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Evaluating the Acceptability and Implementation of a System-Level Bowel Cancer Screening Intervention in Blackburn with Darwen Primary Care

13/10/2025 Version: 3.1

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Evaluating the Acceptability and Implementation of a System-Level Bowel Cancer Screening Intervention in Blackburn with Darwen Primary Care

OCT 2025

Authors:

Dr Rebecca Jefferson, University of Lancashire

Dr Yasemin Hirst, University of Lancashire

Acknowledgements:

We thank all participants who took part in the interviews and provided important information for this evaluation. The initiative was project managed by Rabiya Gangreker and Liz Johnston from the Public Health Department at Blackburn with Darwen (BwD) Borough Council. Angela Dunne from NHS Lancashire & South Cumbria ICB Cancer Alliance aided in recruiting practices for the initiative and evaluation.

Ethics Statement:

This research was approved by the University of Lancashire's Health Ethics Review Panel (HEALTH01170). Data were collected by the authors of this report in line with ethical procedures.

Funding Source:

The project was funded by NHS Lancashire & South Cumbria ICB Cancer Alliance and the evaluation was commissioned by the Public Health Department at BwD Borough Council. The funders did not have any influence on the evaluation. The views expressed are those of the authors and not necessarily those of the funder and commissioners.

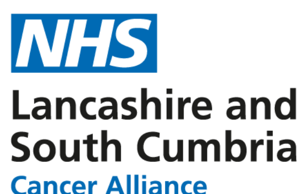

Table of Contents

Executive Summary 3

Key Findings 3

Conclusion 5

Recommendations 5

Introduction 6

Overview 6

Background 7

Bowel Cancer and Screening Uptake in the North West 7

The Need for Evaluating the Implementation of Primary Care System-Level Interventions 7

The Intervention 8

Evaluation Aims 8

Methods 9

Design 9

Theoretical Underpinnings 9

Recruitment and Participants 11

Procedure 12

Data Analysis 13

Results 14

Quantitative Findings 14

Table 1. Descriptive Statistics 15

Interview Findings 16

Theme 1: Understanding and Awareness of the Intervention 16
Theme 2: Confidence and Capacity for Implementation 19
Theme 3: Emotional and Ethical Engagement 22
Theme 4: Practical and Resource Constraints 25
Theme 5: Perceived Impact and Effectiveness 27
Theme 6: Recommendations for Future Initiatives and Implementation 31
Discussion 33
Interpretation of Findings 34
Strengths and Limitations 35
Recommendations for Practice and Future Research 36
Conclusion 38
References 39
Appendices 41
Appendix 1 - Letter to inviting practices to the project 42
Appendix 2 - Practice Guide 44
Appendix 3 - PLT engagement poster 48
Appendix 4 - PLT data table 49

Executive Summary

This report presents the evaluation of the Blackburn with Darwen (BwD) Bowel Cancer Screening Project, a system-level intervention designed to increase uptake of bowel cancer screening among eligible residents aged 53–74. The initiative was developed in response to persistently low screening rates in the borough and aimed to leverage existing digital tools within primary care settings to engage non-responders.

The intervention included:

1. **EMIS pop-up alerts** to prompt **opportunistic conversations** during patient contact.
2. **Targeted SMS messaging** from GP practices, with options for patients to request kits.
3. A **Protected Learning Time (PLT) event** to share best practices and promote wider adoption.

Key Findings

The University of Lancashire conducted a mixed-methods evaluation, focusing on implementation experiences across 22 GP practices. Quantitative data shows that SMS messages had a minimal impact on improving participation with less than 1% of the non-responders subsequently completing a test kit (n=33/4995). The low test kit return rate is concerning, despite a considerable number of non-responders having requested a replacement kit (n=645). This warrants an exploration of individual-level data to understand the characteristics of individuals who are likely to respond to SMS messages. This could provide insights to ensure those who are less likely to respond to SMS messages could be approached using other methods (e.g., telephone or face to face consultations).

The qualitative interviews with 11 stakeholders—including GPs, practice managers, and implementation leads—provided rich insights into the acceptability, feasibility, and

perceived impact of the intervention. Six themes were developed from the qualitative analysis:

1. **Understanding and Awareness of the Intervention:** Primary care staff demonstrated varying levels of awareness and understanding of the intervention's aim and operational requirements, with communication gaps and the rapid launch impacting coherence.
2. **Confidence and Capability for Implementation**: Confidence in delivering the intervention was shaped by digital literacy, role-specific experience, and access to supportive systems, with collaborative team dynamics acting as key enablers.
3. **Emotional and Ethical Engagement:** Participants expressed strong professional commitment to improving screening uptake, though this was tempered by ethical concerns, emotional fatigue and the complexities of engaging diverse communities.
4. **Practical and Resource Constraints**: Time pressures, administrative burden, and competing priorities affected the feasibility and sustainability of the intervention, especially in practices with limited staffing or digital literacy.
5. **Perceived Impact and Effectiveness**: Text messaging and clinician-led conversations were seen as valuable, but barriers such as digital exclusion and lack of follow-up data limited reach.
6. **Recommendations for Future Delivery**: Participants suggested included clearer messaging, visual demonstrations, culturally tailored approaches, streamlined workflows and greater integration into routine workflows to enhance future delivery.

The findings were framed using the Theoretical Framework of Acceptability (TFA), which helped identify the factors most influencing staff engagement. Staff generally found the intervention acceptable, particularly where there was clear communication, supportive infrastructure, and integration into existing workflows. High levels of professional commitment and ethical alignment were evident, though practical constraints and opportunity costs sometimes limited engagement. The intervention's perceived

effectiveness was greatest when personalised and relationship-based approaches were used.

Recommendations

- Strengthen onboarding and internal communication.
- Provide templates and training to support implementation.
- Use culturally sensitive messaging that utilises trusted patient and health care professional relationships.
- Integrate screening prompts into routine appointments.
- Ensure timely feedback and outcome data to sustain engagement.

This report offers transferable learning for Integrated Care Boards, Cancer Alliances and commissioners of screening programmes seeking to improve cancer screening uptake through scalable, system-level approaches.

Conclusion

Overall, the intervention had a small but positive impact on screening uptake among previous non-responders. Stakeholder perspectives indicated that the intervention was broadly acceptable to primary care staff while its effectiveness has been less than optimal. Its sustainability and impact will depend on addressing resource constraints, enhancing onboarding and training, and ensuring culturally sensitive delivery that utilised trusted relationships between health care professionals (HCP) and patients. Embedding these elements into routine practice will be critical for maximising both acceptability and effectiveness in future initiatives.

Introduction

Overview

This evaluation report presents the implementation and impact of the Blackburn with Darwen (BwD) Bowel Cancer Screening Project, which aimed to improve uptake of bowel cancer screening among eligible residents, particularly in areas with historically low participation rates.

The final project included:

1. **EMIS pop-up alerts** for non-responders aged 53–74 across participating GP practices, prompting opportunistic engagement during patient contact. All practices were eligible to participate.
2. **Targeted SMS messaging** from practices with <60% screening uptake, encouraging eligible patients to request kits. These practices were also permitted to order kits on behalf of patients, while practices with ≥60% uptake could send texts, but patients had to order kits themselves.
3. **Protected Learning Time (PLT) event** to promote awareness and share best practices.

The total funding allocated for the project was £26,477, and the evaluation focuses on understanding how digital prompts and targeted messaging influenced screening uptake. Within this, funding was allocated to the development of culturally relevant videos around bowel screening to provide information in the most common languages that the residents of BwD speak. The project aligns with national priorities for early cancer diagnosis and health inequality reduction and aims to generate transferable learning for similar initiatives across Lancashire and South Cumbria.

Background

Bowel Cancer and Screening Uptake in the North West

Bowel cancer is the fourth most common cancer in the UK and the second leading cause of cancer-related deaths (CRUK, 2024). Early detection through screening significantly improves outcomes, yet uptake of the NHS Bowel Cancer Screening Programme (BCSP) remains suboptimal in many areas (Office for Health Improvement and Disparities, 2025). In the North West of England, particularly in Blackburn with Darwen (BwD), screening uptake is among the lowest nationally. Despite targeted interventions aimed at non-responders, such as reminder letters and community outreach, there is growing recognition that primary care system-level approaches may offer a scalable and sustainable way to improve participation.

The Need for Evaluating the Implementation of Primary Care System-Level Interventions

National guidance from NHS England and Cancer Research UK (e.g. *Bowel Screening: Good Practice Guide*, October 2023) outlines a range of tools that GP practices can use to engage non-responders. These include EMIS pop-ups, text messaging systems, and prompts during routine appointments. Much of the evidence is based on population-based randomised controlled trials such as text-message reminders in CRC screening in London (Hirst et al, 2017), the use of primary-care endorsement in improving uptake (Benton et al. 2017; Wardle et al, 2016). However, while these tools are widely available and used for other purposes in primary care, there is limited evidence on their real-world implementation, acceptability, and effectiveness within primary care settings for improving bowel cancer screening uptake.

To date, there are no published academic evaluations on primary care-based implementation of system-based tools, nor of the barriers and facilitators to their adoption.

This limits the ability of Integrated Care Boards (ICBs) and local authorities to make informed decisions about wider rollout.

The Intervention

In response to this evidence gap, the BwD Borough Council and the Lancashire and South Cumbria Cancer Alliance piloted a system-level intervention across 22 GP practices in BwD. The intervention includes:

- **Universal intervention**: Reinstating EMIS pop-ups for all non-responders aged 53–74 (approx. 4,164 males and 3,867 females coded as non-participants in the last 18 months).
- **Targeted intervention**: Sending text messages to non-responders enabling patients to request a screening kit. Practices are reimbursed per message sent and per kit ordered.
- **Qualitative evaluation**: Partnering with the University of Lancashire to explore the acceptability and perceived effectiveness of the intervention among primary care staff.
- **Knowledge sharing**: Hosting a Protected Learning Time event to disseminate learning and encourage wider adoption.

These tools are not novel; they are embedded within existing primary care systems (e.g. EMIS, AccuRx, iPlato) and are available to all practices. However, their use depends on local decision-making, knowledge, capacity, and perceived value.

Evaluation Aims

The University of Lancashire was commissioned to evaluate the intervention in relation to its implementation, with the following objectives:

1. **To understand the acceptability and willingness to implement system-based tools** (e.g. EMIS pop-ups, text messaging platforms) to improve bowel cancer screening uptake in primary care.

2. **To identify barriers and facilitators** to implementing these tools, from the perspective of those involved in decision-making and delivery (e.g. GPs, Practice Managers, Nurses).

Methods

Design

A **mixed-methods approach** was used to evaluate the primary care intervention.

- **Quantitative data** were collected to assess the effectiveness of the intervention, including the number of AccuRx text messages sent, screening kits ordered on patients' behalf, and the number of returned test kits (as indicated by a recorded QFIT result).
- **Qualitative data** were collected to explore the acceptability of the intervention among primary care staff and implementation managers. This component was guided by the Theoretical Framework of Acceptability (TFA; Sekhon, Cartwright, and Francis, 2017), with additional concepts drawn from the Theoretical Domains Framework (TDF; Mitchie et al., 2005; Cane, O'Connor & Mitchie., 2012) where relevant.

Theoretical Underpinnings

Theoretical Framework of Acceptability (TFA). The Theoretical Framework of Acceptability (TFA) is a model used to understand how acceptable a healthcare intervention (or any new practice) is to those delivering or receiving it (Sekhon et al., 2017). It defines acceptability as a multifaceted construct that reflects the extent to which people consider an intervention to be appropriate, based on their cognitive and emotional responses.

The TFA includes seven key constructs that help assess acceptability at both the design and implementation stages:

1. **Affective attitude** – how individuals feel about the intervention.
2. **Burden** – the perceived effort required to engage with it.
3. **Ethicality** – the extent to which the intervention aligns with personal values.
4. **Intervention coherence** – how well the intervention is understood.
5. **Opportunity costs** – what participants must forgo to engage.
6. **Perceived effectiveness** – the extent to which the intervention is believed to achieve its purpose.
7. **Self-efficacy** – confidence in performing the behaviours required by the intervention.

In short, the TFA provides a structured way to evaluate whether and why an intervention is acceptable, which is crucial for successful implementation and sustainability.

Theoretical Domains Framework (TDF). The Theoretical Domains Framework (TDF) is an implementation science framework that helps identify the factors influencing behaviour change in healthcare and other settings (Mitchie et al., 2005; Cane et al., 2012). It was originally developed in 2005 (and refined in 2012) by synthesizing constructs from numerous psychological and organizational theories into a single, comprehensive framework.

The TDF includes 14 domains that capture the wide range of influences on behaviour:

1. **Knowledge** – awareness of information relevant to the behaviour.
2. **Skills** – abilities or competencies required.
3. **Social/professional role and identity** – how the behaviour fits with one's role.
4. **Beliefs about capabilities** – confidence in one's ability to perform the behaviour.
5. **Optimism** – confidence that things will go well.
6. **Beliefs about consequences** – perceptions of the outcomes of performing the behaviour.

7. **Reinforcement** – rewards, punishments, or incentives.
8. **Intentions** – commitment to performing the behaviour.
9. **Goals** – priorities and objectives.
10. **Memory, attention, and decision processes** – cognitive processes influencing behaviour.
11. **Environmental context and resources** – external factors that enable or hinder behaviour.
12. **Social influences** – interpersonal pressures, norms, or support.
13. **Emotion** – feelings that shape behaviour.
14. **Behavioural regulation** – strategies and self-monitoring for behaviour change.

In short, the TDF provides a structured way to identify barriers and facilitators to behaviour change, which can then guide the design of interventions and implementation strategies.

Recruitment and Participants

A total of **11 participants** working within the Blackburn with Darwen area were interviewed:

- Three participants were involved in the design and implementation of the intervention, based in either the Blackburn with Darwen Borough Council Public Health Department or the NHS England ICB Cancer Alliance.
- Eight participants were involved in the delivery of the intervention across six GP practices, including:
  - 2 GP Partners
  - 1 Locum GP
  - 2 Practice Managers
  - 2 Quality Outcomes Framework (QOF) Leads
  - 1 Healthcare Assistant

Recruitment was facilitated by key contacts at the Cancer Alliance and the Council, who distributed study information to GP practices across BwD. Practices were asked to share

the study advert and participant information sheet with staff. Interested individuals contacted the research team directly and were sent a consent form. Upon return of the signed form, a mutually convenient interview time was arranged. The study was also promoted at Primary Care Network (PCN) meetings and other engagement events. The study has been extended to a wider population in the North West of England to further explore whether the findings support generalisable evidence on barriers and facilitators of implementing interventions to improve bowel cancer screening uptake in primary care. The data collection is ongoing.

Procedure

Quantitative Data Collection

Quantitative data were collected monthly by the Cancer Alliance from the start of the intervention, with a final EMIS search conducted in August 2025. Data were extracted and reported at the practice level using existing EMIS-specific codes identifying patients who have not completed their bowel cancer screening.

Qualitative Data Collection

Qualitative interviews were conducted between January and September 2025. All interviews were held online via Microsoft Teams, recorded with participant consent, and transcribed using the platform's auto-transcription feature. Transcripts were then reviewed and corrected for accuracy.

A semi-structured interview guide was developed based on the Theoretical Framework of Acceptability (TFA), with supplementary constructs from the Theoretical Domains Framework (TDF) to capture broader implementation factors. Interviews lasted between 30 and 45 minutes.

Approximately halfway through qualitative data collection a Protected Learning Time (PLT) Event occurred where approximately 100 Primary Care staff attended, and the preliminary

results of the qualitative analysis were presented by the evaluation team. Within this, participants of the PLT were provided with a discussion form and asked to discuss four questions based on the data analysis and to anonymously write these on the form (See appendices 3 for the discussion form).

Data Analysis

Quantitative Analysis

We described the data descriptively using sum, range, mean and standard deviations and calculated the proportions of test kit requested and returned in percentages (%). We carried out exploratory independent samples t-tests to compare whether there are differences by GP practices based on their uptake in 2023/24 financial year (under 60% versus over 60%) and based on their involvement in the "Call for a Kit (CFAK)" project delivered by the NHS Lancashire and South Cumbria Bowel Cancer Screening Programme (Yes/No). An exploratory multivariable linear regression model including text messages sent, uptake, kits requested and CFAK involvement was carried out investigating potential factors associated with number of test kit returns. All analyses were carried out using SPSS Version 29.

Qualitative Analysis

Deductive thematic analysis was used to analyse the interview data where a coding framework was developed based on the TFA and TDF domains the interviews were based on. These allowed the data to be coded based on the theoretical domain it related to. After the first five interviews, preliminary thematic analysis was conducted. Preliminary findings were presented at a protected learning time (PLT) event for GP practice staff across Blackburn with Darwen on 24th April 2025. The remaining six interviews were conducted following this event, allowing for further exploration of themes and validation of early insights. All data was then coded using the coding framework on NVivo (a qualitative data management software). Data was then analysed by domain to identify patterns and

variations across participant accounts. These variations were then written up as subthemes within the domain (theme) it pertained to. Data collected from the PLT were collated into a table and compared to the data analysis of the qualitative data.

Results

Quantitative Findings

According to PHE Fingertips data, the uptake of bowel cancer screening in BwD in 2023/2024 is 62.21% [Range:43-75%]. Table 1 describes the number of text messages sent, kits requested and returned per practice. Practices are anonymised.

Between July 2024 and March 2025, 4995 text messages were sent via GP practices in BwD to facilitate test kit replacement request among screening non-responders and resulted in 645 replacement kits (12.9%) to be requested from the bowel cancer screening programme. The findings show that among the population with kit requests, 5% (n=33) were returned with results recorded in primary care. No data was extracted for clinical findings. Among the population targeted using text messages (n=4995), this is equivalent to less than 1% kit return rate. No data available for the population size and other sociodemographic characteristics for individuals who were eligible for text-messages during the project period.

Table 1. Descriptive Statistics

Anonymised GP Practice	Text-messages Sent (N)	KIT requests (N)	QFIT results (N)	Screening uptake via PHE Fingertips (22/23) (%)	Screening uptake via PHE Fingertips (23/24) (%)	CFAK in place during intervention period
Total	4995	645	33	63.04	62.21	
A	119	1	0	69.0	67.2	Y
B	127	1	0	64.4	64.9	Y
C	10	1	0	60.3	60.3	N
D	8	1	1	68.8	67.7	Y
E	444	2	1	63.6	66.7	N
F	72	80	4	66.9	73.1	N
G	207	1	0	44.3	43.3	Y
H	149	95	4	61.2	61.5	Y
I	15	6	1	59.0	50.0	Y
J	866	126	8	64.0	62.4	N
K	71	0	0	57.8	55.6	Y
L	429	13	0	74.4	75.1	Y
M	155	5	1	67.7	70.5	N
N	102	32	0	69.4	68.1	Y
O	283	63	3	73.6	68.8	N
P	222	13	1	62.3	63.3	Y
Q	434	69	3	50.0	53.3	Y
R	39	0	0	62.9	58.8	Y
S	556	124	6	51.7	47.0	Y
T	637	2	0	71.4	70.1	N
U	46	0	0	58.2	55.0	Y
V	4	0	0	66.1	66.0	N

The number of text messages sent per practice varied ranging from a minimum 4 to maximum 866 [mean=227, standard deviation (SD)= 236.4] and an average 28.8 kits requested per practice (SD=42.83). Further exploratory analyses comparing GP practices with less than 60% uptake and those with above 60% uptake identified no statistical differences by the number of text messages sent, kits requested, and kits returned. There were also no significant differences between the practices where NHS England commissioned Call for a KIT (CFAK) Bowel Cancer Screening improvement project was in place. Multivariate linear regression model results showed that greater number of test kit request is positively associated with the number of kit returns while past uptake of the GP practice, the number of text messages sent and the delivery of CFAK during the implementation period had no impact on kit return rates ($F(1,17) = [57.53]$, $p = < .001]$).
Further information such as time since the last screening invitation, sociodemographic characteristics of the population who requested replacement kits using text-messages will be useful for tailored approaches.

Interview Findings

Six themes were developed from the analysis to meet the research objectives. The themes pertain to primary care staff's capability and understanding of the intervention, emotional and ethical engagement, practical and resource constraints, and the perceived impact and effectiveness of the initiative. The final theme outlines the ideas for future improvements and initiatives to increase screening uptake. Data from the PLT supported these themes (See appendix 4 for the PLT data table).

Theme 1: Understanding and Awareness of the Intervention

This theme explores the extent to which primary care staff understood the aims, scope, and operational requirements of the intervention. It highlights variation in awareness across roles and practices, and identifies key barriers to coherent implementation, including communication gaps and a rushed launch process.

Mixed Levels of Awareness and Understanding. Participants demonstrated varying degrees of familiarity with the intervention. While some were well-informed and actively engaged, others were unaware of their practice's involvement or unclear about their responsibilities. While some staff were aware of the initiative, others were unclear whether their practice was formally participating or what actions were expected of them:

> *"I didn't even know about this project until you emailed me..." (P11, Administrative staff)*
>
> *"I'm not sure if we are [taking part] I think our practice managers would know." (P01, GP).*

Despite these mixed understanding and awareness, many participants were able to describe key components of the intervention, such as EMIS pop-ups and AccuRx messaging systems used to flag non-responders and prompt action:

> *"We have pop-ups on the side, so it alerts us what's outstanding." (P07, HCA)*
>
> *"I sent out text messages to all the patients that were eligible..." (P05, Administrative Role)*

Practices with clearly defined roles and collaborative working arrangements reported smoother implementation suggesting that internal clarity and team coordination are critical enablers:

> *"It's just about developing a process that you follow that works... having those administrative processes in place and having the flow of how that happens and who does that work" (P02, GP)*

Communication and Dissemination Challenges. Several participants attributed their lack of awareness to poor internal communication and the volume of concurrent initiatives. The absence of structured onboarding or formal dissemination materials contributed to confusion and inconsistent uptake:

> *"Some GPs hadn't heard of the project and wanted to know if it was starting now… it was disheartening." (P08 Implementer)*
>
> *"I feel like somebody mentioned something a few months ago, but there's so much so many different initiatives ongoing at one point." (P01, GP)*

In some cases, participants relied on personal judgement or informal team agreements to interpret and implement the intervention. These adaptations reflected a working understanding of the goals, shaped by local context:

> *"I've just used my own initiative and just done it with my experience really." (P07, HCA)*
>
> *"We just agreed it amongst ourselves and started doing it." (P01, GP)*

Implementers acknowledged that the launch was unconventional and rushed, which may have impacted protocol clarity:

> *"The launch was slightly rushed, which may have impacted how well practices understood the protocols." (P10, Implementer)*

Impact of Launch Timing and Consultation. Implementers acknowledged that the intervention was launched under time constraints, with limited consultation during bid development. This disrupted continuity and hindered the usual process of learning from previous schemes:

> *"It ended up being really rushed… if we'd had more time, we would have done more consultation before the bid had gone in." (P09, Implementer)*
>
> *"We used to like launch everything in March, we'd wrap up all the old schemes, projects and we'd launch the new ones. So, they have that continuum and they could see, 'this is the learning, this is what we're going to do, this is what we've learned, this is what we're going to change, and here's the new ones'. They didn't have that. This just came in from kind of nowhere*

> *and I think it was July and I just think that perhaps it just missed hitting the mark" (P10, Implementer)*

Summary: Staff demonstrated varied levels of awareness regarding the intervention's aims and their roles within it. While some practices had clear processes and collaborative structures, others lacked formal communication, leading to confusion and inconsistent engagement. The rushed launch and limited consultation during bid development further contributed to gaps in understanding and procedural clarity.

Theme 2: Confidence and Capacity for Implementation

This theme examines staff confidence in delivering the intervention and the systems and team dynamics that supported or hindered implementation. It highlights how digital literacy, role-specific responsibilities, and peer collaboration influenced uptake and effectiveness.

Confidence in Routine Delivery. Many participants felt confident in their ability to carry out key tasks such as sending text messages, running searches, and initiating opportunistic conversations. This was particularly evident among administrative staff and those with prior experience in similar campaigns:

> *"It's [Running the searches and ordering the kits] easy. Well, I think it is. I've been doing it that long. (P11, Administrative role)*
>
> *"We also got the nurses that if they've got like bowel cancer screening, at the bottom of the right-hand corner in EMIS, not completed or declined or whatever, the nurses talk to them as a one to one… We've been doing it for many years" (P04, Administrative role)*

Confidence was higher in practices that had embedded the intervention into existing workflows, and delegated tasks appropriately:

> *"It's just about developing a process that works… and embedding that into the day-to-day working lives of the admin team." (P02, GP)*

Role-Specific Variation and Training Needs. Confidence levels varied depending on professional role. Generally, the confidence in using AccuRx was high and the majority of GPs and HCAs felt comfortable initiating screening conversations. Others, particularly newer or returning staff, described uncertainty about procedures or technical aspects:

> *"I'm not really that up to date with [EMIS pop-ups] I need to get back to that." (P06, GP).*

This lack of awareness was being down to being a recent starter within a practice with multiple difficulties leading to communication issues, along with being unaware of normal screening processes:

> *"I wasn't quite sure what they expect us to do about [non-responder results] It's quite hard to get hold of the partner GP to ask questions." (P06, GP)*

Despite being confident in initiating screening conversations, several participants expressed the need for further training or clearer guidance to improve their ability to explain the screening process to patients:

> *"Maybe I could research a bit more… get some more training… so I can explain [the FIT test] better." (P07, HCA)*

Confidence was higher in practices where tasks were clearly delegated to appropriate staff (e.g. administrative teams or nurses). This approach reduced reliance on GPs and improved feasibility:

> *"It doesn't have to be a GP… practices decide how to incorporate it." (P02, GP)*

System and Infrastructure Support. In addition to role clarity, confidence was often linked to the availability of supportive systems, such as templates, automated pop-ups, and clear referral pathways. Where these were in place, staff felt more able to deliver the intervention efficiently:

> *"I just press run on my searches and it just runs for me… it doesn't take me long." (P11, Administrative role)*
>
> *"You can use the pop-up… it's quite straightforward. (P05, Administrative role)"*

Conversely, limited access to tools or difficulty navigating practice systems undermined self-efficacy but did not deter willingness to try:

> *"I don't know how we could bring that into normal practice in a full way. But I'd be willing to do it." (P06, GP)*

Implementers acknowledged that digital literacy and system familiarity varied across practices, which influenced uptake and confidence:

> *"Very different skill sets across some of the practices." (P10, Implementer)*

Peer Support and Team Dynamics. Collaborative working and informal peer support also played a role in boosting confidence and enabling the intervention. In some practices, staff worked together to share responsibilities and troubleshoot challenges with many participants describing a collaborative team environment where screening promotion was seen as a shared responsibility. Informal agreements and mutual encouragement helped embed the intervention into routine practice:

> *"We just agreed it amongst ourselves and just started doing it." (P01, GP)*
>
> *"My staff have got that mentality… any new project that comes along that we're having to encourage patients I don't think they'd see that as an extra task, they'd see that as their work in general." (P03, Practice Manager).*

Some practices used creative strategies, such as friendly competitions, to motivate staff and increase engagement:

> *"We put a little game together… a reward for the person who ordered the most kits." (P02, GP).*

On the other hand, in practices with limited communication or team cohesion, staff described feeling isolated or unsure about their responsibilities. The attitudes and behaviours of colleagues, particularly senior staff, shaped how others engaged with the intervention. In some cases, younger staff looked to more experienced partners for guidance or approval:

> *"I could speak to the younger one and let him introduce the idea to the older partner." (P06, GP)*

However, generational differences in digital literacy and openness to change sometimes created barriers:

> *"The older locum... he can't send the text messages; he just ignores them." (P06, GP)*

Summary. Together this theme highlights how confidence in delivering the intervention was shaped by role-specific experience, digital literacy, and access to supportive systems. Administrative staff and those with prior campaign experience felt more capable, especially where workflows were embedded and tasks delegated. Peer support and team cohesion emerged as key enablers, while limited infrastructure and generational differences in digital skills can hinder uptake.

Theme 3: Emotional and Ethical Engagement

Professional Commitment and Ethical Alignment. Across both clinical and non-clinical roles, participants expressed strong emotional and ethical commitment to the aims of the intervention. Many described feeling motivated and personally invested in improving cancer screening uptake, often linking this to their professional identity and public health values:

> *"It's always about trying to improve outcomes for patients... I was really happy when they started." (P05, Administrative role)*
>
> *"We're looking out for patients that have got ill health or any cancer and we want to prevent [cancer] as well." (P03, Practice Manager).*

Some staff noted they would continue engaging with the intervention regardless of financial incentives, reflecting intrinsic motivation:

> *"I do that without being paid for it, to be honest (P02, GP)*

The intervention was generally viewed as ethically sound and aligned with the goal of improving population health. Implementers and frontline staff alike saw it as part of their duty to support patient wellbeing:

> *"It's a massive part of my responsibility… I'm passionate about improving outcomes." (P05, Administrative Role)*
>
> *"GPs didn't mind doing it… they always said we don't mind doing it if we've got the time." (P10, Implementer)*

However, participants also recognised the emotional and ethical complexity of engaging patients in areas with high deprivation, low literacy, or cultural sensitivities. There was concern that digital tools alone might not be sufficient:

> *"It needs that real individual touch… people having their hand held." (P09, Implementer)*
>
> *"I think with bowel screening a lot more interaction needs to be done with patients. I think understanding why they don't want to do it." (P05, Administrative Role)*

Staff emphasised the importance of culturally sensitive communication and trust-building, particularly when working with diverse communities:

> *"You know how they work and what they listen to and what they don't." (P07, HCA)*
>
> *"if I got something from my local hospital or my GP, I'd be more tempted to do what they advise rather than just some letter in the post off Rugby" (P11, Administrative Role)*

Emotional Strain and Structural Constraints. Despite positive intentions, participants described emotional fatigue and frustration when structural limitations prevented them from acting in line with their values. Competing priorities, lack of formal targets, and limited resourcing made it difficult to sustain engagement:

> *"We would do it at the beginning and then slowly, slowly, slowly it would dwindle off...If it was a target... it would definitely continue." (P02, GP)*

Implementers acknowledged that without financial incentives or dedicated time, practices were unlikely to prioritise the intervention:

> *"They've got other competing priorities... if they're not going to get paid, I don't think they will." (P08, Implementer)*

There were also ethical tensions around the appropriateness of messaging. Some staff worried that unsolicited prompts could disrupt rapport or cause distress:

> *"It might put a spanner in the works to the rapport you've got with the patients." (P06, GP)*
>
> *"Patients just think you're bombarding me... I just want to get on with my life." (P05, Administrative Role).*

Concerns were raised about digital exclusion, message clarity, and the risk of sending texts to the wrong individuals:

> *"Some of them just thought it was a nuisance or couldn't understand it... just some more noise on the phone." (P10, Implementer)*
>
> *"Sometimes you can accidentally send it to someone inappropriate... we just have to be a bit careful." (P01, GP)*

These reflections highlight the emotional burden of delivering care in constrained systems, where staff were often caught between what they felt was right and what was feasible.

Summary. Participants expressed strong emotional and ethical alignment with the goals of the intervention, viewing it as consistent with their professional values and public health responsibilities. However, emotional investment was tempered by structural constraints, competing demands, and ethical concerns around communication and patient engagement. While affective attitudes were largely positive, sustaining engagement will require clearer support structures, cultural sensitivity, and alignment between values and resources.

Theme 4: Practical and Resource Constraints

This theme explores the perceived effort and trade-offs involved in delivering the bowel cancer screening intervention. It reflects the burden experienced by staff in terms of time, workload, and system usability, as well as the opportunity costs of engaging with the intervention alongside other clinical and administrative responsibilities.

Time, Workload, and System Burden. Staff described a wide range of experiences with the intervention, shaped by their role, practice infrastructure, and familiarity with digital systems. For some, the process was straightforward and easily integrated into routine work:

> *"No, it doesn't take me long… I just press my buttons and go." (P11, Administrative Role)*
>
> *"It was quite straightforward… you bulk send it, get responses back, and that's it." (P05, Administrative Role)*

However, others reported significant challenges due to staffing shortages, lack of team coordination, and absence of dedicated time within appointments:

> *"There's no regular team meetings… no impetus in that team working." (P06, GP)*
>
> *"I've just sent a lot of messages out yesterday and then I got this message saying, 'please don't send any more messages out because we've only got two people on the front desk, they can't manage the calls coming in'. And you think, well, we've got to hit the targets" (P04, Practice Manager)*

> *"I think it's just a passing remark. Because it's, it's just they're just don't have that type of time when I can spend myself 20 minutes on the phone. (P04, Practice Manager)*

Time was the most frequently cited source of burden. Even small tasks—like sending texts or reviewing notes—were perceived as cumulative when scaled across patients:

> *"It adds about two minutes per result… if I've got 10 results, that's another 20 minutes." (P01, GP)*

Administrative tasks such as ordering kits or managing responses added to existing workloads, particularly in practices with limited automation or search functionality:

> *"What took me long was actually sending out for everyone's screening." (P05, Administrative Role)*
>
> *"We haven't got a search mechanism for people who haven't done it." (P04, Practice Manager)*

This also suggests a lack of engagement with the procedures sent by implementers who provided instruction on searching for non-responders.

While implementers believed the intervention was simple to deliver, some acknowledged that EMIS usability varied and that clearer visual aids might have helped:

> *"From our end of the table, it sounded easy… but we don't use EMIS… Would visual screenshots have worked better?" (P08, Implementer)*

Competing Priorities and Implementation Trade-offs. Participants frequently reflected on the trade-offs involved in delivering the intervention alongside other responsibilities. Opportunistic conversations were seen as valuable but time-consuming, especially during busy clinics:

> *"It just extends the consultation by a few minutes… at least two or three minutes." (P01, GP)*

> *"If you've got a backlog of patients… it'll have a knock-on effect." (P07, HCA)*

Some practices developed structured workflows to mitigate disruption:

> *"We have dedicated time for each HCA to do the extra work on the day… that works." (P07, HCA)*

Clinical complexity further complicated implementation. Staff were cautious about raising screening during unrelated consultations, particularly with patients presenting multiple issues:

> *"It might open a whole can of worms in a consultation and you're already… having to bring them back." (P06, GP)*

Implementers recognised these challenges and encouraged delegation to reduce disruption:

> *"I accept that a clinician in 5 minutes isn't going to be able to bridge that gap. So, a lot of it was down to that kind of professional judgment at that moment in time to determine whether or not that was a valid conversation to have." (P08, Implementer)*

Summary. Practical and resource constraints were shaped by time pressures, system usability, and competing demands. While some practices found the intervention manageable, others struggled with cumulative workload, unclear responsibilities, and limited infrastructure. Sustainability depended on financial support, clear role allocation, and integration into existing workflows. Implementation adaptations, such as streamlined processes and targeted incentives, helped reduce burden, but engagement remained sensitive to resource constraints.

Theme 5: Perceived Impact and Effectiveness

This theme explores participants' perceptions of how effective the intervention was in increasing bowel cancer screening uptake. It reflects both optimism about the

intervention's potential and concerns about its limitations, particularly in relation to communication methods, patient diversity, and the need for follow-up data.

Belief in the Value of the Intervention. Implementers recognised the value of text messaging as a low-cost, efficient way to reach large numbers of patients, particularly non-responders:

> *"You can send out a message to that person's personal device… for a low cost and in a short time frame." (P09, Implementer)*

The intervention was also grounded in evidence suggesting that clinician-led conversations can positively influence screening decisions:

> *"a healthcare professional is seen as someone who's trusted and trusted professional whose advice people will take" (P09, Implementer)*

Many participants expressed optimism about the initiative's potential to increase screening uptake, particularly when messages were timely and came from trusted sources:

> *"I think definitely the text messages will be more effective… they'll be going out to everybody." (P01, GP)*
>
> *"If it increases screening uptake, then it was useful." (P02, GP)*

Some staff noted anecdotal improvements in response rates and expressed interest in auditing data to confirm impact:

> *"I'm hoping that we've increased… I really want to know." (P05, Administrative Role)*
>
> *"I've noticed more people seem to be taking it up now than they were at the beginning." (P011, Administrative Role)*

Importance of Personalised and Trusted Communication. Messages sent directly from the GP practice were perceived as more effective than those from external organisations.

Familiarity and trust were key factors in patient responsiveness:

> *"They've responded when I've sent a text… but ignored the one from Rugby… It's come from the GP they know… I'd be more tempted to do what they advise." (P011, Administrative Role)*

Trust in the clinician was seen as a critical factor in patient decision-making, particularly in communities where relationships with healthcare providers are longstanding and valued:

> *"It's having that trust with that clinician… they're advising you on a good thing." (P05, Administrative Role)*

In addition to trusted sources, the mode of communication also influenced effectiveness. Face-to-face or phone conversations were consistently viewed as more impactful than generic messages, particularly for patients with questions, concerns or hesitancy:

> *"Some do, some don't… but I think the more it was encouraged, the more it works." (P03, Practice Manager)*
>
> *"Phone calls are more effective… 1-to-1, deliberate ones, yes." (P04, Practice Manager)*
>
> *"By far the highest uptake was as a result of when the GP had the conversation face to face." (P10, Implementer).*

However, implementers acknowledged that this approach was not scalable for all patients and required time and continuity.

Barriers to Effectiveness. Despite overall support, staff identified several barriers that could limit the intervention's impact. These included:

- **Text message fatigue**: Overuse of messaging for various purposes may lead patients to ignore important reminders.

> *"People just say 'it's just them again' and delete them." (P05, Administrative Role)*

- **Digital exclusion**: Older or vulnerable patients may lack the skills or access needed to engage with digital communications.

> *"A lot of our patients aren't very mobile friendly." (P07, HCA)*

- **Cultural and literacy challenges**: Some patients may struggle with the nature of the test or understanding instructions, particularly in communities with language barriers or cultural sensitivities.

> *"It goes against the grain… it doesn't go with them." (P04, Practice Manager)*
>
> *"we've got quite a few patients that English isn't their first language. I've got even got a couple of patients in the sort of more affluent sort of half of the practice who actually can't read and write." (P01, GP)*

Need for Follow-Up and Data. Several participants highlighted the lack of follow-up mechanisms to confirm whether patients who received messages actually completed the screening. This gap made it difficult to assess true effectiveness:

> *"I don't know whether they've actually done the screening… it would be good to know." (P07, HCA)*
>
> *"I would love to [check the results] because that would give you the evidence… have the people been more likely because they've spoken to one of my HCA's and have a better understanding? Or have they just said yes, but they've still not done it?" (P05, Administrative Role).*

Some practices planned or had begun auditing their data to evaluate outcomes more rigorously:

> *"My next step is to reaudit and see if it's made any difference." (P01, GP)*
>
> *"I want to see if our percentage has gone up… that would be the evidence." (P05, Administrative Role)*

Summary. Participants generally viewed the intervention as a valuable and potentially effective approach to increasing screening uptake, particularly when communication was personalised and delivered by trusted sources. However, barriers such as digital exclusion, message fatigue, and cultural or literacy challenges limited its reach. The absence of follow-up mechanisms also made it difficult to assess actual impact. These findings highlight the importance of culturally sensitive, relationship-based communication and robust data systems to support the perceived and actual effectiveness of screening interventions.

Theme 6: Recommendations for Future Initiatives and Implementation

Participants offered a wide range of practical suggestions to enhance bowel cancer screening uptake, drawing on both frontline experience and strategic insight. These ideas spanned communication, education, system design, and cultural sensitivity, and reflect a strong desire to improve both the reach and effectiveness of the intervention.

Enhanced Communication and Messaging. Many participants emphasised the need for clearer, more engaging messaging, particularly for patients who may not respond to standard text messages. Suggestions included using bold, personalised language, incorporating urgency, and leveraging emotional narratives to prompt action:

> *"Sometimes scare stories and scare tactics are what patients need… Jade Goody's case massively improved uptake." (P03, Practice Manager)*
>
> *"If you've got in bold and it's underlined and it says, 'please do not ignore this', it runs to your attention." (P03, Practice Manager)*
>
> *"Text message overload now… people just delete them." (P05, Administrative Role).*

Visual and Practical Demonstrations. Several staff highlighted the value of showing patients how to complete the test, especially for those with low health literacy or cultural reservations. Visual aids, role-play, and physical demonstrations were seen as effective tools to demystify the process:

"I handed out gloves to support that... they're not given anything to support them." (P04, Practice Manager)

"If we had a kit with us and a little bit of training, we could explain exactly what it looks like...It's that visual feeling, that presence, that touch. And I think that's important." (P07, HCA)

Community and Cultural Engagement. Participants stressed the importance of culturally tailored interventions, including language support and trusted messengers. There was strong support for involving community organisations and using culturally competent staff to build trust and understanding:

"The local community hub came out and spoke to patients in their own language... face-to-face is much better for that culture... someone of the same language." (P04, Practice Manager)

System and Workflow Improvements. Operational suggestions focused on streamlining processes and reducing administrative burden. Participants proposed integrating screening prompts into existing appointments (e.g. flu clinics, chronic disease reviews) and using opportunistic moments to engage patients:

"We need templates for the texts. If I have to free text every time, it's a deterrent." (P06, GP)

"If we had a load of kits we could just hand out... that would save time." (P01, GP)

"We could have a separate clinic just to manage these numbers." (P07, HCA)

Group Education and Peer Influence. Some practices had experimented with group sessions and suggested expanding them. These were seen as a way to normalise screening and reduce stigma through shared experience and peer encouragement:

> *"We did a smaller one and did the acting… it was fun and laughter at the time." (P04, Practice Manager)*
>
> *"Group consultations might be the way forward… have a mix of people who've done the screening and those who haven't." (P05, Administrative Role)*

Summary. Participants shared a range of practical and creative suggestions to improve future bowel cancer screening initiatives. These recommendations focused on enhancing communication strategies, improving patient understanding, and tailoring delivery to diverse communities. Suggestions included using more engaging and emotionally resonant messaging, incorporating visual aids and demonstrations to support patients with low health literacy, and involving trusted community figures to improve cultural relevance and trust. Operational improvements, such as pre-written templates, opportunistic screening during routine appointments, and dedicated clinics, were also proposed to reduce administrative burden and improve workflow efficiency. Group education sessions were seen as a promising way to normalise screening and encourage peer support. Collectively, these ideas reflect a strong appetite for more personalised, accessible, and culturally sensitive approaches to screening delivery.

Discussion

We have carried out a mixed methods evaluation of the BwD Borough Council and the Lancashire and South Cumbria Cancer Alliance pilot system-level intervention across 22 GP practices in BwD in July 2024-March 2025. The quantitative results demonstrated that 4995 text-messages sent to screening non-responders which yielded <1% (n=33) of the test kits returned at the end of the intervention period irrespective of the current uptake at the GP practice, the number of text messages sent and the concurrent delivery of CFAK during the implementation period. Low test kit return rate (n=645) could be explained by the characteristics of the people who have requested a test kit and underlying barriers to

screening, as well as whether or not those individuals would be receiving a test kit from the Bowel Cancer Screening Programme soon after as part of their next screening invitation. Future projects should consider repeat screening invitations as well as respondents characteristics to ensure resources are used effectively.

Further qualitative evaluation looking at the implementation barriers and facilitators using TFA identified six key themes that reflect primary care staff's experiences with implementing a bowel cancer screening intervention aiming to improve participation among screening non-participants. Intervention coherence and staff capability were shaped by clarity of communication, system support, and team dynamics, with confidence varying across roles and practices. Emotional and ethical engagement was strong, with participants expressing professional commitment to improving screening uptake, though this was tempered by structural constraints and ethical concerns around communication. Practical and resource constraints, particularly time pressures, administrative burden, and competing priorities, affected the feasibility and sustainability of the intervention. While the initiative was generally perceived as effective, especially when communication was personalised and clinician-led, barriers such as digital exclusion and lack of follow-up limited its reach. Finally, participants offered a range of practical recommendations to improve future initiatives, including clearer messaging, visual demonstrations, culturally tailored approaches, and streamlined workflows. Together, these findings highlight the importance of embedding interventions into routine practice, supporting staff capability, and tailoring delivery to local contexts and patient needs.

Interpretation of Findings

The TFA provided a useful lens to identify which factors most influenced staff acceptability of the intervention, highlighting the importance of *intervention coherence*, *self-efficacy*, *affective attitude*, *ethicality*, *opportunity cost, burden*, and *perceived effectiveness*. Staff understanding of the intervention varied, often shaped by the clarity of communication and the extent to which the intervention was embedded into existing

workflows. This reflects the importance of *intervention coherence* in ensuring staff can meaningfully engage with new initiatives. *Self-efficacy* was influenced by role-specific confidence, digital literacy, and access to supportive systems. Practices that delegated tasks appropriately and fostered peer support reported smoother implementation, echoing previous research on the value of team-based approaches in primary care settings. The strong emotional and ethical alignment with the intervention's goals reflects a high level of *affective attitude* and *ethicality*. However, this was undermined by structural constraints, including time pressures and lack of financial incentives—factors that contributed to emotional fatigue and reduced sustainability. These findings are consistent with broader literature on the challenges of implementing preventive interventions in resource-constrained primary care environments (Rubio-Valera et al., 2014) Participants' perceptions of *effectiveness* were shaped by both the mode and source of communication. Messages from trusted clinicians were seen as more impactful than generic or externally branded messages, particularly when delivered face-to-face. However, barriers such as digital exclusion, message fatigue, and cultural or literacy challenges limited reach—highlighting the need for more personalised and inclusive approaches.

Strengths and Limitations

A key strength of this evaluation is the diversity of perspectives captured across clinical and non-clinical roles, offering a comprehensive view of implementation experiences. The inclusion of general practitioners, practice managers, administrative staff, and implementation leads enabled a nuanced understanding of how the intervention was received and operationalised across different settings. The use of the TFA provided a robust analytical framework to explore both individual and contextual factors influencing acceptability.

However, there are limitations. The findings are based on a specific regional context, Blackburn with Darwen, and may not be generalisable to all primary care settings, particularly those with different demographic profiles or system infrastructures.

Additionally, while qualitative data provided rich insights into staff experiences, the quantitative component was limited by timing constraints. Specifically, patients who requested kits close to the start of their next screening cycle may not have received them, potentially underestimating the intervention's impact on kit return rates. This limitation should be considered when interpreting the effectiveness data and planning future evaluations.

Recommendations for Practice and Future Research

The findings suggest several actionable strategies to improve the design, delivery and sustainability of bowel cancer screening interventions in primary care. These strategies reflect both operational learning and broader considerations around equity, engagement, and system integration.

Strengthening onboarding and communication to improve intervention coherence

Clear, consistent messaging at the point of launch is essential to ensure staff understand the aims, processes, and expectations of the intervention. Structured onboarding, visual aids, and timely updates can support coherence and reduce confusion.

Supporting staff confidence through training, templates, and system integration

Role-specific training and practical resources, such as EMIS templates, search tools and knowledge on bowel screening programme, can enhance digital literacy and procedural clarity. Delegating tasks to administrative and nursing staff can reduce reliance on GPs and improve feasibility.

Embedding screening prompts into routine workflows and opportunistic consultations

Integrating screening reminders into existing appointments (e.g. flu clinics, chronic disease reviews) can normalise the intervention and reduce disruption. Opportunistic engagement during patient contact remains a valuable strategy.

Using culturally tailored, relationship-based communication to engage underserved populations

Personalised messaging from trusted sources (e.g. GP practices) is perceived to be more effective than generic outreach. Involving community organisations and culturally competent staff can improve engagement among patients with low literacy, digital exclusion, or cultural sensitivities.

Providing timely feedback and outcome data to sustain motivation and guide improvement

Sharing practice-level data on kit requests and completions can help teams monitor progress, identify gaps, and maintain momentum. Local auditing and feedback loops are critical to understanding impact and informing future delivery.

Future research should explore the scalability of personalised approaches, the role of community partnerships in enhancing cultural competence, and the long-term sustainability of interventions in the absence of financial incentives. Further investigation into the effectiveness of visual education tools, group consultations, and hybrid communication models may also support more inclusive and impactful screening strategies. Investigating individual-level data is also required for targeted delivery of interventions and improving the efficacy and cost-effectiveness of using system tools in primary care for promoting cancer screening participation.

Conclusion

Overall, the Blackburn with Darwen Bowel Cancer Screening intervention had a small but positive impact on screening participation among previous screening non-responders. However, the intervention was found to be acceptable to primary care staff, as evidenced by strong alignment with the Theoretical Framework of Acceptability (TFA) domains. Staff demonstrated a clear understanding of the intervention's aims (intervention coherence) and, where supported by training and clear delegation, felt confident in their ability to deliver it (self-efficacy). The intervention was viewed as ethically sound and consistent with professional values (ethicality), and staff expressed positive attitudes towards its potential to improve patient outcomes (affective attitude).

However, acceptability was moderated by practical constraints, including time pressures, administrative burden, and digital literacy challenges (burden, opportunity cost). The perceived effectiveness of the intervention was highest when communication was personalised and delivered by trusted clinicians, but barriers such as digital exclusion and lack of follow-up data limited its reach (perceived effectiveness).

In summary, while the intervention was broadly acceptable and valued by staff, its sustainability and impact depend on addressing resource constraints, enhancing training and communication, and ensuring culturally sensitive, relationship-based approaches. Embedding these elements into routine practice will be critical for maximising both acceptability and effectiveness in future initiatives.

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Appendices

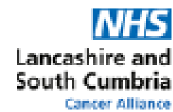
Appendix 1 – Letter to inviting practices to the project

Appendix 2 - Practice Guide

Appendix 3 - PLT engagement poster

Appendix 4- PLT data table

Appendix 1 - Letter to inviting practices to the project



Please contact: Angela Dunne

angela.dunne2@nhs.net

Lancashire & South Cumbria Cancer Alliance
County Hall
Preston
PR1 8RL

25th June 2024

FAO: Practice Managers
Blackburn with Darwen practices

Dear Practice Manager

Re: Lancashire & South Cumbria Cancer Alliance Early Diagnosis Bowel Cancer Screening

Lancs & South Cumbria Cancer Alliance has agreed to fund a project across the Blackburn with Darwen practices supporting them to increase the uptake of bowel cancer screening. There are slight variations in the project dependent on the current level of bowel screening uptake with practices currently below 60% achievement receiving additional funding to undertake more intensive interventions.

The funding is to deliver the following:

- **Below 60%** practices identifying people who have not undertaken their bowel cancer screening
- Send accurex message with information, links, encouragement to participate
- Offer to order a kit on the patient's behalf and action if requested to do so
- **All practices** – re-establish the single kit request process in EMIS
- Undertake opportunistic interventions during patient contact encouraging them to be screened
- Recording the intervention and requesting a kit if the patient indicates they do not have their original kit and would like one ordering on their behalf
- Submission of all kit requests to the Bowel Screening hub in Rugby
- Supporting the use of EMIS to record all activity

KPIs – to be reported quarterly (CSU will extract from EMIS systems)

- **Below 60%** - number of people contact via accurex
- Number of kits subsequently requested
- **All practices** – number of opportunistic conversations held
- Outcomes of the conversations
- Number of kits requested following the conversations
- Outcomes of any kits requested – completed, not completed etc
- Results of any kits completed

The practice will be expected to

- Provide quarterly feedback on progress in terms of engagement, initiatives that had an impact and any promotion undertaken (template will be provided).

Payment
The CSU Data Quality team will remotely access and extract data from practice systems and this will be used to determine the quarterly payment to practices. Payment will be made via the ICB Enhanced Service payment process.

The funding will be non-recurrent throughout this year 2024/25 and will end on the 31st March 2025.

Lancashire and South Cumbria Cancer Alliance

The amount of funding received by each practice is dependent on:

Under 60% currently

- The number of messages sent to non participating patients
- The number of kits requested for patients following the contact

Over 60% currently

- The number of kits requested following opportunistic interventions, with an aim of 4 kits requested per 1,000 registered population.

Funding
£3 per accurex sent
£5 per test kit requested following an accurex message

£20 per test kit ordered following opportunistic intervention

Evaluation
Information requested from practices will ask them to consider the impact of the project and any resultant learning.

Please note that if the above criteria are not met funding could be withheld. Project monies will be paid quarterly arrears based on actual activity delivered per quarter.

If you are happy to participate in the project, please could you sign and return this document to angela.dunne2@nhs.net adding the information requested below.

Practice Name	
Practice Code	
Practice manager	
Practice Manager e-mail	
Lead staff member for the project	
Lead staff e-mail	

If you have any questions, please don't hesitate to contact Angela.dunne2@nhs.net

Yours sincerely

Fleur Carney
L&SC ICB Cancer Alliance
Programme Director

Appendix 2 - Practice Guide

Blackburn with Darwen Bowel Screening Early Diagnosis project 2024-25
Practice Guide

This project aims to improve patient engagement in the national bowel screening programme. Practices will be supported to identify patients who did not engage with their last bowel screening Faecal Immunochemical Test (FIT) kit.

All practices will be able to udertake opportunistic interventions, whilst those with screening uptake currently below 60% will provide targeted support to their non participating patients. The split of practices is indicated in Appendix A below.

This project is supported by the Lancs & S Cumbria Cancer Alliance and the LMCSU. It is designed to run until 31 March 2025.

All practices can engage in opportunistic interventions advocating bowel screening with patients who are identified by the bowel screening pop up. The CSU DQ team has ensured all practices have access to the pop up protocol.

Practices should

- Ensure the pop up protocol is activated, that practice staff are aware of this and have the information they need to have an informed discussion with the patient
- Advise patients identified by the pop up that screening for bowel cancer is the best method of detecting any changes or higher risk indicators, allowing for further investigations and treatment if required.
- If a patient agrees to undertake a FIT test they should be asked to use any kit they have at home, request a replacement on **0800 707 6060** or the practice can request a replacement kit on their behalf.
- Double clicking on the pop up will guide the clinician through the kit request process, recording if the patient wants a kit ordering.
- Selecting 'yes' on the pop up will bring up a patient consent form. Closing this will record the kit request in the patients records using snomed code 121875000000105 (*NHS Bowel Cancer Screening replacement faecal immuochemical test kit requested*).
- On a regular basis (weekly) the EMIS search (*Replacement kits*) can be used to identify patients who want replacement kits.
- The outcome from this search should be submitted, as an excel spreadsheet, to the bowel screening hub on **bowelscreening@nhs.net**

The aim is for an additional 3 kits per 1,000 registered population to be requested but the funding allows for the time taken when patients decline to participate.

Practices below 60% current uptake The national bowel screening programe has a minimum standard of 60% acehivement and currently around 10 practices in Blackburn with Darwen are not achieving this standard. This project aims to support these practices to enagage with their non participating patients offering to request a FIT kit from the screening hub on their behalf. Practices should:

- Make an offer of support, in the form of an accurex/SMS text message, including a link that patients can use to respond back to the practice that they would like a FIT kit ordering. A suggested text is included in Appendix B, but practices can create their own message, tailoring it to patients needs as appropriate.
- The positive response back to the practice should be coded using snomed code 1218750000000105 (*NHS Bowel Cancer Screening replacement faecal immuochemical test kit requested*)
- Using this code will ensure the request is included in the (*Replacement kits*) search for submission to the bowel screening hub
- As above – on a regular basis (weekly) run the EMIS (*Replacement kits*) search and extract the information for submission in excel format to the bowel screening hub in Rugby on **bowelscreening@nhs.net**

This process will allow practices to follow up with those patients if they feel this would be of benefit.

EMIS - location of searches is indicating in the screenshot below

Search – Practices below 60% - bowel screening uptake currently (*MLCSU DQ Bowel screening BWD_project24_25*)

Patients identified by this search should be contacted via accurex and supported to complete their kit or have a replacement ordered

Search – All practices - Weekly search (*Replacement Kits*) for patients who agree to a kit being ordered on their behalf. The date parameters can be altered on this search to reflect the time period covered.

The search identifies patients who have indicated, either following practice contact or opportunistic intervention, that they want a kit to be ordered on their behalf. The

outut from the search should be submitted in excel format to the bowel screening hub in Rugby on a weekly basis. This should be sent to **bowelscreening@nhs.net**

Protocol - All practices - Non participation pop up

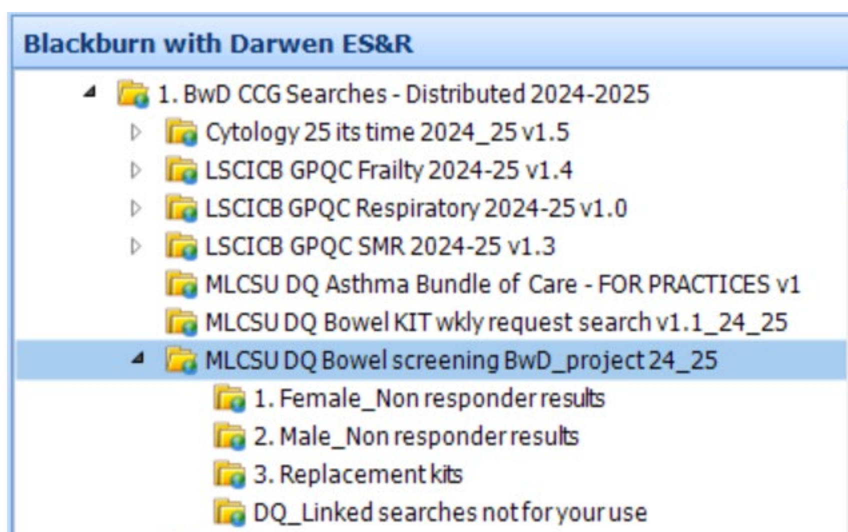
All practices should check that the protocol is activated, that practice staff are aware of it and have the information they need to have an informed discussion with the non participating patients identified.

EMIS codes

The key code for identifying the request for a replacement kit is 121876100000105 (*NHS Bowel Cancer Screening replacement faecal immuochemical test kit requested*)

This should be assigned to positive responses to accurex messages. It is already embedded in the patient consent form generated by the pop up process.

Location of EMIS searches



In addition we will request a brief amount of feedback from practices about their experience of this project, a template will be provided for this.

Appendix A Practice split (Data taken from OHID's Fingertips tool Q4 2022/23)

Practices below 60% current participation	Practices above 60% current participation
P81683	P81214

P81694	P81058
P81724	P81125
P81707	P81061
P81622	P81005
P81167	P81022
P81734	P81633
P81704	P81140
P81771	P81155
P81709	P81721
	P81051
	Y02657

Appendix B

Suggested text message for contact with non responders

Dear Mr/Mrs/Miss xxxx We have noticed that you have not completed your latest bowel screening test (FIT kit). If you no longer have the kit we can request one for you. Please use this link to let us know you would like a replacement kit (*insert link here).*
If you still have a test kit please complete and post it.
The bowel screening test is the best way to detect early signs of bowel cancer when treatment options and outcomes are better. Please see us if you have symptoms you are worried about – tummy pain, bleeding from your bottom diarrhoea, weight loss.

Thank you *GP name, surgery*

Appendix 3 - PLT engagement poster

Acceptability of improving Bowel Screening uptake using text-messages and EMIS pop up

What you think is your responsibility to improve uptake?	Who would be the most suitable person to deliver the interventions?
How has this project impacted your practice? (e.g. time, patient experience, financially, opportunity costs)	
What would make you adopt text-messages/EMIS into your usual care for improving bowel screening?	Your contact details if you would like to have an interview (name, email)

University of Central Lancashire
UCLan

Appendix 4 - PLT data table

PLT Table number	What you think is your responsibility to improve uptake?	Who would be the most suitable person to deliver the interventions	How has this project impacted your practice?	What would make you adopt text-messages/EMIS into your usual care for improving bowel screening?	Other comments
Table 1	Duty of care Make patient aware of programme and provide information	An identified member - would need allocated time/funding to support	Time Lack of patient participation	Funding Allocated time Support from bowel screening team Keep screening kit in house to hand out to patients = easier access for patients	No response
Table 2	Holistic care Encourage patient	Someone trained to do it Text - admin - assistant for requesting kits (need training?)	[from a] running a practice point of view - no infrastructure & not a priority	Promote opportunity widely Infrastructure Improve awareness Complement intervention	No response

Table 3	Earlier detection & better patient outcomes	Administrative Does not need to be done individual practice basis - can this not be done centrally for all practices?	Time taken Costs of text messages	A budget/funding for the cost of the texts & the time taken to carry out the texting and ordering N/a	No response
Table 4	If we see prompts regarding bowel cancer screening then we encourage, but respect patient's decisions	A combination of practicing healthcare professionals and the admin staff as the screening programme coordinators	Time takes to encourage both appointments and admin time. It diverts time from higher priority tasks	Financial incentive ?Youtube? Tv advert Best use of funding Mrt to do a tv advert	No response
Table 5	Every clinician has an ethical obligation to encourage health screening/participation in health checks however uno response reasonable expectations to address this during consultations	Quality control/admin to send out texts etc.	Possible increase of uptake Reassurance from clinical but also reminder & opportunity for all questions to be asked	Make part of quality contract or incentivise this	No response

Table 6	Explain importance of cancer screening to non-responders Barriers to screening Text - more personalised and need funding	Everybody Coordinator	Independent agency Invited non responders to text Finances	Pharmacy investment	No response
Table 7	EMIS searches, texts, opportunistic engagement	Searched/texts - admin - GP name on text Opportunistic - all staff	Unfortunately, we didn't do this project Yes, some time but worthwhile	See what the message was from the practices with the highest uptake and incorporate that across the board Funding	No response
Table 8	No response	No response	No response	No response	A celebrity e.g. Jade goody + cervical screening - BBC, this morning, hello magazine
Table 9	Screening should be opportunistic so everyone should be involved especially in the event of competing interests	No response	No response	No response	No response

Table 10	Practice and patient responsibility National programme awareness Patient education	No response	No response	No response	Add to a template. Different form of delivery - text followed by letter explaining to expect a kit through post. Video link with text
Table 11	Patient education and awareness Reassure Posters in waiting room Computer system alerts	Clinician - opportunistic Admin - AccuRX Reception - when booking appointments	Positive: cost/time effective - AccuRX Dependent on accurate phone data Negative: computer crash Kits should be ordered by patient No financial incentive Clinical time to discuss with patient who may have already refused/declined	No response	Text from named GP (clinical impact)