Scrutiny Review Breast Screening Services
Minutes of the meeting held January 18th 2010
DRAFT

Present: Cllrs Alexander, Beynon and Winskill (Chair)

In attendance: Dr Kathie Binysh (London Quality Assurance Reference Centre), Fiona Bonas (North West London Cancer Network), Martin Bradford (Overview & Scrutiny), Debbie Brazil (North London Breast Screening Unit), Alison de Metz (NHS London),Tamara Djuretic (NHS Haringey), Dr Jane Moore (NHS London) & Dr Zelenyanselu (North West London Cancer Network).

1. Apologies
Cllr Bull & Debbie Peaty (Haringey LINk).

2. Late items of urgent business.
None.

3. Declarations of interest
None.

4. Panel Discussion

4.1 Dr Jane Moore (NHS London), Alison de Metz (NHS London), Dr Kathie Binysh (London QARC), Fiona Bonas (North West London Cancer Network) Dr Zelenyanselu (North West London Cancer Network) all gave evidence to the panel. It was agreed however, that instead of giving evidence to the panel individually, invited speakers would respond to issues raised by the panel. The following provides a summary of the main points of discussion.

Monitoring and performance data

4.2 The panel noted that NLBS continues to run with a 46 month round length. This was on the advice of the National Screening Office, as it was felt to be safer to have a planned recovery of the service rather than double running (to catch up on clients missed while the service was closed). It was expected that the round length would be down to 36 months (national standard) by June 2010.

4.3 It was noted by the panel, that the extended round length at the NLBSS had impacted on the breast screening coverage (the proportion of women who had been screened within a 3 year interval). The low coverage rate recorded at NLBSS was observed to impact on London wide figures.

4.4 The panel assessed a number of charts which related to the performance of the NLBSS alongside other screening units. It was noted that in some instances the service was performing comparatively well. For example in screen to notification (time taken to notify women if the screen is abnormal) and screen to assessment (time taken to see women with an abnormal screen for further assessment).

4.5 The panel noted that the screening round length and screening coverage were the main areas where the NLBSS was not performing as well, both aspects which relate to the closure of the service in 2006/7. The panel heard that, because of the way that the screening programme operates it will take approximately 3 years for the coverage (the proportion of women who have been screened every three years) to come back up to regional average.

Screening Uptake

4.6 The panel noted that there were wide variations in the uptake of breast screening services month by month at the NLBSS: in some months uptake was as high as 67% but in others just 50%. It was understood that screening is performed on an area by areas basis and this variance was caused by the inclusion of different practices within the screening round: some practices had naturally high responses whilst others low. The month where there was a high uptake of appointments was due to the inclusion of high response practices together in that month.

4.8 The panel heard that the variation in the proportion of women taking up a breast screen at the practice was quite significant. In some practices, uptake of invites to breast screen was about 70%, but in other practices this was as low as 20%. The panel felt that this should provide a focus for initiatives to improve screening uptake.

Agreed: That further data is provided, at the general practice level, on the take up of breast screening invites in Haringey.

4.9 The panel heard that NLBSS had worked hard to develop capacity in the service to be able to offer appointments for women (first and assessment). It was noted that the availability of radiologists were critical to service capacity and that the service had worked hard to retain a pool of these skilled workers across acute hospital sites in North London. The panel noted that there were 9 radiologists working for NLBSS on a sessional basis one day a week. Although the system has its disadvantages (continuity, coordination) it is less susceptible to service disruptions through staff absence.

4.10 The panel heard that in London although attendance was ok for those women who have screened before, attendance was very poor among first attendees at the breast screening service. It was reported that NHS London were particularly aware of this problem and were working on this as a priority (work commenced in summer 2009). Similarly, it was noted that there were strong variations in age take up, with younger women within the breast screening programme less likely to attend than older women. It was noted that first time invitees have different invites to those women who have attended before.

4.11 It was noted that there were a wide range of problems associated with poor uptake including the non receipt of invites. In some areas up to 40% of invites were estimated not to get through to intended recipient (gated communities, shared mailboxes, dumped by mailmen).

4.12 It was reported that Tower Hamlets had undertaken some development work to improve breast screening uptake. It was noted that this PCT have focused initiatives around 1) non attendees 2) improving accessibility i.e. clinic location. Although they were working from a low base, it was recorded that this PCT had recorded a 10% increase in breast screening uptake. The panel noted that the detail of this work has been summarised in the recent publication.

Agreed: to circulate recently published research paper outlining what had been achieved in Tower Hamlets to improve breast screening.

4.13 The panel heard that it was important that initiatives to improve breast screening uptake were sustainable. One off projects were perhaps useful in raising awareness, but given the nature of the breast screening programme, this would only bring a short lived improvement to screening figures. Instead, it was recommended that there should be a programme of sustained development to maintain the upward momentum for screening uptake.

4.14 To this end, it was reported that NHS London has developed a breast screening action plan template (previously circulated) which all PCTs are required to complete. These were basically a set of good practice standards which the PCT is required to assess itself against. Trusts are currently completing these strategies and will be assessed and signed off in February 2010. It was noted that this process provided a good mechanism for sharing good practice across the PCTs.

Agreed: NHS Haringey breast screening action plan to be circulated to the panel.

4.15 The panel heard that extensive press coverage of screening services, as seen with Jade Goody and cervical cancer, was beneficial in raising awareness and in increasing attendances. It was noted however, that increased attendances were mainly amongst the worried well and that only marginal increases attendance were recorded among the key target groups for cervical screening. This view was shared by those giving evidence to the panel, namely that mass marketing through the media does not appear to work. What is really needed is action at the PCT level to assess what is needed locally and to commission services to meet those needs.

4.16 The panel heard that the system through which women are invited to breast screen was established over 20 years ago (at the inception of the national programme) and this has not changed. The present system generated a number of anomalies in the three year cycle – as PCTs performance would vary according to which practices or areas are invited within this 3 year programme. Women were not always invited in exact 3 year intervals, this depended on the rotation of the screening round sites. Indeed, those women that move practices may be screened earlier or later than 3 years depending on where the practice which they moved to was in the screening round.

4.17 It was noted that NHS London is undertaking preparatory work to move to a London wide call and recall system which is based on the date of women screen. Thus it was hoped to develop a system whereby women are invited on the three year anniversary of their last screen as opposed to the practice rotational basis.

Digital screening

4.18 The panel heard that the NLBSS now operated a fully digitalised service where mammography was undertaken digitally rather than by film. Digital imaging was necessary for a number of reasons.

- Firstly, it was easier to store and would improve quality assurance processes (i.e. the ability to compare screens where cancer had been detected with previous screens which had been negative).
- Secondly, digital imaging produced much more sensitive images which was necessary to pick up abnormalities, particularly in younger women (where breast tissue may be denser).
- Thirdly, improved image quality may minimise the occasions when a repeat or duplicate screen may be necessary and reduce patient anxiety.

4.19 The panel heard that the new digital x-ray machines were highly sensitive and had to be routinely checked by a physicist to ensure that the correct x-ray dosage was being used and that the machines were calibrated to provide clear and precise images.

4.20 The panel also noted that the NLBSS is undertaking a pilot project to digitalise past films to assess what benefits that this would bring for breast screening service. It was possible to digitalise all past film screens, but this would require a significant investment.

Primary Care and breast screening

4.21 The panel were keen to hear how GPs and primary care services were involved in the breast screening process. It was noted that the list of women screened was derived from GPs through the national Exeter database. Local lists of invitees are developed through local public health directorates ensuring that those women who have had a double mastectomy have been removed from the list. GP list cleaning was also critical to ensure that up to date data was being used to formulate breast screening invites.

4.22 Ahead of women being screened from a particular practice, the breast screening service writes to GPs in that practice to notify that screening is about to get underway. In addition, posters are distributed to the practice to notify women that breast screening is being undertaken in their practice.

4.23 The panel heard that at the end of the screening operation in a particular practice, GPs receive a list of women who have not attended. It was noted with concern however, that there is little if any follow up on these non attendees, primarily because there is no (financial) incentive for them to do so. NHS London reported that it was the responsibility of local PCTs and primary car commissioners to resolve this issue and to ensure that GPs act appropriately with this list.

4.24 The panel heard that GPs are not paid for any breast screening work within the general contract as they are for cervical screening (where financial incentives are provided for the level of uptake in individual practices). It was suggested that one way forward was to develop a local Enhanced Service for GPs which provided terms for GPs undertaking breast screening work i.e. pre-screening letter or call reminder or generally working with non attendees. Westminster PCT has an enhanced service (telephone call and follow up of DNA letters) which has resulted in an increased uptake of breast screening.

4.25 A number of options for further primary care involvement were discussed by the panel to help improve uptake of breast screening services including:

- Original invite to come from patients on GP – more likely to attend- this was possible though would need to be specifically costed and commissioned.
- GPs write to women in their practice making them aware that they will be receiving an invite from the breast screening unit and encouraging them to attend.
- Telephone/ written reminder to those who have not attended.

4.26 It was noted that some PCTs have already established an enhanced service for GPs which required some breast screening interventions in primary care. The nature of these interventions and the remuneration GPs received was known to vary across PCTs. It was reported to the panel that NHS Haringey considered the inclusion of Breast Screening within the Local Enhanced Services, but this was not a commissioning priority for 2009/2010.

4.27 It should be noted that not all GPs wanted to be involved within the screening process as there were some which had doubts about the efficacy of the breast screening programme. A minority of GPs and other medical staff hold the view that screening detects growths which may be benign or that may go away naturally.

4.28 The panel heard that in some localities, the uptake rate of breast screening services from individual practices was published so that practices and other professional can compare performance. It was hoped that this might incentivise those practices where uptake was low to implement initiatives in their practice.

Agreed: it would be useful to have this data for Haringey practices.

4.29 The panel were keen to hear what new technologies were being used to help improve screening uptake. Whilst texts and other mobile phone technology was being used for other screening services such as Chlamydia, it was difficult to implement this for breast screening as this would require individual consent for phone numbers to be used/ passed to another agency.

<u>Screening invite and accompanying information</u>

4.30 The panel discussed the screening invite which is sent to women. It was noted that this was a very dense letter with a lot of information contained

within it. The panel heard that this letter is used as standard across screening units and was sent out with an accompanying booklet: “Breast Screening the Facts.”

4.31 The panel were concerned that there was no information in any other languages on the invite. It was noted that there is no facility to print off the letter in different languages and process to identify which women speak which languages from the Exeter dataset.

4.32 The panel heard that other screening services had issued talking invitations which invited the women in a number of key languages. Other services had enclosed pictorial guides to breast screening services alongside other printed material to help those who do not speak English or cannot read to understand the importance of breast screening and the need to attend for a screen.

4.33 It was suggested, as is the case with most council literature, a summary statement is provided in a number of key local languages on the back of the invite. This need not go in to any detail, but perhaps provide further details of where further information can be obtained i.e. via a website, phone and community groups. Similarly, this can be done on a Haringey or NLBSS wide basis (i.e. top 10 languages for the NLBSS area.

Agreed: that it would be helpful to include a summary of screening information in a number of key languages in the screening invite issued to women.

4.34 It was noted that all breast screening units in London have their own websites. It was suggested that these could have breast screening information in different languages available on the site. The panel noted if such information was developed, this could be referred to within the invite.

Agreed: that breast screening information should be available in different community languages through the breast screening units website.

<u>Health Equity Audits</u>

4.35 It was noted that Redbridge have recently completed a Health Equity Audit which systematically sought to assess the barriers that groups of women faced in accessing breast screening services. Interestingly, the audit found that men were a key access point for some groups of women from BME groups as they decided whether women in the household should attend. It was reported from NHS London that health equity audits were standards practice across London (and included in local strategies). It was noted that Haringey had undertook a social marketing campaign which had a similar purpose.

4.36 The panel also noted that Tower Hamlets had also undertaken some peer communication projects to develop community outreach for breast screening. The panel heard that research with local Asian women had indentified GPs and community elders/ leaders as important sources of influence in health service uptake.

Screening across unit boundaries

4.37 The panel heard that women may not always be convenient to access screening services available in the area in which they live. For example, a woman that lives in Haringey may not find it at all convenient to access the breast screening services provided by NLBSS (Whittington, NMH and Forest Road) when they work in central London. It was understood that whilst cross unit referrals were possible this was technically difficult.

4.38 It was noted in the meeting that breast screening is available out of hours. Though in respect of the NLBSS, evening and Saturday appointments are only available at NLBSS headquarters at the Barnet and Chase Farm site.

4.39 The panel sought clarification as to whether breast screening services would be available through the Hornsey Health Centre (polyclinic/ neighbourhood health centre). It was noted that there are strict governance arrangements for the location of mobile units and that screening services were currently being provided through the Whittington. It was noted that another screening service in London (South West) had plans to develop breast screening sites at each of its polyclinic locations.

Agreed: the panel would like further clarification whether mobile breast screening units will be available through planned neighbourhood health centres in Haringey.

Other interventions to improve uptake

4.40 It was stressed to the panel that any interventions to improve breast screening uptake should be long term and sustainable. There were interventions which were of low cost and could be maintained, such as pre invitation letters, the offering of fixed first appointment and follow up reminders. It was also suggested that approaches to improving uptake should be multi-layered, i.e. on a broad awareness basis (screening is happening in your area) and more targeted follow up (i.e. by a GP).

4.41 The panel heard that there were some interventions to help improve screening uptake among particularly vulnerable women, such as those with a learning disability or with mental health problems, though it was accepted that more should be done to facilitate access. Some established learning from working with this group was that it was necessary to target care workers as well as the women themselves and that it was helpful to offer these women longer appointments from static sites. Pre visits to explain the process was also seen to be helpful.

4.42 The panel also heard that work has commenced to help identify those women are of particularly high risk of breast cancer (i.e. where there are other familial cases). It was noted that current work is patchy, though work is being undertaken at the regional level.

Health promotion/ public health function

4.43 It was noted that it was the responsibility of individual PCTs to undertake health promotion and public health programmes to support breast screening i.e. breast cancer awareness, breast care and promoting of breast screening. It was reported that PCTs may want to seek partnerships in developing these roles, for example with the local council or community and voluntary sector. It was important that the same messages were heard from a range of different sources within individual localities.

4.44 It was noted that North West London Cancer Network had developed a reference guide to improving screening uptake. This was tabled at the meeting.

Agreed: that the reference guide be circulated with the agenda for the next meeting.

5. Update on service user consultation

5.1 There was not time to provide an update on the service user consultation. It was agreed that this would take place with members informally before the next meeting.

6. Date of next meeting

6.1 11am Monday 1st February 2010.