her GP surgery. This work is in hand although some more work is needed to ensure coordination between training programmes.

2.5 The work of theimplementation group will continue for at least 6 months and further reports can be provided at that time.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

The report above sets out the implications for this priority, being entirely focussed on prevention of ill health. .

3.3 Supporting and protecting vulnerable people

The following bullet points set out details of implications identified by officers

- Detailed analysis of the data indicates that some groups in the population have lower uptake rates
- It has been recognised that certain groups such as Travellers may have specific access issues
- Overall access to services, mainly the breast screening service, is an issue in some areas
- However the pattern is not a clear one of poor uptake among more deprived populations as there are also issues in more affluent areas

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Statutory, Risk and Legal Implications

Statutory responsibility to address equality. See wording under 3.3 and 4.3.

4.3 Equality and Diversity Implications

The report above sets out details of significant implications. The report and the work of the Task & Finish Group seeks to identify any equality and

diversity issues and address them to ensure good uptake of these preventative services by the whole female population.

4.4 Engagement and Consultation Implications

The report above sets out details of significant implications.

- Healthwatch Cambridgeshire are supporting this work with public surveys
- GPs will be surveyed to help identify issues faced by their patient populations

4.5 Localism and Local Member Involvement

There are no significant implications within this category

4.6 Public Health Implications

See wording under 3.2.

Source Documents	Location
Public Health Outcome Framework reports	http://www.phoutcomes.info/public-health-outcomes-framework