

Merton ACE Bowel Cancer Screening Project Report

Introduction

This paper provides background into The Merton ACE Bowel Cancer Screening Project (Pilot) which ran for 12 months from 1st October 2015 to 30th September 2016.

Local Picture

It's just over 10 years since the national Bowel Cancer Screening Programme was rolled out in England, Wales and Scotland.

Uptake of bowel screening within Merton is low, currently at 50.2%, as opposed to England's national average of 57.9%, amongst 60-69 year olds. This project aims to increase screening for 60-74 year olds. However, the incidence of bowel cancer in Merton is 70.6 per 100,000 which is similar to England's average 74.1 per 100,000. Evidence shows uptake is lower in ethnic minorities and deprived groups.

In general, the population density is higher in the east than the west of the borough where residents are more disadvantaged, younger, poorer and ethnically more diverse, with lower education and qualification levels.

According to the 2011 Census the main languages spoken by Merton's population of 190,500 was;

- English by approx. 150,400 (79%)
- Polish 6,600 (3.5%)
- Tamil 6,000 (3.1%)

Approximately 6,500 residents (3.5%) spoke none or very limited English, with higher levels in the east of the borough.

Three of these wards, namely: Cricket Green, Figges Marsh and Pollards Hill are more socially and economically deprived than the average for London. GPs in the east of the borough were showing bowel cancer screening take up well below the national average.

Closing the gap in health inequalities between the east and the west of the borough is challenging, however, with a heightened awareness of the issues that impede the screening process we can work in conjunction with primary care to develop strategies to break down these barriers.

Overview ACE Project

This was a twelve month GP incentive scheme, provided in partnership with NHS England, ACE (Accelerate, Coordinate, and Evaluate) national cancer project team, Merton Public Health, Merton Macmillan GP, NHS Merton CCG and SWL Bowel Cancer Screening Centre; uptake and services.

The main aims and objectives of the project are to support primary care to proactively encourage non-responders, between the ages of 60 – 74 to participate in the national bowel cancer screening programme. This offers men and women screening every two years up to the age of 74, those 75 and over can opt into the programme, if they wish.

GPs are informed electronically after 13 weeks of patients that fail to respond to the screening invitations from the Bowel Cancer Screening Hub.

Primary Care were asked to target non responders and provide advice, information and explain the process to enable patients to make an informed choice about participating in the bowel screening programme.

As part of the project Merton CCG set up a Data Processing Deed which enabled the Project Manager to assist practices, if required, and in contacting non responders.

Summary of the project aims:

- to look at ways of increasing bowel cancer screening uptake in Merton
- to identify and treat bowel cancer at an earlier stage
- to reduce deaths from bowel cancer

Merton Project Launch

Merton CCG acknowledged that to achieve higher screening levels within the borough it was key to have maximum GP involvement and as much local/community support and engagement as possible.

We held two project launches at The Nelson Centre in October 2015, for GP clinical and administration staff, both events were well attended. However, we subsequently provided in house surgery based training for practices unable to attend either launch; resulting in contracts signed by 24/24 of our GPs, 100% commitment.

This was a twelve month GP incentivised project commencing 1st October 2015, although three GPs started in September, with tranche payments made to GPs at the following key stages;

Stage 1

Flat rate of £250 paid to GPs for attending the initial training session and agreeing to take part in the project.

Stage 2

Reimbursement at the end of the project at a rate of £2 per successful patient contact, which could be a phone call or letter sent. Practices were expected to maintain a patient log to record all actions.

The patient's clinical record annotated accordingly with date of contact and the outcome.

Stage 3

Premium payments were available for GPs who successfully contact 80% or more of the target group. Successful contact is defined as a phone call completed in accordance with a telephone script or a letter being sent if unsuccessful after two attempts.

GPs were designated in accordance with practice size into three payment tiers, as detailed below:

Tier 1 practices where the 80% target is up to 121 patients

Tier 2 practices where the 80% target is from 122-179 patients

Tier 3 practices where the 80% target is equal or greater than 180 patients

Payment structure for practices achieving the 80% target:

Tier 1 £320

Tier 2 £350

Tier 3 £380

Payment structure on non-achievement of the 80% target:

- For practices successfully contacting 60-79% of the target group will be paid 50% of the premium for their tier.
- For practices successfully contacting 40-59% of the target group will be paid 25% of the premium for their tier.

At the start of the project GPs were given the number of contacts to be made within the target groups, with additional payments made to practices that exceed initial targets.

GPs were asked to identify champions to focus on patients that had not responded to the BCSP invitations, apart from patients that were exempt due to other health conditions. Telephone scripts were available together with templates for GP follow up letters to be sent if unsuccessful at contacting the patient after two telephone attempts.

All actions were recorded on a record log spreadsheet with anonymised data returns forwarded to the Project Manager on a monthly basis for review.

Promotional material, leaflets and test kit instructions were available in 21 and 19 languages respectively, together with booklets, posters etc. to assist GPs in raising screening awareness, encouraging patient participation by ensuring that they understood the rationale behind the test. In addition, a translation service could be provided, if required.

Project Audit

An integral part of the ACE Bowel Cancer Screening Project was an annual audit of non-responders. The purpose of which was to ascertain the eminence of the interventions undertaken, to ensure a high quality project, for which the data could be assimilated with recommendations considered for inclusion in the national evidence base on best practice for bowel cancer screening.

This audit was undertaken by a local cancer screening clinician, whose full report is set out below. Summarised are two notable findings from the audit report that highlight the effectiveness of the bowel cancer screening programme:

Screening: Overall the uptake of bowel cancer screening has increased by 3.9% compared to the same cohort 2 years before and by 4.41% compared to last year.

Completed kits: After contacting 1,077 non-responders it yielded a further 74 completed kits; 71 results recorded were normal, 2 were recorded as inadequate and needed to be repeated and 1 showed abnormality which went to be investigated by colonoscopy.

Background

As part of the project it was agreed that an experienced clinician would go over the records of some of the patients who had been contacted in Merton, as part of the bowel cancer screening non responder project. The aim was to review a proportion of those contacted to see if they went on to complete the kit, having been given more information to make an informed choice either by phone or letter.

Two surgeries in Merton who were felt to represent the patient's demographics in Merton and were contacted and agreed to take part in the audit.

Procedure

The clinician followed confidentiality procedures and checked the clinical records to identify the following;

1. Record of change in registration due to moving out of the surgery or no record of consultation in last 4-5 years (potential ghost patient) or those who have died, since being sent the bowel screening kit (this could have been within the last 1-15 months).
2. If the patient had been recorded as declined after contact made by the surgery to offer further information and identify any issues.
3. After contact with either phone or letter how many still did not complete the bowel cancer screening kit
4. If the problem screen identified any clinical reasons why the patient may not have taken part in Bowel Cancer Screening e.g. under investigation for gastrointestinal problems; receiving treatment for any cancer (bowel/ breast / prostate etc.); severe mental illness; recent hospital admission; comorbidity of long term conditions.
5. If there were any problems of learning disabilities; Physical disabilities; Blindness; language problems etc. which could indicate a problem in completing the screening.
6. Record of a recent bowel screening result following the non-responder contact made by the surgery.

Outcomes

The initial figures showed 3596 contacts were made as part of the project throughout Merton. Two surgeries were audited, with 368 patient records audited at surgery one and 709 at surgery two a total of 1,077 patient records were checked. Therefore 29.95% of the patients who were contacted as part of the project were audited.

The following number of patients were then recorded and audited from each of the two surgeries;

1. **Have moved.**
2. **Deaths** during the time of the project.
3. **Potential 'ghost' patients.**
4. **Declined**
5. **Continuing non responders**
6. **Under investigation**
7. **Has cancer**
8. **Problems identified** (clinical and non clinical)
9. **Completed kit by a) phone b) letter**

Table 1 - No longer at the surgery

No longer at the surgery?	surgery 1 (368)	% of Patients	surgery 2 (709)	% of Patients	Total both (1,077)	Total %
1. Moved	14	3.80%	32	4.51%	46	4.27%
2. Death	3	0.82%	5	0.71%	8	0.74%
3. Ghost's	28	7.61%	40	5.64%	68	6.31%
Total	45	12.23%	77	10.86%	122	11.33%

The total percentage of patients who are, or are potentially, no longer at the surgery is 11.3% these represent a cohort of patients who would not respond to any invitations for screening.

Table 2 - Failed to complete screening kit

Failed to complete kit	surgery 1 (368)	% of Patients	surgery 2 (709)	% of Patients	Total both surgeries	Total %
4. Declined	52	14.13%	102	14.39%	154	14.30%
5. No response after contact	221	60.05%	391	55.15%	612	56.82%
Total	273	74.18%	493	69.53%	766	71.12%

The total percentage of patients who declined when contacted by phone or who did not respond to the letter sent out (if phone contact could not be made) is 71.1%.

There are many reasons why patient declined or do not complete the kit, even when further information has been given and any issues addressed, this is discussed in another section of this report.

Table 3 - Clinical / non clinical reason

Clinical / non clinical reason	surgery 1 (368)	% of Patients	surgery 2 (709)	% of Patients	Total both surgeries	Total %
6. Under investigation	6	1.63%	27	3.81%	33	3.06%
7. Has cancer	16	4.35%	25	3.53%	41	3.81%
8. Clinical & Non-clinical	10	2.72%	31	4.37%	41	3.81%
Total	32	8.70%	83	11.71%	115	10.68%

Table 3 shows the number of patients who were recorded as potentially having a reason why they did not complete the screening kit. This was due to medical problems including recent hospital admission and comorbidity of long term conditions as well as receiving treatment for cancer of any kind and also if they were already under investigation for gastrointestinal problems and had a recent colonoscopy etc. Some had had a recent M.I. or stroke.

Those with severe mental illness including severe depression were also counted as probably not going to complete the kit due to other more important things happening in their lives.

Other non-clinical reasons which are more of a challenge include those with learning disabilities; Physical disabilities; Blindness and language problems.

The total percentage of those who had potential reasons for not completing the kit was 10.7%

Table 4 - Completed kit due to project

	surgery 1 (368)	% of Patients	surgery 2 (709)	% of Patients	Total both surgeries	Total %
9. Completed kit (following contact)	18	4.89%	56	7.90%	74	6.87%

These findings show that contacting 1,077 non responders yielded an additional 74 completed kits. Most of them return a kit within 4 weeks of the 'reminder' some took up to 6 months.

71 results recorded were normal, 2 were recorded as inadequate and needed to be repeated and 1 showed abnormality which went to be investigated by colonoscopy.

Table 5 - Contacts made yielding completion

letter	34	phone	40
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Additional benefits of contacting non responders

Endorsement follow up of non responders by the GP surgery, by phone, letter or during consultation does increase uptake.

More importantly the surgeries taking part in the project reported the following additional benefits to contacting non responders;

1. Records were able to be checked –those that had died / moved / not see in the surgery for 4-5 years and could then be contacted before being removal from the register
2. Telephone numbers and mobile numbers were also check and alerts put on the records if unobtainable.
3. The importance of checking address and contact details of individuals who contact the surgery were understood more.
4. A lead in each surgery was identified and made the contacts as well as submitted monthly reports to the project lead at the CCG. The leads enjoyed taking ownership of the project and reported that they felt they were being valued by the GP surgery.
5. The project and the training and support which was given raised awareness of the importance of bowel screening to all clinical and non-clinical staff at the surgery.
6. Admin. staff also felt that as they did not have daily contact with patients if gave them more insight into patient's needs.
7. There was a positive feedback from patients " thank you for calling me" despite talking about a sensitive subject " do you know how to collect your poo sample".
8. Elderly patients, some housebound, were happy to have a call.

9. Some patients were identified as being abroad in Europe or Asia for example.
10. It was also noted that some patients that have not completed the screening kit this time had not completed it before.
11. Those who were 60 years old were told the benefits of the screening and that they would continue to receive a kit every 2 years until they reached 75.

Quarterly uptake

Data was extracted from Open Exeter on 29th January 2017 to identify if there had been an increase in Q2 uptake across Merton and in the individual surgeries who took part.

Q2 figures show uptake for July/ August/ September.

Q2 data is shown for 2014-15 two years before the completion of the project, this enables comparison with the same cohort of patients being screened two years ago (please note those now over 75 would not appear in the most recent data).

Q2 data for 2015-16 prior to the project commencing is also shown.

Q2 data for 2016-17 shows the final figures at the end of the project (those who were aged between 60 -74). Table 6 is an extract of this data which is attached in the appendix.

Please note this data is not complete as it may change over the months as figures are added. It was extracted in January 2017 from Open Exeter Dashboard.

National data is available from NHSE and TCST (transforming Cancer Service Team) who distribute final figure with a 6 month time lag.

Table 6 - Uptake for Q2 over the last 2 years

	Q2 UPTAKE 2014-15	Q2 UPTAKE 2015-16	Q2 UPTAKE 2016-17
July	49.03%	49.26%	49.61%
August	49.58%	46.80%	54.72%
September	44.28%	45.34%	50.28%
Total Q Uptake	47.63%	47.13%	51.54%

The uptake has increased by the end of the project, by 3.9% compared to the same cohort 2 years before and by 4.41% compared to last year, further increase may also be noted over the next couple of months.

Data not shown here for individual surgeries in Merton also shows an increase in uptake for each quarter.

This project data does not look at trends across SWL neither does it compare London data to Merton data.

What worked well in Merton?

The overall service delivery for this project was overseen by the Merton Bowel Cancer Screening Group, who met quarterly to ensure that quality standards and performance indicators were achieved, group members comprised of:

ACE Lead
GP Merton & Macmillan Lead
London Borough of Merton
NHS Merton CCG Lead
SWL Bowel Cancer Screening Centre
Project Manager

This project forms part of the national ACE Programme which looks at evidence of good practice to increase uptake of bowel cancer screening.

The ACE Project appointed a Project Manager, on a part time basis, whose role was to coordinate the project and be the main contact point in providing support and training to GPs.

Informal meetings were conducted at practice level to discuss and review progress and any issues that impeded on. Listening to the issues raised by administration and clinical staff aided in overcoming some of the perceived barriers in completing the bowel cancer screening kit and dispel major concerns raised in delivering a quality intervention, such as;

- Negative attitudes
- Lack of confidence or embarrassment in discussing bowel cancer screening
- Fear of irritating / annoying the patient
- Conflicting priorities

Although telephone scripts were available and can be a valuable tool when contacting patients, a less scripted approach when GP staff contacted individuals often achieved more positive outcomes.

Listed below are the most common reasons for non- responders;

Did not receive a bowel screening invitation
Did not see the relevance, as no health problems
Did not realise the importance of screening
Did not like the idea of the test
Too many other health issues
Too embarrassing
Alarm at sending poo samples via post
Misplaced kit
Personal issues, bereavement, depression etc.
Just not got around to doing it
Not nice, messy etc.
Scared of results, rather not know if they had cancer
Did not understand English adequately
Difficult to do as they had disabilities

Practice visits were a good opportunity for the Project Manager to maintain a presence that kept bowel cancer screening on the agenda, just by association, and also aided in building up a good rapport with practice staff.

Due to GP staff turnover on site bowel cancer screening training was provided, as and when required; this was key to the continuity of the programme. It helped to encourage new staff to feel more inspired to assist and promote the bowel cancer screening initiative, as they felt

more empowered with the knowledge gained to have the confidence to raise the screening issue with patients.

GPs are advised on a fortnightly basis via Primary Care Newsletters, emails or during the course of the Project Manager's visits on the updates and developments to the programme both locally and nationally. Posters and leaflets were also distributed.

IT support and guidance was provided to GPs to enable pop up automatic alert flags to be activated. This prompted staff to raise the issue of the importance of screening during the course of the patient consultation and set up monthly searches of non-responders and add template to audit results of non-responders contacts.

Congratulations to all the GP staff who played such a pivotal role in delivering these interventions by contacting and consistently following up with non-responders. Providing support and reassurance to patients concerned about the necessity and need to be tested, and the advice and information given to others who did not appreciate the relevance of screening. Overall the majority of staff both clinical and administration were happy to participate and take ownership of the bowel cancer screening project, working together to put robust systems in place to assist in achieving the aims and objectives of the project. From the 1st September 2015 to 30th September 2016 GPs successfully contacted **3,651** non-responders.

Final Merton ACE Bowel Cancer Screening performance data was collated by the Bowel Cancer Screening Specialist at SWL Bowel Cancer Screening Centre whose findings are set out in Appendix 1.

Recommendations

1. Encourage all Primary Care staff to be aware of the Bowel Cancer Screening Programmes, and the benefits of using cancer screening to identify cancer at an early stage when treatment and outcomes are more effective. Cancer Research UK and SWL Bowel Cancer Screening Centre can offer training to Primary Care Staff to support this.
2. Identifying GP champions/ cancer leads as the main point of contact in surgeries, to take ownership of cancer screening and provide updates to key practice personnel and patients.
3. Use the Best Practice Guide available from NHS England or Cancer Research UK, together with various resources and information leaflets.
4. Carry out monthly data base searches to identify non responders and contact them to identify and overcome any issues. This has already been established as part of the bowel cancer screening project and should be encouraged as Best Practice.
5. Bowel cancer screening templates should be standardised, to ensure that patient's records are correctly annotated and that coding is consistent to allow for more accuracy and streamlined bowel cancer screening reporting.
6. EMIS/Vision template alerts should be activated to identify patients that have not responded to bowel cancer screening invitations. This will give surgeries the opportunity during the course of consultation to raise and discuss the reasons why they have not responded and perhaps influence patient's decision.
7. During opportunistic consultations discuss bowel cancer screening with patients about to turn 60, or those who have not completed the bowel cancer screening kit, and give out the national freephone helpline number 0800 707 6060.

8. Alert flags should be set up to identify patients approaching their 60th birthday. This could also generate a screening letter informing patients of a forthcoming screening invitation and may influence them on the importance of bowel cancer screening.

However, whilst Alert flags are an effective tool, there is the risk that these can be ignored due to multiple flags against any one particular patient record and the time available for patient consultation.

9. Review methods that GPs communicate with their patients since texting via NHS Net is no longer an option, unless GPs have privately secured a contract.
10. Regular GP patient newsletters/information sheets to update and maintain awareness amongst patients of screening developments, and the promotion of national screening campaigns.
11. Bowel cancer screening kits should be available in surgeries to demonstrate to patients how they should be completed, hypothetically speaking of course.
12. Encourage patient engagement / involvement via patient participation groups amongst the local community, hard to reach and vulnerable groups, via Healthwatch, and other local agencies, to empower patients into making informed decisions regarding their health and wellbeing.
13. GPs should identify and engage with their vulnerable, disabled, mentally ill and special needs patients to encourage screening and provide any additional support where necessary.
14. GPs records should clearly reflect patient's ethnicity, learning disabilities, etc.
15. Multi language bowel cancer screening leaflets and signposting information should be readily available for patients and prominently displayed in waiting areas and consulting rooms in surgeries.
16. Posters displaying the bowel cancer screening freephone hotline number 0800 707 6060 and CRUK website www.cancerresearchuk.org should be prominently displayed and refreshed by practice staff on a regular basis.
17. General screening strapline could be prominent on GP headed paper and prescriptions if collected from the practice.
18. Clinical Commissioning Groups continue to support GPs to improve Bowel Cancer Screening uptake rates.
19. Support the introduction in late 2018 of FIT (Faecal Immunochemical Test), which requires only one poo sample and has increased sensitivity that enables the detection of more pre-cancer lesions.
20. Encourage patients to reduce their risk of bowel cancer by making lifestyle changes; eating healthy, exercise, weight management, give up smoking and limiting alcohol consumption.

Conclusion

It is evident from the screening data that screening levels and detection rates in Merton have increased as a direct result of the ACE Bowel Cancer Screening Project.

The above provides and demonstrates a solid basis for continuous improvement within primary care; via pursuing non responders and raising awareness with targeted group on the importance of early detection/intervention.

It is clear that offering brief advice is the single most effective intervention that a healthcare practitioner can give a patient, and is consistent with good practice. Most patients view their family doctor as a key and trusted source of advice and influence and by sending invitations for screening via GP endorsed letters gives more credence to the intervention, and does have a substantial impact on screening levels and detection rates, as the success of the ACE Merton screening programme demonstrates.

Despite the financial constraints and significant pressures placed on GPs, it is hoped the full benefit to patients is realised by health care professionals, and the work associated with the follow up of non-responders can be absorbed with existing GP staff on a routine basis. This could be the most cost effective way in improving local health outcomes and contribute to reducing health inequalities.

Bowel cancer screening is a focus for NHSE / PHE / CCG's / Screening Centres / charity organisations / Local Authority Public Health Services as well as Primary Care. We all need to work together to increase life expectancy of those with bowel cancer by early diagnosis and increasing uptake of National Bowel Cancer Screening programmes.

References

Bowel Cancer Screening – The Facts
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Macmillan – Understanding Bowel Cancer Screening
<http://www.macmillan.org.uk/community>

Public Health England – Health matters Improving the prevention and diagnosis of bowel cancer
<https://www.gov.uk/government/publications/health-matters-preventing-bowel-cancer>

Cancer Research UK- Engaging Primary Care in Bowel Screening - GP Good Practice Guide England Version, May 2016
<http://cancerresearchuk.org>

Cancer Research UK's Local Cancer Stats Online
<http://www.cruk.org/localstats>

Good Practice Guide for Bowel, Breast and Cervical Cancer screening in Primary Care 2016
<https://www.myhealth.london.nhs.uk/healthy-london/programmes/cancer/resources>

Healthcare Quality Improvement Partnership, National Bowel Cancer Audit 2015
<http://www.digital.nhs.uk/bowel>

APPENDIX 1

Final Data for Merton ACE Bowel Cancer Screening Project

Final data for Merton ACE Bowel Cancer Screening Project to involve GP surgeries in contacting patients who were non-responders and did not return the bowel screening kit after 3 months.

The project finished on 30th September 2016 and final figures of uptake were not available on Open Exeter until the beginning of April 2017.

The following shows the data collated by the Bowel Cancer Screening Specialist at SWL Bowel Cancer Screening Centre during Q3 (Oct – Dec 2015), Q4 (Jan – March 2016), Q1 (April – June 2016) and Q2 (July – Sept 2016), and shows the Bowel Cancer Screening Q data uptake reported on Open Exeter after 3 months and then again at 6 months to show the uptake after the GP intervention to contact patients.

Total Uptake Bowel Cancer Screening for Merton Oct 2015 - Oct 2016

Q3 (initial figures)	Q3 (after intervention)	Q4 (initial figures)	Q4 (after intervention)	Q1 (initial figures)	Q1 (after intervention)	Q2 (initial figures)	Q2 (after intervention)
40.13%	45.51%	45.51%	48.64%	47.93%	48.43%	49.02%	49.53%

We also looked at individual GP surgeries in Merton and found that prior to the project 10 surgeries were below 40% and no surgeries were at the 60% national target.

After the project only 4 surgeries were still below 40% and one surgery was achieving 60%, with 2 other surgeries reaching the 60% target during the project time.

At some point during the project all but 2 surgeries showed a quarterly increase at 6 months.

Other data is available to show the uptake over a 2-year period, but is not detailed in this report.

