UNIVERSITY OF CENTRAL LANCASHIRE

Evaluation of NWCSQARC Coverage Projects

Final Report

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QA
CERVICAL SCREENING

Evaluation of NWCSQARC coverage projects

Final report to NWCSQARC – February 2010

Background
The NHS Cervical Screening programme was introduced to reduce inequalities in access to cervical cytology testing. Since its introduction, there has been a reduction in cervical cancer mortality among older age groups eligible for screening and in all socioeconomic groups. However, there remains a socioeconomic differential between the most and least affluent groups and there is an inverse relationship between socioeconomic group and cervical screening coverage. The North West has one of the highest rates of cervical cancer mortality and lowest rates of coverage in England.

In June 2005, the NWCSQARC invited PCT in the NW to bid for monies to support innovations aimed at improving low coverage. Seven projects were funded for a maximum of a year each. An external evaluation, led by the University of Central Lancashire, was set up prior to the commencement of the pilot projects. The objective of the evaluation was to assess the progress of projects against original plans, to collect information on the barriers and drivers to implementation and sustainability of the projects and to assess their impact on population coverage.

The projects
The following PCT were successful in attracting funding for a pilot project: Blackpool, Bolton, East Lancashire (including East Lancashire and Blackburn with Darwen), Liverpool, Manchester, Rochdale and Wirral. Rochdale PCT was unable to implement the project within the timeframe. Detail on the content of the remaining 6 projects is summarised in the table overleaf. All projects included the involvement of a community development or link worker(s) to promote awareness about cervical tests. These workers were offered relevant training about the programme by NWCSQARC.

The evaluation
All PCT chose a locality within their boundaries, which they targeted during the period of funding. The area was identified to the NWCSQARC by primary health care teams or geographical boundaries. They were also asked to identify another area within the PCT, of a similar size and with a similar coverage rate to the target area, to act as a comparator. PCT were asked to provide annual population coverage data for these localities and for the PCT as a whole at 4 time points: 2 and 1 year prior to implementation of the project; the first year of the project (when it was funded by the NWCSQARC) and the year after the funding ends irrespective of whether the intervention continues to be implemented or not. At six months and one year after the project commenced, PCT were asked to provide information on the progress of the project, the components which have proven difficult to implement, other initiatives within the PCT affecting the projects success and future plans about extension or expansion of the project. This report outlines the findings of the evaluation.

Table

	Blackpool	Bolton	East Lancs	Liverpool	Manchester	Wirral
Project start date	1/8/2007	1/1/07	1/11/06	1/1/07	1/11/06	1/1/07
Locality/PHCT	Both	Both	Both	Both	Practice	Locality
Population targeted		BME	BME		BME	
Components of intervention						
Outreach or community development worker (s)	√	√	√	√	√	√
(re)Development of Promotional materials	√		√			√
Targeted locality promotion				√		√
Group awareness sessions	√	√	√	√		√
Promotional campaigns on practice premises	√		√		√	
One to one awareness sessions			√	√	√	√
Targeting non-attenders			√ phone	√ letters	√ phone	
Additional smear sessions	√		√			√
Accompanying/ booking women to smear sessions			√	√	√	
Audit/log of contacts	√	√	√		√	√
Identification of barriers to attendance	√	√	√			
Additional information in letters of invitation				√		√
Developing links with practices	√	√	√			√
Developing links with other health professionals			√			
Improving practice quality				√		

PHCT = primary health care team Green = additional services added after project commencement Red = services which proved difficult to fully implement

During the year of funding:-

- Bolton PCT experienced a delay in implementing their group awareness sessions which were mainly undertaken in the final six months
- Blackpool PCT changed the focus of their project from locality to practice-based
- East Lancashire PCT focussed on different practices/areas within the targeted localities in the first and final six months
- Manchester PCT experienced difficulties maintaining support to all targeted practices as time progressed and, towards the end of the project, focussed their efforts on two of five practices.
- Wirral PCT implemented all the components of their project in the first six months; however, they experienced difficulties in providing outreach services because of a lack of community development workers.
- Liverpool PCT had no changes to the proposed programme.

Results

The interim report has already highlighted the barriers to women accessing smears observed by workers contributing to the projects. These included:

- attitudes of practice receptionist staff and their lack of understanding of the screening programme
- previous bad experiences with smear-takers and dissemination of these experiences among women
- cultural barriers relating to attitudes to health, to female empowerment and to sexual activity outside marriage
- lack of capacity for offering tests either within primary care or within the community.

It also highlighted the issues raised which hindered the progress of the projects. These included:

- difficulties in accessing some primary health care teams
- recruiting and retaining community development and/or link workers
- PCT restructuring

In addition, PCT also often commented that their proposed programmes of work had been too ambitious either because they expected to cover too wide an area within the limitations of the funding or they had underestimated the additional project management support needed to facilitate the work of community engagement workers. When the project relied on a single outreach worker, it was often felt that success was often due to the specific skills of that outreach worker rather than the skills required for the role.

One year on from completion of the project, none of the PCT had continued with the specific schemes. However, Bolton PCT, who had used a community ambassador scheme to raise awareness in community groups, were continuing to use this approach in bowel and breast screening. Blackpool PCT had invested in two new initiatives to promote uptake. They had set up locally enhanced services with some general

practitioners and were working with the Improvement Foundation targeting younger women who had not attended.

The coverage rates for the 2 years prior to the commencement of the project and for the 2 years after commencement are presented below. The coverage rates for the year following commencement of the project are presented in two six month periods. This was undertaken on request of the PCT, to help them in interpreting the data because the actual intervention period was less than a year or the intensity of the intervention differed across the year of the project. This is retained in figures and therefore care should be taken when interpreting the figures as not all time periods are equivalent. Two PCT, East Lancashire and Manchester, are seen to achieve a continued increase in coverage rates in the target areas since the commencement of the programmes which is not observed in the comparator areas or the PCT overall. Both these projects combined a community approach to promoting awareness with a practice-based approach to promote uptake and were focussed mainly in areas with high minority ethnic women. Blackpool PCT has seen a more recent reversal in the previous decrease in coverage rates across the whole PCT since the completion of project funding; this is likely to be related to the Locally Enhanced Service set up by the PCT in the last year and the work with the Improvement Foundation.

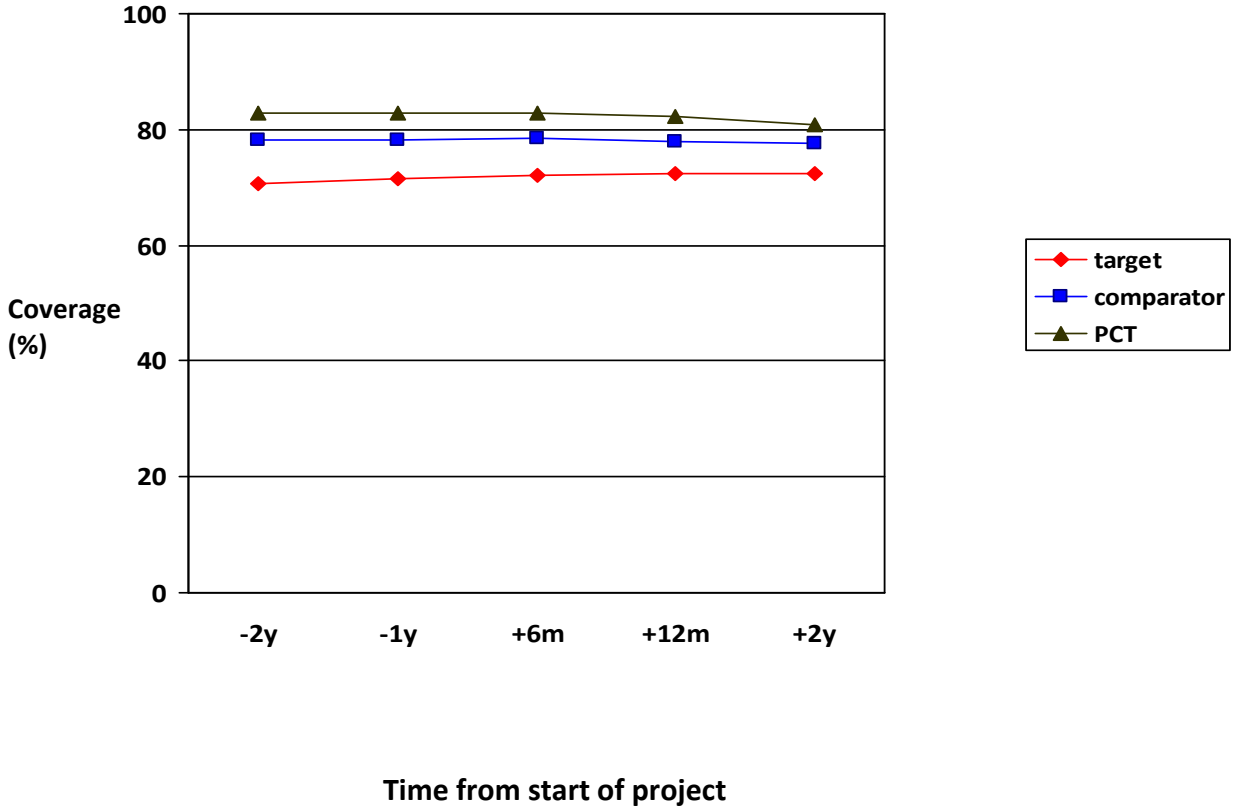
The key components to ongoing investment in initiatives to promote screening coverage highlighted by the project leads include:

- Alignment with PCT strategic and management objectives
- Robust commissioning processes
- Strong leadership and ownership within public health

Temporal trends in coverage by PCT for target, comparator and PCT areas*

Bolton PCT

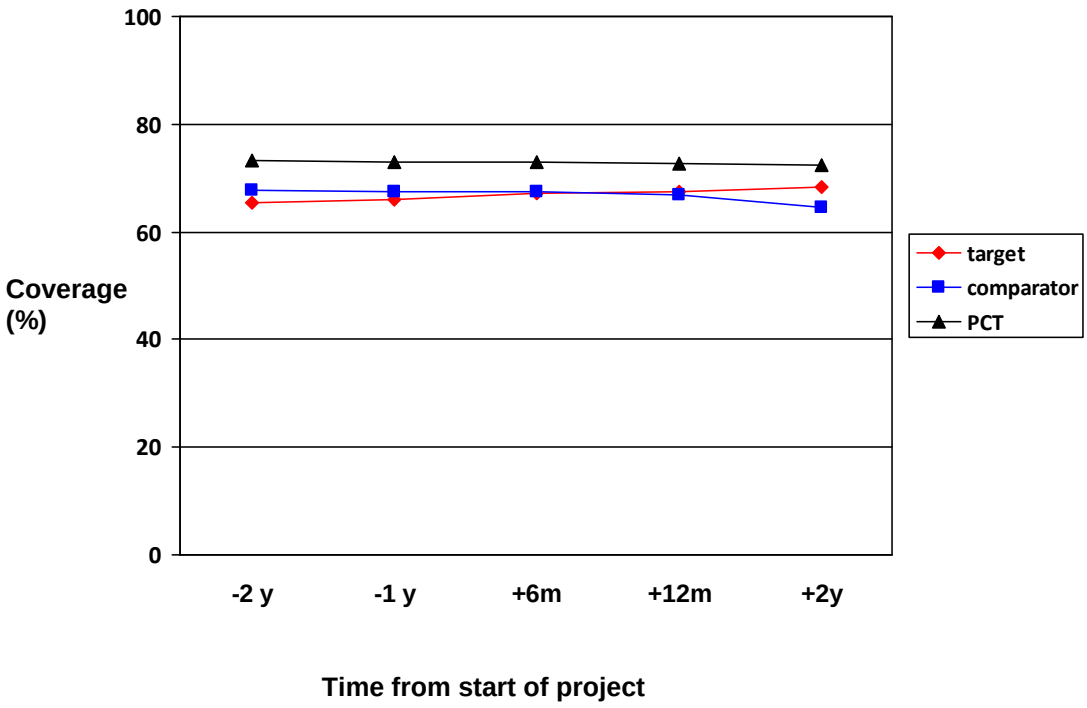
Time	Target area	Comparator area	Primary Care Trust
2 years before start of project (-2y)	70.8%	78.2%	82.7%
Year preceding start of project (-1y)	71.5%	78.3%	82.7%
First six months of project (+6m)	72.2%	78.4%	82.8%
Second six months of project (+12m)	72.3%	77.9%	82.2%
Year following project (+2y)	72.4%	77.5%	80.8%



***NB. Time periods are not equal**

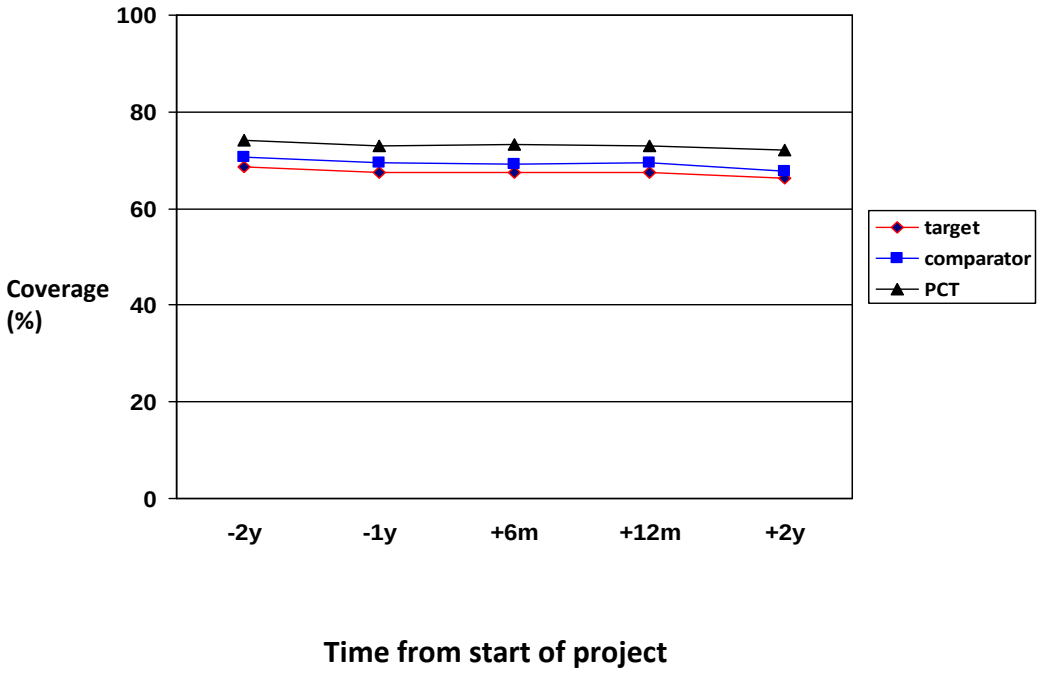
Manchester PCT

Time	Target area	Comparator area	Primary Care Trust
2 years before start of project (-2y)	65.3%	67.6%	73.3%
Year preceding start of project (-1y)	66.0%	67.4%	72.9%
First six months of project (+6m)	67.3%	67.4%	73.0%
Second six months of project (+12m)	67.3%	66.8%	72.8%
Year following project (+2y)	68.3%	64.5%	72.3%



Liverpool PCT

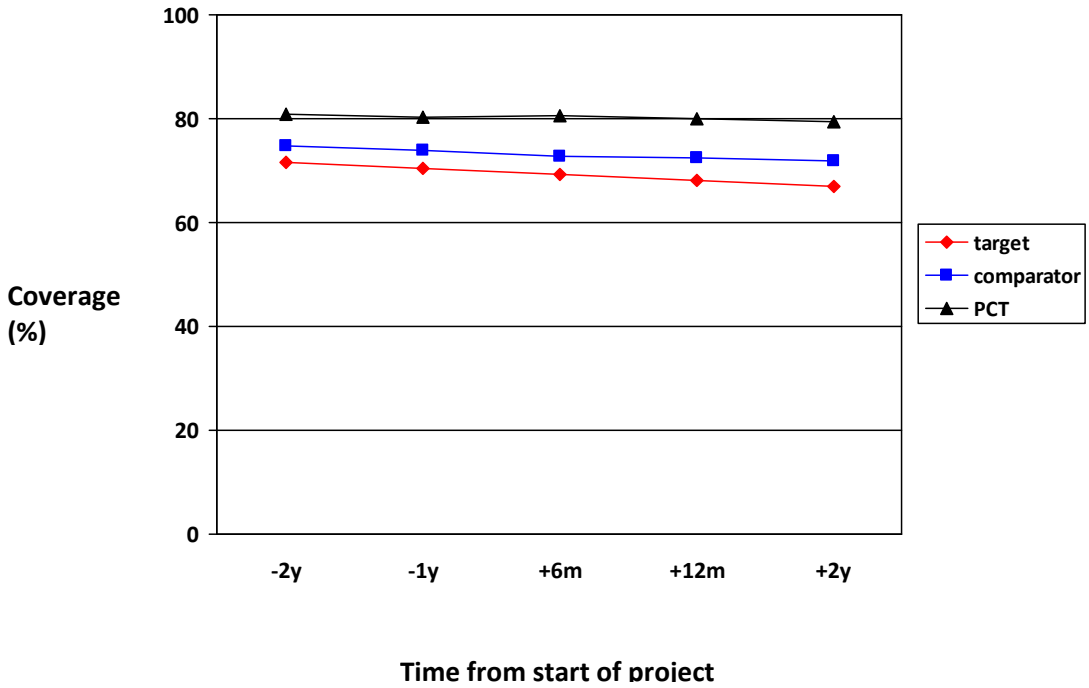
Time	Target area	Comparator area	Primary Care Trust
2 years before start of project (-2y)	68.6%	70.6%	74.1%
Year preceding start of project (-1y)	67.4%	69.5%	69.5%
First six months of project (+6m)	67.3%	69.3%	73.2%
Second six months of project (+12m)	67.4%	69.5%	72.9%
Year following project (+2y)	66.4%	67.8%	72.0%



Wirral PCT

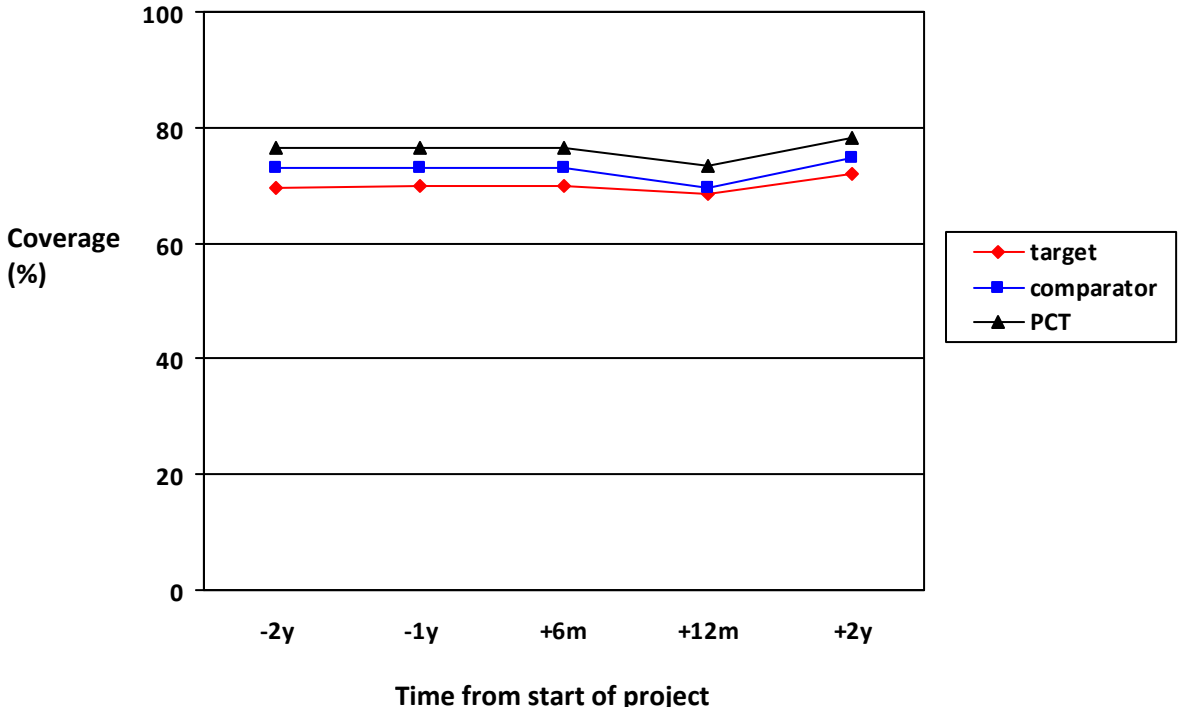
Time	Target area	Comparator area	Primary Care Trust
2 years before start of project (-2y)	71.7%	74.9%	80.8%
Year preceding start of project (-1y)	70.4%	73.8%	80.3%
First six months of project (+6m)	69.4%	72.8%	80.6%
Second six months of project (+12m)*	68.1%	72.5%	80.0%
Year following project (+2y)	67.0%	71.9%	79.4%

*The project was designed such that all interventions were undertaken in the first six months of the project



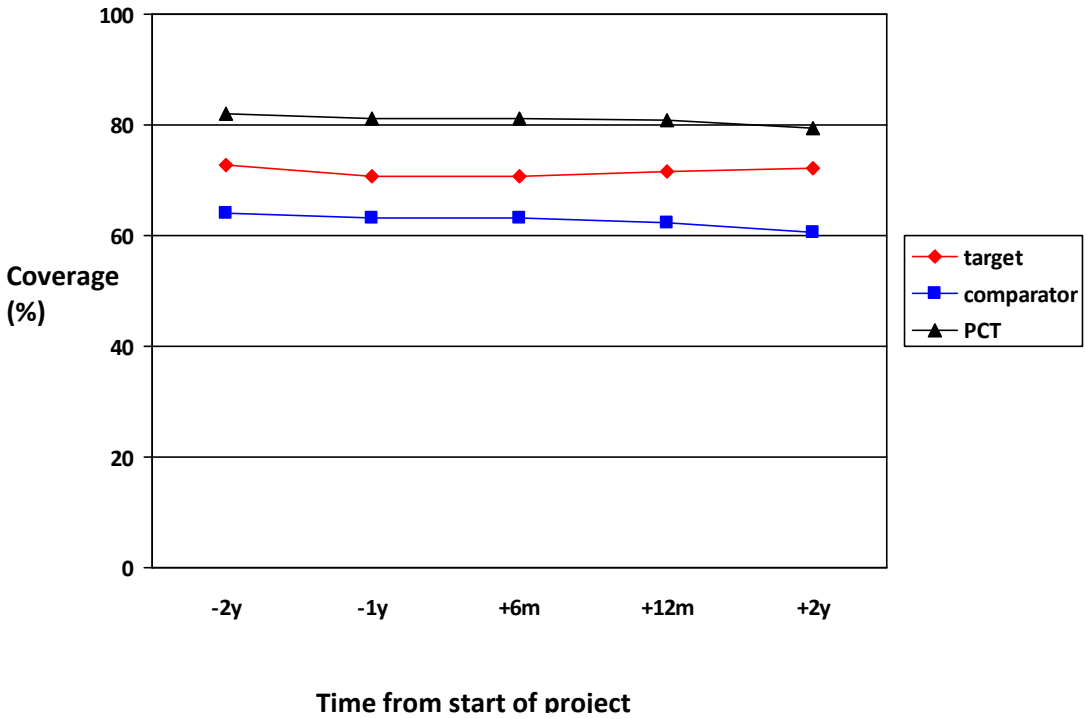
Blackpool PCT

Time	Target area	Comparator area	Primary Care Trust
2 years before start of project (-2y)	69.7%	73.1%	76.6%
Year preceding start of project (-1y)	69.9%	72.9%	76.3%
First six months of project (+6m)	69.9%	71.6%	75.9%
Second six months of project (+12m)	68.6%	69.7%	73.3%
Year following project (+2y)	72.1%	74.7%	78.3%



East Lancashire (East Lancashire PCT and Blackburn with Darwen PCT)

Time	Target area	Comparator area	Primary Care Trusts*
2 years before start of project (-2y)	72.6%	64.0%	82.0%
Year preceding start of project (-1y)	70.7%	63.3%	81.1%
First six months of project (+6m)	71.6%	63.9%	81.2%
Second six months of project (+12m)	71.5%	62.2%	80.8%
Year following project (+2y)	72.3%	60.6%	79.3%



Discussion

Although the initiatives were not universally successful, this project has provided some useful information to guide the development of interventions to promote improved screening uptake. In two areas, the coverage rates have increased since the commencement of the project in the face of decreasing coverage in the PCT overall. In Manchester PCT, this trend was to an extent occurring before the start of the project and the cervical screening project was a more focussed extension of the Community Health Educator project which had already been working with local Black and Minority Ethnic population.

However, there is some suggestion that the coverage rates in the East Lancashire target area have improved since the onset of the project against a general decline in rates observed in the comparator area and the PCT. This intervention was also focussed on BME groups and incorporated locality and practice based initiatives including group and individual awareness raising, involvement of health professionals, development of tailored health promotion materials, targeting of non-attenders and provision of additional access. The projects have not continued in either area since funding ceased.

However, it is unwise to draw too many inferences from the findings. The analysis of coverage rates is descriptive, which is appropriate to the study design and the data available for analysis. The evaluation does suggest that simpler initiatives which fail to take into account the complex interaction between individual, practitioner and organisational barriers to smear uptake are unlikely to succeed. Discussions with the PCT and workers during the evaluation further highlighted the complexity of these issues. GP and practice staff were felt to be key to increasing uptake through increasing access, providing a supportive environment for women seeking out a test, promoting screening and facilitating processes to identify non-attenders. It is of interest that a number of projects observed a lack of understanding of the programme among administrative practice staff and that this had an impact on women accessing cytology tests. The locally enhanced service initiated by Blackpool PCT may go some way to overcoming some of these barriers and should be further explored. However, Blackpool PCT also had a delayed start to their intervention and, compared to the other PCT, a greater part of final year of the evaluation covered the time period when there was increased media coverage of the death of Jade Goody from cervical cancer compared to the other PCT.

A common theme was lack of skilled community engagement staff, and it was felt important that future schemes should consider utilising more generic staff such as health trainers. The practical implications of some of the cultural barriers also need further exploration as these extended beyond language barriers to concerns among young, unmarried women about the confidentiality of the process. These concerns have been addressed in the past for the wider community.

Finally the project highlighted the need for embedding screening uptake issues in PCT strategic and management objectives and for strong leadership within Public health to continue to drive initiatives to promote screening uptake.

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