Rapid health impact assessment (HIA) of the Implications of Introducing First Line FIT into the Bowel Screening Programme in Wales

Introduction

Health Impact Assessment (HIA) is a process which supports organisations to assess the potential consequences of their decisions on people's health and well-being. The Welsh Government (WG) is committed to developing its use as a key part of its strategy to improve health and reduce inequalities.

Health impact assessment provides a systematic yet flexible and practical framework that can be used to consider the wider effects of local and national policies or initiatives and how they, in turn, may affect people's health. It works best when it involves people and organisations who can contribute different kinds of relevant knowledge and insight. The information is then used to build in measures to maximise opportunities for health and to minimise any risks and it can also identify any 'gaps' that can then be filled. HIA can also provide a way of addressing the inequalities in health that continue to persist in Wales by identifying any groups within the population who may be particularly affected by a policy or plan.

In most uses of HIA, 'health' is viewed as holistic and encompasses mental, physical and social well-being. Based on a social determinants framework, HIA recognizes that there are many, often interrelated factors that influence people's health, from personal attributes and individual lifestyle factors to socioeconomic, cultural and environmental considerations (such as housing).

The Head of Bowel Screening Wales approached the Wales HIA Support Unit (WHIASU) to support them to undertake a HIA so that any health and wellbeing impacts or unintended effects could be identified of the proposed introduction of a First In Line FIT bowel screening test in Wales. It would also consider any inequality implications of the proposal. The current test, the guaiac faecal occult blood test (gFOBT), is a multi time test whilst the proposed new test, the faecal immunochemical test for haemoglobin (FIT), is a one time test.

Bowel Screening Wales is run from the Welsh Bowel Screening Centre in Llantrisant and is part of the Screening Division of Public Health Wales, who currently run other national screening programmes including Breast Test Wales and Cervical Screening Wales.[1]

[1] Bowel Screening Wales. http://www.bowelscreening.wales.nhs.uk/home

The Wales Health Impact Assessment Support Unit (WHIASU) was established in 2001 to support the development of HIA in Wales and is funded by Welsh Government via the Policy, Research and Development Division (PRD) of Public Health Wales (PHW). Its remit is to support, train, facilitate and build capacity in HIA and raise awareness of how the process can support and contribute to improving health and wellbeing. A particular focus of WHIASU in recent years has been the use of HIA within traditionally 'non-health' sectors such as mining, regeneration and housing, waste, land-use and transport planning as a method of encouraging a consideration of 'Health in All Policies' (HiAP). The Unit has a strong research function and has published a number of guides, evidence reviews and resources to support the practice of HIA by specialists and non-specialists[2]

Background

Colorectal cancer (CRC) is the third most common cancer in the UK accounting for 13% of all diagnosed cancers and is the second most common cause of cancer death (10% of all cancer deaths)[3] with 95% of cases being diagnosed in people aged 50 years and over. The average lifetime risk of CRC in the UK is significantly higher in men (1 in 14) than women (1 in 19). Recent data records a 5-6% increase in CRC incidence over the last decade as well as a fall in mortality of 14% over the same period[4]

In Wales, Bowel Cancer is the third most common cancer and the second most common cause of cancer death. It is more common in men and also in deprived areas[5]

Screening for bowel cancer

The National Screening Committee recommends bowel screening as it satisfies their criteria. Bowel polyps are common but some develop into cancer. This process usually takes around 10 years. Removing polyps can prevent cancer.

'The aim of screening is to lower the burden of cancer in the population by discovering disease at an early stage. This permits more effective treatment than if diagnosed later when symptoms occur'. Early treatment of cancer i.e. by endoscopic re-section *'can be generally less detrimental for quality of life. The endoscopic removal of pre-malignant lesions also reduces the incidence of CRC by stopping the progression to cancer. Randomised trials in people of average risk invited to attend screening have shown a reduction in CRC mortality and incidence'* [6]

Currently, each UK country uses a guaiac faecal occult blood test (gFOBT) as the screening test for bowel cancer. Bowel Screening Wales invites all men and women aged 60-74 for bowel screening every two years[7] . There is good evidence that gFOBT screening reduces CRC mortality by 16% in people of appropriate age invited to attend screening[8].

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[2] Wales HIA Support Unit website. www.whiasu.wales.nhs.uk

[3] Bowel Cancer Statistics. Cancer Research UK. http://www.cancerresearchuk.org/cancerinfo/cancerstats/types/bowel/.

[4] Bowel Cancer Statistics. Cancer Research UK. http://www.cancerresearchuk.org/cancerinfo/cancerstats/types/bowel/.

[5] Bowel Screening Wales. http://www.bowelscreening.wales.nhs.uk/bowel-cancer

[6] Mackie A. (with thanks to Stephen Halloran). 2015. Moving from guaiac faecal occult blood test (gFOBT) to a faecal immunochemical test for haemoglobin (FIT) in the bowel screening programme: A consultation

[7] Bowel Screening Wales. http://www.bowelscreening.wales.nhs.uk/

[8] Mackie A. (with thanks to Stephen Halloran). 2015. Moving from guaiac faecal occult blood test (gFOBT) to a faecal immunochemical test for haemoglobin (FIT) in the bowel screening programme: A consultation

However, in England in 2014 a pilot scheme to move from a guaiac faecal occult blood (FOB) test to a faecal immunochemical test for haemoglobin (FIT) was introduced. This changed the test from a multi time use test to a one time easy to use test. It was evaluated throughout and a number positive outcomes and insights were gained. These included improvement in uptake rates[9].

Bowel Screening Wales wish to introduce a FIT based screening scheme or pilot scheme for Wales and have established a Project Team to plan implementation. An outline Business Plan has been developed. This HIA was undertaken as one component of the evidence gathering and stakeholder consultation process to inform any decision making.

The Health Impact Assessment

While some impacts on health determinants may be direct, obvious, and/or intentional, others may be indirect, difficult to identify, and unintentional. An HIA can identify health inequalities in not only the general population but in 'vulnerable groups' (e.g. children, young people or older individuals) as well. The main output of any HIA is an evidence-based set of recommendations that should lead to the minimization of risks or unintended consequences and maximization of potential benefits. It can provide opportunities for health improvement and to fill in any identified 'gaps' in service provision or delivery.

HIAs can vary in terms of their timing and depth. They can be undertaken prior to implementation of a proposal (prospectively), during implementation (concurrently) and post implementation (retrospectively). Prospective HIAs give the greatest opportunity for influencing change while concurrent and retrospective HIAs are more monitoring and evaluation exercises, respectively. The scope of an HIA will be determined by a number of factors, including the nature and complexity of the proposal being assessed, the availability of resources, the type of data that would be needed, and the decision-making timescales.

HIAs generally take one of three forms – desktop, rapid or comprehensive. A desktop HIA may take only a few hours or a day to execute, a rapid HIA may take a few days to a few months to complete, and a comprehensive HIA is more in-depth/time and resource intensive and can take many months to complete. The most appropriate type to conduct can be decided through a short scoping meeting and discussion of timeframes and resources and levels of stakeholder involvement.

This HIA was prospective and rapid participatory. It built on a variety of evidence that had already been collated by the Bowel Screening service at PHW and from discussions with Public Health colleagues in Wales and those who had been involved in the introduction of the FIT test pilot in England. [10] [11] [12]

[9] Moss S, Mathews C 2015. NHS Bowel Cancer Screening Programmes: Evaluation of pilot of Faecal Immunochemical Test: Final report.
[10] Mackie A. June 2015 (with thanks to Stephen Halloran). Moving from guaiac faecal occult blood test (gFOBT) to a faecal immunochemical test for haemoglobin (FIT) in the bowel screening programme: A consultation
[11] Moss S, Mathews C 2015. NHS Bowel Cancer Screening Programmes: Evaluation of pilot of Faecal Immunochemical Test : Final report.
[12] Halloran S (2015) Replacing gFOBT with FIT as the primary screening marker in the NHS Bowel Cancer Screening Programme in England. Commissioned Report for the National Screening Committee.

This HIA concentrated on gathering Welsh and English stakeholder knowledge and insight into the proposed introduction of the FIT Test from both service users and those responsible for delivering the service.

HIA workshop

The Head of Bowel Screening, Hayley Heard approached the Wales HIA Support Unit (WHIASU) to support them to undertake a HIA so that any health and wellbeing impacts or unintended effects could be identified and also consider any inequality implications of the proposed introduction of a FIT Test pilot scheme in Wales.

The workshop took place on September 8th 2016. A number of key stakeholders were invited to participate and contribute to the discussion. In total, 22 attended the workshop and included a number of Bowel Screening service staff, Local Health Board representatives, PHW officers and several service users and service group members. Bowel Cancer UK, Tenovus and Cancer Research UK also participated. The agenda is included in Appendix One.

As statistical evidence and other robust research on the health impact of the FOB and gFIT tests had been considered already, the aim of this workshop was primarily to gather professional and community knowledge and evidence about the potential impacts of introducing the FIT test. It assessed the proposal against the current national population and policy context and the information gathered will be complementary to other evidence gathered to inform any decisions around the FIT tests introduction or any pilot scheme in Wales.

The HIA was led by Liz Green, Principal HIA Development Officer and Lee Parry-Williams from the Wales Health Impact Assessment Support Unit (WHIASU) of PHW and was qualitative in nature. It followed the systematic methodology described in the Welsh HIA guidance of 'Health Impact Assessment: A Practical Guide'[13] It supports work and training that WHIASU has recently been undertaking across Wales to develop HIA and a consideration of health, wellbeing and inequalities within PHW itself [14] [15]

At the outset, the group identified the main vulnerable groups who would be affected by the proposed FIT test using Appendix 2 of the Welsh HIA guidance (Appendix Two). A lively discussion followed and a wide ranging number of groups were highlighted as being directly affected by the FIT screening test.

These were (in no particular order):

- Gender:
    - Men – evidence shows that across the whole population men take up the test less and those within the most deprived communities have the lowest take up (there is evidence available to gain insight into the reasons why there is a reduced take-up)
    - Women – In relation to the setting of the sensitivity level for the test. The FIT test provides the opportunity to apply different sensitivity levels for specific groups

[13]Wales Health Impact Assessment Support Unit (2012). 'Health Impact Assessment: A Practical Guide'.
[14] Public Health Wales (2016) Our Space – Phase One HIA Report.
[15] Public Health Wales (2015) HIA Report for proposed changes to Microbiology services in North Wales.

within the population. Gender is a factor and if the sensitivity is set too low there will be reduced numbers of potential positives test results for women. For initiation of the FIT test it is being proposed to set one sensitivity level but build in review of these levels as the FIT test progresses. It was **noted** that key messages regarding sensitivity and reliability of the test are an important consideration when marketing the test and that care should be taken not to raise hopes/expectations. This could potentially disadvantage women.

- Ethnic minorities – BME groups. The groups are currently not identified within the screening programme.
- Travellers – The invite to bowel screening is triggered by age from GP registers and therefore travellers are at a disadvantage due to significant numbers of this population group not being registered with GPs. There are a number of factors related to this which include health literacy and that it is not deemed a priority culturally.
- Prisoners – A different approach is applied to targeting this group and there is recognition that there is more to be done to ensure this group receive the appropriate screening.
- Carers – Professional/unpaid (need to differentiate). This has been identified as an issue regarding the potential lack of informed consent. If it is not properly addressed at the initial testing stage then problems can arise if the test results identify the need for further interventions.
- Disabilities –
  - Physical – sensory impairment – Those with sight impairment are a specific group from a number of perspectives. Firstly, the functionality/usability of the test kit and text size etc on test kit and instructions. N**ote** – the group made a recommendation that representatives/advocates for this specific group should be involved in the procurement group to ensure 'Real life' services users can input into the decision making for which test kit is to be used (RNIB, plus others)
    - It could be that possibly the packaging per se will not be such a problem but the process/practicalities could be more of an issue
    - It was identified that there are potential limitations for the size of the tube and font in the test kits to be changed but there are definitely opportunities in relation to text, guidance etc
  - Learning – again issues regarding informed consent and issues arising from living independently in addition involvement within the procurement group as above
  - Requires a range of mechanisms and approaches to ensure both identification and involvement of key vulnerable groups within procurement and promotion.
- Genetic predisposition – Currently it is acknowledged that services for these groups is in need of improvement. There is concern that they could be further disadvantaged with the introduction of this test because the focus on addressing the rates of bowel cancer will be mainly on the potential improvements FIT will bring to detection and uptake. It could thereby take away the focus on other necessary improvements in related bowel cancer prevention and intervention services.

Appraisal

After agreement on the above, the group then worked systematically through the wider or social determinants of health in turn and assessed the health and wellbeing impacts (as listed in Appendix 1 of the Welsh guidance) of the proposed introduction of the FIT test. Positive or negative impacts were identified as were any gaps or unintended consequences. Suggestions were made for mitigation and actions documented.

All of this is summarised in the table below.

<table>
<tr><th colspan="2">Lifestyles</th></tr>
<tr><td>+ve
• Diet/ nutrition. Potential for less false positives as red meat can currently affect/interfere with the reliability of the existing test
• Screening can extend their role in supporting more health promoting messages
• Opportunities for using MECC (Make Every Contact Count Brief Intervention training and implementation) within service user contacts increasing the opportunities for health promoting messages and conversations
• If the test is easier and take up increases individuals could be encouraged to engage with other screening services. Positive experience with one will encourage further uptake.</td><td>-ve
• Could become too focused on bowel screening and overlook the wider health promotion messages
• Diabetics – evidence indicates that this group of patients are less likely to take up bowel screening important when considering lifestyles and related matters when managing the condition</td></tr>
<tr><td colspan="2">Comments/ questions/recommendations
• Comment/recommendation – opportunity to make better linkages with other screening services and more pro-active links/collaboration across PHW divisions and Health Boards and other frontline services around health promoting messages
• Recommendation – strengthen messages within the MECC training package re uptake of screening
• Comment evidence shows increase of co-morbidity when undergoing cancer treatment therefore increased opportunities to combine messages</td></tr>
<tr><th colspan="2">Social and Community Influences on Health</th></tr>
<tr><td>+ve
• Potential to gain more support from others to support individuals to undertake the test – easier and better procedure
• 1 test not over 3 days therefore not so intrusive to individuals routines/socialising, planning days/trips away
• No storage of test kits therefore reduced anxiety in the home for other family members/children</td><td>-ve
• None identified</td></tr>
</table>

<table>
<tr><td>• Opportunities for ‘word of mouth after undertaking the test – local net works important in promoting the take up</td><td></td></tr>
<tr><td colspan="2">Comments/ questions/recommendations
• Comment – how it is rolled out needs to be adaptive to the communities & individual vulnerable groups insight required into social and community influences in relation to this type of promotion – backed by education and communication
• 2 plans – implementation in terms of practical considerations and underpinned by focus on specific vulnerable groups
• Q. Is there evidence that Fit test is better
• EQiA – to reduce inequalities across and between groups and individuals to be completed
• Recommendation – identified need to improve data collection including ethnicity to inform:
o uptake interventions
o Ongoing development of service in relation to setting of the sensitivity levels of the test , can be set differently and informed by evidence regarding sensitivity and certain characteristics such as gender, These are important opportunities and not to be missed as the service evolves requires these considerations to be embedded in service plans
o Monitoring important should be evaluated closely regarding take-up across social groups & vulnerable groups that have historically had low uptakes of screening services qualitative and quantitative is required</td></tr>
<tr><th colspan="2">Mental wellbeing</th></tr>
<tr><td>+ve
• Positive experience and confidence in services increased
• Kit test could reduce anxiety in the test process
• Informed choice – opportunities to improve information and guidance
• Telephone helpline for those with queries between tests</td><td>-ve
• Difficult with sensory loss</td></tr>
<tr><td colspan="2">Comments/ questions/recommendations
• Prison population – evidence shows raised levels of mental health issues within prison population and this population group are not registered with GP – alternative approaches in place for Prison population
• Potential to improve communication between service and service users between screening updates etc. to build relationship/connection between and therefore hopefully improve take up</td></tr>
<tr><th colspan="2">Living and Environmental Conditions affecting health</th></tr>
<tr><td>+ve
• Shared housing – 1 test no storage should make things easier
• Learning disability, supported housing/sheltered accommodation/care setting easier test should improve things in these settings</td><td>-ve
• Implications for waste- packaging choice for test kits does have implications both for waste and process:
o Incineration
o Re-cycle
o Liquid
o Chemical waste
All of the above will factor in final choice of packing
• Homeless are a specific vulnerable</td></tr>
</table>

<table>
<tr><td></td><td>group , there has been some liaison with homeless groups ongoing work to be undertaken</td></tr>
<tr><td colspan="2">Comments/ questions/recommendations
• None identified</td></tr>
<tr><th colspan="2">Economic Conditions Affecting health</th></tr>
<tr><td>+ve
• Minimum impact on Bowel Screening staff – lab staff no redundancies shared services with cervical screening. There may be some changes to what they screen and change management procedures will be in place
• Those in employment with shift working new test should be better one test not over 3 days easier to plan and undertake</td><td>-ve
• Greater number of screening colonoscopies than needed and other diagnostic treatment services
• Need to look at reducing unnecessary referrals – recommendation education and awareness raising</td></tr>
<tr><td colspan="2">Comments/ questions/recommendations
• Question – raised had there been any health economic analysis of the FIT test – and yes there had and more expensive within diagnostic phase but across referral/treatment cost effective</td></tr>
<tr><th colspan="2">Access and quality of services</th></tr>
<tr><td>+ve
• use of multimedia to promote new test</td><td>-ve
• Need to improve education and awareness with GP's and primary care - new test provides opportunities to improve awareness of bowel screening and process and role for GP's and primary care
• Care needed to get the balance right between maximising PH benefit without putting too much pressure on services – ethical considerations here to balance especially related to the setting of the sensitivity test are you setting this to max PH benefit or setting it with pressures on service in mind
• Potential increase across clinical services which requires planning now not in future
• Potential to increase waiting times after screening results – requires ensuring back up services are in place to increase capacity to enable them to cope with potential increases this is also linked to the setting of the sensitivity level of the test
• There is potential for a considerable risk of impact on specific vulnerable group who are at risk outside of the age banding for testing , those with genetic predisposition and are one of the groups with the highest risk of developing</td></tr>
</table>

<table>
<tr><td></td><td>bowel cancer specific risk relates:
to post implementation of FIT if uptake rates increase focus on other vulnerable groups outside of screening programme may be reduced
Currently services for this group are inadequate and not consistent
Surveillance for this group requires improving</td></tr>
<tr><td colspan="2"><u>Comments/ questions/recommendations</u>
Implementation of FIT incorporate HIA methodology within implementation and evaluation stages
Improve and more pro-active engagement with primary care to improve uptake and confidence with bowel screening and FIT test
Evaluation to include clinical effectiveness
Recommendation – requires a very defined service development plan to include future considerations to changes of sensitivity levels etc
Recommendation specific point re services and impact risks for genetic predisposition group needs to included in business case/plan</td></tr>
<tr><th colspan="2">Macro economic, Environmental and sustainability Factors</th></tr>
<tr><td>+ve
With the WG approach of integrated working and joined up thinking opportunities arise to maximise the PH benefits from the introduction of the FIT test
Focus has to remain on maximising PH benefit as mentioned in previous sections the risk of introducing the FIT test with specific sensitivity levels if the uptake target is reached risk of seeing ‘job done’ whereby increased PH benefit could be achieved by developing service further by introducing specific sensitivity levels for specific groups and introduce extended age groups as initially envisaged for the service</td><td>-ve
Uncertainty if WG will approve implementation - no confirmation yet</td></tr>
<tr><td colspan="2">Comments/ questions/recommendations
None identified</td></tr>
</table>

There were also a number of key discussions and points raised throughout the session by the participants. These included:

- All invites are based on age as recorded in GP registers therefore no medical history or identification for individuals who the test is not appropriate i.e. no colon unknown status
- The take up of the test by men:

    - Partner ‘nagging’ this has shown to be effective for certain male groups within the population however there are known differences within different cultures – related to power balances within relationships in different cultures
    - Evidence suggests different approaches – up front messages and instant implementation are more effective i.e. very short run in time to undertake the test as is do it now. Differences between genders in how they deal with anxiety regarding the test
    - Local champions can support
- Alternative access to test kit: Questions were asked as to whether the new test kit could be accessed in a different ways other than being sent to individuals home. What was the potential to issue direct at GP/primary care to facilitate immediate take up. With the new test using just one sample could this be undertaken away from home? Other options - using the Tenovus ‘Man Van’ to issues kits? Could having test kits available in different settings aid the promotion and take up of the test? Could the difficulties in respect of eligibility be addressed to enable test kits to be given out at different settings i.e. GP surgeries?
- Promotion of the test: Could there be opportunities in linking more closely with district nursing to promote the screening test as part of Brief Intervention and Making Every Contact Count (MECC)
- Repeat tests:
    - 85% of those who have undertaken the test previously will undertake the test on subsequent invites.
    - Caution needs to be taken when promoting the new test/kits to those who have undertaken the test previously. Some may require careful explanation of how it works etc
    - If communication/promotion messages are not balanced then there is a risk that those who have undertaken the test previously and are ready for their next test may wait for the new test to be issued rather than use the old kit during the phasing in of the new FIT test. They could therefore end up missing a test which could have negative implications for their health outcomes because they are waiting for the new test which is being promoted as having a greater sensitivity/accuracy etc.
- The participants believe that the introduction of the new test provides opportunities to the Screening service to redevelop and strengthen the existing literature that accompanies the test kits. It can strengthen the promotional messages from an access and a health literacy perspective.
- Communication: A detailed communication plan is required which will be flexible to ensure updates and dialogue regarding the test development and the promotional and marketing literature can be tailored for specific groups and their needs.
    - All identified vulnerable groups have different needs in relation to communication/promotion/informing of new test bit most groups have advocates/support groups to support their engagement
    - The FIT Project Development Group will have a number of sub-groups including communication – The project group are aware of the need to develop different forms of communication using a number of media formats including social media and consideration of the welsh language and use of language and cultural considerations

  - Communication and procurement sub-groups service user involvement key
  - New test and its subsequent promotion and accompanying advice literature provides an opportunity for Bowel Screening to re-evaluate their approach and quantity of information they provide, increase its use of mixed media and develop a philosophy of 'less is more'. There was awareness that in the past the amount of information included in test packs may have been overwhelming to the point that individuals will ignore/throw it away without reading everything. Need to send the minimum level of information but screening have to decide what that is and what will meet the regulatory requirements. In addition a major consideration should be to enable fully informed consent from those requiring assistance to access and undertake the test along with any future intervention resulting from the test results. The Bowel Screening call desk does get feedback regarding the quantity of information sent with kits. It was recognised that there is more work to do to get the balance right in terms of quality, clarity and essentials and potential for a staged/layered approach. **Note: a very important element**
  - It was identified that it is very important to have a set of 'key responses' ready for those involved in the call desk to ensure consistency and accuracy of responses to questions raised by the public and service users
- Screening has dedicated engagement roles and vast experience in engaging a number of diverse groups
- Test Kits: There has to be some form of bar coding/dating of test sample and identification of individual in relation to the returned test kit however Bowel Screening Service recognise there are potentially a number of issues that could arise from this and have an impact on both uptake and also rejection of test if not completed fully, therefore they are keen to minimise the responsibilities placed on the individual when returning the kit and will be looking at options to address this where possible. It is important to remember that timing between test and return is an important part of the test process in terms of accuracy and viability of test.
- Service Delivery: Issues raised re capacity of related services following the introduction of the FIT test. There was recognition that there are timeliness difficulties with symptomatic colonoscopy.

<u>Recommendations and suggestions for the introduction of the FIT test from the participants</u>

Several suggestions were proposed during the discussions in respect of strengthening the delivery of FIT. These are summarised below:

- There is an opportunity to make better linkages with other screening services and more pro-active links/collaboration across PHW divisions and Health Boards (and other frontline services) around health promoting messages. There is a need to strengthen messages within the MECC Brief Intervention training package in respect of the uptake of screening services.
- There is huge potential to improve communication between service deliverers and service users to build relationships/connections between them and therefore hopefully improve the take up rate.

- Change to the FIT test requires a defined service development plan. This must include any future considerations about changes to sensitivity levels etc
- It was specifically highlighted that in relation to the impact risks of the service for those who are genetically predisposed to cancer needs to included in business case/plan
- There is a need to explore alternative approaches for the prison population. Evidence shows raised levels of mental health issues within the prison population and this population group are not always registered with a GP.
- How it is rolled out needs to be adaptive to the communities & individual vulnerable groups. Insight is required into social and community influences in relation to this type of promotion – backed by education and communication
- Identified need to improve data collection including ethnicity to inform:
    - uptake interventions
    - Ongoing development of the service in relation to setting the sensitivity levels of the test (which can be set differently) and informed by evidence regarding sensitivity and certain characteristics such as gender. These are important opportunities and not to be missed as the service evolves requires these considerations to be embedded in service plans
- Monitoring is very important. Any pilot should be evaluated closely regarding the take-up across social groups and vulnerable groups – particularly those who have historically had low uptakes of screening services. Qualitative and quantitative data is required as part of this.

<u>Summary</u>

The workshop followed a systematic process, provoked a lively and wide ranging discussion and beneficial connections to other policy areas, services and stakeholders. Overall, it was concluded that the FIT test has the potential to be highly beneficial to the population of Wales. It will positively deliver to key populations and can facilitate better health and wellbeing by increasing uptake rates. However, it also highlighted there are some issues which need to be addressed in order to enhance its effectiveness and the effectiveness of the screening service delivered.

As part of the HIA, an evaluation form for the workshop was distributed and participants were asked to leave anonymous feedback (Appendix Four). The comments provided were highly positive.

The information and evidence gathered as part of the HIA will be now used as part of all the collated evidence to inform any decisions about the introduction of a pilot FIT test scheme or a full screening programme.

<u>Authors:</u>

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Appendix One

Programme for the HIA Workshop

9:30am	Registration (Tea/Coffee available)
10:00	Introductions – *Hayley Heard, Head of Bowel Screening, Public Health Wales*
10:10	An outline of the new Bowel Screening Test - *Hayley Heard, Head of Bowel Screening, Public Health Wales*
10:20	Outline of Health Impact Assessment and the morning – *Liz Green, Principal Health Impact Assessment Development Officer, Public Health Wales/Wales HIA Support Unit*
10:30	Introduction to Appraisal Tool - *Liz Green*
10:35	Screening session – using appraisal tool to identify key health impacts of the proposal. *Liz Green and Lee Parry-Williams, Senior Public Health Practitioner, Public Health Wales/Wales HIA Support Unit*
11:30	Refreshment break
11:45	Screening session – continued
12.15pm	Feedback or recommendations – *Liz Green and Lee Parry-Williams*
12:45	Finish and Evaluation
13:00pm	Close

Appendix Two

Vulnerable/Disadvantaged Groups Checklist

(Please note that this list is a guide and is not exhaustive)

The target groups identified as vulnerable or disadvantaged will depend on the characteristics of the local population and the nature of the proposal itself. The most disadvantaged and/or vulnerable groups are those which will exhibit a number of characteristics, for example children in living poverty. This list is therefore just a guide and it may be appropriate to focus on groups that have multiple disadvantages.

Age related groups*

- Children and young people
- Older people

Income related groups

Groups who suffer discrimination or other social disadvantage

- People with physical or learning disabilities/difficulties
- Refugee groups
- People seeking asylum
- Travellers
- Single parent families
- Lesbian and gay and transgender people
- Black and minority ethnic groups**
- Religious groups**

Geographical groups

- People living in areas known to exhibit poor economic and/or health indicators
- People living in isolated/over-populated areas
- People unable to access services and facilities

The impact on the general adult population should also be assessed. In addition, it may be appropriate to assess the impact separately on men and women

* Could specify age range or target different age groups for special consideration.

** May need to specify

Appendix Three Health and Well-Being Determinants Checklist

1. Lifestyles	• Diet • Physical activity • Use of alcohol, cigarettes, non-prescribed drugs • Sexual activity • Other risk-taking activity
2. Social and community influences on health	• Family organisation and roles • Citizen power and influence • Social support and social networks • Neighbourliness • Sense of belonging • Local pride • Divisions in community • Social isolation • Peer pressure • Community identity • Cultural and spiritual ethos • Racism • Other social exclusion
3. Living/ environmental conditions affecting health	• Built environment • Neighbourhood design • Housing • Indoor environment • Noise • Air and water quality • Attractiveness of area • Green space • Community safety • Smell/odour • Waste disposal • Road hazards • Injury hazards • Quality and safety of play areas
4. Economic conditions affecting health	• Unemployment • Income • Economic inactivity • Type of employment • Workplace conditions
5. Access and quality of services	• Medical services • Other caring services • Careers advice • Shops and commercial services • Public amenities • Transport including parking • Education and training • Information technology
6. Macro-economic, environmental and sustainability factors	• Government policies • Gross Domestic Product • Economic development • Biological diversity • Climate

Appendix Four

Health Impact Assessment
Bowel Screening HIA Workshop Evaluation
8th September 2016
(22 present 20 returns)

1. **What did you learn during the workshop?**

1	Really interesting to see the different options available with the new fit test and consider the impact of this on the different communities we work with.
2	Broader perspectives on the FIT rollout
3	Diabetic take up of bowel screening is lower
4	Very interesting discussing +ve & -ve
5	How positive the service is
6	Importance of future planning Different stakeholders opinions relevant & importance Making the most of this FIT opportunity
7	-what is HIA - the importance of joint working
8	Communication is key Vulnerable groups will still struggle to complete the new kit- need further continuing work to ensure inclusivity
9	About the wider public health agenda and plan for FIT That implementing FIT and increasing uptake will not necessarily mean a reduction in equalities in health
10	Public Health involvement in future planning of healthcare needs – different views of screening engagement & how many 'hard to reach' groups there are
11	That improvements in sending/receiving and evaluating tests are being implemented. FIT will be more likely to be taken up
12	The process involved in implementing the new test
13	To consider all groups separately
14	People's perceptions of how the FIT should be rolled out/implemented Interesting to see how FIT will impact on BSW
15	I learnt so much about the issues currently facing Bowel Screening and the potential future pathway
16	See item 3
17	We need joined up working! Engagement with local Public |health Teams and BSW. Public Health team need to communicate this!
18	A greater understanding around the impact of introducing FIT on the population of Wales.
19	How screening in Wales fits with other health care agencies. What is involved in HIA.
20	- about the project and HIA - Challenges and opportunities of the project - how these issues fit with wider health service issues in terms of implementing

	HIA and EIA

2. **What do you feel were the positive outcomes resulting from this workshop?**

1	Really good discussion generated during the morning
2	Better understanding of the possible outcomes + impact
3	Support for FIT implementation
4	Having input from multidisciplinary teams
5	Being shown exactly how the new FIT test will work
6	\identified different groups we are not accessing Developing IT systems to catch ethnic data in future . Future planning
7	- positive attitude to change in test kit - covered the potential to work across boundaries in screening and with primary and secondary sectors
8	Positive move to introduce the kit Opportunity to improve communication & cross working
9	The input from charity ‘cancer’ which kept us in terms of vulnerability and thinking that the increase in uptake will solve all the problems
10	Acknowledgement of ‘hard to reach’ groups. Seeing the impact on members of general public
11	Very informative and interesting
12	That a better test is coming
13	Discussion about how to improve collaborative with relevant groups
14	More clarity of the FIT
15	Great debate and group consensus
16	The FIT Programme will, I am sure, have a positive outcome by increasing uptake as a (one only) test
17	The passion from all for the beast possible test kit for all who want to participate in BSW
18	How positively FIT is being received.
19	A common wish for services to join up and promote screening together with other health issues and to reach all groups of the population. That FIT is the way forward.
20	- sharing of ideas – could have positive impact - networking + links to take things forward - not just a tick box exercise

3. **What do you think worked and what didn’t?**

1	The session was facilitated really well, facilitators were engaging and it was really interesting to see HIA in action.
2	Good that session was structured but we also talked about topics on schedule so maybe stricter sticking to topic more detailed breakdown instructions
3	Good discussion Framework worked well
4	Understanding everyone’s role + responsibilities – on introductions info of

	everyone's roles to understand their points + concerns
5	The input of all the professionals present
6	N/A
7	All worked – did no have any negative points
8	-
9	All worked well
10	Good, valuable discussion & having the opportunity to hear others' points of view.
11	-
12	Flow of the meeting was good
13	Worked well
14	-
15	Open session and the large groups worked very well
16	The idea of having many health professionals with their thoughts and ideas on how to progress and expand the FIT programme really helped me understand more of the complexities needed to roll out a new health programme.
17	We needed more participants from all backgrounds at the meeting/workshop
18	Positive experience + well facilitated
19	Interaction within the group and short introduction worked well.
20	+ open discussion good -ve not everyone inputting - lack of diverse, third sector representation

4. **What were your expectations prior to the session? Did the session meet them? (Please rate them 1-10 where 1 = not at all, 10=very much met them).**

1	8
2	7
3	8
4	10
5	10, I learnt a lot , thank you
6	8
7	Did not know what HIA was. Was very impressed with the way the session was handled. 10
8	7
9	10
10	8
11	Very good to meet everyone and getting viewpoints etc. 10
12	7
13	10
14	10
15	Expectations – I didn't have any (My 1st HIA) end expectations 10
16	Really no expectations but it has been a privilege to be part of workshop programme and to contribute in some small way. Expectation
17	Expectation 4

	Meeting them 8
18	8 – very useful morning
19	Wasn't sure what to expect really but very useful
20	-Talk through HIA - 8

5. **Any other comments you wish to make?**

1	--
2	-
3	Interesting session Thanks
4	-
5	As a lay person I still found many interesting and positive
6	-
7	-
8	-
9	Onwards & upwards
10	-
11	No – just good to meet BSWales team again!
12	-
13	Excellent morning thank you
14	Feedback on the comments made from today's session
15	N/A
16	-
17	Good start!
18	-
19	-
20	-