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### **The Project Team**

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## Summary

Community Links was commissioned by NHS Newham to increase the take-up of breast screening by women, residing in the London Borough of Newham, in 2010/11.

To achieve this Community Links recruited and trained a team of local women, who could speak a range of community spoken languages, to call 10,600 women in the borough, who were due a mammogram at the breast screening unit.

Breast screening is a method of detecting breast cancer. The aim is to identify breast cancer at an early stage and provide relevant treatment, so increasing survival rates.

Newham has higher rates of mortality from Cancer than the rest of London (122.7 rate per 100,000 for Newham, and 112 rate per 100,000 for London (DH, 2005-2007)); with take-up of breast screening hovering around 50% (NHS Newham, 2010). For 2009-10, uptake in England was 73%, while the average for London was 61.5%.

The objective of this project was to increase breast screening take-up rates in the London Borough of Newham by 10%.

The project aimed to:

- Remind women by telephone of their upcoming breast screening appointments (First Timers)
- Remind women to reorganise their missed appointment (Did Not Attend)
- Confirm receipt of their invitation letter from NHS Newham
- Answer basic questions about breast screening and the appointment system
- Support women in their decision to attend screening through information on the benefits and risks of breast screening.

The results achieved were:

**Take-Up** Breast screening take-up for the 'Stratford round' has risen by 15% compared to the last round when these women were screened in 2007. Uptake increased from 51% in 2007 to 66% in March 2011.

**Coverage** Breast screening coverage across the whole of Newham has risen by 8.6%, from 58.5% in January 2010 to 67.1% in March 2011.

**Numbers called** 14,186 women were called during the period, via a total of 23,095 phone calls.

**Numbers reached** The callers got through and talked to 60% of the women called. The proportion of women reached is differentiated by category: 60% of first timers, 82% of women who had had a breast screening before; and 52% of the women who did not attend their breast screening appointment.

## Background

### 1. About this report

Community Links was commissioned by NHS Newham to increase the take up of breast screening by women, residing in the London Borough of Newham.

This report describes the first year of activity of Community Links' Breast Screening Uptake project, conducted between January 2010 and January 2011.

### 2. About Community Links

Community Links is an innovative charity running community-based projects in east London. We have helped over 30,000 vulnerable children, young people and adults every year, with most of our 60 projects delivered in Newham, one of the poorest boroughs in Europe. We pioneer new ideas and ways of working locally and share the learning nationally with other practitioners, policymakers and the press.

### 3. Breast Screening

Breast screening is a method of detecting breast cancer. The idea is to identify breast cancer at an early stage and provide relevant treatment, so increasing survival rates.

The NHS Breast Screening Programme (NHSBSP) is a nationally coordinated cyclical programme which invites women aged between 50 and 70 for a free mammogram every three years. Women who are eligible on the basis of their age are identified from the GP register. Women will receive their first invitation between the ages of 50 and 53. Once women reach the upper age limit for routine invitations for breast screening, they are encouraged to make their own appointments and are not routinely recalled. In Newham breast screening is run by the Central and East London Breast Screening Service (CELBSS), not local GPs.

### 4. Barriers to Breast Screening Take-Up

There are a number of well documented barriers to cancer screening (COI and Commissioning Support for London, 2011; NAEDI, 2008; Cancer Reform Strategy, 2007).

The barriers faced by individuals and communities, common also to Newham (Focus on Newham, 2009), include:

- High population mobility: GP lists can be inaccurate with a high turnover of population and screening invitation letters do not reach people
- Socio-economic deprivation: Amongst these groups there tends to be Low perceived risk and Low awareness of cancer risks and screening programmes. Lower literacy levels and language can become barriers to take up.
- Ethnic Minority Groups: Although screening take-up is lower in ethnic minority groups, some of this difference can be explained by other factors such as deprivation, language barriers and literacy.

There are also a number of systemic barriers with the NHS, common across the UK, these include:

- Out of date or inaccurate GP lists. Eligible population figures are inflated, rendering take-up figures inaccurate; High population mobility causes lists to become outdated, and new residents may not register with a GPs when they move to a new area
- Lack of GP and primary healthcare teams involvement
- Lack of financial incentives and interest
- Attitudes and knowledge of staff to screening
- Lack of resources and administration
- Poor screening experience by patients
- The importance of the screening site location and transport links

The more that can be understood about the barriers to screening take-up, the more strategies can be developed to target specific groups who are not taking-up screening. For example, by raising awareness of the signs and symptoms of early cancer and encouraging people to seek help sooner, this in turn would lead to earlier diagnosis and a corresponding reduction in mortality.

This project sought to find ways to overcome some of these barriers and increase the take-up in Newham.

## 5. Coverage and Take-Up in Newham – some statistics

- Breast cancer is now the most common cancer in the UK.
- The lifetime risk of being diagnosed with breast cancer is one in eight for women in the UK.
- In 2008 in the UK almost 47,700 women were diagnosed with breast cancer, that's around 130 women a day.
- Eight in ten breast cancers are diagnosed in women aged 50 and over.
- In the UK in 2007/2008 the NHS breast screening programmes detected more than 16,000 cases of breast cancer.
- Estimates suggest that the screening programme saves around a thousand lives each year in England alone.
- In Britain breast cancer is now the second most common cause of death from cancer in women after lung.

*Source: Cancer Research UK, 2011*

Newham has higher rates of mortality from Cancer than the rest of London (122.7 rate per 100,000 for Newham, and 112 rate per 100,000 for London (DH, 2005-2007)).

Actually our mortality rates are higher or average for most cancers but we do have poorer survival from most cancers. Late diagnosis of cancer leads to poorer prognosis, poorer survival rates and increased mortality (Interim report, NAEDI, 2010).

The barriers to presenting include lack of knowledge on how to check, lack of knowledge and confidence to self examine, fear of diagnosis, not feeling at risk.

Uptake of breast screening for each screening round has hovered around 50% (NHS Newham, 2010). For 2009-10, uptake in England was 73% while the average for London was 61.5% and Newham 56% (an improvement from the previous year of 50%).

Coverage for breast screening (which includes women who attend screening through invitation and those who self-refer) is the measure used by the Department of Health to set targets for Primary Care Trusts (PCT). For 2009-10, England's coverage was 76.9%, London 67% and Newham 61.2% (an increase of almost 6% from the previous year). The minimum government target for breast screening is 70%.

The number of eligible women aged 50-70 years in Newham is about 23,000. The eligible women were invited in two screening rounds of 10,000 and 13,000 women to a mobile screening unit. The Community Links project described in this report took place during the 'Stratford Round' which invited about 13,000 women, from 38 GP practices, to the mobile screening unit parked at Morrison's supermarket in Stratford for ten months, and then briefly at East Ham Town Hall in January 2011. These practices were located in the following post codes: E6, E7, E12, E13 and E15.

## 6. The Breast Screening Invitation Process

(Summary of A guide to Breast Screening Services for Primary Care Staff, August 2010)]

The NHS Breast Screening Programme (NHS BSP) is a national programme which is commissioned locally to meet the needs of the local population.

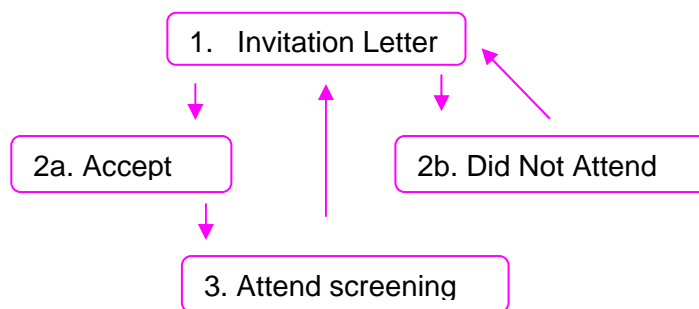
Newham is part of a consortium of six PCTs which commission the Central and East London Breast Screening Service (CELBSS) to provide services that meet national quality standards and the needs of local women. Women aged 50-70 must be invited every three years for breast screening; and the invitation process works as follows:

- a) CELBSS informs the relevant Primary Care Trust (PCT) of practices to be screened with estimates of screening numbers and dates.
- b) The PCT Breast Screening Manager then meets with each GP Practice Team two months prior to their patients being screened to engage them in the screening process, and discuss the benefits of using the calling service.
- c) Amendment forms are sent to GPs due to be invited by CELBSS asking them to return the names of any women ineligible for screening within a fortnight. This step is done approximately six to eight weeks prior to screening. Any ineligible women are removed from the list; and the revised list is transferred to CELBSS who sends the letters of

invitation with a date, time and location for screening to women two to three weeks prior to the appointment date.

- d) In the letters of invitation women are offered the option to change their appointments by contacting the unit via telephone and e-mail.
- e) Invited women then attend a breast screening appointment. Mondays through Fridays, at mobiles or static units.
- f) Women not attending a screening appointment are sent a letter asking them to call the breast screening unit directly to re-arrange their appointment or are offered a second-timed appointment.
- g) Women are notified of their results within two weeks; if the results are normal, she will be re-invited in three years. If the results are unclear or positive for cancer, she will be recalled for further assessment at Bart's Hospital.

### The invitation process





## 7. Community Links' Breast Screening Take-Up Project

At the time this work was commissioned breast screening take-up had become a priority for our local PCT and NHS London – take-up needed to improve across the capital, and more effective programmes needed to be established. The idea for this project of offering support to women to overcome their barriers to attend screening initially came from Tower Hamlets. However this project differed slightly as this project was the sole new intervention in the borough. NHS Newham did not combine it with other awareness raising activities e.g. a media campaign, new leaflets and brochures, as they wanted to test the veracity of the approach, and apply sole-attribution to the results of the project in relation to an increase or decrease in breast screening take-up.

### Objective

To increase breast screening take-up rates in the London Borough of Newham by 10%. (This 10% target was set by Community Links. However NHS Newham had a lower initial target of 3%, which they subsequently revised mid-year up to 6%).

### Aims

- Remind women by phone of their upcoming breast screening appointments (First Timers)
- Remind women to reorganise their missed appointment (Did Not Attend)
- Confirm receipt of their invitation letter from NHS Newham
- Answer basic questions about breast screening and the appointment system
- Support women in their decision to attend screening through information on the benefits and risks of breast screening.

### Targets

The project had a target of calling 10,600 women during a ten month period to remind them of their breast screening appointments.

### Timing

Local women were called between 18<sup>th</sup> January 2010 and 24<sup>th</sup> January 2011.

### Community Links project team

To do this Community Links recruited a team of six local women, known as 'callers'. They spoke a combination of languages from the local community because in Newham over 100 languages are spoken. The callers had knowledge of the area, as well as a good understanding of the socio-cultural nuances of the communities to which the women being invited to a screening belonged.

The team was coordinated by a dedicated member of staff from Community Links. This person managed the project by:

- Establishing a plan, monitoring and reporting processes
- Managing the budget
- Recruiting and training the caller team
- Managing the team – rotas, salaries and expenses, CRB checks, personnel issues
- Brokering and maintaining the relationships with the GP practices
- Acting as the first point of contact with the NHS Health Improvement Manager, the GP Practice Managers and the team of callers.
- Ensuring quality control
- Overseeing the data inputting and analysis of the phone call data, and producing reports.

NHS Newham and Community Links ran an initial three hour training programme for the team of callers which covered information on breast cancer, how breast screening works and the pathway of care, the benefits and risks of screening, informed consent, and information governance. Two flow charts were produced to guide callers through the different categories of women. This was followed up by a second refresher session which focused on peer-to-peer learning at how the service could be improved.

The success of the project was in part due to the collaborative partnership approach that the Project Co-ordinator from Community Links and the Health Improvement Manger from NHS Newham took. They had a strong working relationship and similar (hard) work ethic.

## 8. The Project Process

Community Links together with NHS Newham developed the following process to deliver the project:

- a) The Newham Health Improvement Manager (NHIM) discusses the calling project with GP practices and obtains their 'buy-in' to the calling initiative.
- b) The NHIM obtains the electronic list of women to be screened from CELBSS (via nhs.net), which is located at St Bartholomew's Hospital.
- c) This Manager sent a copy of the first timers, never screened and did not attend list to all the GP practice Managers with a brief explanation of how the calling project will work.
- d) At the same time, the Manager communicated with the Project Coordinator at Community Links about the number of women invited from each participant GP practice and the dates of the screening.
- e) Once this information was in the hands of the Project Coordinator, she made telephone contact with the GP Practice Managers to coordinate when the callers should visit the GP practice to make the phone calls from there. There were data protection issues which prohibited making the calls from a central location such as PCT premises.

- f) The Practice Manager downloads the list of women invited onto a spread-sheet for the callers to use.
- g) The weekly scheduling of the callers' time was completed based on GP practice's suggested dates and times. The callers' time, when they can go the relevant GP practice, had to be flexible, due to fitting in the calling at a convenient time for the GP practice. Calls could not be made more than five days before the appointment date.
- h) The callers signed confidentiality agreements with each GP Practice and also wore ID badges supplied by the PCT.
- i) The callers were assigned a desk, a computer where the list of women invited are stored, and a telephone to conduct the phone calls.
- j) Before the callers start, they agree with the managers whether or not it would be acceptable to leave phone messages for the women who couldn't be reached. The callers followed the managers' preference, mainly to do with reasons of costs and administration of being able to respond to the call backs to the GP practice.
- k) The list (database) was saved in an excel spreadsheet at the practice computer. The callers added four columns to record the day and time of the phone calls, and any comment the researches deemed necessary to include, and the name of the caller (for quality assurance).
- l) The outcome of the call was chosen from a drop down menu, which was added to the database.
- m) After each phone call session, the Project Coordinator contacted the callers to monitor progress, and follow up with the GP Practice Manager if necessary.
- n) Quality assurance was practiced by all callers. The callers went to the GP practice offices one at a time. The first researcher of the day handed over the task to the subsequent researcher making a brief description of her work and showing the recording of the information in the database. Any inconsistency was checked, noted and resolved.
- o) Depending on the number of women still to come, the Project Coordinator agreed with the Practice Manager the times and dates to return and finish the calls.
- p) Once all the calls have been made from that specific GP practice, the GP Practice Manager e-mailed the database to the Newham Health Improvement Manager using nhs.net (a secure network) used for patient level data.
- q) The Project Coordinator did not have direct access to the list with the updated information entered by the callers, due to data protection.

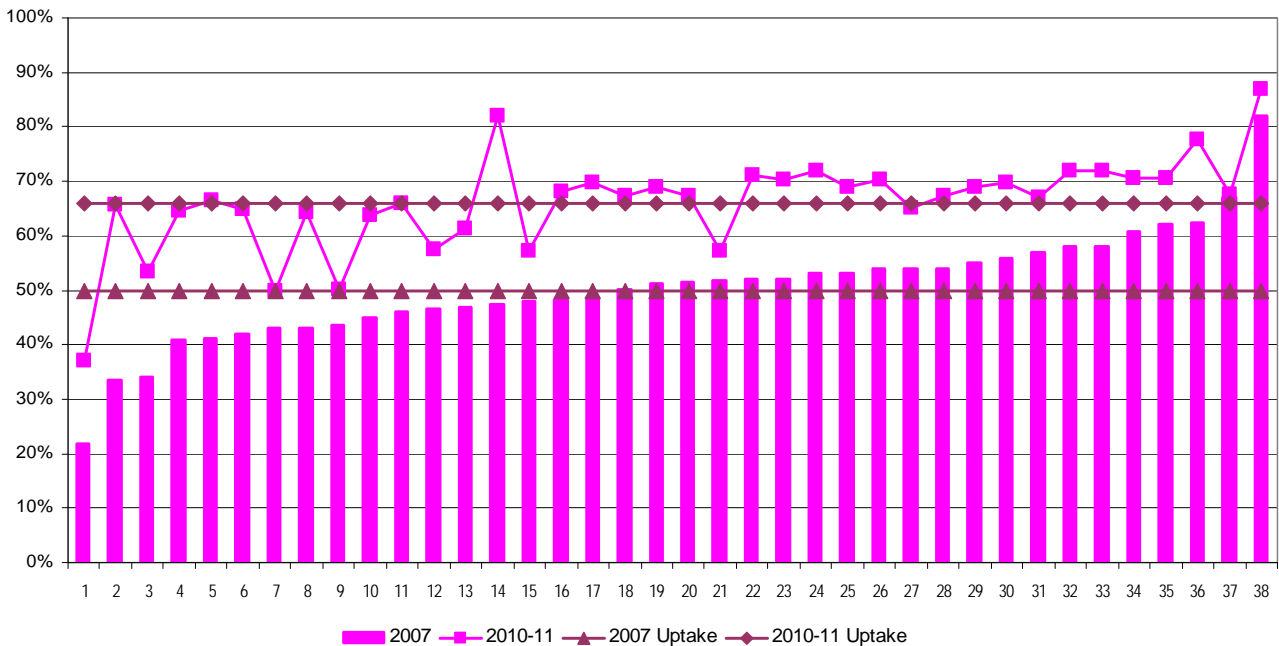
- r) The Project Coordinator went to the offices of the Newham Health Improvement Manager to gain access to the database to monitor the consistency of the information input by the callers.
- s) The Project Coordinator contacted callers to get feedback about how things went with the calls and the GP practice; and to ask how things could be improved for the next session.
- t) The callers moved onto the next GP practice, and the process started again.

**9. The Project Results**

Breast screening uptake for the ‘Stratford round’ has risen by 15% compared to the last round when these women were screened in 2007. Uptake increased from 50% in 2007 to 66% in March 2011.

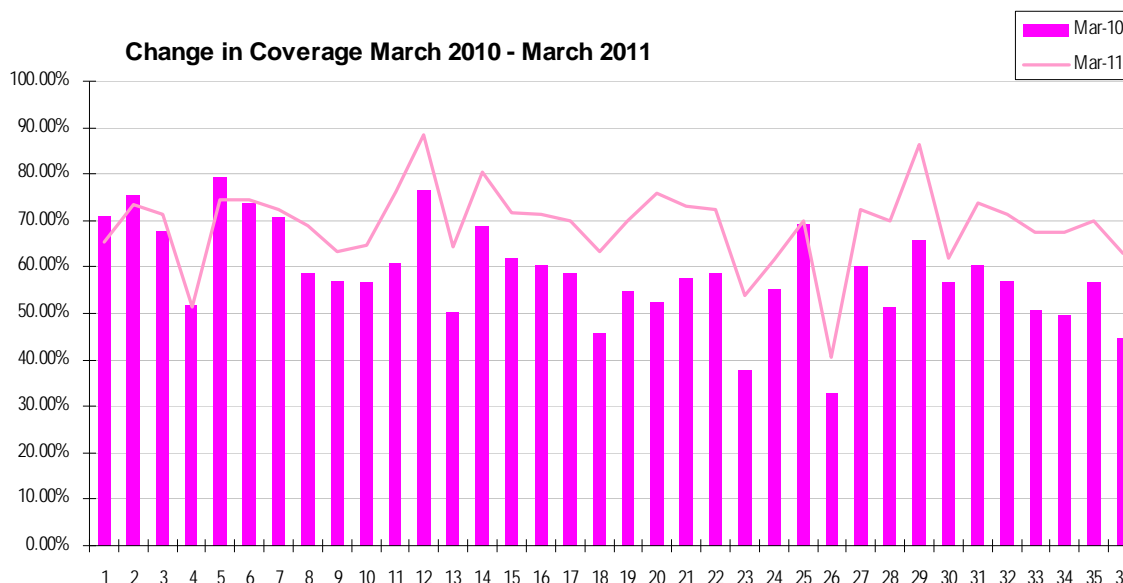
Graph 1 shows the change across 38 GP practices for which uptake data has been received. Community Links worked with 31 of these GP practices. The remaining five practices elected to make their own reminder calls.

**Comparison of uptake at 38 GP practices in the "Stratford Round" 2007 and 2010-11**



The numbers represent different GP practices in the screening round and each number represents the same practice for uptake and coverage data.

Graph 2 shows that breast screening coverage across the whole of Newham has risen by 8.6%, from 58.5% in January 2010 to 67.1% in March 2011.



### Project Targets

Overall, this project’s targets were amply achieved. The team called 93.7% of the women invited to attend the breast screening unit. The team surpassed the target number of calls made to the women invited by 33.8%.

Categories (see Appendix for glossary of terms)	Women to be called <sup>1</sup> (target)	Women called	% difference
First timers	5,800	4,411	-14%
Did not attend appointment	3,500	4409	+25%
Recall	1,300	5366	+312%
<b>Total</b>	<b>10,600</b>	<b>14,186</b>	<b>+33%</b>

### Average calls made per category of women

Community Links calculated that the team of callers would make between 10-15 calls per hour per caller. This target was reached. In total, the team made 23,095 phone calls and spent 1,636 hours to complete them. The callers made an average 14 calls per hour worked.

A record of the number of women that were spoken with per hour was not kept. However, anecdotal evidence provided by the callers indicated that, in general, when women were reached by phone, the calls lasted between five and ten minutes each. However, these calls tended to last longer when the callers spoke the same language as the women contacted.

<sup>1</sup> The target number of women called to attend the breast screening is found in the contract and project proposal between Community Links and NHS Newham.

According to the callers, these women would be likely to ask questions relating to the impending appointment. The callers, based on the training they received, did answer their queries when these could be answered by them, if not they told them to direct them to their GPs.

On average, the callers made 1.6 phone calls per woman invited to the breast screening. The total calls were 23,095 total calls made over a twelve month period and 14,186 women called). The women who had had a previous breast screening and were called for a second time had a slightly higher average of phone calls per woman (1.7). However, this is not significant.

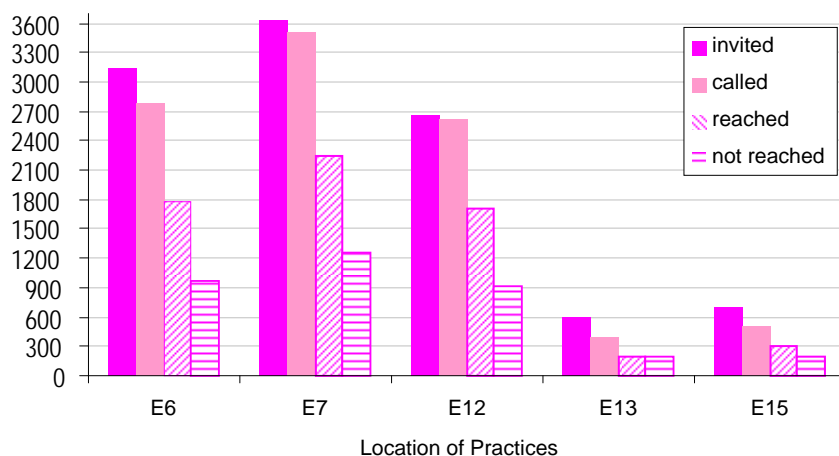
### Proportion of women called and spoken to

The callers got through and talked to 60% of the women called (six out of ten women called). Again, the proportion of women reached is differentiated by category: 60% of first timers, 82% of women who had had a breast screening before; and 52% of the women who did not attend their breast screening appointment.

Two-thirds of the total phone calls made during the life of the project were first attempt phone calls, a quarter of the total phone calls were second calls and 15% third time phone calls. It should be noted that calls were only made during the opening hours of the GP practices – predominately the daytime. A number of women will therefore have been missed as they would have been out, presumably and for example, at work, studying, or meeting caring responsibilities.

### First timers, Never Screened and Recalls: Summary of Results

Almost 11,000 women were invited in this round. The research team was able to call 91% of the total of women invited. The remaining proportion of women not called was due to lateness in getting the data. Of those called the callers were able to reach 64%. However, this figure is not uniform throughout the participant surgeries, this is pretty uneven. (See Graph 3 below which shows in summary: Women called to be reminded of initial invitation and those reached

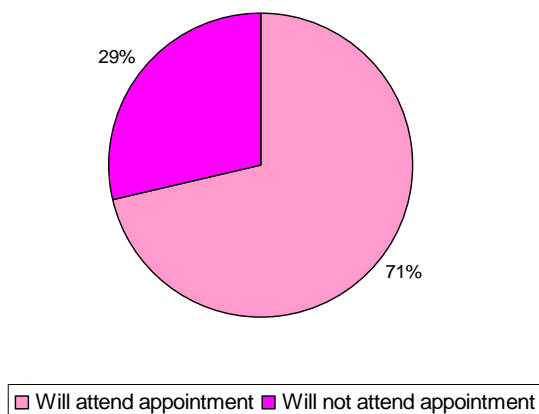


n=10724

In terms of relative figures, the patients not reached by post code are between 35-39%. The practices, only two, located in E13 do show a high proportion of women not reached.

The callers were able to reach the great majority of patients (first time, never screened and recalls). Of these, approximately three-quarters said they would be attending the scheduled appointments. (Data on the proportion of those not attending is not yet available)

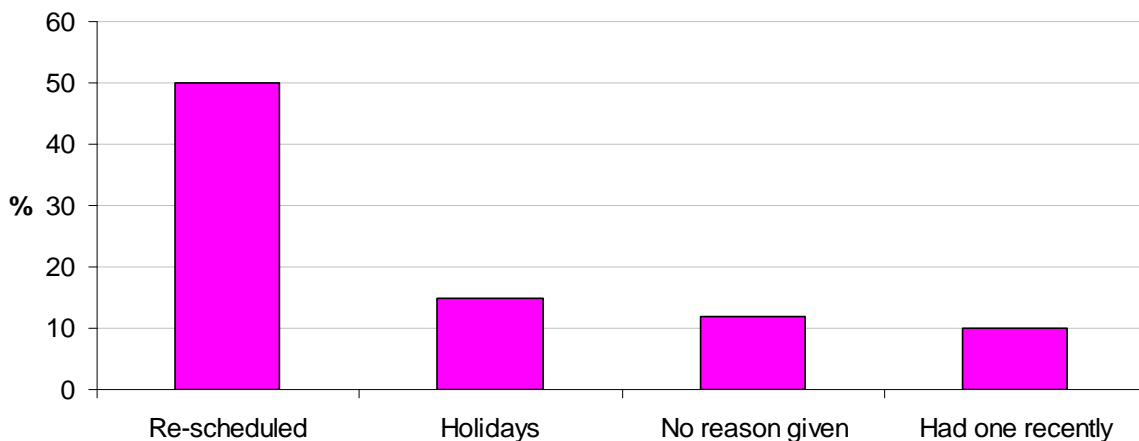
First timers: Proportion of attendance to scheduled appointment



### Not attending scheduled appointments: Reasons given

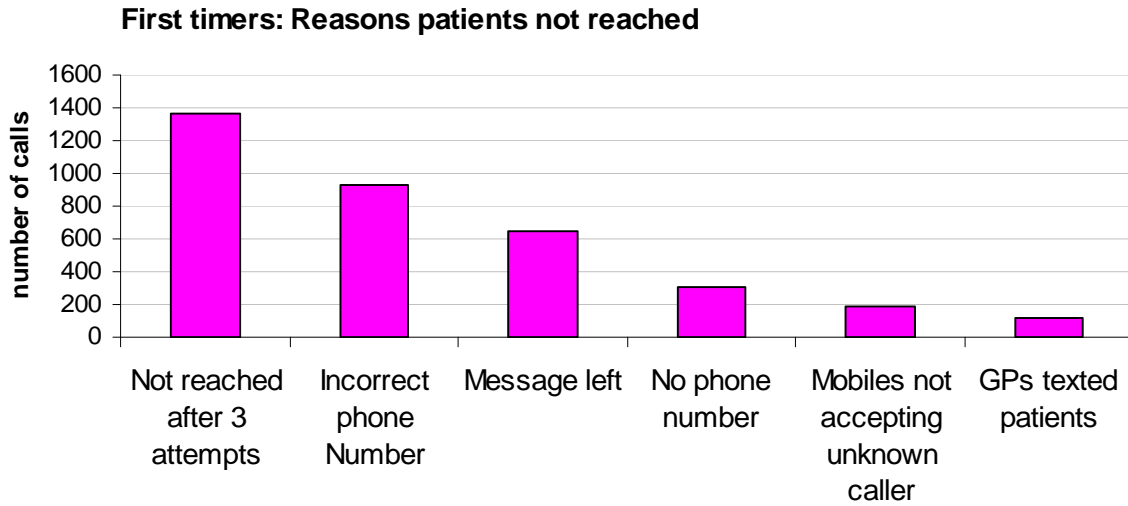
For the categories first timers and recall, 72% of the women reached by the callers said they will attend their scheduled appointments. The women contacted give four main reasons for not attending their scheduled appointment, see below:

First timers reached and reasons to miss scheduled appointment



n=1550

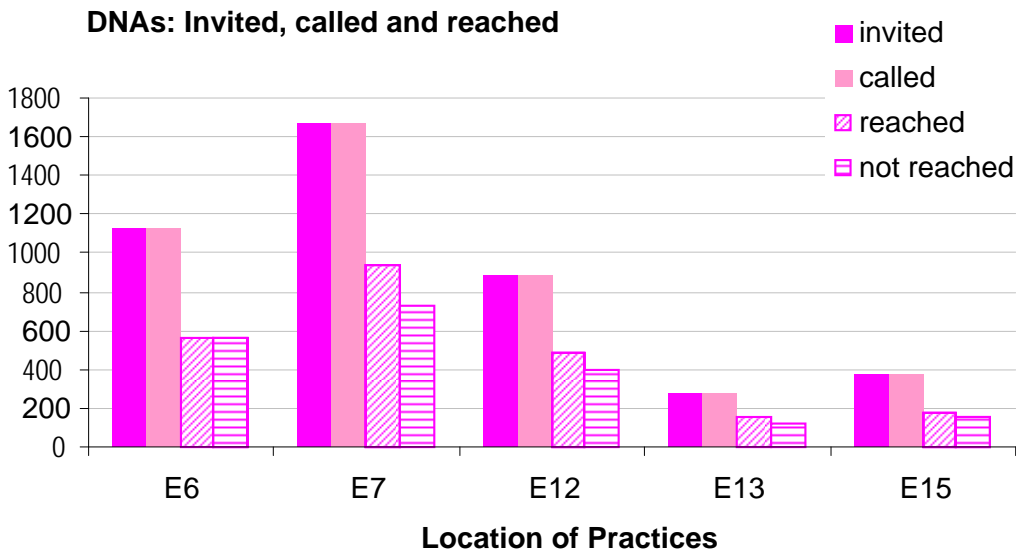
Over a third of the first timers could not be reached. Those not reached after three attempts make the overwhelming majority (56%). In 32% of these cases the callers were able to leave phone messages. However, we have no way of determining whether leaving messages contributed to a woman called become woman screened. (See Graph 6 below)



n=3541

**Did Not Attend (DNA)**

DNA women are those who have not attended the initial invitation and neither did they re-schedule their appointments. These women are identified using attendance / non-attendance lists provided by CELBSS and comparing them with appointment lists. These women reached expressed a number of reasons for not attending their breast screening scheduled appointment, below is a summary of the main reasons given.

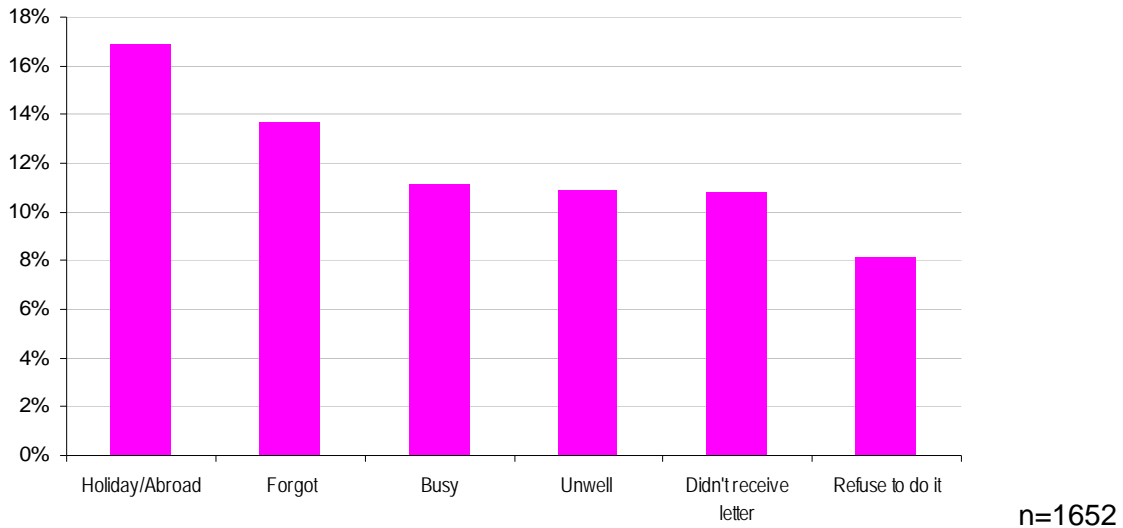


n=4310



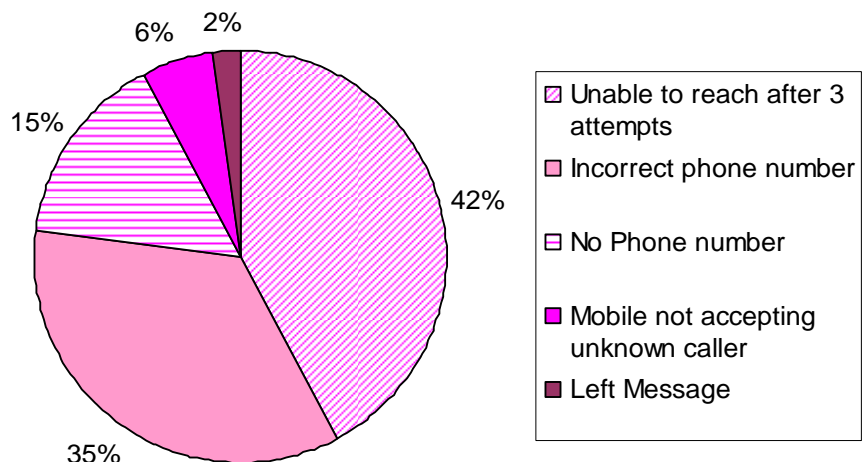
Reaching women who did not attend their scheduled appointment was more difficult than contacting women about their initial invitation. On average, between 41-50% of those called were not reached. Those who were reached gave a number of reasons for not attending their appointments. (See below)

**DNAs: Reasons for not attending scheduled appointment**



The great majority of the patients who did not attend their appointments could not be contacted after three attempted phone calls. GPs participating in the round of screening did not have a correct phone number for more than a third of those who did not attend their screening scheduled time.

**DNAs: Reasons patients could not be reached**



n=1960

## 10. Additional service improvements

This project did not happen in isolation. There were a number of additional service improvements that helped to lift the Take-Up. These included:

- An improved round length (36 months)
- Offering second time appointments
- Getting the lists (first time and DNA) from the Breast Screening Unit in a timely manner to be able to cross-refer with GP lists for accuracy.
- Revamped invitation letter and accompanying leaflet for first time appointments
- Improved communication and better planning between NHS Newham and the Breast Screening Unit, which has contributed to a better response rate.
- Stronger relationships and improved communication with NHS Newham and local GPs. The Health Improvement Manager briefed the whole GP practice team (not just the practice manager) prior to the calling. This gained endorsement and trust for the project, cooperation by the staff with the Community Links team, and an increased awareness about the importance of screening (sometimes translated into active encouragement by staff to patients to attend a screening).

## 11. Challenges experienced by the Project

The team faced a number of challenges to make this project successful. These included:

### a) Coordination between the team and GP Practices

It was difficult at times to develop a rota with for the callers with the GP practices. The team did not want to disrupt the normal working of the practice and this left the callers only limited time to make the phone calls and, in some practices, the team members had to complete the three phone calls in one day. However the flexibility of the callers, and acknowledgement of limited resources, helped to build trust and improve working relationships.

### b) Access to data / quality of data

The databases were not always accessible in the network used by a given GP practice, but on one computer. At times, this computer was not available for use by the callers and had to reschedule resulting in the compression of the times to call women. This probably lowers the likelihood to reach women at different times during the day.

A high number of women's telephone number information records were incomplete or incorrect. With incorrect numbers, the team made phone calls which contributed to an increase in the number of hours spent calling the patients.

Amendments to the invitation list (by GP practices) were not always up-to-date and as a result callers came across women who were already undergoing breast cancer treatment, others had signed a disclaimer to participate in the screening process, and others said they had not received the letter of invitation.

A few of the GPs practice did not return the updated spreadsheet with calling data on completion of calling to the PCT in a timely fashion.

The team depended on the provision of the data by CELBBSS, and at times this was received late which, again, limited the options of times to call the women.

In 2011/12 Newham is a national pilot site for Next Due Date (NDD) which is a new way of inviting women when they are due for breast screening. This is an improvement on the current method of invitation which invites women based on the GP practice they are registered with. As a result, women from several GP practices are invited simultaneously. To ensure that women receive their reminder calls in a timely way, the PCT is using a combination of GP practice staff calling their own patients, and Community Links calling from PCT premise as well as GP practices. So far, uptake at the screening mobile at Newham General Hospital has been good.

### c) Rooms and telephones

A few of the GP practices operate with very little space to spare. The callers could not be 'housed' during the calling period.

In one of the GP practices the callers could only call those who did not attend their scheduled appointment.

At times, the GP practices did not have a telephone available for our callers to use. The callers had to wait until one became available which limited further the time we could spend at a given practice.

Some of the GP practices would not allow us to call mobile phones. Calls to mobile phone are an expense to the practices which they could not recover. Mobile phones are becoming the only means of contact for some people and a restriction on making a call to these could further limit reaching the women invited to the scheduled breast screening appointments.

Despite these challenges, the calling service established good working relationships with practices and overcame these barriers to achieve excellent uptake results. Building on this reputation, Community Links have been re-commissioned to provide the same service for the PCT for the duration of the next screening round. GP practices in the next round are enthusiastic about using the service having seen the improvements.

## 12. Views on the Project by the GP Practices

In the preparation of this report three GP practice Managers were contacted and completed a short questionnaire about how the project helped achieved their uptake goals and how the approach could be used with similar cancer screenings programmes (e.g. bowel cancer or cervical cancer).

The Managers said the project was excellent given the level of screening attendance by the women belonging to this practice. All three said they were 'happy' to be part of the project. One of practice Managers said, "*The project was very helpful*" (practice Manager 1). Another one expressed, "*I think this was (an) excellent project, as you can see the outcome. [T]here were many [women] attending their screening [appointment]*" (Practice Manager 2).

When asked about their views on how the telephone calls had contributed to the uptake of the breast screening they said that overall these helped. *“The calling increased numbers of attendance for screening from our practice”* (practice Manager 1). Another practice Manager said that it had helped and the practice contributed by calling the patients as well (Practice Manager 3)

One of the Managers mentioned that some of their patients were appreciative of the call reminding them of their upcoming appointment. *“Yes very positive feedback from patient appreciating the call for reminder”* (Practice Manager 2).

The team also wanted to know what the practice Managers thought about the team of callers, especially around issues of confidentiality given the sensitive nature of the information handled. The Practice Managers considered that the callers did a great job. They did not mention any concern. *“They were alright and [I] was quite happy to accommodate [the team]”* (Practice Manager 3). *“The [young women] did the great job out of it”* (Practice Manager 2). *“We have arranged date according to availability of room and it was not an issue. The [young women] had the skills to be able to perform well”* (Practice Manager 1).

When asked for suggestions on what to improve one of the practice Managers said, *“If we are all proactive, as we did for this one, it can always have great results”* (Practice Manager 3). Another one expressed, *“[s]ame project would be helpful for the next round, but calling them nearer to appointment date would be bit more helpful”* (Practice Manager 1).

One of the respondents suggested having more options of languages spoken by the callers. This practice Manager said, *“Maybe more multilingual for e.g. Bengali, Hindi, Urdu”* (Practice Manager 2). It is worth pointing out that our callers spoke a combination of Somali, Bengali, Hindi, Urdu, Punjabi, Gujarati, Spanish, French and Albanian. The other respondent said to continue with the proactive approach, the results show that it has paid off.

Regarding the usefulness of using a similar approach in similar health interventions, they said, *“[s]mear attendance can be improved if same service is applied”* (Practice Manager 1). *“Yes. Something like this was done some time ago around cervical screenings and did have good results. Definitely, it will be good to have something like this for other types of cancer”* (Practice Manager 3). *“[Y]es, it could be done for other programmes as well, definitely”* (Practice Manager 2).

### 13. Conclusion

NHS Newham commissioned Community Links to increase the attendance of breast screening appointments in the London Borough of Newham. To do this Community Links recruited and trained a team of local women, who could speak a range of community spoken languages, to call 10,600 women in the borough who were due a mammogram at the breast screening unit.

Breast screening uptake has risen by 15% to 66% as of March 2011, with the 31 GP practices Community Links worked with. This is compared to the last time women from these GP practices were screened in 2007 when uptake was 51%.

Breast screening coverage across the whole of Newham has risen by 8.6%, from 58.5% in January 2010 to 67.1% in March 2011.

#### 14. Suggested Improvements to the Project

##### a) GP practices

Access to screening database in the GP practice should be made available for longer periods of time during the day to allow flexibility and more options around when to call women.

GP practices should update their women's contact information more regularly. We recognise this is an on-going issue for all GP practices given mobility of patients in Newham.

Request more flexibility from GPs regarding the times and days to call the patients.

Keeping in mind the sensitivity of the information handled, back up systems should be in place to ensure that when computer crashes occur the updated database is not lost.

##### b) Breast Screening Unit

When the callers are working late in a GP practice (after 4pm) the Breast Screening Unit is closed and cannot be contacted with queries. The Breast Screening Unit's hours of operation could be extended. Perhaps a late closing one day a week.

Update CELBSS website for direct booking of appointments.

About 10% women when called said that they hadn't received an invitation letter – develop strategies to counter balance this.

Facilitate rescheduling of appointments and offer an alternative when women call BSU rather than wait for a letter of invitation because the proposed times and days may not be convenient to women.

Offer women information and ease of opting out of the breast screening process.

##### c) Community Links Project Team

Throughout the course of the project the Community Links team was continually improving and refining its work and approach. The process described above reflects these improvements.

## Appendix

Glossary of Terms	
<b>Coverage</b>	The proportion of women resident in the screening target area (excluding those who are ineligible for screening) who have had a recorded test result at least once in the previous three years, including women who are invited and self-referrals to the service.
<b>DNA (Did Not Attend)</b>	Women who Did Not Attend their invitation to screening. First timers and recall women who DNA are re-invited with a date and timed appointment. Never Screened women are written to and asked to make their own appointment with the screening unit.
<b>First timers</b>	Women invited for the very first time to attend a breast screening appointment (those 50-53 years). These women are also called 'call' women
<b>Never Screened</b>	Women who have <i>never</i> taken up their invitation for screening invitation.
<b>Recall women</b>	Women who have previously been invited and attended an appointment.
<b>Uptake</b>	Corresponds to the proportion of women invited for screening and who have a test result is recorded.

## Contact

For more information about this project and the Community Links approach please contact:

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### About Community Links

Community Links is an innovative charity running community-based projects in east London. We have helped over 30,000 vulnerable children, young people and adults every year, with most of our 60 projects delivered in Newham, one of the poorest boroughs in Europe. We pioneer new ideas and ways of working locally and share the learning nationally with other practitioners, policymakers and the press.

### Consultancy Services

Our consultancy services and approaches are grounded in over 30 years of delivering community-based projects in east London. We share our learning by providing practitioner-led research and evaluation, organisational development, community engagement, and bespoke skills training services.

Since 2003 we have worked with over 90 organisations across the UK, helping communities achieve their own potentials through capacity building, knowledge development, and community engagement. We share our expertise, experience, and network through a participatory skills-building approach so that we leave behind an enabled and self-sustaining community.



## Breast Screening Take-Up Project Year One Report

Community Links was commissioned by NHS Newham to increase the take up of breast screening by women, residing in the London borough of Newham.

This report describes the first year of activity of Community Links' Breast Screening Uptake project, conducted between January 2010 and January 2011.

Community Links recruited a team of six local women, who spoke a combination of languages from the local community. The callers had knowledge of the area, as well as a good understanding of the socio-cultural nuances of local communities. The Team worked with local GP practices and spoke individually to local women to encourage them to attend.

As a result the percentage of women invited for screening who actually got tested in the areas covered increased from 50% to 66%.

**A Project report by Community Links in  
partnership with NHS Newham**

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