



Lancashire and South Cumbria  
**Call for a KIT**  
NHS Bowel Cancer Screening

# Implementation Manual

Supporting equitable participation  
in bowel cancer screening



Version 1.1 | Oct 2026

## Version Control

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If you wish to provide feedback on the manual, please send this to the research team.

**AI Transparency Statement:** Microsoft Copilot was used to support the redrafting of some sections of this manual to improve accessibility, readability, and the use of plain English. All AI-assisted content has been reviewed, edited, and approved by the lead authors RJ and YH. The remaining authors have also reviewed the content to verify its accuracy.



# Acknowledgements

We would like to dedicate this implementation manual to bowel cancer patients, underserved and less acknowledged communities in Lancashire and South Cumbria, our research participants and those who supported the development of Call for a Kit (CFAK) since its inception.

**Sadiq Patel**, one of the key leaders and early adopters of the Lancashire BCSP CFAK, who sadly passed away in October 2024. Sadiq Patel led the implementation of the CFAK clinics in Lancashire which made significant contributions to addressing bowel cancer inequalities in this region.

**Carol Ratcliffe**, who was a bowel cancer survivor and a patient representative for our project. She helped us shape our research to better understand patient experience of CFAK and sadly passed away November 2025.

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## How we co-developed this implementation manual

This manual provides a practical framework for organisations and staff to implement, deliver, monitor and continuously improve Call for a Kit (CFAK) in a way that remains faithful to its core principles of patient navigation, relationship-based support, informed choice and reducing inequalities in bowel cancer screening.

The CFAK implementation manual was developed through an iterative process involving service staff, managers, commissioners, researchers, and other stakeholders involved in the design and delivery of the programme. The manual was initially developed to capture existing knowledge, procedures, and good practice accumulated throughout the implementation and evolution of the CFAK service.

Throughout its development, regular meetings and discussions were held with members of the CFAK team to review content, identify areas requiring clarification, and ensure that the guidance reflected the realities of day-to-day service delivery. These discussions drew on the practical expertise and experience of those involved in delivering and supporting CFAK across a range of settings.

Following completion of the implementation evaluation, findings from qualitative interviews with CFAK staff and stakeholders were used to review and strengthen the manual. The evaluation identified a number of factors that influence successful implementation, including the importance of relationship-based delivery, workforce support and training, partnership working with GP practices, digital systems and data collection processes, and approaches to reducing inequalities and meeting the needs of diverse communities. These findings informed revisions and additions to the manual and helped ensure that the guidance was grounded in implementation experience.

The manual also incorporates learning from quantitative evaluations of CFAK. In particular, regional needs assessment, evidence regarding consultation delivery models, implementation processes, and service outcomes was used alongside qualitative findings and team expertise to inform recommendations throughout the guidance.

As a result, this manual represents a synthesis of:

- Existing CFAK operational knowledge and practice.
- Experience and expertise from members of the CFAK team.
- Ongoing discussions and feedback from stakeholders involved in delivery.
- Qualitative implementation research.
- Quantitative evaluation findings.
- Evidence-informed implementation principles.

The guidance presented should therefore be viewed as a living resource that combines research evidence with the practical realities of implementing and sustaining CFAK in routine practice.

## How you can use this manual

This manual has been designed as a practical guide to support the consistent and effective implementation of the Call for a Kit (CFAK) intervention. It brings together evidence from service evaluation, staff interviews, quantitative findings, and ongoing collaboration with members of the CFAK team to provide practical guidance for delivery.

The manual is intended to be used by Health Promotion Officers (HPOs), Team Leads, managers, commissioners, and organisations seeking to implement or sustain the CFAK model. Different sections may be relevant to different audiences depending on their role and responsibilities.

### For Health Promotion Officers

Health Promotion Officers can use this manual as a practical guide to delivering CFAK consultations and engaging non-responders. The chapters provide guidance on:

- Building trust and rapport with patients.
- Conducting face-to-face and telephone consultations.
- Addressing common barriers to bowel screening.
- Supporting informed decision-making.
- Working with diverse communities and reducing inequalities.
- Recording data and using digital systems effectively.

Staff may find it useful to refer to relevant chapters before starting delivery in a new practice or when encountering challenges in patient engagement.

### For Team Leads and Managers

Team Leads and managers can use the manual to support:

- Induction and training of new staff.
- Supervision and workforce development.
- Implementation planning.
- Quality assurance and fidelity monitoring.
- Service improvement activities.
- Consistent delivery across teams and locations.

The manual can also be used as a reference document when reviewing local delivery models or introducing new processes.

### For Commissioners and Service Partners

Commissioners, GP practices, and partner organisations can use the manual to better understand:

- The aims and principles of CFAK.
- Infrastructure requirements for implementation.
- The evidence underpinning the intervention.
- Roles and responsibilities within delivery.
- Factors that support successful implementation and sustainability.

## Using the Manual in Practice

The manual is not intended to be read once and then set aside. Instead, it should be used as a practical implementation resource throughout the lifecycle of service delivery.

Teams are encouraged to:

- Use the implementation checklists when establishing delivery in new practices.
- Refer to the guidance when training new staff
- Use reflective questions and case examples during team meetings and supervision.
- Review recommendations when adapting or developing the service.
- Use the implementation principles to maintain fidelity to the CFAK model while responding to local needs.

## A Note on Professional Judgement

The guidance contained within this manual should not replace professional judgement.

Every patient, community, and practice setting is different. Staff should use the principles and recommendations outlined in this manual alongside their professional skills, local knowledge, and organisational policies to determine the most appropriate approach in each situation.

## Key Message

This manual should be viewed as a practical guide to implementing CFAK effectively, consistently, and equitably. It is intended to support the delivery of high-quality, relationship-based consultations that maximise opportunities for informed choice, improve engagement with bowel screening, and reduce inequalities in participation.

## We want to implement Call for a KIT in our region, what should we do?

If you are interested in adopting the programme, please contact us at [bfwh.lancscfak@nhs.net](mailto:bfwh.lancscfak@nhs.net).

## Can we collaborate?

We welcome collaboration opportunities to help raise awareness of the Bowel Cancer Screening Programme. We offer training and work closely with researchers at the University of Lancashire and University College London to ensure our processes are evaluated and that health inequalities are not exacerbated. Collaboration requests will be considered on a case-by-case basis, depending on alignment with the screening programme's priorities.



This picture shows the CFAK Team members from Community CVS; Left to right: Andrea Pugh, Shakil Salam, Yasmin Patel, Saima Zeb, Syka Quraishi, Lorraine Morris, Rubina Anwar.

# The Implementation Manual Launch Event

The official launch of this implementation manual took place on Wednesday 21 October 2026 at the Gujarat Hindu Centre, Preston. The event brought together approximately 60 delegates representing NHS organisations, screening services, community partners, researchers, and public contributors from across Lancashire and South Cumbria, Liverpool and Merseyside, Sheffield, and the Midlands.

The programme showcased the journey of Call for a Kit (CFAK) from an innovative local initiative to an evidence-based intervention with the potential to support equitable participation in bowel cancer screening. Throughout the day, speakers highlighted not only the importance of increasing bowel cancer screening uptake but also the need to ensure that support is person-centred, culturally responsive, and accessible to those who face the greatest barriers to participation.

Taras Daneliuk provided a powerful reminder of the life-saving potential of bowel cancer screening through sharing his personal experience, while Kathryn Jones (NHS England) outlined the opportunities and challenges presented by the national age extension programme. As screening expands to people aged 50-54 years, there remains a clear need to engage groups with lower participation rates and respond to growing concerns regarding increasing bowel cancer incidence among younger adults.

Presentations from Sarah Orcherton and Dr Kam Chatha (NHS Bowel Cancer Screening Programme Rugby Hub) demonstrated changing patterns of participation across the screening pathway and reinforced the importance of innovative approaches that support individuals not only to return a FIT kit, but also to engage with subsequent diagnostic investigations where required.

Research presented by Dr Rebecca Jefferson, Dr Sandro Stoffel, and Shahida Hanif highlighted that the value of CFAK extends beyond reminder calls. Findings from the programme consistently demonstrate that personalised conversations, reassurance, trust, opportunities to ask questions, and culturally appropriate support help people navigate barriers to screening and make informed decisions about participation.

Sessions led by the Call for a Kit team illustrated the importance of working within communities rather than simply delivering services to them. Examples included flexible appointment options, video consultations, partnerships with community organisations, and work within prison settings. Collectively, these experiences demonstrated that successful implementation relies on trusted relationships, local partnerships, and adapting delivery models to meet community needs.

The afternoon session led by Dr Alison Doherty, Meghann Ewing, Deborah Taylor, and public advisors from Pathways Associates provided an important focus on the experiences of people with learning disabilities. Their work emphasised the value of accessible information, tailored support, meaningful engagement with carers, and meeting people where they are to make screening more equitable and inclusive.

The event concluded with a panel discussion featuring Alastair Richards, Dr Naheed, Deborah Taylor, Andrea Pugh, Dr Kam Chatha, and Shahida Hanif. Discussions highlighted that inequalities can occur at every stage of the screening pathway, not only in FIT kit return but also in attendance for diagnostic colonoscopy following an abnormal result. Panellists also reflected on the challenge of reaching those who remain underserved despite current invitation approaches, highlighting the need for continued innovation and research to understand how CFAK can become even more accessible to individuals who do not initially engage with screening services. A key message emerging from the panel was that the principles underpinning CFAK, including personalised support, community partnership, co-design, and informed choice, have relevance across the entire pathway and can help ensure that people receive the support they need from invitation through to diagnosis and beyond.

The launch event reinforced the central message of this manual: successful implementation depends on understanding local communities, building trusted relationships, and placing people's experiences at the heart of service delivery.



## Executive Summary

This manual presents the Call For a Kit (CFAK) programme, a patient navigation intervention designed to increase participation in the NHS Bowel Cancer Screening Programme among people who have not responded to a previous screening invitation and provides practical guidance for organisations wishing to implement, adapt, or sustain it in their own populations.

**The problem.** Despite improved participation following the introduction of the faecal immunochemical test (FIT), substantial inequalities persist in bowel cancer screening. Uptake is consistently lower among people living in deprived areas, some ethnic minority communities, people with disabilities, people with severe mental illness, and those with lower health literacy. Bowel cancer outcomes in Lancashire and South Cumbria remain poorer than the national average.

**The intervention.** Established as a pilot in 2015 and now an established service, CFAK is delivered by trained Health Promotion Officers who act as link workers. They identify non-responders through GP practices, offer personalised consultations (face-to-face, telephone, or video), address practical, emotional, informational, cultural, and system-level barriers, and facilitate access to replacement FIT kits alongside community engagement and awareness raising activities.

**Evidence of impact.** The programme is supported by a substantial evidence base including a regional needs assessment, quantitative and qualitative evaluation, patient experience research, economic evaluation, and ongoing service learning. Findings demonstrate that CFAK successfully engages non-responders, generates additional FIT kit returns, and is particularly effective at reaching groups with historically low screening participation, including some ethnic minority communities and people with disabilities or long-term conditions.

**Six key lessons.** Successful implementation depends on: (1) relationship-based delivery built on trust and personalised support; (2) offering face-to-face consultations where possible, given their higher FIT completion rates, while recognising that meaningful support can also be delivered effectively through telephone and video consultations according to patient needs and preferences; (3) strong GP practice partnerships for identifying and recruiting patients; (4) tailoring approaches to individual needs and circumstances; (5) investing in workforce training, supervision, and reflective practice; and (6) digital systems that support rather than hinder patient-facing work.

**Recommendation.** Organisations seeking to reduce inequalities in bowel cancer screening should consider adopting the CFAK framework, adapting delivery to local circumstances while maintaining its core principles: patient navigation, relationship-based support, informed choice, and inequality reduction.

# Foreword

## Call For A Kit: Reducing Health Inequalities

*I was diagnosed with Stage 3C bowel cancer just one month before my invitation to start bowel cancer screening. It was hard and has had a lasting impact on me and my family. In 2018 my brother was also diagnosed with bowel cancer. It was late stage and he died 6 months later. I know why early detection is important.*

*Finding cancer early gives people the best possible chance of survival. When cancer is detected at an early stage, treatment is often more effective, most people return to a normal life. In addition, valuable time and resources can be saved across the NHS and wider society.*

*The National Bowel Cancer Screening Programme demonstrates the power of early detection. Each year, it identifies more than 5,000 cancers, most of them before symptoms have become apparent.*

*Yet the full potential of screening has not been realised. The programme is offered free of charge to everyone aged 50 to 74, and the national ambition is achieve 80% uptake. Currently in some parts of England, around three in four residents complete the test every two years; elsewhere, fewer than half do so, and in some communities participation falls to only one in three.*

*Closing this gap would benefit us all. Greater participation could prevent*

*deaths, relieve pressure on health services, reduce costs and, above all, spare individuals and families avoidable suffering.*

*Low participation is not simply a matter of individual choice; it is a serious health inequality. Uptake is lowest in deprived communities, where people are 25% less likely to survive bowel cancer. The injustice is compounded by the fact that some of these communities also face a greater risk of developing the disease.*

*There is no single explanation for non-participation. A disability may make the kit difficult to use; cultural concerns may stand in the way; practical circumstances may make the process feel unmanageable; or the information provided may not be fully understood or recognised as personally relevant.*

## Call For A Kit

*It is against this background that Call For A Kit (CFAK) has been developed: a practical method designed to reduce inequalities in bowel cancer screening and increase participation across communities.*

*Its strength lies in its simplicity. Call For A Kit can operate through existing NHS and public health structures, whether in a single locality or across an entire region. Its purpose is clear: to help more people take part in screening and to narrow the inequalities that shape who benefits from early detection: who dies and who gets the chance to live.*

*It's approach recognises that people living in the same community may face very different obstacles. Rather than treating non-participation as a uniform problem, it provides a framework centred on the individual and on the particular reasons that person has not taken part.*

*Call For A Kit was first piloted in 2015 and has since been monitored and measured to ensure that experience informs improvement. This continuing attention to collecting the evidence has helped refine both the service and the outcomes it seeks to achieve.*

## **About This Manual**

*This implementation manual brings together the process and tools needed by health promotion officers, team leaders, managers, commissioners and service partners. It is intended to help users establish the service in their own areas and improve the early detection of bowel cancer.*

*The guidance is practical and comprehensive. It takes the one through each stage, from setting up the service, defining responsibilities and training staff, to conducting individual consultations, engaging different communities, monitoring data and evaluating results.*

*The manual and its supplement also provide materials ready for use, including checklists, flowcharts, data-collection sheets, consultation scripts and resources for social media campaigns.*

*At its heart, this manual is an invitation to act. Saving more lives does not depend on inventing a new drug or surgical technique. It begins with removing a barrier, opening a conversation and making it easier for one more person to complete a screening test. I hope this manual gives you the confidence and practical support to do exactly that.*



## **Stephen Rowley**

Patient Advocate

Bowel Matters – Founder/Trustee

Bowel Cancer Support Group UK on Facebook – Founder

Member of the Patient Advisory Committees for the following organisations:

GI Cancers Alliance

Digestive Cancers Europe

Global Colon Cancer Association

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# Section 1

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## Introduction to Call for A Kit (CFAK)

# Section 1: Introduction to Call for A Kit (CFAK)

## 1.1 Why Bowel Screening Matters

### Bowel Cancer

Bowel cancer, also known as colorectal cancer, is one of the most common cancers in the United Kingdom and a leading cause of cancer-related mortality (CRUK, 2026). It develops in the colon or rectum, usually from pre-cancerous growths known as adenomatous polyps, which can take several years to progress into cancer. Early-stage bowel cancer often presents with few or no symptoms, making population-based screening a crucial strategy for early detection and prevention. Evidence shows that detecting bowel cancer at an earlier stage significantly improves treatment outcomes and survival rates, while the identification and removal of pre-cancerous polyps can prevent cancer from developing altogether (Cardoso et al., 2022).

The incidence of bowel cancer increases with age, although recent trends have also highlighted a rise in diagnoses among younger adults (Sung et al., 2025). Risk factors include increasing age, family history, obesity, physical inactivity, smoking, alcohol consumption, and dietary factors such as high consumption of processed and red meat. Given its substantial health burden, bowel cancer remains a national priority within cancer prevention and early diagnosis strategies across England.

### Bowel Cancer Screening Programme

In 2006, The NHS Bowel Cancer Screening Programme (BCSP) was introduced in England to reduce mortality from bowel cancer through the early detection of cancer and pre-cancerous lesions. The programme invites eligible adults to complete a home-based faecal immunochemical test (FIT), which detects tiny amounts of blood in stool samples that may indicate bowel abnormalities, including cancer or polyps. Individuals with abnormal FIT results are offered further assessment, typically through colonoscopy.

The programme currently offers screening every two years to adults aged 50 to 74 years who are registered with a GP in England. Following the phased expansion of eligibility from age 60 to age 50, all individuals within this age range are now being incorporated into the programme. Adults aged 75 years and over can request a screening kit every two years through the NHS bowel screening helpline.

The FIT test was introduced nationally in 2019, replacing the guaiac faecal occult blood test (gFOBT). FIT is easier to use, requires only one stool sample, and has been shown to improve participation rates while maintaining high sensitivity for detecting bowel cancer and advanced adenomas (Moss et al., 2017). Since its introduction, screening uptake and

cancer detection rates have improved, contributing to earlier diagnosis and better outcomes.

## 1.2 Inequalities in Screening Uptake

Within the context of bowel cancer screening, health inequalities occur when certain groups are less likely to access, understand, or participate in screening compared with others. Lower participation has consistently been observed among people living in deprived areas, ethnic minority communities, people with disabilities, individuals with severe mental illness, and those with lower levels of health literacy. These inequalities can contribute to delayed diagnosis and poorer bowel cancer outcomes.

Although the introduction of the faecal immunochemical test (FIT) has increased participation across all socioeconomic groups, with almost 7 out of 10 eligible people now participating in screening (OHID, 2026; Moss et al., 2017) substantial inequalities remain. Uptake in the most deprived areas continues to be more than 20 percentage points lower than in the least deprived areas (Hirst et al. 2018), indicating that population-level interventions have not fully addressed persistent structural and social barriers to participation.

**Health inequalities** are the systematic, avoidable, and unfair differences in health outcomes, access to healthcare, and opportunities to achieve good health between different population groups. These differences are influenced by a wide range of social, economic, environmental, and demographic factors, including deprivation, ethnicity, disability, geography, gender, and age.

**The NHS Core20PLUS5 framework** identifies reducing health inequalities as a national priority by focusing on the most deprived 20% of the population (Core20), alongside locally identified underserved groups (PLUS), and targeting key clinical areas including early cancer diagnosis. Improving equitable participation in bowel cancer screening is therefore an important strategy for reducing cancer-related health inequalities.

Extensive evidence demonstrates lower screening uptake among people with low socioeconomic status (Hirst et al, 2018; Bright et al, 2022; NHS England, 2026), people from non-white ethnic communities (Campbell et al., 2020), people with learning disabilities (NHS Digital, 2022), sensory impairments (Young and Robb, 2021), and severe mental illness (Kerrison et al. 2023). First-time invitees are also less likely to take part in screening than previous participants (Lo et al., 2015), suggesting that initial engagement with screening remains a significant challenge. This issue may become increasingly important following the extension of screening eligibility to adults aged 50 years and older (NHS England, 2026).

Multiple factors contribute to lower participation, including limited awareness of bowel cancer and screening, language barriers, difficulty understanding written information, fear of cancer, low perceived risk, concerns about completing the test, and practical barriers to returning kits. Individuals who are not registered with a GP or who frequently change address may also fail to receive screening invitations.

Many of these differences represent **health inequities** because they result from unequal access to resources, support, and opportunities needed to make informed screening decisions. In response, a range of locally developed and community-based initiatives have sought to improve participation through targeted and tailored approaches, including the co-development of culturally appropriate and accessible resources (Christie-de Jong et al., 2022). However, these interventions are often resource intensive, limited in scale, and difficult to sustain. While the NHS Bowel Cancer Screening Programme provides information in multiple languages, British Sign Language, Easy Read, and other accessible formats (NHS England, 2025), further action is needed to improve inclusivity, accessibility, and equity in screening participation across England.

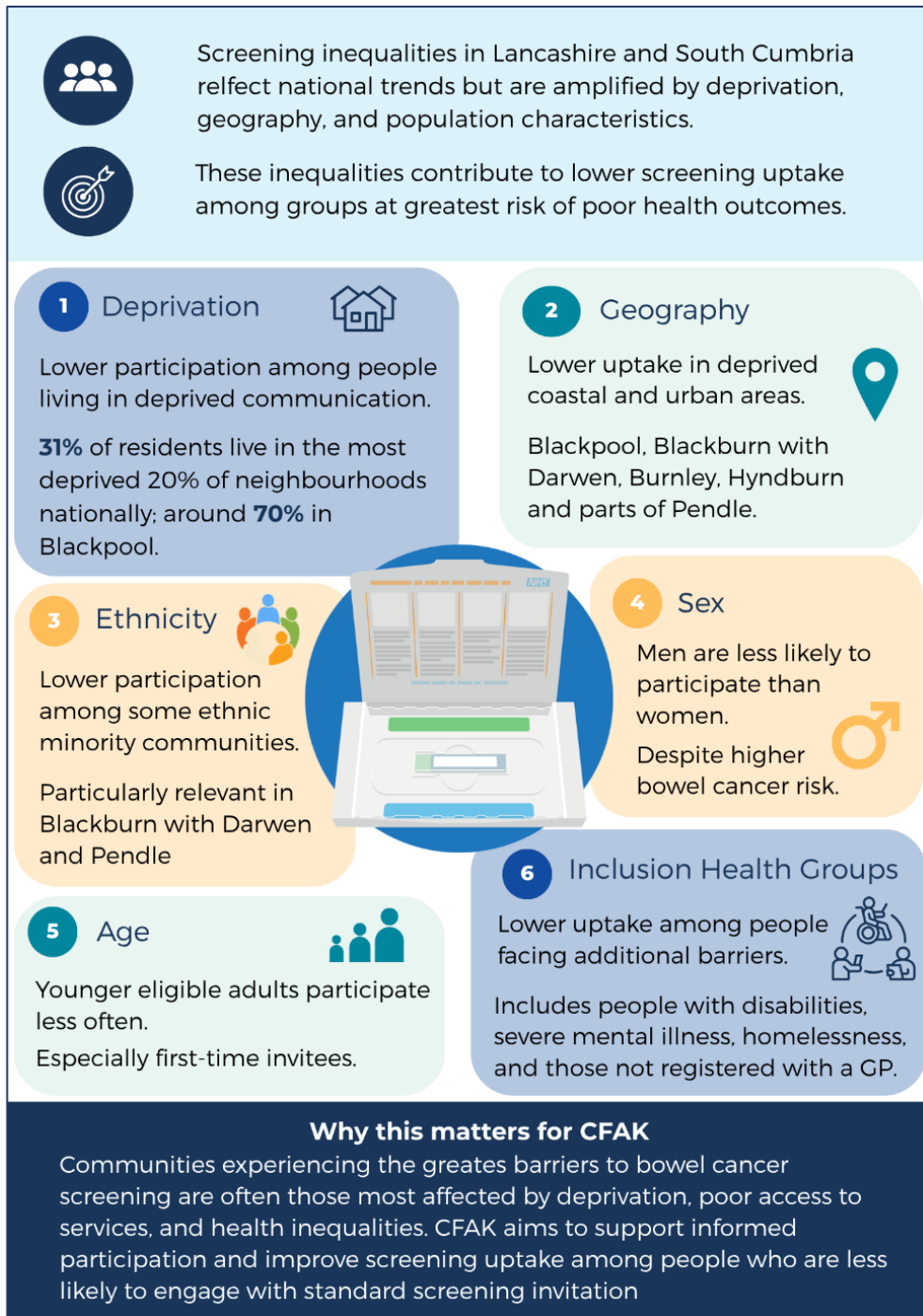
## Inequalities in bowel cancer screening in Lancashire and South Cumbria

Bowel cancer remains a major public health challenge in Lancashire and South Cumbria and is a leading contributor to cancer-related mortality across the region. Recent evidence indicates that outcomes remain poorer than the national average, with significant geographical and socioeconomic variation in both incidence and survival. North West Cancer Research highlights persistent cancer inequalities across Lancashire and South Cumbria, noting that several cancer types, including colorectal cancer, continue to have worse outcomes than those observed nationally (NWCR, 2025).

The recent uptake data (24/25) from NHS England (2026) show that, compared with the 65.2% national average, Northwest England has the lowest BCSP uptake (63.9%) outside of London (54.2%). Improving the uptake of BCSP in Northwest England can reduce mortality by detecting cancers at an early stage when the cancer treatment is more effective. **Box 1** highlights population groups within Lancashire and South Cumbria that are most likely to be underserved by bowel screening. Addressing these inequalities is a key priority within the NHS Core20PLUS5 framework to reduce health inequalities and improve cancer outcomes.

### 1.3 Why CFAK was developed

The **Call for a KIT** started as a small pilot in 2015, built on the ethos of “**community engagement with a clinical twist**”. The initiative targets non-responders to the BCSP in areas of low uptake across Lancashire. These individuals are invited to consultations held within primary care practices where they are seen by a Community Health Promotion Team. Various community engagement models are used to encourage participation in the BCSP. Following a successful two-year pilot, the project received core funding from NHS England and Lancashire BCSP for a further two-years. Due to its strong outcomes, Call for a KIT is now block contracted and has become a mainstream service within Lancashire.



**Box 1. Groups most likely to be underserved by bowel screening in Lancashire and South Cumbria**

## 1.4 What is CFAK?

CFAK is based on the principles of **patient navigation**, which involve providing personalised support to help individuals overcome barriers to accessing and completing healthcare services (Hanif et al, 2026).

**Patient navigation interventions** in cancer screening programmes aim to facilitate progression through the care pathway by identifying and addressing practical, cognitive, emotional, cultural, and system-level barriers to participation. Recent systematic reviews have shown that patient navigation interventions can increase bowel cancer screening rates, particularly among minority groups and economically disadvantaged populations (Xia et al., 2025).

### CFAK procedure summary

CFAK is a patient navigation intervention that supports bowel cancer screening non-responders to navigate the screening pathway. Consistent with the Health Education England definition of care navigation, trained Health Promotion Officers (HPOs) act as link workers, providing personalised assessment, education, reassurance, problem-solving and coordination to overcome barriers to screening participation. By facilitating access to replacement FIT kits, addressing emotional and practical concerns, and connecting individuals with relevant support, CFAK helps participants access the right support at the right time and progress through the bowel screening pathway.

CFAK processes start with GP practices agreeing to have HPOs to support screening participation for their non-responders and setting up governance at each practice. GP practices identify individuals who are not up to date with bowel cancer screening. All potential individuals receive a text-message informing them that they would soon receive a phone call from the health promotion team and they can opt-out if they do not wish to receive this phone call. During the call, the health promotion team offers individuals the choice of a 15-minute in-person or telephone consultation to discuss bowel screening. During the in-person consultation, barriers to screening are identified and discussed. Participants are shown the screening kit and a video on how to use it. They are also offered a replacement kit if needed. Similarly, during the telephone consultation, barriers were identified and discussed, with a new replacement kit offered if needed. At the end of the

**Health Education England Care Navigation Competency Framework (2016)** definition of patient navigation: *"A person-centred coordination process that assists individuals in navigating complex health and social care systems by identifying needs, overcoming barriers to access, facilitating connections with appropriate services, and ensuring timely access to care, support and treatment. Navigation functions as a linking mechanism between individuals, healthcare providers, community resources and support services to promote coordinated, seamless and integrated care."*

**Navigators act as link workers who help people access the right support, at the right time, and in the right place, through personalised assessment, coordination, signposting, advocacy and problem-solving.**

consultation, the individuals are encouraged to decide if they would like to a new test kit to be requested from BCSP on their behalf.

## **Who delivers it?**

Community CVS is commissioned by NHS England North West & NHS Lancashire BCSP to promote and improve bowel screening uptake, with a focus on reducing inequalities by targeting groups with historically low participation. Community CVS established the Lancashire BCSP Health Promotion Team, employing BCSP Health Promotion Officers to deliver the project. The team also includes a BCSP Health Promotion Specialist, employed through NHS Lancashire BCSP.

## **1.5 Where CFAK fits into the screening pathway**

Figure 1 shows a simplified BCSP pathway and highlights where CFAK fits in on this pathway. CFAK identifies individuals who have not returned their test kit based on their primary care records. Currently, individuals who have been identified would have not returned their test kit 18 weeks after the kit was dispatched by BCSP and up to 6 months before they receive their next test kit. The NHS BCSP pathway with clinical outcomes available here: [Bowel cancer screening: care pathways - GOV.UK](#)

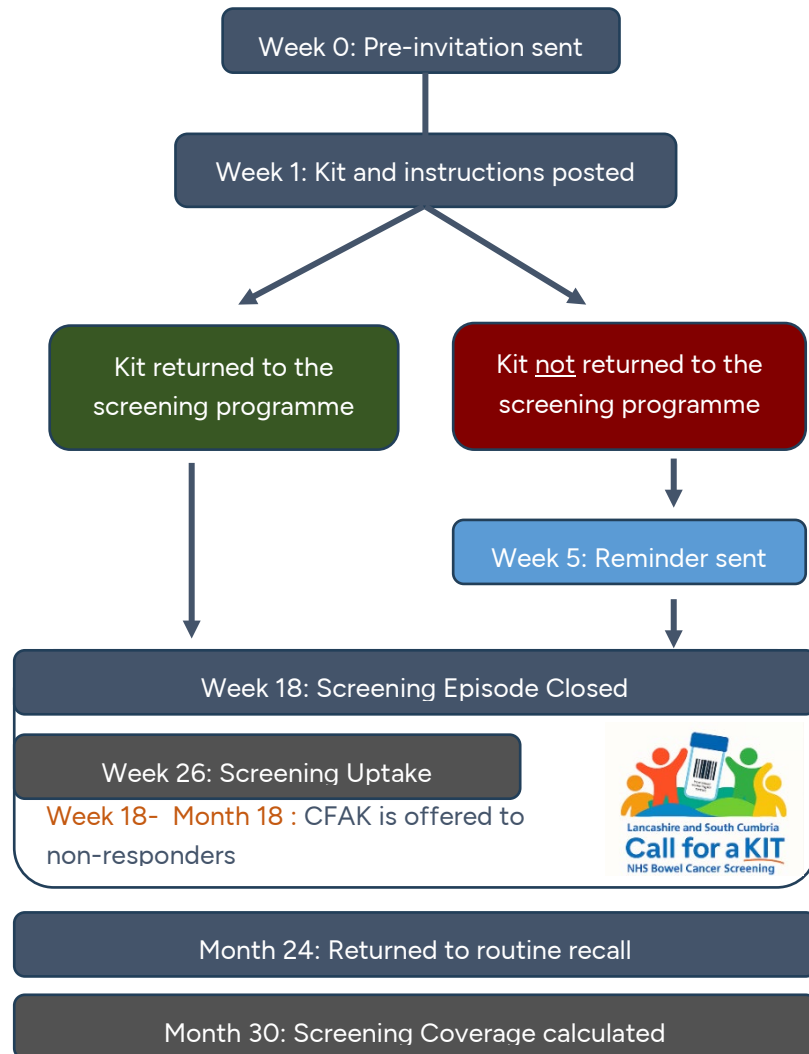


**Figure 1: Simplified BCSP pathway for demonstrating CFAK delivery timeline without clinical outcomes**



# Section 2

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## The Evidence for CFAK

## Section 2: The Evidence for CFAK

This guidance presented in this manual is informed by a programme of research, evaluation and service learning funded by North West Cancer Research (NWCR) to support the development, refinement, and implementation of Call for a Kit (CFAK). This work has helped strengthen understanding of the barriers individuals experience when engaging with bowel cancer screening and identify approaches that can support participation and reduce inequalities.

The evidence base includes a regional needs assessment, effectiveness evaluation, patient experience evaluation (funded by National Institute for Health and Care Research Applied Research Collaboration North West Coast), economic evaluation, social media campaign outcomes and implementation research involving patients, practitioners, and delivery partners. Together, these studies have informed the ongoing development, refinement and delivery of CFAK.

The programme was underpinned by several complementary theoretical and implementation frameworks. Understanding of screening behaviour was informed by the **Behaviour Change Wheel (BCW)** and **COM-B model (Michie et al., 2011)**, which provided a framework for identifying capability, opportunity, and motivation barriers influencing FIT kit completion. The evaluation and implementation studies were further informed by the **Consolidated Framework for Implementation Research (CFIR; Damschroder et al, 2022)**, which supported understanding of the factors that influence implementation across individuals, organisations, intervention characteristics, and wider systems. In addition, principles of patient navigation and person-centred care underpin CFAK, recognising the importance of tailored support, trust, and relationship-building in addressing health inequalities.

The following sections summarise the evidence generated through this programme of work and the key learning that has informed the ongoing development and delivery of CFAK.

### 2.1 What Evidence Informed CFAK?

#### Needs assessment

To better understand the barriers contributing to low participation in bowel cancer screening, a regional needs assessment was conducted in 2024 involving 1,784 adults from across North West England. The assessment explored demographic, behavioural, practical, and attitudinal factors associated with participation in the NHS Bowel Cancer Screening Programme and was undertaken to inform the ongoing development and delivery of CFAK.

The findings demonstrated that non-participation in screening is driven by a combination of practical, behavioural, and emotional barriers rather than any single factor. Several barriers were found to be significantly associated with lower FIT completion, including forgetting to

complete the test, competing life priorities, not knowing how to complete the FIT kit, concerns about finding cancer, perceptions that the test is unpleasant or messy, and worries about follow-up investigations.

When all factors were considered simultaneously, four barriers emerged as the strongest independent predictors of non-participation in the region:

- **Not knowing how to complete the FIT kit.**
- **Competing life priorities.**
- **Forgetting to complete the test.**
- **Fear of finding cancer.**

These findings suggest that many barriers to screening are potentially modifiable and can be addressed through personalised support, practical problem-solving, and clear communication.

The needs assessment also identified important demographic inequalities in participation. Women and older adults were more likely to participate in screening than men and younger eligible age groups.

Local analyses further demonstrated that barriers varied across different geographical areas. For instance, in **Lancashire and South Cumbria**, those who identified as South Asian/Asian ethnicities were less likely to take part and key behavioural barriers were **forgetting to complete the test kit and competing life priorities**. In comparison, participants residing in **Manchester** were less likely to take part if they were younger than 65 years old and key barriers were **messiness of the test kit, not wanting to know and forgetting to complete the test kit**. These findings highlight the importance of tailoring implementation approaches to local populations rather than relying on a single standardised strategy.

## Implications for CFAK

The needs assessment provided an important evidence base for the development and refinement of CFAK. The findings reinforced the need for a patient navigation approach that combines education, behavioural support, practical assistance, and personalised discussions about screening.

In particular, the findings informed several core components of the intervention, including:

- Providing clear explanations and demonstrations of FIT kit completion.
- Supporting individuals who have forgotten, misplaced, or not completed their kit.
- Addressing practical barriers and competing priorities through problem-solving and personalised action planning.
- Offering reassurance and opportunities to discuss concerns about bowel cancer and potential screening outcomes.

- Tailoring delivery approaches to meet the needs of different communities and local populations.

Overall, the needs assessment demonstrated that many barriers to bowel screening participation are addressable through personalised engagement and support, providing a strong rationale for the patient navigation model underpinning CFAK.

## Effectiveness findings

The effectiveness of CFAK has been evaluated through a series of observational data analyses conducted. Early evaluation findings demonstrated that CFAK increased bowel screening uptake among individuals who had previously not responded to routine screening invitations (Stoffel et al., 2022). More recent research has conceptualised CFAK as a patient navigation intervention and highlighted its potential to address persistent inequalities in bowel cancer screening participation through personalised, community-based support (Stoffel et al., 2026).

The latest evaluation of CFAK activity between June 2022 and March 2024 examined outcomes for 6,919 bowel screening non-responders registered across 45 GP practices with screening uptake below 60%. Overall, the programme generated 968 additional FIT kit returns, representing 14.0% of all individuals contacted. Of those who answered the initial telephone call, 82.5% agreed to participate in a consultation, demonstrating high acceptability of the intervention once contact had been established.

The evaluation identified several important findings regarding implementation and effectiveness. The greatest loss in the patient pathway occurred during the initial recruitment stage, with approximately half of eligible non-responders answering the telephone call. However, engagement among those successfully contacted was high, suggesting that the primary implementation challenge is reaching eligible individuals rather than encouraging participation once contact has been established.

Importantly, CFAK appeared particularly effective among groups that traditionally experience lower bowel screening participation. Higher FIT return rates were observed among individuals from several ethnic minority communities and among people with disabilities and long-term health conditions. These findings suggest that the personalised and culturally responsive nature of the intervention may help address barriers that are not adequately addressed through standard screening invitations alone.

The evaluation also provided evidence that consultation mode influences outcomes. Individuals who attended face-to-face consultations were more likely to complete and return a FIT kit than those receiving telephone support. While telephone consultations increase accessibility and flexibility, these findings suggest that face-to-face delivery should remain an important component of the CFAK model where feasible.

Overall, the evidence suggests that CFAK can successfully engage a substantial proportion of bowel screening non-responders and support additional FIT kit completion among populations experiencing health inequalities. The findings also highlight opportunities for further service development, particularly in relation to improving initial patient contact rates and extending engagement with individuals who remain difficult to reach.

### **Key Learning from the Quantitative Evaluation**

- CFAK can increase participation among bowel screening non-responders.
- Personalised patient navigation appears to be an effective mechanism for supporting uptake.
- Face-to-face consultations may achieve higher FIT completion rates than telephone consultations.
- Different groups may benefit from different approaches, highlighting the importance of flexible and tailored delivery.

### **Patient experience findings**

In 2024, a mixed-methods evaluation was undertaken to understand patient experiences of CFAK and explore how the intervention supports participation in bowel cancer screening. The study combined a survey of 113 CFAK attendees with follow-up interviews involving 12 participants. The findings were subsequently published in a peer-reviewed journal (Hanif et al., 2026).

Overall, participants reported positive experiences of CFAK. Survey findings indicated high levels of satisfaction with the service, and more positive consultation experiences were associated with greater intention to complete a FIT kit. Interviews highlighted that many individuals had limited awareness of bowel cancer screening prior to their consultation and often lacked confidence in completing the FIT kit. Participants described how consultations helped improve understanding of bowel cancer screening, clarify misconceptions, and increase confidence in completing the test.

The evaluation also highlighted the importance of relationship-based support. Participants valued the opportunity to discuss concerns in a supportive, non-judgemental environment and appreciated being able to ask questions and receive personalised explanations. Face-to-face consultations were particularly valued for enabling real-time discussion and clarification. Participants reported that personalised support helped address emotional barriers, including anxiety about bowel cancer and concerns about potential screening outcomes.

The findings also emphasised the importance of culturally sensitive and accessible delivery. Participants highlighted the value of receiving support in their preferred language and being able to discuss bowel screening with someone who understood their communication needs and cultural context.

## Implications for CFAK

The patient experience evaluation provided further support for the relationship-based patient navigation approach underpinning CFAK. The findings suggest that the intervention works by increasing knowledge, understanding, confidence, and motivation to participate in screening, rather than simply facilitating access to a replacement FIT kit. The evaluation reinforced the importance of:

- Providing personalised, non-judgemental support.
- Creating opportunities for discussion and questions.
- Offering clear explanations and demonstrations of FIT kit completion.
- Addressing emotional concerns and fears about cancer.
- Delivering culturally sensitive and accessible support.
- Maintaining opportunities for face-to-face engagement where possible.

Further details of the study methods and findings are available in the published evaluation (Hanif et al., 2026).

## Economic evaluation

An economic evaluation of CFAK was undertaken using programme activity and financial data from the 2023-24 financial year. A cost-consequence approach was used to describe the resources required to deliver the intervention alongside key service outcomes.

The total annual cost of delivering CFAK was £179,602. Staff costs accounted for the majority of expenditure (86.7%), reflecting the relationship-based and patient-centred nature of the intervention. The remaining costs related to premises, travel, service provider costs, IT, and administrative overheads.

Analysis of programme activity showed that CFAK engaged large numbers of bowel screening non-responders through personalised telephone outreach and consultations.

| Outcome                         | Number Achieved | Average Cost per Outcome |
|---------------------------------|-----------------|--------------------------|
| Calls made                      | 4,434           | £41                      |
| Calls answered                  | 2,123           | £85                      |
| Invitations accepted            | 1,799           | £100                     |
| Consultations attended          | 1,316           | £136                     |
| FIT kits returned               | 620             | £290                     |
| Abnormal FIT results identified | 24              | £7,483                   |

The evaluation highlighted that much of the programme cost is associated with establishing contact and engaging individuals who have previously not responded to routine screening invitations. Once individuals attended a CFAK consultation, progression through subsequent stages of the pathway was high, with most participants requesting and returning a FIT kit. Importantly, these figures represent average programme costs rather than the cost of individual activities. They reflect the cumulative investment required to

progress participants through the entire pathway from initial outreach to screening completion.

The evaluation also identified important differences across population groups. Men had slightly higher FIT return rates than women, resulting in a lower cost per returned kit (£265 versus £337). Larger differences were observed across ethnic groups. Participants of Pakistani and Indian ethnicity were more likely to answer outreach calls, accept invitations, and return FIT kits than White participants. Consequently, the average cost per returned kit was lower among Pakistani (£159) and Indian (£192) participants than among White participants (£330). These findings suggest that personalised patient navigation may have particular value for populations who have not engaged through routine postal screening.

### **Implications for CFAK**

The economic evaluation showed that delivering CFAK requires investment in a skilled workforce capable of providing personalised engagement and support. Programme costs are driven primarily by workforce capacity and the resources required to identify, contact, and engage screening non-responders.

The evaluation also highlighted the importance of maximising engagement at the earliest stages of the pathway, as initial contact accounted for the greatest drop-out. Strategies that improve contact rates, consultation attendance, and patient engagement improve contact rates, consultation attendance and patient engagement may therefore improve both programme efficiency and overall impact.

Although the evaluation was not designed to estimate cost-effectiveness in terms of cancers detected or healthcare costs avoided, the findings show that CFAK can engage large numbers of screening non-responders and support progression through the bowel screening pathway. Further details of the economic evaluation methods and findings are available in Supplementary Material 2.1.

## **2.2 What have we learned about delivering CFAK?**

### **Key Learning 1: Relationship-based delivery is central to success.**

Across patient interviews, staff interviews, and service evaluations, one consistent finding was that CFAK works through relationships rather than information provision alone. Participants valued having the opportunity to discuss concerns, ask questions, and receive support from a trusted Health Promotion Officer in a non-judgemental environment. Staff similarly described rapport-building as a core component of successful consultations, particularly when discussing sensitive topics such as cancer risk, fear of diagnosis, or previous negative healthcare experiences.

The evidence suggests that personalised conversations help increase confidence, address misconceptions, and support informed decision-making. Relationship-based support should

therefore be viewed as a core component of CFAK rather than an optional addition to screening promotion.

#### **Key actions**

- Prioritise building rapport and trust.
- Allow time for questions and discussion.
- Use active listening and personalised communication.
- Support informed choice rather than persuasion.

### **Key Learning 2: Consultation mode matters**

Evidence from the effectiveness evaluation and patient experience study suggests that consultation mode can influence outcomes. Face-to-face consultations were associated with higher FIT completion rates and were valued by participants for allowing demonstrations, discussion, and reassurance. However, telephone and video consultations remain important options for increasing accessibility and flexibility. Services should offer a range of delivery modes while monitoring outcomes across consultation types.

#### **Key actions**

- Offer face-to-face consultations wherever feasible.
- Retain telephone and video options to maximise accessibility.
- Encourage face-to-face attendance for individuals requiring more intensive support.
- Monitor outcomes by consultation mode.

### **Key Learning 3: Strong GP practice relationships are essential**

Implementation experience consistently demonstrated that successful CFAK delivery depends upon positive working relationships with GP practices. Practices play a central role in patient identification, communication, clinic organisation, access to systems, and local implementation.

Staff interviews highlighted that implementation was often easier where trusted relationships already existed and where practices understood the benefits of CFAK for their patients and populations. Conversely, difficulties engaging practices could delay implementation and limit programme reach. GP practice engagement should therefore be viewed as an ongoing activity rather than a one-off implementation task.

#### **Key actions**

- Invest time in relationship building.
- Identify practice champions and key contacts.
- Maintain regular communication.
- Share outcomes and impact data with practices.
- Adapt delivery processes to fit existing practice workflows.

## **Key Learning 4: Tailored approaches support engagement and reduce inequalities**

The needs assessment, patient experience evaluation, and effectiveness findings all demonstrated that barriers to screening vary considerably between individuals and communities. Common barriers included forgetting to complete the FIT kit, competing life priorities, fear of finding cancer, low awareness of screening, language barriers, and practical difficulties completing the test. The evidence suggests that patient engagement is most effective when consultations are tailored to individual needs, concerns, communication preferences, and cultural contexts. A standardised approach is unlikely to address the diverse barriers experienced by different populations. Tailoring support appears particularly important when working with underserved populations and communities experiencing lower bowel screening uptake.

### **Key actions**

- Prioritise personalised conversations.
- Support informed choice.
- Address misconceptions and fears.
- Adapt communication to individual needs.
- Consider language, cultural, accessibility, and health literacy requirements.

## **Key Learning 5: Workforce support and development underpin successful implementation**

Staff interviews highlighted the importance of workforce development, supervision, and ongoing learning. Health Promotion Officers require a broad range of skills, including communication, behavioural support, patient navigation, cultural competence, and knowledge of bowel screening. Staff also emphasised the value of learning from colleagues, sharing experiences, reflecting on challenging consultations, and receiving ongoing support from managers and peers. Successful implementation therefore depends not only on recruiting staff but also on providing the training, supervision, and support structures required to maintain high-quality delivery over time.

### **Key actions**

- Provide structured induction programmes.
- Offer shadowing opportunities.
- Schedule regular team learning and reflective practice sessions.
- Provide ongoing supervision and mentoring.
- Review competencies regularly.

## Key Learning 6: Digital systems should support rather than hinder patient-facing activity

Digital systems play an important role in patient identification, appointment management, data collection, monitoring, and reporting. However, staff interviews highlighted that systems are most effective when they reduce administrative burden and support patient-facing activity rather than creating additional work. Several examples of service improvement arose from efforts to streamline delivery processes, including the introduction of self-booking systems, development of the CFAK Master Sheet, and piloting of remote consultation approaches. At the same time, staff highlighted challenges relating to system interoperability, appointment management, and monitoring cancellations. Implementation experience suggests that digital systems should be designed around the needs of staff and patients, with a focus on improving efficiency while maintaining the relationship-based principles of CFAK.

### Key actions

- Use digital tools to reduce administrative burden.
- Ensure data systems are simple and consistent.
- Monitor the impact of digital innovations on patient engagement.
- Balance technological efficiency with personalised support.
- Review systems regularly to identify opportunities for improvement.

## 2.3 Summary

The evidence presented throughout this section demonstrates that barriers to bowel cancer screening are complex and multifaceted, encompassing practical, behavioural, emotional, and structural factors. Collectively, the findings suggest that patient navigation can help address many of these barriers by providing tailored support, improving confidence and understanding, and supporting informed decision-making about screening.

Across all strands of evidence, six key lessons consistently emerged. Successful CFAK delivery was characterised by relationship-based support, opportunities for face-to-face engagement where feasible, strong partnerships with GP practices, approaches tailored to the needs of underserved populations, investment in workforce development, and systems that support efficient delivery while maintaining a patient-centred approach.

Together, these findings provide a strong rationale for the CFAK model and underpin the implementation recommendations presented throughout the remainder of this manual. The evidence suggests that reducing inequalities in bowel cancer screening participation requires more than increasing awareness alone. It requires personalised, flexible and culturally responsive support delivered through trusted relationships, strong partnerships and ongoing service improvement.



# Section 3

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## Preparing to Implement CFAK

## Section 3: Preparing to Implement CFAK

Successful implementation of CFAK requires more than simply establishing clinics and contacting non-responders. Evaluation findings and experience from delivering CFAK across Lancashire and South Cumbria have shown that effective delivery depends upon having the right organisational structures, workforce, partnerships, governance arrangements, and systems in place before patient-facing activity begins.

This section provides practical guidance to support organisations in planning, establishing, and delivering CFAK. The guidance is intended to support local implementation planning rather than prescribe a single approach. Organisations may choose to adapt aspects of delivery to reflect their local context, workforce, resources, and population needs. When making adaptations, it may be helpful to consider how the underlying principles of CFAK, including patient-centred support, informed choice, and reducing inequalities in screening participation, can continue to be reflected in service delivery.

Throughout this section, readers will find practical tools, checklists, and implementation resources designed to support service planning, workforce development, governance arrangements, and assessments of implementation readiness. The chapter should be used alongside the operational guidance and step-by-step procedures presented later in this manual.

### 3.1 Implementation Readiness

#### Why Implementation Readiness Matters

Introducing CFAK requires coordination across multiple organisations and stakeholders, including bowel screening services, GP practices, community delivery partners, commissioners, and information governance teams. Establishing these foundations early can help avoid delays, support effective delivery, and improve longer-term sustainability. Before implementation begins, organisations may find it useful to assess whether the key organisational, workforce, operational, and governance arrangements are in place to support delivery.

#### **What does 'Readiness' mean?**

Implementation readiness refers to the extent to which an organisation has the structures, resources, relationships, and processes needed to support successful delivery of CFAK. Readiness is not a fixed threshold, and organisations may begin implementation from different starting points. However, considering readiness before launch can help identify potential gaps and support implementation planning.

#### Assessing Readiness for Implementation

Implementation readiness is influenced by a range of factors operating at organisational, service, workforce, and system levels. Experience from CFAK delivery suggests that readiness extends beyond having staff available to deliver consultations. Successful implementation is also shaped by leadership

support, effective partnership working, governance arrangements, data infrastructure, workforce development, and processes for monitoring and improving delivery over time.

While organisations may vary in their starting point, considering these factors before implementation begins can help identify potential barriers, inform planning, and support a smoother introduction of the service. The following areas are particularly important when assessing readiness to implement CFAK:

- Strategic and organisational preparedness
- Workforce capacity and capability
- Partnership working with GP practices and stakeholders
- Operational processes and patient pathways
- Information governance and data systems
- Monitoring, evaluation, and quality improvement arrangements
- Sustainability and longer term service planning

These areas are reflected throughout the remainder of this section. For example, workforce capacity and capability are explored in the Workforce Requirements and Competency Framework sections, while operational processes, governance arrangements, and monitoring systems are addressed in subsequent chapters. Organisations seeking to assess their readiness for implementation may also wish to complete the **CFAK Implementation Readiness Checklist** (Supplementary Material 3.1)

## Key Implementation Considerations

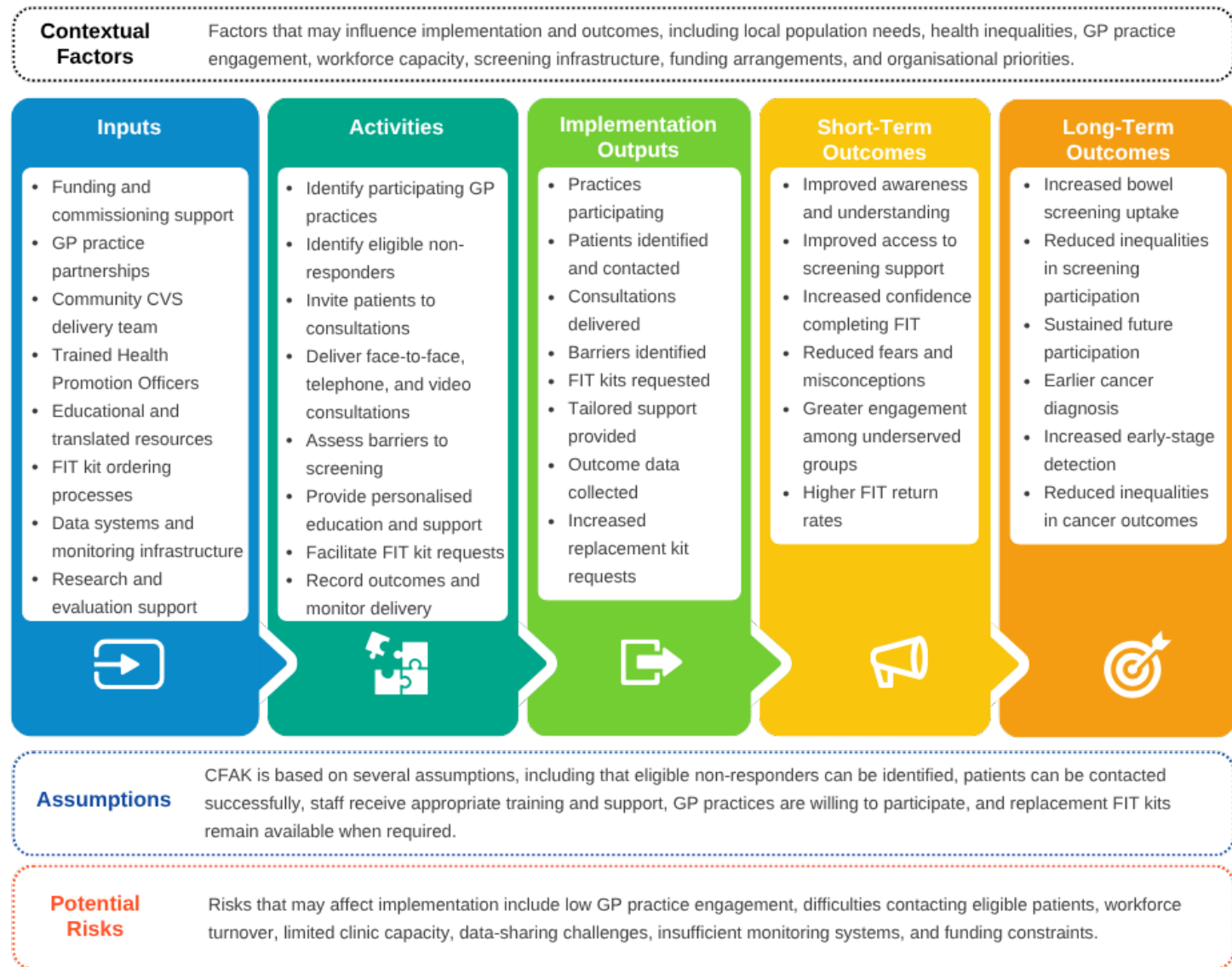
Experience from CFAK implementation suggests particular attention should be given to:

- Building relationships with GP practices.
- Securing workforce capacity.
- Establishing data-sharing arrangements early.
- Developing clear referral and patient-identification processes.
- Agreeing monitoring processes before patient recruitment begins.
- Considering how delivery can be adapted to meet the needs of underserved communities.

Before considering the specific workforce, governance, and operational requirements needed to deliver CFAK, it can be helpful to understand how the intervention is expected to achieve its intended outcomes. Logic models are commonly used within implementation and service development to illustrate how resources and activities contribute to desired changes and impacts over time.

**Figure 2. CFAK Logic Model**

**Inputs:** The resources and foundations that support implementation, including workforce, partnerships, funding, training, governance, and digital systems; **Activities:** The key implementation and delivery processes undertaken as part of CFAK; **Outputs:** The measurable products of implementation and service delivery; **Short-Term Outcomes:** Early indicators that CFAK is working as intended; **Long-term Outcomes:** Intended population and system-level impacts of CFAK.



## 3.2 The CFAK Logic Model

A logic model provides a visual representation of how CFAK is expected to achieve its intended outcomes. It describes the resources required to deliver the intervention, the activities undertaken, the outputs generated, and the outcomes anticipated in both the short and long term. The logic model in Figure 2 is intended to support implementation planning, service development, monitoring, and evaluation by clearly articulating the mechanisms through which CFAK is expected to improve bowel screening participation and reduce inequalities. The model should be viewed as a guide rather than a fixed representation, as local adaptations to delivery may occur while maintaining the core principles of the intervention.

### Underpinning Mechanism of Change

CFAK operates as a patient navigation intervention. Through personalised discussions, education, reassurance, problem-solving, and facilitation of FIT kit access, Health Promotion Officers support individuals to overcome barriers to screening participation. These activities aim to increase capability (knowledge and understanding), opportunity (access to screening resources and support), and motivation (confidence and willingness to participate), thereby increasing FIT completion and reducing inequalities in screening uptake.

This logic model provides a visual representation of how CFAK is expected to improve bowel screening participation and reduce inequalities through patient navigation support for bowel screening non-responders. The model can be used alongside the implementation readiness domains to support planning, implementation, monitoring and evaluation of CFAK services.

## 3.3 Role and Responsibilities

Clear roles and responsibilities help support consistent, accountable, and effective delivery of CFAK. While local delivery models may vary, organisations should ensure that key leadership, operational, and delivery functions are clearly defined before implementation begins. Table 1 outlines the roles involved in CFAK implementation and delivery including the key responsibilities associated with each role.

**Table 1 Roles and responsibilities**

| Role                                                     | Key Responsibilities                                                                                                                                                                                                                                                       |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>BCSP Strategic Project Lead (Implementation Lead)</b> | Strategic oversight, governance, stakeholder engagement, KPI monitoring, reporting, escalation management, service development, and research activity.                                                                                                                     |
| <b>Operational Team Lead</b>                             | Day-to-day operational management, staff supervision, performance monitoring, reporting, quality assurance, data management, and service improvement.                                                                                                                      |
| <b>Health Promotion Officer (HPO)</b>                    | Patient engagement, consultation delivery, data recording, practice engagement, patient navigation, safeguarding, and information governance.                                                                                                                              |
| <b>Events Co-ordinator</b>                               | Organises volunteer-led health promotion activities and community engagement events to raise awareness of CFAK and bowel cancer screening, coordinating volunteers, partnerships, event logistics, and outreach activities to support programme visibility and engagement. |
| <b>GP Practice/PCN</b>                                   | Practice engagement, identification of eligible non-responders, referral processes, access to systems, and support with local implementation.                                                                                                                              |

### 3.4 Workforce Requirements

Successful delivery of CFAK requires a workforce with the capacity, skills, and support needed to engage bowel screening non-responders effectively. Services should consider workforce requirements during implementation planning, including staffing levels, supervision arrangements, administrative support, training needs, and ongoing professional development.

#### **Suggested workforce considerations:**

- Number of HPOs required
- Administrative support requirements
- Team leadership arrangements
- Clinical support and escalation pathways
- Supervision and mentoring arrangements
- Workforce capacity for community engagement activities
- Coverage during annual leave and sickness absence

## 3.5 HPO Competency Framework

HPOs play a central role in delivering CFAK. In addition to knowledge of the bowel screening pathway, effective delivery requires strong communication skills, the ability to build trust and rapport, and the confidence to support individuals experiencing practical, emotional, or informational barriers to participation. The competency framework provides a structured approach to training, supervision, professional development, and competency assessment. It is intended to support induction of new staff, ongoing development, and quality assurance.

The framework is organised around six core competency domains that reflect the knowledge and skills required to deliver CFAK effectively and consistently.

### Competency Domain 1: Knowledge of Bowel Screening

HPOs should demonstrate an understanding of:

- The purpose and principles of bowel cancer screening
- The NHS Bowel Cancer Screening Programme pathway
- Eligibility criteria and screening intervals
- The FIT kit and how it is completed
- The benefits and limitations of screening
- Common questions, concerns, and misconceptions about bowel screening
- Local screening inequalities and priority populations

### Competency Domain 2: Communication and Patient Engagement

HPOs should be able to:

- Build rapport and establish trust with patients.
- Use active listening skills.
- Communicate clearly and effectively.
- Adapt communication to individual needs and preferences.
- Facilitate informed decision-making.
- Discuss sensitive or potentially challenging topics confidently and respectfully.
- Respond appropriately to patient concerns and questions.

### Competency Domain 3: Patient Navigation and Barrier Resolution

HPOs should be able to:

- Identify emotional, practical, cultural, and informational barriers to screening.
- Explore barriers using a patient-centred approach.
- Provide tailored education and support.
- Use problem-solving techniques to address barriers.
- Facilitate access to replacement FIT kits.
- Signpost patients to additional support and services where appropriate.

- Encourage progression through the screening pathway while maintaining informed choice.

## **Competency Domain 4: Reducing Inequalities and Working with Diverse Communities**

HPOs should be able to:

- Deliver culturally sensitive support.
- Adapt consultations to meet individual needs.
- Work effectively with interpreters and translated materials.
- Support individuals with learning disabilities and additional communication needs.
- Recognise and respond to health literacy challenges.
- Apply an understanding of health inequalities in practice.
- Tailor approaches for underserved and underrepresented populations.

## **Competency Domain 5: Data, Digital Systems and Information Governance**

HPOs should be able to:

- Use the CFAK Master Sheet accurately and consistently.
- Record consultation outcomes appropriately.
- Maintain accurate audit trails and documentation.
- Use digital systems required for delivery.
- Follow information governance and confidentiality requirements.
- Comply with local data protection policies and procedures.
- Contribute to routine monitoring and performance reporting.

## **Competency Domain 6: Professional Practice and Service Improvement**

HPOs should be able to:

- Work within the scope of their role.
- Demonstrate professional conduct at all times.
- Participate in supervision and reflective practice.
- Contribute to service improvement activities.
- Identify personal learning and development needs.
- Support quality improvement and evaluation activities.
- Recognise when additional advice, support, or escalation is required.

The competency framework is intended to support recruitment, induction, supervision, appraisal, and ongoing professional development. Competence should be reviewed during induction, supervision, annual appraisal, and whenever significant changes are made to service delivery models or procedures.

## 3.6 Training, Development and Competency Assessment

Effective delivery and sustainability of CFAK relies on staff and volunteers having the knowledge, skills, and confidence required to fulfil their role effectively. Training and development should be tailored to role-specific responsibilities while ensuring a shared understanding of the aims of CFAK, bowel cancer screening, health inequalities, and person-centred engagement.

The CFAK team may include Health Promotion Officers (HPOs), service managers, administrative staff, event coordinators, and volunteers. While training requirements will vary across roles, all team members should receive an appropriate induction proportionate to their role, covering:

- The purpose and objectives of CFAK
- The bowel cancer screening programme and screening pathway
- Health inequalities and barriers to screening participation
- Effective communication and culturally sensitive engagement
- Information governance, confidentiality, and data protection
- Safeguarding and lone working procedures, where applicable

### Recommended Training for Staff Delivering CFAK

Organisations may wish to ensure that Health Promotion Officers and other staff delivering CFAK consultations receive the training outlined in Table 2 before commencing independent patient-facing delivery. The training recommendations are intended to support the development of the knowledge, skills, and behaviours described within the HPO Competency Framework and promote consistent, high-quality delivery of CFAK.

**Table 2. Mapping of Training Requirements to CFAK Competency Domains**

| Competency Domain                                                        | Recommended Training                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Competency Domain 1:<br/>Knowledge of Bowel<br/>Screening</b>         | <ul style="list-style-type: none"><li>• Project induction, including overview of the CFAK model, service aims, and local delivery context</li><li>• Bowel cancer screening awareness training, including knowledge of the BCSP pathway, FIT kit processes, eligibility criteria, benefits and limitations of screening, and common patient concerns and misconceptions.</li></ul> |
| <b>Competency Domain 2:<br/>Communication and<br/>Patient Engagement</b> | <ul style="list-style-type: none"><li>• Call handling guidance, including use of approved scripts, consent procedures, and failed encounter protocols</li><li>• Training in patient-centred communication and engagement techniques</li></ul>                                                                                                                                     |

|                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                    | <ul style="list-style-type: none"> <li>• Mandatory video consultation training, covering use of Accurx Desktop and delivering CFAK clinics by video call</li> </ul>                                                                                                                                                                                                                                                                                                        |
| <b>Competency Domain 3:<br/>Patient Navigation and<br/>Barrier Resolution</b>                      | <ul style="list-style-type: none"> <li>• Training on the CFAK patient navigation approach.</li> <li>• Training in identifying and addressing practical, informational, emotional, and behavioural barriers to screening participation.</li> <li>• Guidance on FIT kit requests and replacement FIT kit processes.</li> </ul>                                                                                                                                               |
| <b>Competency Domain 4:<br/>Reducing Inequalities and<br/>Working with Diverse<br/>Communities</b> | <ul style="list-style-type: none"> <li>• Equality, diversity and inclusion training</li> <li>• Training on reducing screening inequalities and engaging underserved communities.</li> <li>• Guidance on working with interpreters, translated materials, and individuals with additional communication needs.</li> </ul>                                                                                                                                                   |
| <b>Competency Domain 5:<br/>Data, Digital Systems and<br/>Information Governance</b>               | <ul style="list-style-type: none"> <li>• Data protection and information governance training, in line with UK GDPR and NHS confidentiality standards</li> <li>• EMIS Web training, including patient searches, consultation coding, and appointment booking.</li> <li>• Completion of the GP Set-Up Tool orientation before attending a new practice for the first time.</li> <li>• Training in CFAK data collection, documentation, and monitoring procedures.</li> </ul> |
| <b>Competency Domain 6:<br/>Professional Practice and<br/>Service Improvement</b>                  | <ul style="list-style-type: none"> <li>• Safeguarding awareness training</li> <li>• Training on local escalation pathways and incident reporting processes.</li> <li>• Introduction to service monitoring, evaluation, and quality improvement processes.</li> <li>• Participation in reflective practice, supervision, and ongoing professional development activities.</li> </ul>                                                                                        |
| <b>Additional Role-Specific<br/>Training</b>                                                       | <ul style="list-style-type: none"> <li>• Lifting and handling training for staff responsible for transporting and setting up the inflatable bowel and other community engagement equipment.</li> </ul>                                                                                                                                                                                                                                                                     |

While the training requirements outlined above provide a useful foundation for CFAK delivery, organisations may wish to supplement these with additional local training requirements to reflect their workforce, service model, governance arrangements, and population needs. Training should be reviewed periodically and refreshed where appropriate to support ongoing competence and professional development.

## Competency Assessment

Competence should be assessed before staff undertake independent patient-facing delivery and reviewed periodically thereafter. Assessment processes may be adapted locally but could include:

- Completion of required induction and training.
- Observation of consultations or patient interactions.
- Shadowing experienced staff.
- Supervised practice.
- Competency assessment and sign-off by an appropriate supervisor.
- Ongoing supervision and reflective practice.
- Annual review and refresher training where required.

## 3.7 Information Governance

All CFAK activity must comply with UK GDPR, the Data Protection Act 2018, NHS confidentiality standards, and any local information sharing agreements in place. All staff and volunteers must complete confidentiality training before commencing work on the project, use only approved systems and must not store patient-identifiable information on personal devices. Patient-identifiable information must never be shared via unsecured messaging systems, including personal email or unauthorised messaging applications.

An approved operational WhatsApp or Teams group may be used to support day-to-day project coordination where authorised by the Project Lead, and in line with local information governance policies. This may be used for operational updates, shift coordination, general communications, escalation notifications (without patient identifiable information) and reporting reminders. It must not be used to share patient-identifiable information, provide clinical advice, share confidential documentation, or informally alter agreed operational processes. All participants must maintain professionalism, follow NHS confidentiality requirements and escalate concerns through formal management routes. The Project Lead reserves the right to moderate and remove inappropriate content or participants where necessary to protect operational integrity and governance standards.

## 3.8 Risk Management

Effective risk management can support the successful implementation, delivery, and sustainability of CFAK. Organisations may find it helpful to identify, monitor, and review risks throughout implementation to ensure potential challenges are recognised early and addressed proactively.

The CFAK Logic Model highlights a number of contextual factors, assumptions, and potential risks that may influence implementation and outcomes. Building on these considerations, organisations may wish to maintain a local risk register and review implementation risks regularly through existing governance arrangements. Table 3 provides an example risk register with mitigation strategies based on Lancashire’s CFAK.

Based on experience of implementing CFAK, it is recommended that risks are reviewed monthly by operational and strategic leads, supported by quarterly governance reviews and an annual strategic review of service performance, sustainability, and future development.

**Table 3.** Example CFAK Risk Register and Mitigation Strategies

| <b>Risk</b>                             | <b>Likelihood</b> | <b>Impact</b> | <b>Mitigation</b>                                                                             |
|-----------------------------------------|-------------------|---------------|-----------------------------------------------------------------------------------------------|
| <b>Low GP practice engagement</b>       | Medium            | High          | Local champions and engagement meetings, develop trusted relationships with practice managers |
| <b>Poor patient attendance</b>          | High              | Medium        | Self-booking, weekend/evening clinics and reminder systems                                    |
| <b>Navigator/HPO turnover</b>           | Medium            | High          | Workforce development and succession planning                                                 |
| <b>Data quality issues</b>              | Medium            | Medium        | Routine audit and validation                                                                  |
| <b>Information governance breach</b>    | Low               | Very High     | IG training and secure systems                                                                |
| <b>Translation services unavailable</b> | Medium            | Medium        | Approved interpreter providers                                                                |
| <b>FIT request delays</b>               | Medium            | Medium        | Monitoring with screening hub                                                                 |
| <b>Funding withdrawal</b>               | Medium            | High          | Demonstrate impact and cost-effectiveness                                                     |
| <b>Loss of fidelity during scale-up</b> | Medium            | High          | Standardised training and fidelity audits                                                     |
| <b>Inequitable reach across groups</b>  | Medium            | High          | Ongoing equity monitoring and targeted outreach                                               |

**Note:** The risks and mitigations presented above are intended as examples and should be adapted to reflect local circumstances, governance arrangements, population needs, and delivery models. Organisations may identify additional risks during implementation planning and ongoing service delivery.

A skilled and supported workforce is fundamental to the successful delivery of CFAK. Clearly defined roles, appropriate training, and ongoing competency development help ensure that staff and volunteers have the knowledge, skills, and confidence required to deliver the intervention effectively and consistently. However, workforce development is only one aspect of implementation. Once the necessary skills, competencies, and support structures are in place, attention can turn to how CFAK is delivered in practice. This includes understanding the core principles that underpin the intervention, establishing productive relationships with GP practices and other partners, identifying eligible patients, and selecting delivery approaches that reflect local needs and contexts.

The next section outlines the key components of CFAK delivery and provides practical guidance to support implementation within different settings.



# Section 4

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## Delivering CFAK

## Section 4: Delivering CFAK

### 4.1 Overview of the CFAK Delivery Process

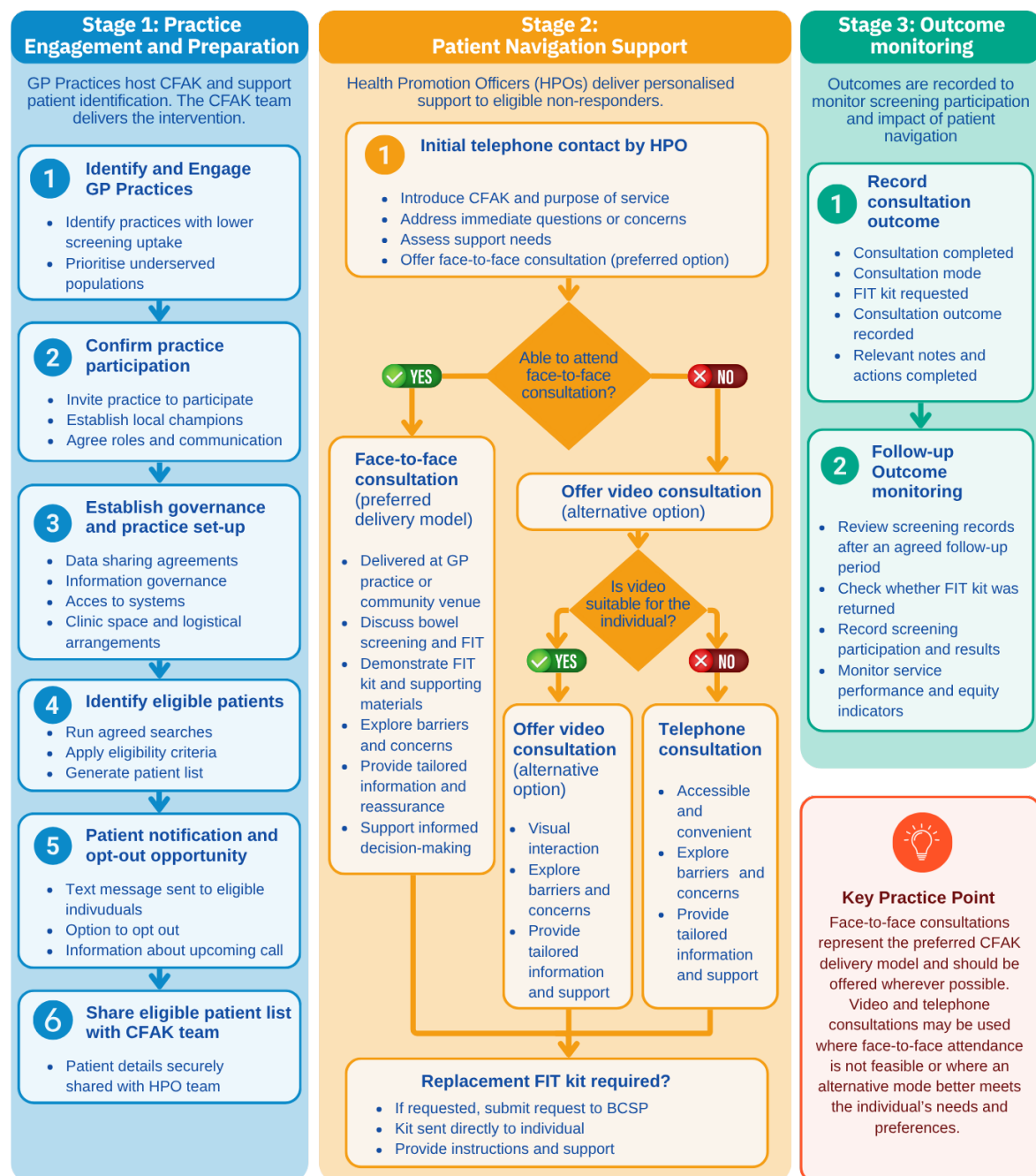
CFAK is a patient navigation intervention designed to support bowel screening non-responders through personalised engagement, barrier resolution, and facilitated access to screening. Consistent with the Health Education England definition of care navigation, trained Health Promotion Officers (HPOs) act as link workers, providing personalised assessment, education, reassurance, problem-solving and coordination to overcome barriers to screening participation. By facilitating access to replacement FIT kits, addressing emotional and practical concerns, and connecting individuals with relevant support, CFAK helps participants access the right support at the right time and progress through the bowel screening pathway.

While delivery may vary according to local context, the core stages of the intervention remain broadly consistent. Implementation begins with the selection and engagement of GP practices, followed by the establishment of local governance arrangements, access to systems, and practice set-up activities. Participating practices identify eligible bowel screening non-responders using agreed eligibility criteria and search processes.

Eligible individuals are sent a text message informing them that they may be contacted by the CFAK team and providing an opportunity to opt out. Health Promotion Officers (HPOs) then attempt to contact individuals by telephone to introduce the service, explain its purpose, and assess their support needs. During the initial call, individuals are offered the opportunity to discuss bowel screening further through a face-to-face, video, or telephone consultation. The most appropriate mode of delivery should be determined through discussion with the individual, taking account of their preferences, communication needs, access requirements, and support needs.

During consultations, HPOs work with individuals to identify and explore barriers to screening, provide tailored information and reassurance, and support informed decision making. In face-to-face consultations, individuals may be shown the FIT kit and provided with a demonstration of how it is completed. At the end of the consultation, the individuals are encouraged to decide if they would like to a new test kit to be requested from BCSP on their behalf. Figure 3 outlines the key stages involved in implementing and delivering CFAK, from GP engagement and patient identification through to patient navigation support, FIT kit ordering, and recording of screening outcomes. GP practices support patient identification and provide a delivery setting, while HPOs work with practices to set up CFAK and deliver the patient navigation intervention and record outcomes.

**Figure 3. Overview of the CFAK Delivery Process**



## 4.2 Core Delivery Principles

The following principles underpin the delivery of CFAK and should be considered alongside local policies, available resources, and the needs of the populations being served.

Collectively, they help maintain the distinctive features of the intervention while allowing flexibility in implementation across different settings.

### Relationship-based delivery

At the heart of CFAK is a relationship-based approach to patient engagement.

Consultations should provide a supportive, respectful, and non-judgemental environment in which individuals can discuss bowel screening, ask questions, and explore any concerns they may have. Building trust and rapport can help individuals feel comfortable discussing sensitive topics and may increase willingness to engage with screening-related information and support.

### Patient-centred and Tailored Support

People may experience different barriers to screening participation, and a single approach is unlikely to meet everyone's needs. CFAK should therefore be delivered in a way that recognises individual circumstances, preferences, communication needs, and cultural contexts. Tailoring support may involve adapting communication styles, providing accessible information, arranging interpreter support, or offering alternative delivery approaches where appropriate.

### Supporting Informed choice

The purpose of CFAK is not to persuade individuals to participate in bowel screening, but to support informed decision-making. Consultations should provide clear, balanced, and accurate information about bowel screening, allowing individuals to consider the potential benefits and limitations of participation and make decisions that align with their values and preferences. Individuals who choose not to participate should have their decision respected.

### Flexibility in Delivery

Services should offer a range of consultation formats to maximise accessibility and respond to patient needs. Face-to-face consultations remain an important component of the CFAK model and should be offered where feasible. However, support should be guided by patient preferences, accessibility requirements, work commitments, caring responsibilities, and practical circumstances. Telephone and video consultations can provide valuable opportunities for personalised support and informed decision-making when attendance in person is not possible or preferred.

## Partnership Working

Successful delivery of CFAK relies on effective collaboration between the CFAK team, GP practices, screening services, community organisations, and other local stakeholders. Strong partnerships support patient identification, communication pathways, operational planning, and the delivery of coordinated and responsive support. Developing and maintaining productive working relationships is therefore an important component of successful implementation.

## Equity-Focused Delivery

CFAK aims to reduce inequalities in bowel screening participation by supporting groups who may face additional barriers to engagement. Delivery should therefore be mindful of equity considerations and seek to identify and address factors that may limit access to information, consultations, or screening services. Where possible, reasonable adjustments and targeted approaches should be used to ensure support is accessible and appropriate for diverse populations.

## Balancing Fidelity and Local Adaptation

The core features of CFAK should be retained across different settings, including personalised engagement, barrier-focused discussions, support for informed choice, and assistance with accessing bowel screening. However, organisations may need to adapt aspects of delivery to reflect local populations, practice arrangements, workforce capacity, and available resources. Adaptations should aim to enhance accessibility and acceptability while preserving the key functions of the intervention

While these principles underpin all aspects of CFAK delivery (see Table 4), they are reflected throughout the practical guidance that follows. **Relationship-based engagement** and **supporting informed choice** are central to the consultation process; **partnership working** underpins collaboration with GP practices and community partners; **person-centred and tailored support** informs approaches to patient identification, engagement, and barrier management; **flexibility in delivery** is reflected in the range of consultation and appointment options available; **equity-focused delivery** guides efforts to reduce screening inequalities; and **balancing fidelity and local adaptation** supports implementation across diverse organisational and community contexts.

**Table 4.** Matching the Core Principles to the Stage of Delivery

| Core Principle                          | Applied within                                                                                          |
|-----------------------------------------|---------------------------------------------------------------------------------------------------------|
| Relationship-Based Engagement           | Initial patient contact, consultations, and ongoing patient support                                     |
| Person-Centred and Tailored Support     | Patient identification, communication approaches, reasonable adjustments, and barrier management        |
| Supporting Informed Choice              | Consultations, screening discussions, and decision-making support                                       |
| Flexibility in Delivery                 | Face-to-face, telephone, video, community-based, evening, and weekend delivery models                   |
| Partnership Working                     | Working with GP practices, community partners, and local stakeholders                                   |
| Equity-Focused Delivery                 | Patient identification, outreach activities, reasonable adjustments, and targeted engagement approaches |
| Balancing Fidelity and Local Adaptation | Adapting delivery to local needs while maintaining the key functions and intended outcomes of CFAK      |

### 4.3 Working with GP Practices

Strong and collaborative relationships with GP practices are fundamental to the successful implementation and delivery of CFAK. GP practices provide access to eligible patients, support patient identification and recruitment processes, facilitate communication with non-responders, and provide the clinical environment within which many consultations take place. Experience from CFAK implementation consistently showed that practices were more likely to engage with the programme when trusting relationships had been developed with members of the CFAK team and when the benefits of participation were clearly understood.

Experience from CFAK implementation has shown that practice engagement is not a one-off activity completed before delivery begins. Rather, it is an ongoing process that requires relationship building, regular communication, responsiveness to practice pressures, and a flexible approach to delivery. Staff described successful implementation as being supported by having identifiable practice contacts, maintaining regular communication, and adapting operational processes to fit within existing practice workflows.

## Why GP Practice Partnerships Matter

GP practices play a central role in enabling CFAK delivery. Their involvement supports:

- Identification of bowel screening non-responders through practice clinical systems.
- Communication with patients prior to CFAK contact.
- Access to practice facilities and consultation rooms.
- Arrangement of appointment systems and self-booking options.
- Access to EMIS and other approved digital systems.
- Collection of outcome data following consultations.
- Ongoing support for local implementation and sustainability.

Experience from implementation suggests that the quality of the relationship between the CFAK team and practices can directly influence the ease with which clinics are established, the number of patients reached, and the overall effectiveness of delivery. Practices that understood the purpose of CFAK and viewed it as a supportive service rather than an additional burden were often more willing to facilitate delivery and identify opportunities to improve patient engagement.

## Selecting Practices for CFAK Delivery

In Lancashire, practices are initially prioritised using bowel screening uptake data, with particular attention given to practices serving populations experiencing lower participation in bowel screening. Practices may therefore be selected based on:

- Low bowel screening uptake.
- High levels of socioeconomic deprivation.
- Large populations from underserved communities.
- Population groups known to experience lower screening participation.
- Local commissioning priorities.
- Existing relationships and readiness to implement CFAK.

Organisations implementing CFAK may wish to use local screening data, health inequalities data, and practice-level intelligence to prioritise locations where the intervention has the greatest potential to reduce inequalities.

## Engaging Practices

Initial engagement should aim to establish a shared understanding of the purpose of CFAK, its evidence base, the anticipated benefits for patients, and the practical requirements for implementation.

Experience from CFAK suggests that engagement is often most successful when supported by:

- Early conversations with practice managers and clinical leads.
- Clear explanations of roles and responsibilities.
- Provision of practical resources and implementation materials.

- Regular communication throughout implementation.
- Demonstrating local impact and outcomes.
- Identifying practice champions who can support delivery.

Several stakeholders highlighted the importance of having a trusted contact within each practice who understands the programme and could help resolve operational issues quickly. In many settings, practice managers play a particularly important role in facilitating clinic delivery, room availability, patient communications, and access to systems.

## Practice Set-Up and Preparation

Once a practice agrees to participate, a structured set-up process should be completed before patient-facing activities begin. Experience from CFAK delivery suggests that investing time in preparation helps minimise implementation challenges and supports smoother clinic delivery.

Key activities during practice set-up may include:

- Identifying a named practice contact or local champion to support communication and coordination.
- Reviewing local bowel screening uptake data and population characteristics.
- Discussing language, accessibility, and reasonable adjustment requirements within the practice population.
- Agreeing clinic dates, room availability, and delivery models.
- Establishing patient communication processes, including text messaging and self-booking systems.
- Confirming arrangements for identifying eligible non-responders.
- Establishing information governance and data sharing procedures.
- Arranging access to EMIS and other required digital systems.
- Clarifying responsibilities for outcome monitoring and follow-up data collection.

Operational arrangements relating to patient communications, appointment systems, digital access, information governance, and clinic delivery should be agreed locally during the set-up phase and reviewed periodically throughout implementation.

## Information Governance and Data Sharing

Information governance arrangements should be agreed before any patient-identifiable data are shared or accessed. The CFAK model operates within established information governance frameworks and treats bowel screening support as a direct care activity. Before implementation begins, organisations should ensure that:

- Appropriate data sharing arrangements are in place.
- Confidentiality agreements are completed.
- Staff have completed relevant information governance training.
- EMIS and other system access is authorised.

- Secure methods of data transfer are agreed.
- Patients are informed that they may be contacted by the CFAK team and are provided with an opportunity to opt out.

In Lancashire, GP practices notify eligible non-responders that they may be contacted by the CFAK team and are responsible for ensuring that individuals who opt out are removed from lists provided to the service.

## Supporting Long-Term Relationships

Maintaining positive relationships with practices is important for sustaining delivery over time. Interview findings suggested that practices were more likely to remain engaged when they received regular feedback about outcomes and could see the value that CFAK was providing to their patients.

Organisations may therefore wish to:

- Share practice-level outcomes and impact reports.
- Provide feedback on screening participation improvements.
- Recognise and celebrate successful partnerships.
- Maintain regular contact between clinic cycles.
- Involve practices in service development and improvement activities.
- Respond flexibly to changes in practice capacity and operational pressures.

### *Implementation Consideration*

Strong relationships with GP practices should be viewed as a core component of CFAK rather than an administrative prerequisite. Implementation experience consistently suggests that investing time in practice engagement, communication, and relationship building can significantly improve the feasibility, acceptability, and sustainability of CFAK delivery.

## 4.4 Identifying and Recruiting Eligible Patients

Once eligible individuals have been identified, the next stage is to establish initial contact and offer participation in the CFAK service. The primary purpose of this stage is to engage non-responders and arrange a consultation with a Health Promotion Officer (HPO), where personalised support can be provided to address barriers to bowel screening participation.

### Confirming Eligibility Prior to Contact

Before contacting an individual, HPOs should review relevant electronic health records to confirm eligibility for both bowel screening and CFAK participation.

This review may identify individuals who should not be contacted, including those who:

- Have opted out of the NHS Bowel Cancer Screening Programme.

- Have opted out of CFAK or declined further contact.
- Have a clinical condition or circumstance that makes bowel screening inappropriate or unnecessary.
- Have recently completed screening or are already receiving relevant follow-up care.
- Are recorded as deceased, no longer registered with the practice, or otherwise ineligible.

Undertaking this final eligibility check helps ensure that CFAK resources are directed towards appropriate individuals and reduces the risk of contacting patients who should not be approached.

## Approaches to Initial Contact

Within the Lancashire CFAK model, two approaches are currently used to invite eligible individuals to participate:

### Direct Telephone Contact

An HPO telephones the individual directly to:

- Introduce the CFAK service and explain its purpose.
- Confirm the individual's identity and willingness to engage with the service.
- Answer brief questions about the service.
- Offer and arrange a consultation with an HPO.

Where an individual agrees to participate, a consultation is scheduled according to their preferences and availability (see 'Selecting the Most Appropriate Consultation Mode').

### Self-Booking Invitations

Alternatively, GP practices may send eligible individuals a text message containing a self-booking link (for example, using Accurx or an equivalent communication platform).

This approach enables individuals to:

- Read information about the CFAK service.
- Book a consultation at a convenient time.
- Access support without requiring an initial telephone conversation.

Self-booking systems may help reduce administrative burden and provide a flexible route into the service for individuals who prefer to arrange appointments independently.

Supplementary Material 4.1 contains the findings from the self-booking text message pilot.

### *Implementation Consideration: Self-Booking Systems*

Self-booking links can increase flexibility and reduce the administrative burden associated with appointment scheduling. However, interviewees reported that some booking systems provide limited visibility of appointment cancellations. Where HPOs are unable to identify which individuals have cancelled appointments, opportunities to re-contact and rebook these individuals may be lost. When implementing self-booking pathways, services should consider how cancellation information will be shared and how non-attenders can be re-engaged where appropriate.

## **Purpose of the Initial Contact**

Regardless of the method used, the initial contact is intended to:

- Introduce and promote the CFAK service
- Encourage engagement among bowel screening non-responders
- Provide an opportunity to answer immediate questions about participation
- Identify any communication or accessibility requirements
- Arrange a consultation with a Health Promotion Officer

The initial contact primarily serves as a gateway to further support and consultation.

However, meaningful patient navigation may begin during this first conversation. Face-to-face consultations should continue to be offered and encouraged wherever feasible, given their potential to provide more tailored support and address barriers in greater depth.

Nevertheless, some individuals may receive sufficient information, reassurance, or support during the initial telephone call and not require a further appointment.

### *Implementation Consideration*

While some individuals may request information or support during the initial contact, the primary objective should remain facilitating engagement and arranging a consultation.

Some HPOs reported that providing substantial support during the recruitment stage may reduce the perceived need for a subsequent consultation. However, other explanations are also possible, including changing preferences for remote healthcare interactions, practical barriers to attending appointments, or reluctance to engage further with bowel screening.

## 4.5 Delivering CFAK Consultations

Once an individual has agreed to participate, the consultation provides the core opportunity for Health Promotion Officers (HPOs) to explore barriers to bowel cancer screening, provide personalised support, and encourage informed participation in the NHS Bowel Cancer Screening Programme.

Consultations should be delivered in a manner that is person-centred, supportive, and responsive to the individual's needs, concerns, and circumstances. Although the content of consultations may vary, the overall aim is to increase understanding of bowel screening, address barriers to participation, and support individuals to make an informed decision about completing a FIT kit.

### Selecting the Most Appropriate Consultation Mode

CFAK consultations may be delivered face-to-face, by telephone, or by video consultation. The most appropriate mode should be determined in partnership with the individual and guided by:

- Patient preference.
- Communication and support needs.
- Complexity of concerns or barriers to screening.
- Availability of language or accessibility support.
- Practical considerations, including travel requirements, caring responsibilities, work commitments, and health status.
- Local service capacity and resources.

Offering multiple consultation formats can help maximise accessibility while maintaining flexibility for individuals with differing needs and circumstances.

### Face-to-Face Consultations

Face-to-face consultations have historically been the primary mode of delivery within CFAK and remain an important component of the intervention.

Potential advantages include:

- Allowing more in-depth discussion.
- Supporting trust-building and rapport development
- Facilitating communication where literacy, language, or health literacy barriers exist
- Enabling HPOs to provide tailored support for more complex concerns
- Allowing demonstration of the FIT kit where appropriate
- Providing opportunities for real-time clarification and reassurance

Patient experience interviews highlighted the value of face-to-face interaction, particularly for individuals requiring detailed explanations or reassurance. Participants described being able to ask questions, clarify misunderstandings, and receive support that they felt would not have been possible through written information alone. Evaluation findings also suggest

that face-to-face consultations are associated with higher FIT completion rates than telephone consultations.

## Telephone Consultations

Telephone consultations are increasingly used within CFAK and maybe appropriate for many individuals.

Potential advantaged include:

- Improving convenience and accessibility
- Reduced travel requirements
- Greater flexibility for individuals with work or caring commitments
- Increased privacy for some participants
- Reduced demand on clinical and administrative resources

Telephone may be particularly suitable for individuals who require less intensive support or who are unable to attend a face-to-face appointment. In Lancashire, HPOs highlighted that telephone consultations are becoming increasingly acceptable to participants, reflecting wider changes in healthcare delivery and growing familiarity with remote interactions.

## Video Consultations

Video consultations provide an alternative approach that may combine some benefits of both face-to-face and telephone support.

Potential advantages include:

- Greater flexibility for individuals who cannot attend in person.
- Opportunities for visual interaction and relationship building.
- The ability to demonstrate the FIT kit remotely.
- Improved access for individuals living in rural or geographically dispersed areas.

A pilot conducted in South Cumbria demonstrated that video consultations were feasible within CFAK and were well received by many participants. Informal feedback suggested that remote appointments were particularly valued by working adults who found attendance during normal surgery hours difficult (See Supplementary Material 4.2). However, implementation challenges were identified, including technical difficulties, variable GP practice readiness, and the need to establish appropriate systems and processes for remote delivery. Where video consultations could not be completed successfully, telephone consultations were often used as an alternative.

### Key Practice Point

No single consultation mode will be appropriate for all individuals. Services should aim to offer a range of delivery options that balance accessibility, patient preference, and effectiveness.

### **Implementation Consideration: Changes in Consultation Preferences**

Several HPOs reported that it has become increasingly difficult to encourage individuals to attend face-to-face consultations, with many expressing a preference for telephone-based support. Evaluation findings indicated that individuals who received face-to-face consultations were more likely to complete and return their FIT than those receiving telephone support. However, HPOs also reflected that meaningful support can often be delivered during the initial telephone call, and some individuals may feel that a further appointment is unnecessary once their questions have been addressed. Services should therefore continue to promote face-to-face consultations where appropriate while ensuring that support remains flexible, person-centred, and responsive to individual circumstances. Services should consider monitoring consultation uptake, attendance, and FIT completion across different delivery modes to better understand local preferences and optimise delivery.

## **Extending Access Through Flexible Scheduling**

In addition to offering a range of consultation formats, services may wish to consider providing appointments outside standard working hours. Evidence from the Lancashire CFAK pilot suggested that evening appointments improved engagement among working-age adults who might otherwise find it difficult to attend appointments during the day (See Supplementary Materials 4.3 for more details). Patient feedback indicated that extended hours increased flexibility and improved access to screening information and support.

When planning service delivery, consideration should therefore be given to:

- Evening clinics.
- Early morning appointments.
- Flexible scheduling approaches that reflect local population needs.
- Appointment times that accommodate employment and caring responsibilities.

Providing flexibility in both consultation mode and appointment timing may increase engagement among groups who traditionally experience barriers to accessing preventive healthcare services.

## **4.6 Core Components of the CFAK Consultation**

CFAK consultations are designed to identify and address the factors that contributed to previous non-participation in bowel cancer screening. While consultations should be tailored to individual circumstances, they typically follow a common process of identifying barriers, providing targeted support, and facilitating informed participation in screening. The consultation should be delivered in a supportive, non-judgemental manner that promotes trust, encourages open discussion, and enables individuals to raise concerns or ask questions about bowel cancer screening.

## Building Rapport and Understanding Individual Needs

The consultation should begin with establishing rapport and creating an environment in which individuals feel comfortable discussing their experiences, concerns, and reasons for not completing previous screening invitations.

Health Promotion Officers should seek to understand:

- Previous experiences of bowel screening.
- Existing knowledge and understanding of screening.
- Current attitudes towards bowel cancer screening.
- Individual circumstances that may affect participation.
- Communication, language, cultural, or accessibility needs.

Understanding the individual's circumstances enables support to be tailored to the barriers they are experiencing.

## Identifying Barriers to Screening Participation

A central aim of the CFAK consultation is to identify and address the factors that contributed to previous non-participation in bowel cancer screening. Barriers should be explored through open discussion rather than assumptions, recognising that individuals may experience multiple and interacting challenges.

As discussed in Section 2.1, common barriers include practical challenges completing the FIT kit, competing life priorities, limited understanding of bowel screening, communication difficulties, and emotional concerns such as fear or avoidance of cancer-related information. HPOs should avoid assuming which barriers are present and instead seek to understand each individual's circumstances through supportive and person-centred discussion. Effective consultations should focus on identifying modifiable barriers, providing tailored support, and enabling informed decision-making.

## Providing Tailored Support

Following assessment of barriers, HPOs should provide personalised support based on individual needs (see Table 5).

**Table 5.** Examples of Support Based on Barriers

| Identified Barrier                                           | Potential Support                                                                                                          |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| Limited awareness or understanding                           | Personalised education about bowel cancer and screening                                                                    |
| Difficulties understanding FIT instructions                  | Demonstration of FIT completion, instructional videos, visual aids, and opportunities to ask questions                     |
| Language or cultural barriers                                | Communication in the individual's preferred language and culturally appropriate information                                |
| Practical difficulties completing or returning the FIT kit   | Problem-solving, discussion of practical solutions, and support with kit return processes                                  |
| Missing or expired FIT kit                                   | Arranging a replacement FIT kit                                                                                            |
| Competing life priorities or forgetting to complete the test | Collaborative action planning, prompts, reminders, and discussion of how screening can be incorporated into daily routines |
| Concerns about access to screening services                  | Liaison with relevant screening services where appropriate                                                                 |
| Fear, anxiety, or embarrassment                              | Reassurance, emotional support, and opportunities to discuss concerns and potential outcomes                               |

Support should focus on addressing the specific barriers identified by the individual rather than providing generic information alone. By combining personalised discussion, practical problem-solving, and emotional support, consultations can increase individuals' capability, opportunity, and motivation to participate in bowel cancer screening.

## Supporting FIT Kit Completion

Where a lack of confidence or understanding regarding FIT completion is identified, HPOs should provide clear, practical guidance on how to complete and return the kit.

Patient experience interviews indicated that personalised explanations and opportunities to ask questions helped dispel misconceptions about bowel screening and increased confidence in completing the kit. Participants frequently described the FIT kit as easier to use than they had originally anticipated once the process had been explained.

HPOs reported using a range of approaches to support understanding and confidence in FIT completion, including:

- Demonstrating the FIT kit using a sample kit.

- Using patient information leaflets, visual materials, or storyboards to explain the screening process.
- Showing instructional videos demonstrating correct FIT completion.
- Talking through the kit instructions step-by-step and answering questions.
- Discussing common mistakes and practical tips for completing and returning the kit.

The specific approach used may vary according to the consultation format, available resources, and the individual's information and support needs.

#### **Implementation Recommendation: Supporting FIT Completion**

Services should ensure that consultations should include a clear explanation of how to complete and return the FIT kit, together with an opportunity for individuals to ask questions and discuss concerns. HPOs may use a range of approaches to support understanding, including demonstration kits, patient information materials, visual aids, storyboards, instructional videos, and personalised discussion. The specific approach should be tailored to the consultation format, available resources, and individual needs.

### **Supporting Informed Decision-Making**

CFAK is intended to support informed choice rather than encourage participation through persuasion. Individuals should be given sufficient information to understand the purpose, benefits, and limitations of bowel screening and to make decisions that reflect their preferences and values.

Where an individual wishes to proceed, a replacement FIT kit should be ordered and appropriate next steps agreed.

### **Intended Mechanisms of Change**

The consultation seeks to improve screening participation through three interconnected mechanisms:

- **Capability** by increasing knowledge, understanding, and confidence.
- **Opportunity** by reducing practical barriers and improving access to screening.
- **Motivation** by addressing concerns, providing reassurance, and increasing confidence in screening.

By enhancing capability, opportunity, and motivation, CFAK aims to increase FIT kit ordering and completion among previous non-responders, ultimately improving screening uptake and helping to reduce inequalities in bowel cancer screening participation.

### Practice Point

Effective CFAK consultations do more than provide information. The consultation should help individuals understand their personal barriers to screening and provide tailored support that addresses those barriers. The combination of personalised discussion, practical problem-solving, and relationship-building appears to be a key mechanism through which CFAK supports participation among previous non-responders.

## 4.7 Tailoring Delivery for Different Communities

A core principle of CFAK is that support should be tailored to the needs, preferences, and circumstances of the individual. While the overall aims of the consultation remain consistent, the approach used by HPOs may need to be adapted to address language, cultural, cognitive, communication, or accessibility needs. Tailoring support can help improve understanding, increase engagement, and ensure that individuals are able to make informed decisions about bowel cancer screening.

### Language support

Language barriers may limit understanding of bowel cancer screening information and reduce confidence in completing the FIT kit. HPOs should identify language needs during initial contact and arrange appropriate support where required.

Potential approaches include:

- Using professional interpreters.
- Delivering consultations in the individual's preferred language where possible.
- Using translated written materials or resources.
- Allowing additional time for discussion and clarification.
- Checking understanding throughout the consultation.

Within the Lancashire CFAK model, several HPOs speak languages commonly used within the local communities they serve. Where possible, individuals may be offered support from an HPO who can communicate in their preferred language. HPOs reported that sharing a common language can facilitate communication, reduce misunderstandings, and increase confidence in discussing bowel screening concerns and questions.

Patient feedback highlighted the value of receiving information in a familiar language and being able to discuss questions directly with someone who understood their communication needs.

### Cultural adaptation

Individuals may hold differing beliefs, experiences, and attitudes towards cancer, prevention, and healthcare. HPOs should avoid assumptions and seek to understand each person's individual perspective.

Culturally responsive approaches may include:

- Exploring beliefs and concerns about bowel cancer and screening.
- Using culturally appropriate examples and explanations.
- Recognising varying levels of familiarity with cancer screening programmes.
- Involving family members or trusted supporters where appropriate and with the individual's consent.
- Ensuring communication is respectful, inclusive, and non-judgemental.

In the Lancashire CFAK model, HPO deployment is informed, where possible, by knowledge of the communities being served. HPOs who share cultural backgrounds, languages, or familiarity with local communities may be particularly well placed to recognise cultural influences on screening behaviour, understand community-specific concerns, and adapt communication accordingly.

To support culturally competent delivery, CFAK has also developed cultural competence training for HPOs and other healthcare professionals. This includes visits to local community venues and community organisations, enabling staff to learn directly from local communities about cultural practices, beliefs, and experiences that may influence screening participation.

Evaluation findings suggest that CFAK can be particularly effective among some ethnic minority communities, highlighting the potential value of culturally sensitive and personalised support.

#### **Implementation Recommendation: Developing Cultural Competence**

Services should consider investing in cultural competence development as part of CFAK implementation. Opportunities to engage directly with local communities, community leaders, and community organisations may help staff better understand local contexts and tailor support in ways that are acceptable, relevant, and responsive to population needs.

## **Supporting People with Learning disabilities**

People with learning disabilities may experience barriers to bowel cancer screening that differ from those encountered by the wider population. These can include difficulties understanding written materials, limited awareness of screening, challenges following FIT kit instructions, anxiety about healthcare procedures, and reliance on carers, family members, or support workers for healthcare decision-making and practical support. Screening invitations and standard written materials may therefore be insufficient to support informed participation.

Consultations should therefore be adapted to meet individual communication and support needs. Potential approaches may include:

- Using clear, simple, and accessible language.

- Breaking information into smaller sections and checking understanding throughout the discussion.
- Allowing additional time for consultations and follow-up support.
- Using visual aids, demonstration kits, storyboards, or easy-read materials, or videos to support understanding.
- Providing opportunities for individuals to ask questions and discuss concerns at their own pace.
- Involving carers, family members, or support workers where appropriate and with the individual's consent.
- Supporting practical aspects of screening participation, including FIT kit completion and return where required.

## Example of Local Adaptation

Within Lancashire and South Cumbria, CFAK was adapted specifically for adults with learning disabilities through a partnership with the Learning Disability Health Facilitation Team. Rather than being delivered by the core CFAK Health Promotion Officer workforce, the adapted model was delivered by Learning Disability Nurses with expertise in accessible communication and supporting people with additional needs.

The adaptation included tailored communication approaches, accessible educational materials, longer and more flexible appointments, and involvement of carers and support networks where appropriate. The service was designed to provide additional support throughout the screening process, helping individuals understand bowel screening, make informed decisions, and overcome practical barriers to participation.

This adaptation demonstrates how CFAK can be modified to meet the needs of specific populations while retaining its core principles of patient navigation, personalised support, and informed choice. It also highlights the value of working with practitioners who already have established relationships, specialist skills, and knowledge of the communities being supported.

### Implementation Consideration

Services should consider whether existing specialist teams, such as Learning Disability Nurses, learning disability health facilitation teams, community learning disability services, or other specialist practitioners, could support the adaptation and delivery of CFAK for people with learning disabilities. Co-designing local adaptations with people with learning disabilities, carers, advocacy organisations, and specialist services may help ensure that screening support is accessible, acceptable, and responsive to local needs.

**Practice Point**

People with learning disabilities are not a homogeneous group and support requirements will vary considerably between individuals. The aim should not be to deliver a standardised consultation differently, but to tailor communication, information, and practical support to the individual's needs while preserving informed choice and respecting personal preferences.

**Accessibility and Additional Support Needs**

Some individuals may experience barriers related to physical disabilities, sensory impairments, mental health conditions, long-term illnesses, or other accessibility needs.

Support may include:

- Offering consultations through alternative delivery modes.
- Providing accessible information formats.
- Arranging interpreter or communication support services.
- Allowing flexibility in appointment timing and duration.
- Exploring practical barriers to completing or returning the FIT kit.
- Identifying reasonable adjustments that may support participation.

The consultation should focus on understanding the individual's specific needs and identifying practical solutions that make participation in screening as accessible as possible.

**Practice Point**

Tailoring delivery is not limited to language translation or accessibility adjustments. Effective CFAK consultations recognise that individuals may experience different combinations of practical, emotional, cultural, and communication barriers. Understanding these needs and adapting support accordingly is a key mechanism through which CFAK seeks to reduce inequalities in bowel cancer screening participation.

**4.8 Community Engagement and Outreach**

Community engagement has been a core component of the CFAK model since its inception. The approach was informed by both practical experience and evaluation findings which indicated that approximately half of eligible non-responders could not be reached through direct telephone contact alone. This highlighted the need for additional approaches to raise awareness of bowel cancer screening and engage communities beyond traditional healthcare settings.

The founders of CFAK recognised that many individuals who experience barriers to bowel cancer screening are also less likely to engage with traditional healthcare services. Consequently, CFAK adopted a community-based approach that seeks to take screening awareness and engagement activities into the environments where people live, work, socialise, and access support.

Community engagement activities aim to:

- Increase awareness of the NHS Bowel Cancer Screening Programme among communities with limited prior knowledge of screening.
- Improve understanding of the purpose and benefits of screening.
- Address misconceptions and concerns about FIT completion.
- Build trust and credibility through local engagement.
- Increase awareness of CFAK clinics and referral opportunities.
- Reach population groups who may be underserved by traditional healthcare services.

## Community Outreach Approaches

Community engagement may be delivered through a range of activities, including:

- Community events and health fairs.
- Workplace health promotion activities.
- GP practice and hospital engagement events.
- Faith and cultural community events.
- Women's health initiatives.
- Carers' groups and support organisations.
- Community venues serving underserved populations.
- Interactive educational resources and demonstrations, including the Inflatable Bowel.

The Inflatable Bowel has been used extensively within the Lancashire CFAK programme as an interactive educational resource. By providing a visual and engaging way of discussing bowel health, bowel cancer detection, screening, and early detection, it can help initiate conversations that may otherwise feel difficult or uncomfortable. The resource is used at community events and engagement activities to support public education and awareness raising about bowel cancer screening.

Delivering activities in familiar and accessible settings can provide opportunities for informal conversations about bowel screening and may help engage individuals who would not ordinarily attend healthcare-based events.

## Working with Community Partners

Community engagement activities are often delivered in partnership with local organisations, charities, employers, faith groups, community leaders, and voluntary sector organisations. These partnerships can help CFAK identify opportunities for engagement, improve access to communities experiencing lower screening uptake, and enhance the credibility and acceptability of outreach activities.

Developing relationships with trusted community organisations may be particularly important when working with underserved populations or communities that have historically experienced barriers to accessing healthcare services.

## **Example: Cancer Champions Volunteer Programme**

One approach used within Lancashire and South Cumbria has been the development of a network of trained Bowel Cancer Champions. During 2024/25, volunteers worked alongside NHS organisations, local authorities, employers, and voluntary and community sector organisations to deliver awareness-raising activities across the region.

Activities reached 1,194 members of the public and supported delivery across community settings, workplaces, faith groups, and public engagement events. The programme also enabled Health Promotion Officers to focus more of their time on direct clinic delivery while expanding the reach of awareness activities.

The programme demonstrates how trained volunteers can complement the work of HPOs by extending the reach of awareness-raising activities and supporting engagement within local communities. Volunteer-led approaches may be particularly valuable where workforce capacity limits the ability of HPOs to undertake extensive outreach activities. More detailed information can be found in Supplementary Material 4.4.

## **Digital Awareness Campaigns**

In addition to face-to-face community engagement activities, CFAK has explored the use of digital awareness campaigns to raise awareness of bowel cancer screening and direct individuals to screening information. One social media campaign reached over 827,000 individuals and generated more than 13,000 visits to the bowel screening website. While the campaign increased awareness and website traffic, there was limited evidence that differences in message framing or imagery substantially influenced deeper engagement. These findings suggest that digital campaigns may complement community outreach activities by increasing awareness and directing individuals to information, but should not be viewed as a replacement for personalised patient navigation support.

### ***Implementation Consideration***

Community engagement should be viewed as a complementary component of CFAK rather than a standalone intervention. While clinic consultations remain central to addressing individual barriers to screening participation, outreach activities can increase awareness, build trust, and create opportunities for engagement among individuals who may be unlikely to respond to conventional recruitment approaches.

Services implementing CFAK should consider how community engagement activities can support clinic recruitment, particularly within communities experiencing lower screening uptake and wider health inequalities. See Supplementary Material 4.5 for more information

on the social media campaign and 4.6 for example promotional material used in community outreach activities.



# Section 5

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## Monitoring, Evaluation and Service Improvement

## Section 5: Monitoring, Evaluation and Service Improvement

Monitoring, evaluation and continuous service improvement are essential components of the CFAK model. While the programme is underpinned by evidence demonstrating its effectiveness in increasing bowel screening participation among individuals who have not responded to routine invitations, ongoing monitoring and evaluation are needed to understand how the intervention performs in different contexts, identify emerging challenges, and inform service adaptations over time.

The experience of delivering CFAK in Lancashire illustrates the value of embedding evaluation within routine service delivery. Quantitative monitoring has provided evidence on intervention outcomes and highlighted factors associated with successful engagement and FIT completion. Qualitative research with participants and Health Promotion Officers (HPOs) has generated insights into patient experiences, barriers to participation, consultation delivery, and implementation challenges. Together, these findings have informed refinements to consultation delivery, community engagement activities, workforce development, approaches to reaching underserved populations, and adaptations designed to improve accessibility and responsiveness.

Monitoring and evaluation have also enabled the programme to respond to wider changes in the bowel screening landscape. As the age of eligibility for bowel screening has been reduced, the characteristics and needs of the target population have evolved. Evaluation activities have helped inform discussions about whether existing delivery approaches remain appropriate for younger, working-age populations and what adaptations may be needed to ensure the intervention continues to engage and support all eligible individuals.

Importantly, monitoring should not be viewed solely as a way of measuring activity or performance. Consistent with the person-centred principles that underpin CFAK, monitoring should also seek to understand patient experiences, barriers to participation, staff experiences, and the changing needs of local populations. Understanding how, why and for whom the intervention works is as important as measuring whether it works.

As CFAK is implemented in new settings, monitoring, evaluation and service improvement should be viewed as integral components of delivery. Collecting and using data on programme performance can support quality improvement, help services respond to local needs, reduce inequalities, and ensure that the intervention continues to achieve its intended outcomes.

## 5.1 Monitoring Programme Delivery

Routine monitoring is essential for ensuring that CFAK is delivered as intended and continues to meet the needs of the populations it serves. Monitoring provides services with timely information on programme activity, reach, participant needs, and outcomes, supporting quality assurance and continuous improvement. While formal evaluation assesses the effectiveness and impact of the intervention, monitoring focuses on the ongoing collection and review of data to support day-to-day programme management and decision-making.

For CFAK, monitoring should be embedded throughout the participant pathway, from the identification of eligible non-responders through to FIT kit completion and progression through the bowel screening pathway.

### Core Areas for Monitoring

Services implementing CFAK should consider collecting information across four broad areas:

#### Programme Reach and Activity

Monitoring programme activity can help assess whether the intervention is reaching the intended population and progressing as planned. Services may wish to monitor:

- Number of eligible non-responders identified
- Number and proportion successfully contacted
- Method of initial contact
- Outcomes of contact attempts
- Number of consultations offered, booked, attended, cancelled, or rebooked
- Consultation delivery mode (face-to-face, telephone, video)
- FIT kits ordered following consultation

#### Patient Characteristics and Equity of Access

Monitoring demographic and accessibility information can help identify variations in engagement and outcomes across different population groups and support efforts to reduce inequalities in bowel screening participation. Relevant information may include:

- Age
- Sex
- Ethnicity
- Geographical area
- Disability status
- Sensory impairments
- Language spoken
- Need for interpretation or communication support.
- Other accessibility requirements.

## Barriers to Screening and Support Needs

A key feature of CFAK is identifying and responding to the barriers that prevent individuals from participating in bowel screening. Recording barriers routinely can provide valuable insight into the needs of the local population and inform future service development.

Examples include:

- Reasons for previous non-completion of a FIT kit
- Reasons for declining CFAK participation
- Practical barriers such as work commitments, caring responsibilities, or transport difficulties
- Limited knowledge or understanding of bowel screening
- Concerns about FIT kit completion
- Fear of results or further investigations
- Cultural, language, communication, or accessibility barriers
- Other barriers identified during consultations and recorded in HPO notes.

## Outcomes

Services should monitor whether participants progress through the bowel screening pathway following CFAK support. Potential indicators include:

- FIT kit completion and return
- Test kit results
- Colonoscopy outcomes, where available
- Patient progression through the bowel screening pathway following CFAK support
- Informed decisions to decline bowel screening following engagement with CFAK

Consistent with the principle of informed choice, an informed decision to decline bowel screening should be recognised and recorded as a valid outcome of CFAK support. The purpose of the intervention is to support informed decision-making rather than to persuade participation. Monitoring systems should therefore distinguish between individuals who remain disengaged from the programme and those who actively decide not to participate following discussion with a Health Promotion Officer.

### *Implementation Recommendation*

Services should use monitoring data not only to measure programme activity and outcomes, but also to understand who is being reached, who is not engaging, and the barriers preventing participation in bowel screening. Regular review of monitoring data can help identify emerging needs, inform service development, and ensure that CFAK remains responsive to changing populations and local priorities.

## 5.2 Data Collection

### Why collect data?

Data is collected to allow for both individual-level care and programme-level improvement. At the individual patient level, data collection helps HPOs understand participants' needs, preferences and circumstances. Information such as language requirements, disability status, accessibility needs, and reasons for declining participation can support person-centred care and help ensure appropriate adjustments are identified and provided. At the programme level, monitoring data allows services to assess implementation, effectiveness, equity, and fidelity. Information on engagement rates, consultation attendance, FIT kit requests and kit returns can be used to evaluate programme outcomes, identify variations between practices or population groups, and support local and national reporting requirements.

### Balancing Data Collection and Patient-Centred Delivery

During interviews, HPOs highlighted the importance of balancing data collection with meaningful patient engagement. Some staff reported that extensive data entry requirements could reduce time available for discussion, relationship-building and responding to individual concerns.

CFAK is fundamentally a patient-centred intervention and data collection should support, rather than detract from, the consultation process. Services should therefore aim to collect data that are meaningful, actionable and proportionate to the needs of programme monitoring and evaluation.

### Building Understanding Among Staff

Training should include not only how data should be collected, but also why data collection is important. Understanding how monitoring data contribute to service improvement, equity monitoring, evaluation and future commissioning decisions can help improve engagement with data collection processes and support data quality.

Staff should understand how the information they record contributes to:

- Improving patient care
- Understanding barriers to screening
- Monitoring inequalities
- Demonstrating programme impact
- Informing service development
- Supporting future funding and sustainability

## Improving the Efficiency of Data Collection

Experience from Lancashire has highlighted opportunities to streamline data collection processes. Future developments may include enhanced digital systems, automated data population, and improved integration between datasets to reduce duplication and administrative burden.

Reducing unnecessary data entry can maximise the time available for patient contact while maintaining the quality of monitoring and evaluation data. Opportunities to further develop digital infrastructure are currently being explored as part of ongoing service development.

### 5.3 Master Sheet Guidance

The CFAK Master Sheet serves as the primary tool for recording programme activity and participant information. It provides a structured approach to monitoring participant progress through the intervention and supports local performance monitoring, service evaluation and reporting requirements. Detailed guidance on completion of the Master Sheet is provided in Section 6.

Services should ensure that:

- Data are entered consistently
- Required fields are completed
- Definitions are applied uniformly
- Information is entered promptly following participant contact
- Data quality checks are conducted regularly

Regular training and refresher sessions may help maintain consistency and support high-quality data collection.

### 5.4 Monitoring Performance

Routine performance monitoring helps services assess whether CFAK is being delivered effectively and achieving its intended outcomes. Services should identify a set of key performance indicators (KPIs) that are reviewed regularly. Services may wish to monitor:

#### Reach Indicators

- Number of eligible non-responders identified
- Number successfully contacted
- Call answer rate
- Consultation booking rate
- Consultation attendance rate

## Screening Indicators

- Number of replacement FIT kits requested
- FIT kit return rate
- Positive FIT results
- Progression through follow-on investigations where data are available

## Process Indicators

- Consultation delivery mode
- Time from contact to consultation
- Barriers identified during consultations
- Data completeness and quality

## Patient Experience

Patient experience should be considered a core outcome of CFAK rather than an optional addition. A patient feedback survey has been developed for use following consultation and is provided in Supplementary Material 5.1.

Areas for exploration may include:

- Feeling listened to and respected
- Understanding of bowel screening following the consultation
- Confidence in completing a FIT kit
- Ability to make an informed decision
- Satisfaction with the consultation

Patient feedback can provide valuable insights into how the intervention is experienced and identify opportunities for service improvement.

## Fidelity Monitoring

To ensure that local adaptations do not alter the core components of CFAK, services should periodically review whether:

- ✓ Informed decision-making remains central to consultations
- ✓ Key consultation topics are consistently discussed
- ✓ Consultations are documented appropriately
- ✓ Data are entered consistently and accurately
- ✓ Recommended consultation processes are being followed

## Reflective Question

*Are staff adapting delivery appropriately to local needs, or is delivery beginning to drift from the core CFAK model?*

## 5.5 Evidencing Impact

Monitoring and evaluation data can be used to demonstrate the effectiveness, reach and equity of CFAK delivery.

### Effectiveness Outcomes

The primary effectiveness outcome is increased bowel screening participation among people who previously did not respond to routine screening invitations. While increased screening participation remains the primary effectiveness outcome, evidence that individuals have engaged with CFAK and reached an informed decision regarding screening, including a decision to decline participation, should also be considered a meaningful outcome of the intervention.

Secondary outcomes may include:

- Successful contact rates
- Consultation attendance rates
- FIT kit requests
- FIT kit completion and return
- Progression through the screening pathway

### Process Outcomes

Process outcomes are measured using the data fields in the Master Sheet and GP Tracker, including the timing of initial contact, mode of delivery (F2F, video, telephone), types of barriers discussed (e.g. 'Test is too messy,' 'I don't have symptoms and the number of kits ordered with or without consent).

### Health Equity Audits

Reducing inequalities is a central aim of CFAK. Data collected on ethnicity, disability, sensory needs, language requirements and geography can support health equity audits and help services understand whether the intervention is reaching and benefiting priority populations.

Services may wish to explore questions such as:

- Are some groups less likely to answer calls?
- Are some groups less likely to attend consultations?
- Which groups benefit most from different consultation formats?
- Are adaptations reducing or widening inequalities?

## Reporting and Accountability

Monitoring and evaluation findings can be used to:

- Demonstrate impact to commissioners and stakeholders
- Inform service planning and resource allocation
- Support funding applications

- Identify areas requiring improvement
- Share learning across organisations and regions

## 5.6 Continuous Service Improvement

Continuous service improvement should be viewed as an integral part of CFAK delivery. Monitoring data, participant feedback and staff experience can be used to identify opportunities to strengthen the intervention, respond to emerging challenges and adapt delivery to meet changing population needs. Lancashire's experience demonstrates how routine review and evaluation can support the development of new approaches while maintaining the core principles of the CFAK model.

### Examples of Service Improvements

Examples of adaptations informed by evaluation and service learning include:

- Introduction of evening and weekend clinics
- Testing of remote and video consultations
- Development of self-booking pathways
- Community champion initiatives
- Adaptations for people with learning disabilities
- Development of digital monitoring systems and the Master Sheet

## Review Cycles

### Quarterly review

Services may wish to review:

- Activity data
- Outcome data
- Patient feedback
- Staff feedback
- Health equity data

### Annual review

Services should consider:

- What is working well?
- What has changed?
- What barriers have emerged?
- What modifications are needed?

HPO feedback should form an important part of this review process. Staff delivering the intervention are often the first to identify emerging barriers, changing patient preferences and opportunities for improvement.

CFAK should therefore be viewed not as a fixed intervention, but as a learning system that continuously uses data, evidence and experience to improve delivery while remaining

faithful to its core principles of patient-centred support, informed choice and reducing inequalities.



# Section 6

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## Step-by-Step Guide for Health Promotion Officers

## Section 6: Step-by-Step Guide for Health Promotion Officers

### Step by Step Guide

This guide takes you through the Lancashire CFAK process step by step in the advised order – from setting up a GP practice through to checking 12-week outcome data.

At every relevant detailed step, you will see a screenshot of the exact Master Sheet columns to complete, colour matched to the live spreadsheet.

A process flowchart is included which maps out key tasks at each stage, mirroring master sheet colours – use this as a quick reference to quickly identify where you are in the process.



**TOP TIP** boxes highlight practical, experience-based advice



**STOP & CHECK** boxes appear at the end of every step – use them as a quick self-check before moving on.

### Quick Reference

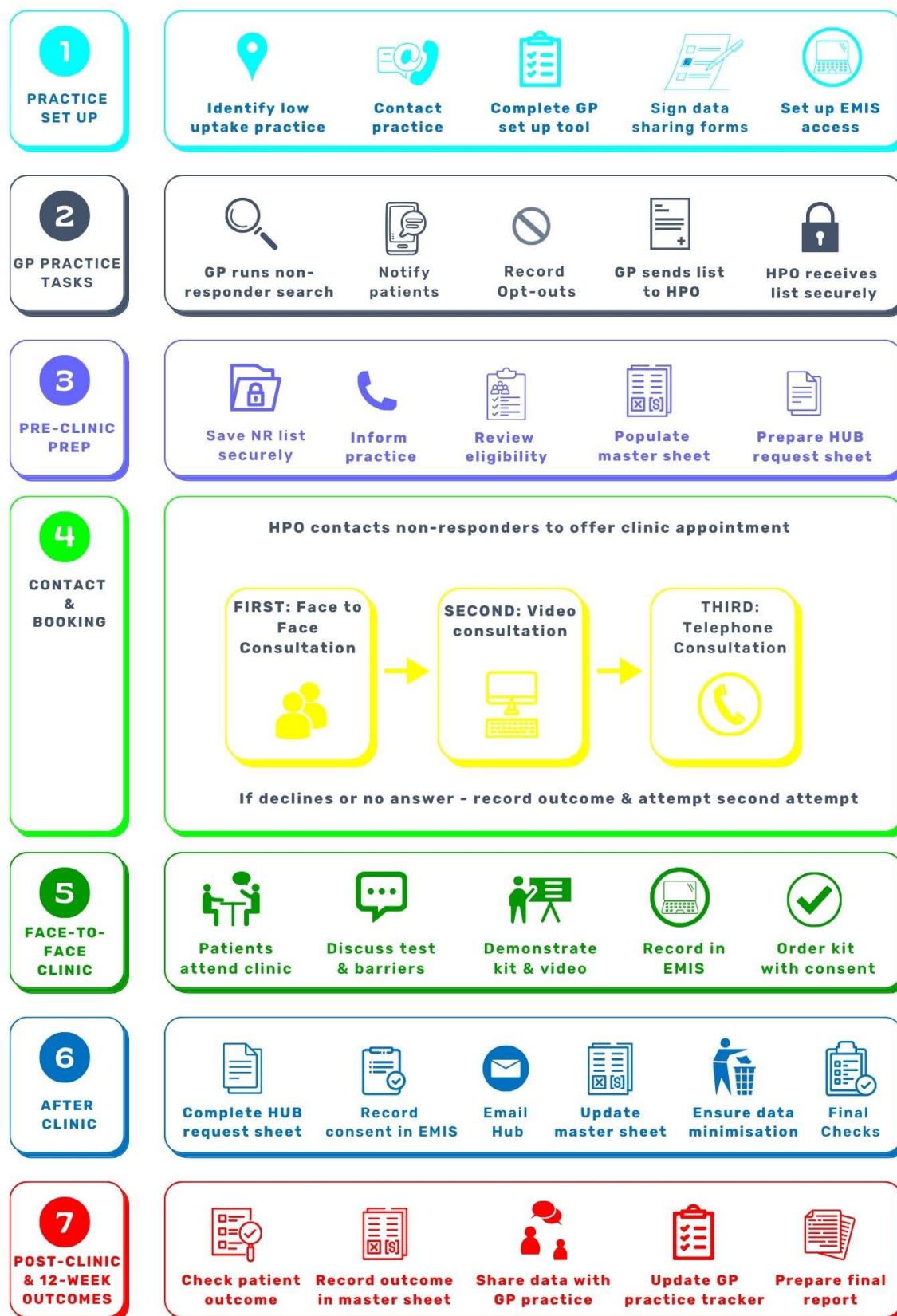
**Navigating this manual:** Use this key to go straight to the step you need.

| Step | What Happens                     | Key                                                     |
|------|----------------------------------|---------------------------------------------------------|
| 1    | Setting up a new GP practice     | Master Sheet <b>cyan</b> columns                        |
| 2    | Tasks completed by GP practice   | Chase practice, confirm NR list received                |
| 3    | Pre-clinic preparation           | Master Sheet <b>darker blue</b> columns                 |
| 4    | Pre-clinic phone calls & booking | Master Sheet <b>yellow</b> & <b>light green</b> columns |
| 5    | Face-to-face clinic processes    | Master Sheet <b>dark green</b> columns, EMIS            |
| 6    | Immediately after clinics        | Master Sheet <b>blue</b> columns, HUB request sheet     |
| 7    | Post-clinic & 12-week outcome    | Master sheet <b>red</b> columns, GP tracker             |

**Master Sheet** colour-coded by stage of the patient journey. This colour key is used throughout this section of the manual – look for the matching coloured square above each screenshot. Supplementary Material 6.1 provides a dictionary for the master data sheet column information.

| Colour | Master Sheet Section                          | Used in    |
|--------|-----------------------------------------------|------------|
|        | Practice & venue details                      | Step 1     |
|        | Patient identifiable & demographic data       | Step 3     |
|        | Initial contact & second contact attempts     | Step 4     |
|        | Delivery mode, language & communication needs | Step 4     |
|        | Clinic attendance & rebooking                 | Step 5     |
|        | Kit ordered with consent                      | Step 5/6   |
|        | HUB kit order & 12-week outcome data          | Step 6/7   |
|        | HPO notes & completed by                      | Throughout |

## CFAK Process Flowchart: Outline of key tasks at each stage



## Step 1: Setting up a new GP practice

This step outlines which GP practices will take part in CFAK clinics for the year ahead, before any patient contact happens. Refer to the GP Set-Up Tool (Supplementary Material 6.2) that guides and records this process.

### 1.1. Identify & allocate low-uptake practices

- The BCSP Strategic Lead identifies low-uptake GP practices using BCSS data
- The low uptake data is shared with the Operational Lead to allocate the GP practices to the Health Promotion Officers (HPOs), starting 1 April each year. Practices are added to the GP tracker with the names HPO for the full April-March cycle.
- The team lead meets with each HPO and discusses their allocated GP practices.

### 1.2. Engage the practice

**Each HPO contacts their own allocated practice using a structured timeline:**

- Initial email sent
- If no response within the same week, follow up with phone call
- If still no engagement by week two, arrange an in-person or Teams meeting to meet the practice manager, discuss the CFAK process and set clinic dates.
- Once agreed, sign the GP practice confidentiality/data sharing forms on the first day of working with that practice.



**TOP TIP:** Keep a log of your email/call/visit dates for each practice – it makes the GP Tracker update quick and gives you evidence of the engagement timeline if a practice is slow to respond.

### 1.3. Complete the GP set-up tool (Supplementary Material 6.2)

The GP Set-Up Tool guides the collection of information needed for planning clinics at each practice. Complete sections you know before contacting the practice; gather the rest in conversation with the key contact. The tool can cover a single practice, a GP collaborative, or a PCN. Review it at the start of each financial year or when clinics restart.

***In conversation with the practice, cover the following:***

- Communication preferences (text, phone, letter) and any known challenges
- Reasonable adjustments needed
- Language requirements
- Mobility issues
- Learning disabilities
- Mental health considerations
- Any tailored engagement approaches the practice already uses that can improve uptake

**Clinic delivery arrangements:**

- Preferred delivery modes: face-to-face, video, telephone, or community-based
- Systems used for contacting patients (AccuRx, iPlato, MJOG, Patches)
- Evening and weekend clinic availability and any associated costs

- Remote EMIS access when practice is not open
- Accessible room availability for face-to-face clinics
- Whether the practice permits CFAK clinics at local pharmacies or community venues
- Ability to send appointment reminders to patients

### **CYAN = Practice & venue details**

Master Sheet columns A-E: Venue, Practice Code, Name of Practice, Postcode, GP Area – **Complete these as soon as a practice is confirmed**

|   | A           | B             | C                | D                  | E       |
|---|-------------|---------------|------------------|--------------------|---------|
| 1 | CFAKC Venue | Practice Code | Name of Practice | Practice Post Code | GP AREA |

#### **1.4. Set up EMIS access**

- Community EMIS access is made available to BCSP/HPO Officers. Smartcard details for the relevant officer will be shared and this information needs to be inputted onto the GP EMIS access system before clinics are arranged - **or** there is an option to log in with an EMIS username & password.
- To use the EMIS system, log in with the specific Username, Password and Organisation ID provided by the practice.
- Once logged in, add key actions like 'Booking an appointment,' 'Consultations,' and 'Patient search' to the quick access bar for efficient navigation.

### **STOP & CHECK – Before moving to Step 2**

*Before you move to the next step, confirm:*

- GP practice confidentiality/data sharing forms are signed
- GP set-up tool is completed and saved (Supplementary Material 6.2)
- Master sheet columns A-E (practice & venue details) are filled in
- EMIS access (Smartcard/login) is arranged and tested
- Practice patient-characteristics discussion has taken place and any tailored adjustments are noted.

## Step 2: Tasks to be completed at the GP practice by and with the GP practice staff

This step is largely carried out by the GP practice itself, with the HPO confirming access and timelines are in place.

### 2.1. EMIS access and non-responder search

- The practice sets up EMIS access for the HPO once the Information Governance (IG) contract is in place.
- The GP practice runs the non-responder search using the CFAK bowel screening search guidance. Key steps are outlined below – see Supplementary Material 6.3 for the full guide.

#### How to import & run CFAK EMIS searches:

- In EMIS, go to Population Reporting, at the bottom left, click NHS Warrington CCG – Enterprise Search and Reports.
- Locate the 'CFAK Bowel Screening 2026-27 inc LD V1.3' folder. Click **COPY** on the header bar.
- Return to your Practice folder and click **PASTE**.
- To run: right-click the folder and select '**RUN**'. No dates are needed. Searches are hard-dated.
- To view results: click the report within the folder and choose **VIEW RESULTS** from the header bar.
- Searches can only be run in the practice area – they cannot be run directly in ES&R.

There are **FIVE** search folders. The practice needs to be aware of all of them.

#### FOLDER 1 & 2: **Female & Male Non-Responders** - Includes LD sub-folder for patients on the Learning Disabilities register

**Who uses it:** GP practice staff, with HPO support if needed

**What it does:** Identifies patients aged 50-74 who have not completed a screening kit and are coded as non-responders. Splits results by contact method: mobile (SMS), email or postal only.

#### FOLDER 3: **Pre-Kit Clinics**

**Who uses it:** GP practice – pilot practices only

**What it does:** Identifies patients <50 who will receive their first screening kit at age 50.

#### FOLDER 4: **CFAK Outcomes**

**Who uses it:** HPO – used at 12 weeks after the clinic (Step 7)

**What it does:** Checks whether the intervention was successful. Identifies patients with a Normal or Abnormal result.

#### FOLDER 5: **No BCSP**

**Who uses it:** GP practice – coding quality check only

**What it does:** Identifies patients aged 50-74 with no bowel screening coding at all. Used to check EMIS coding accuracy – not for generating NR lists. Contact the screening hub if you find patients who should have been contacted.



**TOP TIP:** The LD sub-folders in Folder 1 & 2 identifies non-responders on the Learning Disabilities register. Always check this list alongside the main NR search – it directly supports your reasonable adjustments planning.

## 2.2. Patient Notification

- The GP practice contacts the first 100 non-responders (NRs) to let them know they may be contacted by the BCSP team to invite them to a CFAK clinic at the surgery by SMS, letter, or phone. This is called '**patient notification.**'
- Patients must be given the option to opt out by contacting the practice. The practice records any opt out in the patient notes.
- A template letter and text message are provided in Supplementary Material 6.4 for practices to adapt.
- Text messages sent via the practices' messaging service (iPlato or MJOG) should explain that the Bowel Screening Health Promotion Team will be working at the practice and may ring to arrange an appointment, with the option to text back '**DECLINE**'



**TOP TIP:** Before your first contact with any patient, always re-check their record to make sure the patient has not opted out.

**NOTE:** The GP practice is responsible for ensuring the list of NRs is provided to the BCSP team only includes patients who have been notified that they will be contacted by BCSP and have not opted out.

## 2.3. Receiving the non-responder list

- The GP practice sends the non-responder list electronically to BCSP officers via a secure NHS email address.
- Data included: Name, NHS number, DOB, age, address and phone contact details.
- Once received, discuss room availability and agree clinic dates with the practice.

## 2.4. Clinic structure

- **Clinic duration:** 15 minute time slots
- **Full day face-to-face clinic:** 10am to 4pm – 20 slots to fill
- **Half-day clinic:** 10am to 12:30pm – 10 slots to fill

**Evening and Weekend Clinics:** Evidence from the 2025-26 pilot strongly indicates that younger NRs (50-67) are more difficult to reach during standard work hours – they are more likely to be at work.

- Where resources allow, consider offering evening/weekend slots for this group. HPOs piloting this found it significantly improved contact rates and kit uptake for this cohort. Make this clear at the first point of contact – it can make the difference between a decline and a booking.
- If the GP practice is not able to provide a room, community venues or local pharmacies may be used as alternatives – agree this with the practice manager and record in the GP Set Up-Tool (Supplementary Material 6.2).

*Full evaluation data from the pilot is available in Supplementary Materials 4.3*

**NOTE:** If room availability is restricted, community venues/local pharmacies may host the CFAK clinics – to be agreed by Practice Manager/Lead GP. (Please refer to the GP setup tool Supplementary Material 6.2 for guidance)

**Self-appointment booking text messages:** If GP practice is happy to send text-messages to NRs to book a time for the clinics, this needs to be carried out after clinic dates are set and facilitated by the GP practice. The GP practice will send text appointment link to all NRs from the list.

**NOTE:** If room availability is restricted, opt to work remotely from the office – this gives the opportunity to offer video consultations via AccuRX/Patches (to be agreed by Practice manager/Lead GP)

### **STOP & CHECK – Before moving to Step 3**

*Before you move to the next step, confirm:*

- *GP practice has completed patient notification and recorded any opt-outs*
- *Non-responder list has been received securely via NHS email and contains all required data fields*
- *Room availability and clinic dates are agreed and confirmed with the practice.*
- *Number of clinic slots matches the agreed clinic length (20 for full day, 10 for half day)*

## Step 3: Pre-clinic preparation

With dates and the non-responder list confirmed, this step is about getting your records and tools ready before you make a single call.

### 3.1. Secure storage and notification

- Save the non-responder (NR) list in the secure NHS Shared Drive folder. This list is for monitoring patient information only and must not be edited.
- On the day of calls, contact the GP practice to let them know you are contacting NRs and they may receive calls back from patients.
- If working remotely, inform the practice that you are using their EMIS system

### 3.2. Populate the Master Sheet

- The Master Sheet needs to be populated with NR details – this is stored on the Teams folder.
- It is the central reporting tool for the whole project: it tracks total calls attempted, calls answered, kits requested, declined participation, follow-up requirements, escalations and practice-level activity.
- All project reporting and performance discussions must reference this approved Master Sheet – **do not keep a separate personal tracker.**

**DARK BLUE = Patient identifiable & demographic details.**

Master Sheet columns F-L & N-P: NHS number, DOB, name, ethnicity, , address, postcode, age, gender, disability and sensory needs. Populate these from the NR list as soon as it's received

| F                  | G                        | H             | I                 | J               | K                | L   |
|--------------------|--------------------------|---------------|-------------------|-----------------|------------------|-----|
| Patient NHS number | Patient DOB (DD/MM/YYYY) | Patients Name | Patient Ethnicity | Patient Address | Patient Postcode | Age |

| N              | O                  | P       |
|----------------|--------------------|---------|
| Patient Gender | Patient Disability | Sensory |



**TOP TIP:** Populate the patient demographic columns (dark blue) in one-batch immediately after receiving the NR list, before you start calling. It will be much faster than doing it row by row mid-call, and reduces data entry errors.

### 3.3. Prepare supporting paperwork

- Prepare the Hub Kit request sheet – a blank template is available on Teams.
- Make sure you have enough protected time to contact as many NRs as possible and to complete the Master Sheet for everyone you contact, not just those who agree.



#### **STOP & CHECK – Before moving to Step 4**

*Before you move to the next step, confirm:*

- *NR list is saved in the secure NHS Shared Drive and has not been edited*
- *GP Practice has been informed that NR calls are starting today*
- *Master Sheet practice columns (cyan) and patient demographic columns (dark blue) are populated*
- *Hub Kit request sheet template is ready to use*
- *You have protected time blocked out to make calls and complete the Master Sheet alongside them*

## **Step 4: Pre-clinic phone calls and booking appointments**

This is the main contact step – where you reach out to non-responders, record outcomes and book them into clinics. Accuracy on the Master Sheet here is essential as it feeds every later stage of reporting.

**Based on the outcomes of the 2025-26 pilot, follow the recommended contact order when reaching out to non-responders.**

#### **1. Offer a face to face appointment face**

- Always lead with a face-to-face invite at the GP surgery. This is particularly effective for older cohorts and patients who prefer in-person contact

#### **2. If declined or not possible: offer a video consultation**

- Video consultations are particularly effective for the 50-67 cohort who are more likely to be working. South Cumbria pilot data showed a 42% kit completion rate via video call for the 50-60 age group. See the video consultation guidance in Supplementary Material 6.6.

#### **3. If still declined: offer a telephone consultation as a last option**

- Some patients have no access to video technology or prefer not to use it – always offer telephone as an alternative.

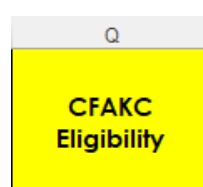
**Non-responders aged 50-67 are significantly more likely to engage if offered an evening or weekend appointment (see Step 2.4).**

#### 4.1. Before you call

- Log on to Cisco Jabber (or use a work mobile) before making any calls.
- If using a work mobile and a call is missed, set your voicemail to: *'Hi, if you have had a missed call from this number, please contact your doctor's surgery for more information about the call.'*
- Record relevant information for each patient on the Master Sheet, ensuring only a single row per patient (dark blue as outlined in Step 3).
- Record eligibility on the Master Sheet before logging any contact outcome.

#### **YELLOW = Eligibility, initial & second contact**

Master Sheet column Q: CFAK clinic eligibility. Confirm and record this before logging any contact outcome.



#### 4.2. Initial contact

- If a patient has already received a GP text message, letter, or other communication inviting them to book a CFAK clinic, record this on the Master Sheet as initial contact.
- If they have not booked by any other means, carry out the initial phone call.
- When checking EMIS for prior contact, use 'search patient' then the text search (magnifying glass) function to look for keywords such as 'Bowel', 'Gastro', or 'Colon' in their notes.
- Record date of initial contact and outcome of the phone call including reasons for declining the phone call, as outlined below.



**TOP TIP:** It is essential not to access any other documents in the patient record beyond this targeted text search – stay within the scope of the bowel screening check.

#### **Non-responder age profiles – tailoring your approach**

**50-60years – worried about ageing:** More likely to be men. Reluctant to see the relevance of test to themselves. Lead with early detection and staying well longer – frame it as wellbeing test rather than a cancer test. Do not need time off work to do it at home.

**50-67years – fearful of cancer:** Strong, negative emotions about cancer, low sense of control. Frame screening as a quick and easy wellbeing test that lets them get on with life. Emphasise that only 2% of completed kits return as abnormal test.

**68+ years – repeat avoiders:** Beliefs based on others' negative experience of cancer. Advise it is a wellbeing test recommend by their GP. Emphasise early detection prevents life-threatening illness.

**YELLOW = Initial Contact**

Master Sheet columns R-X: Mode, date and time of initial contact, outcome, and reasons for declining each delivery option. Record the date, outcome and any decline reason immediately after the call.

| R                       | S                                    | T                       | U                                  | V                              | W                                         | X                       |
|-------------------------|--------------------------------------|-------------------------|------------------------------------|--------------------------------|-------------------------------------------|-------------------------|
| Mode of Initial Contact | Date of Initial Contact (DD/MM/YYYY) | Time of Initial Contact | Outcome of Mode of Initial Contact | Reason For Declining F2F CFAKC | Reason For Declining CFAKC Via Video Call | Reason For Declining TC |

**4.3. If the patient agrees to a face-to-face clinic**

- Record on the Master sheet (light green section) – completed at the clinic.
- Add a 'Consultation' in EMIS GP notes using code 8CAY (select the second option: advice given and kit ordered with consent), or the relevant code for the encounter.
- Book the appointment in the clinic template on the practice PC: go to the appointment book, select date and time, right click to book the current patient.
- If the patient needs an interpreter, document this at the time of booking.

**Light Green = Delivery mode & communication needs**

Master Sheet columns Y-AC: Reason for non-completion of previous kit, mode of delivery, language spoken, interpreter needed and communication needs.

| Y                                         | Z                | AA              | AB                 | AC                  |
|-------------------------------------------|------------------|-----------------|--------------------|---------------------|
| Reason for non-completion of previous kit | Mode of delivery | Language Spoken | Interpreter Needed | Communication Needs |

**4.4. If the patient agrees to a telephone or video consultation**

- Record on the Master Sheet (as above) and in EMIS GP notes (as above).
- In the consultation record, specify whether the interaction was a 'Telephone Consultation', 'Video Consultation', or 'Face to Face Consultation.'
- Add verbal consent to order the kit to the patient record.
- Order the kit using the HUB kit request sheet – complete with patient details and send to [bowelscreening@nhs.net](mailto:bowelscreening@nhs.net) at the end of each clinic day, stating the request is from the Lancashire Call for a Kit Service.

**NOTE:** For video consultations, follow the video consultation guidance in this manual. Ensure Accurx Desktop and is installed and EMIS video clinic access is confirmed before the clinic day.

#### 4.5. Second contact

If the initial mode of contact was not successful, a second contact attempt is made and recorded separately.

 **Yellow = Second Contact**

*Master Sheet columns AD-AG: Second contact mode, date, time and outcome – use only when the first contact attempt did not succeed.*

| AD                                                           | AE                               | AF                     | AG                     |
|--------------------------------------------------------------|----------------------------------|------------------------|------------------------|
| Second Contact if Initial Mode of Contact Was Not Successful | Date of 2nd Contact (DD/MM/YYYY) | Time of Second Contact | Outcome of 2nd Contact |

**Declined Encounter:** If NR declines invite, this is recorded on the master sheet and in patient records on EMIS - episode for CFAK is closed.

#### **Failed Encounter:**

- If an individual does not answer the call or is not at home, first record on the master sheet for initial contact and re-contact one more time
- If the individual is still a failed encounter, update in EMIS GP record '**Failed Encounter**' – Please invite to bowel screening appointment on ..... This is recorded in patient records on EMIS system.



**TOP TIP:** EMIS must be updated after both the first call and the second call, since the recontact call usually happens on a different day. Don't wait until the end of the day to update both at once – update EMIS straight after each call.

Every patient you engage with should appear on the Master Sheet as one row, even if the outcome is a decline – this is what makes the uptake and engagement reporting accurate.



#### **STOP & CHECK – Before moving to Step 5**

*Before you move to the next step, confirm:*

- CFAK clinic eligibility (column Q) is confirmed and recorded for every patient contacted.
- Initial contact mode, date, time and outcome are recorded for every patient (columns R-X).
- EMIS has been updated immediately after each call – first and second contact
- Every patient contacted has exactly one row on the Master Sheet – including declines
- Second contact details are recorded where a first attempt was unsuccessful (columns AD-AG).
- Any interpreter or communication need is documented at the time of booking.

## Step 5: Processes during face-to-face clinics

This step goes through what happens on the day of the clinic itself, from setting up the room through to recording each outcome of each consultation.

### 5.1. Setting up

- Place the IG Data Protection poster in reception or the consultation room

### 5.2. Running the appointment

- Invite the NR into the appointment, introduce yourself and explain the reason for the appointment.
- Provide the CFAK leaflet (Supplementary Material 4.4) and information sheet (Supplementary Material 5.1).
- Use the physical sample kit to demonstrate the steps and show the instructional video (available on CFAK Teams files or via the Vimeo link) – use subtitles if the NRs first language is not English.
- Discuss barriers and concerns and explain how to complete the kit. Use the example script and 'Do's and Don'ts' table in Supplementary Material 6.5 for guidance on specific concerns e.g. the test being messy, fear of a cancer diagnosis, lack of symptoms or embarrassment.



**TOP TIP:** Lead with a storyboard and physical kit before discussing concerns – patients are often more receptive to addressing worries once they understand what the test actually involves.

### 5.3. Recording in EMIS and the appointment book

- Add the 8CAY code into EMIS notes: Bowel Cancer Screening advice given. NR seen by CFAK team and consultation conducted.
- Update the appointment status into the EMIS appointment book: press 'S' when the patient is seen, and 'L' once they have left the clinic.
- If the NR is more than 15 minutes late, classify as 'Did Not Attend' (DNA) – a 'D' will appear beside their name.

### **Light Green = Clinic attendance & rebooking**

Master Sheet columns AH-AK: Date of CFAK clinic, initial attendance, date of rebooked CFAK clinic and rebooked attendance. Complete this during or immediately after the appointment.

| AH                        | AI                    | AJ                                 | AK                     |
|---------------------------|-----------------------|------------------------------------|------------------------|
| Date of CFAK (DD/MM/YYYY) | Initial CFAK Attended | Date of Rebooked CFAK (DD/MM/YYYY) | Rebooked CFAK Attended |

#### 5.4. Completing the Master Sheet during the consultation

- Complete the Master data collection sheet to record the processes and outcomes of the consultation, including disability status (e.g. Learning Disability, Physical Disability, Sensory Disability), specific communication needs (e.g. Easy Read, BSL, Braille, Large Text), and whether an interpreter was needed.
- If any issues are highlighted, or extra information is needed, ring the HUB freephone number for support.

#### 5.5. Information and consent

- Give the IG Clinic information sheet to all NRs attending, with the right to withdraw consent embedded in the sheet (GDPR requirement)
- Advise that if they have not received the kit within 3-4 weeks, they should ring the 0800 number and ask the HUB why the kit has not arrived.
- Encourage patients to scan the QR code on the information sheet to complete the Patient Experience Questionnaire, or offer a hard copy – this feedback supports continuous improvement of the service.



**TOP TIP:** Be aware of current timelines so you give the patient accurate information about when to expect their kit.

Encourage patients to scan the QR code on the information sheet to complete the Patient Experience Questionnaire, or offer a hard copy - this feedback supports continuous improvement of the service.



#### **STOP & CHECK – Before moving to Step 6**

*Before you move to the next step, confirm:*

- *IG Data Protection poster is visible in the clinic room*
- *8CAY code (or relevant code) added to EMIS notes for every patient seen*
- *Appointment book status updated correctly ('S', 'L', or 'D', for DNA as appropriate)*
- *Master Sheet attendance columns (AK-AK) completed for every booked patient, including DNAs*
- *Disability, communication needs and interpreter requirements recorded for the consultation*
- *IG Clinic information sheet given to every patient seen*

## Step 6: Immediately after clinics

These tasks should be completed on the same day as the clinic, while the detail is fresh and before the patients information moves further along the pathway.

### 6.1. Ordering the kit

- If the patient consents to a kit being ordered, complete the HUB kit request sheet once the NR has left.
- Record in EMIS that consent was given to order a new kit.
- Send the kit request sheet to the HUB via the teams nhs.net email address.

 **Blue = Kit ordered with consent**

*Master Sheet columns AL-AO: Received a kit in the last 3 months, kit ordered with consent, reason kit not ordered, and updated GP records. Complete immediately after the clinic.*

| AL                                  | AM                       | AN                     | AO                 |
|-------------------------------------|--------------------------|------------------------|--------------------|
| Received a Kit in the last 3 months | Kit ordered with consent | Reason Kit NOT ordered | Updated GP records |

### 6.2. Data minimisation

- Patient data should only be collected for individuals who are ordering a FIT test kit.
- For all other NR contacts only collect: gender, age, first three letters of postcode and ethnicity. Ensure NRs are not recontacted again by closing their CFAK episode.

### 6.3. Final checks

- Check you have completed the Master Sheet in full for every patient contacted that day.



**TOP TIP:** Treat the kit request sheet and EMIS update as same-day, non-negotiable tasks - leaving them until the following day increases the risk of a kit request being missed or sent with incomplete details.



### **STOP & CHECK – Before moving to Step 7**

*Before you move to the next step, confirm:*

- *HUB kit request sheet completed and sent via nhs.net for every consenting patient*
- *EMIS updated to reflect consent given to order a kit*
- *Master Sheet columns AL-AO completed for every patient seen that day.*
- *Data minimisation followed – only gender, age, first 3 letters of postcode and ethnicity recorded for non-kit contacts*

## Step 7: Processes after clinic and outcome data check (after 12 weeks post CFAK clinic)

### 7.1. Requesting outcome data

- The CFAK team send HUB Kit request sheet to the practice manager to check results in patient notes *or*, with consent, the HPO can check outcome results on behalf of the practice manager.
- 12-week outcome data is checked by the Practice Manager or CFAK team officer.

### **Red = HUB kit order & 12-week outcome data**

Master Sheet columns AP-AU: Kit ordered from HUB by, date kit ordered, date of HUB notification, data check due by, test kit result, and colonoscopy results.

| AP                       | AQ                            | AR                                    | AS                              | AT              | AU                  |
|--------------------------|-------------------------------|---------------------------------------|---------------------------------|-----------------|---------------------|
| Kit ordered from hub by: | Date Kit Ordered (DD/MM/YYYY) | Date of HUB Notification (DD/MM/YYYY) | Data check due by: (DD/MM/YYYY) | Test kit result | Colonoscopy Results |

### 7.2. Reporting

- The GP practice shares anonymous uptake data with the CFAK team to be added to the final project report, which can be submitted to the CQC or CCG.
- The final report to the GP practice is informed by data from the Master Sheet and the GP practice Tracker, which monitors practice engagement status, outstanding actions, and uptake conversion figures.

### 7.3. Optional nudge calls

- A nudge call session can be arranged by the CFAK team with the practice to chase up NR who did not complete their kit, where capacity allows.

### 7.4. Closing the loop

- The final project report is submitted to the GP practice.

### **Orange = HPO notes and completed by**

Master Sheet columns M and AV: HPO notes and Completed by. Keep these current throughout the project, not just at the final stage.

| M         | AV            |
|-----------|---------------|
| HPO Notes | Completed By: |



**TOP TIP:** Calendar the 12-week check date as soon as a kit is ordered (column AS, 'Date check due by'), rather than relying on memory - outcome checks are easy to lose track of across a busy caseload.



### **STOP & CHECK – Project closure checklist for this practice**

*Before you finish at this practice, confirm:*

- *12-week outcome date checked and recorded for every kit ordered (columns AP-AU)*
- *Anonymous uptake data shared with the GP practice for the final report*
- *GP Practice Tracker updated with engagement status and outstanding actions*
- *Nudge call session considered and arranged if capacity allows*
- *Final project report submitted to the GP practice*
- *HPO notes (column M) and Completed By (column AV) are complete and up to date*

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