Improving uptake of bowel and cervical screening at WellBN: a primary care and voluntary sector partnership as part of ACT on Cancer together

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Introduction

Act on Cancer Together is a voluntary sector partnership in Brighton and Hove, commissioned through Brighton and Hove Public Health and NHS Sussex to facilitate earlier diagnosis of cancer in the local population, and increased access to cancer support, particularly among groups facing health inequalities. Voluntary sector partner, the Hangleton and Knoll Project (HKP) deliver community development and youth work in areas of deprivation in the West of the city and have led this project in partnership with West Hove PCN and WellBN surgery (Goldstone PCN) as part of their work in leading on Primary Care partnership development.
The aim of the project was to increase patient engagement with, and uptake of, bowel and cervical screening programmes and to showcase how VCSE can add capacity and value to primary care in the city.

Following the success of HKP initial 3-month project at Portslade Health Centre, it was agreed that HKP's Act on Cancer Together Coordinator would build on this pilot, implementing lessons learned and developing the work at WellBN, this time for an extended time period. This secondment was decided upon to overcome the barriers inherent in data sharing between the NHS and a voluntary sector organisation. All respondents who needed additional support agreed for contact details to be shared with HKP to enable this, otherwise data held by HKP is numbers only.

It was decided to contact non responders of the Bowel Cancer Screening Programme (BCSP) first, as Faecal Immunochemical Test (FIT) kits could easily be ordered, and this did not rely on availability of appointments. The coordinator worked on this initial set of calls during June-October 2023. Following this, patients who had not responded to cervical screening invitations were contacted initially focusing on women aged 50-64 years old September – November 2023. Then the 25–49-year-old cohort were contacted between December 2023 – August 2024.

Activities

1. Induction/IT training and mandatory training for the GP practice.
2. Identification of patient cohort – reports were run from practice data to create lists of patients that had not responded to the screening invitations.
3. Development of appropriate scripts and offers of support for both bowel and cervical cancer screening.
4. Non-responders to the bowel cancer screening programme were then contacted directly by telephone to encourage take up and explore fears/barriers.
5. If a patient did not answer the call, then a text was sent inviting them to participate in the programme, with details of how to contact the local screening hub and a link for further information. If it was not possible to contact a patient by phone or text, then a letter or email was sent.
6. Telephone calls also offer tailored, flexible support from HKP to address barriers identified, e.g. translated materials, transport to an appointment as needed
7. When the full patient list had been completed, the coordinator moved onto cervical screening. The same model was followed but this time the coordinator was able to book people in for cervical screening appointments at the practice there and then. Initially cervical screening non responder patients aged 50-64 were contacted.
8. If it was not appropriate to book the patient in for cervical screening at the time of the call either a text was sent with an online booking link, so that they could do this at a more convenient time themselves or it was agreed they would contact the surgery later.
9. Texts or emails/letters were sent to patients who did not answer the initial telephone call or where telephone numbers were not in service.
10. An audit of the responses was taken at a timely point to establish response rate and if further follow up was required (dependent on workload).
11. Follow up calls were made to relevant patients and further results noted.

Approach

A gentle, non-judgemental approach was adopted when contacting patients via telephone to talk about the screening programmes. The calls sought to provide a space to explore the barriers/concerns about participating in the programmes, assess knowledge of the programmes, refer the patient to appropriate resources and provide further advice on the screening programmes. Asking open questions was important to give patients an opportunity to explore barriers without being judged, and to explore decision making without overwhelming the patient. At times, viewpoints were gently challenged, with varying degrees of success in creating behaviour change. Understanding the barriers and challenges patients face is essential in being able to offer meaningful support to encourage screening uptake.

Executive summary of outcomes

	Total patients on the list	Patients spoken to directly	Number of direct calls that resulted in completed test	Patients texted	Number of texts that resulted in completed test	Patients emailed or sent a letter	Number of emails/ letters that resulted in completed test
Bowel screening	732	284	53 (18.6%)	249	17 (6.8%)	87	1 (1%)
Cervical screening	1844	321	114 (35.5%)	621	66 (10.6%)	505	4 (0.8%)

NB The total patients on the list is greater than the number of patients contacted across the four different communication channels. This is due to a combination of factors; inaccurate contact details, inactive patients and others for whom it wasn't appropriate to contact them, for example because they were already undergoing cancer treatment.

Bowel Cancer Screening

Contacts made

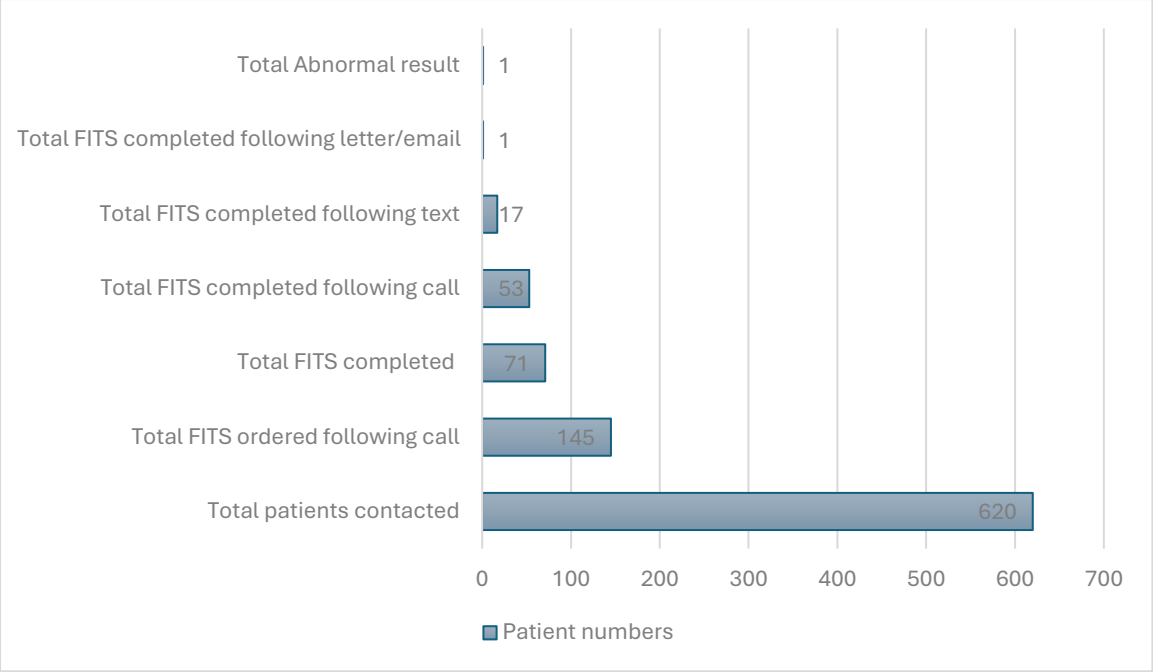
Total attempted calls/patients on list	732
Total patients spoken to at initial call	238
Total patients spoken to at follow up stage	46
Total texts sent	249
Total letters/emails sent	87
Total referral to HKP for further support	3

Outcomes – screening uptake

New FIT ordered for home delivery to patient	130
FITs re-ordered after follow up call	15
FITs completed following initial call	45
FITs completed after follow up call	8
FITs completed following text reminder	17
FITs completed following email or letter	1

Outcomes – clinical

	Tests completed	Normal result	Referred for colonoscopy
Initial call	45	45	0
Follow up call	8	8	0
Texts	17	16	1
Letters	1	1	0
Total	**71**	**71**	**0**



Common barriers to Bowel Screening

Barrier	Explanation	Quotes from community members
Forgetfulness	One of the most cited reasons for not completing FIT kits/engaging with the BCSP was that patients had merely forgotten to complete the test. Many of these patients were appreciative of the reminder and advice about the BCSP and then were keen to do the test as soon as they could.	***"I appreciate the reminder. I am one of those guys that need it!"*** ***"Thank you for reminding me. I have not done the test out of bone idleness!".***
Health-related overwhelm/complex needs	A number of patients felt overwhelmed with other health issues that they were dealing with and did not want the stress of having to address a potential health issue such as bowel cancer or even the prospect of going for further tests. Several patients with complex physical and/or mental health issues were either in care homes or had carers. Bowel screening was discussed with their carer to ascertain the	***"I have lots of other health issues, but I guess this is important"*** ***Conversation with carer: "he refuses to do such tests as he would rather not know. He struggles to address a lot of his health needs".***

	appropriateness of completing the test. A common outcome of these conversations was that the carer would speak with the patient and encourage them to do it, however expressed that due to other health issues it was unlikely that they would be able to get them to do the test. Referring into ACT for additional support was offered but often declined by these patients. The call also offered an opportunity to remind staff about the BCSP and provide contact details if they wanted to request a FIT kit for any of their residents/patients.	***Carer: "I have been trying to get a FIT sample for over a year"*** ***"I will discuss this with the patient but feels he may struggle as he is neglecting his physical and mental health".***
Declined but with no explanation	A common reason for not engaging with the BCSP was that patients stated that they did not want to do it and would not expand on the explanation. Advice was provided on the reasons for testing and the symptoms to be aware of in relation to bowel cancer and when to see a doctor. Patients were advised how to remove themselves from the BCSP if they wanted and it was emphasised that they could decide to re-engage at any point.	***"I do not want to do it"***
Transient lifestyles	A number of patients were abroad for lengthy time periods or had recently returned and so had missed the BCSP invitation. Ensuring patients were clear on how to order FITs was important – e.g. providing the BCSP helpline or encouraging them to ask for a test at the surgery.	***"I have been moving away and not completed FIT. I will come to the surgery to request a new FIT kit when I am back in Brighton"***
Language barriers	A number of patients had English as a second language. Assessing communication needs and preferences was key. Translated information regarding bowel screening and instructions on how to complete the FIT tests were offered to be sent to them. Information was sent via email,	**"My son is not here to help me with my English"**

	text or letter. The most common language requiring translated materials was Arabic. Farsi, Polish, Punjabi and French to a much lesser extent. With a number of ethnic minority patients, they were keen for the call to be interpreted by a family member. At times this was helpful as they could provide further reinforcement to do the test. It was noted that a number of ethnic minority patients did not answer initial calls and so texts or letters were sent- however these potentially were ignored or not read due to the language barrier and so offers of further support/adjustments could not be made.	
Misunderstandings re screening – perceived good health	A number of patients felt that because they had no issues with their bowels or felt healthy there was no need to complete a test. Information was provided to debunk such myths and misinformation about the need for screening.	***"I feel that I have a good diet and therefore at low risk"*.** **"I have a healthy diet and no family history and so don't want the stress of taking a test"**
Lack of awareness about the BCSP	A number of patients had not been aware of being sent a FIT kit and were uncertain/uninformed of the BCSP. Information and advice about the programme were provided repeatedly. This included provision of the following information: how often the kits were posted; screening age ranges; what the tests are looking for; how to do the test and return; expiry dates of the kit; how quickly to expect results; what a positive result could mean and how they could get a FIT kit independently. A number of patients seemed unclear that the test was completed at home rather than at the surgery. Finding out the test could be done without booking	***"I have a knee issue and would struggle to get to the doctors" (on finding out the FIT is done at***

	an appointment appealed to these patients and encouraged them to do it.	***home she agreed to having a test ordered for her)***
Finding the test unhygienic/unappealing:	Several patients stated they did not like the thought of doing the test and so had put off doing it. Providing information and guidance about how to do the test was helpful for some. The collection of the sample for a number of patients was the main barrier as they would state they were unclear as to how to take a stool sample. An explanation of how to collect a sample was provided to these patients who then felt more confident to try.	***"I have felt daunted by the test in the past and therefore not done it".*** ***"My faeces are really watery, so I haven't done the test"*** ***"I have been putting it off as it is unpleasant".*** ***"It makes me feel sick"***
Fatalistic view of health	Some patients declined the BCSP citing fatalistic views around getting cancer. Providing information about the importance of early diagnosis and signs and symptoms of bowel cancer was provided to these patients.	***"If I die, I die!"*** ***"If you have it, you have it"***
Negative view of NHS	Negative views of the NHS and accessing care were also common barriers. One lady felt that she couldn't get an appointment with her GP and had given up trying to address her health issues. She was told about the Hangleton and Knoll Project's health forum and referred to HKP E Newsletter for further details of events. She seemed to appreciate having an opportunity to vent her feelings despite still declining the BCSP invite.	***"I feel that the NHS does not act quickly enough if something is wrong and the whole thing petrifies me".*** ***"I feel despondent about the difficulties in accessing the GP and getting the help needed."*** ***"I have no public trust in the system and feel that it would do more harm than good"***

Case study, S, Male, white European 65 yrs

A call was made to S who stated that he did not understand how the BCSP worked. He thought that he had to attend the clinic to complete the test. The process was explained, and it was agreed to order a FIT test for him. Following an audit of responses, it was ascertained that he had not completed the test. A follow up call

was made to S, he admitted that he was still confused as to how to do the test. Following further explanation, he decided to take a sample at the time, and it was agreed to contact the patient 10 minutes later to find out how he got on. He had struggled to write the date on the sample tube as the pen was not working well. A phone call was then made to the BSCP hub who made a note of the date the sample was taken on the patients record. He received a normal result.

Cervical Cancer Screening

Contacts made.

Total patients on lists	1844
Total actual contacts made (calls, texts, emails)	1447
Patients directly spoken to	321
Text reminders sent	621
Letters/email reminders sent	505
Test appointments booked by coordinator (following call)	199
Test appointments booked by patients (following call, text, email)	82
Total DNAs	24
Total CNAs (cancelled by patient or surgery)	76
Total tests completed	184
Total abnormal result	17
Total ACT and HKP referrals for support	6

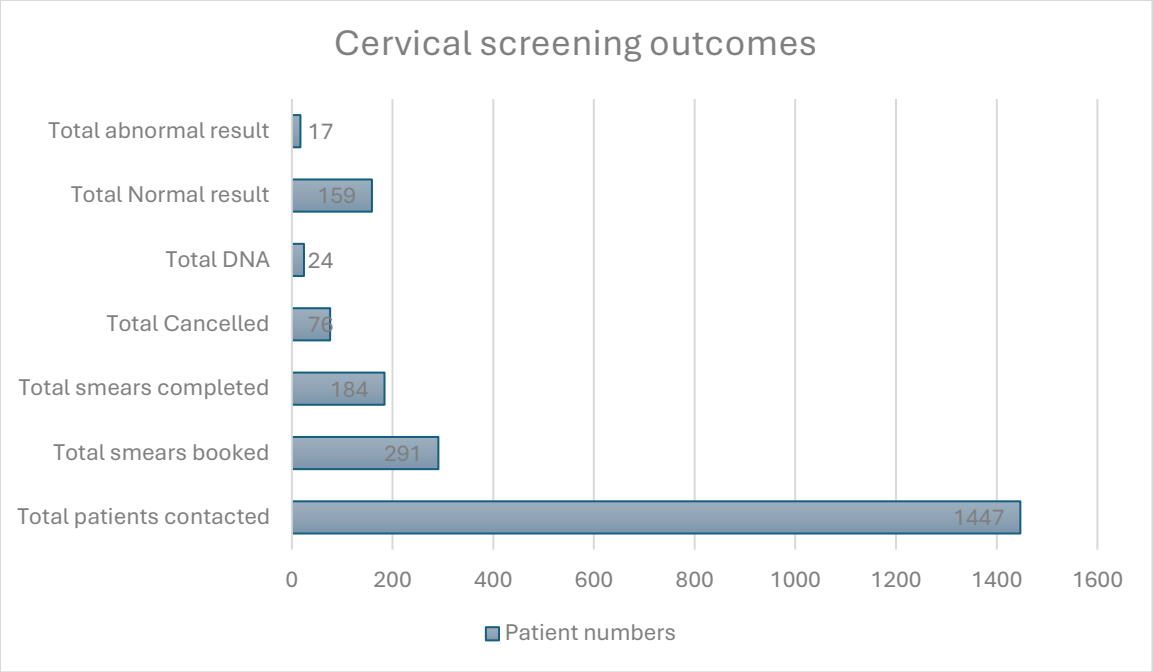
Outcomes – screening uptake

	Test completed	Booked but did not attend	Booked but cancelled	Booked but test didn't happen*
Booked by coordinator.	103	22	68	6
Booked by patient after telephone reminder	11		1	
Booked by patient after text reminder	66	2	7	
Booked by patient after email / letter	4	0	0	0
Total	**184**	**24**	**76**	**6**

*NB test didn't happen due to pregnancy or test not due (inaccurate patient data)

Outcomes – clinical

	Tests completed	Normal result	HPV+ 12-month recall	Referred for colposcopy	Awaiting results/future date/inadequate result
Booked by coordinator.	103	89	2	9	3
Booked by patient following call	11	11	0	0	0
Booked by patient following text	66	55	2	4	5
Booked by patient following email	4	4	0	0	0
Total	**184**	**159**	**4**	**13**	**8**



Common barriers to cervical screening

Barrier	Explanation	Quotes from community members
Fear of procedure	Fear of having the test was the most commonly cited reason for not wanting or putting off booking a screening appointment. This was either because it was perceived or assumed that the test would be painful for patients who had not had a smear in the past. Intervention to provide detailed information about the test, what it entailed and answering specific questions was key to providing reassurance. Sending texts with links to specific websites was helpful as well as agreeing to call a patient back at a later date to check in meant the patient did not feel rushed in the decision-making process. Some patients was afraid around the procedure due to past negative experiences of screening that had been uncomfortable or painful. One patient was very anxious about screening due to significant pain in the past and had been informed that her cervix was at an angle. She was encouraged to talk to the nurse about having a smaller speculum and offered support to attend the appointment. Some patients reported a condition called Vaginismus, which could potentially cause significant pain during such a procedure. Support to encourage patients to discuss this further with nurses was encouraged, booking longer appointments, consider breathing techniques and follow up support were offered.	**"do I need to take time off after test"** **"Does it hurt? How long does it take? Where do you have it?"** **"My last smear was very painful and distressing – I have been putting it off for this reason".** **"I absolutely hate smears. Do I need one?"** **"If we were men, they would have found tests that were less painful/barbaric. At best its invasive and at most traumatic"**
Pain due to menopause	A number of women in the older age range identified pain and discomfort as a result of menopausal symptoms, specifically vaginal dryness, as a major reason as to why they did not want to have a smear test. Often these patients were offered appointments with clinicians to discuss this further which frequently resulted in oestrogen gel being prescribed.	**"The last smear took 5 attempts, 3 diazepam. It was excruciatingly painful. I bled for 3 days. I will**

		not put myself through that again. Pre-menopausal I never had any problems"
Sexual trauma	A number of patients disclosed histories of sexual violence which meant that having a smear test felt invasive and triggering for them. During these calls it was vital to adopt a sensitive approach and not probe. Options on how to best support such patients were presented during the calls, such as: booking double appointments, having a chaperone present, providing further information on the procedure and sources of support and offering additional appointments with the nurse prior to the procedure. One patient was able to provide information about a service in London called My Body Back which specialised in providing services including screening for people who had experienced sexual trauma. A patient disclosed that she had been raped in the past and so had been putting off the procedure. She was able to arrange a double appointment, and the ACT coordinator agreed to chaperone her at the appointment. Unfortunately, the surgery cancelled the appointment twice due to staff sickness and it has not been possible to contact the patient again to re-book despite follow up calls.	**"I'm terrified of having a smear due to past trauma".** **"I get overwhelmed and can only focus on one thing at a time. I was raped and as a result have high anxiety about this test"**
Access to appointments	Several patients were unable to get to screening due to difficulties with transport. One patient cited mobility issues as a reason why they could not get to the surgery for a smear. Support was offered to take the patient to the appointment. Some patients due to uncertainty regarding work rotas and other commitments were unable to book appointments and preferred a text with a booking link to be sent so they could book appointments at a more convenient time.	

	Several patients requested appointments to be made before or after working hours or in the school holidays.	
Mental health	A number of patients had complex mental health and substance misuse history. This had led to screening appointments not being booked. A patient with mental health issues described the difficulties she would have in preparing/bathing prior to the procedure and then physically being in the waiting room. Further support was offered to this patient. However, she decided her mental health needed to be resolved before booking a smear.	**"I get depressed and then end up missing appointments"** **"Talking about it makes me feel upset and anxious"**
Overwhelm	Frequently other health issues or life events meant that they wanted to delay cervical screening as they felt too overwhelmed by these personal circumstances.	**"It has been a very busy period and I would like to wait"** **"I have recently lost my husband and so have had a lot going on and I can't face booking cervical screening at present but will do in due course"**
English as a second language	Several patients had English as a second language which created issues with patients being able to understand invitations to screening, the reasons for screening and difficulties with booking appointments. With some of these patients it was agreed to follow up the call with translated information sent via email, text or a letter. One patient was sent a text with a link to a video in Hindi about screening. Jo's Trust was a helpful resource as it had a translation function on it – however unfortunately they no longer exist. It was not always possible however to send translated	**"I struggle to make appointments with my GP as English is not my first language".** **"I didn't know what screening was as I am Italian, and it is called**

	information due to the language not being offered in cervical screening publications or the language not being translated in Word. One patient stated she struggled to make appointments online and complete E consults due to ESOL. She was referred to HKP for support with her digital literacy with the aim of improving her ability to navigate the online appointment booking systems.	**something different but after your explanation I understand what it is now".**
Having smear in another country	A number of patients stated that they had had screening in other countries and so felt it was not necessary to have another. When patients disclosed this, they were encouraged to have screening at their practice due to HPV testing. Further details such as date, and result of the test taken abroad were recorded.	**"I had smear in my home country and do not feel I need another one so soon"**
Forgotten to book or that was overdue	Frequently patients had forgotten to book the smear test and appreciated being reminded to do so.	**"It has been a while, what does it involve?"** **"Thank you for the reminder. I will contact the surgery on my return in the Autumn"**

Less common barriers

- Patients needing an appointment prior to screening due to gynae issues.
- Had smear at sexual health clinic.
- Declined due to wishing to follow natural approach to health care vs medical interventions.

Case Study – female, black British, 59 years

M was extremely anxious about having a smear test due to significant trauma caused by a previous cervical screening test. As a result, she had ignored previous invitations to screening and not had a test for over 15 years. It was agreed to meet her at the surgery at the time of the appointment to help to address her anxiety. On meeting techniques to help her manage her anxiety were discussed such as breathing and mindfulness techniques. It was agreed to wait in the waiting room for her. She was encouraged to speak openly to the nurse about how she was feeling prior to the procedure. She declined a chaperone. M was able to have the screening successfully despite panicking at one point. She was able to implement breathing techniques and talk to the nurse so that they could proceed. She stated that just knowing someone was waiting for her was very helpful and had made

a considerable difference. She expressed that by discussing how it went with someone she was able to process the appointment as opposed to pushing it away and then trying to get on with her day.
She has since been informed that her cervical smear result was normal.
"Thanks so much for your support this morning, it was so helpful having you there to speak to! And thanks for these details, I'll defiantly have a look at the projects, and will recommend you to anyone who needs support with their smear tests" M

Case study – British Bangladeshi, F, 47yrs

S had not had a cervical screening test for over 20 years, put off by previous difficulty having a smear taken and experiencing significant pain. She felt that her requests to stop the procedure had been ignored. To support her during the appointment, it was agreed to meet her at the surgery, book a double appointment and chaperone her during the procedure.
However, at the first appointment following a conversation with the nurse, it was agreed not to proceed at this time but re-book at a later date and have diazepam prescribed so that she was more relaxed for the screening.
At this appointment it was agreed to pick up the patient from her home address as she lived a considerable distance from the surgery and had identified that such a long bus journey would exacerbate her anxiety.
S was chaperoned during the appointment to help her relax. The nurse tried several sized speculums, needing to use the smallest speculum but still struggled to visualise her whole cervix. S reported that although the procedure was painful it was a much more positive experience than previously. The appointment was not rushed, and her concerns discussed throughout. The nurse was able to take a sample and hoped that it would be adequate.
S stated that it had made a huge difference to have someone with her throughout the procedure and during the journey.
"I know if doesn't seem much, but this support has made a huge difference to me and enabled me to have screening".
A normal test result was received, and she will be recalled in 3 years' time. Whilst attending these screening appointments she also was able to disclose some issues with heavy bleeding. She is being followed up with further investigations/hormone blood tests at the surgery.

Lessons learned – successes.

- **Potential prevention of cervical cancer** – despite the majority of results being normal the clinical outcomes show clearly the importance of this work in identifying abnormal results. 9% of patients who completed cervical screening had abnormal cervical smears – requiring 12 month recall or referral to colposcopy.
- **Removing logistical barriers.** Engagement was more successful when it was clear to the patient that engaging with the screening would not take much time or effort on their part – e.g. the coordinator taking responsibility for ordering the FIT kit or booking the cervical screening appointment.

- **Reasonable adjustments.** Assessing communication, psychological and practical needs was vital in offering reasonable adjustments and tailored, individual support.
- **Advice and guidance.** Providing advice about how to complete and send back FIT kits and further details about what is involved in cervical screening appeared to reinforce engagement with the programmes.
- **Methods of contact**. Speaking directly with the patient was the most effective method of engaging with patients and improving screening uptake. Texts had some positive impact on engagement. Letters or emails produced a very low response rate. The more proactive and direct the contact with patients, the more likely they would complete screening.
  "*It's amazing what the power of a personal conversation versus a text can deliver."* Lindsay Coleman, WellBN
- **Being transparent about who was calling**. Using a "soft" telephone that showed the surgery's phone number was helpful in encouraging patients to answer the call.
- **Dedicated resource.** Having a coordinator whose sole role was to make these calls, and who couldn't be sidetracked into other practice business (because they weren't a regular member of practice staff), ensured that the calls got made, as practice staff themselves are often pulled into more urgent practice business. The partnership has clearly demonstrated the advantages of having someone from the voluntary sector embedded in a surgery with a clear remit of working solely on cancer screening uptake.
- **Added health promotion benefits.** The calls provided a good opportunity to provide extra health promotion advice. For example, providing information about cancer risk factors, how to reduce the risks and what signs and symptoms to look out for. If the patient was also identified as a non-responder for other cancer screening programmes these would be discussed if appropriate and further information provided.
- **Positive campaign messaging.** This approach in raising hope, delivering positive messaging about cancer screening rather than creating fear seems effective. This has been reflected in the recent ACT cervical screening awareness campaign – focusing on positive messaging that screening can prevent cancer before it starts.
- **Community Support.** The conversations enabled several direct referrals or signposting to HKP to help with a number of issues including difficulties around accessing NHS services/booking appointments (Health Forum and digital support services at HKP), isolation (HKP 50+ offer) and specific health concerns (HKP diabetes groups, menopause sessions).
- **Behaviour change –** it is hoped that the result of the interactions with patients around screening will encourage future engagement with screening programmes. Longer term analysis of screening uptake at the surgery is required to ascertain the impact of this work.

- **Partnership working.** With patients with more complex needs it has been helpful to work jointly with either a support worker or carer to provide additional support and encouragement to engage in the screening programmes. Having a trusted person who understood the needs of the individual to encourage participation and to assess if in fact screening was appropriate.
- **Peer support.** Provision of peer support to an ACT colleague who is replicating the work in the East of the city has been helpful in sharing challenges and best practice.

Lessons learned – challenges.

- **DNAs/cancelled appointments and continued non-response.** The figures demonstrate the need to follow up FIT requests and appointment bookings with further calls to further reduce DNA rates, ensure tests are completed, re-book appointments and understand the reasons behind non-attendance.
- **IT issues.** Due to the part-time and remote nature of the coordinator role, learning IT systems took some time and required support from practice staff and the IT helpdesk. Some functions of System One are still not understood fully.
- **Language/cultural barriers.** Frequently ethnicity and/or main language spoken was not recorded by the practice. Often these patients were difficult to contact directly, and it is assumed that alternative contact methods have not been successful in reaching the majority of these patients.
- **Access to clinicians**. Some patients had complex health needs which required access to advice from medical staff to assess the appropriateness of screening and discuss potential reasonable adjustments. Due to capacity issues at the practice access was often delayed
- **No contact details held.** Several patients did not have up to date contact details
- **Transmen.** We were unable to establish practice protocol for working with Transmen around cervical screening. It felt important to be clear regarding this to avoid duplication and potential insensitive contact with this cohort. This is an area of potential development, perhaps with the Clare Project, as WellBN has the largest trans male list in the City and extensive experience in working with this community.
- **Time constraints.** The non responder patient lists were substantial which meant that providing follow up calls to patients was limited and auditing individual screening outcomes for those contacted took time**.**
- **Breast screening.** There appeared some uncertainty regarding the process for identifying non-responders to breast screening and accuracy of these patient lists so commencing this work has been delayed. This is certainly in part due to this being a national screening programme with little flexibility or capacity to offer additional appointments.

Next steps for the Act Primary Care partnership project

1. In conjunction with the practice put together a Screening Resource Pack (ideally for each screening programme) to include: How to guides on: Screening searches; QOF searches; AccuRx SMS messaging (including how to translate texts, add booking links etc); Telephone scripts; Common questions asked re different screening programmes; considerations for specific groups and available additional resources/supporting organisations/links to accessible information.
2. Continued development of the support to be offered to patients facing barriers to screening e.g.: potential use of volunteers to support with transport and attending screening appointments/completing tests.
3. Collaborative work with specialist services, carers, support staff and family members when dealing with individuals in groups experiencing high levels of health inequality.
4. Future work to focus on these high-risk groups with increased follow-up with patients in these groups.
5. Providing follow-up support to patients requiring ongoing tests and investigations e.g. offering to support at a colonoscopy/colposcopy appointments.
6. Deliver training/information sessions to local groups and communities, working with primary care to invite a cohort of patients and staff from GP practices (eg inviting women who are due their first cervical screening to a Q&A session at the practice or in community venues).
7. Provide peer support to first point of contact staff to share challenges and best practice in contacting non-responder patients.
8. Provide campaign materials and promotion of screening programmes in waiting rooms.
9. Have a library of accessible/translated and Easy Read information available to provide to patients on screening programmes and cancer awareness.
10. Work collaboratively with practice staff when approaching Transmen about cervical screening to avoid duplication and ensure best practice.
11. Commence work with patients who have not responded to breast screening invitations.
12. Consider the use of skilled volunteers recruited and supervised by the Act on Cancer Together team to continue this work on a wider scale.

Suggestions for primary care and wider system colleagues

1. Review the reasons for DNA and cancelled appointments and implement strategies to address these issues – e.g. send reminder text prior to screening appointment, follow up text/letter to remind to complete test, call patients who DNA and cancel to understand reasons.
2. Ensure a whole team approach to include training of GP practice staff on screening programmes and Making Every Contact Count; e.g. following up screening during health checks/LD/MH reviews/women's health review (contraception and menopause).
3. Identify patients who need alternative invitation or information about screening due to being in higher risk groups (flag on primary care system).
4. Identify and remove patients who are no longer contactable or have moved out of the area.
5. Longer term review of data around non-responders/screening uptake to look at impact in terms of behaviour change.
6. Work with Brighton and Hove Federation to look at extending access to cervical screening appointments, e.g. accessing women's health clinic at Mile Oak Medical Centre/setting up nervous patient cervical smear clinics.
7. Community outreach work to offer screening at alternative community venues.
8. Library of accessible resources including translation of invitation texts and letters in most common languages, Easy Read and videos.
9. Increase communications between staff to increase engagement and ability to make reasonable adjustments that can be offered to patients who face barriers to screening - such as: referrals to specialist clinics/hospital/ACT, pre-screen appointments to discuss concerns; longer appointments; alternative equipment and appointments at quieter times or alternative venues.
10. Replicate model in other areas of the city, working with Act on Cancer Together team to facilitate wider uptake of this work – think together about how we could resource this.