Evaluation of Nepean Blue Mountains Primary Health Network (NBMPHN) Cancer Screening Program

I’m actively doing more pap smears and reminding people that come through, “Have you had your screening done?”...I think we definitely have an increase in uptake in a lot of the screening services. (Practice Nurse)
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**Suggested Citation**


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- The NBMPHN Cancer Screening Advisory Committee, and the Cancer Screening Evaluation Working Party who oversaw the research; and
- The many participants who contributed to the project. Their voices lie at the heart of this report.
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<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>BCI</td>
<td>Westmead Breast Cancer Institute</td>
</tr>
<tr>
<td>Best Practice [TM]</td>
<td>General Practice software</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>FOBT</td>
<td>Faecal Occult Blood Test</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>KPI</td>
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<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>Medical Director – MD [TM]</td>
<td>Commercial general practice electronic health record</td>
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<tr>
<td>NBMPHN</td>
<td>Nepean Blue Mountains Primary Health Network</td>
</tr>
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<td>Non-Government Organisation</td>
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<td>New South Wales</td>
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<tr>
<td>N-Vivo 11 [TM]</td>
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<tr>
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<td>PDSA</td>
<td>Plan, Do, Study, Act quality improvement cycle</td>
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<td>PEN CAT [TM]</td>
<td>General practice electronic health record data extraction tool</td>
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<td>Program Logic Model</td>
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<tr>
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</tr>
<tr>
<td>TM</td>
<td>Trademark</td>
</tr>
<tr>
<td>Top Bar [TM]</td>
<td>Commercial user interface linking electronic health record to other applications</td>
</tr>
<tr>
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<td>World Health Organisation</td>
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<td>WSU</td>
<td>Western Sydney University</td>
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Executive Summary

Introduction

Cancer is a leading cause of death globally and is also the leading cause of disease burden in Australia, thus it has a significant social and economic impact on individuals, families and the community. National screening programs in Australia aim to detect breast, bowel and cervical cancer. Screening is free to all individuals in particular target groups, defined by age and gender, however barriers to engaging in cancer screening are common.

The aim of the Nepean Blue Mountains Primary Health Network (NBMPHN) Cancer Screening Program is to work with primary health care providers and the local community to raise cancer screening rates across its four local government areas by targeting specific population groups where breast, cervical and bowel cancer screening participation rates are lower than NSW state averages.

Commissioned and jointly funded by Wentworth Healthcare Limited and the Cancer Institute NSW, we conducted a qualitative study aimed at evaluating the implementation of the NBMPHN Cancer Screening Program.

Method

The Western Sydney University (WSU) research team was guided by the NBMPHN Cancer Screening Evaluation Working Party and Program Advisory Committee. Approval was granted from the WSU Human Research Ethics Committee and the Aboriginal Health and Medical Research Council of NSW.

In consultation with NBMPHN, we developed a program logic model (PLM) to guide evaluation of the Cancer Screening Program. We discussed and agreed on intended impacts, the outcomes and outputs which would result in the impacts, and the activities and inputs required to achieve these outputs and outcomes. Evaluation indicators were assigned in each of these areas to assess progress over time. We then conducted a qualitative evaluation aligned with the PLM to explore the experiences of participants engaging with the NBMPHN Cancer Screening Program.

Semi-structured individual interviews and one focus group were conducted with a total of 33 participants, purposively sampled from a range of key stakeholders, including NBMPHN staff, general practice staff and consumers. Following an initial invitation from NBMPHN, we contacted consenting general practice and PHN staff to arrange interviews. These participants included general practitioners (GPs), practice nurses, practice managers, NBMPHN staff, including contractors and committee representatives. Consumers were recruited opportunistically through NBMPHN sponsored educational sessions and by Aboriginal liaison workers. Interviews were conducted either face to face or by telephone, recorded and transcribed verbatim. The interview data were analysed thematically using an iterative approach to identify and describe meanings or themes in the data.

Results

Analysis of the interview transcripts revealed four overarching themes: setting up and implementing the Cancer Screening Program; patient and community education and promotion; engaging patients and communities in screening; and general practice enhancement.

Interviewees highlighted a range of issues related to setting up and implementing the Cancer Screening Program. The NBMPHN Cancer Screening Advisory Committee was supported by management, however difficulties initially engaging clinical representatives on the committee were
noted and review of the committee was suggested. Program management staff, committee members and contractors generally reported a good understanding of their roles and felt supported, although one was less satisfied. Funding for the program was regarded as adequate and incentive payments described as helpful. However, some interviewees considered the payments inadequate and others felt that the payments should compensate practice staff rather than doctors.

Practice staff valued the practice-based support, such as the training they received to set-up the program and practice visits from the NBMPHN. Nepean Blue Mountains Primary Health Network staff were described as accessible and collaborative, tailoring their support to individual practices and assisting practice staff to set relevant goals. Staffing changes at the NBMPHN, however, presented challenges in continuity and the pace of program activity. Practice software was described as being limited in capacity, and sometimes provided unreliable data.

Respondents were generally highly motivated particularly by a desire to provide high quality patient care, and improve their practices. Some stated that without continued motivation, screening activities could decline and strategies were recommended to maintain motivation including ongoing regular contact and support from the NBMPHN, continuous audit and more frequent feedback. Comparison of results with other practices, and celebrating successes, regardless of how small, were also seen as powerful motivators.

Interviewees described their experiences of patient and community education and promotion of screening. General Practitioners and practice staff provided screening education with patients and held health promotion days. This active promotion of screening was described as increasing awareness and improving attitudes towards screening and also lifestyle change. Some consumers encouraged others to be screened. Community-based workshops and events promoting screening were tailored to particular target groups, for example bowel screening workshops at men’s groups and breast screening events for Aboriginal women. These events were seen as an opportunity to discuss the somewhat taboo topic of screening. Building rapport with the community was seen as crucial in attracting consumers to screening education events particularly for men who were not involved in regular cancer screening. The importance of support from elders in the Aboriginal community was highlighted. Bowel screening consumers identified men’s groups and other places where men met regularly as suitable venues for screening education. Consumers also recommended that screening education be promoted through schools, television, and the internet.

Several factors were identified to facilitate engagement of patients and communities in screening. For GPs these included building practice registers, developing recall and reminder systems, and collecting and auditing practice data. The screening program was noted to have raised staff awareness about the need to engage patients in screening and, in many cases, the practice team was involved in this process. Challenges to engaging patients in screening included a lack of time and having competing priorities. Equipment and technological barriers were reported, including lack of access to bowel screening kits, and an information disconnect with pathology providers whereby time consuming manual entry was required to enter results electronically.

Consumers described positive screening experiences, noting the simplicity of the bowel screening test and helpful diagrams in the screening kit. However, consumers also reported reluctance to being screened and described barriers such as a risk of breach of confidentiality, and screening as a taboo topic. Some commented on the lack of screening follow-up with their usual GP. Breast
screening interviewees highlighted the location and inaccessibility of the mobile breast screening van as barriers to screening.

Consumers recommended provision of educational materials that were visually appealing and easily understood. Aboriginal women suggested ways to make their screening van experience more comfortable such as having shelter, shade, seating and refreshments, and to situate the van near where the Aboriginal community lives and gathers. They also suggested that the screening timetable be aligned with other community events. Aboriginal liaison roles were seen by interviewees to be important for supporting and encouraging women in screening and Aboriginal consumers strongly advised that health workers working with Aboriginal communities be trained in cultural awareness.

Leadership and teamwork were considered crucial to general practice enhancement by keeping staff informed and focussed on program goals. Some interviewees reported improved teamwork as a result of the program, with knowledge and expertise shared. Conversely, others reported disengagement from the program. More regular meetings of all practice staff were suggested to avoid disengagement. Interviewees reported a variety of preferences for accessing learning resources provided by NBMPHN. Practice staff noted that training in use of practice software improved efficiency and increased staff awareness of screening rates, data entry, and often enabled staff to expand their roles. However, finding time for training was challenging especially with pressing clinical commitments. Further support for staff with poor Information Technology (IT) literacy was needed at some practices and there were suggestions to incentivise workshops and to include peer to peer learning.

Interviewees described quality improvement activities, such as establishing screening registers and refining the recall and reminder systems as resulting in improved data entry and more accurate audit. Actual rates of screening were also reported to have improved. Plan, Do, Study, Act (PDSA) cycles assisted staff to develop plans and to become familiar with their practice goals. However, for some, implementing a PDSA cycle was time consuming and difficult especially in practices with limited staff capacity. Access to Continuing Professional Development (CPD) points was valued by most GPs although some were unaware that CPD points were offered as part of the program. Supporting practices to engage in quality improvement was considered by the NBMPHN as key to sustaining screening improvements. Many interviewees were committed to continuing with the quality improvement initiatives. A major impediment to ongoing quality improvement was the time required and the competing priorities of clinical care.

**Discussion**

We described participant experiences of the NBMPHN Cancer Screening Program in terms of the PLM domains and identified facilitators and barriers to the program.

The identified inputs included establishment of an Advisory Committee informed by clinical and consumer expertise to oversee the program. Periodic review of committee membership was recommended. Program funding was considered sufficient and appropriately dispersed. Resources and IT support were provided to practices and staff including opportunities for CPD. Staff reported a good understanding of their roles and satisfaction with the support. A range of communication and media strategies were implemented as part of the program activities. Community workshops and cultural events engaged consumers, and general practices were commissioned. Practice staff
expressed satisfaction with training and QI initiatives aimed at practice redesign. Time constraints and clinical priorities were a barrier for practice staff.

Key program outputs described increased engagement between GPs and patients. Reminder and recall systems and screening registers were improved. Practice staff valued their ability to audit and compare against other practices. Plan, Do, Study, Act cycles assisted practice staff with their QI activities. Program outcomes involved stakeholders being more informed about screening and services, and improved consumer access and use of screening services. Consumers attended educational sessions and were proactive in accessing health information. Many consumers reported changes in their attitudes toward screening and their lifestyle behaviours. Practice staff reported increases in screening rates. Program impacts of improved community health outcomes and sustained and integrated health services are long term and were beyond the scope of this evaluation. The PLM provides the capacity for ongoing evaluations and over time evidence of impact may be identified, especially in comparison with baseline information.

We identified a number of program facilitators. These included clear staffing roles and governance structures in program set-up and implementation. There was good practice-based support from the NBMPHN and leadership and teamwork within practices. Community-based events were tailored to target groups and strong communication across the program was a key component.

Barriers to the program were also described including IT issues, staffing changes, and attitudinal and accessibility barriers to screening. Some practices lacked time and reported competing priorities.

Recommendations for the future

For NBMPHN

- Continue to promote the screening program to all stakeholders;
- Continue providing screening information, tailored training and support to NBM practices;
- Use a variety of strategies to communicate with practices and a range of modes to provide resource information;
- Enable opportunities for practices to learn from each other e.g. peer to peer learning;
- Advocate for the needs of the Aboriginal community to be addressed in terms of the mobile breast screening service;
- Continue to identify at-risk groups in the community and to promote screening through community education and in general practice;
- Advocate for public cancer screening education e.g. via schools, radio and television; and
- Ensure evaluation continues to inform the development of screening strategies.

For practices

- Provide strong leadership in implementing program initiatives;
- Engage in support and training provided for cancer screening and use of practice software;
- Engage all practice staff in the program and support active communication across the team;
- Build practice capacity through encouraging and supporting staff to take on new roles;
- Use audit data to evaluate screening rates and improve clinical care; and
- Continue a strong focus on patient education and empowerment.
Introduction

Background

Cancer is the leading cause of death across the world (WHO) (1) and estimated to be the leading cause of disease burden in Australia (2). The Australian Institute of Health and Welfare reported that cancer as a disease group accounted for 19% of the total disease burden in Australia in 2011 (3). Furthermore, it is estimated that 48,586 deaths will be due to cancer in 2018 which represents an increase from the 44,000 cancer deaths recorded in 2013 (4). There will also be an estimated 138,320 new cases of cancer diagnosed in Australia in 2018 – an increase from the 124,465 new cancer diagnoses in 2013 (4). As a major cause of illness in Australia, cancer has a substantial social and economic impact on individuals, families and the community (2).

Screening programs aim to reduce the incidence and mortality from cancer (5). Screening involves tests to look for particular changes, or early signs of a disease, before a disease has developed or while still in its early stages before symptoms develop. National screening programs are available in Australia to detect breast, bowel and cervical cancer (6). These programs, provided at no cost to the individual, are designed to find cancer at a stage when treatment is more effective (7). In a population level approach, screening is offered to all individuals in a target group, usually defined by age, gender or ethnicity, as part of an organised program (8).

Despite the availability of screening programs, barriers to engaging in screening are common (9). For consumers, markers related to socioeconomic status such as education, income, and health literacy have been linked to poor colorectal cancer screening uptake in population-based cohort studies in the United Kingdom (10, 11). Embarrassment and perceived unpleasantness as well as fear and pain of testing were noted barriers in other studies of bowel cancer and cervical cancer screening (12, 13). Talking about screening can also be a social taboo among particular cultural groups (14, 15). From the provider perspective, contextual factors such as service organisation, as well as healthcare provider training and practices, can be barriers to screening (16).

Nepean Blue Mountains Cancer Screening Program

Improving participation in cancer screening in the Nepean Blue Mountains population across Australia’s three National cancer screening programs (bowel, breast, cervical) is a key priority for Nepean Blue Mountains Primary Health Network (NBMPHN). The Nepean Blue Mountains region consists of four Local Government Areas (Penrith, Hawkesbury, Blue Mountains and Lithgow) that include people from a range of cultural backgrounds. There is also variability in health care provider capacity to engage actively with screening programs. Particular Local Government Areas (LGAs) have low levels of screening for one or more of the three cancer types within particular target populations.

The cervical cancer screening participation rate for eligible women 20-69 years in the Nepean Blue Mountains region in 2014-15 was 53.3% which was lower than the NSW state average of 56.0%. The participation rate was lowest in the Penrith LGA with a screening participation rate of 49.1% (17).

The breast cancer screening participation rate for eligible women 50-69 years in the Nepean Blue Mountains region in 2014-15 was 46.2% which was lower than the NSW state average of 51.6%. This compares to a National rate of 54%-55% (18). The participation rate was lowest in the Lithgow LGA with a screening participation rate of 42.5%. The breast screening participation rate among
Aboriginal and Torres Strait Islander women in the Lithgow LGA was less than half the NSW state average for Aboriginal and Torres Strait Islander women (13.9% vs. 40.2%). Furthermore, women from a culturally and linguistically diverse (CALD) background residing in the Blue Mountains LGA had the lowest breast screening rate for CALD women in the region, with a participation rate of 40.7% compared to the NSW State average of 46.1% (19).

The bowel cancer screening participation rate for eligible men and women 50-74 years in the Nepean Blue Mountains region in 2014-15 was 33.3% and was lower than the NSW state average of 35.1%. The participation rate was lowest in the Penrith and Hawkesbury LGAs, at 30.2% and 33.6% respectively. Bowel screening participation was lower for males compared to females for every 5-year age strata between 50-74 years and was as low as 20.7% for 50-54 year males in 2014-15 in the Penrith and Hawkesbury LGAs (20).

Nepean Blue Mountains PHN is working with primary health care providers, the local community and other stakeholders to improve participation rates across these three National screening programs. The NBMPHN is providing support to enhance general practice capacity through a range of quality improvement (QI) initiatives and is working to increase consumer engagement through various strategies that build awareness and motivation (21). These initiatives and strategies are summarised in Table 1.

Table 1. NBMPHN Cancer Screening Program Strategies and Initiatives

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Quality Improvement Initiatives and Supportive Strategies</th>
</tr>
</thead>
</table>
| General Practices | • Establish and/or clean practice cancer screening register  
• Establish and utilise provider reminder and patient recall system  
• Conduct periodical clinical audits – data analysis and feedback  
• Support Information Technology with data extraction and assist with practice software including screening updates  
• Establish/promote women’s health checklist  
• Develop Health Pathways for cancer screening  
• Provide information on the local mobile breast screening service  
• Practice staff training including consumer engagement and QI coaching  
• Support practice nurse participation in Well Women’s Screening course  
• Promote PDSA (Plan, Do, Study, Act) approaches/cycles  
• Incentive payments and continuing professional development (CPD)  
• Provide educational materials for display in practices  
• Provide practice information packs and information at NBMPHN website |
| Consumers         | • Develop and distribute culturally appropriate education material for the three cancer types  
• Provide information and promote the local mobile and fixed clinic breast screening services  
• Coordinate and promote workshops and information sessions  
• Commission an Aboriginal health liaison officer  
• Commission a men’s preventive health education provider |
| Community         | • Implement publicity and communication strategies  
• Develop linkages with women in Aboriginal communities  
• Engage with community organisations including local councils, men’s sheds, and men’s work places |
Research aims
The NBMPHN is collecting routine general practice data to evaluate changes to bowel, breast and cervical cancer screening rates across its region as a result of the above initiatives.

The evaluation described in this report complements the quantitative data collected by NBMPHN by adding a qualitative component based on in-depth interviews, in order to gain an understanding of how the program is working from the perspectives of the different stakeholders.

A program logic model (PLM) was developed to guide the evaluation activities and provide a comprehensive framework for future cancer screening evaluations by the NBMPHN.

Reading this report
This document reports the findings of our qualitative research. The methods section provides a detailed description of the research design including ethics approval, participant recruitment, and development of the PLM, interview schedule and analytic approaches.

In the results section we report on our data analysis. Our themed analysis looks across all strategies and stakeholder groups to gain a broader understanding of how the NBMPHN Cancer Screening Program is working and what has been learned in the process. The more detailed analysis is included as a separate appendix to the report (Appendix A).

In the discussion, we draw together findings of the research by reflecting on areas of achievement, and conclude the report by describing facilitators and barriers to the NBMPHN Cancer Screening Program. Based on our research, we present recommendations for the future and these are noted in the executive summary at the beginning of this report.

Methods
Overview
We developed a program logic model (PLM) in consultation with the NBMPHN Cancer Screening Evaluation Working Party and their Program Advisory Committee. The PLM mapped the NBMPHN Cancer Screening Program inputs, activities, outputs, outcomes and impacts (22). Evaluation indicators were assigned in each of the PLM components to assess progress over time. We then conducted a qualitative evaluation (23, 24) aligned with the PLM to explore the experiences of participants. We conducted semi-structured, in-depth interviews with 33 participants and undertook thematic analysis of the interview data using an iterative approach to identify and describe meanings or “themes” in the data (25, 26). The analysis provided different perspectives on the engagement with the NBMPHN Cancer Screening Program and its implementation.

The research team
The research was undertaken by experienced researchers from the Department of General Practice in the School of Medicine at Western Sydney University (WSU). Associate Research Fellow, Dr Steven Trankle, led the project, working closely with Dr Christine Metusela the project research officer. Professor John Macdonald provided advice as a consultant to the research team, whilst Professor Jennifer Reath oversaw the design and implementation of the research. The WSU research team consulted regularly with the Cancer Screening Evaluation Working Party recruited by the NBMPHN, who provided advice and guidance.
Ethics approval

We received ethics approval from the following Human Research Ethics Committees:

- WSU Human Research Ethics Committee (H12252); and
- Aboriginal Health and Medical Research Council of NSW (1276/17).

Developing the Program Logic Model with indicators and measures

Program logic models are recognised for their capacity to effectively evaluate complex and changing phenomena (27, 28). Primary health systems are recognised as complicated and dynamic and research has shown program logic approaches helpful in understanding and evaluating these systemic environments (29, 30). The PLM approach is said to “provide learning opportunities, better documentation of outputs and outcomes, and shared knowledge about what works and why” (22).

We developed a comprehensive and specific PLM for the NBMPHN Cancer Screening Program. This was informed by literature, NBMPHN and Westmead Breast Cancer Institute (BCI) cancer screening program documents and developed in consultation with the NBMPHN Cancer Screening Evaluation Working Party. The PLM was designed to guide evaluation of the entire program from development to implementation.

We discussed and agreed on intended impacts, the outcomes and outputs which would result in the impacts, and then the activities and inputs required to achieve these outputs and outcomes (see Figure 1). Inputs include the human, financial, organizational, and community resources a program has available to direct toward doing the work. Activities refer to the way resources are used to bring about the intended program changes or results. Activities are the processes, tools, events, technology, and actions that are an intentional part of the program implementation. Outputs are the direct products of activities and may include new resources and/or types, levels and targets of services and programs delivered by the NBMPHN. Outcomes are the changes in program participants’ behaviour, knowledge, skills, status and level of functioning. Impacts are the fundamental intended or unintended change occurring in organizations, communities or systems as a result of program activities (22).

In further consultation with the Evaluation Working Party we assigned indicators that would mark achievement of each of the agreed impacts, outcomes, outputs, activities and inputs. The full PLM with indicators and measures is provided at Appendix B.
**Figure 1 Summarised PLM of NBMPHN Cancer Screening Program Evaluation**

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>ACTIVITIES</th>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>IMPACTS</th>
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<tbody>
<tr>
<td>Funding</td>
<td>Program planning and development including:</td>
<td>Program implemented:</td>
<td>GPs/engaged consumers and other stakeholders are informed about screening and services:</td>
<td>Enhanced local community health and wellbeing:</td>
</tr>
<tr>
<td>Management and governance structures</td>
<td>- commissioning contractors and GPs</td>
<td>- staff / contractors recruited</td>
<td>- GP/staff awareness</td>
<td>- sustained improved community screening rates</td>
</tr>
<tr>
<td>Staff</td>
<td>- communication and media strategies</td>
<td>- publicity strategies implemented</td>
<td>- consumer knowledge</td>
<td>- reduced incidence of cancer and increased survival rates</td>
</tr>
<tr>
<td>Community and consumer stakeholders</td>
<td>- training initiatives</td>
<td>- cancer registers developed</td>
<td>- consumer self-efficacy</td>
<td>Integrated and coordinated health services:</td>
</tr>
<tr>
<td>Research and evaluation expertise</td>
<td>- practice redesign QIs</td>
<td>- QIs implemented</td>
<td>Improved consumer access and use of screening services:</td>
<td>- integrated and coordinated health services across public and NGO sectors</td>
</tr>
<tr>
<td>Technology including information technology (NBMPHN and GP)</td>
<td>- evaluation strategies</td>
<td>- training/educational initiatives implemented</td>
<td>- targetted consumers utilise screening services</td>
<td></td>
</tr>
<tr>
<td>Other resources that are program specific</td>
<td></td>
<td>- Evaluation of program:</td>
<td>Program achieves stated outcomes:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- periodic data collected/reported</td>
<td>- improved consumer health status</td>
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<td></td>
<td>- improved provider knowledge and skills</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>- staff/cross-provider collaborations</td>
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Sampling and recruitment

In consultation with the Cancer Screening Evaluation Working Party and the Program Advisory Committee, we determined a sampling frame of key stakeholder groups who would provide important and varied perspectives on the Cancer Screening Program initiatives. These comprised consumers, management and staff of the NBMPHN and their contractors, and general practice staff including general practitioners (GPs), practice nurses (PNs), and practice managers (PMs). As other evaluation activities were being conducted by NBMPHN, the agreed scope for our consumer interviews was males in the Penrith/Hawkesbury area in regards to bowel cancer screening and Aboriginal women in the Lithgow area in relation to breast cancer screening. Using a stratified approach, participants were recruited across all stakeholder groups and LGAs to ensure adequate representation.

Consumers were recruited opportunistically at educational sessions and workshops provided by the NBMPHN and in Lithgow, by Aboriginal liaison workers from the NBMPHN and Nepean Blue Mountains Local Health District. General practice staff were purposively sampled to engage a range of staff and varied engagement with the program. Nepean Blue Mountains Primary Health Network staff recruited general practice participants while working with them on-site and through email and telephone contact. All participants were provided with a WSU letter of invitation to the study and a participant information sheet and consent form. Participants had the option of either contacting the WSU researchers directly or allowing the NBMPHN to forward their contact details to the researchers (ST and CM) who then arranged interviews. In all cases, prior to commencing interviews, a signed consent form was provided by the participant, either in person or mailed.

Interviews (data collection)

In consultation with the Cancer Screening Evaluation Working Party and the Program Advisory Committee, and aligned with the PLM, we designed a semi-structured interview guide to collect participants’ perspectives on their engagement with initiatives of the NBMPHN Cancer Screening Program. We piloted the guide in the first eight interviews, after which interview transcripts were reviewed by the research team to ensure the clarity and comprehensiveness of the interview questions. The interview guide underwent further minor revision throughout the data collection period, informed by ongoing data analysis and further consultation with program management. Questions and prompts were added to explore emerging areas of interest in more depth. The semi-structured interview guide is provided at Appendix C.

Interviews were mostly conducted one-on-one and face to face by two interviewers (ST and CM), although some were conducted by telephone. One focus group was conducted with two Aboriginal participants in Lithgow and another Aboriginal participant was interviewed by telephone. All interviews were audio-recorded and transcribed by an independent transcription service. Transcripts were then checked for accuracy. Interviewees were offered the opportunity to review their transcript.

Thematic Analysis

We explored the experiences and perspectives of participants with the cancer screening initiatives using a thematic analysis. This approach allows patterns and meanings to be captured from qualitative datasets (25). Our thematic analysis was inductive and data-driven, enhancing our
understanding of the NBMPHN Cancer Screening Program, and its outcomes without trying to fit them into a preconceived coding framework.

Three research team members (ST, CM, and JR) coded 3-4 interviews each of the first 10 interviews to identify patterns within the transcripts. The research team then discussed the coding and agreed on core initial themes. ST and CM then continued to code the remaining interview transcripts and consulted together to check and refine the emerging analysis. At the conclusion of coding, the research team reviewed the completed coding frame. This provided the opportunity to discuss the positioning of individual categories and codes, and clarify themes, and ensure the framework was accurate and inclusive of the data. Any differences in interpretation were resolved through a process of consensus. We used N-Vivo 11® software to aid organisation of interview data. The full analysis table is included as Appendix A.

Results

We conducted 33 semi-structured interviews over four months from December 2017 to the end of March 2018. The interview structure was aligned with the PLM but provided scope for some participant direction which allowed us to further explore their unique experiences. We interviewed seven males in relation to bowel cancer screening and three Aboriginal women in relation to breast cancer screening. We interviewed 18 general practice staff across the four LGAs. These included PMs, PNs and GPs. We also interviewed five NBMPHN staff and contractors including a consumer representative. The duration of individual interviews varied between 20 and 60 minutes. Participant information is detailed in Table 2.

Table 2. Interview participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Number</th>
<th>LGA</th>
<th>Cancer type</th>
</tr>
</thead>
<tbody>
<tr>
<td>NBMPHN Staff and Contractors (designated below as PHN)</td>
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<td>N/A</td>
<td>All cancer types</td>
</tr>
<tr>
<td>Aboriginal Women</td>
<td>3</td>
<td>Lithgow</td>
<td>Breast</td>
</tr>
<tr>
<td>Males</td>
<td>7</td>
<td>Penrith and Hawkesbury</td>
<td>Bowel</td>
</tr>
<tr>
<td>General Practitioners (GP)</td>
<td>6</td>
<td>Lithgow (1x PN) Hawkesbury (2x GP, 3x PM, 1x PN) Penrith (2x PM, 1x PN, 3xGP) Blue Mountains (3x PM, 1x PN, 1x GP)</td>
<td>All cancer types</td>
</tr>
<tr>
<td>Practice Nurses (PN)</td>
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<td></td>
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<tr>
<td>Practice Managers (PM)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Participants</td>
<td>33</td>
<td></td>
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</tr>
</tbody>
</table>

Data analysis

On thematic analysis of the interview data four overarching themes emerged. These related to setting up and implementing the Cancer Screening Program; patient and community education and promotion; engaging patients and communities in screening; and general practice enhancement. Findings in relation to these themes are described below.

Setting up and implementing the NBMPHN Cancer Screening Program

Interviewees highlighted a range of issues broadly related to setting up and implementing the program. These included staff roles, governance structures, funding adequacy and disbursement,
communication strategies, providing program information, practice support, Information Technology (IT) challenges, and motivation to participate. These subthemes are described below.

**NBMPHN staff, contractor and committee roles**

Program management staff, contractors and committee representatives generally reported a good understanding of their roles. Most interviewees said that role expectations were well defined, although one noted a lack of clarity.

*It was very clear, and it was verbalised and set in writing, as well.* PHN 2

*I was very, very heavily involved in the development and design and then the implementation of the program activities so I felt clear from all of that work what was expected of me.* PHN 4

*Well, we got documents, pages of terms, questions and answers, terms and conditions, but for somebody actually sitting down and saying, look, this is what we expect from a [role de-identified], no, there was nothing like that.* PHN 1

Some staff brought previous experience to their role which assisted in their orientation to the program tasks. However, at times they reported inadequate orientation to the program. One, engaged in a committee role, noted that better communication between committee meetings would have been beneficial.

*I felt that I was well oriented because I’ve done quality improvement before.* PHN 5

*The handover wasn’t very streamlined...no time to even orient myself around all of the different components of cervical screening, mammograms, and FOBTs [Faecal Occult Blood Tests]. I had to hit the ground running, pretty much.* PHN 5

*Probably an email or two just to say look, following on from the last meeting, this is what we’ve done...rather than just getting the minutes.* PHN 1

Generally most staff felt supported in their role. They knew who they could go to for guidance and assistance. However, one committee representative reported that at times their views were dismissed.

*I think it’s been a case of if I need something then there’s people I go to. There’s been that sort of support and it’s been pretty good.* PHN 3

*It’s mainly academics and I’m certainly not an academic. I’ve been swatted down a couple of times when I’ve said different things.* PHN 1

Staff changes at NBMPHN presented challenges. At times, this resulted in poor continuity and slowing of general practice activity on the program. Sometimes this created confusion for practice staff who felt the messages from NBMPHN were conflicting.

*It took us I think, another five months to find another person to fill that role.* PHN 4

*We had three or so different people that have taken over the program...I think it just got confusing as to where we were up to and then when the next person would come in and say something completely different to the one before.* PM 7
Governance structures

An Advisory Committee was set up to oversee the program and ensure diverse consumer representation. Management supported staff in setting up the program. The program was stated to be evidence-based and staff drew on expertise from other organisations involved in similar programs.

The early [Cancer Screening Program Advisory Committee] meetings were to help embed the committee and the work they were doing and the communication with the committee members. PHN 4

Senior management and management here were supporting enough of the program to give us the interest and attention to help it along its way. I also was fortunate to have the time to reach out to other program coordinators...and other primary health networks. PHN 4

It was difficult initially engaging clinical representatives on the Advisory Committee. One interviewee reported that the consumer voice was under-represented and suggested a review of the committee.

Probably the people that we found hardest to reach or engage initially were our clinicians. PHN 4

We probably could have done more to get more a voice from our consumers in the region. We probably did have a top heavy representation from either clinicians or from people working in quite familiar and confident in top-tier services, or from academia, even, they tend to take a certain tone...it would have been worth us reviewing the structure and make-up of the committee membership or governance. PHN 4

Funding adequacy and disbursement

Funding for the program was regarded as adequate and external funding grants assisted with other program activities.

I felt as though the funding was suitable or appropriate for the activities...I think it was appropriate for what we were attempting to achieve. PHN 4

Incentive payments were described as helpful for practices and an incentive for some to become involved. These helped cover time spent on the program including on staff education. However, some respondents considered the payments inadequate in covering their costs.

Definitely a determining factor [incentive payments]...so to have some sort of compensation for that is appreciated. GP 2

...it was quite useful to get financial assistance because it involved time and effort from our practice nurses. GP 1

Last manager, she actually end up putting a girl on just to do it [implement program] - doing the whole thing - and that cost us a lot of money. PM 2

There was a view that incentive payments should go to the practice rather than doctors. Some thought payment should compensate the practice nursing staff.

If the funding comes to the practice, I think, will be better, I think...doctors, when they're doing their screening things - they already get paid by Medicare, or they already charge the patient. PM 2
What about the nurses doing cervical tests...spent hours calling and going back into history and putting all those recall systems? I know it’s part of their day to day, but this is not. This is an extra thing. PHN 5

**Communication strategies**

A communications strategy was developed with communication and marketing staff and was refined with practices and consumers. Relationships were established and enhanced through regular face to face communication. Two way communication was crucial especially for better understanding unique practice needs.

*We did develop the communication strategy for the program with the input from marketing and communications team managers...we received feedback from at least a couple of GPs. From then, we actually either sent out or we made available on a website or both, posters that could be displayed with general practices that they could use to pin up in their waiting rooms...PHN 4*

*We do a lot of face to face interactions, interviews with practices and that’s been really, really beneficial. PHN 5*

*...program officers going out and really engaging and understanding what the practices need and having that two way communication, not just the one way communication where you’re updating them with changes. PHN 5*

The NBMPHN staff were very accessible and collaborative, tailoring their support to the individual practices and assisting practice staff to set relevant goals. Practice staff felt supported.

*They’ve been very accessible, and in areas that they didn’t have answers they endeavoured to get back to us with an answer...it’s been a good collaborative team effort. GP 2*

*They’ve offered me all kinds of support. They were very helpful throughout the whole process. They were available and patient. I’ve had many rescheduling and cancellation of appointments and they supported throughout the whole process. PM 5*

*They began at the beginning at the program, just identifying what numbers the practice had...the size of the practice, and the staff that we have...They certainly do try to personalise it, but in just setting achievable goals...you can get a goal that’s appropriate for this practice, so that was really good. PN 1*

**Providing program information**

Practice staff reported receiving the information they needed, including information packs and practical information on data extraction. The PHN was reported to be keeping practices up to date.

*I had questions about it and had some information sent out to me from PHN, the whole information booklet that came out, so they were really good at getting me information. PN 2*

*They gave lots of leaflets on how to extract data and use that process. PN 1*

*They send out a newsletter every week, so I always go through that and pick up stuff that I need from it, keep up to date with what’s going on. PN 4*

However, not all practices received information and some staff used other sources of information. Others preferred information to be provided verbally.
They [PHN] don't offer any handouts or written materials...Because of the changes I've had to get the information about the cervical screening actually from pathology...go to the breast screening place and get information. PN 3

Practice-based support

Respondents described the training they received to set-up the program. This training was through a range of modalities including online, through workshops and was also shared between practice staff.

I did an online meeting with them about reminders...there was some detail in it. It gave me the basics. PN 4

I got to sit in on the workshops, we always started with those ladies [from BCI] coming and talking about the screening and the bus, and cancer in its stages. I got all of it really. PHN 2

I had to learn it first so that I could relay it onto everybody else what is happening and if I didn’t have the PHN here to help me do that, I would be stuck. PM 4

Practice visits from the NBMPHN were valued. Practice staff reported receiving personalised assistance and skill development related to use of software, data extraction, and clinical audit. This support seemed to be available on call.

We had a very good personal support. This would not have worked if they said go on-site to a website, read about it and then do it, you needed the people coming in. GP 1

I often went in and held their hand and then spent sometimes an hour or hour and a half per visit, maybe for two or three visits in a row each week in order to support their skill development and knowledge and understanding of how to really use their clinical system optimally...PHN 4

IT support has been very good, they’ve shown us lots of opportunities that we weren’t aware of, to extract data and use that to enhance our recall programs and improve the overall care to our patients. GP 2

Any time we have any problems all we had to do was ring them and if they could come out straight away they would or they would send us emails to help us. PM 8

Different practices had different IT support requirements with some quite self-sufficient and others requesting greater IT support.

We didn’t really need too much from them. We use PEN CAT all the time so we were pretty familiar already with the software...so they’d just come in and get the data off us. PM 7

It was quite good but it wasn’t well maintained. They set up a few things here and there, and then they left us alone with it. So we didn’t get regular IT support, which was the biggest problem. PM 5

Information Technology challenges

Practice software was described as limited in its capacity, not fit for purpose and sometimes provided unreliable or inconsistent data. There was also no way to flag patients if they had been screened elsewhere or did not require screening.
...in Best Practice and Medical Director there’s no ability for them to build a register. They actually have to do advanced queries, and those advanced queries spit out different results to what PEN CAT spits out. PHN 5

Challenges in using software took valuable time from the patient consultation and not all GPs used computers. Problems with data entry and lack of connectivity between software programs meant the NBMPHN sometimes had to manually extract data rather than relying on automatic data extraction. The multiplicity of programs also created challenges for practice staff.

It takes 20 clicks...you have to go into a different section, set the reminders in and a GPs consult is 15 minutes, the patient might have multiple issues. You are now taking away from the patient. PHN 5

We’ve only got two doctors that use the computers completely...that also makes it difficult for PHN because then they’ve got to say, well, okay then this has to be done manually, it’s not going across properly, automatically. PM 8

There’s lots of new electronic based systems and it’s information overload for practices and teaching them their software, PEN CAT, the national cervical screening, the MBS item lists, My Health Record. It’s really overwhelming for them...needs to be more streamlined. PHN 5

Improved patient outcomes were considered the goal of data collection but some respondents did not believe data was being used to assist in achieving this goal.

...it doesn’t seem to me that getting all this data actually has the outcome of improved patient care and there’s no point us doing it unless that’s the goal and that actually happens...PM 1

Motivation to participate

Respondents described a range of motivating factors including provision of high quality patient care particularly through improving screening recall and screening rates.

We’re a practice that prides ourselves on providing a relevant and comprehensive and appropriate medical service to the community...we want to achieve a certain degree of excellence in that regard and therefore I think that’s another motivation. GP 4

The cancer screening recall system wasn’t running smoothly before that, so the patient was missing care of their screening. I knew that if we got the right system in place that would be good for the patient. GP 3

They [PHN] gave us information about the cancer screening rates within our region...they were all very low so that was a big enough incentive to...increase those levels. GP 6

Other interviewees were motivated by the opportunity to improve their practices through policy development and data informed care, and in role modelling these improvements for GP registrars.

Anything that can help us to achieve some standardisation of policy particularly when it comes to a...screening and recall system is really quite helpful. GP 4

Knowledge is power and if you know where you’re not doing as well as you should, that gives you some clear guidance and direction as to where you need to improve...so I was curious. That’s what attracted me. GP 2
Because we’re a training practice, we do have registrars and that was a trigger for me...GP 1

As noted above, financial incentives motivated some practices but others considered the incentives to be token.

Truthfully I have learnt here, when you have worked here, that it is all about money. PM 4

They’re some financial support which is insignificant. That’s not a reason I would do it. PM 1

Interviewees recommended a number of strategies for maintaining motivation. These included more regular contact and support from the NBMPHN, for example, in practice meetings; ongoing auditing and more frequent feedback.

It’s helpful to have PHN representation at our meetings just to remind everyone of the support that’s there, but certainly there was some specific information in relation to the screening programs. GP 4

I would like it [PHN visits] to be more frequent so then we know where is our percentage, where is our goal, how much work do we need to do to achieve that? We love achieving things. PM 2

Comparison of results including with other leading practices was seen as a powerful motivator by some practices. Similarly, celebrating successes, regardless of how small, could further maintain motivation.

Receiving statistical feedback can be a good motivator...and how it compares with other practices and how it compares with the national standards. GP 4

I benchmark my practices...I do create that competition between the practices. This practice has done it and they’ve received these results. PHN 5

Actually have that celebration of success...even if it’s 0.1% of an increase in a mammogram - that is still an improvement. PHN 5

Some interviewees suggested that without continued motivation, screening activities could decline, especially with competing priorities and lack of time to maintain the IT skills required.

If you’re not constantly engaging them in quality improvement and showing them how their current activities are actually making or enhancing their practices, what their day to day tasks are, they’ll just forget about it. It will just go into, you know, “I’ll do that later.” PHN 5

We are a big practice, we’re a busy practice, and at the moment clinical always comes first so patient care and treatment room duties are higher up my priority list. PN 2

Patient and Community Education and Promotion

Interviewees described their experiences of patient and community education and promotion of screening. Common issues raised included provision of screening education for patients, community-based workshops and events, and the importance of patient empowerment. These subthemes are described below.
**General Practice screening education for patients**

GPs and practice staff described providing screening education with their patients including through written material such as brochures and posters in practice waiting rooms, on practice websites, at regular health promotion days and opportunistically whilst providing holistic preventive health care.

*Every month we have a health promotion drive – we have mufti days, to draw attention to it. We put the posters up, we encourage, we put pop-ups on our website for patients when they’re doing their online bookings because it goes through our website and just say, “Have you had your faecal occult checked?” whatever the topic happens to be.* — *PM 3*

*You get the opportunity just to talk about general health... so basically it’s not only for the screening, it’s also to see the person from the general medical point of view.* — *GP 3*

Active promotion of screening was described by some GPs and practice staff as facilitating changes in awareness and attitudes in the wider community.

*I think if the health professionals, like the doctors and nurses, are talking about screening with them [patients] they’re more likely to consider screening, or it might spread culturally to their friends or family, they might talk about screening with their friends or family.* — *PN 3*

Conversely, some consumers observed a lack of screening education from their health provider, stating that cancer screening had never been a topic brought up by their health provider.

*Well, I’ve been to the doctor on a regular basis. It would be useful if it [bowel screening] was brought to your attention when you visit.* — *Consumer - bowel 6*

**Educating patients through community-based workshops and events**

Interviewees described community-based workshops and events promoting screening education. The NBMPHN facilitators of these events tailored them to a particular target group, for example bowel screening workshops at men’s groups and breast screening events for Aboriginal women.

*We’re sort of saying with men, if there was a big football game on you’d get in early to get a ticket or you’d get in early for something that you want. Now, using the same idea, we’re saying get in early to have this test - an earlier diagnosis means better treatment...* — *PHN 3*

*...the way that I found easiest to engage the community, was to run events. So I had people come in to do little workshops with them...they were all events where we offered lunch and had morning tea and stuff ready for them.* — *PHN 2*

Most consumers we interviewed were satisfied with these events and described their learning. The events were seen as part of holistic health care and an avenue to discuss screening - a topic that was often taboo, particularly amongst men who were perceived to be reluctant to engage in conversations about bowel screening.

*They were just showing a few pictures of healthy breasts...I think that information was good.* — *Consumer - breast 1*

*Well, he as a presenter was very, very good...I just thought that there was a lot of worthwhile information that he was passing onto us.* — *Consumer - bowel 2*
We had a mob of blokes there and the reality is they don’t really want to listen to that stuff...but at the end of it they were all asking a lot of questions and they were quite interested in what he had to say. Consumer - bowel 3

However, both NBMPHN facilitators and consumers also spoke about the difficulty in building rapport with the community, and in getting consumers to attend screening education events. It was seen as particularly difficult to persuade Aboriginal women to attend events if they did not know the facilitator. Similarly, men were described as difficult to engage with screening education. Additionally, it was perceived that men’s health had not been made a priority, or previously been a focus in community-based men’s groups. This highlighted the need to reach men in the community who had not received screening education and were not involved in regular cancer screening.

I had to build rapport...there were never that many women because being the new kid on the block...they’d come but it would take a lot of chatting to them. PHN 2

The thing is to get men to turn up. We have a group of blokes that you have to put a chain around them to get them in there. Consumer - bowel 3

I think one of the factors of why men’s health is so bad in Australia is because we don’t deliver a very simple message to men that their health is important and it matters. PHN 3

We actually have to do a lot more work at getting to the groups of men that we want to get to...we want to talk to those people who haven’t actually used a kit properly. PHN 3

Interviewees provided many suggestions for promoting community-based screening education. In the Aboriginal community word of mouth was suggested and the support of elders and other trusted advocates was highlighted.

...having people they trust [elders], just mention, “We’re going to this”...PHN 2

It was suggested that there may be an opportunity for those involved with community-based screening education for men to learn from women’s community-based screening promotions.

...there’s less of those places for men than there are for women. It would be interesting to know about the breast cancer operations, who they’re targeting, how they’re targeting women. PHN 3

Bowel screening consumers identified men’s groups and other places where men meet as potential venues for screening education. Suggestions included workplaces, men’s clubs and groups such as walking groups.

There’s lots of retired groups too like Vietnam Vets, the Nepean Retired Men’s Club, and there’s the University of the Third Age...those are good places to go because it’s rather spot on for our age group that we want to raise awareness around bowel cancer. PHN 3

Consumers recommended that screening education could be promoted through public channels such as schools, television and radio. Additionally, the internet was considered a source of screening information for many consumers.

To promote it [breast screening] I would put it in all the school newsletters. Consumer - breast 1

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My major influence that I can remember is that Ray Hadley was a great advocate there for bowel cancer...he was very high profile...He raised it as an issue and it was out there before thousands and thousands of people. Consumer - bowel 4

**Patient empowerment**

Some consumers described being proactive with screening for many years and had sought screening information, prior to being involved in the cancer screening program. Others had become proactive after participating in screening education. GPs and practice staff noted that the program had increased patient awareness about screening. This sometimes was associated with positive lifestyle changes.

I’ve always done my breast screen. I’m nearly 75. I have never ever missed it...I think I am just pro-active and involved in a lot of things. Consumer - breast 3

Heightened awareness of the importance of early prevention, early intervention, and prevention of the type that we receive from [PHN educator], public education, and public awareness campaigns. Consumer - bowel 7

It [cancer screening program] has increased their awareness, how to prevent it, what to look for it, how to change their lifestyle, how to look after themselves. GP 5

GPs and practice staff were encouraged by patient engagement in screening especially when patients undertook screening for multiple cancer types.

...encouraged when the patients come in here, telling us, “I received this letter and I’m here just to do such and such test.” GP 3

The last three results in some women’s files is their mammogram, their FOBT, and a cervical screening, so they seem to be doing it simultaneously, they’re like, “okay well I’m on the bandwagon I might as well get it all done now”. PN 1

Some consumers described talking about screening to others and encouraging them to be screened.

I know that I’ve encouraged a lot of people to do the test...but you’ve got to be proactive, you’ve got to point it out to people. Consumer - bowel 6

We tried to get people’s names in for the breast screening. Yeah, trying to encourage. Consumer - breast 1

**Engaging patients and communities in screening**

Issues identified in engaging patients and communities in screening (as opposed to education about screening) included GP strategies and challenges, consumer experience of screening, and suggestions to improve engagement of patients in screening including cultural awareness. These subthemes are described below.

**General Practice strategies and challenges in screening patients**

Interviews with GPs and practice staff highlighted strategies they are implementing to engage patients in cancer screening. All practices were building their practice registers, developing their recall and reminder systems, and collecting and auditing practice data. This enabled GPs and practice staff to engage patients in screening, both opportunistically and by identifying and following up patients on screening recall lists.
We are quite big on our data entry and data extraction so just trying to educate the staff and the admin people of entering certain information in certain places where it gets picked up by the tools, and just making sure that there is a unified approach of doing things. PM 5

If you’re practicing preventive medicine, you need to have systems in place and those systems need to be consistent and consistently used by everybody so that patients don’t drop through holes in the system. GP 1

You can target those people that haven’t been through and you put a warning on that patient’s file saying, “Encourage screening” and “FOBT” or whatever it might be that’s not done and that’s where you can allay the myths and the fears and ask them why. PN 1

Interviewees described reminder systems including provision of patient information. GPs often checked the recall list before patients were recalled and follow up processes were discussed at meetings and in informal conversations.

We developed a policy that people will get three reminders for things, so if they’ve got a mobile, they get a text from the practice and then if nothing happens, I write to them, and then they get a phone call...[Practice manager] developed a letter saying you’re due for your cervical screening. There’s a lot of information in that letter for the patient to look at. PN 4

We’re more likely to give it to the doctors first and let them check on the list. And then they will come back saying, “Yes, call this one, yes, call this one.” The practice manager will just pick up the phone, or sometimes she sends them an SMS message and just tell them, look, you’re whatever is due. Come in and make an appointment and see your doctor. PM 2

I’m still working with the doctors trying to say, if that phone is flashing in the patient’s file in Medical-Director, that means there’s an out of date recall and it would be really great if you could look at that and just see if it’s still relevant. PN 2

Interviewees noted that the screening program had helped raised staff awareness about the need to engage patients in screening. In many cases, all members of the practice team were involved in this process, at times in a rotating whole of practice focus on different health areas, including screening.

I think it’s just because it’s more in the GPs minds now, so they’re likely to trigger when they’re seeing a patient and have that conversation with them. PM 7

I guess just being more aware and when I have patients at my desk, I just always will check with them if they’re due for screening. I ask the doctors to check and [name of practice nurse] certainly does that with the PAP smears. PN 4

Every month we have a topic and so we put up information sheets around the practice...and we promote that with the doctors as well to try and encourage them to identify patients and to disseminate information to them during the consults...PM 3

There were several challenges highlighted by GPs and practice staff in engaging with patients in screening. Interviewees described being time poor and the many competing priorities in their busy practices that took priority over encouraging patients to be screened. Patients also observed these challenges.

Sometimes...we’ve got other thing is priority and more higher and we need to look at that first...when you’re too busy you just let it go [cancer screening]...PM 2
It’s whether they’ve got time to discuss that with you because they’re overwhelmed or and they don’t have time. Consumer - bowel 6

GPs and practice staff described the reluctance of patients to engage in screening, or to respond to conversations and reminders, as a major challenge.

The hard part is convincing patients to come in... I think patient engagement is probably the bit that needs the biggest push. GP 6

They’re kind of reluctant, they just want to come in, take their script and walk out, so that’s the main struggle we had. PM 5

A lack of GP engagement with particular communities was observed by some interviewees, with this attributed at times to practice reception staff guarding access to GPs. Some GPs reported an absence of patient cultural diversity in their practices and were therefore not involved in targeting at-risk populations.

When [the Aboriginal liaison] took over this job she went around to all the doctors’ surgeries and seen the doctors. But some of the people would say, “Oh no, he hasn’t got time,” which they did at my doctors... and he said they had never ever told him... where the girls at the office said he didn’t have time. Consumer - breast 2

We’re relatively homogenous. I think most of our patients tend to get lumped into one group because they are, you know, we don’t have a massive ethnic subpopulation or a massive Aboriginal subpopulation. GP 1

Equipment and technological barriers to screening were also reported by GPs and practice staff. These included lack of access to bowel screening kits, and an information disconnect with pathology providers whereby results were not sent through electronically, thus requiring time consuming manual entry. Non-standardised language across providers also meant that mammogram and faecal occult reports often needed to be coded manually.

I rang the Department of Health and they were supposed to send me out 20 kits but to date I haven’t received them. I mean I can send out letters to each individual that it’s time for their bowel screening but it is no good if they don’t have a kit. PM 4

...with breast screening and mammography, the reports were entered as documents when we got those reports back and therefore they had no coding on them...GP 1

A similar challenge was presented for bowel screening. There was an option for the contracted pathology provider... to send results electronically to practices but that wasn’t the default setting. So most practices in the region and probably across the state are just receiving all of their results by letter. PHN 4

Part of our problem with just screening for certain words is that from this end, it’s not always identified in the same way by every pathology provider or radiology department. I think there are issues around a lack of common terms. PN 2

Consumer satisfaction with screening experience

Consumers spoke of positive breast and bowel screening experiences. The simplicity of the bowel screening test was noted and the diagrams in the screening kit were considered helpful.
I found the lady that actually did it very good. It didn’t hurt me...She was very, very gentle [breast screening]. Consumer - breast 1

It’s quite self-explanatory because it’s not only in text, but they also do graphic also...if you’re not too conversant of reading at least you can follow the diagram...Consumer - bowel 1

Breast and bowel screening consumers also described a range of barriers to screening. For some consumers, breach of confidentiality was a barrier to screening. This was particularly a problem when cancer screening was seen to be a taboo topic, not to be discussed in public.

Just public knowledge and fear, of getting the cervical screen done...it’s only a little town that we work in and they’re worried that we might talk about what their screening process involves, or they all talk about the myths, you know of getting a cervical smear done...PN 1

[Cancer screening is] not topics to talk about...I personally believe the hardest part is to get people to talk about things. Consumer - bowel 4

Many consumers noted their reluctance to be screened and described needing a reminder before they would actually go and get screened. Similarly, some were unhappy about the lack of screening follow up with their usual GP and felt that the responsibility for screening was too often left to the patient.

I’m the same. I had to get pushed to have it. I had to get pushed and pushed and nagged and nagged. Consumer - breast 1

If I get a reminder for something I’ll go but otherwise I’ll put it aside. Consumer - bowel 3

...my GP over the years, it’s one of those things, they tend to leave it to you to follow up more so than them. Consumer - bowel 4

Breast screening interviewees highlighted barriers to screening with the mobile breast screening van. Mobile screening was the only option for these interviewees due to their geographic location, yet the location and accessibility of the van were seen to be a problem, as was the physical access to the van. The steps into the van were described as too steep and not sturdy enough, and the door into the van not wide enough, especially for people with limited mobility. Additionally the amenities within the van were considered inadequate.

It’s right out the back...a lot of people wouldn’t know about it. Consumer - breast 2

I am not understanding why the steps have to be so steep...I didn’t think they were very stable and, for older people, if they had a walking stick or anything, there’s no way they could get up there. Consumer - breast 1

It also has no shelter if it rains. So there’s nowhere to get the old people out of the weather...there is nowhere for them to sit. Consumer - breast 2

These concerns over safety were magnified by one consumer’s experience of falling over in the van. The attitude of the staff in the van heightened the dissatisfaction.

There will be a lot of people that won’t go because I have noticed a couple of older people trying to get up them steps and they can’t and even [name] had a trip up the steps...You won’t get older women, older ladies or bigger ladies climbing up and down these stairs. Consumer - breast 3
...the lady on the counter who had no...consideration that I had just had a fall...Didn’t even offer me a glass of water, didn’t ask me how I was getting home. Have to be more – yeah, have a bit of compassion is the word. Consumer - breast 1

Consumers also highlighted lack of time being a barrier to screening, particularly for those working. Travel to another location for screening was raised as another disincentive.

I received it in the post, they just stuffed in the post and said, “Yeah, go take a test and away you go. Send it back to us.” And the hours I was working, I don’t know, I only get time on the weekend to do those sorts of chores, but I didn’t have time to do concentrate on stuff like this. Consumer - bowel 5

There’s no way Aboriginal people [from Lithgow] will go to Bathurst. Like we can walk up and down the main street and do all the things like that but when it comes to the health they won’t make that extra – and I can’t talk. I’m the same. Consumer - breast 1

Suggestions to improve engaging patients in screening

Many consumers provided suggestions about improving patient engagement in screening. This included provision of written materials that were attractive visually and easy to understand for the target group.

The pamphlets would have to be for the older people, the ones that haven’t actually had a lot of schooling and that. They can’t be really, really detailed...something that is going to take their eye and they are going to know that is for medical or breast screening or whatever. Consumer - breast 1

Aboriginal women made suggestions about the mobile screening van: where to locate it, when to have screening, and how to make it a more comfortable experience. They recommended having shelter, shade, seating and refreshments and to situate the van near where the Aboriginal community lives and gathers, at places accessible for the community. They also suggested the screening timetable be aligned with other community, family orientated events.

It’s not trying to bring them somewhere else. It’s to go where they are. Consumer - breast 1

...the Healthy Footprints bus and they had free needles for the flu and all that...a lot of the Aboriginal people do go to that because it’s free. And it’s near [name of street] where a lot of the ladies live. Consumer - breast 2

People come from all over town to go to it because if you are going to get a free needle for your kids...And they are families that go to it. Because they don’t sort of do that for themselves but, if they are there as a family, well, it’s there. Consumer - breast 1

It was also considered important to have GPs involved in encouraging screening with the authoritative voice of the GP seen to be a facilitator.

I think they would have to be told and, once you tell them and say, “Look, that would be good for them.” Because it’s coming out of the mouth of the doctor. Consumer - breast 1

I think it’s all got to revolve around the GP and whatever knowledge the GP has on you as an individual. Consumer - bowel 2

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Importance of cultural awareness

An Aboriginal community health worker/liaison appointed as part of the screening program worked with the Aboriginal community to support and encourage breast screening. The community health worker was consulted from the start of the program about how to engage Aboriginal women in screening. She recommended community-based events and was able to progress these ideas in discussions already underway about community health needs.

They asked me first of all how would I engage, and how would I get the people there, and we discussed then, that it was my belief that if we held events, where they weren’t just sort of singled out...if we gathered them together - it always seems to work. PHN 2

...talk about what the community needs and what’s happening around the community and what they can do to get more services here – which that’s one of them [breast screening]. Consumer - breast 2

Aboriginal Liaison roles were observed by interviewees to be important for supporting and encouraging women in screening, as one consumer said; “It was the support through them” (Consumer - breast 1) that encouraged her to have her breast screen. Rapport building with the community was critical in encouraging women to attend breast screening promotion events, and to attend screening. Engaging Aboriginal elders in screening and then in promoting screening to other women was another recommended strategy.

It was just getting the rapport, building that. I mainly concentrated on trying to get that to happen. PHN 2

I got some of the key aunties to come first, and say, “Look, it’s not that bad, I went, and you should come too.” So that helped very much. PHN 2

The Aboriginal consumers strongly advised that health workers working with Aboriginal communities should have cultural awareness training.

I think a lot of the staff [health workers in general] need cultural awareness training, definitely. Consumer - breast 3

Practice enhancement

Under the final of the four themes identified, we gathered those issues relating to practice enhancement. These are discussed below and include leadership and teamwork, practice learning activities, and quality improvement initiatives.

Leadership and Teamwork

Practice leaders arranged meetings to keep their staff informed and focussed on program goals. Reflecting this team-based approach, most general practice interviewees reported improved teamwork as a result of the program, with knowledge and expertise shared amongst team members.

We have practice meetings where we all meet over a lunch time, to update them on what’s happening. So for everyone to be aware of what we want to achieve with the data extraction, they all need to know about it and why we’re doing it. GP 2

It’s a team approach and we’ve got a clinical meeting next week and I’ve said to the doctors, “We need to talk a bit more how we’re entering the cancer screening.” PN 2
The nurses will ask some of the doctors who know how to use PEN CAT about how to do things. So we’ll go and help them, in terms of doing extractions or helping with recalls...that improves our teamwork. GP 6

Conversely, examples were provided where practice teams were not working well together and this was said to result in disengagement with the program. Staff not understanding why the practice was involved, poor communication and poor team work were some of the concerns mentioned. Poor communication within practices also affected staff confidence.

Reception staff are doing the work...and the doctors are not telling them why they’re doing the work, so they become disgruntled. It’s lack of communication. It’s so important to have that early on at the establishment stage...really having that team effort. PHN 5

General staff I would say not very confident...and this is due to the lack of regular communication in regards to the topic. PM 5

Accordingly, more regular meetings of all practice staff were suggested to avoid disengagement.

More regular meetings with the staff which providers are also included, I think that would be the way going forward. That would create a greater interest from the providers which obviously reflects on the rest of the team. PM 5

Whilst team work was important leadership was also critical. At times practice leaders did not maintain their commitment to the program and passed on responsibility to other practice staff who expressed their frustration with this.

A lot of the time they leave it up to the staff and I don’t think that the doctors actually get involved. PM 8

It has been really frustrating...it led to quite a few frustrations and initially it felt like, well, why would the staff bother when there’s no direction from the leadership, and it evolved and we decided, we’ll do it ourselves. PM 3

In terms of wider organisational networking, although practice staff generally reported that their clinical and professional networks remained unchanged at this early stage of the program, NBMPHN staff noted that services were working more closely together.

The services have always been around, we use the same type of services that we’ve always used. So I wouldn’t say our network has increased any more than what it was before. GP 6

I think as a result of our program we had very good examples of services working together...There were some good examples of the Breast Screening Assessment Service working with the community health team at the Local Health District. They offered a number of screening and information days for Aboriginal women in the region. PHN 4

**Practice learning activities**

The NBMPHN provided many practice learning activities throughout the program and interviewees commented extensively on these. They reported varied preferences for accessing learning resources. Whilst online information was popular with many, others preferred face-to-face learning and webinars, and some regarded newsletters as helpful. Specific information such as “cheat sheets” that could make day to day activities easier was appreciated and GPs found these helpful to keep at hand.
I google around until I find the resources that we need. PM 3

I’ve used the [PHN] website…PN 3

I prefer face to face. But webinar if we can’t do that. PN 1

I read my newsletters and things that come through, so I get that information that way. PN 2

If you need detailed information or a crib sheet for doing something over and over again, you print it off. GP 1

Staff at the NBMPHN were a reliable source of information although at times practice staff sourced their information outside the NBMPHN, reporting that this provided them with more accurate information.

I’ve got a very good liaison officer at the PHN so if I do have any problems I usually just write to her or give her a ring and she will steer me in the right direction. PM 8

I think we went straight to the websites of the actual provider as opposed to theirs [PHN]. Sometimes their information on their sites is not as accurate as the direct one. PM 7

Practice staff spoke about the training they received in using practice software, and how this improved their efficiency. Training also increased staff awareness of screening rates as well as their knowledge of data entry and cleansing.

The reception staff got a lot of training as well...you know, learning how to use MD better...we all learnt to use MD a little bit more efficiently for entering coded things and making sure that results are entered properly. PN 1

When I first started, I went to a day’s training on the clinical software, because I hadn’t used the package that they have here. PN 4

So it [training] improved, I guess improved knowledge of - an awareness of how we are in our screening rates, and how we should improve our screening. PN 3

I think it helped improve her [PN] knowledge of particular programs and probably even the importance of updating the records and keeping all the data, doing a data cleanse and that sort of thing. PM 6

The training built staff knowledge about reminder and recall systems and this resulted in new practice systems. Practice staff often expanded their roles and capacity.

The girls are far more knowledgeable about how the systems works now, particularly, with the FOBT recall and the mammograms...they understand why we’re doing it and how important it is for early detection. GP 2

Since there’s a new system in place, she knows how to get the patient in on time here, how to record the patient, how to communicate with the patient, and all this stuff basically. I see lots of improvements in all aspects of being at the front desk as a receptionist...GP 3

We’ve got a practice nurse who previously wasn’t doing much practice nurse stuff, was doing more reception work...now we’ve got her doing more practice nurse things, including looking at PEN CAT, and doing the audits and extractions from there. GP 6
Finding time for the training was a challenge especially with pressing clinical commitments. Also interviewees suggested some additions to the current training initiatives such as peer to peer learning workshops.

It [webinar training] was always on when it was unsuitable for me, plus I find it very hard to have the time to devote to just sitting down at the computer. PN 3

It’s about utilising the advanced exemplar practices that are actively doing things and helping others...showing their peers that they can help each other...this is missed out as part of this program, with the collaborative wave approach there’s learning workshops. PHN 5

Some practice staff suggested incentivising workshops and training. Further support for staff with poor IT literacy was also needed at some practices.

A few workshops and maybe five or six training sessions at the practice compulsory within the program, and create an incentive environment so that everyone knows what they’re doing throughout the whole process...specific staff training and regular follow ups. PM 5

We still have two GPs that don’t use the computer, if they had something like IT support for them the doctors would feel more comfortable to use the computer...PN 3

**Quality Improvement Initiatives**

General practice staff described the quality improvement activities implemented as part of the program. All spoke of the screening registers that were established. Practices were able to refine their recall and reminder systems, resulting in more screening activity.

This program really enabled those patients to be picked up who are actually dropping out of being screened and may have been dropping out because we weren’t reminding them. GP 1

When you looked at our recall system we had recalls that were so out of date it was amazing, and we’ve been gradually tidying those up. PN 2

[...screening registers] done more regularly in the practice now. GP 6

Access to and proficiency using the PEN CAT tool increased staff awareness of increased screening activity. There was a view that screening increases were influenced by improved data entry enabling more accurate audit. Nonetheless actual rates of screening rates were also reported to have improved.

We were already doing screening, but we didn’t have the PEN CAT tool. Or even if we did we weren’t checking on our screening rates. PN 3

Thanks to this new screening system...we are, I think, improving in all the three areas, breast screening, the bowel screening, and the cervical screening. GP 3

Looking at the numbers in front of me now, what I’ve observed is that I don’t know how many increased mammograms have been done. All I know is that the number of reported mammograms has increased. GP 2

You could see their change in completed cancer screening results over time from the base line data collection through to the three month and then six month data collection...the higher number in proportion of patients were getting screened and those results were being saved
in the right place and therefore completed cancer screen results could be identified, using a search tool. Whereas that was previously invisible. PHN 4

Plan, Do, Study, Act (PDSA) cycles were used to encourage quality improvement and the NBMPHN assisted practices to develop plans. Practice staff became familiar with their practice goals. However, some staff found implementing PDSA cycles time consuming and difficult especially in practices with limited staff capacity.

I think that’s one of the most useful tools [PDSA] actually throughout the program because it did give the admin staff a better guidance, so it did tell us what to do, how to do it, when to do it kind of thing, which made life a little bit easier, so that was a very good initiative. PM 5

The most frustrating part for me is trying to do the PDSAs...from my perspective, we don’t have a practice manager, so I wear that hat as well...I found that very time consuming, when I’ve got huge clinical demands. PN 1

Access to Continuing Professional Development (CPD) points was valued by many of the GPs we interviewed although some were unaware of the CPD points offered as part of the program.

It provided quality improvement and, you know, sort of, Category A CPD points which are always welcome. GP 1

I haven’t actually been involved in any CPD activities specifically in relation to the program. In fact I’d have to say I wasn’t aware that they were available. GP 4

Supporting practices to engage in quality improvement was considered by the NBMPHN to be key to sustaining the practice improvements achieved. Many interviewees described a commitment to continuing with quality improvement initiatives.

I try to make sure that they understand how to do that next time, because it’s important for me that once I leave the program that that becomes a sustainable practice that they are able to implement themselves. PHN 5

For us it’s not something that will be stopped, it’s going to be an ongoing process. PM 6

Once they get used to it [implementing QI initiatives] they [practice staff] are quite smooth, they are quite good with it, and they are still doing it. GP 5

Conversely, other interviewees recommended ongoing support and there was also a perception in some practices that the responsibility for ongoing data collection rested with NBMPHN.

We can do these audits and we can do them for six months, or a year, or two years. But the question is how do we keep going year after year? That means that the GPs or whoever the clinical leads are, need that little bit of encouragement or a nudge just to say keep doing this kind of thing...if we keep getting some of these reports that are coming through, that’s the encouragement that we need to keep doing these sort of things. I just hope it doesn’t, you know, come to a stop at some stage. GP 6

They [PHN] run the tests, the data extraction...probably once a quarter. I’m pretty happy with it because I don’t have time to have it more often than that. PN 3

A major impediment to ongoing quality improvement, in engagement with program activities, was the time required and the competing priorities of clinical care. GPs were considered very busy and a
perceived lack of financial reward by some respondents was another disincentive to participate in the program.

*We’ve all got the drive in us to do these things, but other things - clinical medicine gets in the way.* GP 6

*Providers are reluctant to work on the program due to financial reasons, which makes it quite limited...they’re always busy...and that means they need to be rewarded, I think, slightly higher for their time for those meetings as well.* PM 5

For future work on quality improvement, some interviewees suggested this be outsourced to organisations already working on changing systems such as the Improvement Foundation.

*I think the project would have benefited from maybe outsourcing someone for the quality improvement part to an external organisation such as the model of the Improvement Foundation.* PHN 5

Some practice staff also recommended restricting the focus of future programs to one cancer screening type due to their limited capacity; however, others recommended the focus be broadened.

*I think focusing on one of the screening at a time...doing the three, threw the practice a little bit, because we were trying to focus on too much in one go.* PM 7

*We need to do other disease screening as well, in order to improve the patient outcome and patient participation.* GP 5

**Discussion**

**Introduction**

The aim of NBMPHN Cancer Screening Program is to raise cancer screening rates across its four local government areas by targeting specific population groups with low rates of breast, cervical and bowel cancer screening. Accordingly, the NBMPHN are working with general practices and consumer groups in implementing a range of initiatives that build practice capacity and increase consumer engagement in screening.

Our research was guided by an Evaluation Working Party and through consultation with other NBMPHN program staff. This qualitative study aimed to evaluate the implementation of the Cancer Screening Program in the NBM region and was designed to complement other data collection activities by NBMPHN. We framed the overall evaluation approach using a PLM in order to evaluate the program across its various components.

**NBMPHN Cancer Screening Program achievement against the Program Logic Model**

The PLM evaluates achievements in terms of inputs, activities, outputs, as well as outcomes and impacts thereby enabling the NBMPHN to assess progress at all stages of the Cancer Screening Program. This evaluation was conducted at an early phase of the program, hence evidence is limited in relation to longer term program outcomes and impacts (22, 29). These early data collection activities will provide a baseline for comparison in the future. We discuss below the findings of the qualitative evaluation within the PLM context.
Inputs

The planned inputs identified in collaboration with the Evaluation Working Party include human and organisational resources related to the program, service providers, community and academic organisations and representatives, governance structures, and material and financial resources.

The qualitative evaluation demonstrates that the NBMPHN had established an Advisory Committee to oversee and guide the evidenced based planning and implementation of the Cancer Screening Program. The committee comprised senior and middle management staff of the NBMPHN, as well as clinical representation from GPs and practice nurses. The committee was further supported by a representative from Westmead Breast Cancer Institute (BCI), an academic representative, two consumer representatives and an Aboriginal liaison member. There were initial difficulties engaging GPs in this committee and also in retaining clinical representation over the length of the program. One consumer representative also withdrew from the committee. Interviewees reflected that the committee would have benefitted from periodic review to ensure it maintained adequate consumer engagement.

Consumer representatives provided input through the Advisory Committee; although one such representative reported struggling to have their voice heard and requested more timely provision of information.

The NBMPHN assigned staff to the various roles required by the program including to recruit and work directly with general practices and support the implementation of quality improvement (QI) initiatives. Most staff reported that they were well oriented with clear role expectations provided. Staffing levels were reported as adequate; however, frequent changes in staff presented challenges to practices in terms of maintaining momentum with program activities and created confusion for some practices when conflicting information was provided.

Most interviewees reported that funding for the program was adequate and appropriately disbursed. The program benefited from additional funding from the Cancer Institute of NSW. Some funding was allocated as financial incentives for general practices to engage with the program. Most practice staff agreed these payments were helpful to cover their costs and some reported they were a determining factor in their involvement. Other respondents considered the payments inadequate and there was also a view that the payments should have been made to the practice or nursing staff rather than GPs. The opportunity for CPD points was welcomed by practice staff, however not all GPs were aware of these.

NBMPHN provided the PEN CAT tool as required by practices and supported their data entry and analysis. It was noted that not all practice staff used computers and their software systems were not all well developed or utilised. Interviewees generally expressed satisfaction with the IT support they received from NBMPHN.

A website was created to hold screening tools and resources, and information packs were also provided to practices. Practice staff considered these beneficial in keeping up to date with program information and also with their data collection activities, however not all were using NBMPHN information and many staff preferred a face-to-face approach for information.
Activities

The planned activities identified include initiating communication/media strategies, community education, commissioning general practices, developing and delivering training for general practice staff, and working with practices to implement QI aimed at practice redesign.

A range of communication strategies were developed and implemented that targeted specific cancer types and consumer groups. These included NBMPHN website information, leaflets and posters in general practices and encouragement for practice staff to promote screening to their patients. There were also community workshops and events with outdoor cafes, Men’s Sheds, and Aboriginal cultural events scheduled to provide opportunities to engage with consumers. These events were promoted through local media and directly to the community groups. Those consumers we interviewed were satisfied with the information provided at workshops and events. Some of those engaged were proactive and also sourced information through the internet. This may reflect a relatively better informed participant group and suggests a need to engage those who are less well informed. Consumers suggested that engagement of media personalities and use of public media such as school newsletters could enhance promotion and education.

NBMPHN staff visited practices to provide information on the program and engage them. They built an understanding of each practice’s IT requirements, staff expertise and any particular resources required. Interviewees expressed their satisfaction with the support provided. NBMPHN staff were easily accessible and competently assisted practice staff to solve problems as they arose.

Practice redesign was a primary focus of the program. NBMPHN staff worked with general practices to enhance their IT capacities including developing staff expertise with specific software, particularly the PEN CAT tool to extract data. The Cancer Screening Program Officer was said to “spend the time with [practice staff] and hold their hand”. The NBMPHN trained practice staff in data entry as well as building and improving screening registers, establishment of recall and reminder systems, methods of engaging with particular consumer groups and conduct of clinical audits. Many practices already had recall and reminder systems but some were inaccurate and underutilised and the training and assistance to further develop these systems was valued. Training also included support in identifying particular practice goals and education in developing PDSA cycles. Practice nurses were offered the opportunity to complete a “Well Women’s Screening Course” although this was described as occurring before the program commenced. Practice staff suggested providing a variety of training approaches, including on-line training modules to address the challenge of finding time for these non-clinical activities.

All expressed their satisfaction with the help they received from NBMPHN. Given the noted differences in practice IT capacity and expertise, manual data entry was sometimes needed and this posed challenges in terms of data reliability. The problem was compounded with staff widely reporting they were too time poor both to learn IT skills and also to maintain data collection, audit and PDSA activities.

Outputs

The planned outputs identified focused on implementing the program according to plan including the various practice-based and consumer oriented initiatives, and evaluation of the program.

One of the PLM indicators assessed the satisfaction of contractors with their orientation to the program. The educator reported that the contract expectations were clear and no orientation was
required. The Aboriginal liaison officer reported she was well oriented with expectations verbalised and written. She received ongoing support from NBMPHN management and from BCI.

An important aspect of the program was to improve GP engagement with patients in relation to screening. This was facilitated through enhanced reminder and recall systems. Practice staff noted that more patients were participating in cancer screening and described reminders including SMS messages, written contact, and phone calls. Patients were also prompted in consults. Perhaps reflecting the relatively small proportion of Nepean Blue Mountains practices participating in the program, many consumers stated that they did not receive prompts from their GP to screen and results were not often provided by their GPs. Consumers who did screen were generally satisfied with the simplicity of tests for bowel screening and “gentleness” with breast screening. Both consumers and practice staff identified consumer barriers to screening including reluctance due to fear and a perception that cancer screening was a taboo issue not widely discussed.

GP and practice staff satisfaction with training was assessed at different stages. As an activity above, satisfaction was related to the different training opportunities available and their delivery. As a program output, satisfaction with training was considered in terms of how training influenced practice quality improvement. Generally, GPs and practice staff agreed that training assisted them to improve practice processes and outcomes. Plan, Do, Study, Act cycles provided guidance to practice staff but were reported to be time consuming. The training and the practice re-design initiatives described above were reported to improve practice engagement in screening and also their awareness of their progress in this area.

We asked about consumer satisfaction with the community education initiatives. Aboriginal women appreciated the inclusion of cultural activities with the education events and activities and found the information helpful. Male consumers appreciated the holistic education provided and valued the opportunity for social interaction and discussion of what was often perceived to be “unpleasant” health topics. All male consumers regarded the sessions as interesting and appreciated being able to ask questions.

Overall, general practice staff were satisfied with the program. Practice capacity had improved especially in terms of the accuracy and reliability of recall and reminder systems and screening registers which enabled staff to better identify patients for screening. Improvements in screening rates were noted by interviewees. Practice staff also reported challenges of time, competing priorities and staffing. There were also difficulties with incompatible IT systems which necessitated time consuming manual data entry and threatened the integrity of data collection and audit. Some interviewees noted a lack of GP support and the challenges of extra work for practice nurses and practice managers and recommended that practice staff be incentivised.

In terms of program evaluation, consumers valued being able to provide feedback at the end of educational sessions. GPs also saw evaluation as helpful in comparing their practice performance against others and saw evaluation as a means of guidance for further patient recruitment activities and engagement in screening.

**Outcomes**

The planned outcomes identified included stakeholders being informed about screening and services, improved consumer access and use of screening services, and achievement of program aims.
GPs, practice staff and consumers clearly received information on cancer screening through this program. Consumers attending educational sessions reported learning about cancer prevention and other aspects of health care and sometimes used this knowledge to motivate others. In addition to the workshops and events provided through the program, some consumers were proactive and used online sources and also spoke with practice staff to gain further information. Information was recommended to be in simple language and include illustrations to assist those with limited literacy. Practice staff also provided patient education.

Many consumers told us about lifestyle changes related to diet and weight management, alcohol and exercise. Patients were described by practice staff as being empowered and once their awareness of these issues was raised they were said to be taking responsibility for screening and follow up. Practice staff reported an increased awareness of cancer screening information including from NBMPHN and other providers through websites, verbally and through NBMPHN newsletters. They described greater knowledge of mobile breast screening dates and locations. Many GPs commented favourably on Health Pathways but described this as a developing service, as it only recently went live on 1 December 2017. We wanted to know whether consumer access to and use of screening services had improved, particularly in the targeted Aboriginal community and men’s groups. Some consumers said they were already engaging in screening and also encouraged others to participate. Most consumers indicated that they preferred to access services through their GP. Practice staff reported that their screening rates had increased, though some of this increase may have related to improved data entry. They described an increased focus on prevention in their practices.

Our evaluation looked for changes in collaboration between GP practices, primary health care services and other agencies. Although most did not experience any significant change in their existing networks, the Breast Screening Assessment Service was said to be working more closely with the community health team at the Local Health District than prior to the program. Generally, practices utilised existing pathology providers for screening services and consulted within their own pre-existing collegial networks.

We did note improvement in team work within participating practices, facilitated by regular meetings, improved communication and whole of practice engagement including in PDSA cycles. This team based approach required a clear understanding of why the practice was involved in the program, and a shared common focus.

Practice staff gained knowledge about cancer screening and were sharing this knowledge with others in their team. They were also more proactive in educating their patients. Some staff were reported to have enhanced their work roles in other areas of the practice.

Practice staff were also becoming more proficient with using the PEN CAT tool to extract data. They were refining and using their recall and reminder systems more efficiently to identify and remind both patients and GPs about screening. Most staff were motivated by the program to improve cancer screening within their practices and felt they had developed the skills required and could draw on support from the NBMPHN as needed.

In terms of the achievement of program aims, all those we interviewed valued the program and most considered it effective. People spoke of changing the “culture” of screening and noted the importance of continuing community education in this area. The question of sustainability was often
raised by practice staff particularly in maintaining motivation after the program concluded. There was concern that without a constant “nudge” motivation could wane. Practice staff identified the need for ongoing strong and committed leadership and pointed out a number of risks that could disengage practices from continued participation such as lack of time and resources, non-committed leaders, and poor teamwork and communication.

Impacts

Planned impacts concerned improved community health and sustained integrated and coordinated health services across public and NGO sectors. Impacts such as these are long term and beyond the scope of the current evaluation. The PLM provides the capacity for ongoing evaluations and over time evidence of impact may be identified, especially when compared with baseline information.

Facilitators and Barriers

Our evaluation of the cancer screening program has highlighted facilitators and barriers in implementing this program. Key facilitators and barriers are summarised below:

Facilitators

NBMPHN staff, GPs, practice staff and consumers identified various factors and strategies that assisted in the success and sustainability of the cancer screening program.

Clear staffing roles and governance structures in program set-up and implementation

Clear staff roles for NBMPHN staff and contractors were seen as important in the setup and implementation of the program. The need for a strong consumer voice, cultural representation and periodic Advisory Committee review was highlighted. It was suggested that the Improvement Foundation could provide guidance and resources for PDSA program development.

Practice-based support from NBMPHN

Many interviewees highlighted the importance of ongoing support and training from the NBMPHN to implement and maintain the program. Nepean Blue Mountains Primary Health Network site visits with tailored support to the individual practices were considered crucial in implementing and sustaining the program. Practice staff noted the benefits of these visits in demonstrating practical aspects of the program such as recall and reminder software and data extraction/audit functions and to solve IT issues, as well as working with practices to identify practice goals and to provide education in developing PDSA cycles.

Leadership and teamwork within practices

It was seen as essential for its success that practice leaders were committed to the program. Engaged leadership facilitated teamwork and engagement in screening and to change practice culture and awareness of screening. Engagement of all members of the practice team in the program was also a key facilitator, as was sharing information and expertise within the team.

Communication

General practices were motivated to participate and maintain their engagement through clear communication of the rationale and goals of the program and through sharing successes of the
program. Practices also needed to communicate effectively with patients both at presentation to the practice as well as through reminders and follow up to improve uptake of screening.

**Tailoring community-based events to target group**

Culturally aware community-based liaison workers and educators ensured screening education and promotion were tailored to local target communities. They built rapport and consulted with the community about how to improve screening awareness and promotion.

**Barriers**

Nepean Blue Mountains Primary Health Network staff, GPs, practice staff, and consumers described a number of challenges and barriers encountered in implementing and participating in the program.

**Information Technology issues**

Interviewees from all practices described the need for ongoing IT training and support. Screening registers required time and effort to build and maintain. Interviewees described an information disconnect between practice software and pathology providers. This meant that much time was taken up by manual entry of results. Some GPs were also unfamiliar with the IT systems used.

**Staffing changes**

Many interviewees described NBMPHN staff turnover as a barrier to the program. The lapse in staffing and introduction of new staff slowed momentum and created confusion both for the practices and for the NBMPHN staff.

**Lack of time and competing priorities**

Many of the general practice staff we interviewed cited lack of time and competing priorities as major barriers to the success of the program. Lack of time often meant that GPs and practice staff did not meet regularly. Attending training was also a challenge as was dedicating time to program activities. Practices were busy with other clinical activities and accreditation that took priority over focusing on the program.

**Attitudinal barriers**

Some interviewees reported that their practice leaders were not engaged with the program. The lack of commitment and guidance from their leaders made it frustrating and difficult for staff to engage with the program. Attitudinal barriers were similarly attributed to consumers, some of whom remained disengaged and reluctant to be screened.

**Lack of accessibility to screening**

Both geographic and physical access were identified as barriers to breast screening, as was discomfort with the amenities.

**Recommendations**

From our research we provide a range of recommendations for the NBMPHN and for general practices aimed at building on the successes of the current program and addressing some of the challenges identified.
For NBMPHN

- Continue to promote the screening program to all stakeholders including NBMPHN staff, GPs, general practice staff and consumers;
- Continue to provide screening information and training to practices in NBM;
- Continue to provide ongoing tailored support visits to participating practices, including IT support and support practices to build their capacity to create follow up registers and recall and reminder systems as well as to audit their practice data and to monitor their success;
- Use a variety of strategies to communicate with practices and a range of modes to provide resource information;
- Enable opportunities for practices to learn from each other e.g. peer to peer learning, implement a shared communication platform;
- Advocate for the needs of the Aboriginal community to be addressed in terms of the mobile breast screening service;
- Continue to identify at-risk groups in the community and to promote screening through community education and in general practice;
- Advocate for public cancer screening education e.g. via schools, radio and television; and
- Ensure evaluation continues to inform the development of screening strategies.

For practices

- Provide strong leadership in implementing program initiatives;
- Engage in support and training provided by the NBMPHN in cancer screening and in use of practice software;
- Engage all practice staff in the program and support active communication across the team;
- Build practice capacity through encouraging and supporting staff to take on new roles according to practice and program needs;
- Use audit data to evaluate screening rates and constantly strive to improve clinical care e.g. through PDSA cycles; and
- Continue a strong focus on patient education and empowerment.
References

Appendix A: NBMPHN Cancer Screening Program Evaluation - Thematic Analysis

The following analysis of the interview data is structured within four main categories: Setup and Program implementation; Patient and community education and promotion; Engaging patients and communities in screening; and Practice enhancement. The key themes corresponding to these categories are provided in the table below. In the analysis, each of these key themes is further elaborated by subthemes which are then described and illustrated by selected quotes.

<table>
<thead>
<tr>
<th>Setup and Program Implementation</th>
<th>Patient and Community Education and Promotion</th>
<th>Engaging Patients and Communities in Screening</th>
<th>Practice Enhancement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff, contractor and committee roles</td>
<td>General practice screening education for patients</td>
<td>General practice strategies in engaging patients in screening</td>
<td>Leadership and teamwork</td>
</tr>
<tr>
<td>Governance structures</td>
<td>Educating patients through community-based workshops and events</td>
<td>Challenges for general practice in engaging patients in screening</td>
<td>Practice learning activities</td>
</tr>
<tr>
<td>Funding adequacy and disbursement</td>
<td>Suggestions to promote community-based screening education</td>
<td>Consumer satisfaction with screening experience</td>
<td>Quality improvement initiatives</td>
</tr>
<tr>
<td>Communication strategies</td>
<td>Patient empowerment</td>
<td>Consumer barriers to screening</td>
<td>Program sustainability</td>
</tr>
<tr>
<td>Providing program information</td>
<td></td>
<td>Suggestions to improve engaging patients in screening</td>
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<tr>
<td>Practice-based support</td>
<td></td>
<td>Importance of cultural awareness</td>
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<tr>
<td>Information technology challenges</td>
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<tr>
<td>Motivation to participate</td>
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</table>
All participants’ voices have been presented in the analysis. Colour coding is provided to identify the stakeholder group and type of participant. The following key provides relevant colour codes and the participant acronyms.

**Participant Key**
- PHN - PHN including contracted staff
- GP - General Practitioners
- PN - Practice Nurses
- PM - Practice Managers
- Consumer - breast
- Consumer - bowel

### Setup and Program Implementation

| NBMPHN staff, contractor and committee roles | *I was very, very heavily involved in the development and design and then the implementation of the program activities so I felt clear from all of that work what was expected of me or what needed to be pursued or followed up. PHN 4 |
| *...it was very clear, and it was verbalised and set in writing, as well. PHN 2 | *
| *...the contract has the brief in it of what to do, what was needed, the reasons why we were doing this, basically to encourage men to use the testing kits because the figures were so low in those areas. PHN 3 | *
| *I felt that I was well oriented because I’ve done quality improvement before. PHN 5 | *
| *I felt very well supported by the organisation in that I was able to receive feedback and advice or critical review of our program and design development. And on that implementation. I had some very good relationships with my manager as well, in overseeing the programme so I felt extremely well supported in that sense. PHN 4 | *
| *I think our manager is a very good support and a lead that I have always depended on. Whenever there are any issues or updates or concerns for any of the practices we have weekly catch ups where I can debrief with her and she’s got a very, very good listening ear. She actively listens very well. She takes the information and she troubleshoots any issues, any problems, any concerns, so I feel very well supported from that side of things. PHN 5 | *
| *I think it’s been a case of if I need something then there’s people I go to. There’s been that sort of support and it’s been pretty good. PHN 5 | *
| *I would have liked the time to orient myself around all of the different components of cervical screening, mammograms, and FOBTs. I had to hit the ground running, pretty much. PHN 5 | *
<p>| *Well, we got documents, pages of terms, questions and answers, terms and conditions, but for somebody actually |</p>
<table>
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<tr>
<th>Changes in staff challenging:</th>
<th>Governance structures</th>
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<tbody>
<tr>
<td>- Poor continuity</td>
<td>- Program planning was evidence-based</td>
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<tr>
<td>- Lapses in practice visits and support</td>
<td>*I had quite a long time, roughly, a six month period to develop a whole broad structure of foundations of what the program would set out to achieve and in that time, I was able to do a lot of investigation work, whether it be accessing and reviewing the cancer screen literature, target groups that we were trying to reach with our activities. Or on the strategies to quality improve cancer screening within the general practice setting. So what had been found to be effective through the literature was what we took on...<strong>PHN 4</strong>.</td>
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<tr>
<td>- Slowed momentum</td>
<td></td>
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<tr>
<td>- Created confusion</td>
<td></td>
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<tr>
<td>- <strong>Challenges with QI activities as a result</strong></td>
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- **Could have benefited from a discussion about the role**

  *I’m still floundering quite a bit on what the actual role was that I had there, and I probably still don’t really know. I think if a [named role] comes along, someone take the time, just sit down and say, well this is what we’re doing...I enjoyed my involvement in there, I just would have liked to have been able to contribute a little bit more knowing what I was contributing. **PHN 1**

  *Clinically I would have liked to have a little bit more of a clinical support. **PHN 5**

  *I’ve been involved where I can. It’s mainly academics and I’m certainly not an academic. I’ve been swatted down a couple of times when I’ve said different things...**PHN 1**

  *Probably an email or two just to say look, following on from the last meeting, this is what we’ve done and that - I think that would help, rather than just getting, just getting in the minutes, and that’s what was discussed and then at the next meeting we talk about what happened and perhaps if there were updates in between the meetings would help the [named role]. **PHN 1**

  *It took us I think, another five months to find another person to fill that role. So given that timeframe I think the program, implementation, I think has still very much continued but it was a challenge at the time **PHN 4**

  *The only thing I thought that, didn’t put off the program, but put me off slightly, there was a high turnover of people. So you just got used to somebody and it was working, and it was working well, and then they’d move on, and somebody else would be coming. So you sort of felt like you had to start again. **PHN 2**

  *...there was a period of time we didn’t do anything and no-one ring up or anything...because I think they also changed from one person to another person. **PHN 2**

  *I think the only downfall was that they kept changing people that were coming, so it was not the same person all the time. We had three or so different people that have taken over the program...I think it just got confusing as to where we were up to and then when the next person would come in and say something completely different to the one before.. **PHN 7**

  *...the handover wasn’t very streamlined. As a QI activity, we would document all of the change ideas in PDSAs. That wasn’t done...I felt it takes time to actually go through and filter through the information. What is the change idea? What are they trying to actually do? What are they trying to achieve? Have they achieved it? Has it actually been done? What’s the carry forward idea? Has that been done? **PHN 5**

- **Lack of support in role**

- **Staff without a clinical background wanted better clinical understanding of the program**

- **Could have benefited from better communication between meetings**

* I’m still floundering quite a bit on what the actual role was that I had there, and I probably still don’t really know. I think if a [named role] comes along, someone take the time, just sit down and say, well this is what we’re doing...I enjoyed my involvement in there, I just would have liked to have been able to contribute a little bit more knowing what I was contributing. **PHN 1**

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<tr>
<td><strong>Adequate funding for PHN to deliver activities</strong></td>
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<tr>
<td><strong>External grant enabled community engagement</strong></td>
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- Liaising with other staff in similar roles
- Creating balance between meetings and planning
- Supported by senior management in setting up governance
- Culturally inclusive
- Difficult getting GPs to participate in Advisory Committee
- Setting up committees took time
- Advisory Committee could have benefited from a review
- Advisory Committee could have had more representation from consumers

*...we brought a lot of those findings to involve in our efforts. I guess, I also, was fortunate to have the time to reach out to other program coordinators or officers like myself in the role and other primary health networks...*

*I think we’ve set up systems that we needed to get the job done...the balance between meetings and planning and working out what to do next has been really good, it’s been really quite well balanced with getting onto running the sessions, and then finding out from evaluations of those sessions how they went, which is where we’re up to now.*

*...senior management, and management here were supporting enough of the program to give us the interest and attention to help it along its way. So I definitely appreciated that especially at the early meetings was to help get to embed the [advisory] committee and the work they were doing and the communication with the committee members, to have that support there.*

*Just to sit in and add an Aboriginal voice to the whole thing really...*

*...probably the people that we found hardest to reach or engage initially were our clinicians, so we did have two GPs that eventually agreed to take part in the committee. But we weren’t able to find them quickly or easily through our initial invitations...eventually we actually asked one or a few GPs directly if they would consider participating.*

*...there was more work involved than I had initially expected, getting the terms of references together...all that documentation and the approval process was longer than I expected.*

*I think the structure of the committee would have warranted a review so two GPs representing did leave towards the end of last year, as did one of the consumer representatives left maybe mid-way through last year. And we also, had the practice manager, leave towards the end of the last year all for different and I think personal reasons. I think possibly some committee members or representatives were more active than others, so it would have been worth us reviewing the structure and make-up of the committee membership or governance.*

*...we probably could have done more to get more a voice from our consumers in the region. We probably did have a top heavy representation from either clinicians or from people working in quite familiar and confident in top-tier services, or from academia, even, they tend to take a certain tone and that may not always welcome their input or the feedback from people who are experiencing healthcare on the ground, like consumers.*

*I was at the meetings, but a lot of the meeting was very, very, I found very academic and medical type stuff, and where your learned professors on the committee sort of had a lot to say and the GP lady and that sort of thing.*

*...from our end I felt as though the funding was suitable or appropriate for the activities...I think it was appropriate for what we were attempting to achieve.*

*We were fortunate to receive a reasonably substantial funding grant from the Cancer Institute New South Wales for part of work which was to support the delivery of quality improvement initiative with general practices in that region. That boosted the capacity of our team to deliver activities within the cancer screening program.*

*...definitely the funding does attract people because at the end of the day without the funding we can’t really do much...*
work to be funded
• Incentive payments attract practices
• Reimbursement for time is appreciated
• Money helpful for education
• Not much remuneration but anything helps
• Costs not covered
• Recommendation that incentive payments go to practice staff

about it. And we’re already very limited with manpower and all that. So if there’s the funding, that means we might be able to do a bit more manpower thing and then we can do more. PM 2
*Yeah, definitely a determining factor [incentive payments] and the time I’ve got on the phone now, I’ve had to basically block out half an hour where I could be seeing three patients, and that all costs time and money, so to have some sort of compensation for that, is appreciated. Whether or not we actually make any money out of it, at the end of the day with it, or it’s just been revenue neutral, I haven’t done the numbers there, I don’t know, it’s not an issue to me, but it is certainly appreciated that we are being paid. GP 2
*I think general practice usually involves doing a lot of things for which there is no monetary reward and it was quite useful to go and get financial assistance because it involved time and effort from our practice nurses. Predominantly the practice nurses and a little bit of education for the doctors as well...recompensed GP 1
*...there’s not a great deal that you get but whatever you get is a bonus. PM 4
*We just incorporate it into the everyday stuff. We didn’t particularly use it to fund anything. We just enhanced what we’re already doing in the practice. PM 7
*Even last manager, she actually end up putting a girl on just to do it - doing the whole thing - and that cost us a lot of money. PM 2
*So with the outcome payments, we only pay doctors. What about the nurses that do cervical screening tests? Just because they don’t have an item number, a provider number, we don’t pay them for those incentivised payments. That’s not right. What about the nurses spent hours calling and going back into history and putting all those recall systems? I know it’s part of their day to day, but this is not. This is an extra thing and so I say to them, look, I’m going to ask for an invoice from your practice and how you allocate that money is up to your prerogative. PHN 5
*If the funding comes to the practice, I think, will be better, I think...doctors, when they’re doing their screening things - they already get paid by the Medicare, or they already charge the patient. PM 2

Communication strategies
• Planning the program communication strategy
• Establishing relationships through face to face communication
• Tailoring communication strategies to suit needs of the practices and

*We did seek to develop the communication strategy for the program with the input from marketing and communications team managers. PHN 4
*We do a lot of face to face interactions, interviews with the practices and that’s been really, really beneficial in helping us establish relationships and engagement and re-engaging especially, because [name] being absent, leaving... PHN 5
*So previously there wasn’t a set system that we had in communicating to our primary care work force where and when the visiting van would be located and when. So initially we developed a strategy and this was to communicate that through our practice newsletter. We received feedback from at least a couple of GPs, that it would be far best to take a different approach. From then, I think, we actually either sent out or we made available on a website or both, posters that could be displayed with general practices that they could use to pin up in their waiting rooms. And actually let the patients, themselves, see, visually where and when the next breast screen van would be visiting. PHN 4
<table>
<thead>
<tr>
<th>consumers</th>
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<tbody>
<tr>
<td><strong>Two way communication with practices</strong></td>
<td><em>...with a QI program there’s a lot of benchmarking that needs to happen and a lot of support that needs to happen, and that can only be done through the program development officers or the program officers going out and really engaging and understanding what the practices need and having that two way communication, not just the one way communication where you’re updating them with changes. You can’t just expect them to give improvement if you haven’t given them the tools and resources to actually improve...</em> PHN 5</td>
</tr>
<tr>
<td><strong>Communicating using a variety of approaches</strong></td>
<td>*I spoke with [name] on the phone, he came and talked at one of our clinical meetings and I think I also attended one of the network nurses meetings at the PHN, so I got the information from several fronts. PN 2</td>
</tr>
<tr>
<td><strong>Being accessible, approachable and available</strong></td>
<td>*I didn’t even have to ask the question half the time, there was always the offer. If you need this or you need that or whatever you need, just tell us and there were some times where I actually took that up, and it happened immediately. They were very good. PHN 2</td>
</tr>
<tr>
<td><strong>Communication to whole primary care team important</strong></td>
<td>*They've been very accessible, and in the areas that they didn’t have answers for they endeavoured to get back to us with an answer...so it’s been a good collaborative team effort. GP 2</td>
</tr>
<tr>
<td><strong>Helping to make personalised goals</strong></td>
<td><em>They are very approachable. They explain things very well, the importance of it especially because I'm a clerk so you tend not to be up in the front as what nurses and doctors and that are so they've explained all the things to me which has been helpful. I have found them very, very good, very patient, knowledgeable...</em> PM 8</td>
</tr>
<tr>
<td></td>
<td>*They've offered me all kinds of support. They were very helpful throughout the whole process. They were available and patient. I've had many rescheduling and cancellation of appointments and they supported throughout the whole process. PM 5</td>
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<tr>
<td></td>
<td>*I probably sound like a broken record but I couldn’t speak highly enough of them...my one for the screening I couldn’t speak highly enough of her and I don’t know her so I have only just met her. PM 4</td>
</tr>
<tr>
<td></td>
<td>*So they engage us by they send somebody out, and they do a print up and talk about progress on how well we're doing in those screenings...they have somebody to come out and talk to us about the importance of screening and making plans on how to improve our screening progress. PN 3</td>
</tr>
<tr>
<td></td>
<td>*They began at the beginning of the program just identifying what numbers the practice had and they just try and encourage it and set realistic goals that are appropriate for the size of the practice and the staff that we have...they certainly do try to personalise it, but in just setting achievable goals...and they just reinforced, it’s an individual practice, goal setting scheme, just to improve our own process so the PHN was really supportive in, it doesn’t matter what the other practices are doing, you can get a goal that’s appropriate for this practice. PN 1</td>
</tr>
<tr>
<td>Providing program information</td>
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<tr>
<td><strong>Information packs helpful, particularly for practice managers and nurses</strong></td>
<td>*I had questions about it and had some information sent out to me from PHN, the whole information booklet that came out, so they were really good at getting me information. PN 2</td>
</tr>
</tbody>
</table>
|  | *Specifically for cancer screening I guess, because we had the transitioning to the new way of doing it. We got a pack with leaflets and it was all included, so we knew what was available...We got the breast screen information for the breast...*
Practice-based support

- PHN is an important facilitator
- Time is required to support

They’re giving us that little push along and reminders to say how are things going? GP 6

Some practices really didn’t have any kind of functioning reminder or recall system or knowledge of where in their clinical database their cancer screening results need to be saved or recorded in order to create an aggregate search in...

Written information helpful

- Information easy to use and understand
- Not all staff have access to or use the PHN information
- Information packs have limited value
- Visits preferred by some
- More information would have been preferred
- Other sources used to obtain information

*So, certainly with people who administered the scheme like practice manager and nurses, they [information packs] were very, very helpful because they provided a lot of resources. GP 1
*Yeah, they [information packs] were useful. It gave us an idea of how to do some of those searches. GP 6
*The information packs [were] about making sure that the results were entered correctly into our software – the information pack was really good for that, to identify the problem that we were having there…PN 1
*Most of the information that we get coming through for any of these programs has been really helpful for the guys getting it running here. PM 6
*I think the only thing really we used from the stuff that we did get from them is just the how to sheets they did for our actual clinical software, to hand out to the GPs and our practice nurse and how to record the data so it’s actually picking it up in PEN CAT. PM 7
*They gave lots of leaflets on how to extract data and use that process PN 1
*They send out a newsletter every week, so I always go through that and pick up stuff that I need from it, keep up to date with what’s going on…PN 4
*…they [information packs] were straightforward, easy to use. PM 3
*To be honest I don’t know. I’d have to ask my practice manager whether she gets them [information pack], because to be honest I don’t get them. PN 3
*I have a recollection of receiving a pack. In terms of using the pack, I personally haven’t used those resources…because it’s a large practice often the other point of contact is with the practice manager, but then often in relation to those services you will use our practice nurses for any promotional material. GP 4
*limited value [of the information packs], obviously verbal stuff tends to work better in this environment we find. PM 5
*…they [PHN] come and visit me and that’s enough information and that’s fine for me. PN 1
*…they [PHN] don’t offer any handouts or written materials…I guess I didn’t think about that they could be offering more handouts. PN 3
*So because of the changes I’ve had to get the information about the cervical screening actually from pathology. PN 3
*To receive information from that, I actually have to go to the breast screening place and get information, like brochures and things from them. PN 3

Screen van again; we got all that information and when I requested a couple of extra posters nothing was ever an issue. PN 2

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*So because of the changes I’ve had to get the information about the cervical screening actually from pathology. PN 3
*To receive information from that, I actually have to go to the breast screening place and get information, like brochures and things from them. PN 3

PN 2
<table>
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<tr>
<th><strong>skill development and knowledge</strong></th>
<th>order to identify patients across the whole of the practice...So for those practices I often went in and held their hand and then spent sometimes an hour or hour and a half per visit, maybe for two or three visits in a row each week in order to support their skill development and knowledge and understanding of how to really use their clinical system optimally or to create an accurate and sustainable recording of screen results. PHN 4</th>
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<tr>
<td><strong>Visits are valued</strong></td>
<td><em>...we had a very good personal support. This would not have worked if they said go on-site to a website, read about it and then do it, you needed the people coming in. GP 1</em></td>
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<td><strong>Face to face visits beneficial</strong></td>
<td><em>I like the face-to-face contact with the staff training because they can sit down and I can actually see which is a lot easier than sometimes seeing it on paper and that. PM 8</em></td>
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<td><strong>Practical support with use of software, data extraction, and clinical audit</strong></td>
<td><em>The people who have come and are looking after this have been very helpful. They talk to us about some of the basic initiatives. But they also do a lot of work with our practice nurses, in terms of going into PEN CAT and drawing out those patients and making the recalls - the practical part of things. GP 6</em></td>
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<td><em>A representative from the PHN came out and talked me through using the PEN CAT tool, the extraction tool... she sat with me to get me to get the data with her guidance. PM 3</em></td>
<td><em>Because I didn’t know my way around everything, they showed me how to use the CAT Tool. They came out and did like a training session on the Cat Tool and is it Top Bar? I am not fully trained in the Top Bar but one of the girls are coming out to do the PEN CAT and the Top Bar, just to update me on how to use it properly again. PM 4</em></td>
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<td><em>[Name from PHN] showed me how to put the results on the audit for the PEN CAT with the mammograms and the FOBTs. PM 8</em></td>
<td><em>[Name from PHN] came out when it was first started. He would come out on roughly a monthly basis, he would check the audits to make sure that the numbers were obviously increasing, that I was doing it correctly and any help that we needed he would provide for us to try and make things a bit smoother or to maybe be able to get out and reach out to more patients. PM 8</em></td>
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<td><em>The staff have been very helpful in helping us to learn about the clinical audit tool - the PEN CAT tool - and how to do extractions and so forth. GP 6</em></td>
<td><em>The IT support has been very good, and they’ve shown us lots of opportunities that we weren’t aware of, to extract data and to use that to enhance our recall programs and to improve the overall care to our patients. GP 2</em></td>
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<td><em>...really happy because any time we have any problems all we had to do was ring them and if they could come out straight away they would or they would send us emails to help us. PM 8</em></td>
<td>*Any information that we wanted that we couldn’t find, they’d find for us. They’re keen whenever we need help they’re...</td>
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</table>
- **Basic IT support needed**
  *Basic IT support - connecting computers and things. When you had the old divisions they used to have an IT person on the staff that would go out to all the practices. They don’t do that anymore. It’s all about data extraction now, which is not really relevant for us because I can do all of that...PM 1*

- **Some practices did not need IT support**
  *Well, I’ve been using all of those things for years so I don’t know that we actually need IT support. The kind of IT support that most practices need is not available anywhere...PM 1*
  
  *We didn’t actually really need too much from them. We use PEN CAT all the time here so we were pretty familiar already with the software and how to use it...so they’d just come in and get the data off us. PM 7*

- **Lack of regular IT support**
  *The IT support I had of the program was how do I put it exactly, it was quite good but it wasn’t well maintained. So they set up a few things here and there, and then they left us, they left us alone with it. So we didn’t get a regular IT support, which was the biggest problem. PM 5*

  *It was mainly set-ups, setting up the practice. I was given a little bit of training. PM 5*

  *I did an online meeting with them about reminders...I basically knew about the recalls and reminders. I think there was some detail in it that I thought was a bit of overkill like stuff they were doing which we actually didn’t do. It was all right, though. It gave me the basics. PN 4*

  *They offered that and gave me that training. And then I got to sit in on the workshops, because we always started with those ladies coming and talking about the screening and the bus and how things were, and then cancer in its stages. So I got all of it really. PHN 2*

  *I had to learn it first so that I could relay it onto everybody else what is happening and if I didn’t have the PHN here to help me do that, I would be stuck. PM 4*

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**Training to set up program:**

- **Online meetings**
- **Workshops**
- **Learning passed on to other staff**

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**IT challenges and issues**

- **Practice software has limited capacity**
  *There are no pre-existing software, so in Best Practice and Medical Director there’s no ability for them to build a register. They actually have to do advanced queries, and those advanced queries spit out different results to what PEN CAT spits out. There’s discrepancy within itself. PHN 5*

  *...if a patient opts out from cervical screening test because they’ve done it at another practice, or they going to have a specialist, or they just don’t want one, Medical Director doesn’t have that option. PHN 5*

  *There’s an issue with the software itself setting – if a result is normal or low risk for cervical screening, and the doctor has already made their decision, has looked at the results, and they have made a decision that this is a normal result, it should really prompt them that - the reminder. It doesn’t do that. It takes 20 clicks later that you have to go into a different section, set the reminders in and if you think of a consult, a GPs consult is 15 minutes, the patient might have multiple issues. You are now taking away from the patient. PHN 5*

  *Some of the work of our team has gone beyond what we initially set out to do...We’ve actually sought to engage one of the major clinical software centre’s Medical Director and there’s quite a bit of work that's just starting now in terms of
The Medical Director team have agreed to improve a number of the functions within their clinical software to...streamline the work flow for GPs in not only recording screen results but identify which patients might actually be ineligible or who wish to opt out of cancer screen. PHN 4

...obviously you need good data, but then what happens to that data afterwards? Where’s the benefit to the patient...it doesn’t seem to me that getting all this data actually has the outcome of improved patient care and there’s no point us doing it unless that’s the goal and that that actually happens. So there’s no reason for the practice to pay me however many hours to be involved in a project unless the end result is an improvement for their patients. So there seems to be a disconnect between getting the information and getting an outcome. PM 1

*We’ve only got two doctors that use the computers completely. We’ve got one doctor that uses the computer half for things and we’ve got two doctors that don’t use the computer so because we’re a real hybrid system, that’s what makes it a bit difficult. I think that also makes it a bit difficult for PHN because then they’ve got to say, well, okay then this has got to be done manually, it’s not going across properly, automatically because the doctors don’t use the computer, so they’ve had a bit of a challenge with us as well. PM 8

*I think it’s just that there are a lot of new systems that are currently – a lot of electronic based systems and it’s information overload for the practices and teaching them their software, PEN CAT, the national cervical screening, the MBS Item lists as well as My Health Record. It’s really overwhelming for them. Needs to be more streamlined. PHN 5

*At the moment, the portal that’s on the [national register] website is only a pathology portal. For me to find out this information, it’s like pulling teeth. At the end it was Telstra Health that’s managing the platform, it wasn’t even the Department of Health, Department of Human Services that was managing this. It was Telstra and the guy came back to me and said, “Oh, sorry, these people are not pathology companies. We are yet to create a medical centre portal.” PHN 5

*...every patient I think from March is now going to have a My Health Record. So, patients should actually go in and see when they have done their last cervical screening test was done, their last mammogram was done, FOBT, that does not exist. Currently it’s just a health share summary. PHN 5

*I think we need to go back to basics. There needs to be some kind of interaction between either PHNs or local health networks or somebody and either PEN CAT or the other practice management software systems so that the [screening] data is actually available because it’s not available. People think it is but it’s not. PM 1

Importantly, good for the patient’s care, that’s what we’re all aiming for. So I’ll support any other program which is designed for general practice improvement, I will basically, I will support that, and I’ll fully contribute to that. GP 3

*I personally was interested in doing this research in case if I can help my patient and improve the outcome of the treatment for that. GP 5

*We’re always interested in improving the health care of our patients. So whether it’s cancer screening, or whether it’s diabetes care, or chronic disease, heart disease, whatever it might be, we’ve always been involved with something or...
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<tr>
<th>Motivation</th>
<th>Quote</th>
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<tr>
<td><strong>Aiming for excellence in care</strong></td>
<td>*...every time they [PHN] call me almost invariably we say yes, mostly just to get data and get information and even if it’s of no relevance to us particularly we still participate in a lot of things just for the greater good... PM 1</td>
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<td><strong>Motivated to improve screening recall</strong></td>
<td>*...we’re a practice that prides ourselves on providing both a relevant and comprehensive and appropriate medical service to the community. So, we want to achieve a certain degree of excellence in that regard and therefore I think that’s another motivation. GP 4</td>
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<td>*We probably do it more for improving the health care and improving the screening within our practice and in the area. GP 6</td>
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<td><strong>Motivated by low rates of screening in the local area</strong></td>
<td>*it was because the cancer screening recall system wasn’t running smoothly before that, so there was some missing, the patient was missing care of their screening. I knew that if we got the right system in place, that would be good for the patient. The main attraction was basically just the patient’s care. GP 3</td>
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<td>*...the attraction was that, because I have missed a lot of my patients, I really, really need to have this type of screening program. I personally could not track down every patient you know which patient is eligible for screening, which one is not. GP 5</td>
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<td><strong>Motivated to educate registrars about screening</strong></td>
<td>*...they [PHN] gave us the general information about the cancer screening rates within our region. Obviously they were all very low so that was a big enough incentive to say well if that is low, then we should be getting on board to try and increase those levels. GP 6</td>
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<td><strong>Motivated to improve data quality</strong></td>
<td>*I need extra work like a hole in the head, but if they’re going to provide quality preventative medicine – general practice is all about prevention, then you just can’t stay comfortable in your own little world, you have to take on a new challenge and do a bit of extra work and reap the benefits from that. GP 2</td>
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<td><strong>Motivated to improve practice policy</strong></td>
<td>*...because we are a training practice, we do have registrars and that was a trigger for me and the other doctors here teaching them about the benefits of screening and the benefits of setting up a system. GP 1</td>
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<td><strong>For some, incentive payments were a main motivator</strong></td>
<td>*Knowledge is power and if you know where you’re not doing as well as you should, that gives you some clear guidance and direction as to where you need to improve. So we had no idea about what our numbers were like until you dig down to the data and extract it and have a look at it, and yeah, so I was curious. That’s what attracted me. GP 2</td>
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<td><strong>Others considered these</strong></td>
<td>*...we always think these programs are good value to our practice in terms of data quality and that sort of thing. I guess it’s why we put our hand up every time there’s one that comes out. PM 6</td>
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<td></td>
<td>*...anything that can help us to achieve some standardisation of policy particularly when it comes to a screening and recall system is really quite helpful. GP 4</td>
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<td></td>
<td>*Probably the incentive payments. Truthfully I have learnt here, when you have worked here, that it is all about money. PM 4</td>
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<td></td>
<td>*They’re some financial support which is insignificant, that’s not any reason I would do it. It’s a couple of thousand dollars probably which probably covers our costs, but that’s not actually an incentive to do it or not. PM 1</td>
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payments as token only and not motivators

**Maintaining motivation:**
- Information and follow up visits from PHN helped maintain motivation
- PHN support at meetings helpful
- Continued visits would help enable practice improvements
- Program information through nurses meetings
- Seeing improvements through audits
- Statistical feedback and data comparisons help motivate and enable practice improvements
- Celebrating successes and ensuring continuous motivation
- Benchmarking against other practices
- Keenness of PHN a motivator

*...they’re not adequate, but it doesn’t make that much of a difference to us. We probably do it more for improving the health care and improving the screening within our practice and in the area, rather than for the money itself. GP 6*
*Probably most motivated by the person who was coming from the Nepean Division of General Practice to show to them how to create a letter, how to send it and how to chase each patient, and whether they have done it or not. GP 5*
*...their [PHN] support is wonderful, and definitely the funding is wonderful and then also them keep giving us the feedback and follow up checking on the program. I think it’s a wonderful technique. We have to give our progress, then our people just tend to forget and just move on and never done it anymore; you know. So they had to follow up I think to each practice. PM 2*
*It was like motivating you, reading [information packs from PHN] and the benefit of the screening. GP 5*
*...it’s helpful to have PHN representation at our meetings just to remind everyone of the support that’s there, but certainly there was some specific information in relation to the screening programs. GP 4*
*I would like it [PHN visits] to be more frequent so then we know where is our percentage, where is our goal, how much work do we need to do to achieve that? We love achieving things. PM 2*
*...they [PHN] bring it up in the nursing meetings that we have, so when all the practice nurses all get together they do a talk on that. I find it helpful...So it’s [the program] being promoted through those meetings...PN 3*
*Definitely the audit reports are probably the thing that urges us on the most, in terms of trying to make more and more improvements as time goes on. If we can see some of the improvements that are happening over time, then obviously that urges us to keep going and improve it further. GP 6*
*I think in relation to the Faecal Occult blood testing or bowel cancer screening and then also the mammography, the receiving statistical feedback can be a good motivator just in terms of seeing what the participation rate in our practice is...and how it compares with other practices and how it compares with the national standards, I think that’s quite a good motivator. We probably don’t see those statistics very often so, you know, in some ways, you know, it may be helpful to be motivated by having some statistical feedback more often. GP 4*
*They [practice staff] need continuous motivation in order for them to actually have that celebration of success...even if it’s 0.1% of an increase in a mammogram - that is still an improvement. PHN 5*
*If you’re not constantly engaging them in quality improvement and showing them how their current activities is actually making or enhancing their practices, what their day to day tasks are, they’ll just forget about it. It will just go into the, you know, “I’ll do that later”. PHN 5*
*...one practice that has done that, and they have an outstanding improvement in their mammograms, well, they are an exemplar for me. And I praise them and I use them as an example, so I benchmark my practices...I do create that competition between the practices. So I enable them to, well, somebody else is doing it. Give it a try. This practice has done it and they’ve received these results. PHN 5*
*...they [PHN] are very keen too, the keenness, sort of rubs off on you. PM 8*
| Difficulties in maintaining motivation: | *Maybe what’s lacking is motivation, and that’s where we would really probably need to do some work as in terms of motivating people to be involved in screening...I’m not particularly dissatisfied with the way things are operating, but maybe I’m not working as efficiently as I could as well. GP 4  
*we are a big practice, we’re a busy practice, and at the moment clinical always comes first so patient care and treatment room duties are higher up my priority list if that makes sense. PN 2  
*If you’re not always using a software people will forget how to use a software or they’re busy people...“I’ll revisit that when I have time.” PHN 5 |
| Competing priorities | |
| Staff are time poor | |

| Patient and Community Education and Promotion | |
| General practice screening education for patients | *So we get up-to-date posters, if there are any up-to-date brochures so that we can put on our front desk. We’ve got a large reception area, so we’ve got room to put pamphlets there for the patients. PM 8  
*I happened to see, just through my own visits to general practices, posters of the QI program. And they had already had posters up about the breast screening van that would be displayed when I was there. So I guess I saw the result first hand of where those posters were put up and what they look like. PHN 4  
*We’ve got posters in the waiting room, so whether they’ve looked at those or there’s been more requests from patients saying, “Where’s the breast screen van at the moment?” it sort of reinforces something that they need to know. PM 3  
*Every month we have a health promotion drive – we have mufti days, to draw attention to it. We put the posters up, we encourage, we put pop-ups on our website for patients when they’re doing their online bookings because it goes through our website and just say, “Have you had your faecal occult checked?” whatever the topic happens to be...It’s an initiative we’ve done anyway, but I think we did pick topics based on the involvement, of this audit. PM 3  
*I can only comment from our health promotion days, like we’ve had a pap screen one, women’s health care day and information about it. There was no clinic or anything, but I guess it’s just raising awareness. PM 3  
*...our practice nursing staff who are really very active in terms of promotions. So for example having almost every week of the year there’s a different sort of promotion. So, some of those promotions will relate very much to the screening programs in which case there will be posters and colour on the walls and maybe a themed day in terms of what we might wear and perhaps just in terms of raising awareness both amongst the patients, but also amongst the doctors and staff. GP 4  
*When they come here, basically, we not only do their screening, we just basically for possible other related to things as well, it might be a person having another medical issue. So you get the opportunity just to talk about general health, they might be having high blood pressure or having a family history of some other type of cancer or it might be heart problem or diabetes. So, basically, it’s not only for the screening, it’s also to see the person from the general medical point of view. GP 3 |
| Education promotion through written material | |
| Health promotion days to raise awareness for patients and also doctors and staff | |
| Website information | |
| Opportunistic screening education and preventative health | |
GPs and staff helping to change the culture of screening

Lack of screening education
- Patients experiencing no screening education

Educating patients through community-based workshops and events
- Using community events to promote screening education
- Tailoring events to particular target group
- Consumers satisfied with screening workshops and events
- Consumer learning and engagement

*...it’s more a prevention rather than treatment. PM 5
*I think if the health professionals, like the doctors and nurses, are talking about screening with them [patients] they’re more likely to consider screening, or it might spread culturally to their friends or family, they might talk about screening with their friends or family. PN 3
*I would like to think that we’ve educated a lot more 49 year olds to expect their 50 year old FOBT gift in the mail, and to get that done. PN 1
*Well, I've been to the doctor on a pretty regular basis, not very regular, on a regular basis. It would be useful if it was brought to your attention when you visit. Just to check even - so you have a record of, I don’t know if you get a record. Consumer - bowel 6
*Interviewer: So what is your experience with going to your GP? Do they mention about having a breast check? Interviewee: Mine has never. Consumer - breast 1
*...nothing has ever been raised with me, the letter that I got back saying everything’s fine and the times that I’ve gone back to my doctor he’s never said to me, “Oh, listen, that test,” blah, blah, blah, so I’m just working on the presumption that whenever anything happens, and there’s a disclosure on my paperwork of who my doctor is, that that information will go to him as well. Consumer - bowel 2
*I don’t know really much about cancer, I’ve never been educated. Consumer - bowel 5

*My role was to create events, or this is the way that I found easiest to engage the community, was to run events. So I had people come in to do little workshops with them. A lady was going to come and bring music and she was going to encourage the ladies to make a song around their health and how they manage it. And the other one was fluid movement for people of our age. But they were all events where we offered lunch and had morning tea and stuff ready for them. PHN 2
*...it’s not a medical session. I’m talking to them about basic facts about bowel cancer and what to do to prevent it. It’s pitched at a blokey level. PHN 3
*And we’re sort of saying with men, if there was a big football game on you’d get in early to get a ticket or you’d get in early for something that you want – now, using the same sort of idea, we’re saying get in early to have this test - an earlier diagnosis means better treatment and better options...PHN 3
*That was lovely [breast cancer screening event]...we made our own oil and she was going to bring someone up to write songs. Consumer - breast 1
*...they were really nice the day I went. You know and we all enjoyed it...Consumer - breast 2
*...they were just showing a few pictures of healthy breasts...I think that information was good. Consumer - breast 1
*Well, he as a presenter was very, very good and he just, to me, emphasised a lot of the things that I’ve become aware of over the last couple of years with the difficulties that I’ve had, and I just thought that there was a lot of worthwhile
Holistic health promotion
Consumers engaging in discussions about screening
Difficulty in building rapport
Difficulties in getting consumers to attend screening education
Difficult, in particular to reach men with education strategies
Message that men’s health is important is not delivered

The need to reach men who

information that he was passing onto us. Consumer - bowel 2
*Yes, yes, it’s reasonably clear, it’s well presented [men’s presentation on bowel screening]. Consumer - bowel 3
*I was quite satisfied really because he was pretty open and very truthful about what he had to say, and he actually opened up a lot of eyes when he stated, “Look, if you want to live longer this is the kind of things you’re going to have to do.” Consumer - bowel 5
*I firmly believe in that sort of thing, because at the men’s shed itself, and somebody comes along and gives us a bit of a talk, oh no, I think it’s excellent. I mean if they’re willing to give their selves some time I think it should be good enough for the men to sit down and listen. Consumer - bowel 1
*He gives a full rundown in detail of what could happen, what to look forward to, how to monitor your eating habits, drinking habits and stuff like that. Consumer - bowel 5
*...how to look after yourself and he mentioned to get daily regular exercise whenever you can and eat the right types of food and stuff like that. Consumer - bowel 5
*...at the end of it they were all asking a lot of questions and they were quite interested in what he had to say Consumer - bowel 3
*I had to build a rapport...there were never that many women because being the new kid on the block, it was very difficult...they’d come but it would take a lot of chatting to them and sending them things...there was a lot of setting things in motion. PHN 2
*...the thing is to get men to turn up. We have a group of blokes that, you know, you have to put a chain around them to get them in there. I found we had a mob of blokes there and the reality is they don’t really want to listen to that stuff [screening education]. Consumer - bowel 3
*...we actually have to do a lot more work at getting to the groups of men that we want to get to. One of the things working against us is over the years places where men gather where they’re like a captive audience who deliver a session on bowel cancer, there’s less of those places for men PHN 3
*Unfortunately, you know, even letter drops and things like that, people don’t bother, they just pick it up, “ah yeah, we’ll just put it in the bin”...It’s a very difficult thing to make people aware. Consumer - bowel 6
*I would have thought at Men’s Sheds that would be happening a lot [health presentations], but in some of them it wasn’t happening a lot, and wasn’t a priority...One of them said, “Nobody’s talked to us about health issues for a few years.” PHN 3
*That’s one of the key messages about men’s health is that I think one of the factors of why men’s health is so bad in Australia is because we don’t deliver a very simple message to men that their health is important and it matters. PHN 3
*...when you look at the health side of it, women seem to be, seem to have much more sort of looking after their health than what you see for men. Consumer - bowel 3
*...when you do it in men’s sheds - those people are aware...it’s the people that you don’t reach - that’s the problem. It’s
| Suggestions to promote community-based screening education | *Word of mouth* I think more than anything [to promote screening education]. Word of mouth. Consumer - breast 3  
*I got some of the key aunties to come first, and say, “Look, it’s not that bad, I went, and you should come too.” So that helped very much.* PHN 1  
* …having people they trust [elders], just mention, “We’re going to this” …* PHN 1  
* …there’s less of those places for men than there are for women. It would be interesting to know about the breast cancer operations, who they’re targeting, how they’re targeting women. PHN 1  
* …we’ve got to look at, well where are the men, and one of the things we’ve identified, they’re in the workplace, so we’re taking more of a stance into trying to go into workplaces, and we’re starting at the Penrith Council; hopefully we’ll be doing both clerical workers and depot workers for the Council, looking at small businesses between 50 to 100 workers. They’re often the ones that don’t get talks on any of this because they’re so small. PHN 1  
*I think it would be a very worthwhile thing for those sort of things [education sessions on bowel screening for men] to be made more aware of in public arena...and that’s why I mentioned go into a police station and talk to the boss there Consumer - bowel 4  
* …people started to talk about clubs and associations...they’ve given us some tips about motor cars and bike clubs, but ...I think if we go to those places we’re going to find a different cohort of men from the ones who go to Men’s Sheds, and I’m guessing, going to find the men that we want that don’t know a great deal about bowel cancer or have responded not terribly well to the kits arriving. PHN 4  
*There’s lots of retired groups too like Vietnam Vets, the Nepean Retired Men’s Club, and there’s the University of the Third Age...those are good places to go as well, because it’s rather spot on for our age group that we want to raise awareness around bowel cancer. PHN 4  
*One of the participants did come up with a really good idea in the last session. He said, “If you want to know about groups to go and see why don’t you ask that question on the evaluation form?”...We’ve got about four or five leads from one group of 40 men that we’ll follow up. PHN 4  
* …there must be heaps and heaps of walkers’ groups all over the place. And it could possibly be another avenue for [promoting bowel screening] if a little session like that was put onto the end of it. Consumer - bowel 5  
*I’d recommend to someone with sufficient motivation to go online where there’s an abundance of material. Consumer - bowel 5  
* …a few things crop up on the Internet [about cancer screening] that I might think, oh, I’ll have a read of that Consumer - bowel 5 |
| haven’t yet received screening education | the people who haven’t suffered up to now that need to be pushed or need the information. Consumer - bowel 1  
*I think one of the major issues for us...is that we actually have to do a lot more work at getting to the groups of men that we want to get to...we want to talk to those people who haven’t actually used a kit properly. PHN 1 |
**Advertise screening through public arena - schools, TV and radio**

*To promote it [breast screening] I would put it in all the school newsletters. Consumer - breast 1*

*I was able to get onto the local radio station twice, and I think we were in the paper three or four times, the local paper, as the van was coming closer. PHN 2*

*I think more ads on TV which is what most people do these days, would be advantageous to point out the issues... Consumer - bowel 6*

*My major influence that I can remember is that Ray Hadley was a great advocate there for bowel cancer...he was very high profile in regards to saying to people, you know, you’re best to go and talk to your doctor, it’s a simple test, to get a check for bowel cancer. He raised it as an issue and it was out there before thousands and thousands of people. Consumer - bowel 4*

**Patient empowerment**

- **Some patients are already proactive with screening**
- **Patients motivated to seek screening information**
- **Patients become proactive after receiving screening education**
- **Increased patient awareness of importance of screening**
- **Screening awareness brings about lifestyle changes**

*I’ve always done my breast screen. I’m nearly 75. I have never ever missed it. Well, I think because I’m not being smart, but I think I am just pro-active and involved in a lot of things. Consumer - breast 3*

*I’m aware enough of the condition to take the initiative myself, I was briefed on the original diagnosis to obtain observations every two years, so I take it upon myself to organise that. Consumer - bowel 7*

*I did make it my business to research my conditions online...but I think there’s a lot of people that aren’t as motivated as what I am, as aware of what I am, they will benefit from being pointed to a lot of self-education and, again, I’ve said online a couple of times and I would reaffirm that. Consumer - bowel 7*

*If you’re not satisfied too much then have a frank discussion with your GP, or when you attend the clinics, as I do, have a discussion with the nurse, in that case maybe there’s also a specialist nurse, or again they may say, have a word with Dr so and so, and so and so, and try and get some more information that way. Consumer - bowel 1*

*Heightened awareness of the importance of early prevention, early intervention, and prevention of the type that we receive from [PHN educator], public education, and public awareness campaigns. Consumer - bowel 7*

*I'm more aware of them now, I'm more proactive in them [bowel screening]. Consumer - bowel 1*

*...it [cancer screening program] has increased their awareness, how to prevent it, what to look for it, how to change their lifestyle, how to look after themselves. GP 5*

*I think it's encouraged women to take on all three aspects of cancer screening, and men, both of them. To be just really proactive and just promoting that preventative health is most definitely better than trying to treat the cure or take a cure. PN 1*

*...the last three results in some women's files is their mammogram, their FOBT, and a cervical screening, so they seem to be doing it simultaneously, they're like, “okay well I'm on the bandwagon I might as well get it all done now”. PN 1*

*Where they’re actively trying to increase their activity, they’re maintaining good weight loss, or maintaining a healthy weight bracket, they’re asking to see dieticians and physios...I think they're embracing that and looking after themselves a bit better. PN 1*
Patients engaging in screening is encouraging for GP practices

Patients encourage others to be screened

*...encouraged when the patients come in here, telling us, “I received this letter and I’m here just to do such and such test.” GP 3
*...you’re passing it on anyway, and that may help somebody else. Because you’ve just actually sat there and talked about the issues...Consumer - bowel 1
*And I know that I’ve encouraged a lot of people to do the test that I’ve had since I was diagnosed. And a lot of people have followed that advice. But you’ve got to be proactive, you’ve got to point it out to people. Because people just, you know, it’s flippant, it’s passing them by. It won’t happen to me. I try and persuade my son to go for tests, you know, it’s ridiculous and now he does. Consumer - bowel 6
*...we tried to get people’s names in for the breast screening. Yeah, trying to encourage. Consumer - breast 1

Engaging Patients and Communities in Screening

General practice strategies in engaging patients in screening

- Building practice registers
- Data collection and audit, software recall and reminder

- Follow up of patients that need to be recalled

*We try to find under screened women...PM 3
*...if you’re practicing preventive medicine, you need to have systems in place and those systems need to be consistent and consistently used by everybody so that patients don’t drop through holes in the system GP 1
*We are quite big on our data entry and data extraction so just trying to educate the staff and the admin people of entering certain information in certain places where it gets picked up by the tools, and just making sure that there is a unified approach of doing things. PM 5
*So at least we get clean data, so when we audit it we can get a clearer picture. PN 3
*...we have reminders pop up in our management system. So when somebody’s due for a PAP smear it will pop up. PM 1
*...because the recall system is there [name of receptionist] checks the recall system every single day, to see who is for recall. GP 3

*You can target those people that haven’t been through and you put a warning on that patient’s file saying, “Encourage screening” and “FOBT” or whatever it might be that’s not done and that’s where you can allay the myths and the fears and ask them why. PN 3
*I just re-ran all the reports last week to go through them again and try to get everybody up to date again...every week [name] runs the report of anyone that is on the recall list, and then we chase up. PN 4
*...it [cancer screening program] has enabled the staff now to go and establish systems of screening and follow-up, which are now being implemented and are being continued GP 1
*...making sure there is a recall and we’ve actually got people really routinely getting their screening done in a preventative health measure. PN 4
*...we’ve picked up people who needed to be re-recalled. There are some people who attend screening services regularly and religiously because they have their own system of ensuring that, but there are other people who don’t, and they’ll do
| **GPs also need reminding to follow up** | It only if they’re reminded and so that depends on us to remind them. GP 1  
*So one of the RNs is calling some patients who were overdue to see if they’d had it somewhere else. PM 6  
*...if we didn’t have that recall where you phone patients, lot of people just forget. PM 4  
*...we’d put warnings into the warning screen so that they [GPs] could see. It’s only a couple of weeks ago I said to them, “Are you guys still watching the warning screen and trying to chase people who need these things”, and “Oh, yeah, yeah, yeah”. PN 4  
*I’m still working with the doctors trying to say, if that phone is flashing in the patient’s file in Medical-Director, that means there’s an out of date recall and it would be really great if you could look at that and just see if it’s still relevant. PN2 |
| **GP double checks recall** |  
*So we pretty much just get the data, find out who has done it, who hasn’t done it. And then we either call the patient to come in to see the doctors or a lot of the time, we’re more likely to give it to the doctors first and let them check on the list. And then they will come back saying, “Yes, call this one, yes, call this one.” The practice manager will just pick up the phone, or sometimes she sends them an SMS message and just tell them, look, you’re whatever is due. Come in and make an appointment and see your doctor. PM 2  
*I ring or write a letter to remind people. We developed a policy that people will get three reminders for things, so if they’ve got a mobile, they get a text from the practice and then if nothing happens, I write to them, and then they get a phone call. PN 4  
*...we’ve developed letters on file to send out and the practice manager had sent a couple of - because patients were saying they wanted to know more information - so she developed a letter that when we sent it out saying you’re due for your cervical screening, there’s a lot of information in that letter for the patient to look at. I think it’s covered fairly well. I looked at the letters and gave the okay on them. PN 4 |
| **An escalating reminder system** |  
*I think it’s just because it’s more in the GPs minds now, so they’re likely to trigger when they’re seeing a patient and have that conversation with them. So they’re likely to get that prompt to actually get the service done. PM 7  
*I guess just being more aware and when I have patients at my desk, I just always will check with them if they’re due for screening. I ask the doctors to check and [name] certainly does that with the PAP smears. PN 4  
*Certainly, I’ve been more proactive in getting the information out there and focussing on the waiting room information and just making sure we had the information available to pass on to the doctors. PN 2 |
| **Screening information sent by practice with reminders** |  
*We explain what it is, why we’re doing it [bowel screen], and hopefully make him comfortable that it’s not as bad as it probably sounds. GP 6  
*They’re [practice staff] pretty good at having that chat with patients and recommending them to go and have the |
- Rotating whole of practice focus on different health areas
  - services done when they’re in those age brackets and all that kind of stuff. PM 7
  - *...you get to know the patients personally so you can actually talk to the patients on that level and stuff like that if they ask and give them that bit more support as well instead of just from the doctor. PM 8
  - *Every month we have a topic and so we put up information sheets around the practice...And we promote that with the doctors as well to try and encourage them to identify patients and to disseminate information to them during the consults...PM 3
  - *...we’ve got a clinical meeting next week and I’ve said to the doctors, “We need to talk a bit more how we’re entering the cancer screening.” PN 2
  - *...it was by talking about it, it made us more aware how important it is to keep on top of screening and cancer screening. PN 3
  - *So when we have our clinical meetings, we try and bring these topics up GP 6

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<tr>
<th>Challenges for general practices in engaging patients in screening</th>
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<td><strong>Competing priorities</strong></td>
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<td><strong>Time poor</strong></td>
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<td><strong>Practice reception staff guard access to GP</strong></td>
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<tr>
<td><strong>Not all practices have cultural diversity</strong></td>
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<td><strong>Not previously targeting different population groups at risk</strong></td>
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*We want to be responsible. I mean, sure sometimes we might have to say, oh, I’m so sorry, we’ve got other thing is priority and more higher and we need to look at that first. PM 2
*...trying to pin doctors down sometimes is a bit tricky because when they’re at work they’re booked pretty solidly and free time to get together is a bit tricky. PN 2
*It’s whether they’ve got time to discuss that with you because they’re overwhelmed or and they don’t have time to sit there, like the bedside manner thing. The family doctor, sitting there, giving you all the advice under the sun doesn’t seem to exist anymore. Consumer - bowel 6
*...but the thing is when you’re busy and all that if there’s no cancer screening, when you’re too busy you just let it go, you don’t look at it or do it too much. PM 2
*When [Aboriginal liaison] took over this job she went around to all the doctors’ surgeries and seen the doctors. But some of the people would say, “Oh no, he hasn’t got time,” which they did at my doctors…and he said they had never ever told him...where the girls at the office said he didn’t have time. Consumer - breast 2
*...we’re relatively homogenous. I think most of our patients tend to get lumped into one group because they are, you know, we don’t have a massive ethnic subpopulation or a massive Aboriginal subpopulation. GP 1
*...we didn’t really target any particular cultural group. So I wouldn’t think there was an actual jump in one particular cultural group as opposed to another, because there wasn’t any targeted promotion of cancer screening towards one particular cultural group. PM 3
*Aboriginal populations I would think would be lower but I don’t know that, but I would think it would be lower screening rates. Younger women are a bit hard to get on board. PM 1
*I know that I can tell them that there are services from the PHN that can drive them to appointments and things like that, if they need too, for Aboriginal people. PN 3
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<th>Feature</th>
<th>Description</th>
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| Reluctance of patients to engage in screening                          | *...you have people that are external to us who, for example, under screened, disadvantaged communities like CALD groups or Aboriginal groups. They’re not really part of the QI programs and there is no target for us to be working with them but we really should be. If we’re doing a QI program well, and we’re looking at under screened patients we should be targeting those groups, working with those external organisations. So that integration hasn’t really happened from what I can see, very well. But again, those communities are difficult to engage with, so maybe a QI program is not the best way, I don’t know. I have no idea, I can’t comment on that. PM 5
*They’re kind of reluctant, they just want to come in, take their script and walk out, so that’s the main struggle we had. PM 5
| Screening kits not received                                           | *We still have a few patients that refuse to have pap smears. As much as you talk to them, they still refuse to do it. PM 8
*...we are still waiting for some of the patients because we did send a letter and everything to them, but they have not yet done it, so we need to do more. A bit of encouraging the patient to participate. GP 5
| Information disconnect with pathology providers                       | *The hard part is convincing patients to come in...when we've got a list of say pap smear patients who have not had one for the last say four years or so, and we've called them up, and for whatever reason, they don’t come in. I think patient engagement is probably the bit that needs the biggest push. GP 6
| Need for ease, accuracy and consistency of data entry                 | *I rang the Department of Health and they were supposed to send me out 20 kits but to date I haven’t received them. I mean I can send out letters to each individual that it’s time for their bowel screening but it is no good if they don’t have a kit... PM 4
| Needing to manually code mammogram reports                            | *...the breast screening results aren’t being delivered electronically into a codable field automatically from the BreastScreen New South Wales to the GP practice - that technology or system capability doesn’t exist yet in New South Wales. PHN 4
*a similar challenge was presented for bowel screening. There was an option for the contracted pathology provider, Dorevitch pathology, to send results electronically to practices but that wasn’t the default setting. So most practices in the region are probably across the state are just receiving all of their results by letter. PHN 4
*...it’s not staying within a codable field in the clinical software...There's no way to know who has or who hasn’t had a mammogram. PHN 4
| *...it [program] will only become reliable if this information is being fed back to PEN CAT. So there must be a way for them to find mammograms in patient records. I don’t know because I’m not the computer expert. PM 1
*Because a lot of information is picked out of the program, but if it’s not recorded in the right spot, then it won’t pick it out. GP 6
*...with breast screening and mammography, the reports were entered as documents when we got those reports back and therefore they had no coding on them so in fact, we discovered from an IT point of view, that our mammograms were not well documented and so therefore we had to go through a process of actually doing it...GP 1
* The letter got scanned into the file and because it didn’t have the right descriptors that the report picked up, we
<table>
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<th>Inconsistent and unreliable data entry for mammogram</th>
<th>actually started off looking like we had no breast screening done at all. The first few months was a big effort and we had to re-put all the results in...I think it would be good if it came through with the correct heading that will pick it up in the reports. PN 4</th>
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<tr>
<td>* the reception girls are the ones that are inputting the data and it’s not picking up the data that they’re putting in. It’s one of those that the GPs then have to manually put in once they see the letter. PM 7</td>
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<td>*...the doctors would have to manually record every mammogram and they don’t do that, and nor should they have to really. That’s the whole point of us spending $15,000 a year on a program to do our data and it’s not consistent. If you’re relying on individual practitioners to remember to manually enter mammogram results then that’s unreliable. The fact that PEN CAT can’t pull that information out is not helping us understand how we’re going. PM 1</td>
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<td>*...it’s been known for, like, 15 years, that you have to add the PAP smear in manually but nobody knew that that was the case with mammograms, so there’s no historical data. Even if I started it today it would only be recorded from today and trying to get everybody to start doing a new process like that, it would be wildly inaccurate. PM 1</td>
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<td>*...part of our problem with just screening for certain words is that from this end, it’s not always identified in the same way by every pathology provider or radiology department. I think there are issues around a lack of common terms. PN 2</td>
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<td>*We do for letters coming in, but we had to change how it was being set in the system so it would pick up that the provider, Breast Screen New South Wales, that was actually a mammogram and not just a correspondence letter. PM 6</td>
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<td>*...the faecal occult blood screening, we also found that the different pathology laboratories coded them differently so we needed to keep an eye on how they came in and I think that involved maybe talking to a couple of the path labs and, sort of, seeing if they could modify their codings. GP 1</td>
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<tr>
<td>Non-standardised language between providers</td>
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<tr>
<td>Coding not consistent for faecal occult screens</td>
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<tr>
<td>Consumer satisfaction with screening experience</td>
<td>*Simple test. I don’t know why everybody doesn’t do it. Consumer - bowel 6</td>
</tr>
<tr>
<td>Simplicity of bowel screening test</td>
<td>*Well, you know, the last time when I did it last year, I read the instructions and filled it out and sent it off and that was pretty much it. Consumer - bowel 4</td>
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<tr>
<td>Diagrams are helpful</td>
<td>*It’s quite self-explanatory because it’s not only in text, but they also do graphic also. So it does. And if you’re not too conversant of reading at least you can follow the diagram, and it’ll still be very helpful. Consumer - bowel 1</td>
</tr>
<tr>
<td>Positive screening experience</td>
<td>*But I found the lady that actually did it very good. It didn’t hurt me or it wasn’t – yeah, she was good. She was very, very gentle. Consumer - breast 1</td>
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<tr>
<td>Lack of empathy during breast screen</td>
<td>*The only thing I had a complaint about was the lady on the counter who had no - what do you call it? People skills? Just no consideration that I had just had a fall. And I was in a little bit of a shock I think. And it was sort of “fill this form out and,” blah, blah, blah. Didn’t even offer me a glass of water, didn’t ask me how I was getting home. Have to be more – yeah, have a bit of compassion is the word. Consumer - breast 1</td>
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<tr>
<td>Lack of follow up</td>
<td>*There’s no kind of follow up. There’s nobody you can go and talk to...Consumer - bowel 6</td>
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<td>*I was sort of expecting there would have been some sort of, like a follow-up diet or something else that may have come...Consumer - bowel 6</td>
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</table>
| **Consumers left to take on responsibility for screening** | along as part of that, but it didn’t occur. Consumer - bowel 3
*...my GP over the years, it’s one of those things, they tend to leave it to you to follow up more so than them. Consumer - bowel 4 |
| **Consumer barriers to screening** | *Just public knowledge and fear, of getting the cervical screen done, you know. But, you know, it’s only a little town that we work in and they’re worried that we might talk about what their screening process involves, or they all talk about the myths, you know of getting a cervical smear done or something. PN 1
*[Screening is] not topics to talk about...I personally believe the hardest part is to get people to talk about things. Consumer - bowel 4
*...a lot of blokes won’t talk about a lot of things... Consumer - bowel 3
*...but it’s just trying to get the people to do it [breast screening]. Consumer - breast 1
*...but a typical male, nothing wrong with me, so I don’t want to do another test, no. Consumer - bowel 3
*It’s something, it’s a male trait, and I think we’re always sort of hesitant to go and see our GP in regards to that sort of thing...If we’re not sick, we don’t go...I tend to be somewhat blasé. If I feel well, I’m not sick. Consumer - bowel 4
*Men, we kind of back away from these things [bowel screening]. Consumer - bowel 6
*I’m the same. I had to get pushed to have it. I had to get pushed and pushed and nagged and nagged. Consumer - breast 1
*...if I get a reminder for something I’ll go but otherwise I’ll put it aside. Consumer - bowel 3
*I’m now closer to 66 than I am to younger years...but I’ve only ever done it once [bowel screening]. Consumer - bowel 4
*I do really think that the location is not good...it’s parked in the shopping centre car park. Consumer - breast 1
*...it’s right out the back if you call it the back and a lot of people wouldn’t know about it. Consumer - breast 2
*I am not understanding why the steps have to be so steep and that...I didn’t think they were very stable and, for older people, if they had a walking stick or anything, there’s no way they could get up there.. Consumer - breast 1
*As I said, even if they had a carer with them, they still couldn’t [get up the steps of the mobile screening van] Consumer - breast 2
*There will be a lot of people that won’t go because I have noticed a couple of older people trying to get up them steps and they can’t and even [name] had a trip up the steps...You won’t get older women, older ladies or bigger ladies climbing up and down these stairs. Consumer - breast 3
*They are very steep steps and they are just silver grating stuff because they are all collapsible stuff. Consumer - breast 1
*And they [steps into van] would be slippery in the winter, really. Consumer - breast 2
*That’s where I tripped. They had cords running along and they had piping over it. It’s not safe at all. Not at all. Consumer - breast 1
*It also has no shelter if it rains. So there’s nowhere to get the old people out of the weather. Consumer - breast 2 |
| **Screening is a taboo topic** | |
| **Consumers need to be reminded** | |
| **Mobile breast screening van:** | |
| **Not visible** | |
| **Poor physical access** | |
| **Steep stairs especially for elderly** | |
| **Concerns over safety** | |
| **Consumer experience of tripping over in van** | |
| **Not enough shelter from rain** | |
Not enough seating

Consumers not prepared to travel a long distance for screening

Lack of time

Suggestions to improve engaging patients in screening

- Easy to understand pamphlets appropriate to target group
- Set aside a specific day for the mobile screening van
- Provide locations that are accessible and have shade, seating, refreshments, and
  include family incentives
- Situate the screening van at places where the Aboriginal community gathers

*There’s not a lot of room. No seating. Nowhere to sit [while waiting]...Especially in winter you need to have older people comfortable. Consumer - breast 1
*I would need somewhere to sit down. And I am a lot younger than what a lot of them are going for it...there is nowhere for them to sit. There’s no chairs out or there’s no stools. Consumer - breast 2
*And there’s no way Aboriginal people will go to Bathurst [from a breast screen if they live in Lithgow]. Like we can walk up and down the main street and do all the things like that but when it comes to the health they won’t make that extra – and I can’t talk. I’m the same. Consumer - breast 1
*We have been fighting for years to get services here in Lithgow for the Aboriginal people. You have either got to go to Katoomba, to Bathurst or Nepean and I said, ”We want the services here.” Consumer - breast 3
*And for her [Aboriginal woman who can’t use the stairs of the mobile screening van] to go either to Katoomba, Penrith, or Bathurst, she would have to hire the car that goes because she doesn’t drive out of town. Consumer - breast 1
*...when someone has to go to Castle Hill for breast screening, then that might be a disincentive or if they have to go to Penrith [travelling far from home]. GP 4
*I received it in the post, they just stuffed in the post and said, “Yeah, go take a test and away you go. Send it back to us.” And the hours I was working, I don’t know, I only get time on the weekend to do those sorts of chores, but I didn’t have time to do concentrate on stuff like this. Consumer - bowel 5

*The pamphlets would have to be for the older people, the ones that haven’t actually had a lot of schooling and that. They can’t be really, really detailed...something that is going to take their eye and they are going to know that is for medical or breast screening or whatever. Consumer - breast 1
*Like maybe if – like in front of Coles – if they had some sheets printed up and done with nice colours and that – maybe people might pick them up and take it...or put the pamphlets down at Link and say the breast screening bus is going to be here on such and such a day. Consumer - breast 2
*Even if they made a certain day of the month – this is when it [mobile screening van] is going to be here. Consumer - breast 2
*...if they had it down at the bowling club, they could probably put up one of them shade mesh things...and have refreshments there...if they wanted to have a cup of tea or a drink and just have a table set up where they could sit around it. Consumer - breast 1
*Link Up, had that day down at the Hall where they had the bus there, the Healthy Footprints bus and they had free needles for the flu and all that...a lot of the Aboriginal people do go to that because it’s free. And it’s near [name] Street where a lot of the ladies live. Consumer - breast 2
*It’s not trying to bring them somewhere else. It’s to go where they are. Consumer - breast 1
*They have a lot of organisations there you know. And people come from all over town to go to it because if you are
- **Coordinate screening van with community events**
  - going to get a free needle for your kids...or if you are going to get a free ice cream or a free sample bag... And they are families that go to it. Because they don’t sort of do that for themselves but, if they are there as a family, well, it’s there.
  - *Well, that’s a good time for us to have the screen bus there. Same time as the health bus.* [Consumer - breast 1]
  - *And maybe you should go through doctors’ surgeries. I don’t know if they even did that. Let the doctors know that you are out there for them so they can say they’ve got a patient that hasn’t had – and they can say, “Well, right, the breast bus is here on such and such a day.”* [Consumer - breast 1]
  - *But Aboriginal women will not listen to that. I think they would have to be told and, once you tell them and say, “Look, that would be good for them.”* Because it’s coming out of the mouth of the doctor and blah, blah, blah. [Consumer - breast 1]
  - *I think it’s all got to revolve around the GP and whatever knowledge the GP has on you as an individual if they’re fully up to date with all the information that’s out there one should click into the other and say, well, okay, look, you’re 74 now, this should happen.* [Consumer - bowel 2]

- **Get the GPs involved**
  - Consumer - breast 1
  - Consumer - breast 2
  - Consumer - breast 3

### Importance of cultural awareness

- **Involving Aboriginal voice at the start of the program**
- **Community events rather than an individual focus**
- **Building rapport with the community**
- **Aboriginal Liaisons have an important role in supporting and encouraging women in breast screening**
- **Elders helped promote screening once they received support and encouragement**
- **Need for health worker cultural awareness training**

- *...they [PHN] would send one or two representatives. And then we had one or two people from the cancer screening unit like [name] or her representative, and then we had an aunty or two aunts mostly that used to come, and they’d provided a space to be in, and then helped with the setting up of morning teas and lunches and things. So I’ve worked closely with each of those people.* [PHN 2]
  - *They asked me first of all how would I engage, and how would I get the people there, and we discussed then, that it was my belief that if we held events, where they weren’t just sort of singled out or where I didn’t just go and see them, and then go to see somebody else. If we gathered them together, but offered them something, that would be - it always seems to work.* [PHN 2]
  - *...talk about what the community needs and what’s happening around the community and what they can do to get more services here – which that’s one of them [breast screening].* [Consumer - breast 2]
  - *...it was the support through them [Aboriginal Liaisons] and also I think we thought well, we need to make an effort because we are trying to bring the services here - that’s the reason [we got involved with the event].* [Consumer - breast 1]
  - *And she [Aboriginal Liaison] just asked who was interested in going. More or less said, “Well, come on, we’re going.” So they took us up to it [breast screening event].* [Consumer - breast 1]
  - *I was very fortunate, and I got some of the key aunties to come first, and say, “Look, it’s not that bad, I went, and you should come too.” So that helped very much.* [PHN 2]
  - *I think a lot of the staff [health workers in general] need cultural awareness training, definitely.* [Consumer - breast 3]
## Practice Enhancement

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<td>• Engaging staff in understanding reasons why the practice is involved in the program</td>
<td><em>...we have practice meetings where we all meet over a lunch time, just to give them an update on what’s happening. So for everyone to be aware of what we want to achieve with the data extraction, they all need to know about it and why we’re doing it.</em> GP 2</td>
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<td>• Time is required for regular staff meetings and clinical meetings</td>
<td><em>So we have a partner meeting regularly, once every two months with the owners of the practice and we sort of set agendas on what we want to do and then have clinical meetings on alternate months with all the doctors and nurses. So we talk about any changes and things that we want to do. We completely changed the way we do our recall systems from a paper based system to an electronic system. So all of that’s discussed regularly at clinical meetings and anything else.</em> PM 1</td>
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<td>• Clear communication within team enables discussion of the program</td>
<td><em>We do have a regular practice meeting where between 100% and 80% of the doctors attend on a weekly basis...but there are times where very often, all the doctors in the practice get together and we will discuss things and we discuss clinical scenarios, we discuss difficult patients, we pick each other’s brains and we also try to formulate strategies, including this one.</em> GP 1</td>
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<td>• Engaging with staff about the program has helped improve teamwork</td>
<td><em>...so it’s a team approach and we’ve got a clinical meeting next week and I’ve said to the doctors, “We need to talk a bit more how we’re entering the cancer screening.”</em> PN 2</td>
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<td>• Including and involving all members of the practice team</td>
<td><em>once the girls knew that we’d signed up for this and we needed to get our recalls out there and our numbers up, we’ve all had a collaborative approach, so teamwork within the practice, has improved.</em> GP 2</td>
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<td>• Staff share information and expertise with the team</td>
<td><em>The receptionists have given information to the female members about, like an information questionnaire thing that they give to the doctors about how long has it been since they’ve been screened, in order for us to improve our screening rates.</em> PN 3</td>
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<td><em>Like the paps for the pap trained nurses…I think it’s been a bit more of, they realise they don’t have to do it all themselves.</em> PM 7</td>
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<td><em>The nurses will ask some of the doctors who know how to use PEN CAT about how to do things. So we’ll go and help them, in terms of doing extractions or helping with recalls. I guess that improves our teamwork.</em> GP 6</td>
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<td><em>It’s fed into our...ethos of practice. It being a teaching practice, I go and feedback and try and involve the registrars in what’s happening, and obviously I try and get the practice nurses to both teach them and try and get the registrars to use the programs which the practice nurses supervise, administer or are involved in.</em> GP 1</td>
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<td><em>I get extra stuff which I read and then sometimes I’ll forward it on to the practice manager if there’s something that she needs to implement into - in fact, the last PHN had something about the bowel screening programs, so I sent it on to her so that she’s aware.</em> PN 4</td>
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|                                                                                         | *...it was more talking to the doctors and providing them with information, so they could then answer their patients’ questions and just dealing with, well, what’s important? How do I deal with this change and what does this mean, and"
Services are working more closely together

Health Pathways a facilitator

Integration of services in early stages

Service provider network remained the same

Disengagement:

Lack of understanding reasons why practice is involved and the importance of teamwork

Improved communication between staff needed

Lack of consistent team meetings

More regular meetings needed

Lack of financial reward a disincentive to participate in program

Lack of commitment from GPs to follow through with program

that’s where I got information from the PHN, so I understood it, because once I can get a grip on it then it’s easier to pass on to someone else. PN 2

That started to happen in [name of place], which I believe from talk, hasn’t happened for a very long time. There’s lots of people that I spoke to about, they kept saying things like, “We’re last on the line,” and “We don’t get services,” and all of that sort of thing, but the PHN came together with the hospital staff and [name of Aboriginal Liaison] and there were lots of people that weighed in on the conversation. PHN 2

I think as a result of our program we had very good examples of services working together...There were some good examples of the Breast Screening Assessment Service working with the community health team at the Local Health District. They offered a number of screening and information days for Aboriginal women in the region. PHN 4

I know that the PHN and the Local Health District and one of our doctors have been working a lot on pathways [My Health Pathways] which I think is really helpful and the doctors are finding that really useful...because otherwise you’re just sending the patients from pillar to post. PM 1

having that explicit integration with I guess, LHD specialists, from my perspective, hasn’t really happened. It’s probably in its infancy stage because of My Health Pathways but...it hasn’t really, from what I can see. PHN 5

The services have always been around, and we use the same type of services that we’ve always used. So no, I wouldn’t say our network has increased any more than what it was before. GP 6

Lack of understanding reasons why practice is involved and the importance of teamwork

Improved communication between staff needed

Lack of consistent team meetings

More regular meetings needed

Lack of financial reward a disincentive to participate in program

Lack of commitment from GPs to follow through with program

A little more communication on our side of things between different people... PN 2

General staff I would say not very confident...and this is due to the lack of regular communication in regards to the topic. PM 5

...add more regular meetings with the staff which providers are also included in the meetings, I think that would be the way going forward. That would create a greater interest from the providers which obviously reflects on the rest of the team, the providers are reluctant to work on the program due to financial reasons, which makes it quite limited. PM 5

I think more input from the medical staff, which is quite hard to enforce, they’re always busy...and that means they need to be rewarded, I think, slightly higher for their time for those meetings as well. So maybe if they come down and meet the staff, the medical staff for half an hour or so, to compensate them I think that would attract a few more medical practitioners to get involved. PM 5

We had three GPs who committed to be involved in the audit, and unfortunately the three GPs for various reasons didn’t get involved. PM 3

I suppose, in my opinion I think if the doctors got more involved. A lot of the time they leave it up to the staff and that
- **Need for more involvement from GPs**
- **Disengagement from leaders is frustrating for practice staff**
- **Need for engaged leadership**

and I don’t think that the doctors actually get involved. PM 8

*I think there was a little bit of a gap or a bit of a distance between the doctors involved in this activity and the PHN...I was somewhat removed from the interaction with the PHN* GP 4

* It has been really frustrating...I think it led to quite a few frustrations and initially it felt like, well, why would the staff bother when there’s no direction from the leadership, and I guess it evolved and we decided, we’ll do it ourselves. PM 3

*I guess encouraging doctors, if they’re going to commit to something, they should do it, rather than say, yeah, yeah, yeah, let’s do this, and nothing happens with it...you need to be more selective on how you get to take part.* PM 3

### Practice learning activities

Staff have a variety of preferences for resources:

- **Online**
- **Emails**
- **Cheat sheets**
- **Face-to-face**
- **Webinars**
- **Newsletters and paper-based materials**
- **PHN staff**

* I prefer just looking it up online. I think it’s easier. You can find more up to date information than paper. PM 7

* I google around until I find the resources that we need. PM 3

* I've used the website. PN 3

* I guess in the first instance, emails with links are always helpful and then looking online, I love cheat sheets. So, any cheat sheet that can be given, that would be great. PM 3

* ...if you need detailed information or a crib sheet for doing something over and over again, you print it off. GP 1

* I prefer face to face. But webinar if we can’t do that. PN 1

* I read my newsletters and things that come through, so I get that information that way. PN 2

* I still like paper - I’m old-fashioned in that way - for me to have it written down so I can read it and copying to share with doctors is really quite helpful, and I like having those resources so if a patient has a question I can say, here. PN 2

* I've got a very good liaison officer at the PHN so if I do have any problems I usually just write to her or give her a ring and she will steer me in the right direction. PM 8

* Sometimes we do ask the PHN. I think the nurse in particular contacts the PHN for resources. PM 3

* I probably went straight to the Cancer Council if I needed to order anything. I probably didn’t look at the PHN website as such PN 2

* I think we went straight to the websites of the actual provider as opposed to theirs [PHN]. Sometimes their information on their sites is not as accurate as the direct one. PM 7

* ...the reception staff got a lot of training through that as well as just, you know, learning how to use MD better. And I suppose we all did. We all learnt to use MD a little bit more efficiently for entering coded things and making sure that results are entered properly. PN 3

* When I first started, I went to a day’s training on the clinical software, because I hadn’t used the package that they have here. PN 4

* PHN have come out and they’ve given one on one tutorials or instructions to two of the main practice staff members who have been involved in the program. GP 2

* I go to most of the sessions they have of different things, but I do do other webinars when they have webinars and
<table>
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<tr>
<th>Training</th>
<th>Increased staff knowledge of record keeping and data cleansing</th>
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<td>Training enables staff to share knowledge with colleagues and patients</td>
<td>they're good. PN 4</td>
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<td><em>It [webinar training] brought me up to speed with why we were changing and to understand, just that understanding as to why the screening process was changing and why they thought it was necessary to change, and then I was better able to communicate with my colleagues why it was changing or with my patients. This is why we are doing it, so it helped me talk about it better. PN 2</em></td>
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<td>Training increased staff awareness of screening rates</td>
<td>So it [training] improved, I guess improved knowledge of - an awareness of how we are in our screening rates, and how we should improve our screening. PN 3</td>
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<td><em>...reception used some training aids to improve the handling of results within the practice. PN 1</em></td>
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<td>Training increased staff knowledge in reminder and recall systems</td>
<td><em>Because she learns from the people coming from the Area Health, so just like sitting there with her behind the front desk, and just like telling her what to do and she's just been involved with the data, like setting up the stuff in the computer... GP 3</em></td>
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<td><em>I think it helped improve her [PN] knowledge of particular programs and probably even the importance of updating the records and keeping all the data, doing a data cleanse and that sort of thing. PM 6</em></td>
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<td><em>I think the girls are far more knowledgeable about how the systems works now, particularly, with the faecal occult blood recall and the mammograms. So I don’t think that my knowledge has increased any more, but it’s good to have the girls trained up, so that they understand why we’re doing it and how important it is for early detection. GP 2</em></td>
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<td><em>...since there’s a new system is in place, she knows more like how to get the patient on time here, and how to record the patient, how to communicate with the patient, and all this stuff basically. I see lots of improvements in basically all aspects of being at the front desk as a receptionist. GP 3</em></td>
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<td>Upskilling of staff</td>
<td><em>...another thing is the general education of the staff members...we trained a few staff members... and how to, yes, just try to take a bit of load of the doctors and the others back. PM 5</em></td>
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<td>Practice staff extend their roles</td>
<td><em>...it improved skills of my secretary, how to do this type of data collection, and notifying patients who require this type of preventative screening such as bowel cancer screening, or breast cancer screening for breast cancer. GP 5</em></td>
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<td>Increased knowledge enables staff to optimise their role</td>
<td><em>We've got a practice nurse who previously wasn't doing as much practice nurse stuff, but was doing more reception work. So now we've got her to do more practice nurse things, including looking at PEN CAT, and doing the audits and extractions from there. GP 6</em></td>
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<td><em>...so the receptionist gives the people a bit of a nudge. Then if the patient wants to talk or ask some questions about it...we send the majority of the people down to the nurse if the doctors are busy or they've already seen the doctor...the nurses down there as well can talk to the patients so it has improved I think the knowledge especially with the receptionists. PM 8</em></td>
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<td><em>I think increased knowledge and increased awareness and they [practice nurses] are able to work more towards the top of the scope of their practice. PM 3</em></td>
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<td><em>Well it [webinar training] was always on when it was unsuitable for me, and plus I find that it very hard to just sit down</em></td>
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• **Time is needed to devote to training**

**Suggestions:**
- Improvement Foundation could be used to provide resources and development
- Make use of shared communication platform
- Peer to peer learning workshops
- Incentivised workshops and training
- IT support for staff with poor IT literacy

*...in hindsight, in regard to the planning stages of the project if they would have approached the Improvement Foundation to mentor and guide and provide resources and development for the project, a lot of streamlining could have happened.* **PHN 5**

*We live in social media technology world where they expect that two-way communications to happen...I think if we set up a base camp platform for the 18 practices and one person has queries about how to get FOBT results electronically and I answer the question, well somebody else can go in there and see that QI information or be able to quickly access all of the resources, all the tools that we have set up for them, rather than emailing me and saying, “Hey, can you resend this cheat sheet in.”** **PHN 5**

*It's about utilising the advanced exemplar practices that are actively doing things and helping others. And showing their peers that they can help each other. And this is something that is missed out as part of this program, with the collaborative wave approach there’s learning workshops. And in these learning workshops they’re really encouraged to have that peer to peer interaction where the doctors talk to the other doctors, which they might not have the opportunity...Nurses can talk about the fact that, “Does your practice do this?” “Yeah, my practice does.” “Oh, okay.” Then I’m normal. I don’t feel victimised or disadvantaged in any way.* **PHN 5**

*I would recommend maybe if they put a few workshops and maybe five or six training sessions at the practice compulsory of that, within the program, which would, one of them be initial set up, second is, just following up and making sure everyone is on track, and create a bit of an incentive environment so that everyone knows what they’re doing throughout the whole process...specific staff training to train people and regular follow ups, I would say.* **PM 5**

*If they were to I guess give classes for the staff and GP’s and things like that, that would help. Because we still have two GP’s that don't use the computer, so if they had something like IT support for them so the doctors would feel more comfortable to use the computer, that’ll be helpful.* **PN 3**

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**Quality Improvement (QI) Initiatives**

- Establishing screening registers
- Carrying out clinical audit to identify who to screen
- Utilising recall and reminder systems

*...this program really enabled those patients to be picked up who are actually dropping out of being screened and they may have been dropping out because we weren’t reminding them...** GP 1*

*[screening registers] done more regularly in the practice now.** **GP 6**

*...when you looked at our recall system we had recalls that were so out of date it was amazing, and we’ve been gradually tidying those up.** **PN 2**

*...it [recall and reminder system] was there before, but it wasn’t that sort of like, it wasn’t running smoothly, so we now have it running in a much, much a better way.* **GP 3**

*...the nurses have been extremely proactive adapting to the new program and continuing with appropriate recall.** **GP 4**

*...this [cancer screening program] enabled us to set up formalised systems, which either were incomplete or we did not have. It made us formalise or tighten up our reminder system more so. Up until that stage, each individual doctor had
- **Problems identified with setting appropriate recalls**
  - sort of had their own way of reminding follow-up...there was the potential for reminders not to be generated as efficiently or effectively or at all. GP 1
  - *...it has enabled the staff now to go and establish systems of screening and follow-up, which are now being implemented and are being continued* GP 1
  - *...now they’re being taught to document it properly so the next recall list will be a lot more accurate now, yes.* PM 2

- **Improvement in entry of screening results**
  - *You could see their change in completed cancer screening results over time from the base line data collection through to the three month and then six month data collection...the higher number in proportion of patients were getting screened and those results were being saved in the right place and therefore completed cancer screen results could be identified, using a search tool. Whereas that was previously invisible.* PHN 4

- **More accurate audit data**
  - *We’ve certainly improved from baseline by a substantial amount... but I suspect that most of that is improved collection of data rather than more people...because I don’t think we’ve improved by 5%. I think that our data collection has improved by 5%.* PM 1

- **Improved awareness of screening rate data**
  - *...looking at the numbers in front of me now, I think that what I’ve observed is that I don’t know how many increased mammograms have been done. All I know is that the number of reported mammograms has increased.* GP 2
  - *I don’t think there was any value added to the patients. I think, really things were happening as they always happened, we were just more aware of results.* PM 3
  - *It helps us with showing us how many percentages that we’re getting...it gives more of a general overview of whether we’re improving, like one month or the numbers are going down as to how well our recall and screening procedures are going.* PN 3

- **Improvement in screening rates**
  - *We were already doing screening, but we didn’t have the PEN CAT tool. Or even if we did we weren’t checking on our screening rates.* PN 3
  - *The program was a success. I think it did help improve the screening rates of our patients.* PN 2
  - *I’m actively doing more pap smears and reminding people that come through, “Have you had your screening done?”...I think we definitely have an increase in uptake in a lot of the screening services.* PN 1
  - *So do you mean do I think that the way we are running it now, we are getting more people in for screening? We do now because I do that recall.* PM 4
  - *I think the only thing we’ve noticed is the increased amount of paps that we’re getting come through.* PM 7
  - *Well, definitely with National Bowel Screening, it has definitely increased, probably quadrupled...and also we can see an increase of the result of the mammogram as well.* GP 5

  *I think in that regard with the pap smears and the mammograms they’re more - the patients are using them a little bit.
- **Improvement in all three areas of cancer screening**
  
  - *...thanks to this new screening system. So we do, I think, improving in all the three areas, breast screening, the bowel screening, and the cervical screening, yes.* **GP 3**

- **Need for feedback to understand improvement**
  
  - *In terms of just getting the message across, it might be useful to have some face-to-face feedback on the program...in relation to what the program has achieved and perhaps opening up a potential for discussion again within our practice as to what we have achieved. But, also probably looking at whether or not there’s been any change in the statistics, so what our participation rates are like and also encouragement to recruit.* **GP 4**

- **Screening systems were already in place**
  
  - *We already had ours set up and running through our clinical software so we just kept using that.* **PM 6**
  - *We had a good recall system anyway. The nurses do the recall system so they were pretty well on top of anything like that.* **PM 8**

- **Using PDSA cycles to encourage quality improvement**
  
  - *I think that’s one of the most useful tools [PDSA] actually throughout the program because it did give the admin staff a better guidance, so it did tell us what to do, how to do it, when to do it kind of thing, which made life a little bit easier, so that was a very good initiative.* **PM 5**
  - *...educating the staff in the practice about what goals we were setting during the PDSAs, and then establishing new routines for the results part in the practice.* **PN 1**
  - *I think the last time they [PHN] came out we went through some PDSAs and things so they give us ideas, or we can bounce things around with them...**PM 6**

- **PDSA cycles can be time consuming and difficult with limited staff capacity**
  
  - *I suppose the most frustrating part for me is trying to do the PDSAs. I know they’re a really good tool for setting goals and trying to move the practice forward. But as a timeframe - I suppose I am talking from my perspective, we don’t have a practice manager, so I wear that hat as well as the practice manager, so I found that very time consuming, when I’ve got huge clinical demands. You know, just to have to be doing another piece of paper - I’ve found that sometimes really frustrating.* **PN 1**

- **Opportunity for Continuing Professional Development (CPD) points are welcomed**
  
  - *It provided quality improvement and, you know, sort of, Category A CPD points which are always welcome.* **GP 1**
  - *...there’s another program with the [name], we use that when they are running the cancer screening for cervical cancer, bowel cancer, and breast cancer. I think that there is some CPD points there, probably would be by mid or end of 2018, I would look into this program.* **GP 3**

- **CPD helps in practice quality improvement**
  
  - *Most of the practice are involved in some sort of research or some sort of QI programs...I guess we’re doing it more for our practice perspective rather than a personal thing. But I think there are some QI points associated with it, but I’m not 100% sure.* **GP 6**

- **Not all GPs were aware of**

  - **more. The bowel cancer one not 100 per cent sure because I get the letters from the patients but they normally come from the National Bowel Cancer Screening Program. PM 8**
  - **...thanks to this new screening system. So we do, I think, improving in all the three areas, breast screening, the bowel screening, and the cervical screening, yes. GP 3**
  - *In terms of just getting the message across, it might be useful to have some face-to-face feedback on the program...in relation to what the program has achieved and perhaps opening up a potential for discussion again within our practice as to what we have achieved. But, also probably looking at whether or not there’s been any change in the statistics, so what our participation rates are like and also encouragement to recruit. GP 4*
  - *We already had ours set up and running through our clinical software so we just kept using that. PM 6*
  - *We had a good recall system anyway. The nurses do the recall system so they were pretty well on top of anything like that. PM 8*
  - *We think we've had a well-developed system and of course there's a long history with the cervical screening program so that I think that actually works very efficiently in our practice. And, I’m not sure how much the PHN support would have really impacted on that. GP 4*
  - *I think that’s one of the most useful tools [PDSA] actually throughout the program because it did give the admin staff a better guidance, so it did tell us what to do, how to do it, when to do it kind of thing, which made life a little bit easier, so that was a very good initiative. PM 5*
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| CPD opportunities through the program | *I haven’t actually been involved in any CPD activities specifically in relation to the program. In fact I’d have to say I wasn’t aware that they were available. GP 4 |
| Practice staff are time poor | *I just could have done with some more time sometimes, but that’s a chronic problem. PN 2 |
| Need for more staff | *...it was a burden, because it was an extra load on what we normally do. So if they had somebody that could come out and just help us do that, that would have been better. PN 3 |
| ...we were given some suggestions about additional recalls to be focusing on...there just wasn’t the manpower to get another recall up and running. PM 3 |
| Staff face competing priorities | *Well we would prefer to have more staff to meet all the goals that they were demanding. PN 3 |
| ...If they could have provided a specific staff member to sit down and give some time to help with all the initiatives, because there were quite a lot of initiatives that they were doing. That would have been better. PN 3 |
| Program sustainability: | *The project wasn’t really at the forefront of other people’s minds. So, there was a lot of distractions that drew our attention away from really giving it a really good go. PM 3 |
| Commitment to continuing with quality improvement initiatives | *We’ve all got the drive in us to do these things, but other things - clinical medicine gets in the way GP 6. |
| Creating sustainability | *we went through accreditation later last year, so that was a huge time consuming deal and then there was some post-accreditation things that needed to be sorted out, and that then took priority again, so unfortunately, I guess, for me, sometimes it’s been on the backseat because there have been other more critical issues to deal with. PN 2 |
| Support needed to keep motivating practices | *Once they get used to it [implementing QI initiatives] they [practice staff] are quite smooth, they are quite good with it, and they are still doing it. GP 5 |
| Perception that ongoing data collection | *I think even once this project is finished, I think that we’ll still just go on doing what we’ve been doing so that we are catching up with people and just giving people the best opportunity that we can. PN 4 |
|  | *I think for us it’s not something that will be stopped, it’s going to be an ongoing process. PM 6 |
|  | *I try to make sure that they understand how to do that next time, because it’s important for me that once I leave the program that becomes a sustainable practice that they are able to implement themselves. PHN 5 |
|  | ...if we had someone who would come along on a semi-regular basis just to give us a bit of a nudge to say how are you going with this? What are you up to on that? And maybe to help us implement some of those things...I think that on a regular basis would keep things going for a lot longer than if a program, for instance, just stops suddenly. GP 6 |
|  | *We can do these audits and we can do them for six months, or a year, or two years. But I guess the question is how do we keep going year after year, ongoing? That means that the GPs or whoever the clinical leads are, need that little bit of encouragement or a nudge just to say keep doing this kind of thing. GP 6 |
|  | *If we keep getting some of these reports that are coming through, that’s the encouragement that we need to keep doing these sort of things. I just hope it doesn’t, you know, come to a stop at some stage. GP 6 |
|  | *...they [PHN] run the tests, the data extraction...probably once a quarter. I’m pretty happy with it because I don’t have time to have it more often than that. PN 3 |
Responsibility lies with PHN

- Perception that PHN is time and resource poor

Suggestions for future programs:

- Outsource quality improvement component
- Additional staffing to resource program
- Need highlighted for other types of screening
- Focus on one cancer screening type at a time

*...unfortunately, I don’t think the PHN had enough manpower to be able to do it for us so we’ve got to do it ourselves...at the end of the day I think PHNs before still had limited time to be able to just focus on - because there were so many practices to do it. PM 2

*I think the project would have benefited from maybe outsourcing someone for the quality improvement part to an external organisation such as the model of the Improvement Foundation, even for them to implement like the model of improvement theory and model. Just because really, when I came from the COPD project which was outsourced to that organisation, the foundation, and the foundation to put a PDSA cycle, the theory behind it, how you make small incremental changes in a small period of time, test it out and make a change. That theory or that model wasn’t really implemented so the structure of this current program hasn’t been as well as informed... PHN 5

*If there was an external person who’s able to drive some of the quality improvement activities that currently happen, would have influenced at the earlier stages of the program how to actually implement the model of improvement, that could have had a good change on the current program. The management - making sure that there is a staff member that’s able to cater to all of the practices. PHN 5

*...but we need to do other disease screening as well, in order to improve the patient outcome and patient participation. GP 5

*I think realistically maybe focusing on one of the screening at a time. I think doing the three, threw the practice a little bit, because we were trying to focus on too much in one go. I think it if had have been done as separate ones, particularly the breast screen one maybe as a separate one as opposed to the other two. PM 7
Appendix B: Nepean Blue-Mountains Primary Health Network Cancer Screening Evaluation Framework

The Nepean Blue Mountains Primary Health Network (NBMPHN) Cancer Screening Evaluation Framework described in this document is based on a Program Logic Model (PLM) (Kellogg, 2004). The model has been developed by the Western Sydney University (WSU) research team from a generic PLM framework for the former Nepean Blue Mountains Medicare Local and in close collaboration with a Project Evaluation Working Party convened by the NBMPHN.

The Inputs, Activities, Outputs, Outcomes and Impacts described in the PLM, as well as the indicators and measures recommended for evaluation, have been aligned with the following program documents:

- WHL Project Brief - Bowel Cancer Screening;
- WHL Project Brief - Breast Cancer Screening;
- WHL Project Brief - Cervical Cancer Screening;
- NSW Primary Care Strategy for the bowel, breast and cervical screening programs;
- Nepean Blue Mountains PHN Primary Care Cancer Screening Engagement Strategy;
- Nepean Blue Mountains Primary Health Network Cancer Screening Program Advisory Committee ToR;
- Cancer Institute NSW Government Cancer Screening and Prevention Grant Application 2016 – 2017 and PROJECT PLAN;
- and Australian Government DoH PHN Performance Framework (v.1).

Please note that program impacts, although identified, are generally long term and unlikely to be achieved within the timeframe of early evaluations.

WSU Research Team:

Dr Steven Trankle, Dr Christine Metusela, Professor Jenny Reath, Professor John MacDonald

NBMPHN Evaluation Working Party:

Glenda Webb, Jerrad Borodzicz, Nikolina Zonjic, Ellen Chatfield, Dr Trudy Rombola, Julie Welsh, David Wilkinson

Senior Manager - Elisa Manley
1. Inputs include the human, financial, organizational, and community resources a program has available to direct toward doing the work.

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Survey</th>
<th>Interview</th>
<th>Document Review</th>
<th>Document/Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1 Funding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sources of funding</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Funding allocated (and timed) according to program priorities e.g.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Staff/salaries</td>
<td></td>
<td></td>
<td></td>
<td>Budgetary documents (incl allocation and disbursement)</td>
</tr>
<tr>
<td>- Community interventions</td>
<td></td>
<td></td>
<td></td>
<td>Audit Report</td>
</tr>
<tr>
<td>- GP interventions</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- Administrative costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Incentives to encourage screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount and adequacy of funding allocated/disbursed</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>GP payment incentives and CPD</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Provided and satisfaction</td>
</tr>
<tr>
<td><strong>1.2 Management/governance structures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Expert reference and advisory group(s) established</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Meeting minutes Guidelines Experience</td>
</tr>
<tr>
<td>- ToR(s) established (including meeting schedules etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Organisational and management support for the program</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.3 Staff</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Staffing according to program requirements.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Commission Aboriginal Health Worker (Lithgow, Blue Mountains) to support Aboriginal women in breast screening</td>
<td></td>
<td></td>
<td>x</td>
<td>Program specific expertise identified and sourced. Numbers and roles. Work contracts</td>
</tr>
</tbody>
</table>
| Clear staff job descriptions | x | x | x | Staff PDs  
| Staff satisfaction with job descriptions |
| 1.4 Community/consumer stakeholders |
| Community organisations engaged in program e.g. Men’s Sheds, Breast Screen, GP reps, Improvement Foundation, Agency for Clinical Innovation, the Australian Practice Nurses Association, NBMLHD Health Promotion Unit, St John of God Healthcare, Penrith Women’s Centre, Family Planning, Hawkesbury District Hospital, Penrith City Council, Hawkesbury City Council | | | x | MoA and ToR Provider contracts |
| Consumers engaged in program implementation | x | x | x | Consumer reps on program committee and roles in implementation of strategies |
| Satisfaction of consumer reps on committee with engagement process including consultation and opportunities for input into development and improvement of the program | x | x | | Satisfaction |
| 1.5 Research/evaluation expertise |
| Identified program research/evaluation goals/priorities | | | x | Noted in NBMPHN Program plans |
| Agreements - research partners/ documented internal processes | | | x | Contracts funded. Evaluation/research plan documented |
| 1.6 Technology including Information Technology (NBMPHN and GP) |
| Adequate IT resources and support for the program. PenCAT clinical tool provided to practices | | | x | Description including numbers and expenditure. Documented evidence of resource acquisition |
| GP and staff satisfaction with PenCAT tool and IT support and efficacy | x | x | | Reminder systems, audits, data extraction |
| 1.7 Other resources that are program specific |
2. Activities refer to the way resources are utilised. Activities are the processes, tools, events, technology, and actions that are an intentional part of the program implementation. These interventions are used to bring about the intended program changes or results.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Survey</th>
<th>Interview</th>
<th>Document Review</th>
<th>Document/Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Program planning and development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs analysis reviewed and incorporated</td>
<td></td>
<td></td>
<td></td>
<td>(From ToR) LGA specific needs analyses</td>
</tr>
<tr>
<td>Committee established to engage key stakeholders</td>
<td></td>
<td></td>
<td></td>
<td>Program plan notes input/ consultations Minutes of meetings</td>
</tr>
<tr>
<td>Program Plan established</td>
<td></td>
<td></td>
<td></td>
<td>Documented program plan</td>
</tr>
<tr>
<td>Program is informed by evidence</td>
<td></td>
<td></td>
<td></td>
<td>Engagement of research partners/ internal evaluation process. Evaluation framework established</td>
</tr>
<tr>
<td>Alignment with Shared Strategic Plans</td>
<td></td>
<td></td>
<td></td>
<td>Program plan notes alignment with shared strategic plans e.g. with DoH, Cancer Institute etc.</td>
</tr>
<tr>
<td>Communication/ media strategies developed to inform relevant stakeholders about program</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>(Publicity as identified in Program briefs) Community fora/ other engagement processes implemented Documented comms/media engagement and targeting (includes timelines).</td>
</tr>
<tr>
<td>Commission local men’s preventive health education providers to conduct community-oriented and/or work-place oriented health promotion activities (Penrith/Hawkesbury LGAs)</td>
<td></td>
<td></td>
<td>x</td>
<td>Work contracts</td>
</tr>
<tr>
<td>Commission General Practices to participate in clinical audit and QI in General Practice Program.</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Provider contracts Measure provider relationships, and ascertain existing skill levels, capacities.</td>
</tr>
<tr>
<td>• Training initiatives for General Practice and other support staff including: o clinical software and cervical screening updates-includes also on recall and reminder systems o training on engaging men in primary health care (with clinical educator) o “Well Women Screening Course” for practice nurses</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>(From Program briefs) Documented training programs Work contracts Program report Pre and post survey Satisfaction with training</td>
</tr>
</tbody>
</table>
- GPs and Practice staff cancer screening promotion practices to encourage women of CALD background to undergo breast cancer screening.
- QI coaching
  - Develop pathways for Bowel Cancer Screening (and in general cancer screening – noted in Cancer Institute Grant doc)

### Practice Redesign

- Reminder/recall system (clinical software prompts)
- Clinical audit strategy
- Practice support by NBMPHN Cancer Screening Program Officer

### Community education

- E-reminder service and prevention portfolio for cervical screening collaborated with Cancer Institute (consumers)
- Develop Women’s Health Checklist (NBM and Lithgow)
- Develop Bowel cancer education and information (e.g. workplace sessions)
- Develop linkages with women in Aboriginal communities

### Develop evaluation strategies, including additional project specific KPIs, for collection at specified intervals (reporting framework for PHN/Practices noted by DoH)

<p>| | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IT systems operational and interventions documented</td>
<td>Satisfaction and delivered (amount and types of support documented)</td>
</tr>
<tr>
<td></td>
<td>Attendances, evaluation reports</td>
<td>Scheduled data collection and reporting PLM by WSU</td>
</tr>
</tbody>
</table>
3. Outputs are the direct products of activities and may include new resources and/or types, levels and targets of services and programs delivered by the NBMPHN.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Survey</th>
<th>Interview</th>
<th>Document Review</th>
<th>Document/Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1 Program Implemented</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff/ contractor recruited, oriented, supported to implement program</td>
<td></td>
<td></td>
<td>x</td>
<td>Program report, Annual report</td>
</tr>
<tr>
<td>Staff/contractor satisfaction with orientation and support e.g.</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal liaison officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program implemented according to plan</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Program report. Participant experience</td>
</tr>
<tr>
<td>• Publicity strategies implemented</td>
<td></td>
<td></td>
<td>X</td>
<td>Media releases distributed to local media</td>
</tr>
<tr>
<td>• Local cervical provider screening register developed</td>
<td></td>
<td></td>
<td></td>
<td>Website and other communications</td>
</tr>
<tr>
<td>• General Practices (GPs and practice staff), primary health care services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and/or other agencies engaged and oriented to clinical audit and QI program</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consumers recruited for Screening Services (documented)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consumer satisfaction with GP engagement/recruitment process and initiatives such as screening recall and reminders (and including information and education)</td>
<td>x</td>
<td>x</td>
<td></td>
<td>GP data extraction (baseline and interval data collection) Numbers of consumers by cancer screening group</td>
</tr>
</tbody>
</table>
- Training/educational initiatives implemented for GP staff
- Community training/educational initiatives implemented

| QI and practice redesign implemented- e.g. | X | X | x | Attendances/satisfaction |
| Cancer screening results recorded correctly in clinical software |  |  |  | PenCAT |
| Cancer screening register established |  |  | x | Documented |
| Cancer screening, diagnosis and management pathways established |  |  | x | Track use/engagement |
| Women’s Health Checklist established |  |  |  | |
| Reminder systems established (provider and consumer) |  |  |  | |

| General Practices satisfaction with program and implementation of initiatives | x | x |  | Include experience of processes |

### 3.2 Evaluation of program

| Evaluation data collected and reported |  |  | x | Clarify DoH requirements (pp. 9, 12, 13, 18) |
| Incremental screening targets met |

| Evaluation informs future program development and innovation |  |  | x | Documentation of evaluation and planning, and use of feedback. Reference and Advisory Group meeting minutes |

| GP and other PHCP/Staff/Stakeholder/consumer experience and value of evaluation focus | x | x |  | |
4. Outcomes are the specific changes in program participants’ behaviour, knowledge, skills, status and level of functioning.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Survey</th>
<th>Interview</th>
<th>Document Review</th>
<th>Document/Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.1 GPs / Engaged consumers and other stakeholders are informed about screening and services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumers and GPs seek information on cancer screening</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Website visits, phone enquiries, turnover of printed material, consultations-Cancer Australia website GP portal, health pathways for GPs</td>
</tr>
<tr>
<td>Consumer knowledge regarding cancer prevention and access to services</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer self-efficacy regarding cancer prevention and access to services</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPs and staff, other PHCPs and other relevant Stakeholder awareness of screening services and pathways</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Increased knowledge</td>
</tr>
<tr>
<td><strong>4.2 Improved consumer access and use of screening services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted consumers utilise screening services (e.g. Aboriginal women, men’s groups)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Reports on consumer numbers, types and frequency of screening Satisfaction, intention to screen, engagement in program (NBMPHN primary measures incl. change in patient participation relevant to each screening program)</td>
</tr>
<tr>
<td><strong>4.3 Program achieves stated outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement in consumer health status</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased collaboration between GP practices, primary health care services and/or other agencies – networking and pathways (e.g. GPs)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>NBMPHN primary measures incl. Change in Practice participation</td>
</tr>
</tbody>
</table>
and BCI communication)

| Staff collaboration and cross-agency relationships, networking | x | x |
| Improvement in provider and staff knowledge, skills, level of functioning | x | x |
| GP improved knowledge and practice capacity to implement QI activities | x | Confidence Value |
| Experience and views regarding the program | x | x |

5. Impacts are the fundamental intended or unintended change occurring in organizations, communities or systems as a result of program activities.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Survey</th>
<th>Interview</th>
<th>Document Review</th>
<th>Documents/Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1 Enhanced local community health and wellbeing</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sustained improved community cancer screening rates</td>
<td></td>
<td></td>
<td>x</td>
<td>Screening rates over time. Registry and GP data by postcode and LGA</td>
</tr>
<tr>
<td>Reduce the incidence of cancer and increase survival rates (CI doc)</td>
<td></td>
<td></td>
<td>x</td>
<td>Comparison of program specific data over time (MoH Data, CI data)</td>
</tr>
<tr>
<td><strong>5.2 Integrated and coordinated health services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated and coordinated health services across public and NGO sectors</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Documentation of shared engagement</td>
</tr>
</tbody>
</table>

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Appendix C: Interview schedule

NBMPHN Cancer Screening Programs Evaluation

Interview Schedule

A brief introduction will be provided. The purpose of the interview and requirements of participation including consent and audio recording, and confidentiality will be reiterated from information provided to the participant earlier. The participant will be given an opportunity to ask further questions and, if ready to proceed, will be given a consent form to sign.

Key:
Consumers (incl. consumer groups) = Green
General Practitioners (and other agencies/primary health services) = Blue

NBMPHN staff (incl. Consumer and GP representatives, contracted staff) = Pink
<table>
<thead>
<tr>
<th>Topic</th>
<th>Lead Question</th>
<th>Probe questions</th>
<th>Participants</th>
</tr>
</thead>
</table>
| **PLM 1.1**<br>Sources of funding Funding allocated (and timed) according to program priorities | Could you please comment on the distribution of funding? | -How adequate was funding for the program?  
-How well was funding allocated according to program priorities?  
-How timely was funding allocated and disbursed? | **NBMPHN staff** |
| **PLM 1.1**<br>Payment incentives and CPD (provided and satisfaction) | What sort of payment incentives did you or other staff receive to support your engagement in the Cancer Screening programs? | -How helpful have these payments been for you (satisfaction/adequacy?)?  
-In what ways have these payments assisted you?  
-Explain e.g. - in supporting the requirements for implementing?  
- in tracking and managing the change process?  
-What were they?  
-What has been your/others experience of CPD in this program?  
-How helpful has CPD been for you/others?  
-explain  
-how has CPD enhanced your skills/other staff skills? (also PLM4)  
-Enhanced your knowledge? (also PLM4) | **General Practitioners** |
| **PLM 1.2**<br>Management and Governance structures | Could you please comment on the set up stages of the Cancer Screening programs? | e.g.  
-reference and advisory groups?  
-ToR and meetings?  
-organisational and management support of the program?  
-Could you describe your experiences of these?  
-What was your involvement in these?  
-How effective were these strategies?  
-Can you recommend any changes in terms of governance? | **NBMPHN staff** |
| PLM 1.3 Clear staff job descriptions | Were you clear about your role in relation to this initiative? | Could you please describe how you were oriented in this role?  
-What support did you receive to fulfill your role?  
-How satisfied are you with the support you received? | NBMPHN staff |
| PLM 1.4 Consumer reps on program committee and roles in implementation of strategies | Could you please describe your engagement in the NBMPHN Cancer Screening Programs? | -What was your role in planning of programs?  
-What is your involvement with implementation of the programs?  
-What about in terms of improving the programs?  
-How well does NBMPHN consult with you?  
-What opportunities do you have for input?  
-How satisfied are you with your involvement? | Consumer Reps on program |
| PLM 1.6 (Technology) | Could you please describe the IT support you received from NBMPHN? | -How has this assisted your use of:  
-Reminder systems?  
-Clinical Audit?  
-Data extraction and the PenCat tool?  
-How satisfied are you with this support?  
-What else would support you in this area?  
-If you didn’t participate (in the webinar training), could you tell us why? | GPs and practice staff |
| | Could you please describe the IT support you provided to general practices? | -How has this (TYPE) support been able to assist practices?  
-Are practice staff developing competencies with IT as a result of PHN assistance?  
-How?  
-What IT challenges are practices presenting with? | NBMPHN Staff |
| PLM 1.7 (other resources) May need explaining-interviewer to have information of these on hand | Have you used or accessed the:  
-Practice Information Packs?  
-Cancer Screening | -Did you find the Information Packs useful?  
-Of what value are the Information Packs to you and your staff?  
-Explain?  
-Did you find the cancer screening tools and other | GPs and practice staff |
| PLM 2.1 Communication/media strategies developed to inform relevant stakeholders about program | What is your experience working with the NBMPHN to develop communication strategies for the program? | -What has been your involvement in developing communication strategies?  
-How satisfied are you with the consultation by NBMPHN about promotion and your level of input?  
-How do you regard promotion of the program?  
-How was it promoted to you?  
-Information about screening registers?  
-Information for mobile breast screening in your area?  
-How satisfied are you with this level of information?  
-Where did you get information about cancer (specify for each type) screening services that are available to you?  
-What information has been provided?  
-How useful is this information for you?  
-How satisfied are you with the quality of the information provided (amount and clarity)?  

GPs and practice staff (and other agencies/primary health care services)  

Consumers | NBMPHN Staff and Consumer & GP reps on the Advisory Committee |
|---|---|---|
| PLM 2.1 Commission General Practices to participate in clinical audit and QI in General Practice Program | What attracted you to be involved in the Clinical Audit and QI initiatives for Cancer Screening?  
*(Interviewer may need to explain and should have information of)* | -How were your needs considered and incorporated in the Clinical Audit and QI initiatives?  
-What support was offered to you by the NBMPHN to participate in these initiatives?  
-How useful were these | GPs and practice staff |
| **PLM 2.1**  
**Training initiatives**  
**for General Practice**  
**and other support staff** | Have you or your staff participated in any training related to cancer screening over the last 18 months?  
-Who provided that training?  
-How well were you oriented to the clinical audit and QI initiatives?  
-was your role clear?  
-What type of training did you participate in?  
E.g.  
-On clinical software  
- Including clinical audit?  
-On cervical screening updates and the register?  
-On recall and reminder systems?  
-On Using PDSA (Plan, Do, Study, Act) approaches/cycles  
**Ask for each of above**  
- Was it relevant  
- in what way?  
- Was it useful?  
- How?  
- Can you comment on the "Well Women Screening Course" for PNs?  
- how helpful was that course for PNs?  
- What about training for engaging men in bowel screening?  
- How did you find the presenter?  
- Explain?  
- Were you able to implement any learnings in your practice?  
- How did training inform or change any processes in your practice? | GPs and practice staff (and other agencies/primary health care services) |
<table>
<thead>
<tr>
<th>Section</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLM 2.1</td>
<td>What activities were undertaken in your practice to achieve change? Did you require support from the NBMPHN to achieve the change?</td>
<td>Who is the person most responsible for coordinating the approach in your practice? Did they achieve the outcome you expected? In what way? How often was support provided? What support was provided? How adequate was this support for you? Was it useful? How was it working for you? Is further support needed? How satisfied are you with the support given?</td>
</tr>
<tr>
<td>GPs and practice staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLM 3.1</td>
<td>Could you tell me what it was like when you started working with NBMPHN on this program?</td>
<td>Was your role clear? How well did you understand the KPIs in your contract? How well were you oriented to your role? What support was given for your role? Specific training?</td>
</tr>
<tr>
<td>Aboriginal Liaison, Bowel screening educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLM 3.1</td>
<td>Could you please describe your experience with the “implementation” of the program?</td>
<td>How satisfied are you with the implementation of program initiatives (identify each element e.g., developing a practice register/lists of patients who have and have not been screened and ask...)? Were you aware of this? Was it implemented in your Practice? What was it like implementing the initiatives? How did it work from your perspective (what changed)?</td>
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<tr>
<td>GPs and practice staff (and other agencies/primary health care services)</td>
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<tr>
<td>Consumers</td>
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<tr>
<td>- Did the activities achieve their intended outcomes?</td>
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<tr>
<td>- What did you need to do to achieve those outcomes?</td>
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<tr>
<td>- Did you/ staff understand why they were making changes?</td>
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<tr>
<td>- How did you engage your staff in making these changes?</td>
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<tr>
<td>- Any recommendations for the future?</td>
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<tr>
<td>- What screening test(s) did you attend or complete?</td>
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<tr>
<td>- When did you last attend or complete test(s)?</td>
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<tr>
<td>- What made it easy for you to attend or complete?</td>
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<tr>
<td>- Were there any difficulties attending or completing?</td>
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<tr>
<td>- What was it like engaging in the (type) cancer screening test?</td>
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<tr>
<td>- What information and education did you receive about the screening test?</td>
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<tr>
<td>- Where did these come from and (for each) how helpful were they?</td>
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<tr>
<td>- Did you receive any reminders about (type) cancer screening?</td>
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<tr>
<td>- Where did these come from?</td>
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<tr>
<td>- How helpful were they (for each one)?</td>
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<tr>
<td>- What role did your GP have in supporting you to receive (type) cancer screening?</td>
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<td>- Did your GP follow up after screening?</td>
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<tr>
<td>- How satisfied are you with your GP’s support?</td>
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<td>- What part of the process would encourage you to</td>
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<tr>
<td>PLM 3.2 Evaluation of program (although placed here according to PLM, in the interview this question should be at the end)</td>
<td>This interview is part of the program evaluation – what other experience have you had of evaluation of this program? (Maybe outline other evaluation if they are not aware)</td>
<td>-Do you think there is sufficient focus on evaluation of this program?</td>
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<tr>
<td>PLM 4.1 GPs /Engaged consumers and other stakeholders are informed about screening and services</td>
<td>Could you please describe your awareness of screening services and pathways?</td>
<td>-In what ways has your knowledge increased as a result of your involvement in the program? -What has been most helpful? -How well are you able to apply this knowledge?</td>
</tr>
<tr>
<td></td>
<td>Could you describe where you can find information on (TYPE) cancer screening programs?</td>
<td>-Have you been able to find the information you need? -How helpful has that information been to you? -Explain? -Recommendations for other information? -What means of receiving this information (GPs)?</td>
</tr>
<tr>
<td></td>
<td>What have you learnt about cancer prevention and screening services as a result of attending education sessions (if attended)?</td>
<td>-Explain? -How will this knowledge help you in the future?</td>
</tr>
<tr>
<td></td>
<td>How (well) have you been able to reduce your risk of (type)</td>
<td>-How confident are you about what you can do to reduce your risk of (type)</td>
</tr>
<tr>
<td>Consumers and consumer groups (e.g. men's shed, community oriented workplace)</td>
<td>Consumers and GPs</td>
<td>GPs and practice staff (and other agencies/primary health care services)</td>
</tr>
<tr>
<td>Consumers</td>
<td>Consumers</td>
<td></td>
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<tr>
<td>PLM 4.2</td>
<td>Improved consumer access and use of screening services</td>
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<tr>
<td><strong>Can you please comment on how <em>(name of targeted patient groups)</em> are using screening services?</strong></td>
<td></td>
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</tbody>
</table>
| -What improvements have you seen in use of services?  
-What are the challenges you see for different population groups to access cancer screening (e.g. CALD, Aboriginal women, and males for bowel cancer screening - note to specific LGAs)?  
-What improvement have you seen in access to screening services?  
-How likely are you to promote cancer screening to target population groups (CALD, Aboriginal women, and males for Bowel - note specific to LGA areas)?  
-Why/why not? |
| GPs and practice staff |

<table>
<thead>
<tr>
<th>PLM 4.3</th>
<th>Program achieves stated outcomes</th>
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</thead>
<tbody>
<tr>
<td><strong>Could I please ask you about how you use <em>(type)</em> cancer screening services?</strong></td>
<td></td>
</tr>
</tbody>
</table>
| -What cancer screening services do you use?  
Why/ why not?  
-Has your use of these services changed because of encouragement by your GP?  
- In what way?  
Or encouragement in your local community?  
- In what way (e.g. Men’s Sheds, community workshops with educators, other fora)?  
-What difficulties do you have in getting the cancer screening services you need?  
-How satisfied are you with your access to services?  
- with your use of services?  
-How likely are you to use cancer screening services in the future?  
- Why/why not? |
| Consumers (targeted e.g. Aboriginal women, men’s groups) |

<p>| <strong>How do you think this program has improved?</strong> |
| -How have the cancer screening activities helped |
| GPs and practice staff |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>the health of your patients?</td>
<td>them (e.g. awareness)? have you noticed any changes they are making in their screening behaviours? or in their lifestyles?</td>
<td>Consumers</td>
</tr>
<tr>
<td>How do you think this program has improved your health?</td>
<td>- how have the cancer screening educational workshops helped you? have you made any changes to your lifestyle because of the program? explain?</td>
<td>Consumers</td>
</tr>
<tr>
<td>Please describe how you are working with other providers (e.g. other GPs, BreastScreen NSW, colonoscopy or colposcopy services) as a result of the NBMPHN Cancer Screening programs?</td>
<td>- How has your networking improved? What about the pathways for referral to other providers?</td>
<td>GPs and practice staff</td>
</tr>
<tr>
<td>I am also wondering about how your practice is working together with its team members</td>
<td>- Has participation in this program assisted with improved teamwork? How? Did the program lead to changes across the team? How? How are changes communicated to other team members?</td>
<td>GPs and practice staff</td>
</tr>
<tr>
<td>How have you developed professionally from your involvement in the screening programs?</td>
<td>- Improved knowledge? Improved skills? Improvements in your day to day work?</td>
<td>GPs and practice staff</td>
</tr>
<tr>
<td>How has your practice engagement with cancer screening improved?</td>
<td>- Improved documentation processes? Improved recall/reminder systems? Improved ability to audit? Improved identification of “who” to screen?</td>
<td>GPs and practice staff</td>
</tr>
<tr>
<td>How has the practice and staff capacity and knowledge improved to implement QI activities/initiatives?</td>
<td>- How confident is practice staff with implementation of QI initiatives? Of what value are the QI initiatives to practice staff? to patients?</td>
<td>GPs and practice staff</td>
</tr>
<tr>
<td>PLM 5.2 Integrated and coordinated health services</td>
<td>Can you describe changes you have observed in terms of services working more closely together?</td>
<td>-How has this changed as a result of the screening program initiatives?</td>
</tr>
<tr>
<td>Thinking about the program more broadly...</td>
<td>Were there any unexpected outcomes as a result of implementing these initiatives?</td>
<td>-What were they?</td>
</tr>
<tr>
<td>Could you please describe your overall experience with the NBMPHN Cancer screening programs?</td>
<td>-Do you have any views about the program?</td>
<td>-What feedback could you provide?</td>
</tr>
<tr>
<td>-to your practice as a whole?</td>
<td>- Are you planning other QI in your practice?</td>
<td>-What are they?</td>
</tr>
</tbody>
</table>

**Final questions:**

Is there anything we might have missed or something you would like to add?

*Participants will be thanked for their contribution.*