Name	Suzannah Carrier
Job Title	Salaried GP
Organisation	Ordsall Health Surgery
Mentor Name	Fiona Hamilton
Project name	Equitable access to primary care services illustrated by approaches to enhance breast screening participation in Ordsall
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Introduction	Ordsall Health Surgery is a GP surgery in Salford South-East Primary Care Network (PCN), Salford. It has approximately 11,000 patients registered. Life expectancy is 78.9 years for women and is 76.5 year for men registered at Ordsall Health Surgery[i], lower than the national average for life expectancy of 83.2 years for women and 79.3 years for men[ii]. The practice population sits within the 2nd most deprived decile under the English Indices of Deprivation 2019[i]. There is a diverse patient population, 37% of ethnicity-coded patients having a Black or Asian minority ethnicity code and 27% of patients coded as not having English as main or second language based on assessment of practice coding. With this knowledge, the assumption can be made that a proportion of the population would fall within the Core20PLUS5 groups or be consider underserved based on socioeconomic deprivation or having protected characteristics described in the 2010 Equality Act. I set out to better understand the patient population and barriers to accessing primary care services and it became clear that there would need to be a specific focus on one area of health to be able to scope, deliver and assess the impact of this work in the 12 months available in the fellowship. Breast screening coverage within the Salford locality is below the average for the rest of the England and significantly lower than the national target of 70%. Data from the Greater Manchester Integrated Care Partnership cancer screening dashboard shows breast screening coverage across localities. This data is based on coding of results from practices. Looking at data from July 2024, when this was chosen as a focus of this project, breast screening coverage (defined by proportion of the eligible population screened in the last 36 months) was 48.1% in Salford. This was the second lowest, after Manchester at 46.6%, of Greater Manchester localities. The average coverage was 57.5% across localities. This cancer dashboard data set showed Ordsall Health Surgery's breast screening coverage was 40.4% in July 2024. Ordsall Health Surgery's previous screening cycle was 1st-28th February 2022, the GM cancer dashboard shows breast screening uptake data for March 2022 at 48.2%. Data prior to March 2023 is presented in the dashboard quarterly, after this there is a monthly update for the data. There are potential issues with data quality due to reliance on practice coding for accurate representation of uptake of screening.

	Data from Fingertips show a concerning downward trend in breast screening uptake. In the 2009/2010 screening period the breast screening coverage for eligible patients aged 50-70 years registered in practices in Salford South-East PCN was 63.1%, suggesting an overall decline in screening uptake[i]. For this reason, breast screening was chosen as an area of clinical priority for the Health Inequality work as part of the PCN DES and a working group was formed in July 2024. Early cancer detection has been highlighted as one of the five clinical areas which requires accelerated improvement for Core20PLUS5 populations; early cancer diagnosis through screening participation would come under this clinical priority. Breast screening is one of 11 NHS national screening programmes available in England. The aim of breast screening is to detect breast cancers by mammogram, with the intention that cancers may be detected earlier, potentially before they would be detectable by patient self-examination. Eligible patients are invited from the age of 50 until their 71st birthday[iii]. The value of breast screening is demonstrated by the early detection of breast cancers, i.e. before a patient is aware of a breast lump or other symptoms or signs of cancer. In England's 2022-2023 screening period 18,942 women had a cancer detected through breast screening, equating to 8.7 cases per 1000 patients screened. Of those detected, 79.3% were invasive cancers[iv]. There are also potential harms from breast screening. There is the potential for overdiagnosis of breast cancers. The screening process does not differentiate between high and low risk cancers. It is thought that for every 1 woman whose life is saved from breast cancer, around 3 women are diagnosed with a breast cancer that would never become life threatening. There is a risk of false positive mammograms, leading to further invasive investigation and psychological distress that can be associated with an abnormal result. There is the potential for false negatives, missed cancers and false reassurance. Some women may experience pain or psychological distress, associated with the mammogram or initial screening process, or further investigation through biopsy or fine-needle aspiration if this is indicated[v]. The screening window for patients registered at Ordsall Health Surgery was due September 2024, with an eligible breast screening cohort of 840 patients and 490 patients due for recall in this cycle of screening, according to searches performed in July 2024 on the practice clinical system EMIS. Ordsall was the practice being first to be screened in the PCN. This timeframe provided an opportunity to develop this project, alongside stakeholders in Salford and the PCN, to understand the barriers to screening participation and develop approaches and interventions to improve uptake.
Central aim of your project	I aimed to collaborate with stakeholders within the Salford South-East Primary Care Network (SSE PCN), Manchester Breast Screening Programme, Public Health Inequalities Improvement Team (PHIIT) and Salford Health Improvement Service to understand barriers to uptake of breast screening and take a unified approach to improve the low screening uptake in the local area. I also aimed to gain a better understanding of the

	barriers to accessing primary care services and an understanding of our local population to help inform future work around health disparities. Together, we aimed to increase breast screening uptake, particularly among under-represented groups in Salford South-East PCN, by 20%. We planned to achieve this through targeted community outreach and education about screening, targeted communication and improved accessibility of screening services. The goal was to ensure equitable access to breast screening and reduce health disparities within the community through earlier detection of breast cancer to improve long-term health outcomes.
Methodology, results, conclusion	A working group was coordinated by SSE PCN, bringing together teams including PHIIT, the Greater Manchester Breast Screening Programme and Salford Health Improvement Service. The fellowship has allowed me the opportunity to connect with this group, to collaborate and work alongside them to contribute to efforts to increase the uptake of screening in Salford. We met twice a month remotely from July 2024. **Insights and understanding barriers** The initial approach was to understand the reasons why the PCN breast screening uptake was suboptimal. We also wanted to understand the population demographic better. My personal focus was in understanding the locally registered population at Ordsall Health Surgery. The catchment area for the registration at Ordsall Health Surgery has changed significantly over the last 20 years. The practice sits within a neighbourhood that forms the southern part of Salford's inner city. The catchment includes the neighbourhoods of Ordsall and Salford Quays. The Ordsall area is mainly social housing, whilst the Quays is predominantly residences made up of apartment buildings, and includes The Lowry, an arts and theatre space, and Media City, home to BBC and ITV media. Both areas have seen a transformation over recent years with a significant increase in population and construction of buildings and residences. The Practice Manager at Ordsall Health Surgery had met earlier in 2024 with a representative from the Hong Kong community to better understand needs around access to care after an increase in registrations from patients from Hong Kong was observed. The conversation specifically focused on the uptake of NHS health checks and child immunisations. However, it highlighted that understanding about NHS systems and processes was a barrier to this community accessing services. They flagged that the health check was not offered in Hong Kong so a message inviting patients, without any information about what it was or why it was being offered, might not prompt someone to book. The lack of awareness of availability of interpreters in the correct language, and messaging in English rather than spoken or written language, were also reasons that patients might not accept an appointment. The working group also shared various insights and good practice from other PCNs' screening cycles. There was a time-pressure to deliver educational materials, so they were able to adapt some materials produced by other areas to use in this project. There was feedback from the Manchester Breast Screening Programme that there are often low-attendance rates amongst first-time attenders, however their evidence was that if someone attends for the first time they tend to

	continue to be screened at following invites. Their recommendation was to promote screening within this group specifically, to improve overall attendance, through targeted endorsement by message or letter. We developed a pre-screening questionnaire to be sent to patients at Ordsall Health Surgery ahead of the screening period to try and gather further insight specifically around breast screening. This was sent to the cohort due to be invited for screening during the September screening period. It was limited to 3 questions, firstly to improve likelihood of completion, but also due to resource limitations. Although it is more challenging to capture detailed nuance around screening behaviours via a survey format compared with a workshop, the limited timeframe for the project to be designed and delivered meant a short survey felt more appropriate to gain quick insight that could be acted upon. There were 129 responses to the questionnaire from the 490 sent in the week that it was live. The insight from the questionnaire showed that 81% indicated intent to attend screening, 10% did not plan to attend and 9% were undecided. Regarding perceived barriers to attending, 55% perceived 1 barrier, 38% perceived 2 barriers and 7% perceived 3 or more barriers. There were barriers identified relating to practicalities of attending screening such as transport, time and location of appointments, language barrier, fear and anxiety about screening, and patient mobility issues. Insight was also gathered during and after the screening period. Attenders to the Pendleton Gateway screening van were asked to complete a questionnaire following their appointment, 110 responses were obtained between September and December 2024, with 57% of responders being registered at practices in SSE PCN. The rest of the responders were made up of patients registered at Eccles and Irlam (34%), Swinton (6%),Walkden (1%), Oldham (1%), and Glossop (1%). Information was gathered about what had promoted their attendance, patient experience of screening and reasons for previously not attending an appointment in first-time attenders. We undertook follow-up of non-attenders of screening at Ordsall Health Surgery. We sent a short questionnaire to patients by text, asking their reason for non-attendance. There were only 24 responses to the 196 surveys sent. This was followed up by a call from the practice care-coordinator. Follow-up of all non-attenders has not yet been completed which has limited the volume of data gathered from the non-attender group. **Approaches to increase uptake of screening** In previous screening cycles, the practice had not undertaken any pre-screening work, or endorsement of screening. Upon receipt of outcomes of screening these would be coded, and non-attenders would be sent a generic letter with instructions to re-book in English. <u>Time or location of appointment and transport</u> Prior to me joining the working group, there had already been discussions exploring the option of bringing the mobile screening van to the Ordsall estate from its location at Pendleton Gateway 1.4 miles away. This was deemed too costly. Insight from the pre-screening questionnaire highlighted barriers around practicalities of attending an appointment. Inconvenient time or location of screening appointment was cited as a

	potential barrier to attending in 48% of responses and lack of time to attend an appointment was also cited as a barrier in 23% of responses. Lack of transport to attend an appointment was cited in 11% of responses. A physical health or mobility issues was reported as a barrier in 6% of response. To overcome issues around convenience of time of appointments, through the Ordsall screening period there were four Saturday clinics offered in addition to the weekday appointments. There were requests from the working group for evening appointments, but this could not be facilitated by the screening programme. The insight from the pre-screening questionnaire around transport as a barrier supported PHIIT with agreeing a transport pilot with Salford Assist. The plan was for this be delivered by the practice Care Coordinator to offer referral patients who had not attended their first breast screening appointment, where low-income or mobility issue was a reason for non-attendance. These patients could be referred to Salford Assist for funding of either a bus pass or taxi depending on patient circumstance. On reviewing the impact of this, unfortunately no referrals were made to this service by our care coordinator when she followed up with non-attenders. Due to staffing issues in the reception team, the care-coordinator had limited time dedicated to this task and had only followed up with 31 patients of the 196 that had not attended by November. On reflection, it might be that affordability of transport was less of a factor and due to the brevity of the questionnaire nuances around this barrier was not captured. Despite poor utilisation of this scheme in Orsdall, the pilot has been rolled out for other practices across Salford, so the uptake and success of this approach could be assessed in the future. <u>Language barrier</u> Language barrier was highlighted as a barrier to attending screening in 8% of responses to the pre-screening questionnaire. In considering approaches to overcome this barrier, we faced some challenge in understanding the screening cohort's language requirement. I looked at Ardens searches built into EMIS and found for the breast screening cohort there was missing data for language and interpreter requirement, with 7% of the cohort not having their main language coded. I found that this had arisen from the processes in patient registration, in which the requirement for an interpreter had been added to a warning pop-up box and not coded in patient records. A new template for registration had been introduced, but the admin team had not been utilising the tab for coding spoken language and need for interpreter, so the impact of this was fed back with a request for this to be utilised. Where this data was available, there were 29 different languages coded as main spoken language. The code for 'interpreter needed' being poorly recorded means this might not reflect the impact of language barrier in the cohort, as patients may speak English despite this not being their main language. From this data, we were able to gather the following insight about the commonest spoken languages where English was not main language, for those due to be invited for screening: • 11% main spoken language Cantonese • 5% main spoken language Portuguese • 2% main spoken language Arabic • 2% main spoken language Polish This was also reflected in interrogation of practice LanguageLine data – where interpreter activity by language over 2023-24 showed that

	Cantonese was most requested, followed by Farsi, Portuguese, Arabic, Tigrinya, Polish and Czech, in order of volume of requests for all appointments. The Breast Screening Programme provided messages as part of the GP pack to send to patients, including notification of the screening period commencing, a targeted message for first-time attenders and a follow-up message for non-attenders. PHIIT translated these to the practice's most needed languages: Farsi, Arabic, Portuguese, Cantonese and Polish. The practice sent the appropriate messages to patients for whom main language and interpreter requirement was coded. We encountered limitations to sending pre-screening and first-timer notifications as a practice, due to difficulties identifying the screening cohort due to be invited because recall list numbers differed between the practice searches and the screening programme. Due to outdated IT systems used by the breast screening programme, they were unable to easily provide prior notification to practices of the patients due to be invited for screening to support targeted messaging. This was escalated by the working group to the screening programme director and cancer screening operational meeting. <u>Awareness and education about screening</u> Pre-screening endorsement messages were also sent in English. In the survey completed by attenders to the screening van, 12% (15 of the 26 responders who were registered at Ordsall Health Surgery) stated that a message from the GP promoted their attendance, 80% (97 patients) stated that the breast screening letter promoted attendance. The insights from the pre-screening questionnaire also demonstrated that fear and anxiety were a factor in previous non-attendance to screening, with 19% of responses citing this barrier. A previous negative experience of screening was cited as a barrier in 6% of responses to the questionnaire. These insights led us to create a practice display with information leaflets, including translated materials, to promote informed decision making about screening and overcome fears through provision of information. We shared posts on social media, however the patient of reach of this is poor, with only 409 followers of the practice Facebook page. Upcoming screening was advertised on digital noticeboards in Salford and on physical poster displays in businesses and community spaces locally. Using already fostered community links, PHIIT, Salford Health Improvement and the Breast Screening Programme delivered community awareness events across Salford throughout September and October including: • Salford Foundation Answer Cancer event • The Cancer Awareness Roadshow • Community outreach at Community Doosti, Salford Loaves and Fishes and Hong Kongers Kick Community • Ordsall estate outreach event with Salford Health Improvement van There was also media coverage around the poor screening uptake in Salford through BBC Radio Manchester. I was interviewed live and this formed part of a week of coverage they developed including; pre-recorded interviews with breast cancer survivors and a breast cancer support group,

	an audio recorded walk-through of the breast screening van experience at Pendleton Gateway and interviews with radiographers and the breast screening team, and coverage of the unveiling of a plaque in Greater Manchester for Girls Aloud star Sarah Harding who died of breast cancer. These recording went out over 4 days as part of a week of coverage to promote breast screening in Greater Manchester. At practice level, I organised a 2-hour Q&A drop-in event targeting patients eligible for breast screening. This was held in the reception area and was delivered by the Breast Cancer Screening Improvement Lead from Manchester Breast Screening Programme. The benefit of this being held in reception was that footfall from patients visiting the practice for other reasons provided opportunistic interactions around breast screening. The event was advertised on practice social media and an invitation was sent by text to all women eligible for breast screening registered at the practice. The aim of the event was to allow patients to gain information, ask questions and address fears or worries about screening. There were several positive stories from the event, including an opportunistic discussion with a patient who was over the automatic recall age who had never attended screening. Whilst at the event she called the screening team to self-refer for appointment for breast screening and the patient later contacted the practice to thank us for the event. In addition to sharing positive messaging and answering questions about screening, there were also practical benefits to the event, as some women attended who had missed their appointment or lost their letter, and had their appointments re-booked at the event. Some women were not aware that they could continue to self-refer for screening after the age of 70 years and so they also made appointments. This event was coupled with delivery of breast screening awareness training to the reception team, to develop their confidence in having opportunistic discussions about screening with patients and to allow them to better understand how to manage queries about screening directed to them by patients. There was excellent feedback from this training from those attending. They fed back that their confidence in broaching this subject had increased, and that they had greater understanding of the pathways for screening and how to direct patient to book appointments for this. <u>Incentivised screening</u> Incentives for screening were offered and advertised on promotional materials that were displayed. A local café supplied a voucher for a hot drink and cake at a local café following screening attendance and there was entry into a prize draw for Love2Shop vouchers and a gym membership. In feedback from patients who had attended screening, the incentives developed were not mentioned as factors that prompted attendance for any of the responders. There was feedback from the café MunchyHub that there was low utilisation of the hot drink and cake voucher in the 6 weeks following the screening period. The voucher was made valid until end of 2024 so there may be further usage but as of last feedback in November this was not heavily utilised. My reflection on this is that knowledge about screening and informed decision making is the main driver for attendance. The person being

	motivated to take a positive action for their health is more powerful that providing incentives to attend. At a later meeting with the working group, it was also raised that caution should be exercised around the incentives offered as from an ethical perspective, as screening should be an informed patient choice. From a patient perspective, it could also contribute to the viewpoint that screening is a negative experience, that they must be persuaded or remunerated to attend. <u>Follow-up and outcomes of screening</u> The screening outcomes were received via post and scanned to patient records. It had been highlighted that issues around coding could lead to practice screening outcomes differing from the data in the Breast Screening Programme, depending on which platform was used. The SSE PCN and their digital facilitator developed an EMIS template with checkboxes to select the appropriate code within each patient record. The PCN have shared this across Greater Manchester, and communicated its use, including creating a guide for using it, with the aim of standardising coding and improving data quality. The responses from the attended patient questionnaire showed that 16% had previously been invited but not attended. Responses also indicated a positive experience of screening, with 90% of responders indicating a 5/5 experience (5 being the most positive score). The practice care coordinator has been following up by phone those patients who did not attend their screening appointment to understand their reasons for not attending and to support with decision making or rebooking appointments. The most common reason, in 19% of those contacted, was fear or anxiety about screening or the results, or a previous negative experience. In some of these patients, a discussion with the care coordinator resulted in a positive outcome, with them agreeing to rebook their appointment. The actual rebooking rates have not yet been analysed. Another common reason for non-attendance was a misunderstanding about the appointment or lack of knowledge about screening (16%), for example not being aware that screening was 3 yearly and they would be re-invited, or having had an appointment at the breast clinic for a lump or abnormality and not being aware screening was different from this. Equally, unintentional missed appointment, through lost letters, attending the wrong venue or forgetting the appointment, made up 12% of non-attenders spoken to. 4 patients spoken to were unable to attend due to ill health or a restriction to leaving the house, due to being housebound or agoraphobic. 2 patients did not attend due to working commitments and being unaware they could re-arrange their appointment at a more convenient time. 12% of those spoken to were out of the UK when the appointment was sent, with some of them stating they had their breast screening in another country. This scenario was discussed at the working group meeting and the advice from the screening programme is that the patient can still be screened in the UK, especially if the last screening was more than 6 months ago, and a screening result should only be coded from elsewhere if the patient is able to provide the report from another screening programme. The feedback from the care coordinator is that the follow-up of non-attenders has been arduous. Often, she is addressing more than breast screening in the call, as the patient may also be overdue other screening or

	have unmet needs that arise in the conversation. This, alongside limited resource to dedicate to this follow-up due to staffing issues, has meant that not all the patients have been contacted for follow-up yet. **Screening uptake** The GM cancer dashboard shows that breast screening coverage as of November 2024 for SSE PCN is at 50.7%. This status reflects that some practices within the PCN have been screened, whilst others are being screened currently or are due to be screened. Ordsall uptake for the screening cycle 1st February-28th February 2022 was 48.2% according to analysis of data from the GM cancer dashboard. The Ordsall Health Surgery 2024 screening cycle ran 14th September-4th October, the uptake for the practice for October 2024 on the GM cancer screening dashboard is 64.9%, an increase of around 16% compared to the previous screening cycle. Analysed by ethnicity coding, the coverage for this screening period for those coded as White British and Irish is 66%, whilst for all minority ethnicity codes it is 61%. In comparison to 3 years ago, there was 42% coverage in ethnic minority patients compared to 55% White British and Irish. This shows an uplift across ethnicity groups, although there remains a disparity in coverage between eligible white and minority ethnic groups. Of note regarding ethnicity, the cancer dashboard also demonstrates a significant increase in patients registered at Ordsall Health Surgery who identify as Chinese ethnicity between the screening periods. This is in-line with observed increases in registrations for patients from Hong-Kong. There has been an increase from 24 patients to 134 patients eligible for breast screening. This further highlights this growing population locally and an ongoing need for the practice to ensure that their needs are understood to provide culturally appropriate care and ensure access to services. Analysis by coded main spoken language shows an increase in uptake across the practice's commonest spoken languages, for which there was targeted messaging translated, apart from in Arabic speakers. Comparing the 2022 cycle uptake to the 2024 cycle uptake the data for eligible patients screened by main spoken language show: • English 54.2% (252/465) to 67.4% (322/478) • Cantonese 11.9% (7/59) to 71.4% (70/90) • Portuguese 50% (7/14) to 45% (9/20) • Arabic 40.3% (7/16) to 53.3% (8/15) • Polish 64.3% (9/14) to 75% (9/12) This data suggests further work is required in promoting breast screening in the Portuguese and Arabic speaking groups and suggests scope for targeted work within communities who speak these languages. **Conclusion** Through this project there has been greater understanding of insights around screening motivations and barriers. There is also greater understanding of the local population and how this has changed. Whilst there has been an increase in uptake of breast screening in Ordsall Health Surgery SSE PCN, the full impact of the work will not be understood until 6 months after the screening period has ended (around spring/summer 2025) where rates of re-booking of appointments can be

	analysed and all the practices within the PCN have been screened. With this understanding there can be further reflection on the impact of the approaches taken to inform ongoing work within this area. From patient insight and feedback so far, I feel that the most impactful work has been the endorsement of screening and education to increase health literacy. Whilst screening uptake has improved, ongoing work is needed to promote understanding of NHS systems and processes for patients, particularly those who are new to the UK, to reduce the disparity in accessing care.

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[iii] *Breast screening: programme overview* (2024). https://www.gov.uk/guidance/breast-screening-programme-overview.

[iv] *Programme summary - NHS England Digital* (27/06/2024). https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme/england---2022-23/introduction.

[v] NICE (2022) *CKS is only available in the UK*. https://cks.nice.org.uk/topics/breast-screening/background-information/benefits-harms-of-the-screening-programme/#benefits.