UCLH MembersMeet
21st June 2018

Bowel Cancer Screening

Dr Lesley M. McGregor CPsychol
Senior Research Associate
l.mcgregor@ucl.ac.uk
@drlmcgregor

Dr Christian von Wagner
Reader
c.wagner@ucl.ac.uk
@chrisvonwagner

Ms Sarah Marshall
Clinical Programme Manager,
St Mark’s Bowel Cancer Screening Centre
sarahmarshall5@nhs.net
@stmarksbrcsc
English Bowel Cancer Screening Programme

Sarah Marshall

Clinical Manager
@ St. Marks Hospital
Roll out of the BCSP

- April 2006: Call for first wave bids
- July 4 2006: First invitations go out
- March 31 2007: 15 screening centres
- April 2007: Second wave begins
- March 31 2008: 33 screening centres
- April 3 2008: Call for final wave bids
- January 2010: All 58 centres open
- August 2010: All 153 PCTs in BCSP
<table>
<thead>
<tr>
<th>First Wave</th>
<th>Second Wave</th>
<th>Final Wave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wolverhampton</td>
<td>Heart of England</td>
<td>Pennine</td>
</tr>
<tr>
<td>Norwich</td>
<td>Coventry and Warwickshire</td>
<td>Lancashire</td>
</tr>
<tr>
<td>South Devon</td>
<td>Bradford &amp; Airedale</td>
<td>Berkshire</td>
</tr>
<tr>
<td>Cheshire &amp; Merseyside</td>
<td><strong>West London</strong></td>
<td>North Staffordshire</td>
</tr>
<tr>
<td><strong>St Marks</strong></td>
<td>Cambridge</td>
<td>South Essex</td>
</tr>
<tr>
<td><strong>South West London</strong></td>
<td>County Durham &amp; Darlington</td>
<td>Surrey</td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>Leicestershire, Northampton &amp;</td>
<td>Sussex</td>
</tr>
<tr>
<td>Bolton</td>
<td>Rutland</td>
<td>Bristol &amp; Weston</td>
</tr>
<tr>
<td>Tees</td>
<td><strong>South East London</strong></td>
<td><strong>North</strong></td>
</tr>
<tr>
<td>South of Tyne</td>
<td>North of Tyne</td>
<td>Essex</td>
</tr>
<tr>
<td>Humber &amp; Yorkshire Coast</td>
<td>South Yorkshire</td>
<td>Bath, Swindon &amp; Wiltshire</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>Dorset</td>
<td><strong>Bedfordshire</strong></td>
</tr>
<tr>
<td><strong>North East London</strong></td>
<td>West Hertfordshire</td>
<td><strong>Cheshire</strong></td>
</tr>
<tr>
<td>Solent and West Sussex</td>
<td>East &amp; North Hertfordshire</td>
<td>Calderdale, Kirklees &amp; Wakefield</td>
</tr>
<tr>
<td>University College London</td>
<td>Nottinghamshire</td>
<td><strong>East Kent</strong></td>
</tr>
<tr>
<td></td>
<td>Hampshire</td>
<td>North Kent</td>
</tr>
<tr>
<td></td>
<td>Cumbria &amp; Westmorland</td>
<td>Harrogate, Leeds &amp; York</td>
</tr>
<tr>
<td></td>
<td>Sandwell &amp; West Birmingham</td>
<td>Peterborough &amp; Huntingdon</td>
</tr>
<tr>
<td></td>
<td>Somerset</td>
<td>West Kent &amp; Medway</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hereford &amp; Worcester</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Buckinghamshire</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cornwall</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shropshire</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Manchester</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Buckinghamshire</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shropshire</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lincolnshire, Oxford</td>
</tr>
</tbody>
</table>

**Total Screening Centres:** 58
Age expansion of the BCSP

- July 2008: Age expansion of BCSP from 70 to 74 years from April 2010 announced in CRS
- Sept 2008: Early Implementer sites commenced invites to older population
- Jan 2010: First wave of age expansion across screening centres
The ‘HUB’

% of Population in Screened Groups

- London: Harrow – 7.5%
- Southern: Guildford – 10.4%
- East: Nottingham – 10.5%
- North West: Rugby – 10.2%
- North East: Gateshead – 10.1%
Programme Hub Responsibilities

• Works collaboratively with up to 10 screening centres
• Undertake call / recall of population
• Assembly and dispatch of kits to invited population
• Laboratory – test the returned kits
• Dispatch of test results to individual within 48 hours of receipt
• Book appointments at nurse positive clinics at local screening centre with result letter
• Provide a help line
• Will have overview of screening centres / clinic space
• Driven by capacity of screening centre and local screening plan
Professional Accredited Laboratory
FOBT kit performance

<table>
<thead>
<tr>
<th>Performance</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity for polyps</td>
<td>10%</td>
</tr>
<tr>
<td>Sensitivity for CRC</td>
<td>33%</td>
</tr>
<tr>
<td>Specificity</td>
<td>98%</td>
</tr>
<tr>
<td>PPV for CRC</td>
<td>8.3%</td>
</tr>
<tr>
<td>PPV for neoplasia</td>
<td>38.3%</td>
</tr>
</tbody>
</table>

Evaluation of the UK Colorectal Cancer Screening Pilot Final Report (February 2003, revised May 2003)
Kit practicalities

- Kit is a non rehydrated guaiac based kit
- Kits valid for 13 weeks
- Use within 14 days of starting
- Don’t take the sample from a motion that has been in the toilet bowl
- Don’t leave in a warm place (we wouldn’t recommend putting them in the fridge!)
- Don’t return spatulas
- Return card in foil lined, Royal Mail approved, prepaid envelope
Dear Mrs Example-Subject:

Thank you for returning the bowel cancer screening test kit recently sent to you. This has shown an abnormal result. **Most abnormal results are not caused by cancer.** There is often another simple cause, such as piles (haemorrhoids). In order to make a diagnosis, you may need to have a further investigation called a colonoscopy. Colonoscopy is currently the best method of detecting bowel cancers. Of those people sent for a colonoscopy, 9 out of 10 will be found not to have bowel cancer.

Colonoscopy does not just look for bowel cancer, it can also identify polyps (small growths of cells). Polyps are not cancers, but can sometimes develop into them. Polyps can be removed without any need for surgery, to give protection from bowel cancer.

Before arranging a colonoscopy, you are being offered an appointment with a screen.

You are welcome to bring a partner or friend with you. The nurse will be able to fully explain the colonoscopy to you and answer any questions you may have. If you wish to do so, you will then be offered a date and time for the colonoscopy examination at your local hospital.

Your screening nurse appointment has been booked for

*Time: 12:00*

*Date: 10 December 2005*

*Location: Shobrooke Hospital*

This is the first available appointment date at the location mentioned. If this appointment date is not suitable, you need additional help such as an interpreter. In the meantime, we enclose a leaflet, *The Colonoscopy Investigation*, which may help you.
Helpline
Freephone 0800 7076060
SCREENING CENTRES

What do the Screening Centres do?

• SSP clinics and follow up clinics
• Colonoscopy clinics
  (inc polyp surveillance)
• Radiology – alternative imaging
• Pathology
• Refer to local hospital / MDT / symptomatic service for treatment
• Collect outcome data/ Monitor & Maintain waits/ national programme
• Education of and liaison with primary care and public health
• Promotion of the service locally
Criteria to be a Bowel Cancer Screening Centre

Successful Quality Assurance Visit (JAG)
– Accredited units delivering a safe, patient centred care service

Capacity
– Low waiting times ensuring equality of access
  • Screening patients
  • Symptomatic patients
    GRS

Experienced & Accredited colonoscopists
STAFFING A SCREENING CENTRE

- Clinical director
- Lead Nurse
- Colonoscopy lead
- Specialist Screening Practitioners (SSP)
- Accredited colonoscopists to provide timely colonoscopy
- Administrative Staff
Quality Assurance....

SSP’s....
- Induction & Orientation
- LJMU Course
- ACSC

Colonoscopist’s
- 150 screening colons per annum
- Data capture....
  - completion rates
  - extubation time
  - Sedation levels etc
Quality Assurance....

Screening Centre

• JAG/ GRS
• QA Visit
• Right Results Visit/ QMS
• 30 day Questionnaire
• KPI’s
• Locality Meetings
SSP Clinic (60 Mins)

- DNA

offered colonoscopy (2 weeks)

- attends

Accept

- non acceptance (patient choice) reminder

Unsuitable CTC

Unsuitable

- CTC

DNA

NAD

polyp

- low risk

- intermediate / high risk

- cancer

- other path

Re-invite for FOBT screening in 2 years if in age range
Positive FOBT SSP Interview:

Objectives:

Set the scene:

Meet & Greet

1. Explanation of FOBT result
2. Bowel Anatomy
3. Colonoscopy/ Alternatives?
4. Health Assessment
5. Consent Obtained
6. Colonoscopy Date Agreed
Bowel Cancer Screening System

Logged in as: BCS005BCSS - SARTOM (Screening Centre Manager)

Main Menu

Organisations >>
Screening Subject Search
Call and Recall >>
gFOBT Test Kits >>
FIT Test Kits >>
Screening Practitioner Appointments >>
Communications Production >>
Reports >>
Contacts List >>
Download >>
Surveillance >>
FS Screening >>

Alerts

Refresh alerts (last updated: 15/01/2015 21:14)

11 subject(s) with inactive open episode
4 symptomatic patient(s) awaiting episode closure
3 patient(s) awaiting post-investigation telephone contact
7 patient(s) awaiting decision regarding another diagnostic test
55 patient(s) awaiting diagnostic test outcome (histology)
1 patient(s) awaiting a decision to proceed with diagnostic tests

1 patient(s) first positive assessment appointment booked more than 14 days in advance

7 patient(s) have not responded to healthcheck form
2 surveillance patient(s) have not yet been invited for a diagnostic test
1 patient(s) awaiting a surveillance practitioner appointment

1 weeks over all sites with no FS availability set in next 10 weeks
Benefit of SSP Presence at Colonoscopy:

- Reassurance & Support
- Continuity of Care
- Familiar Face/Named Contact
- Established Relationship

- First Hand Knowledge of Procedural Events
- Access to Consultant to discuss issues re patient management/ treatment
- Procedural Information to patient before discharge
- Job Satisfaction
<table>
<thead>
<tr>
<th>Actual Type of Test</th>
<th>Colonoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Offered Appointment Date</td>
<td>02/01/2015</td>
</tr>
<tr>
<td>Actual Appointment Date</td>
<td>05/01/2015</td>
</tr>
<tr>
<td>Attended Screening Centre</td>
<td>BCS005 - St Marks Bowel Cancer Screening Centre</td>
</tr>
<tr>
<td>Diagnostic Test Result</td>
<td></td>
</tr>
<tr>
<td>Outcome of Diagnostic Test</td>
<td></td>
</tr>
<tr>
<td>Reason for Ongoing Referral</td>
<td></td>
</tr>
<tr>
<td>Endoscopist Authority</td>
<td></td>
</tr>
<tr>
<td>Site</td>
<td>St Mark's Hospital - RV8M2 (St Marks Bowel Cancer Screening Centre)</td>
</tr>
<tr>
<td>SSP in Attendance</td>
<td>Yes</td>
</tr>
<tr>
<td>Attending SSP</td>
<td>Turi, Yasmin (Screening Practitioner - St Marks Bowel Cancer Screening Centre)</td>
</tr>
<tr>
<td>Testing Clinician</td>
<td>Humphries, Adam (Consultant Colonoscopist - St Marks Bowel Cancer Screening Centre)</td>
</tr>
<tr>
<td>Number of Polyps Seen</td>
<td>1</td>
</tr>
<tr>
<td>Number of Polyps Excised</td>
<td>1</td>
</tr>
<tr>
<td>Number of Polyps Retrieved</td>
<td>1</td>
</tr>
<tr>
<td>Number of Cancers Seen</td>
<td>0</td>
</tr>
<tr>
<td>Dataset Last Updated</td>
<td>05/01/2015</td>
</tr>
<tr>
<td>Dataset Completed?</td>
<td>No</td>
</tr>
</tbody>
</table>

### Drug Information

### Endoscopy Details

<table>
<thead>
<tr>
<th>Endoscope Inserted</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Type</td>
<td>Therapeutic</td>
</tr>
<tr>
<td>Bowel Preparation</td>
<td>Good</td>
</tr>
<tr>
<td>Comfort during examination</td>
<td>No discomfort</td>
</tr>
<tr>
<td>Comfort during recovery</td>
<td>No discomfort</td>
</tr>
<tr>
<td>Sedation during examination</td>
<td>Awake</td>
</tr>
<tr>
<td>Sedation during recovery</td>
<td>Awake</td>
</tr>
<tr>
<td>Endoscopist defined extent</td>
<td>Ileum</td>
</tr>
<tr>
<td>Scope position</td>
<td>Ileum</td>
</tr>
<tr>
<td>Retorted view</td>
<td>Yes</td>
</tr>
<tr>
<td>Start of intubation time</td>
<td>11:10</td>
</tr>
<tr>
<td>Start of extubation Time</td>
<td>11:26</td>
</tr>
<tr>
<td>End time of procedure</td>
<td>11:38</td>
</tr>
<tr>
<td>Withdrawal time</td>
<td>12 minutes</td>
</tr>
<tr>
<td>Scope ID</td>
<td>2310699</td>
</tr>
<tr>
<td>Insufflation</td>
<td>Carbon Dioxide</td>
</tr>
<tr>
<td>Early outcome</td>
<td>Leave department</td>
</tr>
<tr>
<td>Late outcome</td>
<td>No complications</td>
</tr>
</tbody>
</table>

### Completion Proof Details

### Failure Details

### Polyp Information
**Polyp info - Classification**

| Polyp Information                        |  |  |
|-----------------------------------------|  |  |
| **Location**                            | Sigmoid colon |  |
| **Classification**                      | Sessile (L)  |  |
| **Size Estimate**                       | 8 mm          |  |
| **Secondary Piece**                     | No            |  |
| **Left In Situ**                         | No            |  |

| Polyp 1 Intervention 1 Details          |  |  |
|-----------------------------------------|  |  |
| **Modality**                            | Polypectomy   |  |
| **Device**                              | Hot snare     |  |
| **Excised**                             | Yes           |  |
| **Retrieved**                           | Yes           |  |
| **Excision Success**                    | Successful    |  |
| **Excision Technique**                  | En bloc       |  |

| Polyp 1 Histology Details               |  |  |
|-----------------------------------------|  |  |
| **Pathology Lost**                      | No            |  |
| **Date of Receipt**                     | Calendar      |  |
| **Date of Reporting**                   | Calendar      |  |
| **Pathology Provider**                  | lookup        |  |
| **Pathologist**                         | lookup        |  |
| **Polyp Type**                          |               |  |
| **Polyp Excision Complete**             |               |  |
| **Polyp Size**                          |               |  |

**Double Reporting**

<table>
<thead>
<tr>
<th>Pathology Provider</th>
<th>lookup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathologist</td>
<td>lookup</td>
</tr>
</tbody>
</table>

**Delete Polyp History**
Polyp Info - Classification

- **PEDUNCULATED (lp)** - Stalk between polyp and underlying mucosa
- **FLAT** - completely flat (llb)
- **SEMI-PEDUNCULATED (lsp)** - Broad-based - base narrower than top but no stalk
- **FLAT** - depressed (llc)
- **SESSILE (ls)** - No stalk - base and top of lesion have same diameter. Height at least the 2.5mm width of closed biopsy forceps
- **FLAT** - laterally spreading type, granular (LST-G) Larger than 10mm with a nodular outline and surface
- **FLAT** - slightly elevated (lla) Height less than 2.5mm width of closed biopsy forceps
- **FLAT** - laterally-spreading type, non-granular (LST-NG) Larger than 10mm, with a smooth outline and surface
- **FLAT** - slightly elevated with depressed centre (lla/c) Height less than 2.5mm width of closed biopsy forceps
**Histology**

<table>
<thead>
<tr>
<th>Polyp 1 Intervention 1 Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Modality</td>
<td>Polypectomy</td>
</tr>
<tr>
<td>Device</td>
<td>Hot snare</td>
</tr>
<tr>
<td>Excised</td>
<td>Yes</td>
</tr>
<tr>
<td>Retrieved</td>
<td>Yes</td>
</tr>
<tr>
<td>Excision Success</td>
<td>Successful</td>
</tr>
<tr>
<td>Excision Technique</td>
<td>En bloc</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Polyp 1 Histology Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology Lost</td>
<td>No</td>
</tr>
<tr>
<td>Date of Receipt</td>
<td>23/04/2012</td>
</tr>
<tr>
<td>Date of Reporting</td>
<td>26/04/2012</td>
</tr>
<tr>
<td>Pathology Provider link</td>
<td>The Phoenix Health Centre - RL402 (The Royal Wolverhampton Hospitals' NHS Trust)</td>
</tr>
<tr>
<td>Pathologist link</td>
<td>Vague, John (Consultant Pathologist-The Royal Wolverhampton Hospitals' NHS Trust)</td>
</tr>
<tr>
<td>Polyp Type</td>
<td>Adenoma</td>
</tr>
<tr>
<td>Polyp Sub Type</td>
<td>Not reported</td>
</tr>
<tr>
<td>Polyp Excision Complete</td>
<td>Yes</td>
</tr>
<tr>
<td>Polyp Size</td>
<td>8 mm</td>
</tr>
<tr>
<td>Polyp Dysplasia</td>
<td>High grade dysplasia</td>
</tr>
<tr>
<td>Polyp Carcinoma</td>
<td>No</td>
</tr>
</tbody>
</table>

**Double Reporting**

<p>| Pathology Provider link       |  |
| Pathologist link              |  |</p>
<table>
<thead>
<tr>
<th></th>
<th>All rounds</th>
<th>Prevalent</th>
<th>Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CANCER</strong></td>
<td>8445</td>
<td>10.04%</td>
<td>6.06%</td>
</tr>
<tr>
<td><strong>High Risk</strong></td>
<td>8632</td>
<td>9.94%</td>
<td>7.24%</td>
</tr>
<tr>
<td><strong>Adenoma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intermediate Risk</strong></td>
<td></td>
<td>18.58%</td>
<td>16.15%</td>
</tr>
<tr>
<td><strong>Adenoma</strong></td>
<td>16,716</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low Risk</strong></td>
<td>15,735</td>
<td>15.87%</td>
<td>20.37%</td>
</tr>
<tr>
<td><strong>Adenoma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Abnormal not polyps</strong></td>
<td>17,478</td>
<td>17.49%</td>
<td>23.06%</td>
</tr>
<tr>
<td><strong>Polyps no histology</strong></td>
<td></td>
<td>0.48%</td>
<td>0.77%</td>
</tr>
<tr>
<td><strong>Normal</strong></td>
<td>23,307</td>
<td>25.31%</td>
<td>24.43%</td>
</tr>
<tr>
<td><strong>No Result</strong></td>
<td>2036</td>
<td>2.28%</td>
<td>1.92%</td>
</tr>
</tbody>
</table>
Caecal Intubation Rate

<table>
<thead>
<tr>
<th>Month</th>
<th>Colonoscopy count</th>
<th>Caecal Intubation (CIR)</th>
<th>CIR %</th>
<th>CIR with photo / video evidence</th>
<th>CIR with PIV Evidence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>58</td>
<td>55</td>
<td>94.83%</td>
<td>54</td>
<td>93.10%</td>
</tr>
<tr>
<td>Feb</td>
<td>52</td>
<td>51</td>
<td>90.08%</td>
<td>51</td>
<td>98.08%</td>
</tr>
<tr>
<td>Mar</td>
<td>66</td>
<td>66</td>
<td>100.00%</td>
<td>66</td>
<td>100.00%</td>
</tr>
<tr>
<td>Apr</td>
<td>48</td>
<td>48</td>
<td>95.83%</td>
<td>46</td>
<td>95.83%</td>
</tr>
<tr>
<td>May</td>
<td>70</td>
<td>67</td>
<td>95.71%</td>
<td>67</td>
<td>95.71%</td>
</tr>
<tr>
<td>Jun</td>
<td>72</td>
<td>72</td>
<td>100.00%</td>
<td>72</td>
<td>100.00%</td>
</tr>
<tr>
<td>Jul</td>
<td>74</td>
<td>71</td>
<td>95.95%</td>
<td>71</td>
<td>95.95%</td>
</tr>
<tr>
<td>Aug</td>
<td>82</td>
<td>80</td>
<td>90.77%</td>
<td>80</td>
<td>80.00%</td>
</tr>
<tr>
<td>Sep</td>
<td>70</td>
<td>69</td>
<td>90.57%</td>
<td>69</td>
<td>88.57%</td>
</tr>
<tr>
<td>Oct</td>
<td>70</td>
<td>70</td>
<td>100.00%</td>
<td>70</td>
<td>90.00%</td>
</tr>
<tr>
<td>Nov</td>
<td>70</td>
<td>68</td>
<td>97.14%</td>
<td>68</td>
<td>97.14%</td>
</tr>
<tr>
<td>Dec</td>
<td>55</td>
<td>55</td>
<td>100.00%</td>
<td>55</td>
<td>100.00%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>775</td>
<td>755</td>
<td>97.81%</td>
<td>767</td>
<td>97.68%</td>
</tr>
</tbody>
</table>

The National Caecal Intubation Rate (CIR) for 2014 is 97.59%, CIR with Photo / Video Evidence is 98.84%
Uptake In England

Norwich (Norfolk PCT)

NEL (Tower Hamlets PCT)

National Average = ~ 51%
Ethnic Uptake
“religion & language”

- A response (i.e at least 1 kit returned)
  - Overall 62.2%
  - Muslim 31.9%
  - Hindu-others 43.7%
  - Non-Asians 63.7%

Evaluation of the UK Colorectal Cancer Screening Pilot
Final Report (February 2003, revised May 2003)
June 2016 marks the 10th anniversary of the NHS Bowel Cancer Screening Programme.

Achievements from the start of the programme to May 2016 include:

- 56% overall uptake of test
- 333,513 definite abnormal results identified
- 2% of tests positive
- 25,528 cancers detected
I've been invited for NHS bowel scope screening.

This leaflet gives you information to help you choose whether to have screening.
St. Mark’s FS Flow chart

Admin!

~40%

Admin!

~ 12,000 per annum

Admin!

~ 1% = ~ 450 per annum

Admin!

~ 6,300/ 50% uptake per annum

Admin/ SSP/ Screening Nurses / Pathology / Endoscopy

Admin/ New PAS Codes!
Numbers......

- Establish structure in BCSC – Manage demand/capacity/ smoothing for Flexi
- ~ 1 million total population
- Admin – allocating appointments for ~12,000 eligible each year (+ self referrals)
- ~6300 Flexi procedures each year
- ~ 10 Flexi lists/ ~2 colon lists per week

(Demand Estimation and Capacity Planning for FS Screening – NHS Cancer Screening programmes tool)
When do I use the enema?

You need to use the enema around an hour before leaving home for your screening appointment.

Don’t eat for 30 minutes before you use it, or afterwards until you’ve had your screening carried out.

You can drink water, but no other liquids.

The effect of the enema wears off within an hour, so you don’t need to worry about travelling to the hospital.

What does the enema do?

An enema makes you go to the toilet within a few minutes of using it. This cleans your lower bowel so that it can be seen clearly during bowel scope screening.

The enema doesn’t give you diarrhoea.

Advice on using the enema:

If you aren’t sure about whether you should use the enema, or need to speak to someone about how to use it, call us on freephone: 0800 707 60 60.

Calls will be dealt with in confidence. Please don’t feel embarrassed to ask for information or advice.

For more information about bowel cancer screening, you can:

- Speak to your GP
- Go to: www.cancerscreening.nhs.uk/bowel
- Call the NHS Bowel Cancer Screening Programme freephone helpline on 0800 707 60 60. Calls are free from UK landlines.

Please read the whole of this leaflet before you use the enema.

In your enema pack you will find:

- A packaged enema ‘pouch’ with a thin tube attached
- A small white plastic clip with the enema (you don’t use this)
- A manufacturer’s patient information leaflet
Patient Journey.....

- Reception arrival
- Changing room/ Waiting room
- Health check
  Questionnaire
- Paperwork checked/
  consent confirmed
- Discharge letter/ book
  colonoscopy assessment/
  PI appt
- Screening nurse – data
  collection/ BCSS
  progression
- Discharged home
- Flexi test
Numbers

• Invited = 31,998 (including self referrals 727)

• Responded = 15,975 – 50.35%

• Reschedule Rate = 49.16% (7853/15,975)

• Attended = 12,799*  
  * Bowel scope procedure/s were attended - 658 attended where the scope was not inserted

• Uptake = 41.85%
Outcomes

• Index colon required = 4.9%

• Ca/ High Risk & Intermediate Results = 2.4%
• Cancers = 16 (0.13%)
• High Risk = 106 (0.83%)
• Intermediate risk = 184 (1.44%)
• No suitable for BoSS = 17 (0.13%)
The Future

• PHASE 1  Roll out
  2006-9
  60-69 FOBt

• PHASE 2  Phasing in the age extension
  2010-2014 (Cancer Reform Strategy)
  60-74 FOBt

• PHASE 3
  Bowel Scope Screening

• Phase 4
  FIT 2018!
7 June 2016

Public Health Minister Jane Ellison

faecal immunochemical test (FIT) will replace the current guaiac feecal occult blood test (gFOBt).

- is easier to use and can be measured more reliably by machine than by the human eye
- is sensitive to a much smaller amount of blood and can detect cancers more reliably and at an earlier stage
- has increased sensitivity that enables us to detect more pre-cancer lesions
- needs just one tiny faecal sample from a single bowel motion compared to 2 samples from 3 different motions for gFOBt

a trial of FIT in 2014 which showed a big impact on uptake, with a 7% increase overall. It increased uptake in groups with low participation rates, such as men, ethnic minority populations, and people in more deprived areas.

It was predicted that FIT will mean 200,000 more people will take part in bowel cancer screening.

FIT is a more sensitive test, so we will find more polyps and prevent more bowel cancers.

To introduce FIT in spring/summer 2018 using a ‘big bang’ approach, rather than a phased implementation.
BOWEL CANCER IS THE THIRD MOST COMMON CANCER IN THE UK

‘Bowel scope screening’ is a new test to help prevent bowel cancer. It looks at the lower bowel to detect small growths known as polyps, which can go on to develop into bowel cancer. The test is being offered to all men and women aged 55 as part of the NHS Bowel Screening Programme. You’ll be invited to your local bowel cancer screening centre to have the test.

For more details:
call our freephone helpline 0800 707 60 60
visit www.cancerscreening.nhs.uk/bowel
or speak to your GP

‘BOWEL SCOPE SCREENING’ IS A NEW TEST TO HELP PREVENT BOWEL CANCER.

It looks at the lower bowel to detect small growths known as polyps, which can go on to develop into bowel cancer. The test is being offered to all men and women aged 55 as part of the NHS Bowel Screening Programme. You’ll be invited to your local bowel cancer screening centre to have the test.

For more details:
call our freephone helpline 0800 707 60 60
visit www.cancerscreening.nhs.uk/bowel
or speak to your GP.
All experiments were on Flexible Sigmoidoscopy (FS)

- All participants were aged 35-54
- Consisted of hypothetical online experiments
- Included filter questions to exclude intenders before exposure to experimental manipulation
- Included control questions to ensure understanding of manipulation
4 online (vignette) experiments on Flexible Sigmoidoscopy

Social norms

1. Influence of perceived behaviour of others.

Choice architecture

1. Influence of information on screening practitioner’s gender.

2. Influence of offering people several appointment slots to choose from.

3. Influence of offering people different screening hospitals to choose from.
Social norms experiment

https://youtu.be/BgRoiTWkBHU
Theory of social norms

- *Our decisions are often influenced by behaviour of others* (Berkowitz, 2004)…

- *…by providing individuals with different information about uptake.*
4 conditions:

- *Echo and confirm* (‘you guessed uptake is x out of 10; uptake is x out of 10’)

- *Echo with proportional augmentation* (‘you guessed x out of 10; uptake is x+3 out of 10’)

- *Echo with standard augmentation* (you guessed x out of 10; uptake is 8 out of 10)

- *Standard augmentation alone* (‘uptake is 8 out of 10’).
Share of individuals stating that they would probably or definitely participate

Percentage intending

- Echo
- Augmented
- No feedback 8/10
- Feedback 8/10

N=1,432
Choice experiments
Tested whether offering choice…

- Increases intrinsic motivation to do the test (self-serving theory) due to higher perceived autonomy or…

- Decreases intentions due confusion and perceived difficulty (choice overload hypothesis).
Experiment 1: Offering women the choice of the practitioner’
- No choice vs choice between 2 alternatives
- Heterogeneous alternatives (female vs male)

Experiment 2: Offering different timed appointments
- No choice vs choice between 2, 4 or 6 alternatives
- Homogeneous alternatives (similar appointment times)

Experiment 3: Offering different hospitals
- No choice vs choice between 2 hospitals
- Heterogeneous alternatives (one hospital is clearly worse)
4 conditions

- *Usual care* (no choice, unknown practitioner sex)
- *Opposite sex* (no choice, practitioner would be male)
- *Same sex* (no choice, practitioner would be female)
- *Active choice* (practitioner’ sex can be chosen)
Share of women saying that they would probably or definitely participate

Practitioner’s sex experiment

(N=1,010)
4 conditions

- Offer 1 timed appointment (no choice)
- Offer 2 timed appointments to choose from
- Offer 4 timed appointments to choose from
- Offer 6 timed appointments to choose from
Appointment choice experiment

Share of individuals stating that they would probably or definitely participate

N=1,908
2 conditions

- Control (standard target hospital is offered)
- Decoy (standard target and inferior* decoy hospitals are offered to choose from)

* Note: inferior only refers to travel or waiting time but not quality of service or other attributes.
Presentation of alternatives

Control condition

- Screening at Hospital X
  - Can detect abnormal growths
  - 30min travel

- No screening
  - Cannot detect abnormal growths
  - No travel time

Decoy condition

- No screening

- Screening at Hospital X
  - No travel time
  - 30min travel
  - Cannot detect abnormal growths

- Screening at Hospital Y
  - 60min travel
  - Can detect abnormal growths
Hospital choice experiment (decoy)

Individuals choosing target hospital

- Control
- Decoy

Percentage choosing

N=506
Presentation of alternatives in 2nd experiment

Control condition

- **No screening**
  - No travel time
  - No waiting time
  - Cannot detect abnormal growths

- **Screening at Hospital X**
  - 30min travel
  - 45min waiting
  - Can detect abnormal growths
Presentation of alternatives in 2\textsuperscript{nd} experiment

\textbf{Weak decoy condition}

- No screening
  - No travel time
  - Cannot detect abnormal growths
  - No waiting time
  - Screening at Hospital X: 30min travel, Can detect abnormal growths
  - Screening at Hospital Y: 60min travel, Can detect abnormal growths
  - 45min waiting

\textbf{Strong decoy condition}

- No screening
  - Cannot detect abnormal growths
  - No waiting time
  - Screening at Hospital X: Can detect abnormal growths
  - Screening at Hospital Y: Can detect abnormal growths
  - 45min waiting
  - 90min waiting

- No travel time
  - 30min travel
  - 60min travel
Hospital choice experiment 2 (ongoing)

Individuals choosing target hospital

- Control
- Weak decoy
- Strong decoy

N=441
* 11. Before continuing with the survey, would you be interested in reading some more facts and figures about bowel scope screening on the next page or do you prefer to skip it?

- Skip information on next page and continue with survey
- Read information on next page before continuing with survey
Facts and figures about bowel scope screening

“Could bowel cancer screening prevent you from getting bowel cancer?”
For every 300 people screened, 2 fewer people will get bowel cancer over 10 years.

“Could bowel cancer screening prevent you from dying of bowel cancer?”
For every 300 people screened, 1 less person will die from bowel cancer over 10 years.

“Are there risks?”
About 1 person in every 3,000 may have serious bleeding caused by bowel scope screening. Even more rarely, the bowel can be torn.

“Could the test miss something?”
Bowel scope screening finds 4 out of 5 polyps that could turn into bowel cancer.

“Could you need more tests?”
About 5 in 100 people who have bowel scope screening will be offered a colonoscopy to look at all of the large bowel.

“How long does the test take?”
Getting ready for your appointment and having bowel scope screening may take up to half a day.

“Is the test embarrassing?”
About 95 in 100 people say that bowel scope screening is not embarrassing.

“Is the test painful?”
About 80 in 100 people say they felt no pain or only mild pain. About 3 in 100 say they felt severe pain during bowel scope screening.

“Will you be pleased you had the test?”
About 98 in 100 people say they are glad they had bowel scope screening.
Hospital choice experiment 2 (ongoing)

![Bar chart showing individuals wanting to read further information about the test across different conditions: Control, Weak decoy, and Strong decoy. The chart indicates the percentage showing active interest, with N=441.](chart.png)
1\textsuperscript{st} experiment shows the potential of descriptive social norms interventions

- **However**, messages were not in line with true uptake
  
  Upcoming projects on framing of true uptake on interpretation of uptake

2\textsuperscript{nd}, 3\textsuperscript{rd} and 4\textsuperscript{th} experiments show the effect of offering choice

- In the absence of dominating options
  
  Choice is worse than random default allocation

- In the presence of dominating options
  
  Choice can outperforms specific allocation
Examples of interventions to help increase participation

Precaution Adoption Process Model (Weinstein, 1988)
Effects of evidence-based strategies to reduce the socioeconomic gradient of uptake in the English NHS Bowel Cancer Screening Programme (ASCEND): four cluster-randomised controlled trials

Lancet 2016; 387: 751–59


Bowel Cancer Screening System

Invitation letter

gFOBt Kit

Reminder letter

Your GP practice, Timbuktu General Practice, supports the Bowel Cancer Screening Programme

Doing the test kit is important because the risk of bowel cancer increases as you get older. If bowel cancer is found early, treatment is more successful. It’s never too late to do the test. Call Freephone 0800 707 60 60 if you need to speak to a helpline assistant.
Bowel Cancer Screening
People’s Stories

Most people (98 out of 100) will get a ‘normal’ result from the test kit.

When I got my test results I was so relieved. I was delighted. It was such a relief.”
(Cynthia)

Bowel cancer often has no early warning signs.

“I was very lucky to have had the cancer picked up through screening. I had no symptoms at all so I would not have known anything was wrong. By the time I had got any symptoms, it would probably have been a lot more serious.”
(Maureen)

A small number of people out of 100 get an ‘abnormal’ result and are offered a follow-up investigation.

“I went and spoke to a very nice lady who explained that even though people get a call back they don’t often get a cancer result. I felt a lot calmer after the appointment.

I had the follow-up investigation the following Monday. They found two growths, which were removed. The results were fine and everything was ok.”
(Monica)

Bowel cancer found through the screening programme is likely to be at an early stage and can be successfully treated.

“The decision I made to complete the test kit was probably the best decision I have ever made in my life. Had I not taken that course of action, there is no doubt in my mind I would not be alive today.”
(Harold)
Intention to complete the FOBT screening test was significantly stronger in the narrative group.

Completion of the FOBT screening test was NOT significantly higher in the narrative group.
Effects of evidence-based strategies to reduce the socioeconomic gradient of uptake in the English NHS Bowel Cancer Screening Programme (ASCEND): four cluster-randomised controlled trials

Lancet 2016; 387: 751–59

Bowel Scope Screening (BSS)

Can patient navigation help?

http://www.hpfreemanpni.org/
Pre-invitation letter

2 weeks

Invitation letter
(with an appointment note and an information leaflet)

2 weeks to respond

Confirmed appointment

4 weeks

No confirmation

Reminder letter
(with an appointment note and an information leaflet)

2 weeks to respond

Confirmed appointment

2 weeks

No confirmation

Appointment cancelled:
Cancellation letter sent

Enema preparation letter and leaflet

Patient Navigation

Do not attend their appointment:
Cancellation letter sent

Attend appointment

Patient Navigation
Over a 6 month study period, **1050** study packs sent out with BSS pre-invitation letters

152 people (14.5%) returned a study consent form and were randomised (4:1)

22 people eligible for PN

<table>
<thead>
<tr>
<th>PN Outcome (n = 22)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No answer</td>
<td>10 (45.5)</td>
</tr>
<tr>
<td>Number not recognised</td>
<td>3 (13.6)</td>
</tr>
<tr>
<td>Lost in study</td>
<td>3 (13.6)</td>
</tr>
<tr>
<td>Wrong number (person not known)</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>Answered call but refused participation</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>Answered call, arranged a call back, and then refused participation</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td>Answered call, spoke with SSP</td>
<td>2 (9.1)</td>
</tr>
</tbody>
</table>

Patient navigation is not a feasible intervention to increase BSS within the current structure of the English NHS Bowel Cancer Screening Programme
“And just I think we give them such a lot of information. Even without the trial information, we give them a lot of information, and as I say, a lot of our patients cannot process that information.” (SSP2)

“And I've found it a little bit frustrating, if I'm honest, because it's been very difficult to get a hold of people. If they have provided us with numbers, they often haven't been the right ones; or people I've contacted just haven't wanted to talk to me.” (SSP3)

“We didn't have high hopes for it, because we know our patient base very well, and the sort of people who are going to not turn up, are the sort of people who won't give you their number, generally speaking, to be contacted.” (SSP2)

“I think they’re probably just out to cause mischief. [...] True non-responders just don't want to engage. They’re not interested in the programme, for whatever reason and they’re just not going to engage. Those people who have sent a response saying, ‘Yes, you can contact me,’ I think they’ve probably done it out of devilment more than anything else.” (SSP1)
Using primary care to increase uptake of Bowel Scope Screening in Yorkshire (Hull): evaluation paper and telephone based interventions

1. Primer letter and local leaflet

Your cancelled appointment
I have been informed that your bowel scope screening appointment was cancelled. Many people simply forget to confirm or attend their appointment. I am writing in case this has happened to you.

When the screening centre receives your form, they’ll contact you to arrange an appointment. They’ll ask you whether:

1) you would prefer the person doing your test to be Male or Female
2) you would prefer your test to be at Castle Hill Hospital or Hull Royal Infirmary
3) you have any other preferences for your appointment (e.g. day, time, etc.)
Using primary care to increase uptake of Bowel Scope Screening in Yorkshire (Hull): evaluation paper and telephone based interventions

1. Primer letter and local leaflet

Pre-invitation letter

2 weeks

Invitation letter (with an appointment note and an information leaflet)

2 weeks to respond

Confirmed appointment

No confirmation

It might save your life
Bowel cancer is the second most common cancer people die from. As you get older, your risk of developing bowel cancer increases. The test removes small growths in the lower bowel, before they can turn into cancer.

2 weeks

Do not attend their appointment: Cancellation letter sent

Attend appointment
BSS: New study in Hull

Using primary care to increase uptake of Bowel Scope Screening in Yorkshire (Hull):
evaluation paper and telephone based interventions

1. Primer letter and local leaflet

   Pre-invitation letter
   2 weeks

   Invitation letter
   (with an appointment note and an information leaflet)
   2 weeks to respond

   Confirmed appointment

   No confirmation

   Reminder letter
   (with an appointment note and an information leaflet)
   2 weeks to respond

   Confirmed appointment

   No confirmation

   Enema preparation letter and leaflet
   2 weeks

   Appointment cancelled: Cancellation letter sent

   Do not attend their appointment: Cancellation letter sent

   Attend appointment

2. Self referral reminder letter

   OR

3. Patient Navigation call
TEST YOUR POO!

WELL EASY!
What do you think would make more people get screened?

How should we disseminate our research results to the general public?

What part do you want to play in research like this?

How do you feel about being part of research without your consent?
Bloomsbury Festival
UCL Festival Hub
Sat 20 October 2018

ucl.ac.uk/culture/festival2018