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Project Logic

Community-led Cancer Screening Project

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1. Acronyms and Key Terms

Abbreviation	Full Name
BSV	BreastScreen Victoria
CALD	Culturally and Linguistically Diverse
CCV	Cancer Council Victoria
CLCSP	Community-led Cancer Screening Project
DHHS	Victorian Department of Health and Human Services
IPC	Improving and Promoting Community Health
NWMPHN	North Western Melbourne Primary Health Network
SES	Socio-economic status
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
WACC	Wyndham Aboriginal Community Cooperation

2. Background

The Community-led Cancer Screening Project (CLCSP) is a three-year project being led by North Western Melbourne Primary Health Network (NWMPHN) and funded by Victorian Department Health and Human Services (DHHS). The project aims to increase participation in bowel, cervical and breast cancer screening programs by building capacity within primary care settings and through facilitated targeted community-led interventions in NWMPHN catchment. The project is specifically focused on under-screened communities including Culturally and Linguistically Diverse (CALD), Aboriginal and Torres Strait Islander and people living in circumstances of low socio-economic status (SES).

This project logic outlines the framework for Workstream 1 and 2 at local NWMPHN project level. Workstream 1 will focus on strengthening systems and knowledge within general practice to support under-screened communities to participate in cancer screening programs. General practices in Brimbank and Wyndham LGA's will be targeted.

For Workstream 1, North Western Melbourne PHN, Western Victoria PHN and Murray PHN have identified that a collaborative quality improvement approach will enable combined resources to be used to develop a high value and quality QI toolkit. There will be an additional benefit of having a consistent approach to QI across the PHNs and an ability to evaluate across the regions. The PHNs are currently developing a brief and process to procure or develop a quality improvement toolkit that will support the implementation of evidence-based strategies to increase population-based screening in general practice, particularly for under-screened populations. The toolkit will include education resources, data management, processes, setting baselines and goals, recalls and reminders, patient centred and culturally sensitive initiatives.

Workstream 2 will target two local government areas within NWMPHN. A place-based approach in Wyndham will be the focus for Aboriginal communities and in Brimbank for low SES and CALD communities. Local communities will be engaged to identify barriers to screening and prioritise and co-design intensive community-based activities to improve cancer-screening rates.

This project logic document outlines key objectives, activities and desired outcomes for the project. This document is informed by the preceding NWMPHN CLCSP Governance Framework and NWMPHN CLCSP Local Cancer Screening Community Profile documents. The local project logic is aligned to sit under the wider DHHS Program Logic.

There are four key principles that will drive the project outcomes;

- Equity;
- Locally driven initiatives;
- Partnerships; and,
- Sustainability.

In accordance with adhering to the principle of locally driven initiatives the project logic is necessarily high level as partnerships will be developed with local stakeholders and community to define project activities led by the local community throughout the project timeline. The project coordination will importantly involve a degree of flexibility and responsiveness to local community aspirations and as such this document should provide some original direction but will evolve and be enriched with detail over the duration of the project.

3. Project Logic

About the Logic Model

The project logic is a simple, clear graphical representation of the theory that underpins the CLCSP at NWMPHN. It provides a common language for all stakeholders and promotes clear communications.

The project logic displays the connections between resources, activities and outcomes. There is a focus on accountability for outcomes and the logical steps to be taken to get to the expected outcomes. The project logic provides a coherent chain of reasoning with the steps following an "If, then" sequence. The assumptions are explicitly stated for clarity.

The outcomes are defined as short-term (changes in knowledge, skills or attitudes), medium-term (changes in behavior or action) and long-term (changes in condition or life status).

The logic model for the CLCSP at NWMPHN will facilitate effective evaluation but is not in itself an evaluation tool. The project logic enables determination of what is important to evaluate.

The following table depicts the project logic of NWMPHN CLCSP. The project logic should be viewed alongside the overall CLCS Program logic model (DHHS).

NWMPHN CLCSP Project Logic Model

Goal:

Equitable participation in cancer screening programs for the Aboriginal community in Wyndham and for low socio-economic and culturally and linguistically diverse communities in Brimbank.

Principles:

1. Equity
2. Locally driven initiatives
3. Partnerships
4. Sustainability

Objectives:

1. From July 2018 to June 2020, start and maintain a cancer screening committee that allows for ongoing advice, support and guidance from a minimum of one GP, one Aboriginal community member and organisation, one CALD partner organisation, Wyndham and Brimbank councils, one CALD community member, IPC Health, Western Health and three state partners (DHHS, VACCHO and CCV) to help project staff to effectively design, implement and evaluate the CLCSP project.

2. By 30 December 2018, three PHNs (NWMPH, Murray PHN, Western Vic PHN) in collaboration with a quality improvement organisation will have developed a Cancer Screening Quality Improvement toolkit including evidence-based resources and tools for general practice staff to plan, implement and evaluate continuous quality improvement activities to increase bowel, breast and cervical cancer screening rates particularly for underscreened patients.

3. By 30 June 2020, eight general practices (four in Brimbank and four in Wyndham) will have practice data accurately showing screening participation rates for identifiable under-screened patients (including Aboriginal) and the all eligible patients in screening programs for a minimum of one (bowel, breast and cervical) cancers and a documented system for reminding all eligible patients about cancer screening and have identified, documented and implemented approaches to improve patient centred care for under-screened patients.

4. By 30 October 2018, a minimum of 25 Aboriginal community members and 50 CALD and low SES community members will have been engaged with using culturally appropriate methods in partnership with local partner organisations to identify and document locally relevant barriers and enablers to cancer screening, locally appropriate cancer screening health promotion ideas and communities and leaders willing to be involved with the project.

5. By 30 January 2019 to have co-designed and planned a minimum of two cancer screening health promotion activities with the Aboriginal community in Wyndham and two cancer screening health promotion activities with CALD and low SES communities in Brimbank in collaboration with partner organsiations.

6. From January 2019 to November 2019 deliver a minimum of two co-designed cancer screening health promotion activities in partnership with partner organsiations with the Aboriginal community in Wyndham and two co-designed cancer screening health promotion activities with CALD and low SES communities in Brimbank.

7. By 30 April 2019 an evaluation plan for NWMPHN CLCSP (aligned with the DHHS External Evaluation Framework RE-AIM), will be developed and documented with input from the evaluator, NWMPHN evaluation team, NWMPHN project staff and the Cancer Screening Committee.

Inputs	Activities	Outputs	Short-term Outcomes	Medium-term Outcomes	Long-term Outcomes
Members of the under-screened community who are interested and have capacity to contribute to CLCSP. Local partner organisations (Lentara, WACC and IPC). NWMPHN staff. Funding. DHHS templates and expertise. CCV cancer screening materials and expertise. VACCHO materials and expertise. Screening bodies (BreastScreen Victoria, National Cervical Screening Program, National Bowel Cancer Screening Program). Evaluation consulting services.	1.1 Write Local Governance Document and submit to DHHS. 1.2 Recruit and maintain key stakeholders, including under-screened community members on CSC. 1.3 Schedule CSC meetings and invite members to attend, record minutes and distribute project information. 2.1 Compare QI Toolkit development capabilities of external agencies. 2.2 Assess option of building or using QI Toolkit from resources already available within the PHNs. 2.3 Document options for QI Toolkit development including advantages, disadvantages, potential timelines and costs. 2.4 Engage with general practices in Brimbank and Wyndham to document key issues around cancer screening for their patient cohort. 2.5 If internal PHNs development of toolkit option decided as the way forward, develop and publish QI Toolkit with MPHN and WVPHN. 2.6 If procurement decided as the way forward; write tender document and agree between 3 lead PHNs specifications for QI Toolkit to be procured or developed. 2.7 Follow competitive tender process and appoint successful supplier.	Approved Local Governance Document CSC meeting minutes show attendance CSC members Evidence of comparative evaluation (attendance at webinars etc) Evidence of PHNs discussing and assessing internal options for QI Toolkit (workshop documentation, PHN team Calls Agenda and Action items) QI Approach document including cost benefit analysis of various development options. Document summarising key themes and issues identified through general practice engagement. QI Toolkit available in web and printed format. Tender document signed off by NWMPHN, WVPHN and MPHN Documentation showing procurement process at NWMPHN (lead agency for procurement) followed	Improved understanding of selected general practices on the issues of under-screening for target populations and of their practice baseline data. Improved capacity for selected general practices to provide appropriate support for under-screened patients to participate in screening programs. Increased awareness of screening environment challenges for NWMPHN and to make workplans agile and reflective of local challenges. Increased opportunities for local community members to participate in project governance. Increased opportunities for local experts to be involved in governance and planning processes.	Improved identification, recording and reporting of under-screened communities at participating general practices. Increased awareness among under-screened communities of the importance, cancer risks, and availability of screening programs. Opportunity for under-screened community members to lead in developing appropriate solutions and develop new skills and empowerment in determining appropriate solutions. Increased access to screening and follow-up assessment for under-screened communities	Embedded cancer screening systems and processes at participating primary care practices in Brimbank and Wyndham. Increased engagement with cancer screening programs for patients at participating primary care practices. Documented and evidenced approach to CLCS that can be replicated or modified to wider areas. Sustainable intersectoral partnerships created with organisations in NWMPHN catchment working with under-screened communities. Improved local community and stakeholder commitment, capacity and

Health Pathways. Practice Incentives. General practices in Brimbank and Wyndham. Population and cancer screening data. Practice data. Evaluations from previous projects involving under-screened communities. Policies.	2.8 Work with supplier to ensure quality toolkit meeting requirements is developed. 2.9 Ensure HealthPathways are developed to support QI in practices. 3.1 Identify and recruit general practices in Brimbank that see high numbers of CALD and low SES patients. 3.2 Identify and recruit general practices in Wyndham that see high numbers of Aboriginal. 3.3 Plan for implementation of QI activities including appropriate practice support and incentives. 3.4 Participating practices undergo training in QI methodology and use of QI tools. 3.5 Participating practices complete project plan with support from PHN staff. 3.6 Participating practices undergo Pen CAT training. 3.7 Participating practices attend cancer screening workshop at NWMPHN. 3.8 Participating practices develop cancer screening principles. 3.9 Participating practices implement PDSA methodology. 3.10 Participating practices complete a cancer screening intervention. 3.11 Participating practices complete evaluation of QI Activities	Complete Cancer Screening HealthPathways live on HealthPathways Melbourne. Documentation of community engagement sessions, including locally identified barriers, potential solutions and priorities Interventions developed based on local knowledge and co-design approach. Evidence of the community identified solutions being run (reports, photographs, stories, videos etc depending on what activities are run) 4 general practices in Wyndham and 4 general practices in Brimbank recruited to participate in Cancer Screening QI Baseline measures identified for the general practices participating in the project QI Implementation Plan document. Staff onboarded and prepared to implement QI activities. PenCAT training run in practices Practice project plans QI Workshops Recall systems in place at selected general practices	Opportunity for local under-screened community to identify relevant barriers to screening and prioritise potential solutions and have meaningful ownership of solutions to cancer-screening issues. Increased commitment and capability of NWMPHN to engage with under-screened communities. Stronger intersectoral partnerships created with organisations in NWMPHN catchment working with under-screened communities.		capability to support cancer screening among under-screened populations. Accessible, culturally safe cancer screening services in Brimbank and Wyndham. Increased participation by under-screened communities in screening for cervical, breast and bowel cancer.

	3.12 Participating practices attend learning and evaluation workshop. 4.1 Collect data from previous work in the area and from available data sources. 4.2 Inform stakeholders of the project and invite participation. 4.3 Run engagement events for under-screened communities. 4.4 Document outputs from community engagement including analysis of themes and opportunities. 5.1. Identify community leaders from under-screened communities. 5.2. Run workshops and assist under-screened community leaders and stakeholders to prioritise and plan and design potential solutions. 5.3. Share outputs from community engagement events and community planning workshops with CSC. 6.1 Deliver activities co-designed with under-screened communities. 1.1 Submit regular progress reports to DHHS. 1.2 Provide External Evaluator with required data and information to evaluate the project using the RE-AIM Framework. 1.3 Evaluate CLCSP using NWMPHN internal evaluation toolkit and framework.	QI Toolkit utilised, and QI activities run in selected general practices Practice project reports Results and data from QI activities collated and documented. QI Practice evaluations Summary and analysis of previous relevant projects and studies in Engagement document Flyers and posters for events Community Engagement document with summary of workshop outputs including quotes, themes, photographs CSC Minutes and emails Co-designed activities Progress reports Contract management forms Data and information in documents and emails to evaluator External evaluation report including NWMPHN CLCSP NWMPHN Internal evaluation report			

Assumptions:

1. Local under-screened community wants to participate in CLCSP and has the capacity to do so.
2. Partner organisations have aligned goals and capacity to be involved with CLCSP.
3. NWMPHN have available and skilled staff to coordinate and support CLCSP.
4. NWMPHN is appropriately placed to lead the CLCSP and can effectively engage with primary care providers and support practice and system change.
5. Funding for the project is provided by DHHS.
6. DHHS have available and skilled staff to coordinate and support CLCSP.
7. VACCHO, CCV and Screening Bodies NWMPHN have available and skilled staff to support CLCSP.
8. Appropriate collateral can be sourced or developed in a timely manner to support the project.
9. Documentation and intelligence on previous projects in the field are available.
10. Policies are in place that support the approach of CLCSP at Federal, State and Local level.
11. NWMPHN, MPHN and WVPHN maintain a collaborative working relationship enabling development of a high quality and timely QI Toolkit for Workstream 1.
12. There are appropriately skilled and resourced organisations to work with to develop QI Toolkit.
13. General practices are willing and appropriately resourced to be involved in the CLCSP.
14. General practices are willing to share data via PenCAT or other data retrieving methods.
15. General practices have capacity and desire to implement system changes.
16. Data can be reliably collected from systems allowing for change analysis.

4. References

Better Care Victoria 2017, *Project Plan Guidance and Template*
https://www.bettercare.vic.gov.au/knowledge-hub/toolkit

Cancer Council Victoria 2017, *Sample Project Plan*
https://screeningresources.cancervic.org.au/media/documents/1D4_Sample_Project_Plan_fiDFAyD.pdf

Department Health and Human Services 2018, *Program Logic for Community-led Cancer Screening Program*

Department Health and Human Services 2017, *Community-led cancer screening program 2017-2020; Program partners – roles and responsibilities*

North Western Melbourne Primary Health Network 2018, *CLCSP Governance Framework*

North Western Melbourne Primary Health Network 2018, *CLCSP Local Cancer Screening Community Profile*