Barriers to colonoscopy in the English Bowel Screening Programme: findings from a key informant interview study

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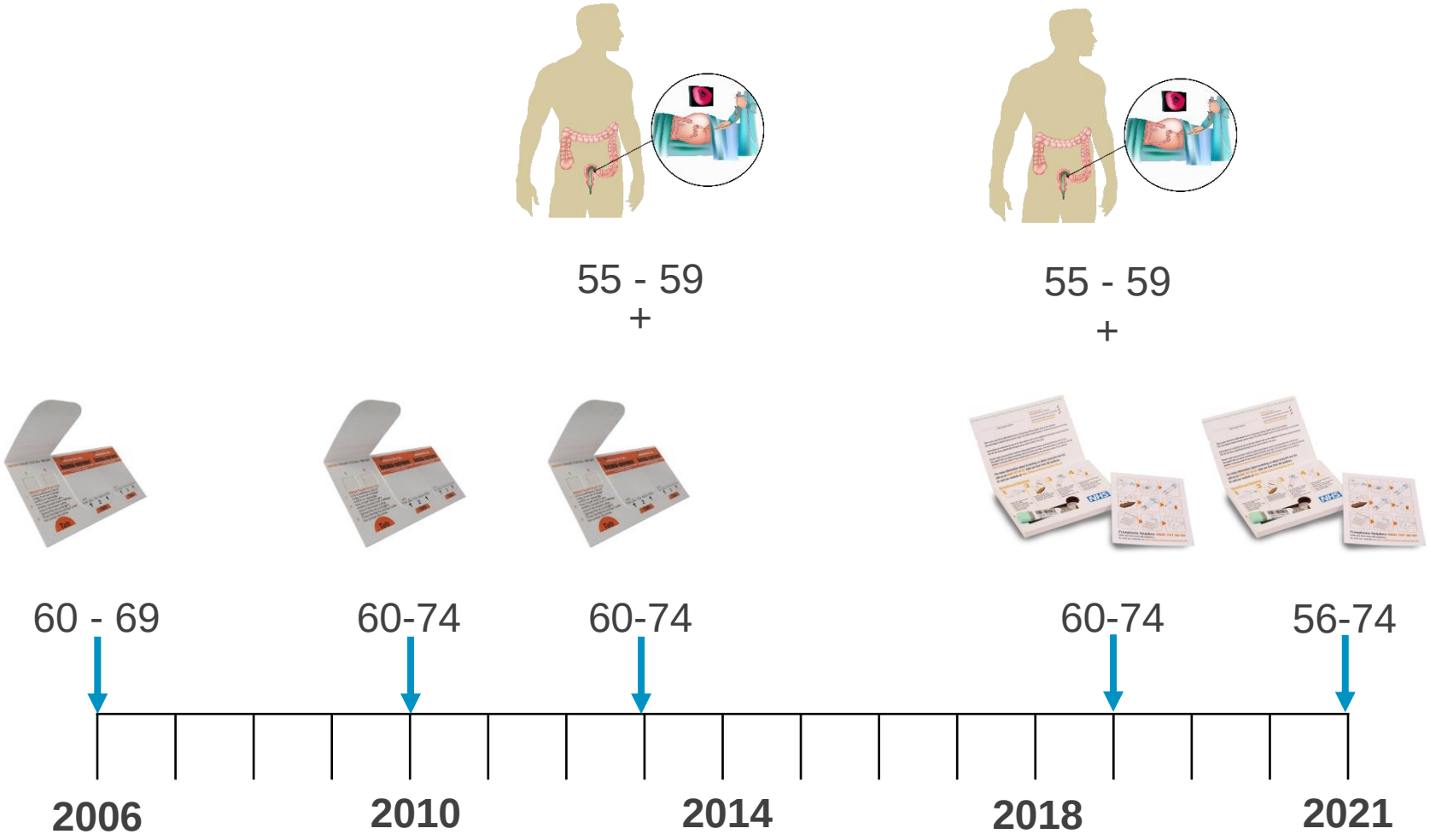
The English BCSP: a brief history



The English BCSP: Switching to FIT

- Uptake ↑↑↑ (~6%)
- Positivity ↑↑↑ (~1%)
- Acceptable kit rate ↑↑↑ (~98.4% → 99.6%)
- One thing which has not changed, is the diagnostic procedure rate (~80%)

Why is this important?

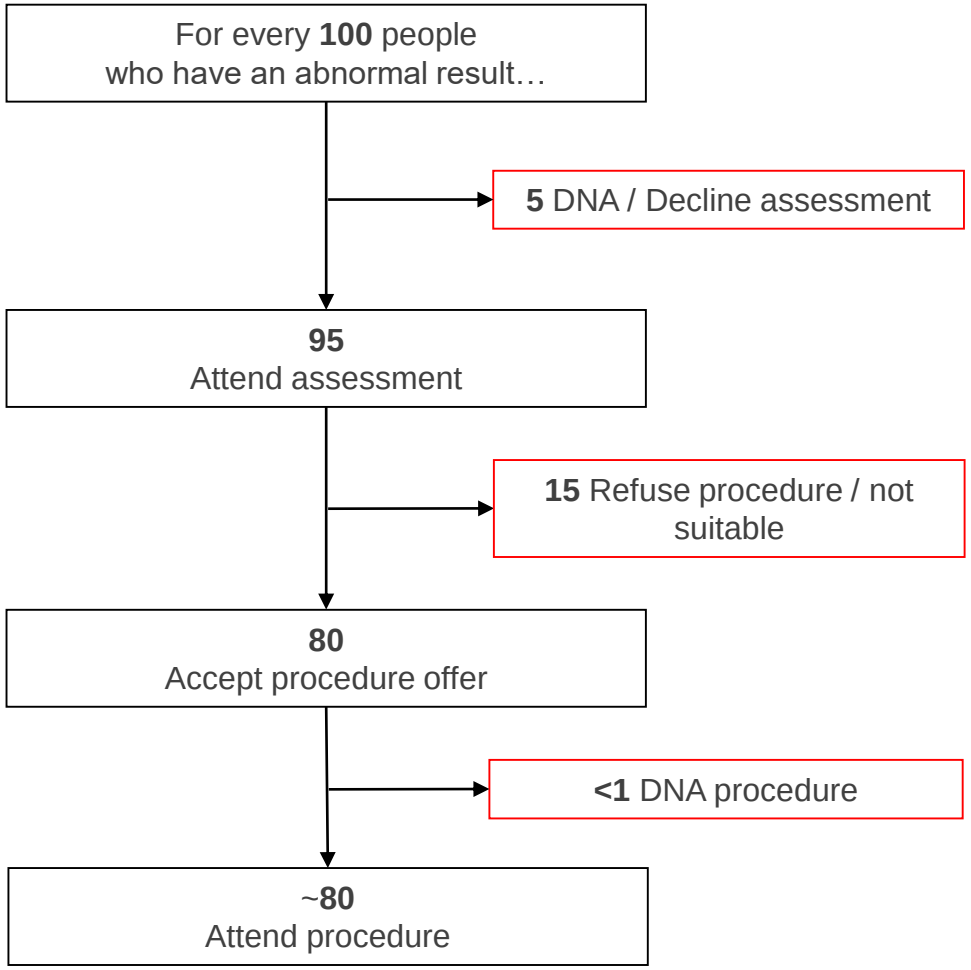
- CRC can only be diagnosed if individuals attend a diagnostic procedure (~8,000 DNA each year)

- Not attending / delaying colonoscopy following an abnormal screening result is associated with:
  - ↑↑↑ risk of being diagnosed with CRC (Kaalby et al., 2019; Zorzi et al., 2020)
  - ↑↑↑ risk of being diagnosed with advanced stage CRC (Kaalby et al., 2019; Beshara et al., 2019)
  - ↑↑↑ risk of CRC Death (Lee et al., 2017)

What do we currently know?

- Epidemiological studies of non-attendance in England (Morris et al., 2012; Kearns et al., 2016) have shown that DP rates are:
  - ↓↓↓ more socioeconomically deprived areas
  - ↓↓↓ more ethnically diverse areas

What else do we know?



Source: Median values for England in 2018 – Data provided by Public Health England

What don't we know

- *Why* people DNA a DP
  - Most qualitative studies have focussed on colonoscopy as a screening test (53/57 ; Kerrison et al., 2021)
  - Most have been conducted in the USA (48/57; Kerrison et al., 2021)

More qualitative research investigating non-attendance is needed

Aim

“To better understand contextual factors concerning colonoscopy use as a follow-up test for an abnormal FIT screening result”

Methods

Method

- Semi-structured interviews with Specialist Screening Practitioners
  - Conducted online (October – November, 2020)

- The interview schedule was developed using the results of a literature review

Methods

Recruitment

- SSPs were recruited through the SSP knowledge hub: an online forum which includes >30% of SSPs working in England

Methods

Analysis

- Interviews were audio recorded and transcribed verbatim
- Transcripts were analysed by two reviewers (RK + LT) using inductive and deductive analysis
- Findings discussed and agreed with a 3rd reviewer (CD)

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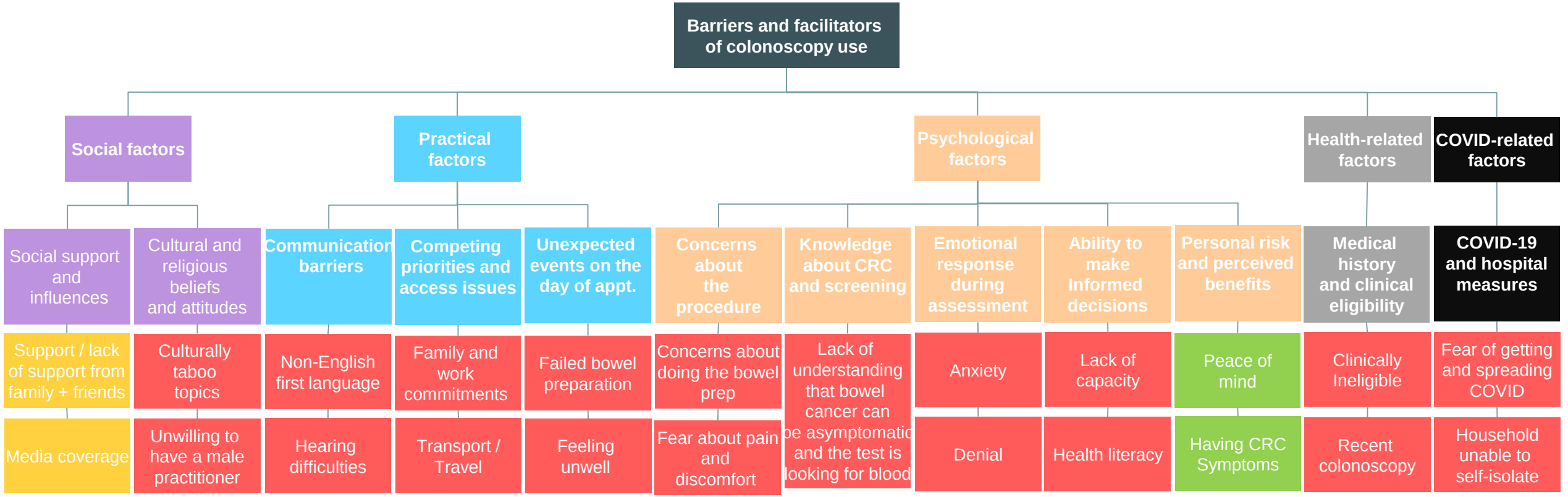
Results

Table 1. Sample characteristics

	n (%)
Gender	
Female	20 (95.2)
Male	1 (4.8)
Occupation	
SSP	16 (76.2)
Lead SSP	5 (23.8)
Years experience as an SSP (mean, range)	
Continuous (years)	6.6 (2-13)
Screening centre	
St Mark's BCSC (NW London)	8 (38.0)
Yorkshire and Humber BCSC	4 (19.0)
East Kent	2 (9.5)
West Kent	2 (9.5)
Blackpool	1 (4.8)
Liverpool	1 (4.8)
Leicester	1 (4.8)
Harrogate	1 (4.8)
Brighton	1 (4.8)

Results


Barriers and facilitators of colonoscopy use
Social factors
Practical factors
Psychological factors
Health-related factors
COVID-related factors
Social support and influences
Cultural and religious beliefs and attitudes
Communication barriers
Competing priorities and access issues
Unexpected events on the day of appt.
Concerns about the procedure
Knowledge about CRC and screening
Emotional response during assessment
Ability to make Informed decisions
Personal risk and perceived benefits
Medical history and clinical eligibility
COVID-19 and hospital measures
Support / lack of support from family + friends
Culturally taboo topics
Non-English first language
Family and work commitments
Failed bowel preparation
Concerns about doing the bowel prep
Lack of understanding that bowel cancer can be asymptomatic and the test is looking for blood
Anxiety
Lack of capacity
Peace of mind
Clinically Ineligible
Fear of getting and spreading COVID
Media coverage
Unwilling to have a male practitioner
Hearing difficulties
Transport / Travel
Feeling unwell
Fear about pain and discomfort
Denial
Health literacy
Having CRC Symptoms
Recent colonoscopy
Household unable to self-isolate

Results

Results

- Concerns about the procedure were described as the most pertinent:

“Um, “is it going to be painful?” tends to be one of the biggest things, “am I going to experience pain?”” (Fear of pain and discomfort: **Participant 11**)

“Um, some of them don't like taking the laxatives, if they have previous experience. So they say, "Oh, I hate having bowel prep, procedure itself is okay". That's one of the things.” (Concerns about the bowel preparation: **Participant 6**)

Results

Results

- SSPs also described patients' knowledge about CRC, screening and colonoscopy as being highly important:

"Some of them will say they've got no symptoms, so they may book and then they'll cancel... or they'll DNA on the day, and then we'll phone them up and say, "Why have you cancelled? Why have you DNA'd?" And it may be that they'll say, "I'm fine, I've got no problem with my bowel, you know, I'll just leave it alone, because I've no symptoms". " (Lack of understanding that bowel cancer can be asymptomatic: **Participant 1**)

Discussion

Summary

- Five main types of barrier and facilitator of colonoscopy use:
  1. Sociocultural
  2. Practical
  3. Psychological
  4. Health-related
  5. COVID-related

- Psychological factors described as being the most important in terms of decision making

Discussion

Next steps

- Validate results through interviews with patients and members of the public

- Explore which (if any) might be more prevalent for low uptake groups (e.g. those living in more socioeconomically deprived or ethnically diverse areas)

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Thank you for listening!