Overview

In 2005/06 Tower Hamlets had one of the lowest breast screening rates in England. To tackle this, NHS Tower Hamlets took a whole systems approach to ensure that the breast screening process was client-focused.

Interventions were developed to address three different groups involved in the breast screening process:

- The client (eligible women) – to encourage them to attend breast screening
- The enabler (primary care) – to improve their role in encouraging eligible women to attend breast screening
- The provider (Central and East London Breast Screening Service) – to make appropriate local changes to the breast screening service to make it client-focused

Specific interventions were focused on white British/Irish and Bangladeshi women, particularly from lower socioeconomic classes, who had been identified as having especially low breast screening attendance rates.

Interventions were piloted from 2008 and included two marketing campaigns, community outreach and service improvements.

Between 2006/07 and 2009/10, breast screening rates in Tower Hamlets increased by 13.6 per cent. Rates varied across participating GP practices, with a high of almost 80 per cent in one practice – a first for Tower Hamlets.
Breast cancer and screening
Breast cancer is the most commonly diagnosed cancer in the UK, and in Tower Hamlets breast cancer is the most common cause of death from cancer among women.

In comparison to the rest of England, Tower Hamlets did not see an increase in the registrations of breast cancers following the introduction of the NHS breast screening programme in 1988. While recognising that this was partly due to lower prevalence of breast cancer amongst Bangladeshi women (the Bangladeshi population makes up 33 per cent of the borough’s population), NHS Tower Hamlets also needed to respond to poor survival rates for women with breast cancer, which may be as a result of them presenting at more advanced stages of the disease. The borough had one of the lowest breast screening rates in the country, at 51 per cent in 2005/06, compared to 76 per cent nationally. It was clear that much work would be needed for the borough to achieve the national minimum target of 70 per cent (with a total national target of 80 per cent).

Faced with this challenge, NHS Tower Hamlets knew it would need to ensure a holistic approach was taken, looking at all key components – the client, primary care and the breast screening service.

Service redesign
Work began to assess what strategic service redesigns were needed. This commenced with the introduction of a Local Enhanced Scheme to incentivise GPs to increase participation in screening. Payment was based on the number of additional eligible women screened within each practice. Training was provided to all 20 GP practices that formed the 2007/08 screening round. Public health teams visited each practice three times, accompanied by a representative of the local breast screening service on the first visit. The benefits of screening were explained to staff and the roles of individuals within the practice team in increasing screening uptake were explored.

Marketing campaign
As work began assessing and introducing service based interventions, NHS Tower Hamlets allocated £106,000 to fund a social marketing project aimed at tackling the poor uptake of breast screening in the borough.

NHS Tower Hamlets undertook some preliminary research to identify who should be the focus of such a campaign. The screening statistics identified that white (54.4 per cent), Bangladeshi (39.3 per cent) and Black African (45.3 per cent) women had the lowest breast screening rates in the borough. Based on this insight it was decided the focus of the campaign would be on white British/Irish and Bangladeshi women, but would not include Black African women due to the small population represented in the borough (3.3 per cent) and to allow the campaign to be as focussed as possible to achieve the greatest impact.

In August 2007, Forster social marketing agency was appointed to undertake research and develop interventions aimed at white British/Irish women and Bangladeshi women.
Stakeholder mapping
Because NHS Tower Hamlets was keen to take a whole systems approach, it was crucial to identify key stakeholders and partners and bring them on board. This involved a process of engaging all stakeholders in discussions about service change, so that all parties were encouraged to consider the way the entire service delivery system works, rather than focusing on their component part in isolation.

The following stakeholders were identified as having high levels of possible interest in and influence on any campaign to be developed in this area:

- Primary care trust (PCT): Public health, acute cancer commissioning, advocacy services
- Central and East London Breast Screening Service (CELBSS)
- Primary care: Medical centres/surgeries, GPs, practice nurses
- Community organisations:
  - Social Action for Health (SAfH) – Community development charity that has strong connections with the Bangladeshi community in the area
  - Neighbours in Poplar – Charity providing support and care for vulnerable people living at home
  - Community Housing
  - Bromley by Bow Centre – Community organisation helping people to improve health and wellbeing

Subsequently a core steering group was set up, consisting of:

- Communications and Engagement, NHS Tower Hamlets
- Screening Commissioner, NHS Tower Hamlets
- Cancer Screening Lead for Public Health, NHS Tower Hamlets
- Health Promotions Specialist, CELBSS
- Project Manager, Social Action for Health
- Tower Hamlets GP Screening Lead

Desk-based research
A range of desk-based research activities were conducted, examining published and grey literature to obtain information on:

- Current services and service provision
- National policy and communications
- Learning from international, national and local social marketing campaigns
- Analysis of the target audience
- Competition and barriers

Stakeholder interviews
Fifteen telephone interviews were conducted with practitioners in the field within Tower Hamlets, including:

- Cancer Screening Lead
- Representative from CELBSS
- Associate Director of Public Health
- Head of Quality Assurance (Cancer)
- LinkAge Plus
- Public health nurse
- A local councillor
- Bangladeshi advocate
Discussions were also held with national agencies, PCTs and local authorities that had carried out interesting work in this topic area and or with the target audiences.

**Focus groups**

Four focus groups were conducted with women aged 50 to 70 from socioeconomic group C2DE (skilled working class, working class, and those at the lowest levels of subsistence). Two groups were held with white British/Irish women – one with those who had attended screening and one with those who had not attended screening. Two groups were held with Bangladeshi women – one with those who had attended screening, and one with those who had not attended screening.

The groups were held in local community centre settings and an interpreter was present for the focus groups with Bangladeshi women.

**Insights and exchange**

This research uncovered a number of insights about the target audiences. For both audiences, ‘breast cancer’ is part of the problem – for Bangladeshi women, ‘breast’ is taboo, while for white British/Irish women, ‘cancer’ is taboo.

For each audience the research found the following additional insights:

**Bangladeshi women:**

- Are unlikely to speak English and unlikely to read Bengali
- Are likely to live very localised, socially deprived lives
- Are not opposed to screening, they just do not know about it or do not think it is relevant to them
- Barriers to screening:
  - Would not normally discuss breast cancer in their community (some think it would bring shame, disgrace and bad luck)
  - Some fatalistic views – it would be wrong to doubt God’s plan for you
- Perceived benefits of breast screening:
  - Peace of mind
  - Being in control
  - Living longer

**White British/Irish women:**

- Have strong localised working class identifications
- Are unlikely to be part of established groups and are hard to reach through standard communications
- Do know about screening and that the Government wants them to go. However they are not very likely to trust the Government’s intentions, and they do not want to go and so choose not to
- Those who attended breast screening reported unpleasant experiences
- Barriers to breast screening:
  - With no guarantee of a cure, their fear of finding cancer is so strong that in their minds it outweighs the benefits of screening
  - Have particularly intense fears of the side effects of cancer treatments and losing their femininity
- Perceived benefits of breast screening:
  - Peace of mind
  - Being in control
  - Living longer

**Communication channels**

Research with the two target groups identified the following appropriate channels for reaching women:

- Interpersonal contact
  - Face-to-face localised campaigns are effective
  - Both audiences listen to peers and word-of-mouth is important
  - Bangladeshi women may not be literate, so multilingual staff can play a key role
• Media
  o Both groups consume and are receptive to specific media, particularly local media
  o For Bangladeshi women, non-English broadcast media is important
• GP contact
  o Most women use their GPs
  o Both groups trust their GPs and value their advice, especially Bangladeshi women
  o Multiple contact works well

Insights gained from the research were used to aid the development of a whole systems approach, with a ‘methods mix’ that would address both the supply and demand side of the service. To do this, the interventions developed needed to address the following groups:

1. **The client** – To reach out to eligible women, specifically targeting white British/Irish and Bangladeshi women where possible and appropriate
2. **The enablers** – To improve primary care’s role in encouraging eligible women to attend for breast screening
3. **The providers** – To adhere to the national programme requirements, but make appropriate local changes to make the breast screening service client-focused

The steering group worked collaboratively with wider partners to develop the following interventions:

1. **The client**

**Marketing campaign**
The scoping phase had identified that any communications would need to be tailored to each of the target audiences.

**Bangladeshi women**
Two factors identified by the research stood out: respect for GPs and peer influence. Any campaign would need to be authoritative, clear, sensitive and inclusive. This group responded very positively to a clear, directional approach from their GP with a message that screening is important for a woman’s health and it is important for her family that she is healthy.

A marketing campaign entitled ‘We’re here to help’ was developed for the Bangladeshi target audience. This was fronted by a local female Bangladeshi GP, Dr Anwara Ali, who was the Tower Hamlets GP screening lead and also sat on the project steering group.

While the research identified that many women within the Bangladeshi target audience did not read Bengali, it was decided that communication materials would also be produced in Bengali, to help emphasise that
Bangladeshi women would be understood and welcomed.

**White British/Irish women**
The research ascertained that using personal experiences of women who had been screened and whom they identified with (‘people like them’) would be effective with the white British/Irish target group. Any messaging would need to be clear, personal and positive. Because of the high levels of fear about ‘cancer’, the focus of the message would need to focus on care for oneself rather than cancer, while highlighting that most women who are screened do not have cancer, and of those who do, most survive. This would emphasise the benefits of screening, rather than flagging up the dangers of cancer.

A marketing campaign was developed, entitled ‘I’ve done it!’, which was fronted by local white British women who had been screened. These women’s stories were written up as case studies to support media activity and they were trained to participate in media and community activity.

**Interpersonal communications**
Engagement events were organised in venues where target women felt comfortable, including:

- Bingo halls
- Asda
- Mosques
- Community centres

**Outreach work with Bangladeshi women**
It was clear that building partnerships with community groups on the ground could improve the ability of the campaign to reach certain women. Community development charity SAfH was brought on board at the beginning of the campaign development and sat on the steering group. With its strong links with the Bangladeshi community in Tower Hamlets, it was decided that SAfH and NHS Tower Hamlets Bangladeshi Advocates would lead on the engagement events targeting Bangladeshi women, with outreach work conducted by SAfH workers. This would involve calling Bangladeshi women who did not attend their appointments, rebooking their appointments and providing transport for groups of women to attend for screening.

2. **The Enablers**
The Tower Hamlets Screening Lead played a key role in bringing the ideas of partners together to develop interventions that would improve the role of primary care in encouraging women to be screened. Ideas included:

- Cancer Locality Teams raising awareness of cancer symptoms and screening programmes (including breast screening) and working with practices to help implement the best practice guidance for cancer screening
- GP well woman checks with a breast screening ‘prescription’
• Text messaging from nine participating practices to remind women about appointments
• Using phone calls from GP practices to women who cannot read the invitation letter so they can make an informed choice about attending

3. The Providers

• Customer service training for staff
• Development of a patient charter by the frontline team, based on the high standard of customer service they aim to achieve
• The first breast screening specific website, through which appointments can be cancelled or changed
• New appointment invitation letter, developed using key research findings and incorporating behavioural science techniques
• Picture-based leaflet to assist understanding of process and reduce anxiety, which addresses illiteracy barriers within the borough
• Extended evening and/or weekend opening times
• ‘Did Not Attend’ (DNA) initiatives to follow up women who had missed their appointments.
  o Initially, capacity was created to allow for a concentrated period of screening DNA women only
  o The screening unit then reduced round length to 33 months, enabling real-time management of DNAs
  o Women now offered second timed appointment, within six months of first offered appointment, as standard
• ‘Talking invitations’ – recorded messages in English and Sylheti and a written message inviting women to attend a screening appointment – aimed particularly at those with poor literacy

Implementation began in 2008 with the trialling of interventions that had been developed with a number of partners and organisations.

Call centre restructuring
McKinsey and Company began work with CELBSS in January 2008 to address some of the inefficiencies in the screening process. Research undertaken in 2004 found that on average 840 calls per day were made to the breast screening services in London, and of these 37 per cent were engaged or unanswered. This can lead to a high number of appointments not being attended, particularly since on average 23 per cent of appointments were cancelled or changed by phone. The call centre was subsequently restructured.

Necessary changes to staff and setting up new IT systems took some time. Throughout 2009 steady improvements were made, and from the start of 2010, all the desired systems were running and the call response rate immediately increased from approximately 85 per cent to 95 per cent, which has since been maintained.

Appointment reminders and support
A particularly successful pilot involved specialist advocates and SAfH calling women to discuss their invitation to a breast screening appointment three days prior to their first appointment, or to discuss why they had not attended their appointment during the previous screening round. The women were asked if they knew about their appointment and if they had any questions about the procedure. The phone calls were conducted in Sylheti (the Bengali dialect most commonly spoken in Tower Hamlets) if needed.

*I think it worked because it is a highly personalised intervention. You can respond to
the specific concerns of women, and educate them about the benefits and costs of breast screening so that they can make an informed choice.” (Rorie Jefferies, Acute Cancer Commissioner)

Those who said the current appointment did not suit them were given new appointments, and those who said they could not attend because they had no one to take them to their appointment and had language barriers were invited to block bookings. These allowed groups of women to be picked up from the surgery and receive advocacy support whilst being screened.

“Being able to offer language support during the block bookings and transport brought in many women who had never been breast screened before.” (Solma Khatoon, Cancer Screening Facilitator)

**Breast screening ‘prescription’ at well woman checks**

Conversely, the pilot that involved GP surgeries offering women a well woman check from which breast screening could be ‘prescribed’ was problematic and thus discontinued. This was because women needed to respond to a screening invitation letter rather than request a screening appointment, which created confusion with the invitation and appointment process.

**Community events**

As part of the wider engagement and awareness raising tailored to both white British/Irish and Bangladeshi women, community events (such as Mother’s Day pampering sessions, use of bingo halls and the Asda tea morning) were conducted and provided good publicity for the campaign. However they tended to attract people older or younger than the target audience and those from outside the borough. While these events were popular it was also difficult to measure their effectiveness. However, as the project progressed further interventions were developed with community groups, including work by a community housing association, which raised awareness and promoted breast screening to Bangladeshi women via education sessions, and by the Bromley by Bow centre, which provided cancer education and health literacy linked to ESOL classes.

Building on the work conducted during 2008/09, further initiatives were developed for later screening rounds.

**Bosom Buddy**

In an attempt to engage more white British/Irish women in Tower Hamlets, NHS Tower Hamlets utilised the enthusiasm of Dymphna Dale, who was the face of the campaign in 2008, when she became an advocate for a Bosom Buddy scheme. Managed by local charity Neighbours in Poplar, the scheme uses women who have attended screening to become ‘buddies’ and recruit other eligible women to attend their own screening appointments.
“One opportunity that arose was developing the role of the lead woman for the campaign, Dymphna. She became an ambassador for the project and was instrumental in setting up the Bosom Buddies scheme.” (Paul Collins, Social Marketing and Stakeholder Engagement Lead)

Open days
A series of open days were held at Mile End hospital, which involved information health stalls, a tour of the breast screening unit and talks by radiographers. This enabled women to become familiar with the environment and ask questions about the process.

Provider incentives
A key accomplishment in 2009 was that NHS Tower Hamlets and the five other PCTs that commission the CELBSS service worked to develop a detailed service specification, which included a number of patient experience standards.

Payment per woman screened was also introduced to replace block payment. This new method of payment would allow the service to afford greater operational flexibility going forward. In addition, the service now provides second timed appointments (shown to almost double response rates, when compared to open invitations to call the service). This change unblocked many logistical challenges NHS Tower Hamlets had faced in trying to make changes to the breast screening system and was pivotal for many of the other successful interventions.

“From a commissioning point of view, I think the biggest obstacle was our payment mechanism with the provider. We did everything on a block contract. Moving to cost and volume provided the service with the financial flexibility to generate additional capacity and see more women.” (Rorie Jefferies, Acute Cancer Commissioner)

The programme was evaluated through breast screening rates, a survey to assess the success of the marketing campaign and one-off appraisals of pilot schemes.

Screening rates
The overall aim of the social marketing campaign was to increase the numbers of women attending breast screening in Tower Hamlets. In 2006/07, prior to the launch of the campaign, the breast screening rate in Tower Hamlets for women aged 53 to 70 was one of the lowest in the country, at 52.3 per cent. Between 2006/07 and 2009/10, the rate increased by 13.6 percentage points:

- 2006/07 – 52.3 per cent (baseline)
- 2007/08 – 53.4 per cent
- 2008/09 – 63.5 per cent
- 2009/10 – 65.9 per cent

Screening rates varied across the participating GP practices, ranging from 35.9 per cent to 79.3 per cent (a first for Tower Hamlets).

Marketing campaign
In June 2008, following the marketing campaign, a survey of women in Tower
Hamlets aged 40 to 85 was carried out, with the following results:

- 94 per cent of respondents believed it was important women aged 50 to 70 attend screening
- 76 per cent felt this sort of campaign would encourage women to attend

Of the respondents aged 50 to 70:

- 29 per cent had seen the campaign
- Two-thirds agreed or strongly agreed the campaign would encourage them to attend screening in the future
- 39 per cent had received an invitation to screening in the last 6 months, and of those, 80 per cent had attended their appointment

Text message reminders
While mobile numbers were only available for 10 per cent of the target women, 70 per cent of those who received messages attended their screening appointments

Pre-appointment phone calls
Phone calls to ‘first appointments’ and DNAs showed a mean average increase in uptake for first appointments in participating practices of 15 per cent, and the mean average increase in uptake for DNAs in participating practices was 14 per cent.

Talking invitation
An evaluation found little difference in uptake of the test group (those sent ‘talking invitations’) and the control group (those sent just written invitations). However Bangladeshi women responded to the talking invitation positively with a greater response in the intervention group compared to the control group. Discussions continue about how this initiative can be taken forward, especially in light of the cost of the scheme.

NHS Tower Hamlets has continuously assessed and amended the work it has conducted to increase the numbers of women in the borough attending breast screening. Learning from each breast screening round has been shared with the steering group and key stakeholders and have fed into developments for the next screening round, including the most recent, which began in October 2010.

NHS Tower Hamlets has been asked to present at a number of national conferences to share lessons learned and insight into the key successes of the project. Good practice gathered from this work is regularly being shared across the network that CELBSS covers through a quarterly group.

The achievements of NHS Tower Hamlets and its partners were recognised when the project was awarded the Best Social Marketing Project in the 2010 HSJ awards.
Lessons learned

Keep focused on your goal
Ultimately any project will be assessed by delivery against targets. This requires strong project management that continually ensures that all work is focused on achieving a set behavioural goal. In times of tight public sector finances this becomes more important than ever.

“Delivering on a target is often about relentless and, to be honest, monotonous focus on the goal. As a result, I would recommend that you develop a delivery team to meet on a frequent basis to manage the project.” (Rorie Jefferies, Acute Cancer Commissioner)

Research and understand your target audience
Design your interventions based on understanding of your target audience. Professionals may feel they know what the target audience wants and what interventions would be the most successful. These assumptions can be fatal to the success of a project, so conduct the necessary research to ensure your project is truly client-centred.

“Practical advice I would give is to know your population and don’t make assumptions of what intervention is best for them. Ask them what changes could be made to the service to make them come to their breast screening appointment. It was through the information that was provided through the focus groups that we were able to ask for a static site and provide transport.” (Solma Khatoon, Cancer Screening Facilitator)

Work in sync with breast screening rounds
Ensure campaigns focusing on breast screening are planned with the breast screening round timings in mind. This campaign’s scoping phase began during a breast screening round and the delivery of the marketing campaign began in February 2008, with the breast screening round finishing in April 2008. This limited planning and delivery time for the marketing campaign reduced early impact. Nevertheless, learning from this initial work fed into developments of subsequent breast screening rounds.

The whole systems approach is highly beneficial, but must be coordinated
Taking a whole systems approach and looking at the entire domain of breast screening allowed NHS Tower Hamlets to make service changes that ensured the whole screening process was coordinated and client-focused. This approach however requires working with a large number of stakeholders. The amount of work this requires should not be underestimated, but is necessary. Ensure information and insights are shared broadly amongst key stakeholders.

“I would recommend a whole systems approach that tackles the supply and demand side of the services, the key influences in the process, and uses partnership working to achieve the targets.” (Paul Collins, Social Marketing and Stakeholder Engagement Lead)