CERVICAL AND COLORECTAL CANCER SCREENING DURING COVID-19

Cardiff University policy briefing, May 2021

Overview

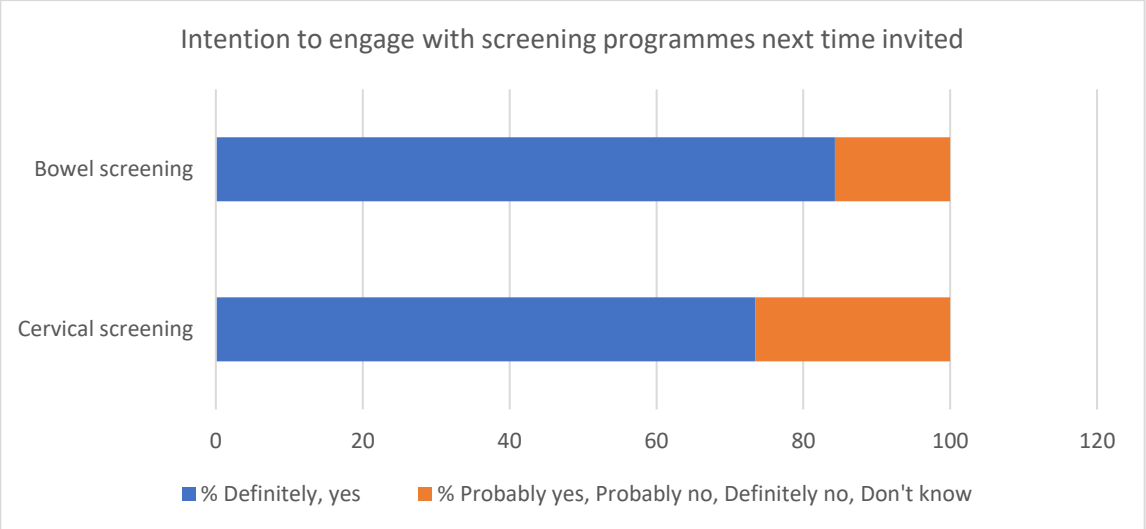
COVID-19 has caused widespread disruption to cancer screening services. The UK's national cancer screening programmes were effectively paused from late March to around June 2020 (depending on the programme/country), amidst government messages for the public to stay at home and protect the NHS. Whilst routine invitations for cancer screening are now being sent out, there is now a significant backlog.

It has been estimated that around 3 million fewer people than normal in the UK had a cancer screening test between March-September 2020. Disruption to cervical screening due to COVID-19 is predicted to cause over 600 excess cervical cancer cases in England, and changes across the care pathway for bowel cancer led to an estimated 3,500 fewer people beginning treatment between April and October 2020.

The COVID Health & Help-Seeking Behaviour Study (CABS) is a dedicated team of researchers from Cardiff University, Cancer Research UK, King's College London, the University of Surrey and Public Health Wales. The researchers have conducted a UK-wide study to assess attitudes towards cancer screening among the screening-eligible population during COVID-19. This briefing sets out how the study findings may be used to inform strategies for mitigating potential long-term adverse effects on screening participation and cancer outcomes.

What the research shows

Working with Cancer Research UK, we conducted an online UK-wide survey of 7,543 adults in August and September 2020.[1] The analysis presented in this briefing includes 2,319 responders eligible for cervical and 2,502 eligible for bowel screening, of whom 1003 were eligible for both screening programmes. Breast screening results are not presented here as not all eligible participants were asked about this.[2] We also interviewed a subsample of survey responders (n=30, of whom n=22 were screening-eligible). The figure below indicates some of the key findings in terms of intentions to engage with screening programmes when next invited:



[1] Participants were recruited via two routes to take part in the survey: 1. an online panel via CRUK/Dynata to take part in the COVID-CAM survey, 2. HealthWise Wales database supplemented with social media recruitment to take part in CABS survey. Full details of participant recruitment can be found in the study protocol (osf.io/zxyp3). Where possible data were merged for analysis.

[2] Only eligible participants (i.e. women, over 50) in the CABS sample (n=488) were asked about their intentions to attend breast screening, of which 88% (n=429) said they would definitely attend. Due to the very small number of eligible participants and responses, and the limited variation in responses no meaningful statistical analysis could be completed on this data.

The study's other key findings include:

- Most responders said they would 'definitely' participate when next invited to attend cervical (74%) or complete bowel (84%) screening.
- Despite high overall intentions, a significant minority agreed with the general statement that they would be less likely to attend an appointment for cancer screening now than before the pandemic (30% for the cervical screening-eligible sample, 19% for the bowel screening-eligible sample).
- Lower intention to attend cervical screening when next invited was associated with being single, not having taken part in screening at last invite, reporting more barriers and being less likely to attend a screening appointment now than before the pandemic. Lower intention to complete home-based bowel screening was associated with not having completed screening at last invite.

- Of those who had not attended their last cervical screen, 70% said this was unrelated to COVID-19. 12% reported being unable to attend due to COVID-19, despite trying, and 15% had chosen not to attend due to COVID-19.
- Around two-thirds of responders said they would feel safe to attend either a GP (68% and 75% for cervical and bowel screening respectively) or hospital setting (62% cervical, 66% bowel).
- Top barriers to attending cervical screening were being worried about pain (12%), having a previous bad experience (9%) and embarrassment (9%). Top barriers to bowel screening were the test kit being too messy (5%), not having any symptoms (4%) and embarrassment (4%).
- Over three-quarters (75%) said they were worried about delays to cancer tests and investigations, and to screening, caused by COVID-19.

- Responders who were interviewed were supportive of the screening programmes but some were unaware that the screening programmes had been paused. They highlighted the value in open and honest communication about the decision to pause cancer screening and felt this had not happened.
- When discussing concerns about engaging with screening during the pandemic, interviewees described fear of attending healthcare settings (cervical screening only) due to increased risk of COVID-19 infection and uncertainty about how to adhere to social distancing rules. No COVID-19 specific barriers were expressed for bowel screening.
- Interviewees who had experienced a delay to cervical or bowel screening were unsure when it would resume and whether they were required to proactively rearrange appointments.

Recommendations

Despite disruptions to UK cancer screening services during the COVID-19 pandemic, this study found high intentions to take part in future cervical and bowel screening, especially among those who had participated in screening in the past. However, a significant minority of responders said they were now less likely to attend a screening appointment than before the pandemic. Barriers such as fear of COVID-19 infection and uncertainty about screening procedures were highlighted by interviewees. Well-known non-COVID barriers were also still putting people off taking part in screening programmes.

In light of this, government and health services need to consider carefully how to best to return screening participation to pre-pandemic levels as quickly as possible and to assess whether the intentions are reflected in actual screening uptake as collected by the different screening programmes. This may involve:

1. Nationally coordinated campaigns with clear messaging to inform members of the public that they will be proactively contacted regarding their screening and to encourage them to take part. Campaigns could also encourage the public to proactively engage with cancer screening.
2. Continued interventions to reduce non-COVID screening barriers among non-responders, as well as clear public health messaging to reassure the public that screening services are open safely and explain what will happen at the appointment to minimise COVID-19 infection (prioritising groups at risk of non-attendance) to promote engagement among women eligible for cervical screening. Timely implementation of HPV self-sampling once the key validation, quality and implementation questions have been answered, may be key to offering more choice in cervical screening.
3. Ensuring sufficient diagnostic workforce capacity to urgently deal with the screening backlog and ensure people who need further diagnostics receive them in a timely manner.

Written: May 2021
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