Evaluation of the role of the Cancer Research UK Primary Care Engagement Programme

Final Report

April 2016

Cancer Research UK
NHS Greater Glasgow and Clyde
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Executive Summary

The Primary Care Engagement (PCE) Programme was established by Cancer Research UK (CRUK) and NHS Greater Glasgow and Clyde (NHS GGC) in June 2014 to support the prevention, screening and early diagnosis of cancer in the health board area. The PCE Programme had operated in selected areas of England since 2012 and Wales since 2015 and CRUK partnered with the Scottish Government’s Detect Cancer Early Team to extend the PCE Programme into Scotland. The Programme aims to improve cancer outcomes by engaging with, and supporting, primary care to: raise awareness of the importance of early diagnosis; support learning from previous cancer cases, adopt interventions that promote the early diagnosis of cancer and make sustainable improvements; enhance and support primary care education; and improve communication between primary and secondary care clinicians. The partnership is designed to utilise expertise and resources from both partners.

In Greater Glasgow and Clyde, a multi-agency Steering Group meets quarterly to oversee the PCE Programme; membership includes representatives from NHS GGC, CRUK, the PCE Team, and Scottish Government’s Detect Cancer Early Team. The PCE Team consists of three full-time members of staff - a Facilitator Manager and two Facilitators – who took up post in June 2014; one of the team is seconded to CRUK from NHS GGC (another team member was seconded temporarily between June 2014 and November 2014 and there was a vacancy for four months before a new Facilitator joined in March 2015). The PCE Team is line-managed by CRUK and located in NHS GGC’s Public Health Directorate. The PCE Programme coincided with the Scottish Bowel Screening Programme that awarded practices that reduced the proportion of patients who did not participate in the bowel screening programme up to six Scottish Quality and Outcomes Framework points.

In September 2015, CRUK and NHS GGC commissioned a qualitative evaluation to explore how the PCE Team had supported and influenced primary care in Greater Glasgow and Clyde in its first year. The main themes of the evaluation were to examine practices’ motivations and experience of working with the PCE Team, to assess the added value of engaging with the PCE Team, and to consider how the PCE Programme had influenced others. The PCE Team supplied a database of 103 practices engaged in the first year, and two waves of sampling invited 65 practices to take part in the evaluation. A further sample of 24 practices was taken from an additional database of practices engaged in the early part of year two. Recruitment was challenging with 51 of the 89 practices (57%) not responding to e-mails and telephone calls inviting them to take part in the evaluation.

This qualitative evaluation gathered the views of 36 health professionals and members of staff from 18 practices across Greater Glasgow and Clyde supported by the PCE Team. It also gathered views from nine stakeholders including members of the Steering Group, and the PCE Team members. All interviews were transcribed and the content organised into an analytical framework, so that material could be coded, thoroughly analysed and written up.

Engagement

The PCE Team promoted the PCE Programme amongst professionals via events, forums and meetings, as well as by direct e-mails and letters to 244 GP practices in Greater Glasgow and Clyde. By the end of the first year, 95% of practices had been engaged face to face at an event or session and 43% had received at least one visit from a facilitator.
Most practices interviewed for this evaluation stated that their first experience of the PCE Programme was an e-mail or letter from the facilitators, only a handful had any previous knowledge of the PCE Programme. The initial contact tended to be directed to the Practice Manager who, in most cases, assumed the lead role for ongoing contact with the practice. In none of the practices interviewed during this evaluation, was a GP felt to have been the key person driving initial engagement with the PCE Programme.

Early communications from the PCE Team to practices emphasised the support facilitators could provide regarding the Scottish Bowel Screening Programme and this led to bowel screening being identified as the main motivation for initial engagement among interviewees. Practices were keen to explore ways of increasing screening uptake or to ensure that everything possible was being done; they did not identify any other specific issues in relation to cancer prevention, screening or diagnosis as being of particular interest to them in advance of their initial meeting with the PCE Team. In some practices the initial visit was the only engagement with the PCE Team, although the majority of practices consulted during the evaluation had subsequent meetings with the facilitators; all of those interviewed who had one meeting with the PCE Team reported that all relevant issues had been addressed and they did not require another meeting at that time. The PCE Team was the main instigator of subsequent meetings following further communication to highlight the availability of support with additional issues.

Engagement tended to consist of small meetings with the Practice Manager (and one or two colleagues) or group meetings with clinical and administrative staff. Group meetings set up specifically to meet the PCE Team afforded more time for discussion than meetings added to the agenda of regular practice meetings. The facilitators were flexible in scheduling meetings to meet the needs of practices and maximise engagement and attendance was generally described as good. The PCE Team experienced some challenges in engaging primary care with some practices not taking up the offer of support. Overall, the practices which took part in this evaluation engaged with the PCE Team enthusiastically.

There was limited awareness of the CRUK branding of the PCE Programme among practices although this may have been partly due to the time elapsed since they met the PCE Team. Branding was mentioned positively in terms of CRUK’s credibility and access to quality, up-to-date resources, as well as links into NHS GGC. It was not, however, seen as a significant issue.

A number of interviewees were not clear about the full range of support available from the PCE Team, despite the facilitators outlining the breadth of support they could provide during the initial visit. Several practices only associated the PCE Team with bowel screening and this may have contributed to a predominantly reactive approach to engagement. Generally, practices would be willing to engage with the PCE Team in the future but mainly on an ad-hoc basis, as new priorities emerge and where contact was instigated by the PCE Team. There was no clear evidence among interviewees regarding more effective engagement than the methods employed to date by the PCE Team.

Experiences of support

Practices identified bowel screening as the main area of support they received from the PCE Team, particularly during the initial meeting, and feedback was overwhelmingly positive. Discussions with the PCE Team included a focus on the administrative processes
to track patients’ participation in the screening programme so non-participation could be raised at their next visit. Support also focused on practical measures that practices could offer patients to encourage them to take the test, such as providing rubber gloves, tongs, or foil bowls. Some interviewees stated that some of the PCE Team’s suggestions were already in place at their practice, however, they still welcomed confirmation that they were following good practice. There was also general discussion about the screening programme with the PCE Team sharing good practice from elsewhere. A small number of practices reported that the PCE Team had delivered staff training sessions on bowel screening and feedback was positive.

12 Support was not confined to bowel screening and the PCE Team discussed other cancers at both the initial meeting and during subsequent meetings. The support covered a number of topics including lung, pancreatic and ovarian cancers, as well as diagnostic issues including other screening programmes (cervical cytology and breast screening). A small number of practices also reported that they had discussed broader issues such as cancer prevention, auditing cancer cases, issues regarding secondary care, roadshows or professional development. To support practices, the PCE Team used a number of different cancer-related resources and tools. Three resources were developed in-house by the PCE Team on bowel screening, breast screening and cervical cytology. The PCE Team has also made use of existing tools including prevention leaflets, and Royal College of General Practice Significant Event Analysis, and Audit Tools.

13 Interviewees were very complimentary about the support provided by the PCE Team and the facilitators themselves. Discussions were described as informative and comprehensive, while the PCE Team members were described as knowledgeable, helpful and easy to work with and they were commended for their communications and understanding of relevant information, research and the availability of tools and leaflets. One Practice Manager highlighted the PCE Team’s understanding of primary care as important. Learning was shared internally with colleagues who had not been at the meetings and this tended to consist of Practice Managers sharing information with administrative staff about procedures for recording participation in the bowel screening programme, or feedback at practice meetings. No interviewees reported sharing learning with other practices.

14 Interviewees made very few suggestions regarding future support needs and this aligns with the finding that engagement appears to have been mainly reactive. Some practices suggested that focussing future support on cancer prevention could be challenging, despite the benefits. A small number of practices stated they would welcome support on forthcoming changes to the cervical screening programme or more hands-on administrative support.

Added Value

15 Added value was most evident in raising awareness of cancer issues, approaches and tools particularly, although not exclusively, on bowel screening. There was a general feeling that the PCE Team had provided a helpful framework, fresh ideas and impetus, encouraging staff at all levels to do what they could and sharing good practice. CRUK describe the PCE Team’s role as catalysts for change and the experience of practices in Greater Glasgow and Clyde shows that they have successfully delivered this awareness raising/facilitation role. A number of practices reported that meetings provided a reason for staff to think collectively about cancer-related issues, something they suggested does not happen in primary care;
some noted the process of talking through issues with an external person was important.

16 Changes in approaches to bowel screening were evident with some practices following up on the PCE Team’s advice (summarised in paragraph 11) to introduce practical measures such as handing out gloves and foil bowls to encourage people to take the test, and others changing administrative processes to track involvement. There are likely to be future benefits as procedures remain in place and information tools continue to be used by practices and circulated to patients. Time and resources were seen as the most significant barriers to implementing change, although more generally, practices suggested that patients’ reluctance to take the bowel screening test was the main barrier to increasing uptake. Change in approaches were reported by a small number of practices in other areas including lung cancer and early cancer diagnosis.

17 Added value resulted from the PCE Team sharing good practice among practices and developing in-house resources. The sharing of good practice occurred directly during visits and through the dissemination of case studies and presentations; generally, practices would welcome further information from the PCE Team on good practice. The three in-house tools were informed by the PCE Team’s experience of engaging primary care and the PCE Team specifically contacted practices that had low defaulter rates during the development of the bowel and cervical resources. The bowel screening workbook is the only one that has been shared widely with practices to date and positive feedback was gathered during this evaluation. Stakeholders were complimentary about the tools and the key role the PCE Team had played in their development; they also commented positively on the PCE Team’s role in sharing good practice.

Strategic Issues

18 Programme governance was viewed positively by stakeholders with participation from all relevant agencies. It was reported that the Steering Group had focused on operational and NHS GGC issues during the first year and this was mainly seen as a positive feature as it ensured that the PCE Programme was well integrated with NHS GGC governance structures and services (thereby avoiding duplication). There was a consensus that the Steering Group was becoming more strategic and there had been recent discussions about the future of the PCE Programme and applying the lessons to other health issues in Greater Glasgow and Clyde (although some members felt that further discussion and action was required to ensure the lessons were applied elsewhere). CRUK noted that the arrangements had led to greater integration into primary care/public health in Greater Glasgow and Clyde than in some of the PCE Programme areas in England and Wales and there were governance lessons that could potentially be applied elsewhere in the future. A number of stakeholders highlighted that partnership working had been established or strengthened between partners particularly CRUK, NHS GGC and the Scottish Government’s Detect Cancer Early Team.

19 Stakeholders regarded the PCE Programme’s delivery model as an appropriate and effective means of engaging primary care practitioners in Greater Glasgow and Clyde. Stakeholders commented very positively on the PCE Team and the support they had delivered – having dedicated staff to engage practices was seen as key. A number of stakeholders stated that seconding staff from NHS GGC had helped provide an understanding of the local context, as well as relationships and links with practices and colleagues in NHS GGC; an understanding of primary care was also cited as important by
one stakeholder.

20 Stakeholders viewed the PCE Team’s initial focus on bowel screening positively because it provided the opportunity for the PCE Team to offer support on a tangible issue and it also gave practices a reason to accept the PCE Team’s offer. A number of stakeholders suggested the link to bowel screening helped to raise awareness of the PCE Team and had built relationships with practices which could be capitalised on in the future. Stakeholders stressed that the PCE Team’s value was not confined to this topic highlighting direct support to practices on other cancers such as breast and cervical, as well as other significant benefits such as the development of local resources, the sharing of good practice, and the primary/secondary care interface. A handful of stakeholders raised the possibility that there could, in theory, be some duplication between delivery of the PCE Programme and the Macmillan GP service although there was no evidence of this on the ground. There were also concerns about the number of time-limited initiatives that sought to engage primary care regarding specific issues such as diabetes, and chest, stroke and heart, as well as the PCE and Macmillan Programmes.

21 Two strategic impacts were highlighted by stakeholders. Firstly, the positive experience in Greater Glasgow and Clyde had demonstrated that the PCE Programme could be applied in Scotland with appropriate modifications to fit the different policy context. Secondly, the PCE Team had provided a strategic role by collating primary care experiences and taking up issues on behalf of primary care practitioners across Greater Glasgow and Clyde around relationships and communication with secondary care. The PCE Team’s integration in governance arrangements at a local and regional level enabled the messages to be relayed appropriately on colorectal referrals and the genetics service.

22 Stakeholders were unanimous in their view that the PCE Programme should continue in Greater Glasgow and Clyde. There was a recognition that this was dependent on funding. Stakeholders suggested that the ending of the bowel screening initiative was an opportunity to focus on a broad range of cancers; prevention, and the interaction between primary and secondary care were also highlighted as potential areas of interest. There was also support for the roll-out of the PCE Programme to other parts of Scotland. Generally, stakeholders recommended applying the broad approach to governance and delivery as in Greater Glasgow and Clyde, subject to local variations where appropriate.

Conclusions and recommendations

23 Overall, primary care practitioners and stakeholders shared positive views and experiences regarding the Primary Care Engagement Programme in Greater Glasgow and Clyde. The following recommendations should inform further discussion between CRUK, NHS GGC, and other partners regarding the future of the PCE Programme:

Recommendation 1: The PCE Team maintain regular contact with practices regarding specific cancer issues or elements of support to encourage engagement. One of the first issues could be forthcoming changes to the cervical screening programme.

Recommendation 2: Engagement should be a flexible process tailored to specific issues that seeks to engage the most appropriate member(s) of a practice including GPs, and should not be limited to the Practice Managers.

Recommendation 3: The PCE Team should disseminate good practice from their work to date, particularly on impacts and issues other than bowel screening, to practices across...
Greater Glasgow and Clyde, in order to reinforce that the PCE Team can offer a wide range of support.

**Recommendation 4:** The PCE Team should consult practices across Greater Glasgow and Clyde to identify specific cancer-related issues that they would welcome future support on.

**Recommendation 5:** The Steering Group should identify actions that are necessary to embed within NHS GGC the learning from the PCE Programme to date and assign responsibility for each action to a member of the group. Progress should be closely monitored.

**Recommendation 6:** The Steering Group should co-ordinate and support the PCE Programme workplan for year three within Greater Glasgow and Clyde.

**Recommendation 7:** CRUK and the Scottish Government agree a way forward for the PCE Programme in Greater Glasgow and Clyde and the roll-out to other health boards in Scotland.

**Recommendation 8:** Wherever possible, new facilitators should possess the knowledge and skills shown to be important to date including an understanding of primary care and communication skills.
1 Introduction

1.1 Cancer Research UK and NHS Greater Glasgow and Clyde established the Primary Care Engagement (PCE) Programme in June 2014. A team of primary care cancer facilitators has worked with general practices across Greater Glasgow and Clyde to support the prevention, screening and early diagnosis of cancer. In September 2015, Cancer Research UK (CRUK) and NHS Greater Glasgow and Clyde (NHS GGC) commissioned a qualitative evaluation to explore how the PCE Team had supported and influenced primary care in Greater Glasgow and Clyde in its first year.

Background

1.2 CRUK, in partnership with the NHS, launched the Primary Care Engagement Programme in two English regions in late 2012 and it has since been rolled out to other selected regions of England and Wales. The partnership approach is designed to allow teams of facilitators to utilise both NHS and CRUK expertise and resources to ensure that the PCE Programme is relevant to local needs and able to draw on nationally developed evidence-based approaches. The overarching aim of the PCE Programme is to improve cancer outcomes by engaging with, and supporting, primary care at a local level to:
  - Raise awareness in GPs and other primary care staff of the importance of early diagnosis.
  - Support practices to learn from previous cancer cases, to adopt interventions that promote the early diagnosis of cancer and make sustainable improvements.
  - Enhance and support primary care education.
  - Improve communication between the primary and secondary care clinicians.

1.3 In 2013, CRUK partnered with the Scottish Government’s Detect Cancer Early Team to extend the PCE Programme into Scotland. NHS Boards were invited to tender for the Programme with NHS GGC emerging from the procurement process as the chosen location.

1.4 The Cabinet Secretary for Health launched the Detect Cancer Early Programme in February 2012 to improve survival for people with cancer in Scotland by diagnosing and treating the disease at an earlier stage. In 2013, the Detect Cancer Early Team launched an initiative to improve uptake of the Scottish Bowel Screening Programme; practices that delivered a reduction in the proportion of patients who did not participate in the Programme were awarded up to six Scottish Quality and Outcomes Framework (SQOF) points. The initiative operated from April 2013 until March 2015 and therefore operated alongside the PCE Programme. As part of the initiative, an additional pilot project operated in NHS GGC with 45 practices accepting the offer of an external organisation telephoning patients around their 50th birthday to encourage them to complete and return their bowel screening test kit. The PCE Programme also coincided with another Scottish Government pilot operating in Greater Glasgow and Clyde with participating practices offering storage boxes to individuals taking the bowel screening test.

1.5 The PCE Programme in Greater Glasgow and Clyde has been overseen by a multi-agency Steering Group. Membership includes a number of representatives from NHS GGC (Public Health, Primary Care Cancer Lead, and Primary Care Support including GMS Contract and Practice Nurse Support teams), as well as CRUK, the PCE Team, and Scottish Government’s
Detect Cancer Early Team. The group meets quarterly.

1.6 Three full-time members of staff - a Facilitator Manager and two Facilitators - were recruited, beginning work in June 2014. One team member was seconded to CRUK from NHS GGC. Another team member was seconded temporarily between June 2014 and November 2014 and there was a vacancy for four months before a new Facilitator joined in March 2015. The PCE Team has been line-managed by CRUK and located in NHS GGC’s Public Health Directorate. Priorities were outlined in a PCE Programme Delivery Plan 2015 and, more recently, a Breast Screening Action Plan 2015-16.

1.7 NHS GGC has 244 GP practices across eight Health and Social Care Partnership (HSCP) areas and these partnership areas have been allocated to individual facilitators. It was felt that this would support more strategic working, informed by greater understanding of the local context and trends. Each facilitator has at least one Glasgow City area and one area outwith the City, with the allocations reflecting local referral pathways or hospital catchments wherever possible. At an early stage, the PCE Team conducted a stakeholder mapping exercise and developed a communications strategy to promote general awareness of the PCE Programme amongst professional audiences (via events, forums and meetings) and greater understanding amongst GP practices (via e-mails and letters).

1.8 By the end of the first year, 95% of practices had attended at least one awareness session about the PCE Team and 43% of practices had received at least one visit from a facilitator (on average lasting 47 minutes). These meetings were attended by various members of practice staff, principally GPs, Practice Managers and receptionists/administrators but also a range of others including District Nurses, trainee GPs and medical students.

1.9 Pre- and post-visit logs are completed by the PCE Team to record and monitor their activities and following each meeting the facilitator e-mails a summary of the discussions and a list of agreed actions (for both facilitator and practice). The follow-up activities recorded include new bowel screening actions, audits/Significant Event Audits (SEA) of cancer cases, implementation of clinical decision support tools and a variety of awareness-raising, prevention, participation in different screening programmes and staff training activities.

**Study aims**

1.10 The overall aim of this evaluation was to explore how the CRUK PCE Team has supported and influenced prevention, screening and early diagnosis approaches to cancer within primary care in NHS GGC in its first year. The study brief also identified three key themes and a number of specific questions which were to be addressed by the evaluation:

- **Motivations and experience of working with the PCE Team**
  - Why did the practice decide to engage with the CRUK PCE Team and who in the practice drove this forward?
  - What are the reflections of practices who have engaged with the CRUK PCE Team? What did they find most/least helpful?

- **Added value of engaging with the CRUK PCE Team**
  - Can GP practices identify any changes in their practice approach to cancer prevention, screening and early diagnosis as a result of engaging with the CRUK PCE Team? If so, what?
  - To what extent were GP practices able to address issues relevant to their
practice as a result of engaging with the CRUK PCE Team?
- Did the practice learn anything new as a result of the CRUK PCE Team?
- What aspects of the support were most helpful to address relevant issues?
- Were there any barriers and difficulties in implementing change following the meeting?
- Any suggestions for improvement/further development of the CRUK PCE Team?
- Any other areas where the team could support practice improvement?

- **Influencing others**
  - To what extent did practices a) want to and b) have the opportunity to share learning with others within and outwith their practice?
  - How do stakeholders outwith GP practices consider the programme to have influenced approaches to cancer and partnership working within NHS Greater Glasgow and Clyde?

**Methods**

**Research design**

1.11 The evaluation was overseen by a steering group with representation from CRUK’s Health Evaluation and Research Team, NHS GGC Public Health Directorate, and the PCE Team. The group agreed the research methods, commented on draft discussion guides, supplied extensive documentation and information regarding the PCE Programme, and provided guidance throughout the study. The evaluation took the form of an in-depth qualitative research study, focusing on gathering the views and experiences of GP practices and stakeholders on their engagement with and experiences of the PCE Programme, as well as any emerging benefits. In order to answer the questions introduced above, depth interviews were required with a cross section of staff in the GP practices including (but not limited to) Practice Managers, GPs, nurses and reception or administrative staff. A key stage was the preparation (and approval by the steering group) of a semi-structured topic guide for these interviews.

**Recruitment process**

1.12 Recruiting practices for the evaluation took the following approach. The PCE Team sent out an initial e-mail to all GP practices that had engaged with the facilitators to introduce the study and inform them that the researchers would be making contact. One practice asked to be removed from the process at this stage.

1.13 The PCE Team then supplied a database containing details of 103 practices they had engaged during year 1 of the PCE Programme; the database included contact details, as well as a summary of the level of engagement and the topics covered during visits. A sample of 33 practices was selected, focusing on those that had been visited by the PCE Team in the second half of the year (in the anticipation that their recollection of the visit would be stronger) and to include a cross-section of practices from Health and Social Care Partnerships across Greater Glasgow and Clyde. All practices received an introductory e-mail from the evaluators explaining the purpose of the research and a request to participate. Additional e-mails and follow-up telephone calls were made to practices that did not respond. From this initial sample, the evaluators interviewed 12 practices; at the same time, 16 practices did not respond to e-mails and telephone calls seeking their participation. To increase involvement in the evaluation, a second sample of 32 practices was selected from this database and the same approach to recruitment was implemented.
The PCE Team’s contact with some of these practices occurred earlier in their first year of operation and this contributed to a lower response rate with five practices participating in the evaluation; 20 practices did not respond to the evaluator’s e-mails and telephone calls.

In a final attempt to increase participation in the evaluation, the PCE Team supplied a second database containing information on 39 practices visited between June and December 2015. Once practices that had contacted the PCE Team specifically about bowel screening appeals were excluded¹ this left a potential sample of 24 practices. Requests to participate in the research were made in December 2015, when practices faced additional workloads with flu vaccinations, and in early January 2016, when practices were starting to prepare for the contractual year end, and this contributed to a low response rate with only one practice taking part in the research. 15 practices did not respond to e-mails and telephone calls seeking their participation.

Recruiting practices to the evaluation was challenging. In total 51 of the 89 practices approached (57%) did not respond to e-mails and telephone calls about the evaluation. In some cases, e-mail receipts were received stating that the e-mail had been deleted without being read, and numerous voice messages were left but not returned. In total over 200 e-mails and 100 telephone calls were made during the evaluation. Fourteen practices declined to take part in the research. In most cases a reason was not given, however where it was, a lack of time was given as the main barrier to participation in the study; one practice also stated that they would not participate because there was no funding to cover their costs. In addition, six practices initially agreed to take part in the evaluation, however they either did not confirm an interview date or were unavailable at the time arranged for the interview and did not respond to requests to re-arrange.

In total 18 practices took part in the evaluation – one fifth of those invited to participate. The geographical distribution of practices invited and participating in the evaluation is shown in the table below.

<table>
<thead>
<tr>
<th>HSCP Area</th>
<th>Engaged with PCE Programme</th>
<th>Invited to participate</th>
<th>Practices interviewed</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Glasgow</td>
<td>38</td>
<td>28</td>
<td>6</td>
<td>21%</td>
</tr>
<tr>
<td>North West Glasgow</td>
<td>27</td>
<td>14</td>
<td>5</td>
<td>36%</td>
</tr>
<tr>
<td>North East Glasgow</td>
<td>24</td>
<td>12</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>11</td>
<td>7</td>
<td>2</td>
<td>29%</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>16</td>
<td>7</td>
<td>1</td>
<td>14%</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>8</td>
<td>6</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>142</strong></td>
<td><strong>89</strong></td>
<td><strong>18</strong></td>
<td><strong>20%</strong></td>
</tr>
</tbody>
</table>

Fieldwork

Fieldwork consisted of eight individual telephone interviews, and 10 face-to-face interviews (five individual, two paired and three group interviews). Overall 36 professionals took part.

¹ It was decided, in conjunction with the PCE Team, that these practices should be excluded as their meetings with the facilitators had the specific, single purpose of supporting appeals related to not meeting the practice’s target to improve uptake of the Scottish Bowel Cancer Screening Programme.
in the interviews, consisting of 15 GPs, 14 Practice Managers, five Practice Nurses, and two Administrators. Although more GPs took part in the research than any other profession, the majority did so via group discussions which were part of their regular practice meetings when time was limited. Individual/paired interviews provided the opportunity to discuss the PCE Programme in greater depth and the majority of these interviews were conducted with Practice Managers.

**Stakeholders**

1.18 The evaluation also gathered the views of nine stakeholders, identified by the study steering group, from CRUK, NHS GGC Public Health and Primary Care Development Teams, Scottish Government Detect Cancer Early Team, Scottish Bowel Screening Service, and Macmillan Cancer Support. Their views were gathered via four face-to-face and five telephone interviews using a semi-structured discussion guide agreed with the steering group. Some of the stakeholders were involved in developing NHS GGC’s bid and a number were members of the PCE Programme Steering Group. A tenth stakeholder did not respond to requests to take part in the study.

1.19 A joint interview was also conducted with the Facilitator Manager and the two Facilitators.

**Data analysis**

1.20 All interviews were transcribed and the content organised into an analytical framework, so that material could be coded, analysed and written up in this report. This took the form of a matrix with the following columns:

- Practice name.
- Partnership area.
- Role of main interviewee.
- Report section (engagement, experience or added value).
- Sub-code corresponding to the main evaluation questions and themes.
- Interview material.

1.21 The contributions made by interviewees were coded against a list of the sub-codes (text was allocated to multiple codes wherever it was able to add value to more than one theme). Information was then filtered down so that the researchers could read and assess all the material under a single sub-code, enabling judgements to be made about the overall tone of comments, common themes or areas of agreement and minority views. This process also facilitated the identification of relevant quotes able to illustrate key themes and provide a more qualitative, nuanced understanding of the views of interviewees. All analysis and written content was checked by another member of the evaluation team. An attempt was made to explore differences in experience or views by job role however this was hindered by the small number of interviewees for some roles and did not provide any conclusive findings.

**Document review**

1.22 To inform the practice and stakeholder consultation, a number of documents were reviewed at the outset of the study, including:

- Programme Logic Model.
- Programme Delivery Plan 2015.

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2 Large interviews with many people contributing were designated as ‘group interview’.
- Breast Screening Action Plan 2015-16.
- Year 1 Progress Report.
- Steering Group minutes for 2015.
- Presentations and cases studies produced by the PCE Team.

Report structure

1.23 This report is structured as follows:

- Engagement with the PCE Programme (Chapter 2) covers pre-existing knowledge, motivations, key contacts, follow-up, format of engagement, ‘branding’ and other emerging themes in relation to engagement.
- Experience of Support (Chapter 3) covers the different aspects of support, views on the PCE Team and other emerging themes in relation to provision of support.
- Added Value (Chapter 4) identified by practices and stakeholders considers benefits in relation to awareness-raising, changes in approach (and barriers to change, the development of local resources, and the sharing of learning.
- Strategic (Chapter 5) is informed mainly by stakeholder views around governance, delivery model, duplication, partnership working, strategic impacts and future direction.
- Conclusions and Recommendations (Chapter 6).
2 Engagement with the Programme

2.1 This chapter describes practices’ engagement with the PCE Programme in Greater Glasgow and Clyde. It covers their prior knowledge of the PCE Programme, motivation for initial engagement, the lead contact and driver of the initial engagement, subsequent engagement, format of engagement, and ‘branding’\(^3\). The chapter also presents and discusses a number of additional themes related to engagement which emerged during the course of the research and may assist CRUK and NHS GGC in planning the future direction of the PCE Programme in Greater Glasgow and Clyde.

Prior knowledge of the PCE Programme

2.2 Despite the PCE Team’s extensive efforts to raise awareness of the PCE Programme in its first year, most of those interviewed stated that their first experience of the Programme was an e-mail or letter from the facilitators, and very few stated they had any previous knowledge of the PCE Programme. A small number of those interviewed had seen a presentation by the PCE Team or heard about the PCE Programme at local health practitioner forums, despite information provided by the PCE Team showing that representatives from 95% of GP practices had attended at least one of the PCE Team’s awareness-raising sessions. It is possible that interviewees had not attended these events, or could not remember where they first heard about the PCE Programme, given the amount of time elapsed since the initial contact and the amount of information they receive.

Motivation for initial engagement

2.3 As stated in Chapter 1 the Primary Care Engagement Programme coincided with the Scottish Government’s Detect Cancer Early initiative to improve uptake of the Scottish Bowel Cancer Screening Programme. Early communications from the PCE Team to practices emphasised the support facilitators could provide regarding the bowel screening initiative. These circumstances led to bowel screening being identified as the main motivation for a clear majority of the practices consulted during this evaluation. More specifically, practices reported that they had engaged with the PCE Team either to explore ways of increasing uptake where participation was felt to be comparatively low, or merely to ensure that everything possible was being done.

“We wanted to make sure we were doing all we could to increase our uptake figures, that we were contacting people who don't respond in the right ways”. Practice Manager, North West Glasgow.

2.4 Some practices explicitly mentioned the Scottish Government initiative as a driver of engagement, in other cases they emphasised a more general desire to help their patients and diagnose bowel cancer as early as possible. A small number of interviewees spoke about a general interest in improving their understanding and knowledge about screening, so (all) staff could keep patients informed and answer their questions.

“Patients often call us first with questions about screening, so it is important for receptionists to know about it...[they] phone us first even if they have a direct contact number”. Practice Manager, North West Glasgow.

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\(^3\) ‘Branding’ refers to way that the PCE Programme was described or presented to GP practices. This relates to a specific query as to the likely impact of the Programme being described as a CRUK, NHS GGC or joint initiative.
2.5 Practices did not identify any other specific issues in relation to cancer prevention, screening or diagnosis as being of particular interest to them in advance of their initial meeting with the PCE Team. One GP mentioned a general desire to update themselves with the latest information tools or research studies, but even in this case this was not the primary reason for engagement - their main motivation was a desire to ensure that their patients are diagnosed as quickly as possible - but rather an added benefit.

2.6 One practice identified their status as a Section 17C practice as a factor in their engagement with the PCE Team.

“The very first meeting was just with myself as I wanted to know what she [the facilitator] could offer us. I told her what we wanted to look at as a Section 17C practice and we wanted to look at cancer and earlier detection and better care”. Practice Manager, North East Glasgow.

2.7 The PCE Team identified the Scottish Government’s bowel screening storage box pilot as a potential way to engage practices in Greater Glasgow and Clyde that had not responded to initial communications about the PCE Programme. The PCE Team was pro-active in approaching the Scottish Government’s marketing team to help promote the storage box pilot and as a means of engaging practices in the PCE Programme. The PCE Team stated that practices engaged in this manner were then given further information about the wider support available from the PCE Team. Three practices consulted during this evaluation stated they had taken part in the storage box pilot and engaged with the PCE Team.

Lead contact and driver of initial engagement

2.8 Practice Managers were generally the first point of contact for the PCE Team and in the majority of practices engagement was subsequently driven by the Practice Manager, sometimes in conjunction with other administrative staff. Mostly, the Practice Manager discussed engagement with at least one of the GPs before arranging to meet the PCE Team.

“When we receive information [like this] I check with the GPs and arrange for people to come in and speak”. Practice Manager, North West Glasgow.

2.9 In none of the practices interviewed during this evaluation, was a GP felt to have been the key person driving initial engagement with the PCE Programme. In one practice, a GP was involved in the governance of the PCE Programme and this heightened awareness, however the Practice Manager appeared to be the main driver of initial engagement. GPs were however consistently described as being receptive to working with the facilitators, and keen to find out if there was anything else the practice could be doing to increase screening uptake. There was one case where the Practice Manager arranged a meeting with the facilitator without consulting GPs.

2.10 The PCE Team has experienced some challenges in engaging primary care with some practices not taking up the offer of support. The vast majority of practices that have engaged have done so enthusiastically for the reasons given above. However, one Practice Manager reported that they had “reluctantly agreed to meet” the PCE Team to see what they could do, and that there was “no way” they could pull together a practice meeting for the initial visit because of diaries and not having a specific focus; this experience demonstrates that

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4 A ‘Section 17C’ practice has a locally negotiated agreement, enabling the flexible provision of services that address specific local circumstances.
Subsequent engagement

2.11 Interviewees were often unclear about the number of meetings attended by the PCE Team, due mainly to the time elapsed and the number of external visitors that some practices have. In around half of cases only one meeting took place with a facilitator, though others have met the PCE Team two or three times since the start of the PCE Programme; all of those interviewed who had one meeting with the PCE Team reported that all relevant issues had been addressed and they did not require another meeting at that time. Subsequent meetings tended to involve an element of ongoing support and guidance on bowel screening, though a variety of other reasons were mentioned. Examples include meetings to discuss breast screening or cervical cytology or even for a more general purpose:

“[The facilitator] came back in to do a practice event...which involved a presentation and quiz with the whole team.” Practice Manager, South Glasgow.

2.12 The PCE Team appear to have been the main instigator of these subsequent meetings following further communication with practices to highlight the availability of support with a number of additional issues. Paragraph 2.19 below addresses the linked issue of the extent to which practices understood that support was available on other cancer topics.

Format of engagement

2.13 Meetings tended to take the form of either small sessions with the Practice Manager (plus one or two colleagues such as the Practice Nurse or a GP) or group meetings with a number of clinical and administrative staff. Even in cases where the PCE Team met only one or two members of staff, those interviewed stated that learning and materials had been shared with all relevant colleagues in the practice through internal meetings and communications.

2.14 The group meetings consisted of either those arranged specifically to meet with the facilitators or existing practice meetings that were attended by a facilitator. It appears that the former were more productive, mainly as more time was available but also because members of staff had gathered to discuss a specific topic, mainly bowel screening. Practices that arranged a specific meeting with the PCE Team, reported that they regularly held special meetings to address issues such as this with two highlighting their status as either a training practice or a Section 17C practice as part of the reason they engaged and arranged a specific meeting.

“We are a training practice here so we have to be seen to be arranging clinical meetings on a regular basis. Every third or fourth clinical meeting we have a speaker of some kind, normally on some issue from the bigger agenda like cancer”. Practice Manager, South Glasgow.

“As a practice we all like to get involved. We went to Section 17C so we’ve made it one of our priorities and so we found time to meet her [the facilitator]”. Practice Manager, North East Glasgow.

2.15 Although attending existing practice meetings could be constrained by time, they were also productive.

“We had to schedule the visit at the end of a practice meeting, but once the facilitators were with the doctors they were able to get the GPs on board and show that [promoting greater bowel screening uptake] was something we could
and should be doing more of”. Practice Manager, South Glasgow.

2.16 Attendance at meetings with the PCE Team was generally described as good. On occasions it was difficult for all members of staff to attend, particularly part-time staff, even when meetings were organised outside surgery hours at lunchtimes or in the early evening. While many interviewees talked about the difficulty of finding sufficient time for meetings, there was no clear consensus on the best times of day or most appropriate formats. The facilitators have had to be flexible in scheduling meetings to meet the needs of practices and maximise attendance.

Branding

2.17 There was a mixture of views on the way the PCE Programme was branded or introduced to practices. Some interviewees - across all parts of Greater Glasgow and Clyde - stated they were unaware which organisation the facilitators were from though this may simply be a difficulty in recollecting.

“I don’t know if people are aware it’s CRUK. I didn’t know. I certainly found them very helpful and reassuring but I didn’t realise [they were part of CRUK]”. Practice Nurse, South Glasgow.

2.18 There were no particularly strong views on the respective benefits of branding the PCE Programme as a NHS GGC and CRUK initiative and none of those interviewed said it would make a difference to the way they engaged with the facilitators. A small number of interviewees stated that the involvement of CRUK provided reassurance that materials were of high quality, while others stated that the explicit NHS link made it clear the facilitators would be able to access a range of resources and contacts within the health service. In addition, a handful of others highlighted the value of a joint approach:

“It possibly comes under that umbrella that it’s more credible that it’s Cancer Research UK. I think most people know it’s part of Cancer Research UK, at least I think they do”. Practice Manager, South Glasgow.

Additional emerging themes

Understanding of the PCE Team’s remit

2.19 Most practices stated that the facilitators had outlined the breadth of support they could provide, in addition to bowel screening, during the initial visit. However, some interviewees were not clear about the additional support and we found limited awareness was an issue at some practices. Several practices only associated the PCE Team with bowel screening. For example, a GP in South Glasgow described the bowel screening initiative as “double edged sword” which gave the PCE Team a reason to approach practices and for practices to meet the Team, however it also meant this became the focus of the PCE Team’s work and may have impacted on discussions about prevention, early diagnosis, and other cancers.

“The e-mail was only about the bowel screening box pilot asking if the practice was willing to do it”. Group interview, North West Glasgow.

“Other practices may be a wee bit more welcoming, maybe they don’t have

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5 As discussed in paragraph 2.7, the PCE Team helped to promote the Scottish Government bowel screening box pilot in Greater Glasgow and Clyde and their initial communication to eligible practices was therefore only about the pilot. However, the PCE Team stated that all practices that participated were then given further information about the wider support available.
enough knowledge about what they [the facilitators] are there for”. Practice Manager, South Glasgow.

“It would be useful to know what other kinds of support are available and the help that other practices are receiving”. Practice Manager, East Dunbartonshire.

Reactive engagement to date

2.20 As described above, the main driver of initial and subsequent engagement was communication from the PCE Team offering their support with a specific cancer issue. We found very few examples of practices pro-actively engaging the PCE Team. This is a significant finding in terms of future planning as, if the current trend continues, engagement will need to be driven by the PCE Team.

“When they [the PCE Team] are on the phone I will focus on them, when they are not, I won’t”. Practice Manager, South Glasgow.

2.21 Generally, practices would be willing to engage with the PCE Team in the future but mainly on ad-hoc basis, as new priorities emerge and were raised by the PCE Team. A small number of practices reported that they would be more proactive in their engagement with the PCE Team, for example, one stated:

“We haven’t sought the facilitator out regarding any specific issues, but we would have no concern about contacting them again if there was something in the future we were needing to look at”. Practice Manager, North West Glasgow.

2.22 There were obvious incentives to engage with the PCE Team on bowel screening given the Detect Cancer Early initiative, and the absence of such a driver in the future may be a barrier to further engagement.

“This is a great resource for practices, especially those that are having more issues than we are. We will probably not engage with them very much in future, unless the government comes up with new initiatives”. Practice Manager, North West Glasgow.

Future engagement

2.23 There was no clear evidence among interviewees regarding more effective engagement than the methods employed to date by the PCE Team. Our experience suggests that e-mails tend to be more effective than telephone calls, though a combination of methods (and repeated communication attempts) will be required if the PCE Team is to maximise the level of engagement amongst GP practices. A small number of interviewees made suggestions on future engagement with the PCE Team which may help shape the planning process:

“The facilitators will have most impact when they speak to a broad selection of people...it should involve the whole practice, everyone has a role in ensuring things get done properly or remind colleagues to do things”. Practice Manager, Renfrewshire.

“Protected learning events may be a better forum for meeting the Team as they are less pressured”. Group Interview, South Glasgow.

“There will always be people who don’t engage, the facilitator should focus efforts on practices or members of the public who don’t engage, to try to understand why not”. Practice Manager, Renfrewshire.
3 Experience of Support

3.1 This chapter discusses practices’ experience of the support provided by the Primary Care Engagement Programme in Greater Glasgow and Clyde. It covers their views on the different elements of support and the tools used, as well as feedback on the PCE Team and how learning was shared by practices. The chapter also discusses issues which will be of interest to CRUK and NHS GGC in planning the future support provided by the Programme in Greater Glasgow and Clyde.

Support

Bowel screening

3.2 Practices identified bowel screening as the main area of support they received from the PCE Team, particularly during the initial meeting. The PCE Team estimated that over 90% of practice visits focused on bowel cancer screening (Source: Colorectal Referrals from Primary Care Summary Report, CRUK/NHS GGC, July 2015). Discussions around bowel screening sometimes led to more detailed discussion about issues experienced with the symptomatic referral pathway. Feedback on the PCE Team’s advice and guidance on bowel screening was overwhelmingly positive.

“It was really very enlightening, telling us information we didn’t know – we are bombarded by information that comes in, and inevitably some gets glossed over. A lot of stuff [the facilitator told us] felt like new information. It started with bowel screening but we also covered breast screening”. GP, North West Glasgow.

“The facilitator gave lots and lots of suggestions [about bowel screening]”. Group interview, East Dunbartonshire.

“[The facilitator] came out and reiterated information [heard at a PCE Team presentation] and gave the reception staff more tips and ways to get patients to engage [in bowel screening]”. Practice Manager, South Glasgow.

3.3 Discussions with the PCE Team focused on tracking patients’ participation in the screening programme so non-participation could be raised at their next visit. Discussions also focused on practical measures that practices could offer patients to encourage them to take the test, such as providing rubber gloves, tongs, or foil bowls. One practice was supported to take part in the bowel screening telephone engagement pilot described in Chapter 1.

3.4 There was also general discussion about the screening programme with the PCE Team sharing good practice from elsewhere.

“They gave us a few suggestions; told us what other surgeries were doing - which we could then share with colleagues”. Practice Manager, North West Glasgow.

“We talked about lots of ideas like sending texts through the MJog6 system, adding notes on records to remind people about screening”. GP, West Dunbartonshire.

3.5 Some interviewees stated that some of the PCE Team’s suggestions were already in place at their practice, however, they still welcomed confirmation that they were following good

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6 An IT system used by GP practices to send messages to their patients in different formats (SMS, e-mail etc.).
practice and that they were not missing something.

3.6 A small number of practices reported that the PCE Team had delivered training sessions for practice staff on the Bowel Cancer Screening Programme. Feedback on the training was positive.

3.7 As noted in paragraph 2.7 the PCE Team helped to promote the Scottish Government’s bowel screening storage box pilot as a means of engaging practices in the PCE Programme. While this was not a core aspect of the Team’s work, and is the subject of a separate evaluation, the negative experience of the pilot impacted on the way the PCE Team was perceived by one GP practice.

Other cancers

3.8 Some practices reported that bowel screening was the only area of support they requested and received from the PCE Team. Other practices noted that bowel screening had been their primary focus of the initial meeting but the visit had led to discussion on other issues and problems.

“This broadened into a more general discussion about cancer and the problems of diagnosing cancers early enough”. GP, North West Glasgow.

3.9 In addition, a number of practices had follow-up meetings that addressed other cancers such as lung, pancreatic and ovarian cancers and diagnostic issues such as cervical cytology and breast screening. This included supporting one practice to take part in a lung cancer detection study.

3.10 Actions taken by practices as a result of these discussions are covered in Chapter 4. Feedback on this support was overwhelmingly positive with practices commenting in particular on the quality of the information provided by the facilitators.

Prevention

3.11 Only a handful of practices reported discussions with the PCE Team about cancer prevention. This appears to have been a relatively small element of the PCE Team’s support and in most cases related to requests for resources, particularly leaflets. A Practice Nurse stated that patients were reading the health promotion posters and leaflets about diet, exercise, alcohol and cancer prevention supplied by the PCE Team when they were in the waiting room and were taking the leaflets away with them.

3.12 Although the PCE Team stated that they explained the breadth of their support to practices during their initial visits, and this was corroborated by many practices during this evaluation, there still appeared to be limited awareness of the PCE Team’s full remit including the availability of support on prevention.

“I did not know that prevention was within the remit”. GP, North East Glasgow.

3.13 The potential for cancer prevention to be a future focal point of programme activity is discussed in greater detail below.

Secondary care

3.14 Two practices commented that the PCE Team had been useful in taking up issues on their behalf with secondary care. At one practice in North East Glasgow, staff had raised with one of the facilitators their experience of communications from secondary care about cancer diagnosis (which they felt lacked clarity) and also issues regarding the information requested
in a referral form; one of the GP’s commented:

“It’s good that we’ve got somebody like that because it’s helps us. You can complain back every time to secondary care but you’re complaining to different consultants each time so there’s nobody there overseeing and getting a general overview of what it’s like. It’s good”. GP, North East Glasgow.

Resources and tools

3.15 To support practices, the PCE Team used a number of different cancer-related resources and tools. Three resources were developed in-house by the Team on bowel screening, breast screening and cervical cytology, and more information is provided in section 4.14. The PCE Team has also made use of other tools including:

- Prevention leaflets and resources.
- Safety netting\(^7\) checklist.
- Royal College of General Practice (RCGP) Significant Event Analysis (SEA)\(^8\).
- RCGP Audit Tool\(^9\).

3.16 One practice reported that the PCE Team had supplied a copy of the RCGP Cancer Audit template. During discussions with the PCE Team, the practice had stated they wanted to review their referrals and were looking for a tool, which led to the Team providing the RCGP audit tool. One of the GPs reported:

“We wouldn’t have known that tool was in existence”. It does have its limitations and I made that clear, but on the other hand we probably wouldn’t have found an easier way to look at it if we hadn’t had somebody to work with”.

3.17 Approximately half of practices commented on receiving tools and other materials supplied by the facilitators.

“We felt the meeting was really productive, covering much more than bowel screening. We discussed various information and screening tools and studies. For example, if you are using the Q Cancer tool and put in a local postcode and that the patient is over 70 then the system always recommends an emergency two-week referral”. GP, North West Glasgow.

3.18 Although they were positive about them on balance, interviewees were generally unable to provide specific feedback on individual leaflets, information packs, toolkits or workbooks. Two interviewees mentioned problems in relation to information tools and materials:

“It’s difficult to get the resources you want. It’s all very well saying you’ll hand out leaflets but if you’ve not got them to hand out it’s difficult....also, you can’t bombard people with information, texts and leaflets”. Practice Manager, South Glasgow.

“The stumbling block comes when it is up to our patients to do things for

\(^7\) Safety netting is a diagnostic strategy or consultation technique to ensure timely re-appraisal of a patient’s condition

\(^8\) The SEA template is specific for cancer and is designed to record and reflect upon the events surrounding a cancer diagnosis.

\(^9\) The audit template for cancer provides a method of identifying and reviewing delays in cancer diagnosis.
themselves. For example, patients always complain that information takes a lot of reading, which is a problem for some.” GP, North West Glasgow.

Other support

3.19 A small number of practices highlighted other support provided by the PCE Team.

3.20 The PCE Team arranged for a GP in North East Glasgow to shadow work at the breast screening clinic as part of their professional development. The GP wanted to enhance their understanding of the referral and diagnosis process and reported that the shadowing experience had been very beneficial. At the same practice, the PCE Team arranged an open day about cancer:

“Something else [the facilitator] helped set up, in fact she arranged it all. We did an open day in the health centre. We had breast screening, someone from prostate cancer, someone from bowel screening and they had stands out in the main foyer as you come in to the health centre, with information for patients, and the patients could approach. The GPs went out to man the stand for half an hour at a time”.

3.21 Another practice highlighted the PCE Team’s assistance in setting up a roadshow within the practice about bowel cancer screening, with the Facilitator helping to find a professional host. This ran in conjunction with advertising in the local paper and was designed to get people talking about the screening and encourage them to take the test.

“There should be more of that, there are shopping centres all over Scotland where they could set up a stand and engage with people about all types of cancer”. Practice Manager, Renfrewshire.

3.22 There were a number of instances where the facilitators contacted other organisations on behalf of practices in order to arrange specific types of support. For example, one practice mentioned that the PCE Team arranged a patient representative from Bowel Cancer UK to speak about screening from a patient’s perspective. This was felt to have been especially useful for administrative staff, helping them to understand the processes and advise patients accordingly. Other interviewees highlighted the facilitators’ role in involving Macmillan, either in the form of practice visits or as a provider of training courses for nurses and specialist advice on clinical matters and patient care.

3.23 It is important to note that the information presented above is unlikely to represent a complete picture of the support provided by the PCE Team as many interviewees struggled to recollect the support they had received. In some cases, there were differences between the outputs recorded in the PCE Programme database and the recollections of interviewees, with the time elapsed since the PCE Team’s visit likely to have been a contributory factor.

Primary Care Engagement Team

3.24 In general, interviewees were very complimentary about the support provided by the PCE Team and the facilitators themselves. The discussions were described as informative and comprehensive and some were pleased that discussions had been positive and upbeat which was seen as important when dealing with this topic. The PCE Team members were frequently described as knowledgeable, helpful and easy to work with and they were commended for their understanding of relevant information, research and the availability of tools and leaflets:
“The Facilitator was absolutely great...she knew what she was on about”. Practice Manager, South Glasgow.

“She was clearly knowledgeable, came across well and managed questions from the GPs well.” Practice Manager, North West Glasgow.

“They are a very motivated team, who are passionate about everything they do. They are trying very hard to make a change and are willing to help in whatever way they can”. Practice Nurse, South Glasgow.

“We were very happy with the way they worked and think we have had a very good service”. Practice Manager, North West Glasgow.

3.25 A Practice Manager in South Glasgow stated that the PCE Team’s previous experience of primary care had been beneficial and made the following comment (there were no comments on this issue from other interviewees):

“If you don’t understand how general practice works then you’ll never understand what we do or how we do it and that is something that impressed me very much [about the facilitator]”.

3.26 It was apparent that facilitators adopted a flexible approach and were not prescriptive with their advice and suggestions, allowing practices to pick and choose the ideas they felt were most relevant and potentially useful for their practice and patients. They also adjusted their delivery methods to fit in with the time made available to them by practices.

“What the Facilitator did was exactly what we wanted and better than we imagined. The Facilitator gave lots and lots of suggestions and we could choose what we thought would be best for our practice”. Group interview, East Dunbartonshire.

3.27 The facilitators were also complimented on their communications. This included getting back to practices with additional information, tools or resources, as well as following up on questions and queries about other NHS services particularly screening centres and secondary care providers.

“She has a good way of feeding back as well, passing on concerns or questions. She was very keen to hear any queries we had about secondary care”. Group interview, North West Glasgow.

3.28 In a few cases, expectations were apparently quite low, suggesting some primary care staff had limited knowledge about the PCE Team or had not had time to digest any information supplied by the Team in advance of the meeting.

“The GPs said it was better than they thought it would be”. Practice Manager, North West Glasgow.

**Sharing learning by practices**

**Internally**

3.29 Interviewees who had met the PCE Team reported that they had shared the information with colleagues who had not been at the meetings. Mainly this took the form of Practice Managers sharing information with administrative staff about procedures for recording participation in the bowel screening programme. It also involved those who met the PCE Team feeding back at practice meetings.
“We used the information to feedback at a practice meeting and a staff meeting to show people what we were doing and that everyone has a role to play”. Practice Manager, East Dunbartonshire.

3.30 Aside from the above, there was limited sharing of information with GPs who did not meet the PCE Team. This, combined with the challenges experienced by the PCE Team in engaging GPs directly, may limit the PCE Programme’s overall engagement with GPs and this is an issue that CRUK and NHS GGC may wish to consider in greater detail.

Externally

3.31 None of the interviewees stated that they had shared information and lessons learned from their engagement with colleagues or other health professionals outwith their practice.

3.32 The PCE Team was responsible for sharing learning among practices and this is discussed in Chapter 4.

Future support

Prevention

3.33 A number of practices discussed focusing future support from the PCE Team on cancer prevention. Some of the comments suggest that this could be challenging, despite the obvious benefits. Some practices suggest they are already aware of prevention and are addressing it, while others stated that wider health promotion or awareness-raising activities was not “part of the contract”.

“As a practice prevention would be our next stage but how would you do that?”. GP, North East Glasgow.

“People know their doctor, and if their doctor tells them to do something, nine times out of ten they will do it”. Practice Manager, Renfrewshire.

3.34 A GP also commented that practices tend not to be in regular contact with the majority of their patients limiting the potential reach of preventative work.

“10% of our patients account for 90% of the work”. GP, West Dunbartonshire.

3.35 There was a suggestion that Practice Nurses might be an important target group for advice and support connected with cancer prevention, as they do more health promotion work than GPs and regularly provide patients with advice on healthy lifestyles.

“The facilitators might be able to help refresh things and give them some new ideas, as nurses find this quite repetitive. Plus, they tend to see the same, often elderly, patients over and over again so any way of encouraging patients to talk more about their lifestyle would be useful”. Group interview, West Dunbartonshire.

Other future support needs

3.36 It was striking how few suggestions practices made with regard to future support needs and this aligns with the finding in the previous chapter that practices do not appear to be very proactive in their engagement with the PCE Team. In most cases, interviewees had to be pressed on the additional issues they might like to discuss or the types of support they would most appreciate from the PCE Team in the future. Often practices suggested it was enough for the facilitators to motivate and encourage them in the future with topical cancer-related issues.
“I think GP education from good quality sources is the way forward, rather than SIGN\textsuperscript{10} or NICE sending round a wee booklet”. GP, North West Glasgow.

3.37 One issue that was mentioned more than any other - although still by only four practices - was support around planned changes to the cervical screening programme. In addition, three practices mentioned that they would appreciate more hands-on administrative support such as making telephone calls, sending letters, and supporting communication work, if it were available.

3.38 In addition, the following suggestions were made regarding specific types of support:

- Training or awareness sessions on less common cancers.
- Advice on earlier detection and balancing this with the risk of over-testing or over-diagnosis.
- Developing patient-centred care, for example single points of contact.
- Updating advice for GPs and nurses on healthy lifestyles.
- Exploring ways to include GP perspectives in new clinical guidelines.

\textsuperscript{10} Scottish Intercollegiate Guidelines Network.
4 Added Value

4.1 This chapter focuses on the added value of the Primary Care Engagement Programme in Greater Glasgow and Clyde identified by practices and stakeholders. It covers awareness raising, changes in approach as a result of engaging with the PCE Team (and barriers to implementing change), the development of local resources, and sharing of good practice.

Awareness raising – catalysts for change

4.2 Added value resulting from the support provided by the PCE Team was most evident in awareness of issues, approaches and tools. There was a general feeling that the facilitators have provided a helpful framework, fresh ideas and impetus, encouraging practice staff at all levels to do what they could and sharing good practice. A number of practices found discussions around the Scottish Bowel Screening Programme particularly useful in raising awareness of specific issues. For example, one Practice Manager noted that she had learnt that replacement bowel screening kits had to be ordered through the Scottish Bowel Screening Centre, commenting “before that I wouldn’t have known”.

4.3 CRUK describe the Primary Care Engagement Team’s role as catalysts for change. They do not seek to engage practices in order to work directly and intensively with them, their role is to advise, inform, guide and support practices. The experience of practices supported in Greater Glasgow and Clyde shows that they have successfully delivered this awareness raising/facilitation role. A number of practices reported that meetings provided a concrete reason for staff to get together and think about issues and problems related to cancer, something they suggested that does not happen enough in primary care given the workload and time pressures. Some practices also noted that even where ideas for improvement came from practice staff, the process of talking through issues with an external person played an important role.

“The facilitation was helpful, it certainly was helpful to get together and share our thoughts on how to improve things”. GP, West Dunbartonshire.

“Having someone external who can tell us about the issues affecting other practices in deprived areas is helpful”. GP, North West Glasgow.

“It maybe reinforced the fact that it was good practice for us to keep doing it. Sometimes you have a list of folk who haven’t attended and you could quite easily let that slide but the fact she [the facilitator] came and told us it was good what we were doing reinforced it and stick with doing it and sometimes a month or two later you get a result in for them”. Practice Nurse, South Glasgow.

“We were at a bit of a stalemate, engaging with the facilitator really freshened things up and inspired us to do more”. Practice Manager, East Dunbartonshire.

Changes in approach

4.4 There was limited evidence presented by practices on changes in approaches introduced following support from the PCE Team. This limited attribution could be a reflection of the PCE Team’s role as facilitators providing advice, support and tools that practices were subsequently responsible for implementing, as well as interviewees’ difficulty in recollecting specific details of the support provided. The changes reported are summarised below.
Bowel screening

4.5 As discussed in previous chapters, bowel screening was the main driver for engagement with the PCE Team and the primary focus of their support. Practices sought advice from the PCE Team to increase uptake in bowel screening, and some did report that they had started to offer patients gloves, tongs or foil bowls to encourage them to take the test. The PCE Team also discussed recording and tracking participation in the screening programme including the provision of appropriate READ codes and there were some examples of this leading to changes. For example:

- A GP in South Glasgow stated that as a result of the administrative changes, bowel screening was “more in the front of my mind when speaking to patients”. The coding in patients’ notes meant that staff were more aware of the screening programme than they would otherwise have been.
- Another practice, also in South Glasgow, reported that they had set up an alert for reception staff which identified when patients had not responded to a recall for screening and the reception staff were being proactive in raising this with patients at appropriate times either in person or on the phone.
- A Practice Nurse in North East Glasgow stated they were “now more proactive about encouraging patients to participate in the bowel cancer screening programme”.

4.6 At most other practices, while they welcomed the advice provided, it was suggested that they were already contacting or reminding non-responders in a number of different ways, and this was not directly attributed to meeting with the facilitators.

4.7 Some practices supported by the PCE Team reported that participation in bowel screening had increased significantly although this was not strongly attributed to input from the PCE Team, for example, a Practice Manager in South Glasgow commented “I think we might have met it anyway”. One practice in North East Glasgow which had seen a significant increase in screening uptake, and reported a very positive meeting with the PCE Team, suggested that the increase “probably did stem from them (the PCE Team)”. Other practices reported more modest increases, or even small decreases, in uptake of the screening programme however they did not attribute this at all to the support provided by the PCE Team. Generally, practices stated that the biggest issue was patients’ reluctance to take the test for a variety of reasons rather than a perception that the advice given by facilitators was inappropriate.

“The biggest barrier is the test, people just don’t want to think about it or do it”. Practice Manager, North East Glasgow.

“We have patients, mostly men, who’ll say to the reception staff: I’m no’ doin’ that, hen”. Practice Manager, South Glasgow.

4.8 There are likely to be ongoing benefits as new procedures are still in place (in most, if not all cases) and information tools are still being used by practices and circulated to patients.

“While the money for increasing screening uptake is no longer available we have kept the new procedures in place”. Practice Manager, North West Glasgow.

Other areas of changes in approach

4.9 Change was reported by a small number of practices in topics other than bowel screening. For example, one of the facilitators signposted a practice to material on lung cancer after it
was raised during their meeting and there has been a subsequent increase in referrals, and lung cancer detections:

“As a result of using various tools and courses we are more likely to order chest x-rays and have probably picked up more cancers from that. This year we’ve had around nine cases of lung cancer, including four lobectomies which is great, especially considering we’ve only had two lobectomies in the previous ten years”.
GP, North West Glasgow.

4.10 Another practice was interested in diagnosing cancer and making appropriate referrals to secondary care and one of the facilitators:

“talked about the Early Intervention Referral Guidelines...which has probably led to more referrals.” Group interview, South Glasgow.

4.11 Some of the meetings included detailed clinical discussions of problems that can complicate cancer diagnosis. The interviewees were keen to detect cancer in their patients as early as possible, but they also wanted to avoid over-diagnosis or potential over-treatment and did not want be at the risk of ‘swamping’ cancer clinics/diagnostic services with large numbers of unnecessary referrals.

“...for a patient with a cough, the chest x-ray can come back normal, it is only when the cough comes back that problems will be picked up.” GP, West Dunbartonshire.

“It is sometimes difficult to pick up cancer where patients have other health and social problems but these are the vicissitudes of working in primary care. It is difficult to balance all this with the need to minimise over-testing, over-diagnosing”. GP, West Dunbartonshire.

Barriers to change

4.12 There were no examples of any specific changes that have not yet been implemented. However, discussions with practices illustrated that limited time and resources were the main barriers to implementation identified by interviewees:

“We know the facilitator is able to help us with audits and has some resources available. We haven’t got round to it yet, but will do if and when we have time”. GP, North West Glasgow.

“There was lots of good information. We haven’t used all of it yet. There’s probably more things we could go back through to be honest”. GP, North East Glasgow.

“An issue will become pressing so we look at it in some more detail but then the spotlight moves on to something else...in general practice we struggle to do everything”. GP, West Dunbartonshire.

4.13 A small number of practices stated that they were unwilling to implement significant changes without incentives or clear evidence that it would lead to improved outcomes. For example, one commented:

“We will only make changes if we are sure outcomes for patients would improve or it would bring in additional income to the practice that would allow us to do other things”. Practice Manager, West Dunbartonshire.
Developing local resources

4.14 Informed by the PCE Team’s experience of engaging primary care in Greater Glasgow and Clyde, the Team has developed the following in-house resources to share learning and good practice among primary care practitioners across the area:

- Bowel screening workbook.
- Breast screening GP Pack.
- Cervical cytology toolkit (draft).

4.15 Of these resources, the bowel screening workbook is the only one that has been shared widely with GP Practices to date. Feedback on workbook was limited to the following comment.

“The workbook was very useful, the facilitator went through it at the meeting”. Practice Manager, East Dunbartonshire

4.16 The development of the tools was also commended by stakeholders. One stated how the bowel screening workbook is being used by the PCE Programme in England:

“The bowel screening toolkit has been revised and used by CRUK in England. It started as something quite small in Glasgow and has become a big tool in Scotland and England”.

4.17 Another stakeholder stated that development of the breast screening protocol and toolkits “just would not have happened without them [the PCE Team]...they added a momentum”. The PCE Team’s involvement in a NHS GGC group to improve uptake of cervical cytology which developed the toolkit was described as:

“outstandingly helpful. They have made themselves available and brought their knowledge and experience to the group. They have helped turn a very small idea of a small learning event into something bigger and we will end up with something - a toolkit and in-house training material - that will be much, much more helpful for practices and will be practical for them to use. The Team brought their experience and stories, making it real, as well as experience in the production of reports and infographics which they know make things more engaging for practices. The other thing they’ve brought to the group is their links to other parts of the structure and linking in to other steering groups. This will be a much better quality piece of work than had they not been involved”.

4.18 One stakeholder commented positively on the possible impact:

“The referral guidance and the direct work with particular practices and particular tumour sites will undoubtedly have improved referral processes and probably reduced inappropriate referrals and increased the identification of the need for referral which can only be a good thing. I’d like to see more of that, refining that referral and entry point”.

4.19 The Team specifically contacted practices that had low defaulter rates during the development of the bowel and cervical resources. The facilitators conducted semi-structured interviews with practice staff to identify what was working well in the practice. A Practice Nurse talked about she had shared her experience with the PCE Team including experiences of screening transgender patients and patients with learning disabilities, as well as broader issues such as female genital mutilation.
Sharing good practice by the PCE Team

4.20 The PCE Team has also developed case studies and presentations to share good practice. The case studies focus on practices that had successfully engaged with the PCE Team showcasing the nature of the support and subsequent outcomes. For example, a case study of a GP surgery in East Dunbartonshire addressed issues around bowel screening patient engagement and skin cancer referrals, the PCE Team supported the practice by providing copies of the RCGP SEA tool and the bowel screening workbook, signposted them to Doctors.net skin cancer module, and delivered staff awareness training on bowel screening. It was reported in the case study this led to improved staff confidence in discussing bowel screening, contributed to a reduction in the practice’s bowel screening non-participation rate, and enabled the practice to apply the lessons to their cervical screening work.

“[The materials are] visual, current and fresh”. Practice Nurse, South Glasgow.

4.21 The PCE Team has also developed a selection of topic specific sessions and workshops for primary care staff covering issues such as cancer decision support tools, cancer audits and SEAs, safety netting, and cancer prevention. The PCE Team also presented at bowel screening learning sessions in May 2015 for primary care practitioners. A Practice Nurse who attended described it as “very thorough”.

“[The facilitator] was very good and we have benefitted from her learning from other practices”. GP, South Glasgow.

4.22 In addition to the above resources, interviewees reported an interest in receiving additional information from the PCE Team about what other practices were doing, how they deal with specific issues or the lessons that have been learnt from difficult cases, and what outcomes have been achieved.

“It is nice to know what other people are doing and anything that helps to get our patients diagnosed as early as possible is fantastic”. GP, North West Glasgow.

4.23 Stakeholders also commented positively on the PCE Team’s role in sharing good practice.

“A big impact has been in helping to promulgate good practice – it’s not just about saying this is best practice, it’s also about asking the GP practices the questions about what’s not working or what problems they have and looking at solutions that fit that practice and its demographics. It’s not a one size fits all Programme. The basis of the model is developing relationships”.

“It’s assuring for practices that have been working together for a very long time, they don’t necessarily discuss these issues anymore and probably don’t tell each other how well they are doing any more. There is an important role for support practices to assure practices they are doing well, when they are”.

4.24 One stakeholder stated that the PCE Team has been able to pass on their experience of engaging primary care. They highlighted the example of how some practices had informed the team they were unaware that specific SIGN Guidance notes had been revised, and this had been fed back to the Scottish Government.
5 Strategic

5.1 This chapter focuses on strategic issues including governance, delivery model, the initial focus on bowel screening, barriers to engagement, duplication, partnership working, strategic impacts, and PCE Programme future. The findings are primarily based on the stakeholder interviews.

Governance

5.2 The multi-agency PCE Programme Steering Group has overseen the initiative; it consists of members from NHS GGC, CRUK, and the Scottish Government Detect Cancer Early Team. Steering Group members consulted during this evaluation were of the opinion that the group’s membership was appropriate with representation from all relevant agencies; one member described the group as having “a good mix” and another stated there were no obvious gaps in representation.

5.3 Overall, the PCE Programme Steering Group members consulted during this evaluation were satisfied with the operation of the group which had provided adequate direction and decisions when required. It was reported that the group had focused on operational and NHS GGC issues during the first year of the PCE Programme. This was mainly seen as a positive feature as it ensured that the PCE Programme was well integrated with NHS GGC services, particularly those delivered by the Public Health and Primary Care Development teams, as well as with NHS GGC’s broader governance structures. CRUK noted that the arrangements had led to greater integration into primary care/public health in Greater Glasgow and Clyde than in some of the PCE Programme areas in England and Wales and there were governance lessons that could potentially be applied elsewhere in the future. Some interviewees highlighted that the Steering Group’s initial focus on integration ensured that the PCE Programme avoided duplication with other services:

“Members of the Steering Group understood the facilitators role and this meant it was integrated and avoided duplication. Anyone with a remit of working with General Practices was round the table”.

“Initially it was more about operational issues with an emphasis on avoiding duplication and providing value for money. This is not a negative, it worked well”.

“The worry was that the facilitators would be followed into practices later by health improvement staff and others. However, the Steering Group has helped minimise this”.

5.4 Although the Steering Group’s initial focus on NHS GGC and operational issues was mainly viewed positively by its members, there were also some other comments. One interviewee stated that this focus meant the Steering Group “didn’t feel very dynamic”, another suggested it was (initially) overly focused on integration within the health board and was “GGC-centric”, and there were a number of comments that it had provided limited steer to the PCE Team and had not focused on more strategic issues. Comments included:

“Because it was so integrated into Greater Glasgow and Clyde Health Board, it became a little too much about integration with other services, with a focus not just on the Primary Care Engagement Programme”.

“It took a while to bed in. It was very GGC focused for a while. It was very much
about their needs but it’s starting to get there now”.

5.5 There was a consensus that the Steering Group was becoming more strategic and there had, for example, been recent discussions about the future of the PCE Programme and applying the lessons to other health issues in Greater Glasgow and Clyde. However, some of the members felt that further discussion and action was required to ensure the lessons were applied elsewhere, for example to the support and guidance provided to practices around chronic disease management and specific diseases such as diabetes and chronic obstructive pulmonary disease. Relevant comments included:

“The learning needs to go somewhere and it needs to be applicable to the whole system”.

“There are lessons in terms of how the Team has worked that can be applied to others with primary care engagement roles. One of the things the Board hasn’t done very well yet is lift some of the learning and apply it to other topics or programmes”.

5.6 Some of the Steering Group members consulted during this evaluation highlighted changes to CRUK’s internal structures, roles, and contacts for the PCE Programme. They suggested these changes were, at times, “confusing” and “challenging”. There were also some comments regarding communications from CRUK, which were described as occasionally inconsistent or requiring clarification.

Delivery model

5.7 There was a consensus among stakeholders that the PCE Programme’s delivery model was an appropriate and effective means of engaging primary care practitioners in Greater Glasgow and Clyde. They identified the number of practices the PCE Team had engaged with, the development and distribution of a number of tools, and the positive feedback received from the practices as evidence of the effectiveness of the approach. Having dedicated time among the PCE Team to engage practices was seen as key and a number of stakeholders suggested that without the PCE Team, NHS GGC would not have been able to engage practices at the level achieved. Generally, there was a recognition that NHS GGC had benefitted greatly from the PCE Programme.

5.8 Chapter 3 reported practices’ positive views about the PCE Team. The Team was also very well regarded by all stakeholders, for example, one commented “as a team they’ve functioned really well”, another stated “everyone in the Team is personable and pleasant which really helps engage practices” and more than one stakeholder commented on the “dependability” or “can do” attitude of the team members. Stakeholders also commented on the PCE Team’s flexibility to support practices in a way that fitted with their needs and availability.

“The Team is very flexible, they are aware of the pressures on primary care. They help those who want help and do not put pressure on those who don’t”.

“The speed with which the Team has really got to grips with the cancer agenda - which is ‘noisy’ with partners, workstreams, programmes, groups, regionally, locally and at government level - they have caught on to it very quickly. The Manager has really steered them through that and helped them to focus”.

5.9 A number of stakeholders stated that seconding staff from NHS GGC had helped provide an understanding of the local context, as well as relationships and links with practices and
colleagues in NHS GGC. One stakeholder suggested it would have been “very challenging” to deliver the PCE Programme if secondments had not been used, adding that “it definitely worked for NHS GGC”. Stakeholders commented that the PCE Team had linked and communicated very well with NHS GGC’s Primary Care and Public Health Teams, for example, one interviewee commented that a member of the PCE Team “had made a significant effort to keep in contact” with the Primary Care Development Team. Stakeholders stated that locating the PCE Team in NHS GGC’s Public Health Directorate and seconding staff had helped in this regard, as illustrated by the following comment.

“The Programme has definitely capitalised on the knowledge the Team brought themselves as individuals but also their proximity to the Health Improvement Team”.

5.10 An understanding of primary care was also seen as a key attribute as demonstrated by the following comment:

“The critical bit is the knowledge of primary care and how it works because then you can align the topic (cancer) and the context in which it happens. One of the criticisms of other initiatives is that people don’t understand primary care and that creates all sorts of issues”.

5.11 In addition, CRUK’s involvement was also seen as crucial with stakeholders commenting:

“CRUK gives it a badge that says we’re serious about cancer and that legitimises the Team’s role”.

“The branding is positive and the access that they have to quality materials is also important”.

Initial focus on bowel screening

5.12 The PCE Team’s initial support on bowel screening was reported on in Chapter 2 and 3, and stakeholders viewed this positively. Approaches made by the PCE Team to practices which coincided with the Scottish Bowel Screening Programme were seen as providing the opportunity for the Team to offer support on a “tangible issue rather than just saying we’d like to talk to you about cancer” and it also gave practices a reason to accept the PCE Team’s offer. Noteworthy comments included:

“It was opportunistic timing for the Programme which was of real benefit in terms of engaging practices. It was really beneficial timing which meant they had more of an open door”.

“There were probably some practices that the Team wouldn’t have got in the door with if it hadn’t been for the bowel screening”.

5.13 A number of stakeholders suggested the link to bowel screening helped to raise awareness of the PCE Team and had built relationships with practices which could be capitalised on in the future. However, there were some comments that the focus on bowel screening may have led some practices to associate the PCE Team’s support only with bowel screening and they may be unaware of their wider remit on other cancers and other elements of support such as prevention and early diagnosis. One stakeholder suggested the PCE Team should seek to counter such perceptions among practices by:

“Communicating that bowel screening [specifically the incorporation of incentives for increasing uptake in the GP Contract] is coming to an end, but it’s
been very successful and what the Team can now do is help to engage with you again around a wider cancer agenda including changes to cervical cytology etc. There’s a raft of areas where they can usefully still be engaging”.

5.14 There was an acceptance among stakeholders that demonstrating a direct impact on bowel screening uptake was not possible at this stage of the PCE Programme. Most stakeholders also suggested it may be unlikely that a direct impact on bowel screening uptake will be evident in the future because the situation was complex and involved a number of additional factors. One stakeholder stated that the bowel screening initiative had shown that linking activities and outcomes to additional funding had produced the desired focus among general practices:

“The contract appears to be what drives engagement – if they get remunerated is what is important to them”.

5.15 Whilst acknowledging the initial focus on bowel screening, stakeholders stressed that the PCE Team’s value was not confined to this topic with direct support to practices on other cancers such as breast and cervical, as well as other significant benefits such as the development of local resources and the sharing of good practice.

Barriers to engagement

5.16 The barriers encountered by the PCE Team in engaging practices related to systemic or strategic issues rather than programme-specific issues in the opinion of one stakeholder:

“Some of it is around the dynamics of the practice and what filters through the Practice Manager. Some Practice Managers will take it to a meeting, others will close it off at point of contact....they are acting as judge and jury”.

5.17 Another stakeholder identified a number of issues that they believed had been barriers to practices engaging with the PCE Team:

“Extreme pressures that practices are under with issues around workload, difficulty getting locums, and difficulty replacing Practice Nurses and GPs. The other side of it is general world-weariness of pilots that you just get used to and they are taken away...they are a real challenge.”

5.18 One stakeholder commented on the limited number of practices that had taken up support from the PCE Team around Significant Event Audits (SEA). This stakeholder suggested that limited time within practices to conduct a SEA may have been an issue, as well as the sensitivities around a process which “potentially puts a practice in quite a vulnerable position by admitting they may have got something wrong”. The stakeholder went on to comment that the PCE Team had however listened to practices’ concerns and come up with solutions such as shadowing in clinical settings and training.

Duplication

5.19 A small number of stakeholders raised the possibility that there could, in theory, be some duplication between delivery of the PCE Programme and the Macmillan GP service. When expressing these views, they stressed they were speaking hypothetically and were unaware of any duplication occurring in practice. Their concerns stemmed from the perceived relationship between the two charities, for example one stakeholder suggested there was “a little tension between Macmillan and CRUK” and another suggested “there was a degree of competitiveness between different charities operating in the same area”. Generally,
stakeholders viewed the two initiatives as complementary with some highlighting key differences between the two such as the additional resources available to the CRUK PCE Team, delivery by a GP for the Macmillan service, and a different focus to the guidance provided by the two organisations. Discussions with the PCE Team and the Macmillan GP demonstrated that links have been established between the two to try to ensure duplication is minimised, and this has included joint visits to practices, shadowing, and sharing of information. Two stakeholders were of the opinion that any duplication between the PCE Team and the Macmillan GP would not be a problem as long as the messages were consistent with one stating “there’s so much work to do with practices, the more hands the better”.

5.20 A small number of stakeholders were concerned about the number of time-limited initiatives operating in Glasgow that sought to engage primary care regarding specific issues such as diabetes, and chest, stroke and heart, as well as the PCE and Macmillan Programmes. Their concerns focused on the demands it created on primary care time, the degree of coordination between them, and the sustainability of the initiatives.

Partnership working

5.21 Stakeholders stated that strong partnership working was apparent throughout the PCE Programme and this was evident in the establishment of new relationships and the strengthening of existing relationships.

5.22 Strong relationships were established between CRUK and NHS GGC, and between CRUK and the Scottish Government Detect Cancer Early team. Stakeholders stated that the two main partners, CRUK and NHS GGC, had worked well together and appreciated each other’s position. Stakeholders also noted that the PCE Team had worked well with other teams and initiatives including the Improving Cancer Journey Team, and linked into national structures such as Scottish Cancer Prevention Network. In addition, it was reported there had been a strengthening of existing relationships between NHS GGC and the Scottish Government Detect Cancer Early Team, and NHS GGC and the Scottish Bowel Screening Centre. One stakeholder also suggested that the PCE Programme had “brought public health and primary care individuals together” within NHS GGC.

Strategic impacts

5.23 Stakeholders identified a number of strategic impacts.

Application in Scotland

5.24 Both CRUK and the Scottish Government Detect Cancer Early Team were satisfied with the PCE Programme’s application in Scotland for the first time. CRUK noted that the positive experience had demonstrated that the PCE Programme could be applied in Scotland with appropriate modifications to fit the different policy context. One stakeholder commented:

“NHS GGC has adapted to working with a programme that originated in England. Some of the tools were just not applicable but have been adapted and they’ve said if things aren’t applicable. Initially, maybe, there was a lack of understanding about how things are different in Scotland. If it wasn’t for the Greater Glasgow and Clyde Team, CRUK would have continued to do what works in England in Scotland. The team has helped the programme, and CRUK, become more relevant in Scotland”.

5.25 Stakeholders stated that the PCE Team had successfully raised awareness of bowel screening
and more generally primary care’s role in the early diagnosis of cancer, and had developed a number of useful tools. For example, one stakeholder commented:

“SQOF has been a big chunk of their work, but actually to get in underneath that a little bit, what they added that wasn’t there before was a clarity really, the ability to sit down and analyse where each of the practices are at, in terms of their screening uptake and the like, and just engage face-to-face has been really useful for the practices as well as the Health Board to understand what is going on out there. The Team as a whole having that insight, that 360 view of all the practices across the board, has really informed some of the more successful pieces of their work which have been about looking at where the gaps are, recognising where we need to think a bit differently, and applying the evidence base in a more systematic way”.

5.26 The same stakeholder was able to provide an example of the way this has been effective:

“The breast screening protocol is a good example of that and some of the workbooks, they’ve been real tangibles, they’re simple, easily understandable tools. Hosting the Team within Public Health was really important. I don’t think those things would have come to fruition had the Team been hosted in a different setting within the Board”.

Primary / Secondary care interface

5.27 As highlighted in Chapter 3, the PCE Team supported some practices on specific issues they had with secondary care. As well as the direct support to these practices, the PCE Team had a more strategic impact by collating primary care experiences and taking up issues on behalf of primary care practitioners across Greater Glasgow and Clyde around relationships and communication with secondary care as demonstrated by the following examples.

5.28 The PCE Team produced the report ‘Colorectal Referrals from Primary Care’ in July 2015 which outlined a number of issues from both primary care and secondary care perspectives, as well as putting forward potential actions to improve the situation. This led to a GP learning session in North East Glasgow, a review of the existing referral form, a review of options to include priority status as part of referral, and proposals to improve ongoing communication between primary and secondary care. The PCE Team also produced a summary report about primary care referrals to the Genetics Service which again outlined both primary and secondary care perspectives and possible solutions. The PCE Team’s integration in governance arrangements at a local and regional level enabled these messages to be relayed appropriately - the colorectal referral issues were raised via NHSGGC’s Bowel Screening Steering Group meeting and the genetics issue was raised via membership of West of Scotland Primary Care Cancer Network Group.

5.29 A number of stakeholders commented positively on the PCE Team’s advocacy role in raising issues around primary and secondary care relationships and communications within NHS GGC. One stakeholder suggested the PCE Team’s impact in this area had been because “they can act as the go between to link the two and show things from each other’s perspective”, another stakeholder emphasised the importance of this impact on a longstanding and challenging issue stating that it “shows GPs have confidence in the Team”.

5.30 Although improved communication between the primary and secondary care clinicians is one of the PCE Programme’s core aims, stakeholders in Greater Glasgow and Clyde
emphasised this as a particularly significant impact. This was seen as an important issue which could be an increasing focus of the team’s work in the future.

**PCE Programme future**

5.31 There was widespread support among stakeholders for the continuation of the PCE Programme in Greater Glasgow and Clyde although there was a recognition that this was very much dependent on funding. There were calls for CRUK, and the Scottish Government, to clarify their future plans as soon as possible to enable planning, or if necessary, an exit strategy. Generally, stakeholders were of the view that NHS GGC would not be able to fund a continuation of the PCE Programme.

5.32 If funding is secured, there was a consensus among stakeholders that the overall approach in Greater Glasgow and Clyde – of facilitators engaging primary care – should continue although there were some suggestions regarding future priorities. A number of stakeholders suggested that the PCE Programme could include a greater focus on prevention, particularly as the Scottish Government is launching new cancer plan in 2016 with prevention expected to be a significant element. There was a recognition that focusing on prevention could increase the likelihood of duplication and would therefore need to be co-ordinated with ongoing public health initiatives. Other stakeholders suggested general practices may not engage in preventative work because they “already did it” however some of these stakeholders suggested that practices may raise some issues such as smoking and alcohol consumption but find others such as employment and debt much more difficult to address. The PCE Team may therefore have a role in supporting practices on ways of addressing these issues. There was a recognition that some of the prevention agenda would be less relevant to CRUK, with one stakeholder stating “it would not just be about cancer then, it stops being niche and becomes mainstream”. There was a suggestion that the PCE Programme Steering Group could in time become part of NHS GGC’s Health Improvement structures and cease to meet as a separate entity. As the PCE Team’s work increases in prevention and other cancers, stakeholders stated that reporting to other relevant groups would need to be formalised.

5.33 Stakeholders acknowledged that the ending of the bowel screening initiative was an opportunity to focus on a broad range of cancers. One stakeholder suggested this could include neurological cancers which have seen a significant increase in referrals without a significant increase in diagnosis. Another stakeholder noted that the use of a tangible issue or hook may help with future engagement in the same way that bowel screening had so far, and suggested that plans to re-run an audit to capture information on urgent referrals for cancer may provide such an opportunity:

“If the Team can move the focus away from bowel screening onto the wider cancer agenda, then hopefully they get embedded in the system in much the same way as the child protection unit at Yorkhill has become embedded. And people clearly see the value in contacting them for training and protected learning events, seeing them as a resource”.

5.34 There was also strong support for the PCE Team to continue to focus on primary/secondary care relationships, with some stakeholders suggesting this should be the main focus in the future. More specifically, stakeholders discussed how the PCE Team could act as the interface between primary and secondary care to improve the cancer pathway and the support provided throughout the pathway, as well as undertake further work on referral
guidelines, and access to radiology. A small number of stakeholders stated that a future focus on the primary/secondary care relationship may have implications for the membership of the PCE Programme Steering Group (with new members from acute services required for example) and the other groups it links or reports to.

5.35 One stakeholder questioned whether Public Health would continue to be the most appropriate ‘host’ for the PCE Team:

“I’m not sure Public Health is still going to be the right home for the Programme. There are reviews of public health nationally and locally, and bigger questions about how public health can influence practices. This is an important issue as there are key drivers upcoming with Health and Social Care Partnerships and GP contracts”

5.36 There was a suggestion that the number of practices per facilitator may increase in the future and if this occurred the PCE Team would need to adjust accordingly. More broadly, two interviewees were concerned about the sustainability of the model and made the following comments:

“Ideally you’d want to seed the process and then hope that practices will ultimately pick it up and run with it, but that’s variable, training practices might”.

“The model is one we’ve had in the past and it has delivered. However, as soon as it stops the issues get parked and there is no drive to address them”.

5.37 There was also support for the roll-out of the PCE Programme elsewhere in Scotland, again stakeholders recognised this was dependent on funding. Generally, they recommended applying the same broad approach as in Greater Glasgow and Clyde with the caveat that delivery elsewhere should be tailored to each specific area, for example adjustments may be required if it were to be delivered in a rural area. There was strong support to replicate the governance arrangements and staff secondments which had helped integration in Greater Glasgow and Clyde.
6 Conclusions and recommendations

6.1 The Primary Care Engagement Programme was established by Cancer Research UK and NHS Greater Glasgow and Clyde in June 2014 to support the prevention, screening and early diagnosis of cancer. A team of three facilitators has engaged general practices across Greater Glasgow and Clyde. This qualitative evaluation gathered the views of 36 health professionals and members of staff from 18 practices that had been supported by the Primary Care Engagement Team, as well as the views from nine stakeholders from CRUK and NHS GGC, and others including the Scottish Government Detect Cancer Early Team. Overall, practitioners and stakeholders were very positive in their views and experiences regarding the PCE Programme in Greater Glasgow and Clyde.

6.2 A review of engagement with the PCE Programme found that practices’ knowledge was limited prior to an approach from the PCE Team. The initial contact tended to be directed to the Practice Manager who, in most cases, assumed the lead role for ongoing contact with the practice. The main driver for initial engagement with the PCE Programme was bowel screening. The PCE Programme coincided with the Scottish Government’s Detect Cancer Early bowel screening initiative which awarded up to six SQOF points to practices that delivered a reduction in the proportion of patients who did not participate in the screening programme. Practices were generally receptive to the PCE Team’s offer of support on bowel screening. In some practices this was the only engagement with the PCE Team, although the majority of practices consulted during the evaluation had subsequent meetings with the facilitators. Engagement tended to consist of small meetings with the Practice Manager and one or two colleagues or group meetings with clinical and administrative staff. Group meetings set up specifically to meet the PCE Team afforded more time for discussion than meetings added to the agenda of regular practice meetings.

6.3 Some practices reported limited awareness of the CRUK branding although this may partly be due to the time elapsed since the practice met the PCE Team in some instances. Nonetheless, branding was not seen as a particularly significant issue – where it was mentioned positively was in terms of CRUK’s credibility and access to high quality up-to-date resources, and links into other parts of NHS GGC. It was noteworthy that a number of interviewees were not clear about the full range of support available from the PCE Team, and we suggest this contributed to a predominantly reactive, rather than proactive approach to engagement.

6.4 Practices’ interest in bowel screening led to support initially focusing on this issue. This included advice on administrative processes such as the importance of recording participation in the screening programme, plus a number of practical steps that could be taken to encourage participation. Support was not confined to bowel screening and the PCE Team discussed other cancers including breast and cervical screening. The PCE Team also supported practices on broader issues such as prevention and auditing cancer cases. Supporting the interaction between primary and secondary care was also highlighted and this is a particularly noteworthy element of the PCE Team’s support given the implications it could have for primary care more generally.

6.5 Practices reported very positive feedback on the quality of the support provided by the PCE Team with the facilitators seen as very knowledgeable and helpful. The experiences shared by practices during this evaluation demonstrated that the PCE Team has delivered the
facilitation role CRUK envisaged as catalysts for change; having the time and space to focus on cancer and the support of an external facilitator were seen as particularly helpful. Generally, practices struggled to identify future support needs although prevention, administrative support and advice on issues relevant at that time were the main areas cited. Future support on prevention was viewed as potentially challenging and would require careful planning by CRUK and NHS GGC.

6.6 Increased awareness, particularly associated with bowel screening, was identified by practices as the main added value of the Primary Care Engagement Programme in Greater Glasgow and Clyde. Some practices had introduced new approaches such as handing out gloves and foil bowls to encourage people to take the test. Most reported that advice on tracking patients was something they were doing or had already identified and generally practices did not attribute administrative changes to the PCE Team, although a small number did. Time and resources were seen as the most significant barriers to implementing change. While information gleaned from the visits was shared internally within practices, practices did not report sharing learning with primary care colleagues in other practices. The PCE Team was also responsible for sharing good practice and they developed three in-house tools, case studies and presentations to share learning; generally there was an appetite among interviewees for further information from the PCE Team on good practice.

6.7 Consultation with stakeholders focused on a number of strategic issues. Programme governance was viewed positively with participation from all relevant agencies and links into NHS GGC seen as particular strengths. A number of stakeholders highlighted that partnership working had been established or strengthened between partners particularly CRUK, NHS GGC and the Scottish Government’s Detect Cancer Early Team. Stakeholders were satisfied that the PCE Programme was effectively delivering support to primary care in Greater Glasgow and Clyde and that duplication was not an issue; there were numerous compliments on the PCE Team, particularly the Manager who was the most visible member of the Team to stakeholders. Stakeholders also reported that the experience had demonstrated that the PCE Programme could be applied in Scotland with appropriate modifications to fit the different policy context. The PCE Team’s role in raising issues around primary and secondary care relationships and communications within NHS GGC and their involvement in other groups and initiatives were cited as particularly important. Stakeholders were unanimous in their view that the PCE Programme should continue in Greater Glasgow and Clyde although there was a recognition that this was very much dependent on funding. The interaction between primary and secondary care was highlighted as a potential focus for the PCE Programme in the future. There was also support for the roll-out of the PCE Programme to other parts of Scotland.

6.8 Overall, primary care practitioners and stakeholders shared positive views and experiences regarding the Primary Care Engagement Programme in Greater Glasgow and Clyde. The following recommendations should inform further discussion between CRUK, NHS GGC, and other partners regarding the future of the PCE Programme:

**Recommendation 1:** The PCE Team maintain regular contact with practices regarding specific cancer issues or elements of support to encourage engagement. One of the first issues could be forthcoming changes to the cervical screening programme.

**Recommendation 2:** Engagement should be a flexible process tailored to specific issues that seeks to engage the most appropriate member(s) of a practice including GPs, and
should not be limited to the Practice Managers.

**Recommendation 3:** The PCE Team should disseminate good practice from their work to date, particularly on impacts and issues other than bowel screening, to practices across Greater Glasgow and Clyde, in order to reinforce that the PCE Team can offer a wide range of support.

**Recommendation 4:** The PCE Team should consult practices across Greater Glasgow and Clyde to identify specific cancer-related issues that they would welcome future support on.

**Recommendation 5:** The Steering Group should identify actions that are necessary to embed within NHS GGC the learning from the PCE Programme to date and assign responsibility for each action to a member of the group. Progress should be closely monitored.

**Recommendation 6:** The Steering Group should co-ordinate and support the PCE Programme workplan for year three within Greater Glasgow and Clyde.

**Recommendation 7:** CRUK and the Scottish Government agree a way forward for the PCE Programme in Greater Glasgow and Clyde and the roll-out to other health boards in Scotland.

**Recommendation 8:** Wherever possible, new facilitators should possess the knowledge and skills shown to be important to date including an understanding of primary care and communication skills.