

**Improving Awareness and Uptake Rates in Bowel Cancer Screening  
across Cheshire and Merseyside**

**Evaluation of a bowel cancer screening awareness campaign for  
Cheshire and Merseyside Public Health Network**

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## Contents

<b>Acknowledgements</b> .....	<b>ii</b>
<b>Contents</b> .....	<b>iii</b>
<b>Chapter 1</b> .....	<b>1</b>
<b>Introduction</b> .....	<b>1</b>
1.1 Introduction to the study .....	1
1.2 Aims and objectives of the study .....	4
1.3 Objectives.....	4
<b>Chapter 2</b> .....	<b>5</b>
<b>Bowel cancer screening</b> .....	<b>5</b>
2.1 The national policy context.....	5
2.2 Bowel cancer screening .....	5
2.3 Cheshire and Merseyside bowel cancer screening.....	6
<b>Chapter 3</b> .....	<b>8</b>
<b>Study design and methodology</b> .....	<b>8</b>
3.1 Introduction.....	8
3.2 Methods employed .....	8
3.3 Quantitative data collection .....	8
3.4 Qualitative data collection .....	8
3.4.1 Interviews with GP practice staff .....	9
3.4.2 Interviews with Bowel Cancer UK members.....	9
3.5 Ethics.....	10
<b>Chapter 4</b> .....	<b>11</b>
<b>Bowel cancer screening uptake rates</b> .....	<b>11</b>
4.1 Introduction.....	11
4.2 Demographics of non-respondents .....	11
4.3 Uptake of screening rates .....	14
<b>Chapter 5</b> .....	<b>21</b>
<b>GP practice staff findings</b> .....	<b>21</b>
5.1 Introduction.....	21
5.2 Description of the sample .....	21
5.3 Interview findings.....	21
5.4 Identifying non-respondents .....	21
5.4.1 Including reminder flags for patient discussions.....	22

5.5	Sending out information .....	23
5.6	Collating demographic data.....	25
5.7	Information provision .....	25
5.8	Engagement.....	26
5.9	Practice developments .....	30
5.10	Conclusion.....	31
<b>Chapter 6</b>	.....	<b>33</b>
<b>Bowel Cancer UK member findings</b>	.....	<b>33</b>
6.1	Introduction.....	33
6.2	Description of the sample.....	33
6.3	Interview findings.....	33
6.4	General comments .....	34
6.5	GP letter .....	35
6.6	DVD.....	36
6.7	Leaflet.....	37
6.8	Poster .....	38
6.9	Small leaflet and bookmark .....	38
6.10	Improving the campaign .....	38
<b>Chapter 7</b>	.....	<b>40</b>
<b>Discussion</b>	.....	<b>40</b>
	Introduction .....	40
	Limitations of study .....	40
	Conclusions.....	41
	Recommendations .....	42
<b>Appendix 1 - Participant information sheet (GP practice staff)</b>	.....	<b>44</b>
<b>Appendix 2 - Interview schedule (GP practice staff)</b>	.....	<b>46</b>
<b>Appendix 3 - Participant information sheet (Bowel Cancer UK)</b>	.....	<b>48</b>
<b>Appendix 4 - Interview schedule (Bowel Cancer UK)</b>	.....	<b>50</b>
<b>Appendix 5 - GP letter</b>	.....	<b>51</b>
<b>Appendix 6 - Poster</b>	.....	<b>52</b>
<b>Appendix 7 – Instruction leaflet</b>	.....	<b>53</b>
<b>References</b>	.....	<b>55</b>

**List of Tables**

Table 1.1 Cheshire and Merseyside bowel cancer screening uptake rates	2
Table 4.1 Non-respondent patient demographic data	13
Table 4.2 Reminders and responses by GP practice	14
Table 4.3 Summary by GP practice within the project of percentage uptake of screening including the non-responders data from table 4.2	17
Table 4.4 Summary of screening uptake by Warrington GP practices who were involved in awareness raising only	18

## Chapter 1

### Introduction

#### 1.1 Introduction to the study

Bowel cancer is the third most common cancer in the United Kingdom (UK), and the second leading cause of cancer deaths, with 37,000 diagnoses and more than 15,000 deaths each year (Cancer Research UK, 2011). Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16% (Hewitson, Glasziou, Irwig, Towler, & I, 2007). In 2006, the NHS Bowel Cancer Screening Programme for England was introduced, following the evaluation of a pilot screening programme, which began in 2000 (Alexander & Weller, 2003). The programme was rolled out in Cheshire and Merseyside from September 2006 until 2007 across primary care trusts (PCTs). Initially, the programme offered screening to men and women aged sixty to sixty nine years every two years using the Faecal Occult Blood test kit (FOBt kit) and was extended in 2010 to include people up to the age of seventy five. Those aged over seventy five may self-refer.

Uptake is defined as the proportion of people sent a standard invitation letter who receives a definitive screening result.

Uptake continues to improve for most PCTs with an overall increase across the North West of around 4% between 2008/09 and 2010/11. Table 1.1 overleaf illustrates the uptake rates from 2007 to 2010 for eight PCTs within Cheshire and Merseyside. All but one of the PCTs showed an increase in uptake levels from 2007 to 2010. The highest increase is Knowsley that showed a 4% increase and the lowest Sefton with a decrease of 4%.

**Table 1.1 Cheshire and Merseyside bowel cancer screening uptake rates**

PCT	2007 (%)	2008 (%)	2009 (%)	2010 (%)
Central & Eastern Cheshire	56.3	55.8	58.8	59.3
Halton & St Helens	49.9	51.0	52.1	51.2
Knowsley	40.5	42.9	43.1	44.8
Liverpool	46.0	45.0	40.8	46.7
Sefton	56.3	51.4	53.9	52.8
Warrington	52.6	53.4	56.5	55.0
Western Cheshire	56.1	57.1	59.2	59.7
Wirral	52.9	52.4	54.5	54.0

Data source: North West Bowel Cancer Screening Quality Assurance Reference Centre (United Kingdom Association of Cancer Registries (UKACR), 2011)

As part of its response and in an effort to increase bowel cancer screening uptake rates, ChaMPs developed a campaign in partnership with sixteen GP practices in Cheshire and Merseyside. Previous research has identified that GP involvement in promoting screening awareness is highly beneficial (Damery, Clifford, & Wilson, 2010). The campaign ran for three months in early 2011. It aimed to increase uptake rates by 5% in the sixteen practices by targeting non-responders and to increase awareness of the programme for other patients.

As part of the campaign, each GP practice was required to undertake a number of tasks as outlined below:

- Send pre-packed patient information/ material to the eighty most recent bowel cancer screening non-respondents<sup>1</sup>, consisting of:
  - Reminder letter from GP practice to complete the FOBt kit (GP Practice to print off and insert in patient pack);
  - Bowel cancer screening information leaflet (A5) ‘Your questions answered’ (already included in pre-packed envelope);
  - DVD explaining how to complete the FOBt kit (already included in pre-packed envelope);
  - Bookmark (already included in pre-packed envelope).
- Include reminder flags and read codes on eighty most recent non-respondents’ patient records to potentially discuss bowel cancer screening the next time the patient visits the GP practice;

<sup>1</sup> non-respondents identified by the screening hub and/ or GP practice

- Capture demographic data on the eighty most recent non-respondents;
- Participating practices were also given a 'Health Professionals Kit' for the GP Practice/ health professionals/ care home workers/ health visitors containing information on bowel cancer screening. As well as a copy of the DVD, information leaflet and bookmark detailed above this also included the following marketing materials:
  - Health professional folder;
  - Briefing sheet for health professionals;
  - A4 sheet showing the marketing material available, contact numbers and links for bowel cancer support;
  - Learning disabilities leaflet.
- Finally, practices also received the following bowel cancer screening awareness campaign marketing materials to raise awareness of the bowel cancer screening programme and increase uptake rates:
  - Copies of the bowel cancer screening DVD to show members of staff or patients how to use the FOBt kit. DVDs were to be displayed and given out by the GP practice/ health professional to relevant patients (including those approaching sixty);
  - A4 posters to be displayed by the GP practice to raise awareness of the FOBt kit;
  - Wallet size six page leaflets showing how to complete the FOBt kit to be displayed by the GP Practice and handed out to any relevant patients;
  - Bookmarks to be displayed by the GP Practice and handed out to any relevant patients.

The text of the materials for the campaign was produced by ChaMPs and was combined with artwork developed for use in an earlier campaign by Sefton PCT, which consented to its use in the project. The DVD was originally developed by the Cheshire and Merseyside Bowel Cancer Screening Programme and updated by ChaMPs for the project.

The awareness campaign was funded by the Merseyside and North Cheshire Screening Centre and the six PCTs which the Centre covers were initially invited to participate. The invitation was extended to two further PCT, Central and Eastern Cheshire and Western Cheshire, so as to include the whole of the Cheshire and Merseyside footprint. Sefton, Western Cheshire and Central and Eastern Cheshire declined to take part due to plans they already had in place for local campaigns. Warrington took part only in the awareness raising aspects of the project by displaying materials. The five PCTs which took part in the campaign were therefore: Halton and St Helens, Knowsley, Liverpool, Warrington and Wirral.

ChaMPs funded, organised, set up and managed the budget for the project. However, liaison with GP practices and roll-out of tasks were managed by the named PCT leads of the participating PCTs. ChaMPs' ability to manage and ensure that the demands of the project were met was therefore limited at times.

## 1.2 Aims and objectives of the study

The overall aim of the study was to evaluate the impact of the bowel cancer screening awareness campaign on uptake rates for bowel cancer screening among participating GP practices covered by Mersey and North Cheshire Screening Centre through the collection of quantitative patient data. The following took part in the campaign:

- Wirral (three GP practices);
- Liverpool (three GP practices);
- Halton and St Helens (five GP practices);
- Knowsley (five GP practices);
- Warrington (all practices) for awareness raising only.

In addition qualitative interviews were carried out to explore:

- The views of GP practice staff in relation to the processes involved in running the campaign;
- The views of local Bowel Cancer UK members people regarding the campaign materials sent to non-respondents.

## 1.3 Objectives

In order to meet these aims the evaluation included:

- An examination of the differences in the sixteen GP practice bowel cancer screening uptake rates before and after the campaign;
- An examination of numbers of FOBt kits completed by the targeted non-respondent bowel cancer screening patients;
- An exploration of the perceptions of staff at the GP practices concerning the campaign;
- An exploration of the perceptions of local Bowel Cancer UK members regarding the materials sent to non-respondents;
- Identification of the strengths and weaknesses of the campaign.

## Chapter 2

### Bowel cancer screening

#### 2.1 The national policy context

The past decade has seen significant focus placed upon bowel cancer and bowel cancer screening. In 2000 the Government published the NHS Cancer Plan, establishing cancer care as a Government priority, specifically in relation to increasing funding of services, improving guidance to health practitioners, and a commitment to increasing public awareness and extending screening programmes, particularly for bowel cancer. The NHS Bowel Cancer Screening Programme was launched in April 2006 (Alexander & Weller, 2003), and was one of the first such programmes to be introduced. A Bowel Cancer Advisory Group was also established with representatives of all key stakeholders. In 2007 the Government produced a Cancer Reform Strategy (Department of Health, 2007) developed with the guidance of a number of cancer charities and experts, which sets out a programme of action across ten areas: six areas of action to improve cancer outcomes and four areas of action to ensure delivery.

In January 2011 the Government announced the launch of the first ever cancer awareness campaign '*Be Clear on Cancer*', with TV, radio and newspaper advertisements encouraging people to look out for early signs of bowel and other cancers. As well as the pilots for a national campaign, £9m has been made available to fund fifty nine local cancer awareness campaigns led by the NHS and supported by Cancer Research UK, aimed at targeting the three biggest killers: bowel, breast and lung cancer.

#### 2.2 Bowel cancer screening

It is suggested that approximately one in twenty people will develop bowel cancer (Cancer Research UK, 2011). However, regular screening has been shown to reduce the risk of death from bowel cancer by 16% (Hewitson, Glasziou, Irwig, Towler & Watson, 2007). A pilot study was established in the UK in 2000 to examine the feasibility of population-based screening for colorectal cancer.

The NHS Bowel Cancer Screening Programme was introduced in England following government support in 2002, offering screening to all adults between the ages of sixty and sixty nine every two years. In 2003 the NHS Cancer Screening Programme commissioned a formal appraisal of cancer screening on behalf of the

Bowel Cancer Advisory Group (Alexander & Weller, 2003). Based on the findings, a dual approach to bowel cancer screening was introduced from April 2006.

The White Paper *Our Health, Our Care, Our Say: a New Direction for Community Services* (Department of Health, 2006) reaffirmed the government's commitment to rolling out a screening programme for bowel cancer phased over three years, with the intention that the whole eligible population would be covered by the end of 2009.

The programme is coordinated through five regional hubs based on the five *Connecting for Health* clusters: Midlands and the North West (located in Rugby), North East and Yorkshire (Gateshead), Eastern (Nottingham), Southern (Guildford) and London (Harrow). These hubs are responsible for the call and recall systems and for sending the FOBt kits to people's homes. They also receive and process the completed FOBt kits. People who are given positive or abnormal FOBt result are then booked in to local screening centres that are responsible for discussing the results with individuals and for undertaking colonoscopies. Presently there are fifty eight screening centres in England.

From January 2012, following successful pilots in the South West and East of England, the first ever national advertising campaign will be rolled out to increase awareness of the early signs of bowel cancer, and to promote early diagnosis by making it easier for patients to discuss bowel cancer with their GP. Results from the regional pilots found:

- There was a 48% increase in the number of people who visited their GPs with symptoms;
- There was a 32% increase in urgent referrals to hospitals over six months, which included the period during which the campaign ran;

### **2.3 Cheshire and Merseyside bowel cancer screening**

The Cheshire and Merseyside Screening Centre commenced in September 2006, working across eight PCTs, and offered screening to approximately three hundred and twenty seven thousand people. As one of the first wave pilot sites, Cheshire and Merseyside played an important role in the development of the national programme. Within Cheshire and Merseyside there are now two screening centres – the Merseyside and North Cheshire Screening Centre and the Cheshire Screening Centre. In 2007, Cheshire and Merseyside Screening Centre was funded by the NHS Bowel Cancer Screening Programme to commission a research project, which set out to explore the accessibility of the screening programme (up to the point of completed FOBt kit) for people with a sensory impairment (Powell, Perry, & Thurston, 2008). A further study was commissioned in Cheshire & Merseyside last year which looked at accessibility of the



entire pathway. Accessibility of the programme is a key issue because the success of the programme in terms of lives saved is, in part, dependent on the uptake of the initial invitation to participate and the early detection of bowel cancer.

## Chapter 3

### Study design and methodology

#### 3.1 Introduction

This study was designed to evaluate the impact of the bowel cancer screening awareness campaign on uptake rates for bowel cancer screening among participating GP practices.

#### 3.2 Methods employed

Both quantitative and qualitative data collection methods were used to evaluate the effectiveness of the bowel cancer screening awareness campaign. Quantitative information describing GP practice uptake rates was compiled, a qualitative analysis of GP practice staff's experiences of the campaign was undertaken and alongside interviews with local members of Bowel Cancer UK to determine the effectiveness of the campaign materials. A mixed methodology was used as the aim of the study was to assess the impact of the campaign on uptake rates as well as to identify the strengths and weaknesses of the campaign.

#### 3.3 Quantitative data collection

Quantitative data for this study were obtained from the following sources:

- Demographic data for the eighty most recent non-respondents were collected by GP practices and electronic/ paper copies received by ChaMPs; the last eighty non-responders were chosen in order to access a similar number from each practice.
- Bowel cancer screening uptake rates at GP practice level were obtained from North West Bowel Screening Quality Assurance Reference Centre, PCT screening leads and GP practices.

#### 3.4 Qualitative data collection

Qualitative data collection methods using telephone interviews were used. Qualitative outcome indicators included the perceptions of health care professionals involved in the delivery of the campaigns, and the views of members of Bowel Cancer UK regarding the campaign materials.

The use of telephone interviews has been demonstrated to provide comparable data to face-to-face interviews (Sturges & Hanrahan, 2004). Telephone interviews were conducted using a semi-structured interview schedule. Semi-structured interviews are flexible in process, allowing the interviewee's own perspectives to be explored (Bryman, 2001). In semi-structured interviews the interviewer has a list of issues and questions to be discussed but has some flexibility in the order of topics covered and can allow the interviewee to elaborate on the issues raised (Denscombe, 1998). Open-ended questions are used which define the area to be explored but allow the interviewer or interviewee to diverge so that particular areas can be followed up in more detail (Britten, 1995).

#### **3.4.1 Interviews with GP practice staff**

The target group for the GP practice staff interviews was approximately ten staff from the sixteen GP practices participating in campaign. Between May 2011 and July 2011, eleven GP practice staff were interviewed by telephone. Purposive sampling took place as recruitment began in order to try and ensure geographic diversity in the sample with regard to PCT and level of deprivation. Thirteen practices were contacted and twelve agreed to take part, with eleven eventually taking part. GP practice staff were approached by telephone or e-mail and asked if they would be willing to help with the evaluation by taking part in a short interview. The information sheet for participants can be seen in Appendix 1. All telephone interviews were transcribed verbatim and analysed by coding interview transcripts and identifying key themes and features that were then organised according to the aims and objectives of the research. A semi-structured schedule was produced for use in the interviews; this can be seen in Appendix 2.

#### **3.4.2 Interviews with Bowel Cancer UK members**

The target group for gathering views on the materials sent to non-respondents was a small group of local members of the Bowel Cancer UK charity. The need to observe patient confidentiality meant that patients could not be interviewed directly and this was seen as an acceptable alternative. In June and July 2011 five local members of Bowel Cancer UK were interviewed by telephone. These five members were approached and selected by the commissioners of the study. Researchers from the University of Chester's Centre for Public Health Research then contacted them by telephone or email to arrange a convenient time for the interview. The information sheet for participants can be seen in Appendix 3. All telephone interviews were transcribed verbatim and analysed by coding interview transcripts and identifying key themes and features that were then organised according to the aims and objectives of the research. A semi-structured schedule was produced for use in the interviews; this can be seen in Appendix 4. All telephone interviews were

transcribed verbatim and analysed by coding interview transcripts and identifying key themes and features that were then organised according to the aims and objectives of the research.

### **3.5 Ethics**

The Centre for Public Health Research received ethical approval for the evaluation of the bowel cancer screening awareness campaign delivered by ChaMPs Public Health Network from the University Of Chester Faculty Of Applied Sciences Research Ethics Committee in February 2011. It was established that NHS Research Ethics approval was not necessary for this research as it was classified as a service evaluation. Research governance approval was sought and gained from each of the PCTs in February 2011.

## Chapter 4

### Bowel cancer screening uptake rates

#### 4.1 Introduction

The project sought to establish whether the measures taken by GP practices outlined in Chapter 1 would increase GP practice level screening uptake rates to 5% or above which was the target set for the project.

In order to identify the percentage uptake of screening the campaign had two further strands of data collection. The first data collection was the numbers of non-respondents out of the eighty who subsequently came forward for screening, which was provided by GP practices. The second strand of data collection for awareness-raising was provided by PCT screening leads via the North West Quality Assurance Reference Centre. With regards to the eighty non-responders, the Reference Centre advised that it would be better to go directly to GP practices for the information so as to be able to pinpoint those who responded as a direct result of the GP reminder letter, despite the fact that it would have been easier to access the data from one source. The data compared uptake rates from January to June 2010 with 2011. The data was in the form of overall numbers of patients who were invited to be screened, including the eighty non-respondents and those who took up the offer and were subsequently screened. These two strands were undertaken because of the difficulties in obtaining data and the complexities of how uptake rates are calculated.

Participating GP practices that provided details of their eighty most recent non-responders from local practice I.T. systems were also required to identify demographic data from their records for these patients, including age, disability and ethnicity for analysis.

#### 4.2 Demographics of non-respondents

Ten of the sixteen (62%) participating GP practices made returns in respect of the demographic data of their most recent non-respondents. These data appear in Table 4.1 overleaf. Some GP practices which made a return did not include information in all the categories requested; returns were complete only in respect of gender. The returns for age were 99% complete.

The demographic data for gender show that 47.8% of non-respondents were male and 52.2% were female. The following age data reveal that half of the total non-respondents were aged between sixty and sixty five:

Age	% of total	Age	% of total
60-61	16.5	68-69	13.5
62-63	19.5	70-71	11.5
64-65	14.1	72-73	3.6
66-67	11.6	74-75	9.7

The data for disability and ethnicity were incomplete. Practices commented that collection of ethnicity data was particularly time consuming and some practices did not appreciate the value of collated data, as opposed to individual patient data.

PCT	GP Practice No <sup>2</sup>	Gender		Age								Disability <sup>3</sup>					Ethnicity						
		M	F	60-1	62-3	64-5	66-7	68-9	70-1	72-3	74-5	PD	LD	MH	HI	VI	WB	W O	A/ AB	B/ BB	Ch	O	DK
Wirral	1	44	35	9	20	7	15	9	11	0	8												79
	2 <sup>4</sup>	31	31	12	17	8	7	3	8	0	8	17					62		1				
	3	35	45	13	19	9	6	6	14	0	13	10	1	0	1	0	80						
Liverpool	4	35	45	11	21	14	11	8	8	1	6												
	5	51	32	14	6	8	6	11	5	12	11	4	1	5	6	4	61	3			2		17
	6	39	45	14	22	6	8	20	9	0	5	5	1		1	1	83						1
Halton and St Helens	7	28	40	11	1	14	12	7	9	7	7	1	1	0	7	0	68	0	0	0	0	0	0
	8	43	37	19	21	16	6	8	3	1	6	0	0	1	0	0	60	1	0	0	0	0	19
	9	39	41	14	11	12	11	14	7	0	11	2	1	2	0	6	54	2	0	0	0	0	24
	10																						
	11																						
Knowsley	12	38	42	11	21	8	7	15	11	0	7	1	5	2	1	1	78		2				
	13																						
	14																						
	15																						
	16	53	70	15	19	19	20	18	19	8	5	4				4							
<b>TOTALS</b>		436	463	143	178	121	109	119	104	29	87	44	10	10	16	16	492	6	3		2		140

**Table 4.1 Non-respondent patient demographic data**

<sup>2</sup> Some GP practices which made a return of respondents did not make a return of demographics at all or in all categories requested. All returns were complete only in respect of gender.

<sup>3</sup> Excludes 'None' and 'Don't know' in each category of disability.

<sup>4</sup> Demographics for age and ethnicity do not sum with gender and overall totals.

### 4.3 Uptake of screening rates

In order to establish if the eighty non-respondent reminder letters from each participating GP practice increased the return of the FOBt kits, the letter asked patients to request a new kit by calling the hub on a free phone number and it was anticipated that data would be available to identify how many previous non-respondents requested a new kit following receipt of the GP letter.

Table 4.2 shows data for each GP practice in respect of the number of reminder letters sent to non-respondents, and the number and percentage of those who responded to the reminder. Data was unavailable for Wirral GP practice 2 and Knowsley GP practices 13 and 14 as they had recorded the data appropriately and then acquired new computer systems and were then unable to access any results.

**Table 4.2 Reminders and responses by GP practice**

PCT	GP Practice No	No. of reminder letters sent	No. of respondents	Response rate 2011 (%)
Wirral	1	80	3	3.75
	2	62	Unavailable	
	3	80	13	16.1
Liverpool	4	80	1	1.25
	5	83	10	12.1
	6	84	6	7.1
Halton and St Helens	7	68	9	13.2
	8	80	6	7.5
	9	80	6	7.5
	10	80	5	6.25
	11	80	6	7.5
	12	80	3	3.75
Knowsley	13	80	Unavailable	
	14	80	Unavailable	
	15	80	7	8.75
	16	123	53	43.1
<b>TOTALS</b>		<b>[1078]</b>	<b>[128]</b>	<b>[11.87]</b>
<b>TOTALS Excluding Practice No 16</b>		<b>[955]</b>	<b>[75]</b>	<b>[7.8]</b>

The data concludes that the campaign was successful as the overall uptake during the campaign was 11.87% and the percentage of non-responder patients who came forward for screening varied from 1.25 to 43%.

The project found that there were considerable challenges in the availability and collection of appropriate data. This was due to current changes in service and key personnel not being available or having moved to a new post. There were also discrepancies in interpretation of the implementation of the project. Knowsley GP practice 16, for example, did not appreciate that reminder letters should be sent to only the most eighty recent non-respondents and instead sent One hundred and twenty three.

GP practice sixteen response rate surpasses the next highest rate by more than three times and distorts the overall response rate by approximately 5 additional percentage points. In telephone discussion with the practice manager which was intended to seek to elicit the reasons for this success rate, the possibility of any special measures having been taken was initially discounted. Further exploration established, however, that the practice manager had followed up non-respondents who had not responded one month after the information was sent out to enquire whether the kit had been received and whether the respondent intended to do anything with it. In some cases these non-respondents were advised why screening might be beneficial for them. In other cases, respondents said that they had thrown kits away, in which case the practice manager asked them to contact the hub to request a replacement kit. The practice manager went on to advise that she sends communications of this type to patients relatively frequently. Her follow-up routine is such that patients expect her to call if a response is not received after a month or so and she suspected that the personal contact from a known individual at the practice may have had some persuasive value in eliciting a response

There was lack of consistency across GP practices in the use of read codes in recording patient data. Some practices only recorded those who took part in the screening and did not appreciate the need to also record the non-responders. This may have contributed to the gaps in the recorded data.

The second strand to the data collection was to monitor the effectiveness of the awareness raising campaign. This was undertaken by comparing percentage uptake of adequate screening by participating GP practices between January to June, 2010 and 2011. Table 4.3 identifies the percentage of patients, by GP practice within the project of percentage uptake of screening including the non-responders. Six out of the sixteen (38%) participating practices recorded an increase between the three months in 2010 and 2011.

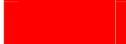
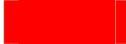
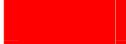
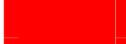
Table 4.4 compares percentage uptake of adequate screening by Warrington GP practices between January to June, 2010 and 2011. Warrington practices were not involved in the screening campaign but took part in the awareness raising.

Eight out of twenty five practices (32%) recorded an increase in the uptake of screening. These results were inconclusive as to if the awareness raising campaign was successful in increasing uptake, although the uptake



was higher in the practices that had taken part in the project as opposed to those who were only involved in the awareness raising.

**Table 4.3 Summary by GP practice within the project of percentage uptake of screening including the non-responders data from table 4.2**

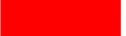
GP Practice	Jan-June 2010			Jan-June 2011				
	Invited	Adequately screened	% uptake	Invited	Adequately screened	% uptake		
Wirral	1	72	30	41.6	247	129	52.23	
	2	50	23	46	136	55	40.44	
	3	52	33	63.4	221	150	67.87	
Liverpool	4	76	45	59.2	275	189	49.74	
	5	86	49	56.9	178	78	43.82	
	6	53	31	58.4	475	219	47.92	
Halton and St Helens	7	161	81	50.3	517	226	43.71	
	8	88	35	39.7	341	144	42.23	
	9	86	37	43	320	148	46.25	
	10	129	62	48	491	221	45.01	
Knowsley	11	150	85	56.6	558	293	52.51	
	12	89	45	40	384	178	46.35	
	13	336	161	47.9	1055	471	44.64	
	14	19	11	57.8	118	49	41.53	
	15	19	6	31.5	68	31	45.59	
	16	22	14	63.6	125	54	43.20	
<b>Totals</b>	<b>1488</b>	<b>748</b>	<b>50</b>	<b>5509</b>	<b>2635</b>	<b>48.00</b>		

 percentage increase lower in Jan-June 2011 from same period in 2010  
 percentage increase higher in Jan-June 2011 from same period in 2010

**Table 4.4 Summary of screening uptake by Warrington GP practices who were involved in awareness raising only**

GP Practice	Jan-June 2010			Jan-June 2011			
	Invited	Adequately screened	% uptake	Invited	Adequately screened	% uptake	
1	195	85	43.59	241	138	57.26	Green
2	304	169	55.59	330	177	53.64	Red
3	176	102	57.95	516	252	48.84	Red
4	1006	646	64.21	352	179	50.85	Red
5	1090	673	61.74	286	167	58.39	Red
6	330	191	57.88	170	65	38.24	Green
7	253	123	48.62	833	524	62.91	Green
8	124	62	50	191	88	46.07	Red
9	208	79	37.98	402	221	54.98	Red
10	198	128	64.65	144	53	36.81	Red
11	610	354	58.03	118	63	53.39	Red
12	421	238	56.53	426	268	62.91	Green
13	417	248	59.47	236	130	55.08	Red
14	553	323	58.41	433	228	52.66	Red
15	92	35	38.04	329	172	52.28	Green
16	401	207	51.62	148	98	66.22	Green
17	687	349	50.8	150	87	58	Red
18	92	57	61.96	214	90	42.06	Red
19	390	256	65.64	148	100	67.57	Green
20	101	53	52.48	69	36	52.17	Yellow
21	54	29	53.7	79	33	41.77	Red
22	299	145	48.49	15	4	26.67	Red
23	492	320	65.04	15	0	0	Red



24	521	278	53.36	67	36	53.73	
25	77	55	71.43	10	4	40	
<b>Totals</b>	<b>9091</b>	<b>5205</b>	<b>57</b>	<b>5922</b>	<b>3213</b>	<b>54</b>	

Key:  percentage increase lower in Jan-June 2011 from same period in 2010  percentage increase higher in Jan-June 2011 from same period in 2010  no percentage increase in Jan-June 2011 from same period in 2010

## **Summary**

The data concludes that the campaign to increase the number of non-respondents to undertake screening by 5% was successful as the overall increase during the campaign was 11.87%. There was an anomaly in GP practice 16 and even in removing this data the total uptake was 7.8% which is a highly successful outcome.

There were substantial challenges with regard to data collection across all GP surgeries. The campaign highlighted the challenges that practices had in identifying the required demographic and non-respondent data. Some practices had problems in accessing demographic data generally. All had problems accessing ethnicity data; commenting it was time consuming and often came down to a manual task.

## Chapter 5

### GP practice staff findings

#### 5.1 Introduction

This part of the study was designed to assess the impact of the bowel cancer screening awareness campaign run in participating GP practices from the practice staff perspective. This chapter presents findings from interviews with a sample of healthcare staff involved in the campaign. Qualitative methods were used to explore the experiences and perceptions of the campaign amongst GP practice staff at participating practices. Fieldwork took place in May and June 2011, shortly after the three month campaign had finished running.

#### 5.2 Description of the sample

Telephone interviews were carried out with eleven participants (nine females, two males) representing eleven GP practices across the four PCTs. Three practices were from Halton and St Helens PCT, three from Knowsley PCT, three from Liverpool PCT and two from Wirral PCT. The sample included practice managers, administration/ office managers, business managers, GPs, a healthcare consultant and prescribing advisor, an information management and technology manager and a data officer.

#### 5.3 Interview findings

The primary aim of the interviews was to establish how staff at the practices found the process of running the campaign, what they thought worked well and areas for improvement. The interview transcripts were analysed under the themes presented below: identifying non-respondents, collating demographic data, information provision, engagement and practice development.

#### 5.4 Identifying non-respondents

Practices received a list of the eighty most recent non-respondents, i.e. patients who had not responded to the invitation to take part in the bowel cancer screening programme, from the screening hub. It became apparent that some of the practices were reliant on this list, unable to easily identify non-respondents themselves. In contrast other practices were routinely using read codes to highlight non-respondents in the electronic patient records. Read codes are electronic systems used by UK GPs to record clinical and administrative information. More extensive use of read codes can facilitate keeping of disease registers, influence service design and

audit (NHS Connecting for Health, 2011). Although practices were recording the results for patients who completed the bowel cancer screening, not all practices were recording details for those who had not taken part (the non-respondents). This is reflected in the extracts from one interviewee below.

‘... we didn’t read code them [non-respondents] at all. What we did is we scanned them into the patient records and then it goes to a GP for them to have a look at and then they just file it. That’s where it fell down. Breast screening and bowel screening, when those reports come in when a patient has completed the treatment as such or responded to the treatment, the read codes are put on immediately by the staff and then given to the GPs. But with the non-responders it wasn’t and the GPs weren’t sending them back to staff to be read coded so nothing was happening.’ (Participant a)

As a direct result of the campaign some of the practices that struggled to identify non-respondents made this a higher priority. The extracts below highlight how the campaign raised staff awareness at the GP practice and highlighted data quality issues.

‘...we had got about twenty coded already, but I think it put more urgency on it but it also showed the staff that are putting the codes in that actually there is a reason for it because we were saying that we wanted it coded but it was more for the fact that I wanted it coded. We do the mammogram service. Again, we get the results back and I was saying I wanted it coded but there was no... staff weren’t understanding why was that useful, if they didn’t attend and there was no results, why? So for the bowel cancer, I turned around and said we have to code this now because we need the data to actually re-contact these patients, so it’s quite good timing.’ (Participant f)

#### **5.4.1 Including reminder flags for patient discussions**

One practice was already identifying bowel cancer screening non-respondents and putting a reminder flag (alert) on their records for the GPs to remind them at their next appointment even before the campaign was introduced. The interviewee described how alerts had also been used for other screening programmes on occasion: ‘So we do use that system for getting some response or trying to make it more obvious to the GP that this patient has got something outstanding.’ (Participant b)

One of the GP interviewees felt the use of a reminder flag (or alert) to discuss bowel cancer screening at patient appointments was a worthwhile part of the campaign and a process they were used to, as detailed below.

‘It was actually a very handy way [of discussing bowel cancer screening opportunistically] because it come up as an alert, you know, it allows me to do the opportunistic um advice, so that was helpful and we’re quite used to that on our systems we have alerts for a number of things that we could reasonably do opportunistically, you know, flu jabs being a good example. So we’re quite used to acting on alerts that may not be directly related to what their original consultation was for. So um yeah, we’re quite happy to do that.’ (Participant k)

Although practices were adding reminder flags to the records of the non-respondents it was acknowledged that it would be hard to know how many of these reminders resulted in a discussion or completion of the kit. The same participant goes on to describe the difficulties in knowing how effective these discussions are.

‘Some people were positive, some people appeared positive, but whether they actually acted upon what they said is quite another question and some people said that it just wasn’t for them and they weren’t interested.’ (Participant k)

Additionally it was highlighted by one participant that reminder flags are becoming more and more commonplace within GP practices, and may become liable to ‘flooding’. It was felt some of the bowel cancer screening non-respondents were likely be part of the group least likely to engage, and this would result in them having several reminder flags.

‘Yes, the only time we have reminder flags on EMIS, we’re actually starting to use them for a lot of things, we’re using them now for smears, we’re using them for patients who default on retinopathy for diabetes, we’re using them on patients whose medications we need checking, so what we are finding is because there’s so much going on in the NHS, that the alert system is starting to get a bit flooded. I would like to put more alerts on but we’re holding back because some patients you click on and they’ve got like 6 alerts and they’re patients who aren’t engaging in anything. So, the bowel cancer one, the only problem that could’ve happened is that they could’ve ended up on notes with other things that the patient needed to come in for.’ (Participant f)

## **5.5 Sending out information**

Sending out the campaign materials to non-respondents (letter, leaflet, bookmark and DVD) was generally seen as an easy process, and one that practices were used to. They appreciated the fact the information was in a format ready to go and all they had to do was print the letter, as the extracts below highlight.

- Participant: You just provide one letter, put in all of the patient's names and it gives a list and then collates them all together and just churns out all of the letters. And then you've just got to put them in the envelopes.
- Interviewer: Okay, and was that time consuming itself? Putting the material in the envelopes?
- Participant: Not particularly. It's something that we do an awful lot of for lots of campaigns. I mean even for our normal work with our national targets, we're sending out reams of paper daily.
- Interviewer: So you're used to the processes?
- Participant: Yeah. It's no easier or harder than anything else we do. (Participant a)

Some practices commented about the size and cost of the materials being sent to patients. A larger envelope and higher postage charge was required, and this needed to be reflected in any costing of the campaign. The only other difficulty mentioned was from one practice which did not think it was clear that they should be sending out DVDs with the letters, and so ended up doing two mail-outs, as detailed in the extracts below. They also highlighted how it would have been beneficial to them to have received all the materials at the same time.

'... we got the information from the hub with the detail of the letter to send out and we send that out and we sent it out as a job lot, we didn't sort of do it in groups, we just sent to the eighty patients that we'd identified at once and then we seemed to get more information with the DVD and that in. So we had to then send that out on top of the letter we'd sent... We read the letter as that we weren't sending the DVDs out, the patients were contacting whoever it was to get a copy of that DVD so it was a bit of a surprise then, we then got them in and had to send out further letters. (Participant h)

Some practices suggested sending the information to non-respondents in batches may be easier. One had already done this and another considered it.

'I think, possibly, a little bit more awareness for us as to what was expected and sort of time frames and stuff because as I say, we sent all letters out at once, we wasn't entirely sure whether we should've broken it down into groups over a period of time.'  
(Participant h)

## 5.6 Collating demographic data

Practices felt that some aspects of the demographic data that they were asked to collate for non-respondents (gender, age, ethnicity, physical disability, learning disability, mental health, hearing or visual impairment) were harder to provide than others. If a read code or register (such as the mental health register) was available that recorded the requested demographic data it was generally seen as an easy process. The exception to this appeared to be ethnicity which many practices admitted is not easy to pull out or record: ‘... the actual ethnicity is always a problem for us’ (Participant a). Some practices found the process quite time consuming, and for some it was largely a manual task: ‘It took a little while, I wouldn’t say, because there were eighty, it wasn’t too bad, if there had of been a couple of 100, probably it would’ve been worse’. (Participant e)

That was a bit time consuming, I had to pass that on to somebody else because there was a manual check, because obviously, not everything was coded in the records so it was a manual check. And there’s quite a lot of criteria from what I can remember.’ (Participant h)

One interviewee questioned how useful an exercise collating the demographic data was as it was not collected at an individual level, as highlighted below.

‘It didn’t influence us that much and because they only needed overall numbers, they weren’t tracking individuals through, it seemed a little bit strange. You know, giving a number of people with severe disability or blind or I can’t remember, whatever the criteria were, if you say, one out of your eighty was visually impaired, how do we know whether that is a big factor,’ (Participant c)

## 5.7 Information provision

The level of information provided by ChaMPs regarding the campaign was generally well received by practices: ‘The information, to me, was self-explanatory. It was all very easy to follow’ (Participant a). There appeared to be some delays and confusion in receiving the correct campaign information for the practices that were to be involved in the initial pilot stage. The extract below highlights how NHS staff are subject to vast amounts of information on a daily basis, so keeping it to a minimum is a big help.

Participant: Yes but most of our staff are aware of it anyway so yeah, I think the problem with the NHS tends to be the other way, that we tend to, with our staff, we tend to over inform them, because they have to know so much information, but it’s often a case that the staff feel they can’t

absorb any more rather than a lack of information so yeah, we did have it available in various formats if they wanted it or required it.

Interviewer: And did you feel there was too much information from ChaMPs?

Participant: I don't think so but because we get so much information, even if it's an A4 page, it's an A4 page on one topic when we're got A4 pages on diabetes, mental health, smoking cessation, etc so it ends up that all information, feels like from my point of view and I'm sure it must feel like this to everyone else, it just feels like we've got libraries worth of it coming in every day. (Participant f)

## 5.8 Engagement

Interviewees were asked to consider their overall impression of the campaign, what worked well and what was not so successful. The campaign was generally well received and the importance of raising awareness appreciated, as highlighted in the following extract: 'It was good to bring the importance of having the bowel screening done to the patient's attention' (Participant J). Whilst some interviewees questioned the effectiveness of sending out an additional reminder to non-respondents who had already failed to respond to the initial FOBt kit and reminder letter, interviewees indicated that GP practices were still willing to engage in the process.

'Um, I thought it needed to be done and it was good to do it and I would quite happily do it again if I was asked to do, I mean, at first, I was thinking, more work but it wasn't that time consuming and obviously I think it's something that needs to be done.'  
(Participant e)

In terms of the process of running the campaign the feedback was generally positive, with practices, on the whole, highlighting how smoothly it ran and how little time it took to administer

'I thought it was fine, I thought the way it was handled was very professional, as I say, the information arrived in a format that was, it didn't give us too much additional work for our day to day job and, yeah, everything went swimmingly.' (Participant g)

One interviewee described the direct impact the campaign had had in identifying patients with abnormal results: 'Cos I know, you did get some positive results and obviously those patients wouldn't have been picked up possibly until a later date.' (Participant b). Other interviewees noted how the campaign had got the attention of patients and got them talking about bowel cancer, '...because people were talking about it, patients were

coming in to the surgery and it seemed to be having an impact.’ (Participant f) The campaign posters displayed in the GP practices made a positive impression on some patients as demonstrated below.

‘We did have all the posters and things up in the waiting room and certainly a lot of other patients were talking about it and mentioning it and like you said earlier has anybody brought it up, yes a few have, not just with the bowel cancer symptoms but a few have mentioned it when you’ve asked about other screening, oh yes, I’ve had this test, that test, the bowel test.’ (Participant c)

Interviewees went on to describe the benefits of the direct message and eye catching design of the posters.

‘I think the posters that have come out that are a bit more blatant, were easy worded and more colours and stuff, I think it’s good because I think we’re trying to over educate and blatant messages seem to be absorbed more. I thought that was good.’ (Participant f)

The materials sent to non-respondents also received positive comments from one interviewee.

‘I think the DVDs and the actual literature that was sent out was excellent. Nice and gory, lots of pictures of exactly how to collect poo, which yes, mightn’t be the nicest thing to look at but that’s the thing that puts people off, don’t know how to do it so don’t do it. And I had a look at the DVD and it all seemed good, so the, yeah, the information for the patients was excellent, they just need to bother to open the envelope.’ (Participant c)

Despite these positive comments many practices were quick to highlight the difficulties inherent in targeting what may be an already hard to reach group, as highlighted in the extract below.

‘I think, from my own personal point of view, it was a good idea, I think any screening that we can encourage people to take as a preventative measure is good but as I say, I think you’re always going to come across patients who don’t attend for anything, I just don’t know how you get messages across to those people.’ (Participant b)

It was also acknowledged that some non-respondents did not appreciate yet another reminder letter, below:

‘I think the only disappointing side was that some of the patients that had still refused or declined in the past were still quite adamant, which part of this do you not understand, I don’t want to do it so didn’t understand again why they’d been asked. I think that was

the only downside but I know some patients did uptake as a result so if we made a difference to those that did uptake, mission accomplished.’ (Participant g)

One interviewee highlighted the need for better co-ordination and planning regarding the timing of campaigns, suggesting it is better to focus on one campaign at a time.

‘That’s the thing with the NHS, it never focuses down, I keep saying to our PCT they want to do everything, I keep saying, why can’t you just run for three months a thing that you want general practices to do on smoking, just smoking for three months, nothing else, forget all the other targets, and then if you want bowel cancer, why can’t you do that for a month, or two months on bowel cancer only so that what we’re giving is consistent messages and we’re not being hassled because, through the bowel cancer screening campaign, we’ll have also been asked for various other bits of information to do with other things that were happening. So it just feels that we never actually ever tackle anything really, what we’re doing is just everything.’ (Participant f)

The letters caused some non-respondents to make direct contact with the GP practice regarding the FOBt kit, either by speaking to reception in person or on the telephone. It became apparent some non-respondents were confused as to why there was no FOBt kit enclosed with the letter, even though this was clearly stated in the letter.

‘The only thing we did find was a few times, patients ended up at reception, they hadn’t read the letter properly, so although the letter clearly stipulated the telephone number, I think the telephone number was in it twice and once it was next to the fact that, it said ‘if you need an extra kit please phone this number’. But a couple of patients ended up at reception saying, we haven’t got a kit and how do we get one. So we then had to, I couldn’t recall exactly what the letter said so had to read it again and then highlight where it said the number and give one to each reception so that they could actually say to patients, yes, it does say, this is where you get it from. So it may have been, some patients got the letter, had used the kit, didn’t read the letter properly and then didn’t bother responding because they didn’t have a kit, and I don’t know how you get round it because it was quite clear when you had the letter how to get the kit.’ (Participant f)

One practice contacted by non-respondents used this opportunity to pro-actively talk to patients about the benefit of completing the FOBt kit and where appropriate order FOBt kits from the helpline on their behalf.

When interviewees were asked if their practice would continue the campaign as part of their day to day work the answers were varied. Some felt they may be too busy to realistically run the campaign without extra time or resources: 'it's finding the time, it's another job for us to do, so if we had the time and the resources to do it, yes' (Participant e). Conversely others did not feel it would be too onerous a task with one practice already identifying and targeting non-respondents. Additionally some felt it was not the responsibility of the GP practice, but that of the screening hub, as highlighted in the extract below when asked if their practice would be prepared to carry on sending reminder letters.

'No. Only because there are that many others... I'm not saying it's not a priority but because of the work we do it's all how we get our income and if there's no income associated with it it's very difficult. It's just more work for somebody to do and there's no reward as such. I'm not saying that keeping your patients healthy isn't a reward but they would probably challenge that it's the bowel screening department's responsibility to do that. As in, even with the breast screening, we don't send reminders for breast screening either'. (Participant a)

The burden on practice time was often cited as a reason not to carry on sending reminder letters to non-respondents. When asked if their practice would carry on sending reminder letters one interviewee suggested that carrying out hits every once in a while may be a more practical approach.

'Erm, it would become a bit of a bind then to be honest. I think if you just do it as a hit twice a year or something like that, from a practice point, that's how I'd prefer to run it to be honest. We have enough day to day stuff that we're continually trying to keep on top of, whereas with just getting that eighty we just dedicated an hour or two to get it done and then it was done rather than it trickling through, sometimes it's easier to have it in a bulk and you can just get it done.' (Participant b)

One interviewee commented that their practice would continue using the reminder flags for non-respondents rather than sending out letters. Another interviewee felt that personal contact, either at appointments or via a telephone call, was more effective in improving uptake rates than letters, as described below when asked if their practice would continue to send reminder letters.

'...only if it proved it had a benefit and from what I've seen of the other screening things we've done, it doesn't seem to work, now whether the graphics of the literature may, um, but certainly sending a letter saying you've not responded to your bowel screening invite, it's very important to do so, blah, blah, blah, that doesn't seem to work, even if you word it very strongly. From the evidence we've got it seems to be that a personal

touch works, when you can actually confront the patient and say well, why haven't you done it and then you can try and get round some of the excuses.' (Participant c)

During the interviews the difficulties in evaluating the impact of the campaign were highlighted. It was acknowledged it may be difficult to attribute a non-respondent's response directly to the campaign, as opposed to any national or local coverage beforehand.

'I'm trying to think about how much nationally or locally the PCT promoted it, you know, to make the patients aware that this is going to happen rather than them, maybe, the first they knew about it was just getting the letter via yourselves, saying, this is going on.' (Participant b)

It was also acknowledged that it was hard to disentangle the separate strands of the campaign to see which approach worked best.

'I think it's valuable because um I know that overall uptake hasn't been as high as we might like - both nationally and locally. It's certainly valuable. I think the campaign posters and literature was easy to understand and not patronising, which occasionally things can be. So I thought it was quite well put together. And I think because it's a fairly new screening FOBt kit unlike say cervical cytology. I think it raised... we're very used to discussing the things that we've been doing for a long time and I think maybe it was an aide memoire for us [GPs] to remind people and I think it was very helpful on that front. Obviously I don't know if lots more people were screened as a result of it. I hope so. But I think as a programme it was well put together and we were happy to be a part of it.' (Participant k)

## **5.9 Practice developments**

As highlighted earlier, for several practices the whole process of identifying the eighty most recent non-respondents had served to emphasise the need to keep accurate and up-to-date records in order to allow patients to receive the best standard of preventative care possible. The extract below highlights how practices took this as an opportunity to develop their systems for identifying who had and had not completed screening programmes.

Participant.... There was initially a coding issue of who had completed and not completed their screening, so we had to kind of go through it manually to ensure all the codes were done rather than just do a simple search. But I think perhaps, this isn't an issue with the campaign, but I think when it first came out the importance of having the screening coded wasn't made clear perhaps nationally which then made it somewhat laborious to then go through and find the patients with un-coded information. But we've learnt that lesson, so we won't fall for it again.

Interviewer: So does that mean you've changed your practice as a result?

Participant: Yes, so we're now aware of what codes, which codes to use so that we can easily search and audit who has, and hasn't had it. (Participant k)

One practice complimented the awareness raising campaign by encouraging any non-respondents contacting the GP practice to talk to the doctors or practice staff about the screening process, and, where applicable, the practice ordered a FOBt kit on their behalf. This is described in the extract below when the interviewee was asked for their overall impression of the campaign.

'I thought it was good. My view was that by doing this we have encouraged the patients to do it and patients were quite, in the beginning, they didn't think, they just DNA'd or didn't return their bowel kit but when we sent them a letter and they called back and they were not sure or they said, we can't do this or this is not something I would ever do, some patients were saying that, that it will be difficult. So, I thought it was good and they were encouraged after a conversation with the doctor or with myself that they should do it. Most of the patients, a few of the patients declined and we have recorded them as declining the bowel screening but most of them, they did, they done their kit.'  
(Participant i)

## 5.10 Conclusion

The primary aim in interviewing GP practice staff involved in implementing the campaign was to establish areas that went well and areas for improvement.

The campaign was generally well received and the importance of raising awareness was appreciated. Campaign materials were generally considered cost effective and formatted in a way which was user friendly both for respondents and GP practice staff.

Differing views were expressed as to the best way of effectively reaching non-respondents who had already declined to be involved. Initiatives that promoted discussion with surgery staff, such as the eye catching posters in the surgery, were felt to have a positive direct impact, and the absence of FOBt kits from the reminder letter which led patients to query this at the surgery led to opportunities for further awareness-raising. Others felt that facilitating GPs to initiate discussion during routine appointments by flagging patient records was a more effective way of initiating discussion and increasing compliance. There was overall consensus from those interviewed that GP involvement in the project was a positive measure.

Practices commented upon the cost and resources involved in sending out reminder letters and this would influence compliance with any future screening initiatives. This project was funded; and it was a once only project fee allocated in order to evaluate the effectiveness of GP involvement.

## Chapter 6

### Bowel Cancer UK member findings

#### 6.1 Introduction

This chapter presents findings from semi-structured interviews with members of a charity to discuss the campaign material. Fieldwork took place in June and July 2011.

#### 6.2 Description of the sample

Semi-structured interviews were conducted with members of Bowel Cancer UK, a charity which aims to save lives by raising awareness of bowel cancer, campaigning for best treatment and care and providing practical support and advice. These patients did not fit the 'non-respondent' profile, that is, someone who had failed to respond to the national programme and then been contacted by their GP. The participants were active members of the Bowel Cancer UK Charity, and therefore had a good level of awareness of both bowel cancer, and the methods of promotion used to encourage uptake. As active members, each of the participants had regularly been involved in charity events, promotional activities and engaging with members of the public through a range of voluntary activities and events. Five interviews were conducted by telephone, in June and July 2011, with four males and one female. The length of interviews varied, according to the comments that participants had to say. Interviews lasted between fifteen and thirty five minutes.

#### 6.3 Interview findings

The primary aim of the interviews was to establish what interviewees thought of the campaign material sent to non-respondents, and displayed in GP practices. Before conducting the interviews, each participant had received examples of the Bowel Cancer Screening programme materials (GP letter; DVD; A5 leaflet; mini-leaflet; poster and bookmark). The interview transcripts were analysed under the themes presented below relating to overall impressions and the individual campaign material pieces.

#### 6.4 General comments

All participants expressed positive views on the purpose of the research and in being able to contribute to what they described as an important topic. It was felt that the issue of bowel cancer should be made more prominent with the general public, because although screening is for a targeted age group, participants were very keen to stress that it can affect everyone and therefore they believed that raising awareness of it in all age groups would reduce the taboo. They did however express some concern about how to engage people with the screening programme, especially if they had already failed to take part in the wider national programme. This should be seen in the context of these participants being survivors of bowel cancer themselves, and therefore having a heightened awareness of the importance of screening.

A number of more general comments were expressed in relation to certain aspects of the screening programme, and reasons why members of the public fail to engage with the programme. All participants pointed out that the subject was a 'taboo' amongst the public, and perhaps more specifically amongst the older population, in part due to sensibilities around talking about bodily functions:

'Because of the nature of it, it's a bit of a taboo isn't it, that's the trouble with bowel cancer, you're on a hiding to nowhere really.' (Participant 4)

'It's not a subject people like to talk about.' (Participant 2)

In addition, it was suggested that there may be difficulties in getting people to recognise the importance of taking part in screening when many of the symptoms of bowel cancer remain hidden for some time, or could be mistaken for other less serious conditions or simply as part of the ageing process. It was felt that people may therefore be less likely to pro-actively engage in screening where they are no obvious signs of ill-health. Thus, bowel cancer may be perceived as an illness that affects the older population only, especially if screening is targeted at the over 60's, and that this might deter younger people from thinking about or looking out for signs and symptoms. This was thought to be part of a wider lack of sensibility about 'unpleasant' and taboo health issues.

'The nation seems to be under the impression that it's an elderly person's disease. You know, it doesn't apply to me because that is what older people get...'. (Participant 4)

It was suggested that there may be a perception that using a FOBt kit may be fiddly, difficult to use, and messy, and that if the reality of its ease of use were more widely known this might encourage people to use it.

‘People tend to be apprehensive about carrying the thing out, that’s the problem, I wonder whether they shouldn’t be putting in more frighteners.’ (Participant 5)

Thus, it was considered valuable that the publicity materials provided information that might allay these fears, and provide clear information on the ease of taking part in screening.

## 6.5 GP letter

Participants all felt that the letter provided adequate information and was clear in terms of how it is presented. One commented on the use of colour to highlight key pieces of information, which was viewed positively. There were some concerns expressed that the letter would not necessarily encourage people to take part, especially if they had already failed to engage in the national screening programme. One male participant said:

‘If they’ve already rejected doing the FOBt initially then there’s nothing in there that says why should I do it now?’ (Participant 2)

It was suggested by several participants that the public may feel that if they have completed a screening FOBt kit once they would not need to remain vigilant, as this comment demonstrates:

‘I’ve had the kit and I’ve done it, I’m fine; they tend to have this impression that’s it, but people still need to be vigilant’ (Participant 4)

It was suggested by one participant that attention should be focussed on the risks and emphasis placed on what happens if you don’t do the FOBt. As such the letter in itself was not seen to be a strong enough warning. It was felt that perhaps for non-responders the letter in itself would not provide incentive enough to engage in the screening programme, especially if people had already chosen not to respond to the national screening programme. One participant suggested removing the 98% figure from the sentence in the letter that highlights ‘...most people (98%) have normal results and a healthy bowel’. He felt it may make people feel complacent about the risks involved and less likely to complete the kit in the belief that they are one of the 98%. However, in conjunction with the other materials, it was seen to be a positive move to increase screening uptake. It was also suggested that because the letter was being sent out from the GP, there may be more likelihood of recipients paying attention to it.

‘Getting GPs on board is an excellent idea... the concept of GPs following up emphasises the seriousness of the campaign.’ (Participant 5)

Comments on the other materials were broadly positive, and participants were generally in favour of the campaign strapline “do your bit and use the kit”. One participant, however, admitted to not being initially

impressed with the slogan as he felt it emphasised doing your bit for the greater good of the campaign, rather than doing it for yourself.

## 6.6 DVD

Generally all participants shared the view that the content of the DVD was good and that it was clear, well presented and the content was well balanced.

‘This is a very good idea because people respond to visual information better.’

(Participant 4)

As such, it was felt that it described the process of screening appropriately, and that the use of visual media would be a more persuasive method of engaging the public in the screening programme.

‘The age range that they’re pitching it at, to have a visual thing, not many of us like reading instructions, to have something like that is quite valid.’ (Participant 4)

It was generally felt that the instructional element of the DVD made the FOBt kit more accessible and easy to use, such that it was felt that more people would be likely to take part. Spoken and visual information was considered to be easier to remember and understand;

‘The DVD is a good idea because people can watch and think I can do that.’

(Participant 4)

In addition, one participant felt that being able to go back and review the content was a benefit, whereas attending an appointment with a health practitioner could only be done once. Additionally, because of the potential ‘embarrassment’ factor of discussing a sensitive health issue, it was suggested that the DVD provides a human face but allows individuals to consider issues about screening etc. without having to meet face to face, which for some may cause some distress.

One participant suggested that there should be an explicit link between the letter and the DVD;

‘Should there be some mention in the letter from the GP to look at the DVD?’

(Participant 1)

It was suggested that there may be a tendency for people to skip through written information which might mean that important information is missed. The DVD allows all information to be imparted and thus is more likely that key messages will be heard.

## 6.7 Leaflet

Despite the fact that the participants felt there was a lot of written information contained in the leaflet (which as previously mentioned may prevent people from identifying all important messages) there was general agreement that the information was easy to understand and well presented. The view was that the issues were presented appropriately and the use of pictorial information to explain the FOBt kit was considered useful.

‘It combines information and reassurance.’ (Participant 3)

One participant drew attention to the comparison of health information to getting a car MOT. This was described by one participant as a good way to engage men, who were identified by all participants as being less likely to engage in health screening in general, as well as specifically to bowel cancer screening. As the following comments convey;

‘Men are probably less likely to follow up and pick things up.’ (Participant 4)

‘Women are more aware of their bodies, especially if they have had children; they’re not afraid of going to see somebody, but men don’t like to talk about it. They keep quiet and hope it goes away.’ (Participant 5)

Some participants expressed positive views on the inclusion of more detailed information on the range of symptoms. However one participant, who had been diagnosed with bowel cancer without having any of the symptoms in the leaflet, highlighted this as a potential impediment to engagement and felt that focussing on symptoms too much, may deter people from being more generally vigilant:

‘I think they could possibly put in there that you may not have any symptoms. People are looking for symptoms, people who haven’t experienced it, it’s difficult to get across to people; you still need to do it.’ (Participant 4)

It was suggested by one participant that whilst the screening programme was aimed at people over 60 years old, the leaflets were good at providing important information on bowel cancer that should be available to the wider population. For example, it was suggested that part of the taboo of the subject could be allayed by increasing awareness across all age groups. In addition, it was suggested by one participant that awareness could be increased by placing leaflets in pharmacies or supermarkets.

The issue of broader public awareness was addressed further through the additional materials, the poster, small leaflet and bookmark.

## **6.8 Poster**

All participants agreed that providing information to people through GP surgeries was a good idea and would play an important part in raising awareness and therefore encouraging participation in screening.

The poster was described as eye-catching, bright, colourful and easy to read. It was acknowledged that there is usually a large number of posters and other items on display in waiting rooms, so being able to stand out was important.

Generally the information was considered appropriate, although thought it was suggested by one participant that the poster should say 'if you have any questions then ask your GP or nurse today as it would seem to make more sense to encourage people to ask for information on the same day that they are at the surgery.'

## **6.9 Small leaflet and bookmark**

Participants agreed that the smaller items were discreet and therefore allowed people to access information easily without drawing attention to it. Mention was made of the various campaigns that participants had been involved in for Bowel Cancer UK which had used similar small promotional items, and these were perceived to be very successful at getting messages out. The most important feature of the other materials was that the contact phone number was clearly accessible. Participants liked the fact that the smaller items contained minimal information, but still maintained a focus on what they felt were the important aspects of the screening programme.

## **6.10 Improving the campaign**

In terms of how the campaign might be improved, some participants suggested that stickers might be a useful addition. Again, this was drawing on previous experience of other similar campaigns through Bowel Cancer UK, which placed stickers in strategic locations such as public toilets in pubs, supermarkets or restaurants etc. where people are more likely to visit on regular basis – possibly more frequently than GP visits – and therefore would be more likely to see them. As one participant said:

'What better place to raise awareness of bowel cancer than when sitting in the toilet?'  
(Participant 1)

Another participant drew on his involvement in a campaign where ‘case stories’ of local people’s experiences of the bowel cancer screening programme were included in materials, believing them to have a bigger impact.

‘I think that a campaign that is both more localised and using examples of people who have “been there and got the tee shirt” rather than health professionals would have more impact.’ (Participant 5)

He also felt that giving talks about bowel cancer screening from the perspective of someone who had ‘been through the system’ would be beneficial, although acknowledged there would be a resource implication to this.

Generally however, participants felt that to some extent there was very little that could be done, in addition to what was already being done, to increase screening uptake.

‘It’s difficult to know what you can put on these things. I don’t know how far you can go to get people to respond.’ (Participant 3)

## **Conclusion**

The primary aim of the telephone interviews was to establish what interviewees thought of the campaign material sent to non-respondents, and posters displayed in GP practices.

The materials were well received. Although participants thought that the GP letter was clear and provided adequate information, views differed on the effectiveness, with suggestions as to how the message could be strengthened. These included links to the DVD and stronger reference to risks.

The DVD’s combination of spoken and visual messages was welcomed as an appropriately persuasive means of engaging the public. The ability to go back and review the content was beneficial, as was the instructional element to using the FOBt kit.

The leaflet was viewed as easy to understand and well written; the small leaflet and bookmark were discrete but highlighted important information such as the contact phone number.

All participants agreed that the posters displayed in GP surgeries played a significant part in raising awareness, positively impacting on participation in screening. The posters were identified as eye-catching, bright, colourful and easy to read and so stood out amongst all of the other information on display.

## Chapter 7

### Discussion

#### Introduction

This chapter will identify the limitations of the evaluation, discuss the findings and make recommendations for future practice

#### Limitations of study

Due to strict confidentiality rules it was not possible to gain the opinions of service users or patients on the impact of the campaign, and so Bowel Cancer UK members who were keen to be involved volunteered to be interviewed instead. These participants generally had experienced, and been treated for, bowel cancer, and so may not be representative of the general body of non-respondents but under the circumstances were an acceptable alternative.

Cheshire and North Merseyside Screening Centre funded the project and ChaMPs initiated, organised, set up and managed the budget. The management and demands of the project were implemented by PCT leads. Furthermore, the introduction and implementation of the project to GP staff may not have been as co-ordinated as might have been expected because a number of project key contacts left due to changes within NHS organisations in the period during which the project was carried out. ChaMPs did not become aware of these staffing changes until the project tasks were too advanced to make any necessary adjustments. More generally, undertaking the project in the current political climate of transition and uncertainty in terms of structures and funding presented additional challenges. For example, PCT leads in some GP practices were not aware that they were required to send the DVD and, as a result, some patients did not receive it.

There were problems during the project in obtaining data. Because of the way the uptake rates are calculated, attributing them to when the FOBt kit was sent as opposed to received back completed, the project was advised by the North West Quality Assurance Reference Centre to access uptake rates directly from GP practices.

A second data issue arose from the fact that permission has to be given from PCTs to access their data and this could have meant seeking permission several times over. Furthermore PCTs were shown to report their

data in different ways and some were reluctant to release the same level of information as other PCTs, often due to local confidentiality policies.

## Conclusions

Overall the campaign was viewed positively by all of those interviewed, who recognised the difficulty in communicating with 'hard to reach' patients, the 'taboo' nature of the disease and the socially unattractive mechanism for collecting samples for screening.

The data concluded that the campaign to increase the number of non-respondents who came forward for screening by 5% was successful. The overall uptake across the participating GP practices was 11.87% and the percentage of non-responder patients who came forward for screening varied from 1.25 to 43%.

It was also clear from this project that personal association of GPs with screening awareness campaigns, for example by signing reminder letters, has a positive impact. This finding is supported by literature on the role of GPs in screening, (Damery et al., 2010). A similar study in France found that one of the factors credited with encouraging patients to complete the FOBt kit was the GP's explanations (55.7%) and the leaflet sent by mail (42.5%) (Arveux et al., 1992).

What was also apparent was that those patients who were personally followed up a member of the GP practice staff showed a substantial increase in compliance. This action was outside of the project and again this was backed up by research undertaken in Italy (Parente, Marino, DeVecchi, & Moretti, 2009). However there are severe cost and resource implications for this as a mainstream activity. This personal touch however might be achieved through the enlisting service users who have undergone screening and follow up in awareness campaigns, as 'cancer champions'.

Materials were considered fit for the purpose that they were designed and well received by both GP surgery staff and Bowel Cancer UK members. Those initiatives that promoted face to face discussion were seen as more valuable and these included the posters, and flagging patients' records to facilitate GP discussion during routine appointments. In light of the above consideration in the future might be given to:

- Adding to existing awareness by distributing leaflets in pharmacies and supermarkets and use of stickers in public toilets in, for example, pubs, restaurants and supermarkets;
- Encouraging an appropriate focus on risk by modifying poster text to invite patients to contact GP practice staff there and then;

- Including in awareness campaign materials personal FOBt testimony from those who have benefitted from screening.

Those involved in the project highlighted that one imperative factor for successful screening is the need to be clear and provide information in a cost-conscious format with clear instructions to staff on distribution. The approximate costs of the packs sent from GP practices to non-respondents were estimated as not less than £3.20 per pack (including postage) with DVD and not less than £1.20 per pack (including postage) without DVD. The GP pack consisted of a GP letter on headed paper, an A5 patient leaflet, a bookmark, a DVD in 9 languages in a printed card wallet and a white jiffy bag. These are not the full costs and do not include, for instance, design or artwork costs or the costs of the posters, health professionals' kits and other materials.

Differing views from practice staff were expressed regarding paying GPs to take part in the evaluation and project. Screening is routinely carried out centrally through the hubs and generally is not a GP responsibility. Some of the practice staff voiced opinions that it should be a mainstream activity, undertaken by GPs and funded appropriately, either from within existing budgets, or as a funded target. This was particularly significant given existing knowledge that uptake rates generally rise when patients receive reminders (Parente et al., 2009). Others felt that it would be too resource heavy and should remain centrally coordinated.

Results from the data collection within the project, with healthcare staff, led to some significant issues and challenges with regards to the management of patient data. The project highlighted a lack of consistency between GP practices in accessing demographic data and the relevance of its use to inform service provision. There was also variation in practices and abilities in the recognition of the importance and significance of using read codes and flags or alerts as a mechanism for identifying non-compliant patients.

## **Recommendations**

These recommendations are aimed at GP and their practice staff, public health screening leads, and other public health professionals.

1. The personal association of GPs with screening awareness campaigns, for example by signing reminder letters, has been shown in this project to promote uptake rates.
2. Consider training and education in the use of read codes for GP practice staff to ensure data are accurately and fully recorded. This would ensure the easy identification of non-responders in screening

3. GP practice staff need to recognise the importance of routine data collection and analysis on age, gender, ethnicity and disability.
4. Within the requirements of patient confidentiality and courtesy, there needs to be processes in place for non-responders to be systematically followed up.
5. The boundaries of responsibility for ensuring following up of non-respondents could be clearer.
6. Campaign materials which use multi-media formats, including visuals and speech, are likely to be most effective in conveying messages to the widest possible audience.
7. Awareness could be raised to the levels of more high-profile cancers by publicity, leaflet and sticker campaigns in public places, pharmacies, supermarkets, pubs and restaurants.
8. The contribution of those who have undergone screening could be enlisted in awareness campaigns (cancer champions).
9. Consideration could be given to development of an annual strategy for coordination and planning of screening as opposed to ad hoc activities

## Appendix 1 - Participant information sheet (GP practice staff)

### Participant Information Sheet

#### Evaluation of a local bowel cancer screening awareness campaign

You have been invited to take part in an evaluation of a local bowel cancer screening awareness campaign. Before you decide whether to take part it is important for you to understand why it is being done and what it will involve. Please read the following information carefully and ask if there is anything that is not clear or if you would like more information.

#### **What is the study for?**

The study is taking place to help Cheshire and Merseyside Public Health Network (ChaMPs) evaluate the success of the local bowel cancer screening awareness campaign. Part of the evaluation includes finding out the views and experiences of a number of GP practice staff involved in the campaign.

#### **Why have I been chosen?**

You have been chosen because the GP practice you work for has taken part in the bowel cancer screening awareness campaign rolled out by ChaMPs in early 2011.

#### **What will happen if I take part?**

We would like you to take part in a short telephone interview lasting around 20 to 30 minutes and tell us about your thoughts and experiences of the campaign. With your permission, we would like to audio record the interview so that the interviewer can take notes after they have spoken to you. If a telephone interview is not convenient we may be able to arrange a face-to-face interview at your place of work or at another agreed venue.

#### **Do I have to take part?**

It is up to you whether or not you take part. If you decide to take part you will be asked to give signed or verbal consent to say you have had this information about the study. Even if you decide to take part, you can withdraw at any time and you do not have to give a reason.

**What are the advantages and disadvantages of taking part?**

Sharing your experiences and views may help to improve bowel cancer screening awareness campaigns in the future. We do not think there are any disadvantages in taking part in the study.

**Will my taking part be kept confidential?**

Yes. No names or details that could identify you would ever be used in any conversations or written reports.

**What will happen to the results?**

A report will be written and will go to ChaMPs. We can also send you a report summary if you would like one.

**Who is paying for the study?**

The evaluation has been commissioned and funded by ChaMPs. Researchers from the Centre for Public Health Research at the University of Chester are carrying out the evaluation.

**What if something goes wrong?**

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact Professor Sarah Andrew, Dean of the School of Applied Sciences, University of Chester, Parkgate Road, Chester, CH1 4BJ, 01244 513055.

**For further information**

If you have any questions or want to know more about the study you can contact the researcher, Claire Tiffany, at the University of Chester, on 01244 512083 or [c.tiffany@chester.ac.uk](mailto:c.tiffany@chester.ac.uk). You can also write to Claire at the Centre for Public Health Research, University of Chester, Parkgate Road, Chester, CH1 4BJ.

**Thank you for reading this.**

## Appendix 2 - Interview schedule (GP practice staff)

### 1. GP/Health Professional questions

1. What is your job title/ role at the practice?
2. What has been your involvement in the local bowel cancer screening awareness campaign?

#### **Patient discussions**

3. What are your thoughts on carrying out opportunistic discussions about bowel cancer screening at patient appointments?
4. Did you discuss bowel cancer screening with any patients during the time the campaign was run at your practice?

If no, why not?

If yes,

5. Was this as a direct result of the campaign?
6. Was this because of the reminder flag?
7. Was this because they received the reminder letter from your practice?
8. Did any patients raise bowel cancer screening without prompting?
9. Is this something you would have discussed prior to the campaign?
10. What advice did you give during the discussion?
11. How did you feel the discussions went?
12. How do you think patients felt about the discussion?
13. What reasons, if any, did patients give for not completing the kit?
14. What feedback, if any, did you get from patients regarding the information they were sent?
15. How often would you say you initiated a discussion as a result of the appointment flag?
16. Do you think many went on to complete the kit?
17. In your opinion, are opportunistic patient discussions a worthwhile intervention?
18. What makes you think that?
19. Why do you believe people are not completing the bowel cancer FOBt kits?
20. What do you see as the main barriers to people completing kits?

#### **GP training and information**

21. Did you have all the information you needed?
22. Was there anything else you would have liked to know?
23. What do you think of the information you received?

#### **Overall impression**

24. How did you feel about the campaign?
25. What worked well with the campaign?
26. What did not work so well with the campaign?
27. How would you suggest the campaign could be improved?
28. How could the Bowel Cancer Screening process be improved?

29. Would you be prepared to carry on sending reminder letters to non-responders as part of the day to day work in your practice?
30. Could you explain your reasons for the answer to the last question?
31. Is there anything else you would like to add?

## **2. Practice/Administration/Data manager questions**

1. What is your job title/ role at the practice?
2. What has been your involvement in the local bowel cancer screening awareness campaign?

### **Identifying most recent bowel cancer screening non-responders**

3. How did you, or your colleagues, find the process of identifying the 80 most recent bowel cancer screening non-respondents?
4. What process does the practice use to record BOWEL CANCER SCREENING non-respondents?
5. How did you, or your colleagues, find the process of sending out information to the 80 most recent bowel cancer screening non-respondents?
6. How did you, or your colleagues, find the process of including reminder flags and read codes on the 80 most recent bowel cancer screening non-respondent patient records?
7. How did you, or your colleagues, find the process of collating demographic data (age, sex, ethnicity, sensory impairment, mental health, learning disability) for the 80 most recent bowel cancer screening non-respondent patient records?
8. What were your thoughts on the practicalities of running the awareness campaign in your practice (including additional copies of DVDs)?
9. Why do you believe people are not completing the bowel cancer FOBt kits?
10. What do you see as the main barriers to people completing kits?

### **Practice staff training and information**

11. Did you have all the information you needed?
12. Was there anything else you would have liked to know?
13. What do you think of the information you received?

### **Overall impression**

14. How did you feel about the campaign?
15. What worked well with the campaign?
16. What did not work so well with the campaign?
17. How would you suggest the campaign could be improved?
18. How could the Bowel Cancer Screening process be improved?
19. Would you be prepared to carry on sending reminder letters to non-responders as part of the day to day work in your practice?
20. Could you explain your reasons for the answer to the last question?
21. Is there anything else you would like to add?

## Appendix 3 - Participant information sheet (Bowel Cancer UK)

### Participant Information Sheet (campaign materials) Evaluation of a local bowel cancer screening awareness campaign

You have been invited to take part in an evaluation of a local bowel cancer screening awareness campaign. Before you decide whether to take part it is important for you to understand why it is being done and what it will involve. Please read the following information carefully and ask if there is anything that is not clear or if you would like more information.

#### **What is the study for?**

The study is taking place to help Cheshire and Merseyside Public Health Network (ChaMPs) evaluate the effectiveness of a local bowel cancer screening awareness campaign. Part of the evaluation includes collecting views from potential participants of the programme regarding the marketing materials used in the campaign.

#### **Why have I been chosen?**

You have been chosen in your capacity as a local member of Bowel Cancer UK.

#### **What will happen if I take part?**

We would like you to take part in a short telephone interview lasting around 20 to 30 minutes and tell us about your thoughts of the material used in the campaign. With your permission, we would like to audio record the interview so that the interviewer can take notes after they have spoken to you.

#### **Do I have to take part?**

It is up to you whether or not you take part. If you decide to take part you will be asked to give signed or verbal consent to say you have had this information about the study. Even if you decide to take part, you can withdraw at any time and you do not have to give a reason.

**What are the advantages and disadvantages of taking part?**

Sharing your experiences and views may help to improve bowel cancer screening awareness campaigns in the future. We do not think there are any disadvantages in taking part in the study.

**Will my taking part be kept confidential?**

Yes. No names or details that could identify you would ever be used in any conversations or written reports.

**What will happen to the results?**

A report will be written and will go to ChaMPs. We can also send you a report summary if you would like one.

**Who is paying for the study?**

The evaluation has been commissioned and funded by ChaMPs. Researchers from the Centre for Public Health Research at the University of Chester are carrying out the evaluation.

**What if something goes wrong?**

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact Professor Sarah Andrew, Dean of the School of Applied Sciences, University of Chester, Parkgate Road, Chester, CH1 4BJ, 01244 513055.

**For further information**

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**Thank you for reading this.**

## **Appendix 4 - Interview schedule (Bowel Cancer UK)**

### **Letter from GP**

1. Do you think the messages in the letter are easy to understand? If not then why?
2. If you received this letter from your GP would it encourage you to take part? If not, then why?
3. Do you have any suggestions on how to improve the letter?
4. Do you have any other comments to make about the letter?

### **DVD**

5. If you were sent the DVD with the letter, would you watch it? If not, then why?
6. Was the DVD useful and did it answer all of your questions or concerns? If not, then why?
7. Would the DVD encourage you to complete your kit? If not, then why?
8. Do you have any other comments to make about the DVD?

### **Leaflet**

9. Were the messages in the leaflet easy to understand? If not, then why?
10. Do you think the leaflet includes the right information? If not, then why?
11. Would the leaflet encourage you to take part? If not, then why?
12. Do you have any other comments to make about the leaflet?

### **Poster**

13. Do you think the messages in the poster are easy to understand? If not, then why?
14. If you saw this poster in your doctor's surgery, would it encourage you to take part? If not, then why?
15. Do you have any other comments to make about the poster?

### **General**

There are many reasons why people do not complete their kit. Fear is usually the main reason and others could include embarrassment and a lack of understanding. With this in mind:

16. Do you think the campaign addresses these issues? If not, then why?
17. Is there anything you would change about the campaign?
18. Overall do you have any other comments to make about the campaign?
19. Do you think there are other ways we could encourage people to take part? If so, what might they be?

## Appendix 5 - GP letter

**To be printed by GP practice on GP practice letter headed paper**

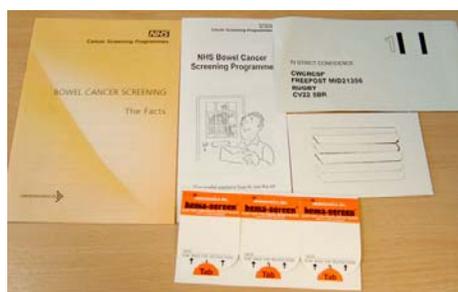
Dear Mrs X,

**If you're taking care of number 1, don't be scared to check your number 2's!**

**Help to prevent bowel cancer by completing your bowel cancer FOBt kit**

You were recently sent a bowel cancer FOBt kit to FOBt your bowel motion (faeces/ poo) but haven't completed it or sent it back yet.

I would like to remind and encourage you to complete and send back your FOBt kit.



*The Bowel Cancer FOBt kit contains FOBt ing kit, sample sticks, leaflet & prepaid envelope*

### **Did you know that bowel cancer can be prevented?**

The FOBt kit is a quick and easy FOBt for your bowel to make sure your bowel is healthy. The kit is sent every two years to monitor your bowels to help prevent bowel cancer from developing.

Don't be scared of doing the kit, **most people (98%) have normal results and a healthy bowel.** The FOBt kit detects blood in bowel motions (faeces /poo). This indicates you may have a bowel problem and would need further FOBt s, but **this doesn't mean you have cancer.**

The signs and symptoms of bowel cancer often go unnoticed until the disease is already well developed, but it is never too late to do something. **If caught early enough 90% of bowel cancers can be successfully treated and cured.**

I have included some information that other patients have asked about the FOBt kit, but if you would like to discuss anything further please call the National Helpline **0800 707 6060.**

I would like to encourage you to complete your bowel cancer FOBt kit as soon as possible. If you no longer have your kit, please call **0800 707 6060** to request a new kit. Once you have received the FOBt kit, if you have any questions please call **0800 707 6060.**

Yours sincerely

GP XXXX

## Appendix 6 - Poster



*Bowel Cancer Screening Programme*

**Aged 60–75?**  
Please return  
your completed  
bowel cancer  
screening kit.

If you have any questions then  
ask your GP or Nurse when you  
next see them or call:

Freephone  
**0800 707 6060**

**DO  
YOUR  
BIT &  
USE  
THE  
KIT.**

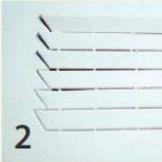


## Appendix 7 – Instruction leaflet

### How to complete the bowel cancer screening kit.



**1**  
Your kit contains testing kit, sample sticks, leaflet & prepaid envelope.



**2**  
The sample sticks are used to collect your bowel sample.



**3**  
Orange & white cardboard testing kit for taking samples, everyday for three days.



**4**  
Get the kit, two sample sticks and a clean container ready to use for when you go to the toilet.



**5**  
When you go to the toilet collect your bowel motion (faeces/poo).



**6**  
Use sample sticks & put a motion (faeces/poo) sample on the kit.



**7**  
Repeat process(4,5,6) on day 2.



**8**  
Repeat process (4,5,6) on day 3.



**9**  
Put the completed kit into the prepaid envelope and post back.

If you have any questions then ask your GP or Nurse when you next see them or call free:

**0800 707 6060**  
[www.cancerscreening.nhs.uk](http://www.cancerscreening.nhs.uk)



Bowel Cancer Screening Programme

# DO YOUR BIT & USE THE KIT.



Bowel Cancer Screening  
Your questions answered.

**Why do you need to complete the screening kit?**

**If caught early enough 90% of bowel cancers can be successfully treated and cured.**

Cars are given MOTs to check that everything is working properly and to prevent problems developing, so why not do the same for your bowel? The screening kit is a quick and easy MOT test for your bowel to make sure your bowel is healthy. The kit is sent every two years to monitor your bowels to help prevent bowel cancer from developing.

The screening kit detects blood in bowel motions (faeces /poo). This indicates you may have a bowel problem and would need further tests.

*This doesn't mean you have bowel cancer.*

**I don't want to complete the test as I'm scared of the results and I don't want to know if there is something wrong.**

*Don't be scared, most people (98%) have normal results and a healthy bowel.*

The screening kit detects blood in your bowel, but this doesn't mean you have cancer. The blood could indicate that you have piles (haemorrhoids), polyps or inflammatory bowel disease (which includes diverticulitis, irritable bowel disease and Crohns disease etc). Further testing will be done to identify which condition it is. It is these tests that can detect polyps which can be removed to prevent bowel cancer developing.

*The tests can also detect bowel cancer at an earlier stage when 90% of people can be successfully treated and cured.*

**There's nothing wrong with me, I feel fine.**

**The screening kit is a FREE MOT for your bowel, so even if you feel fine it's worth doing the kit to make sure everything is ok and to prevent problems developing.**

The signs and symptoms of bowel cancer often go unnoticed until the disease is well developed. The screening kit finds signs of blood in bowel motions (faeces /poo) which may indicate that there is a bowel problem before you start to have symptoms.

**I'm embarrassed about doing the kit and I don't want to touch my bowel motion (faeces/ poo).**

**Everybody has to go to the toilet, so don't be embarrassed to do this simple bowel MOT that helps to detect and prevent bowel cancer.**

The thought of doing the kit is often worse than actually completing it. Although it may seem embarrassing and unhygienic, if you get everything ready before you go to the toilet and follow the instructions in the kit, it really is a very simple process. You complete the kit in your own home, at your own pace. After you have done the kit once, you'll realise how easy it is to do.

**I can't do the test by myself**

If you need assistance to complete the screening kit please let your partner, carer, care assistant or home helper know and they may help you complete it or call your GP.

If you need another kit sending, ask your GP, nurse or carer to request one on your behalf by calling 0800 707 6060

**What are the symptoms of bowel cancer?**

**If you have any of the following symptoms get them checked out by a doctor;**

- Bleeding from your bottom
- Lump, bloating, swelling, discomfort or pain in your tummy
- Unexplained extreme tiredness or weight loss
- Persistent change in your normal bowel pattern to diarrhoea or constipation (hard poo)

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