Together we will beat cancer

CANCER RESEARCH UK

Cancer Research UK

Cancer Awareness Measure (CAM)

This survey instrument (CAM) was developed by Cancer Research UK, University College London, Kings College London, and University of Oxford in 2007-2008.

INTERVIEWER NAME (FULL NAME)	INT. I.D. NUMBER
INT. TIME: (USE 24 HOUR CLOCK) _____ HRS _____ MINS	INT. DATE:
DATABASE REFERENCE NUMBER:	WARD NAME: SOA:

Good morning/afternoon. My name is xxxx and I am from BMG Research. We are carrying out research on behalf of Mount Vernon Cancer Network.

This set of questions is about cancer awareness and should take around 15 minutes to complete. This is not a test, we are interested in your thoughts and beliefs so please answer the questions as honestly as you can. All your answers are confidential. Please be aware that I am unable to answer questions during the interview, but there will be time to address any queries at the end. Please also be aware that I can not go back to a question that has already been asked.

Q1. This first set of questions is about warning signs of cancer. There are many warning signs and symptoms of cancer. Please name as many as you can think of:

Instructions: prompt "*anything else*" until respondent can think of no more warning signs or symptoms. If a respondent states that they do not know or can not think of any signs or symptoms for cancer please prompt with *"are you sure"* and if necessary "*take a minute to think about it"*.

Q2. The following may or may not be warning signs for cancer. We are interested in <u>your</u> opinion:

Read out and code one box per row

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

If the respondent asks for clarification about certain items within this set of questions, please refer to the ‘Point of clarification’ written with the items. Please only read these out if necessary.

	Yes	No	Don’t know
Do you think an unexplained lump or swelling could be a sign of cancer?	☐	☐	☐
Do you think persistent unexplained pain could be a sign of cancer?	☐	☐	☐
Do you think unexplained bleeding could be a sign of cancer?	☐	☐	☐
Do you think a persistent cough or hoarseness could be a sign of cancer?	☐	☐	☐
Do you think a persistent change in bowel or bladder habits could be a sign of cancer?	☐	☐	☐
Do you think persistent difficulty swallowing could be a sign of cancer?	☐	☐	☐
Do you think a change in the appearance of a mole could be a sign of cancer?	☐	☐	☐
Do you think a sore that does not heal could be a sign of cancer?	☐	☐	☐
Do you think unexplained weight loss could be a sign of cancer?	☐	☐	☐

Q3.If you noticed an unexplained lump or swelling how soon would you contact your doctor to make an appointment to discuss it? SHOWCARD 1

Read out and code one only.

DO NOT give “don’t know” or “Prefer not to say” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3a. If you had unexplained pain how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3b. If you had unexplained bleeding how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3c. If you had a cough or hoarseness how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3d. If you noticed a change in bowel or bladder habits how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3e. If you had difficulty swallowing how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3f. If you noticed a change in the appearance of a mole how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3g. If you had a sore that did not heal how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3h. If you had unexplained weight loss how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never	Prefer not to say
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q4. If you had a symptom that you thought might be a sign of cancer how soon would you contact your doctor to make an appointment to discuss it? **SHOWCARD 1**

Read out and code one only.

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Don’t know	Never
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q5. Sometimes people put off going to see the doctor, even when they have a symptom that they think might be serious. These are some of the reasons people give for delaying. Could you say if any of these might put you off going to the doctor?

Read out and code one per row. **SHOWCARD 2**

DO NOT give "don't know" as an option but record it if the respondent says it spontaneously.

Only ask about the barriers that are listed.

	Yes often	Yes sometimes	No	Don't know
I would be too embarrassed	☐	☐	☐	☐
I would be too scared	☐	☐	☐	☐
I would be worried about wasting the doctor's time	☐	☐	☐	☐
My doctor would be difficult to talk to	☐	☐	☐	☐
It would be difficult to make an appointment with my doctor	☐	☐	☐	☐
I would be too busy to make time to go to the doctor	☐	☐	☐	☐
I have too many other things to worry about	☐	☐	☐	☐
It would be difficult for me to arrange transport to the doctor's surgery	☐	☐	☐	☐
I would be worried about what the doctor might find	☐	☐	☐	☐
I wouldn't feel confident talking about my symptom with the doctor	☐	☐	☐	☐

Other (please specify)

Q6. What things do you think affect a person's chance of getting cancer?

Please write in below.

Prompt "*anything else*" until respondent can think of no more warning signs or symptoms. If a respondent states that they do not know or can not think of any risk factors for cancer please prompt with *"are you sure"* and if necessary "*take a minute to think about it"*.

Q7. Medical scientists suggest that these are some of the things that can increase the chance of getting cancer. How much do you agree that each of these can increase the chance of getting cancer? SHOWCARD 3

Read out and code one per row. DO NOT PROMPT

DO NOT give “don’t know” as an option but record it if the respondent says it spontaneously.

If the respondent asks for clarification about certain items within this set of questions, please refer to the ‘Point of clarification’ written with the items. Please only read these out if necessary.

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
Smoking any cigarettes at all	☐	☐	☐	☐	☐
Exposure to another person’s cigarette smoke	☐	☐	☐	☐	☐
Drinking more than 1 unit of alcohol a day	☐	☐	☐	☐	☐
Eating less than 5 portions of fruit and vegetables a day	☐	☐	☐	☐	☐
Eating red or processed meat once a day or more	☐	☐	☐	☐	☐
Being overweight (BMI over 25)	☐	☐	☐	☐	☐
Getting sunburnt more than once as a child	☐	☐	☐	☐	☐
Being over 70 years old	☐	☐	☐	☐	☐
Having a close relative with cancer	☐	☐	☐	☐	☐
Infection with HPV (Human Papillomavirus)	☐	☐	☐	☐	☐
Doing less than 30 mins of moderate physical activity 5 times a week	☐	☐	☐	☐	☐

Q8. Here is a picture of 100 people. Out of 100 people, how many do you think will develop cancer at some point in their life? SHOWCARD 4

Please write in below on the dotted line.

DO NOT PROMPT

___ ___ ___ people out of 100 will develop cancer at some point in their life

Q9. What do you think is the **most** common cancer in women? DO NOT PROMPT
Please write in below

Q9a. What do you think is the **second** most common cancer in women? DO NOT PROMPT
Please write in below

Q9b. What do you think is the **third** most common cancer in women? DO NOT PROMPT
Please write in below

Q9c. What do you think is the **most** common cancer in men? DO NOT PROMPT
Please write in below

Q9d. What do you think is the **second** most common cancer in men? DO NOT PROMPT
Please write in below

Q9e. What do you think is the **third** most common cancer in men? DO NOT PROMPT
Please write in below

DO NOT PROMPT
Read out and code one box per row

	Yes	No	Don't know
Q10a1. Is there an NHS breast cancer screening programme?	☐	☐	☐
Q10a2. If yes, at what age are women first invited for breast cancer screening? _____			☐
Q10b1.Is there an NHS cervical cancer screening programme (smear tests)?	☐	☐	☐
Q10b2.If yes, at what age are women first invited for cervical cancer screening? _____			☐
Q10c1.Is there an NHS bowel cancer screening programme?	☐	☐	☐
Q10c2. If yes, at what age are people first invited for bowel cancer screening? _____			☐

Q11. Please put the following things in order of how much you think they contribute to cancer in the UK:

Read out and put in order of importance with 1 being most important and 5 being least important.

Only ask about the factors listed.

Lifestyle (e.g. smoking, diet, physical activity)

Chance

Aging

Environmental factors (e.g. pollution, radiation)

Genetic inheritance (e.g. runs in the family)

1. _____ (Most important)
2. _____
3. _____
4. _____
5. _____ (Least important)

Q12 (18). What is your age? ☐☐

Q13 (19). What is your gender?

☐ Male ☐ Female

Q14 (20). Which of these best describes your ethnic group? Code one only **SHOWCARD 8**

White	Mixed	Asian or Asian British	Black or Black British	Chinese/other
☐ White British	☐ White and Black Caribbean	☐ Indian	☐ Black Caribbean	☐ Chinese
☐ White Irish	☐ White and Black African	☐ Pakistani	☐ Black African	☐ Other……
☐ Any other White background	☐ White and Asian	☐ Bangladeshi	☐ Any other Black background	
	☐ Any other Mixed background	☐ Any other Asian background		☐ Prefer not to say

Q15 (21). What is your marital status? Code one only **SHOWCARD 9**

Single/never married	Married/living with partner	Married separated	Divorced	Widowed	Civil partnership	Prefer not to say
☐	☐	☐	☐	☐	☐	☐

Q16 (22). What is the highest level of education qualification you have obtained? Code one only **SHOWCARD 10**

- ☐ Degree or higher degree
- ☐ Higher education qualification below degree level
- ☐ A-levels or highers
- ☐ ONC/BTEC
- ☐ Prefer not to say
- ☐ O Level or GCSE equivalent (Grade A - C)
- ☐ O Level or GCSE (Grade D - G)
- ☐ No formal qualifications
- ☐ Other …….

Q17 (23). Please tick the box which best describes your living arrangement: Code one only **SHOWCARD 11**

Own outright	Own mortgage	Rent from Local Authority/Housing Association	Rent privately	Squatting	Other (e.g. living with family/friends)	Prefer not to say
☐	☐	☐	☐	☐	☐	☐

Q18 (24). What is your Postcode? Please write in below

Q19 (25). Are you currently: Code one only **SHOWCARD 12**

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Unemployed
- ☐ Self-employed
- ☐ Prefer not to say
- ☐ Full-time homemaker
- ☐ Retired
- ☐ Student
- ☐ Disabled or too ill to work

Q20 (26). Does your household own a car or van? Code one only

No	Yes, one	Yes, more than one	Prefer not to say
☐	☐	☐	☐

Q21 (27). Have you, your family or close friends had cancer? Code one per row

	Yes	No	Not sure	Prefer not to say
You	☐	☐	☐	☐
Partner	☐	☐	☐	☐
Close family member	☐	☐	☐	☐
Other family member	☐	☐	☐	☐
Close Friend	☐	☐	☐	☐
Other Friend	☐	☐	☐	☐

Q22 (28). How many years have you been living in the UK? Please write in

☐☐

Q23 (29). What is the main language spoken at home?

- ☐ English
- ☐ Urdu
- ☐ Punjabi
- ☐ Gujarati
- ☐ Sylheti
- ☐ Cantonese
- ☐ Other (please specify)……..
- ☐ Prefer not to say

Q24 (30). Mount Vernon may want to follow up this interview with additional research, such as focus groups, to further explore levels of awareness of cancer and the symptoms of cancer, and how best to promote awareness. Would you be interested in finding out more about this further research? Code one only

Yes	No	Don't know
☐	☐	☐

Thank respondent and close – give information sheet and letter to respondent.

RESPONDENT'S NAME :	
ADDRESS : (Address Line 1)	
(Address Line 2)	
(Address Line 3)	
(Postal Town)	
(County)	
POSTCODE : **(ESSENTIAL)**	
TELEPHONE : (INCLUDING **STD**) **(ESSENTIAL)**	

Interviewer: Someone from BMG Research may call you, as part of our quality control processes to ensure I have completed this interview with you.

RESPONDENT TO COMPLETE:

I CONFIRM THAT THIS INTERVIEW WAS CONDUCTED WITH MYSELF IN A PROPER MANNER AND THAT THE DETAILS HAVE BEEN RECORDED ACCURATELY.

SIGNATURE: _____

PRINT NAME:_____

Interviewer's signature: _____

Research Report

Cancer Awareness in Hertfordshire, Luton and South Bedfordshire

Prepared for: Mount Vernon Cancer Network

bmg research

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Prepared for: Mount Vernon Cancer Network

Prepared by: Jenna Allen, Associate Account Director

September 2010

Produced by BMG Research

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1 Introduction

1.1 Background

This report summarises the results of a survey of cancer awareness across the Mount Vernon cancer network area, carried out by BMG Research in 2010. The Mount Vernon cancer network is made up of Luton, South Bedfordshire, West Hertfordshire and East and North Hertfordshire Primary Care Trusts. The survey took place prior to the merger of the two Hertfordshire PCTs.

The survey was carried out using the Cancer Research UK Cancer Awareness Measure, a validated instrument developed by University College London, King's College London and University of Oxford. It is used to assess level of awareness and anticipated help-seeking behaviour amongst the public in relation to cancer.

The questionnaire included questions relating to:

- Knowledge of the warning signs and symptoms of cancer;
- Anticipated delays before contacting a doctor;
- Barriers to seeking medical advice;
- Knowledge of risk factors of cancer;
- Knowledge of lifetime risk of cancer;
- Knowledge of most common cancers; and
- Knowledge of NHS screening programmes.

1.2 Survey Method

A total of 2,018 interviews were conducted face-to-face with residents using CAPI (Computer Aided Personal Interviewing) technology. Interviews took place between February and May 2010. During interviewing, quotas were set for PCT, age, gender and ethnicity to ensure the sample represented as closely as possible the population of the Mount Vernon cancer network area. Upon completion of the interview, respondents were provided with an information sheet which gave them the answers to the questions contained within the interview, as well as providing details of support services should they require further information or wish to discuss anything that the survey had highlighted. The interviews lasted an average of 15 minutes.

1.2.1 Sampling

The target population for the survey was the adult population (18+) of the Mount Vernon cancer network area. The survey was conducted via a household face-to-face methodology, using a stratified random sample obtained from the Royal Mail's Postcode Address File (PAF). The sample was selected by stratifying Super Output Areas (SOAs) according to their deprivation quintile and then selecting every 'nth' address within the selected SOAs. Fixed interviewing targets were set by PCT in proportion to the resident population. In addition, responses were also monitored by age, gender and ethnicity to ensure the survey was representative of the resident population. Interviews were conducted weekdays, weekends and evenings to ensure a representative sample. All sampled households were visited up to a further three times

if the initial knock did not illicit a response. To further ensure the randomness of the sample, respondents were selected using the birthday rule, whereby the interview was conducted with the person aged over 18 years who has had their birthday most recently.

A unique sampling strategy was applied for this study, which incorporated a number of boost areas, with set targets within each:

- Main sample: The target for the main sample was 1,000 interviews and these were to cover the entire Mount Vernon cancer network area using the sampling strategy described above. A total of 1,002 interviews were conducted in total.
- Intervention area: The Mount Vernon Cancer Network was interested in exploring the impact of sending out an information leaflet to residents in advance of the survey taking place (leaflet shown in Appendix 1). This leaflet informed residents of the symptoms of cancer as well as health promotion advice. The Mount Vernon Cancer Network was responsible for distributing these leaflets and provided BMG Research with the necessary postcodes from which to sample the interviews. Interviewing took place at least 4 weeks after the delivery of the leaflets. A total of 507 interviews were conducted in Watford.
- Control area 1: To be able to give a valid measurement of the impact of the leaflets on resident awareness of cancer, a control area was selected to closely reflect the attributes of the intervention area (for example, by deprivation, education attainment levels and type of area). 5 SOAs were selected for inclusion in the sample, all of which were located in Luton. A total of 249 interviews were conducted in this area.
- Intervention area 2: An additional requirement was to explore the impact of not only sending an information leaflet to residents, but to also enclose a covering letter signed off by the Network Director and the primary care lead (see Appendix 2). The hypothesis being that residents would be more inclined to read the leaflet and hence demonstrate higher levels of awareness. Again, 5 SOAs were selected as the sampling areas, and were chosen because they display the same characteristics as the intervention area and control area 1. A total of 254 interviews were conducted in this area.

The following table gives a summary of the number of interviews conducted in each of the different survey areas and the associated confidence we have in the data:

Table 1: Number of returns and confidence interval per survey area

Survey area	Number of completed interviews	Confidence interval
Main sample	1002	+/-3.1%
Control area 1 (no letter or leaflet sent)	249	+/-6.2%
Intervention area (leaflet sent)	507	+/-4.4%
Intervention area 2 (letter and leaflet sent)	254	+/-6.1%
Total	**2018**	**+/-2.2%**

1.2.2 Questionnaire design

The CAM is a validated questionnaire and as such is standardised to ensure consistency and comparability of data. However, upon review of the questionnaire some issues were raised by BMG Research with Cancer Research UK, who designed the validated questionnaire, and minor changes to its design were approved. These changes did not affect any of the questions asked or reduce the data comparability with surveys conducted in other areas.

1.3 Data

In total, 2,018 interviews were completed with respondents aged 18+ years. The sample size of 2,018 is subject to a maximum standard error of ±2.2% at the 95% confidence level on an observed statistic of 50%. Thus, for the quantitative survey, we can be 95% confident that responses are representative of those that would be given by the total population of Mount Vernon, if a census had been conducted, to within ±2.2% of the percentages reported.

This means that if the total population of Mount Vernon had completed the survey and a statistic of 50% was observed, we can be 95% confident that the response lies between 47.8% and 52.2%.

1.3.1 Weighting

To ensure that the results are representative of the population, the data has been weighted by PCT, gender, age, and ethnicity to match the 2001 Census data. Weighting is a statistical technique used to counteract the deviations that occur in survey samples against the population as a whole. In this case, weighting by PCT, age, ethnicity and gender has been used to ensure that the sample used here corresponds to the overall population of Mount Vernon.

At its most basic level, this means that if a national survey of 1,000 people is made up of 550 men and 450 women, then the survey is unrepresentative of the UK population as 51% is female. Therefore weighting would be applied to give the responses from female respondents slightly more weight (in this case each female respondent would be equivalent to 1.133 people) to give them a representative impact on the final results. Conversely, men would be weighted to each count as 0.891 so that their responses were not over represented in the final data.

1.4 Reporting

Throughout this report the word significant is used to describe differences in the data. This indicates where the data has been tested for statistical significance. This testing identifies 'real differences' (i.e. differences that would occur if we were able to interview all residents in the borough rather than just a sample). However, as already noted the actual percentages reported in the data may vary by ±2.2% at the 95% confidence level on an observed statistic of 50%.

Figures and tables are used throughout the report to assist explanation and analysis. Although occasional anomalies appear due to 'rounding' differences, these are never more than +/-1%. These occur where rating scales have been added to calculate proportions of respondents who agree at all (i.e. either agree or strongly agree).

On receipt of each completed questionnaire, BMG coded the verbatim (open-ended) questions, input and then analysed the data. Throughout this report there is analysis at both a total and sub sample level, e.g. gender, ethnicity, age and economic status.

Important: The majority of the results included within the report are based on the combined figures of those residents interviewed in the main and control area 1 samples (n=1251). This is because these residents had not been given any health promotional material prior to the survey commencing. These are the results that are to be fed back to Cancer Research UK as part of the standardised CAM survey process. However, where necessary, tables / graphs have been provided that present the comparisons between the different survey areas, as a means of identifying whether promotional materials sent out to the intervention area and intervention area 2 had an impact on responses.

2 Awareness of warning signs of cancer

2.1 Introduction

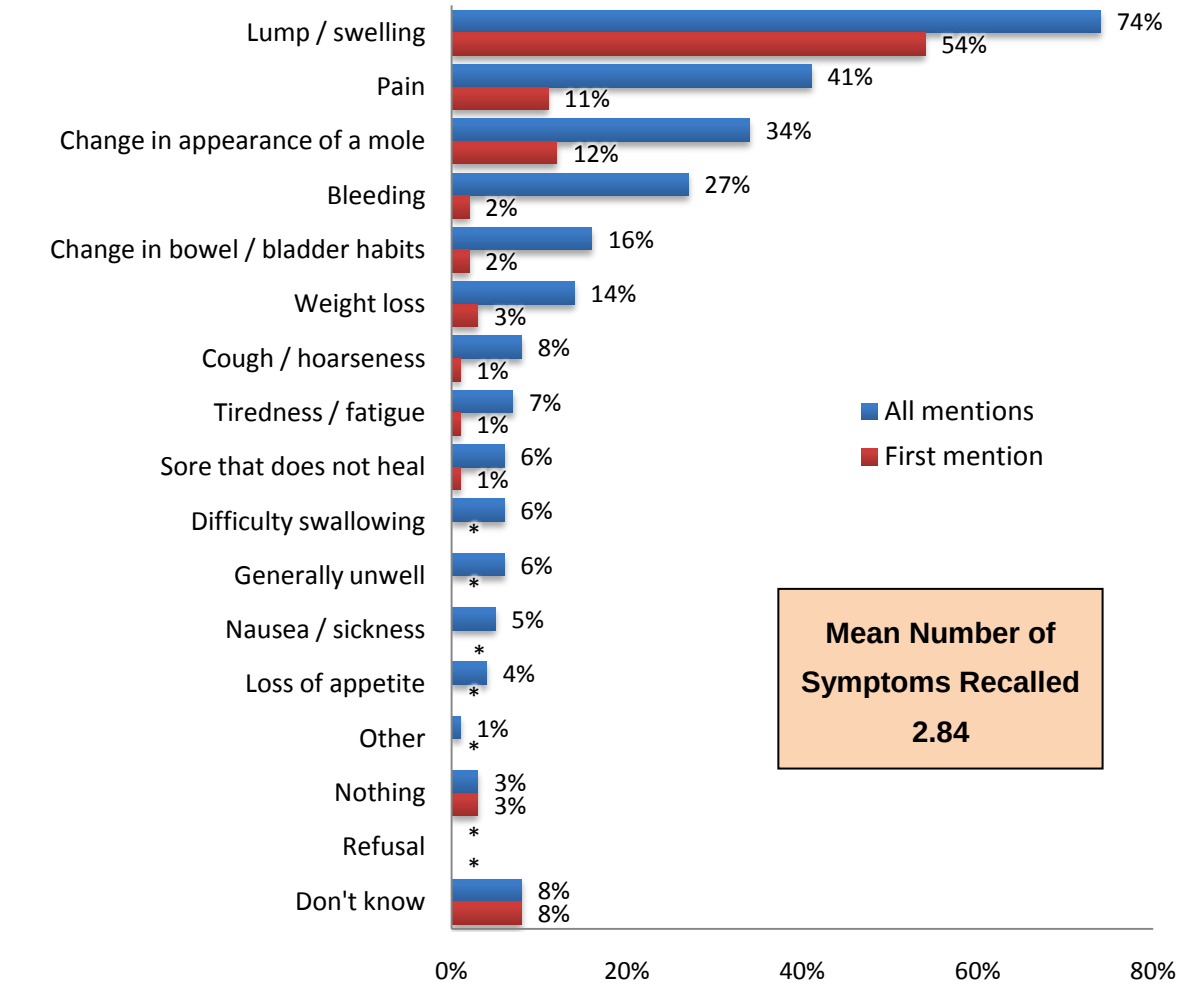
The following section explores resident awareness of the warning signs of cancer.

2.2 Unprompted awareness of warning signs

All respondents were asked to name as many warning signs and symptoms of cancer as they could think of. The first mentioned sign or symptom was recorded separately to enable analysis of the top of mind awareness.

The most highly recalled warning sign or symptom of cancer is the classic tumour symptom of a lump or swelling and this is spontaneously mentioned by around three quarters of the sample (74%). All other symptoms were recalled at comparatively lower levels, around two fifths mentioned pain (41%), a third the change in appearance of a mole (34%) and a quarter, bleeding (27%). Only 6% of respondents mention a sore that doesn't heal or, difficulty swallowing. On average, 2.84 symptoms were recalled, but the symptom that gains the highest top of mind awareness, i.e. the symptom that is most tightly associated with cancer is a lump or swelling and this is the first mentioned cancer warning sign or symptom by just over half of all respondents (54%). Pain and the changing appearance of a mole were the first recalled cancer symptom by just over one in ten (11% and 12% respectively). Full details of the first mentioned and all mentioned symptoms are provided in the chart below.

Figure 1: There are many warning signs and symptoms of cancer. Please name as many as you can think of (unprompted) (All respondents)



Unweighted base: 1251

* denotes <0.5%

Men and women spontaneously recall the same top three signs or symptoms, a lump or swelling, pain and a change in the appearance of a mole. However, women are more likely to spontaneously recall a greater number of symptoms overall than men, 2.94 compared to 2.7. The symptoms that women recall at a significantly higher level are pain (43% c.f. 37% males), changing moles (36% c.f. 31%), bleeding (30% c.f. 23%) and a sore that won't heal (9% c.f. 3%).

Analysis by PCT shows higher levels of spontaneous awareness of cancer warning signs within both Luton PCT and South Bedfordshire PCT (98% mentioned a symptom) when compared to the East and North Hertfordshire PCT (80% mentioned a symptom) or West Hertfordshire PCT (84%). There is also an increased depth of awareness of cancer symptoms in both Luton and South Bedfordshire with participants in these areas each recalling a greater number of symptoms (3.23 and 3.24 respectively).

Table 2: Unprompted awareness of warning signs / symptoms of cancer

(All mentions by PCT – All responses) * denotes <0.5%

	East and North Herts	West Herts	Luton	South Bedfordshire
MENTIONED SOMETHING	**80%**	**84%**	**98%**	**98%**
Lump / swelling	59%	65%	94%	94%
Pain	24%	33%	59%	58%
Change in appearance of a mole	13%	24%	56%	59%
Bleeding	17%	25%	37%	23%
Change in bowel / bladder habits	11%	17%	17%	22%
Weight loss	20%	14%	9%	12%
Cough / hoarseness	6%	7%	10%	8%
Tiredness / fatigue	8%	9%	2%	5%
Difficulty swallowing	3%	4%	10%	6%
Sore throat that does not heal	4%	9%	4%	10%
Generally unwell	4%	5%	8%	10%
Nausea / sickness	7%	5%	4%	2%
Loss of appetite	3%	3%	5%	4%
Feeling weak	3%	1%	2%	1%
Bruising	*%	*%	*%	1%
Blurred vision	0%	0%	*%	0%
Other	2%	1%	*%	0%
Don't know/nothing	20%	16%	2%	2%
MEAN NO. OF MENTIONS	**2.33**	**2.67**	**3.24**	**3.23**
Unweighted base	**402**	**380**	**382**	**87**

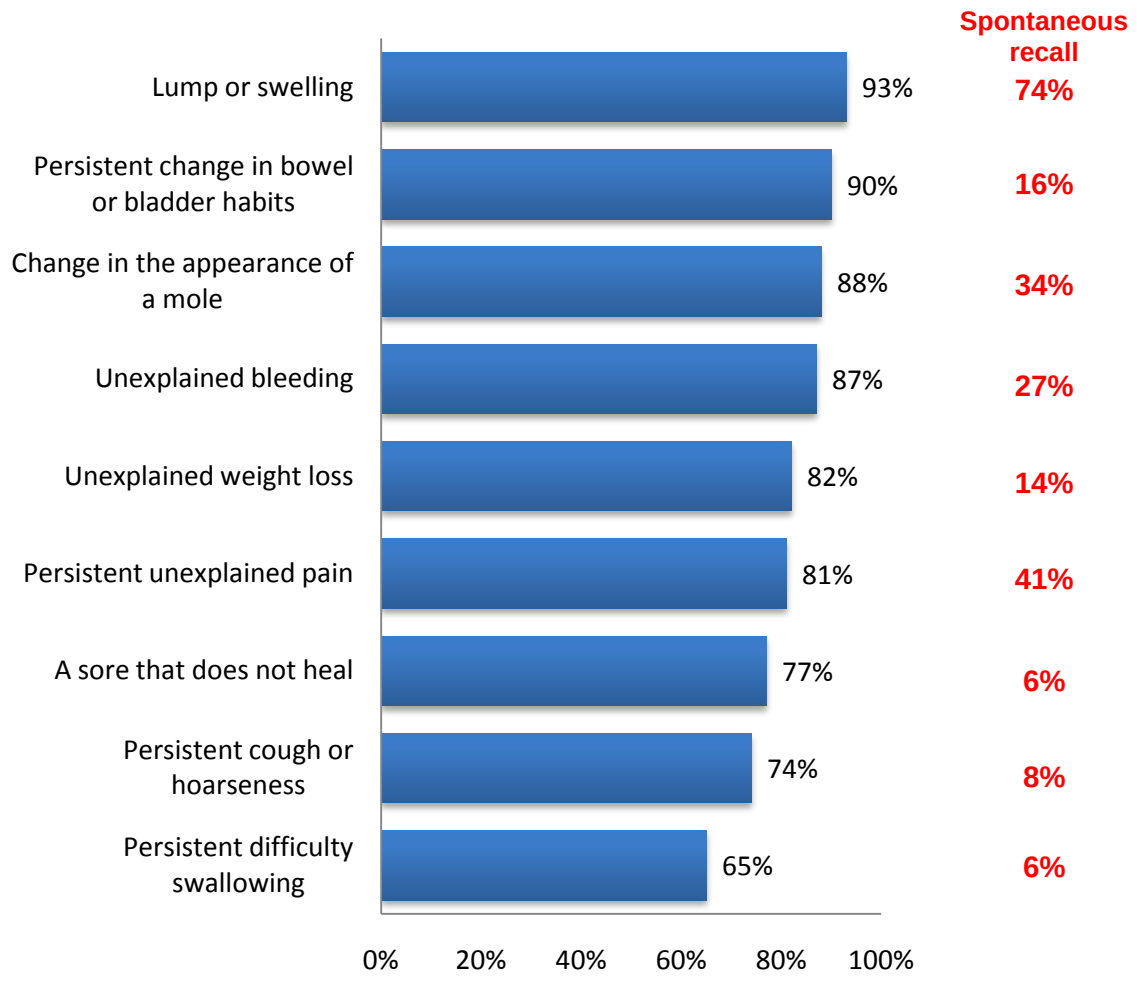
2.3 Recognition of warning signs of cancer (prompted)

Respondents were then read a list of different symptoms, such as an unexplained lump or swelling, or persistent unexplained pain, and asked if they thought each were a warning sign of cancer. 'Persistent' in reference to any of the warning signs refers to 3 weeks or longer.

Prompted recognition of symptoms gave a considerably higher score than recall. A lump or swelling (93%) and changes in bowel or bladder habits (90%) were the most recognised signs, identified by more than nine in ten respondents. Even the least recognised potential warning sign, persistent difficulty in swallowing, was acknowledged by two thirds of participants (65%). The mean number of symptoms recognised was 7.4 out of 9.

Reviewing the level of prompted recognition to spontaneous recall identifies the warning signs or symptoms that participants would most readily associate with cancer i.e. a lump or swelling (93%:74%) and persistent unexplained pain (81%:41%). A sore that doesn't heal reveals the highest ratio of prompted recognition to spontaneous mention (77%:6%).

Figure 2: Do you think that the following could be a sign of cancer? (All respondents)



Unweighted base = 1251

Women showed similar levels of recognition for each symptom when compared to men and the mean number of symptoms recognised was also comparable (7.4 recognised by men, 7.48 recognised by women). Whilst not always a significant variance, the pattern of data shows that older respondents were more likely to recognise warning signs than the younger 18-24 year old respondents and this was true for lumps or swellings, unexplained pain, bleeding, changes in bowel or bladder habits, difficulty swallowing, change in appearance of a mole, a sore that doesn't heal and weight loss. For example, 79% of 18-24 year olds recognised that a change in the appearance of a mole could be a sign of cancer, a significantly lower proportion than those aged 25 years or above (87% 25-44 years, 91% 45-64 years and 89% 65+ years).

In addition, those from a Black and Minority Ethnic (BME) background had significantly lower levels of cancer warning sign recognition than non BME for all symptoms excepting a persistent cough, difficulty swallowing and a sore that doesn't heal. For example, 94% of non BME respondents recognised an unexplained lump or swelling could be a sign of cancer, compared to 86% of BME respondents. Counting the number of symptoms recognised, non BME respondents were familiar with more symptoms (7.51 out of 9) than the BME (7.22 out of 9).

Level of education did not appear to be a factor influencing recognition of cancer warning signs. Comparing those respondents who had been educated beyond O'levels/GCSEs to those educated only towards O'level/GCSEs, there were no significant differences in the proportion recognising each potential sign of cancer. However, perhaps unsurprisingly, respondents that have themselves, a family member or friend had cancer are more likely to be aware of each of the signs of cancer.

Analysis by PCT shows the East and North Hertfordshire PCT participants have a lower level of prompted awareness of cancer warning signs or symptoms than all other PCT areas. The South Bedfordshire PCT in particular has significantly higher prompted levels of recognition for six of the symptom types; this is denoted by the bold, underlined figures in the table below, in comparison to those figures underlined but not in bold (i.e. the significantly lowest figures).

Table 3: Prompted awareness of signs/symptoms of cancer?

(by PCT - All responses)

	East and North Herts	West Herts	Luton	South Bedfordshire
Lump or swelling	91%	93%	93%	**98%**
Persistent unexplained pain	76%	78%	87%	**90%**
Unexplained bleeding	82%	86%	**90%**	89%
Persistent cough or hoarseness	67%	71%	**82%**	81%
Persistent change in bowel or bladder habits	87%	91%	89%	**94%**
Persistent difficulty swallowing	63%	65%	**68%**	66%
Change in the appearance of a mole	84%	90%	87%	**97%**
A sore that does not heal	70%	75%	**84%**	**84%**
Unexplained weight loss	80%	82%	82%	**86%**
Unweighted base	**402**	**380**	**382**	**87**

3 Contacting the doctor

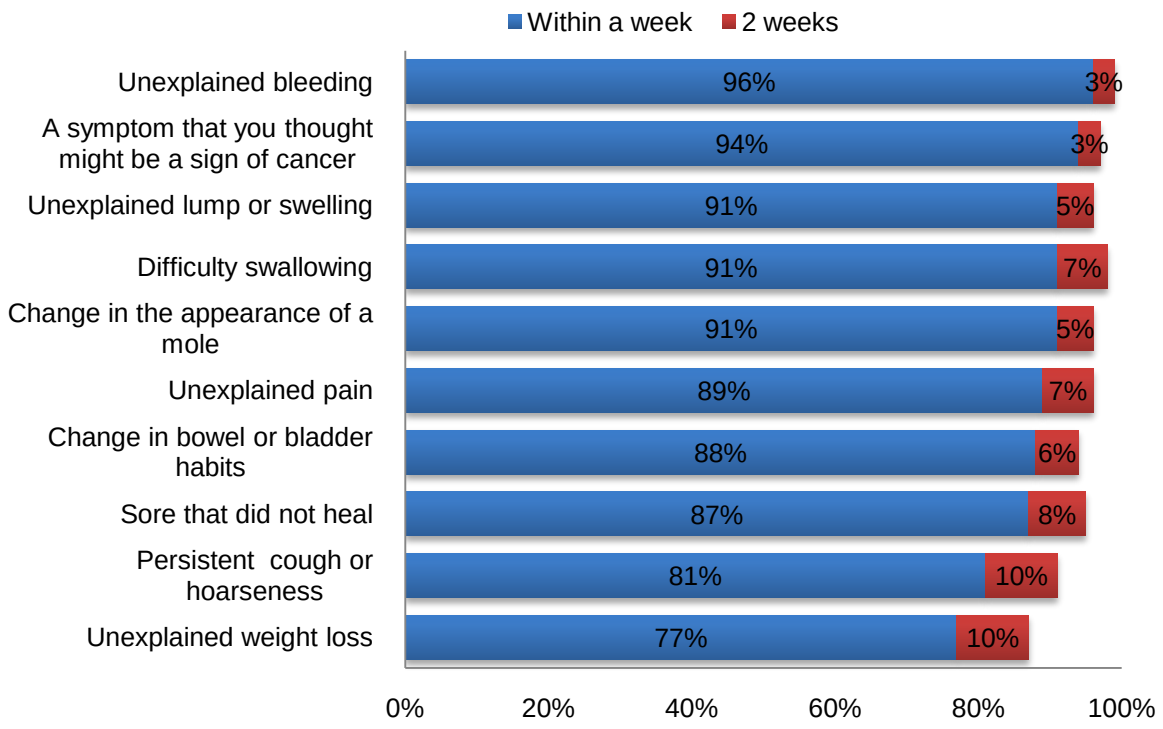
3.1 Anticipated delays before contacting the doctor

Respondents were presented with a range of symptoms and asked if they were to have any of these symptoms how long it would be before they contacted their doctor to make an appointment.

Few respondents anticipated they would delay contacting their doctor beyond a week to discuss any of the prompted symptoms, with the large majority stating that they would contact their doctor within a two week period. Full details of the anticipated delay in contacting the doctor are provided in the table overleaf.

Figure 3: If you noticed (symptom) how soon would you contact your doctor to make an appointment to discuss it?

(2 week summary - All responses)



Unweighted base = 1251

Unexplained bleeding, a lump or swelling, or a symptom that the respondent thought may be a sign of cancer were associated with the least delay in presenting the symptom to a doctor, with two thirds of respondents claiming that they would seek help within 1-3 days. Unexplained weight loss would incur the greatest delay in approaching a GP (12% would wait more than a month) but reflect that this may be due to the nature of the symptom which could potentially take longer to notice. Grey shading has been used to highlight where delays are the shortest (+60% or more would visit a doctor with 1-3 days of noticing the symptom).

Table 4: Delay in presenting symptoms to the doctor (All respondents)

	1-3 days	4-6 days	1 week	2 weeks	1 month	6 weeks	3 months	6 months	12 months	Never	Don't know
Unexplained lump or swelling	66%	15%	10%	5%	3%	*%	*%	*%	*%	*%	0%
Unexplained pain	53%	22%	14%	7%	2%	*%	*%	*%	*%	*%	0%
Unexplained bleeding	68%	19%	9%	3%	1%	0%	*%	0%	0%	0%	0%
Persistent cough or hoarseness	46%	19%	16%	10%	4%	1%	1%	*%	*%	1%	*%
Change in bowel or bladder habits	53%	22%	13%	6%	4%	1%	*%	0%	0%	*%	0%
Difficulty swallowing	52%	24%	15%	7%	2%	*%	*%	0%	0%	*%	0%
Change in the appearance of a mole	59%	20%	12%	5%	2%	*%	1%	*%	*%	*%	0%
Sore that did not heal	49%	21%	17%	8%	4%	*%	*%	0%	*%	*%	0%
Unexplained weight loss	49%	14%	14%	10%	6%	3%	2%	*%	0%	1%	0%
A symptom that you thought might be a sign of cancer	67%	16%	11%	3%	2%	*%	*%	0%	0%	*%	0%

Unweighted sample bases vary ***% denotes less than 0.5%** **Grey boxes used to highlight the highest scores**

Comparing those who said they would seek help promptly, within a week, across the demographic groups, shows no real variance between men and women with the exception of seeking help from the doctor for unexplained weight loss, where four fifths (81%) of women would contact their doctor within a week to discuss it in comparison to just three quarters of men (76%).

Older people (aged 65+ years) were less likely to delay a visit to their doctor for most symptoms, but in particular for a cough (87% within a week c.f. 81% 18-24 years, 79% 25-64 years), a sore that won't heal (93% within a week c.f. 82% 18-24 years, 86% 25-64 years) and unexplained weight loss (87% within a week c.f. 70% 18-24 years, 76% 25-64 years).

BME groups were similarly likely to report seeking help within a week compared to non BME groups for most symptoms, but were significantly more likely to present a persistent cough within a week (86% c.f. 80% non BME).

Analysis by PCT shows the East and North Hertfordshire PCT participants are less likely to present their health problems to the doctor within a week when compared to all other PCT areas.

Table 5: Delay in presenting symptoms to the doctor

(Present within a week by PCT - All respondents)

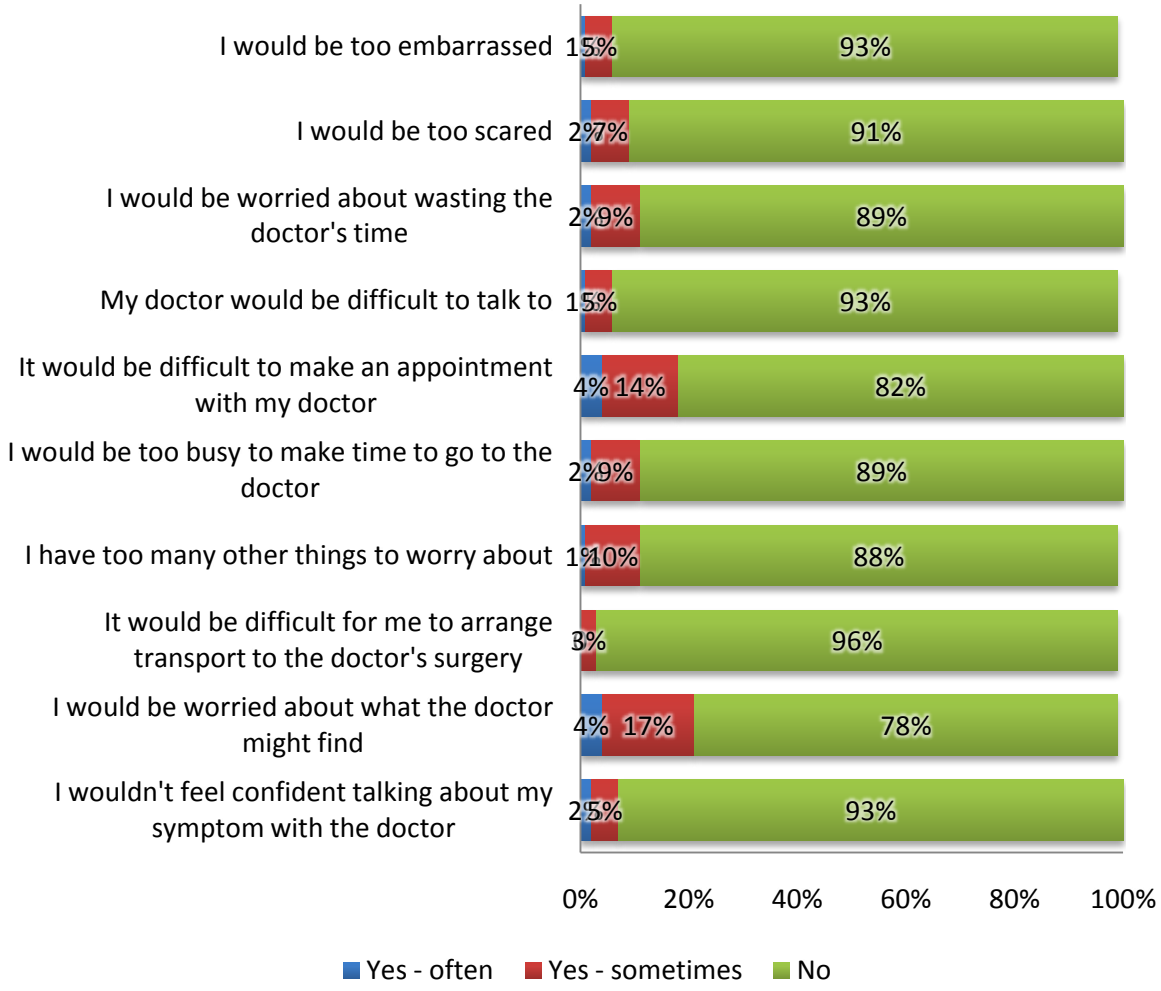
	East and North Herts	West Herts	Luton	South Bedfordshire
Lump or swelling	85%	90%	96%	98%
Persistent unexplained pain	81%	86%	97%	99%
Unexplained bleeding	92%	94%	99%	100%
Persistent cough or hoarseness	67%	77%	95%	94%
Persistent change in bowel or bladder habits	78%	87%	96%	96%
Persistent difficulty swallowing	80%	88%	98%	98%
Change in the appearance of a mole	84%	89%	97%	101%
A sore that does not heal	77%	86%	95%	97%
Unexplained weight loss	63%	76%	88%	87%
Symptom that may be a sign of cancer	89%	91%	100%	100%
Unweighted base	**402**	**380**	**382**	**87**

3.2 Reasons for delaying a visit to the doctor

It was explained to respondents that sometimes people are put off going to see their doctor, even when they have a symptom that they think could be serious. They were then shown a list of reasons and asked to state which, if any, would put them off going to see their doctor.

The chart below shows that the suggested reasons that people delay a visit to the doctors do not apply to the majority of respondents in this survey. The two highest scoring barriers to going to see the doctor was the worry about what the doctor might find (21%), followed by the difficulty in making an appointment (18%).

Figure 4: These are some of the reasons people give for delaying going to see the doctor. Could you say if any of these might put you off going to the doctor? (All respondents)

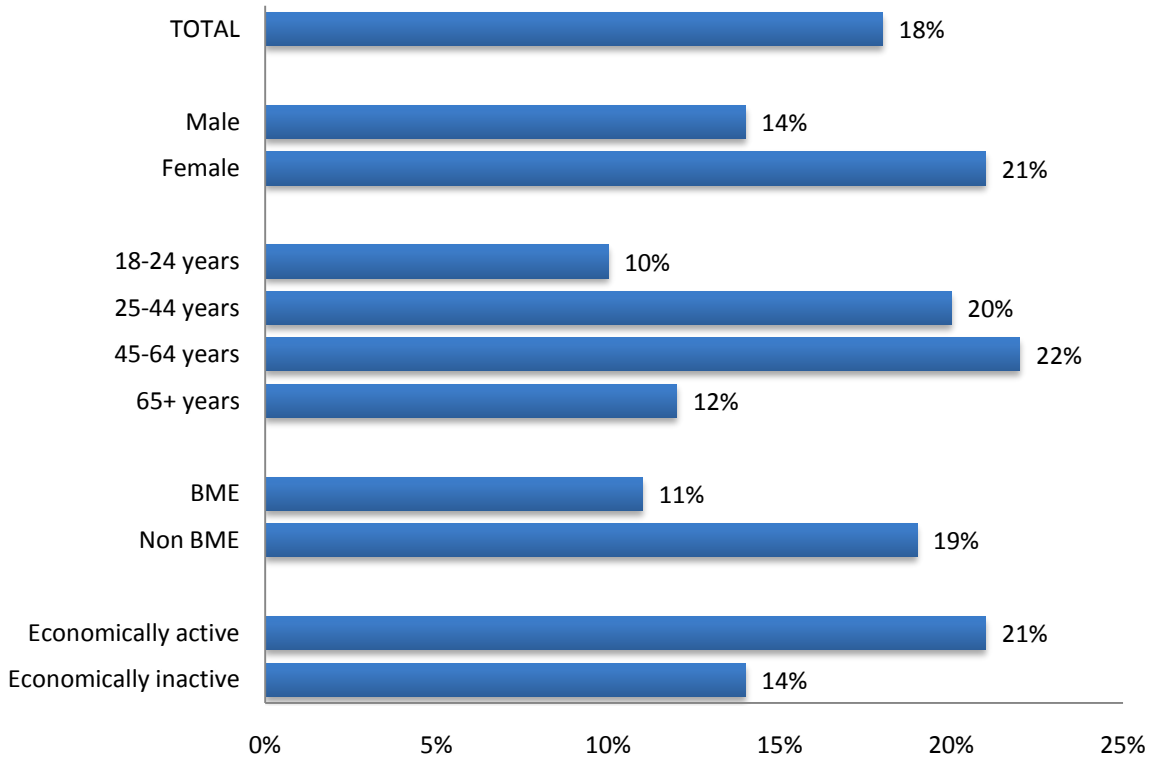


Unweighted base = 1251

The two barriers to help-seeking identified above are quite different, the difficulty in making an appointment with the doctor is a rational issue about service, but worrying about what the doctor might find is a more emotional response. Further analysis by demographic group is provided on both these barriers.

The difficulty in making an appointment with the doctor is a problem more likely to be raised by females (21%) than males (14%), non BME (19%) and those of a working age (20% 25-44 years, 22% 45-64 years). This barrier is clearly more of an issue for those who are economically active (21% c.f. 14% economically inactive).

Figure 5: Barriers to help-seeking – difficulty in making appointment with the doctor % yes by demographics (All respondents)

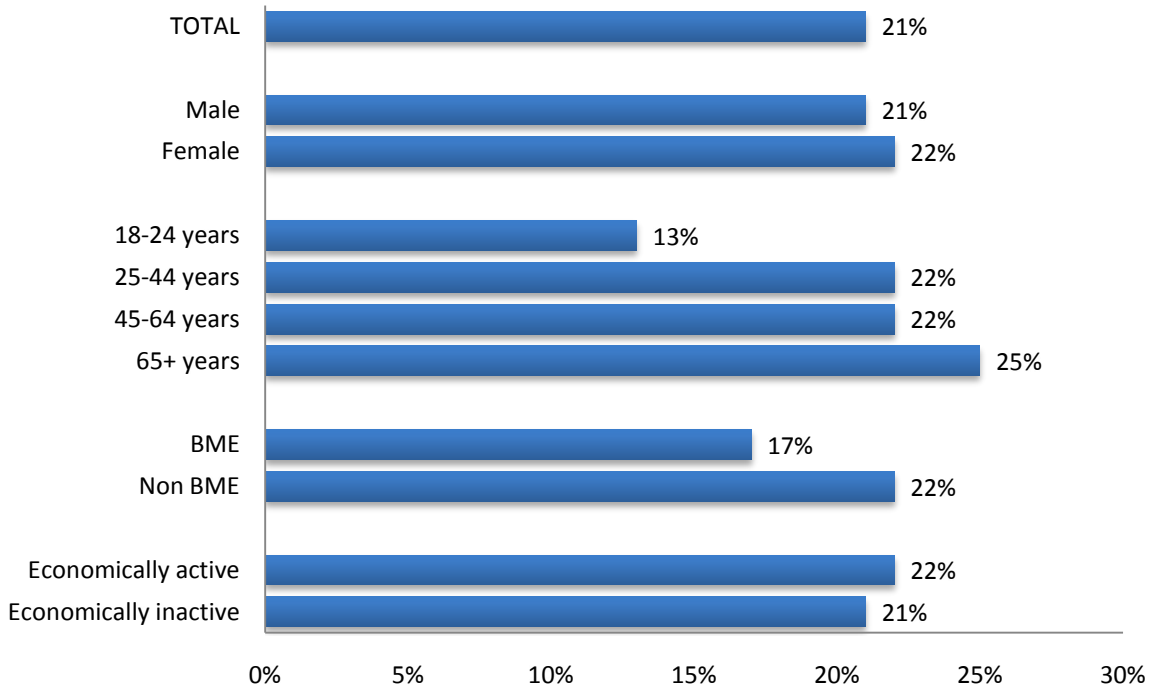


Unweighted base: 1251

The more emotional barrier to seeking help, that of being worried about what the doctor might find, shows no significant variance by gender, as men (21%) are equally likely to raise this as an issue as women (22%). Age is however a factor with the younger 18-24 year olds (13%) significantly less likely to express this concern when compared to all other age groups (22% 25-44 years, 22% 45-64 years, 25% 65+ years).

Figure 6: Barriers to help-seeking – worried about what doctor might find

By demographics (All respondents)



Unweighted base: 1251

Comparing reactions to all the suggested barriers to help-seeking by PCT shows a familiar pattern of response. The East and North Hertfordshire PCT participants are more likely to endorse eight of the ten suggested barriers to help-seeking at higher levels when compared to all other PCT areas. The following table highlights (bold and underlined) which figures per PCT are statistically significantly higher than the remaining figures (those underlined but not in bold). Figures not underlined are not statistically significantly different to its counterpart measures.

Table 6: Barriers to help-seeking

By PCT (All respondents)

	East and North Herts	West Herts	Luton	South Bedfordshire
I would be too embarrassed	**18%**	4%	4%	1%
I would be too scared	**19%**	6%	5%	6%
I would be worried about wasting the doctor's time	**18%**	10%	8%	8%
My doctor would be difficult to talk to	**11%**	5%	5%	6%
It would be difficult to make an appointment with my doctor	**26%**	18%	12%	18%
I would be too busy to make time to go to the doctor	**19%**	11%	7%	4%
I have too many other things to worry about	**21%**	11%	7%	6%
It would be difficult for me to arrange transport to the doctor's surgery	**7%**	2%	4%	1%
I would be worried about what the doctor might find	21%	19%	**26%**	16%
I wouldn't feel confident talking about my symptom with the doctor	**9%**	**9%**	2%	3%
Unweighted base = 1251			*** denotes <0.5%**	

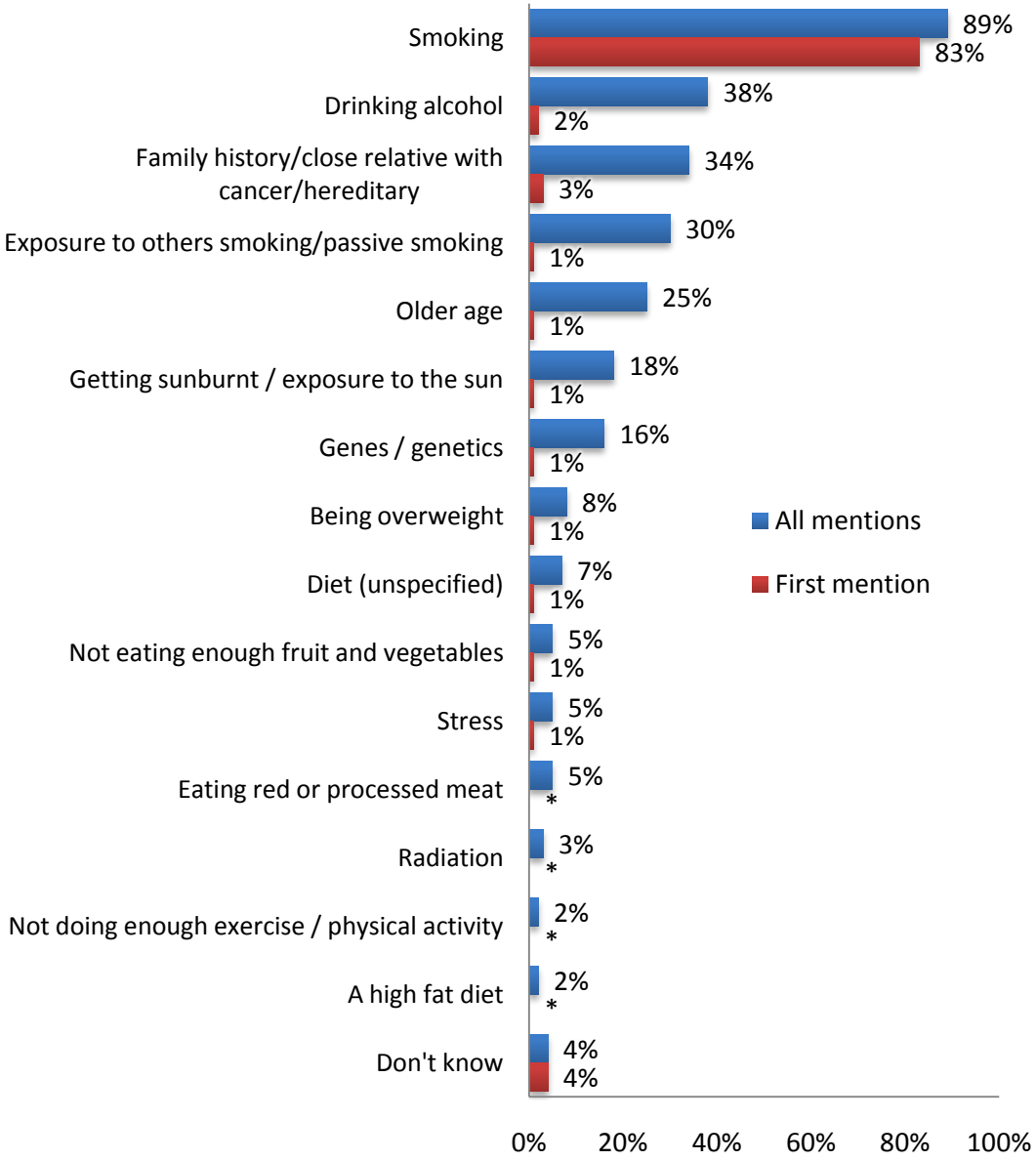
4 Awareness of cancer risk factors

4.1 Recall of risk factors for cancer (unprompted)

Initially, respondents were asked what things they think affect a person's chance of getting cancer. Interviewers were instructed to give respondents time to think about their response and to keep asking if they could think of anything else until the respondent could think of no more risk factors. The following chart provides both the first mentioned risk factor and the combined mentions.

As might be expected, spontaneous recall of smoking as a risk factor was high (89%), with smoking dominating the top of mind awareness (83% mention this risk first). Other factors recalled by around a third were drinking alcohol (38%), a family history of cancer (34%) and passive smoking (30%). Spontaneous recall of exposure to the sun as a cancer risk is perhaps a little lower than would be expected, but this could be a reflection of the fieldwork timings.

Figure 7: What things do you think affect a person's chance of getting cancer? (Unprompted) (All respondents)



All other mentions by 1% or less

Unweighted base: 1251

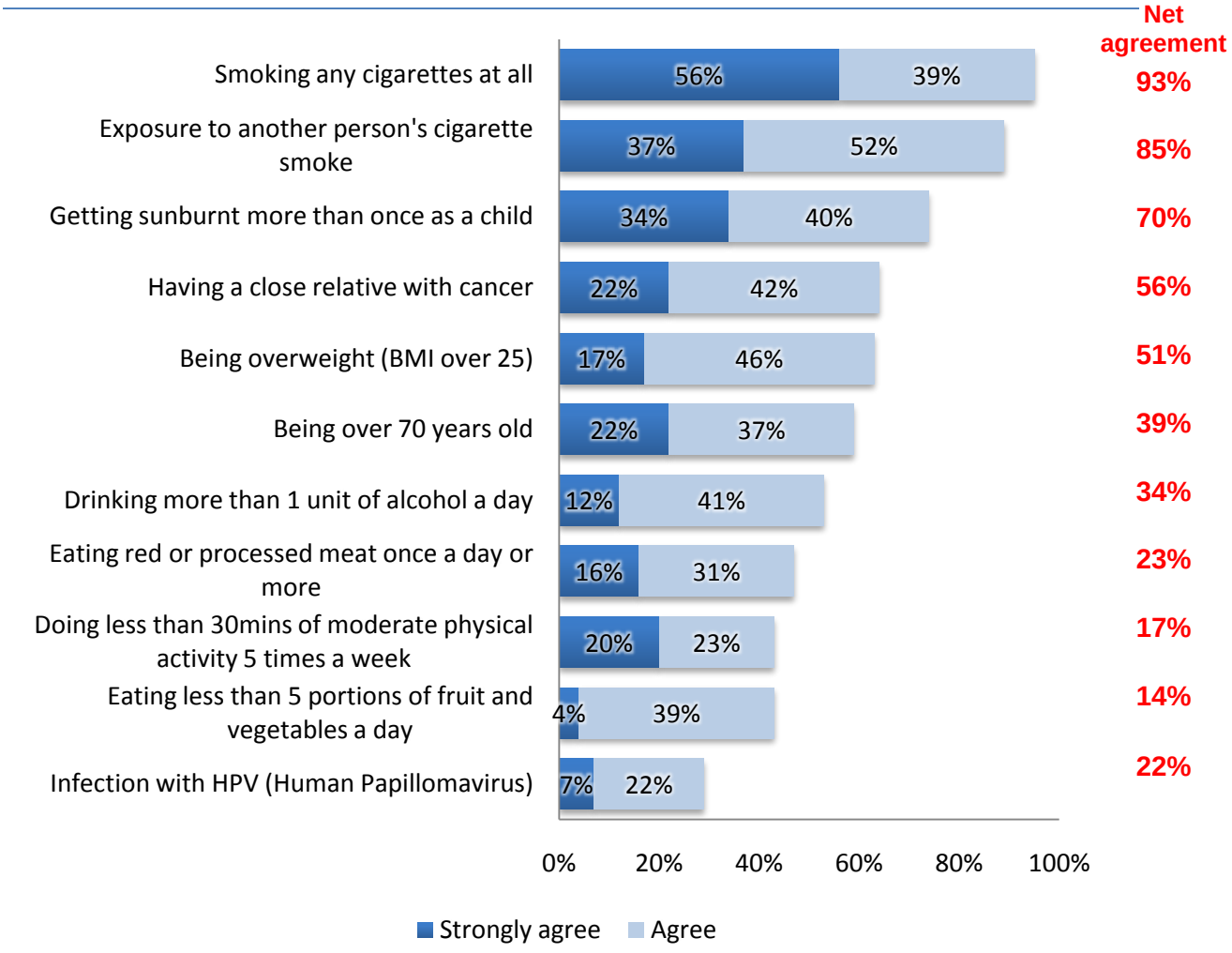
* denotes <0.5%

4.2 Recognition of risk factors for cancer (prompted)

Respondents were then shown a list of factors which medical scientists suggest increases the chance of getting cancer and were asked to what extent they agree or disagree that each factor presents a risk. For each factor the net agreement score has been calculated by subtracting the percentage of respondents strongly disagree/disagree from those that strongly agree/agree and this is summarised in the chart below.

Smoking is clearly the best recognised factor for increasing the risk of cancer, with 95% agreeing that smoking any cigarettes at all poses a risk and a minority disagreeing (2%), resulting in an overall net agreement of 93%. Passive smoking and getting sunburnt more than once as a child is also well recognised as increasing the risk of getting cancer and again there are very low levels of disagreement with this (85% & 70% net agreement). However, recognition of fruit and vegetable and red meat intake, exercise and HPV infection is low, with less than a quarter in net agreement that each is a cancer risk factor.

Figure 8: Medical scientists suggest that these are some of the things that can increase the chance of getting cancer. How much do you agree that each of these can increase the chance of getting cancer? (All respondents)



Unweighted base: 1251

* denotes <0.5%

Women showed higher net agreement than men that alcohol intake was a cancer risk factor (36% c.f. 30%), as was eating less than 5 portions of fruit and vegetables a day (15% c.f. 10%). There were no significant differences, however, in recognition of smoking, getting sunburnt or having a close relative with cancer.

Younger respondents were less likely to acknowledge that eating less than 5 portions of fruit and vegetables a days was a cancer risk factor. In fact, more 18-24 year olds disagreed with this suggestion (40%) than agreed (32%), giving a negative net agreement score. All other age groups showed a low, but positive level of net agreement (14% 25-44 years, 21% 45-64 years, 7% 65+ years). Overall, younger respondents tended to be less likely to acknowledge the suggestions as giving an increased chance of getting cancer.

Levels of net agreement with each suggested risk factor can be seen to vary quite widely across the PCTs, though recognition of smoking, passive smoking and sunburn are the top three suggestions in each area that respondents agree give an increased cancer risk. Interestingly, Luton PCT has higher levels of awareness that poor diet and lack of exercise are factors that can increase the chance of getting cancer.

Table 7: Recognition of cancer risk factors

Net agreement by PCT (All respondents)

	East and North Herts	West Herts	Luton	South Bedfordshire
Smoking any cigarettes at all	90%	92%	93%	100%
Exposure to another person's cigarette smoke	78%	84%	90%	98%
Drinking more than 1 unit of alcohol a day	24%	32%	41%	50%
Eating less than 5 portions of fruit and vegetables a day	2%	7%	**31%**	8%
Eating red or processed meat once a day or more	13%	19%	**35%**	14%
Being overweight (BMI over 25)	53%	56%	42%	55%
Getting sunburnt more than once as a child	77%	75%	57%	69%
Being over 70 years old	31%	34%	46%	67%
Having a close relative with cancer	63%	63%	41%	57%
Infection with HPV (Human Papillomavirus)	17%	28%	19%	12%
Doing less than 30mins of moderate physical activity 5 times a week	5%	9%	**35%**	31%
Unweighted base = 1251				*** denotes <0.5%**

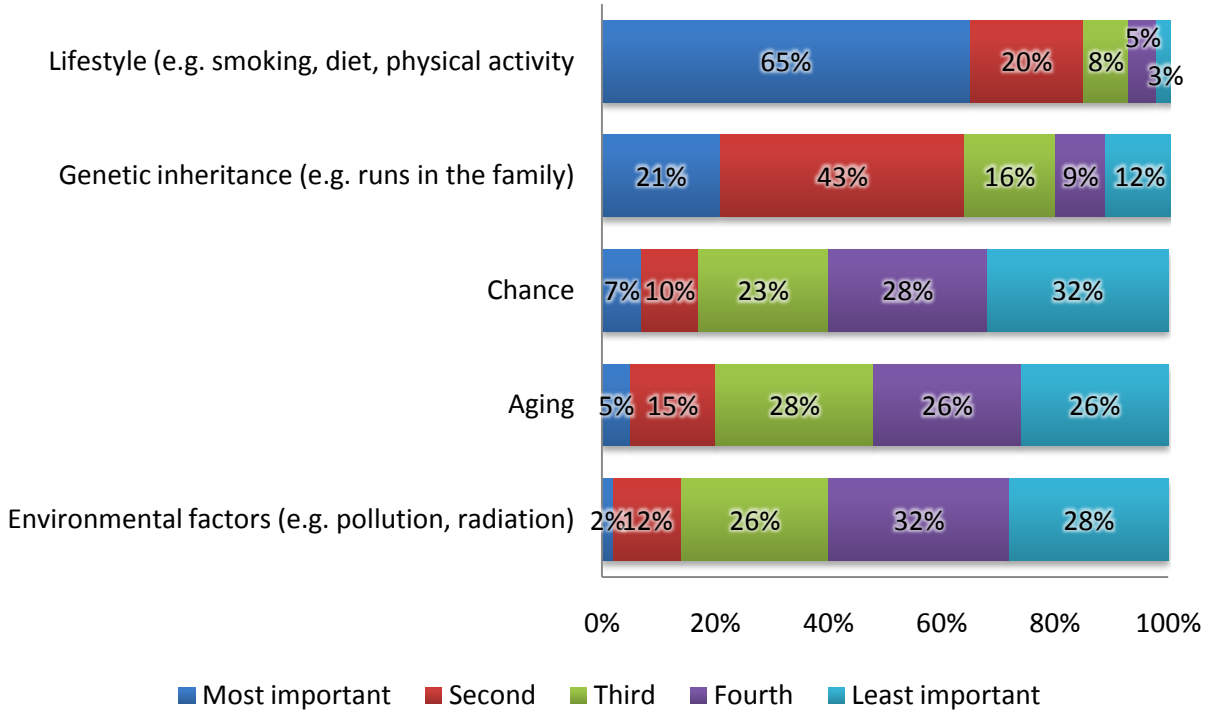
4.3 Contributing factors

All respondents were provided with a list of five cancer contributing factors and asked to put them in order of importance.

Lifestyle, described as smoking, diet and physical activity, was believed by around two thirds of participants to be the most important contributor towards cancer in the UK (65%). Genetic inheritance was ranked the most important by a fifth (21%) and a minority endorsed chance (7%), aging (5%) or environmental factors (2%) as the largest contributing factor.

Chance was most likely to be ranked as the least important contributing factor (32%), whilst just over a quarter put environmental factors (28%) and aging (26%) into the bottom position.

Figure 9: Please put the following in order of how much you think they contribute to cancer in the UK (All respondents)



Unweighted base vary

Men are as likely as women to believe that lifestyle is the biggest contributing factor towards cancer in the UK (64% male c.f. 65% female), followed by genetic inheritance which was endorsed as the biggest contributing factor by around a fifth (20% male c.f. 22% female). There were no variations by age in the level of endorsement of either lifestyle or genetic inheritance as most important contributing factors when comparing the younger 16-44 year olds to the older 45+ years. However, a significantly greater proportion of non BME participants rank lifestyle as the most important contributing factor (68%) when compared to BMEs (53%), whilst BMEs cite genetic inheritance (31%) as the most important factor at significantly higher levels than non BMEs (19%).

Four fifths of respondents within the South Bedfordshire PCT rated lifestyle as the most important contributing factor to cancer in the UK, a significantly higher proportion than noted within either East and North Hertfordshire (65%), West Hertfordshire (63%) or Luton (65%) PCTs.

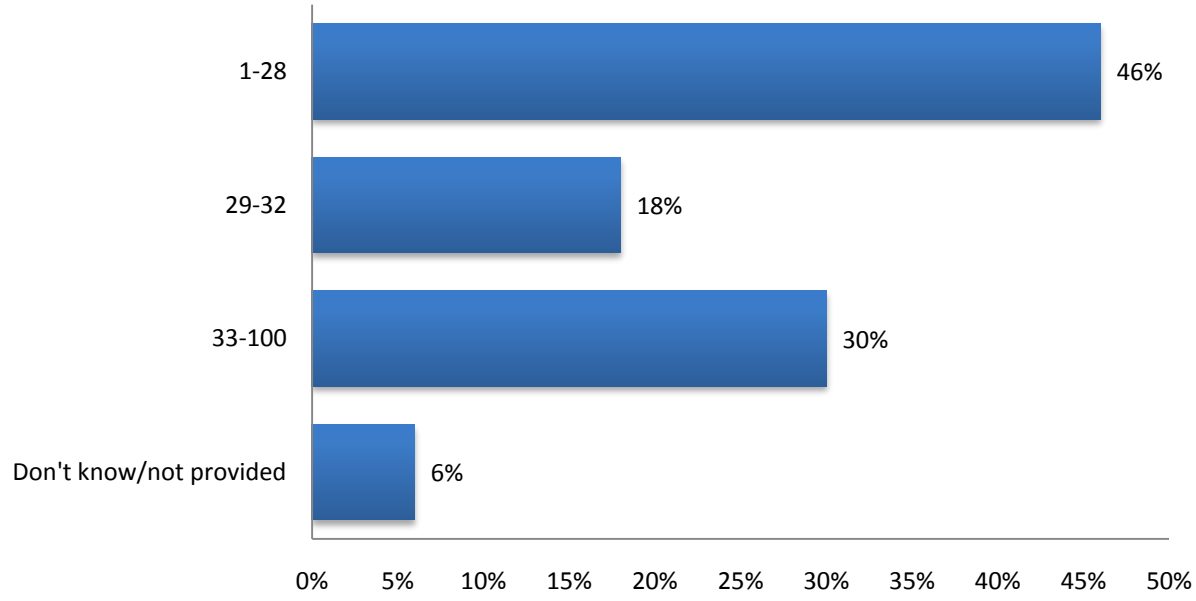
4.4 Knowledge of lifetime risk of cancer

Respondents were shown a picture of 100 individuals and asked to estimate how many of the 100 will develop cancer at some point in their lives.

The actual numbers of people who will develop cancer at some point in their life is approximately one in three (33 out of 100); the average estimated lifetime incidence from this survey was 29.42 out of 100, a relatively accurate estimate of the chances of developing cancer.

The following chart shows the proportion of people who have both under and over-estimated their chances of developing cancer. Just under a fifth (18%) are broadly correct with their estimate of around one in three, whereas almost half under-estimate (46%) and three in ten (30%) over-estimate the incidence of cancer. The full range of responses to this question can be seen in Appendix 3.

Figure 10: Out of 100 people, how many do you think will develop cancer at some point in their life (All respondents)



Unweighted base: 1251

Women thought more people would develop cancer than men (31% compared to 27%) but there was little difference according to age with estimates ranging from 29% amongst 18-24 year olds to 31% amongst 25-44 year olds. Those from the non BME ethnic group estimated a higher proportion would develop cancer (31%) than BMEs (24%).

Analysis by PCT shows a higher estimate of cancer incidence amongst those residing in East and North Hertfordshire PCT (32%) and West Hertfordshire PCT (32%) when compared to Luton (25%) and South Bedfordshire (27%) PCTs.

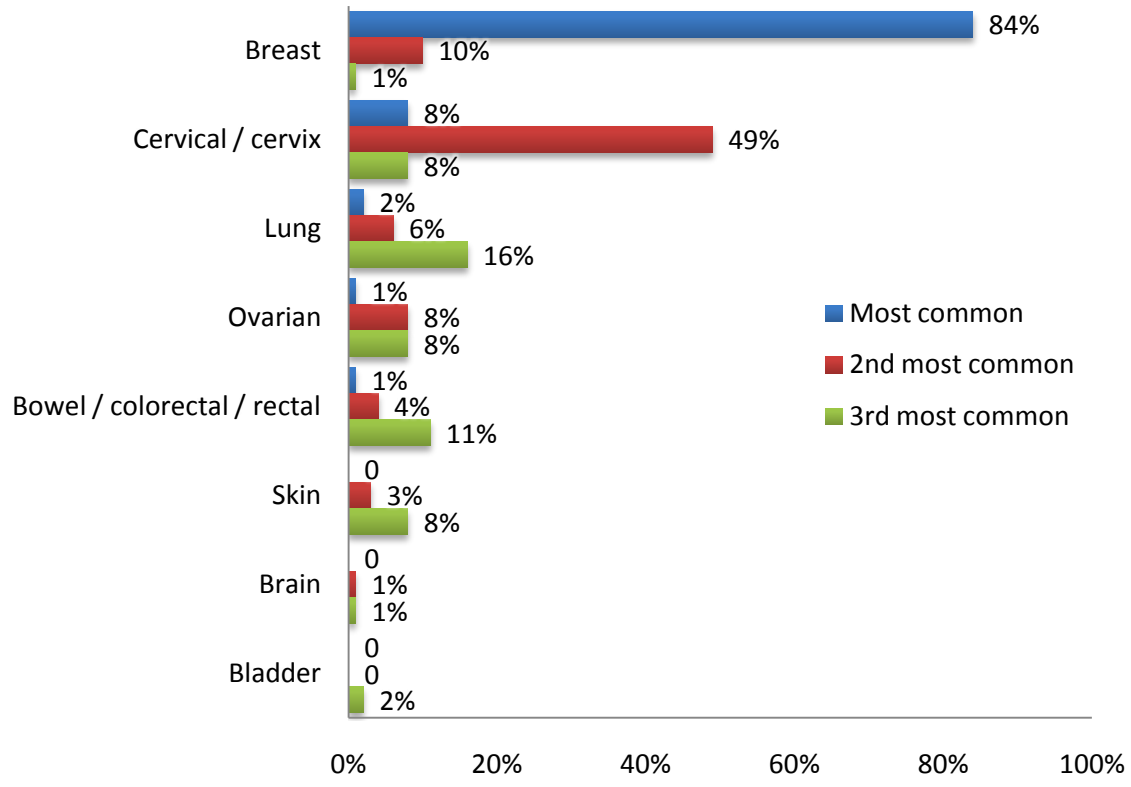
5 Knowledge of the most common cancers

5.1 Most common cancers in women

The most common cancer in women is actually breast cancer (31%), followed by bowel (colorectal) cancer (12%), and lung cancer (11%)[1]. When respondents were asked, without prompting, to name the top three cancers in women the majority of respondents correctly identified breast cancer as the most common cancer type in women (84%), with the next most commonly mentioned being cervical cancer (8%) and lung cancer (2%).

Cervical cancer is thought to be the second most common cancer in women (49%), with just 4% stating the correct answer bowel cancer. Cervical cancer is in fact a rare cancer (<1% of all cancers). The third most common cancer mentioned lacks the focus of the first and second, but the highest mentioned cancer type is lung cancer (16%), with 11% suggesting bowel cancer.

Figure 11: What do you think is the most common cancer in women? Second most common? Third most common? (All respondents)



Unweighted bases = 1251

General awareness of breast cancer as the first most common female cancer was similar for men and women and across age groups. Non BME respondents, however,

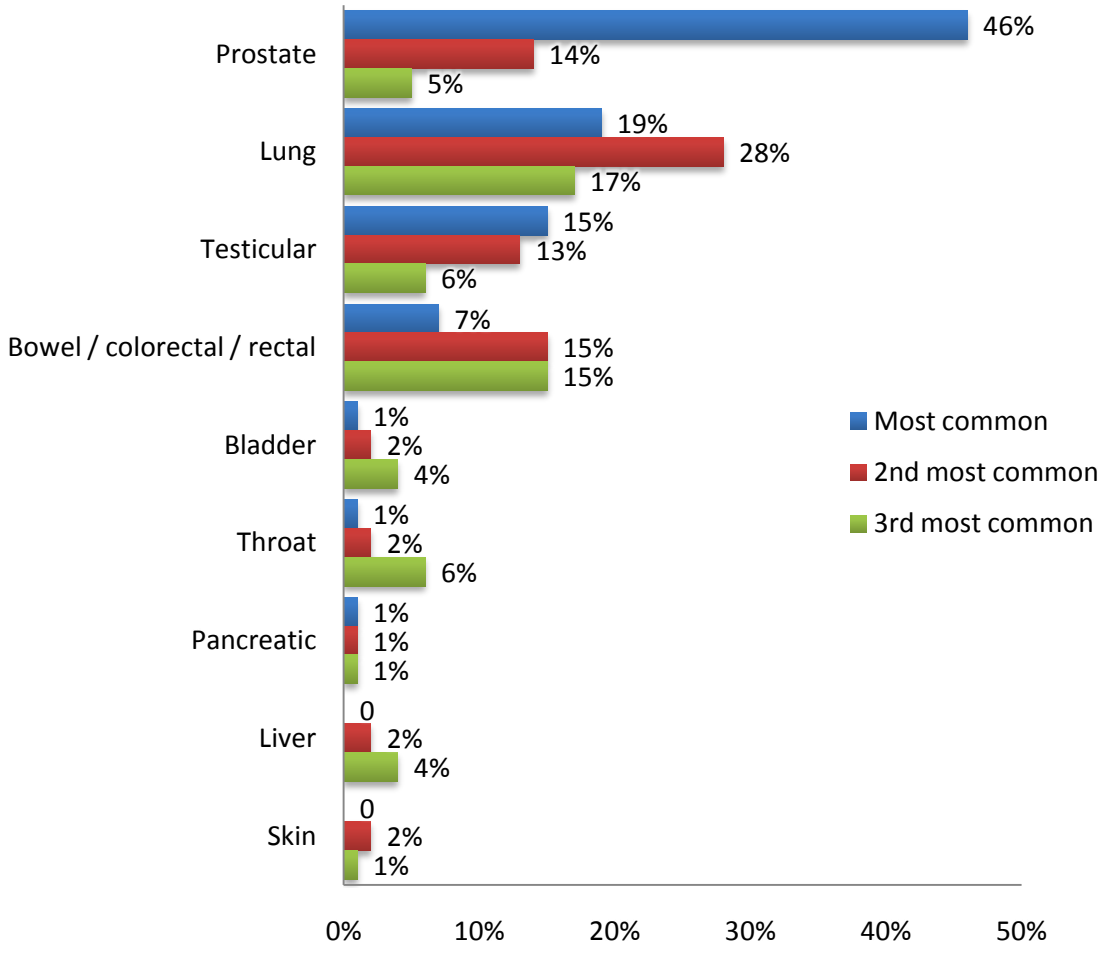
[1] Source: CRUK 2006

are significantly more likely to recall breast cancer (87%) than BME respondents (73%), as are residents in South Bedfordshire PCT (92%) when compared with East and North Hertfordshire (83%) and Luton (82%).

5.2 Most common cancers in men

The most common cancer in men is prostate cancer (24%), followed by lung cancer (15%) and bowel (colorectal) cancer (14%)[2]. When asked what was the most common form of cancer in men, the most frequent responses were prostate (46%), lung (19%) and testicular (15%). In fact, testicular cancer is rare (<1% of all cancers in men). Lung cancer is correctly identified by just over a quarter (28%) as the second most common form of cancer in men with prostate, testicular and bowel cancer all receiving similar levels of mentions. The third most common cancer lacks focus, with lung cancer (17%) and bowel cancel (15%) identified at similar levels.

Figure 12: What do you think is the most common cancer in men? Second most common? Third most common (All respondents)



Unweighted bases = 1251

[2] Source: CRUK 2006

Women (51%), older respondents (54% 45+ years) and non BMEs (50%) are more likely to be aware that prostate cancer is the most common cancer in men. Residents in South Bedfordshire (57%) and West Hertfordshire (50%) also have significantly higher awareness of prostate cancer as the most common male cancer when compared to both East and North Hertfordshire (43%) and Luton (41%).

6 Knowledge of NHS cancer screening programmes

6.1 Introduction

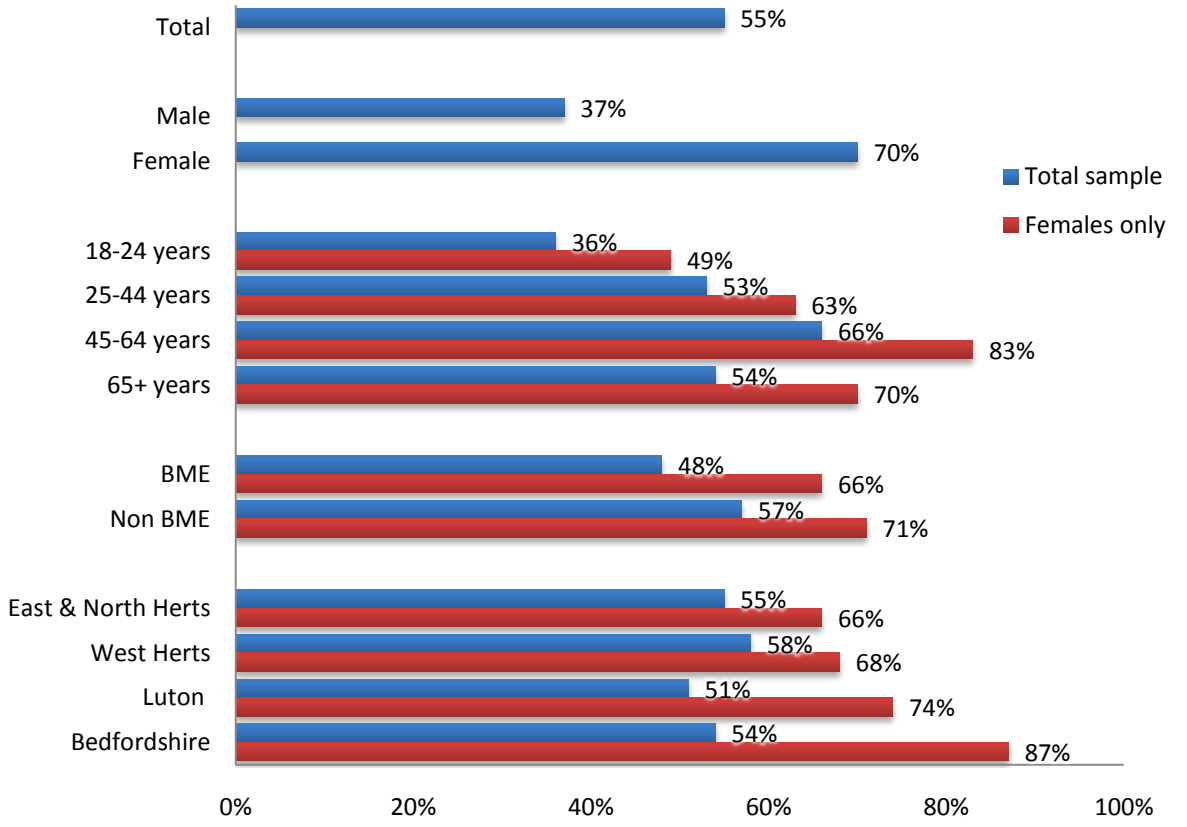
Respondents were asked if NHS screening programmes exist for breast cancer, cervical cancer and bowel cancer.

6.2 NHS breast cancer screening programme

The breast cancer screening programme is available for females aged between the ages of 47 and 69 years. They are encouraged to have a screening every 3 years.

Overall, approaching three fifths (55%) were aware of the NHS screening programme for breast cancer. Women had a greater awareness of the screening programme when compared to men (70% c.f. 37%) and awareness was also highest amongst people aged 45-64 years (66%) and non BMEs (57%). Awareness of the screening programme in West Hertfordshire (58%) is significantly higher than in Luton (51%). It is also interesting to explore the views of females specifically within these different characteristics (shown by the red bars below). Encouragingly, the proportion of females aware of the breast cancer screening programme within the target age range is high at 83% (aged 45-64 years).

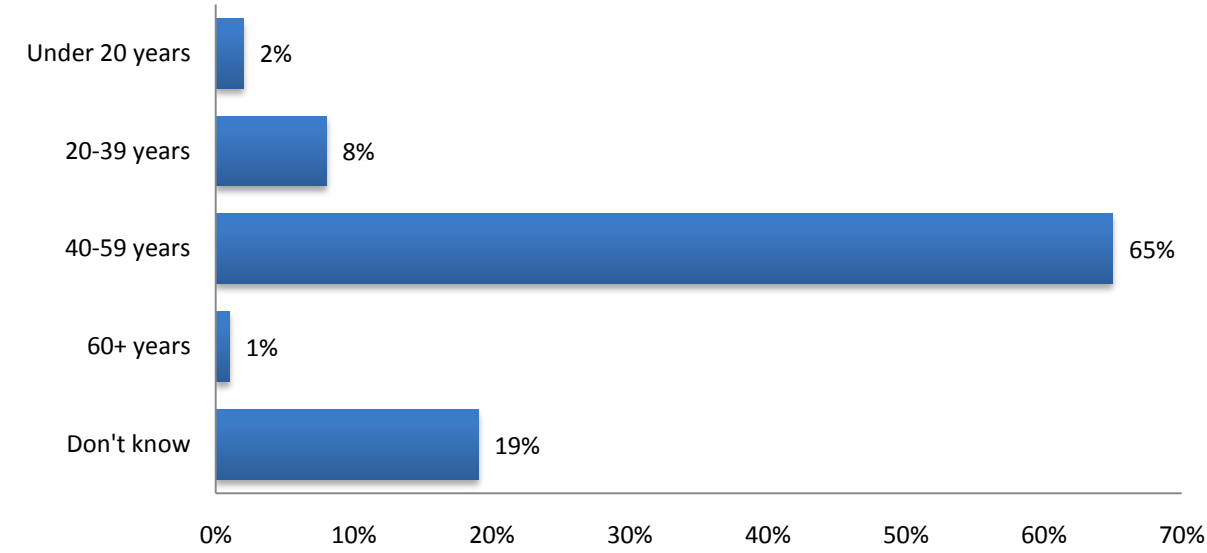
Figure 13: Is there an NHS breast cancer screening programme? % yes (All respondents)



Unweighted bases = 1251

Two thirds of those who are aware of the breast cancer screening programme correctly state that women are first invited for screening between the ages of 40 and 59 years.

Figure 14: At what age are women first invited for breast cancer screening? (All respondents that state there is a breast cancer screening programme)



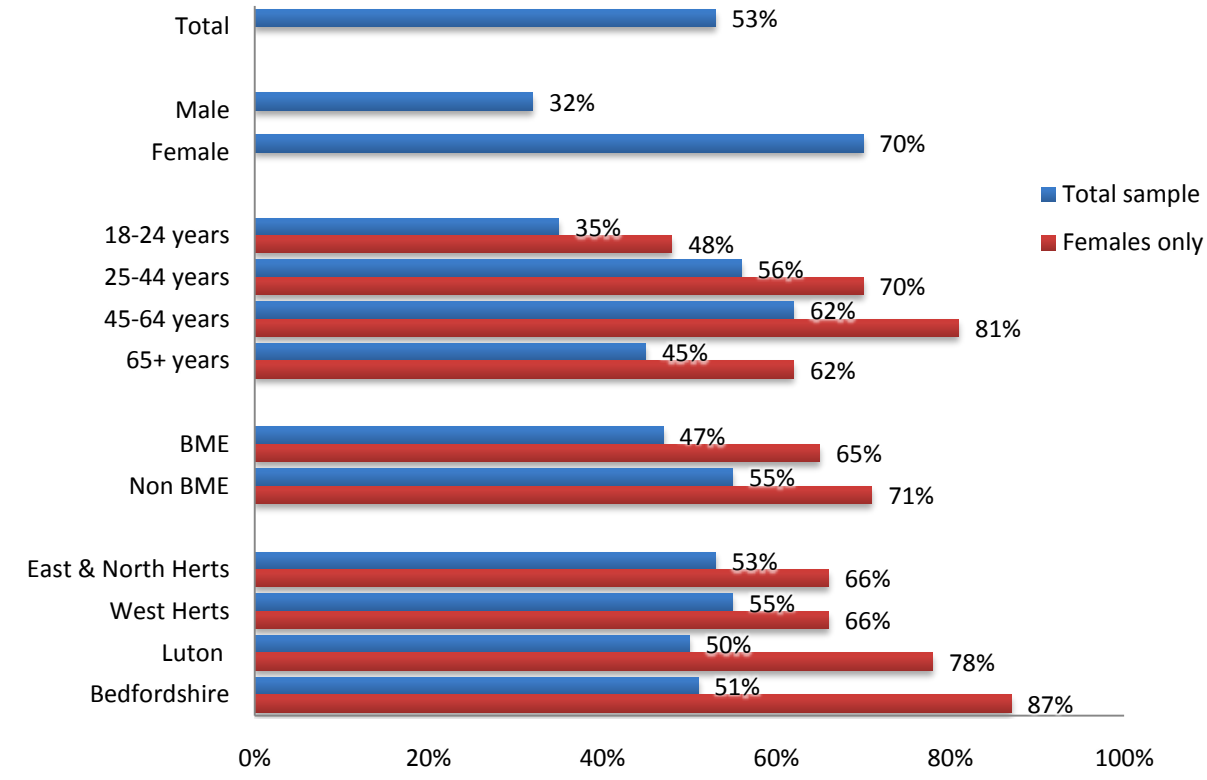
Unweighted bases = 1251

6.3 NHS cervical cancer screening programme (smear tests)

The cervical cancer screening programme is available for females aged between the ages of 25 and 64 years. They are eligible for a free screening every 3-5 years.

Just over half (53%) were aware of the NHS screening programme for cervical cancer. As would be expected, women had a greater awareness of the screening programme compared to men (70% c.f. 32%) and awareness was also highest amongst people aged 25-64 years and non BMEs. There is no significant variance in the awareness levels of the cervical cancer screening across the PCT areas. Again, exploring the results of females only, it is surprising to find that 70% of women within the target range (25-44) are aware of the programme, which means 30% don't know or are not aware.

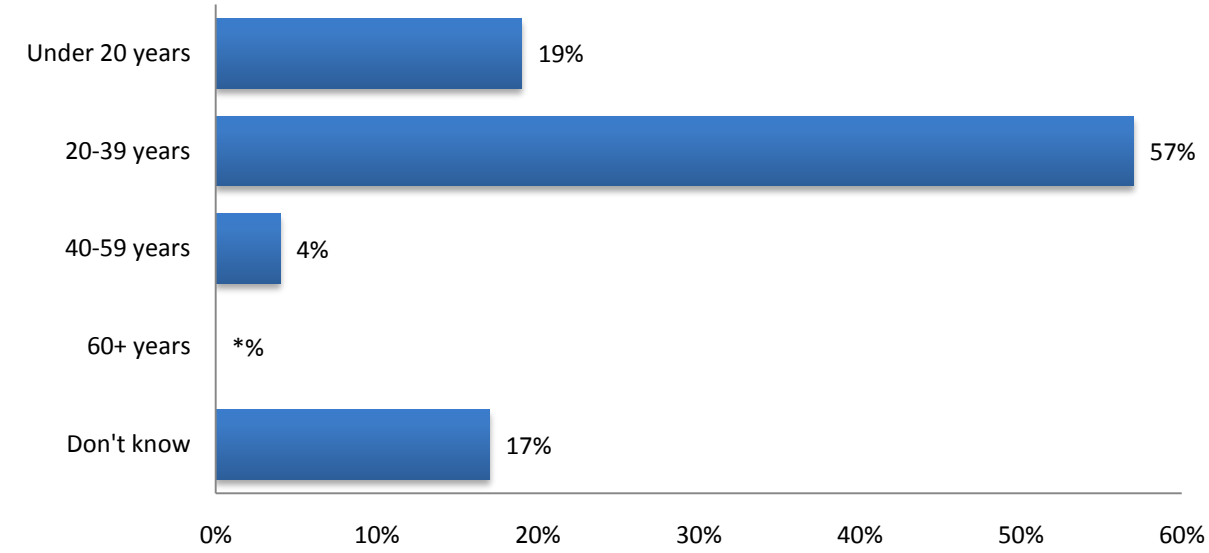
Figure 15: Is there an NHS cervical cancer screening programme? % yes (All respondents)



Unweighted bases = 1251

Almost three fifths (57%) of those who are aware of the cervical cancer screening programme correctly state that women are first invited for screening between the ages of 20 and 39 years.

Figure 16: At what age are women first invited for cervical cancer screening? (All respondents that state there is a cervical cancer screening programme)



Unweighted bases = 1251

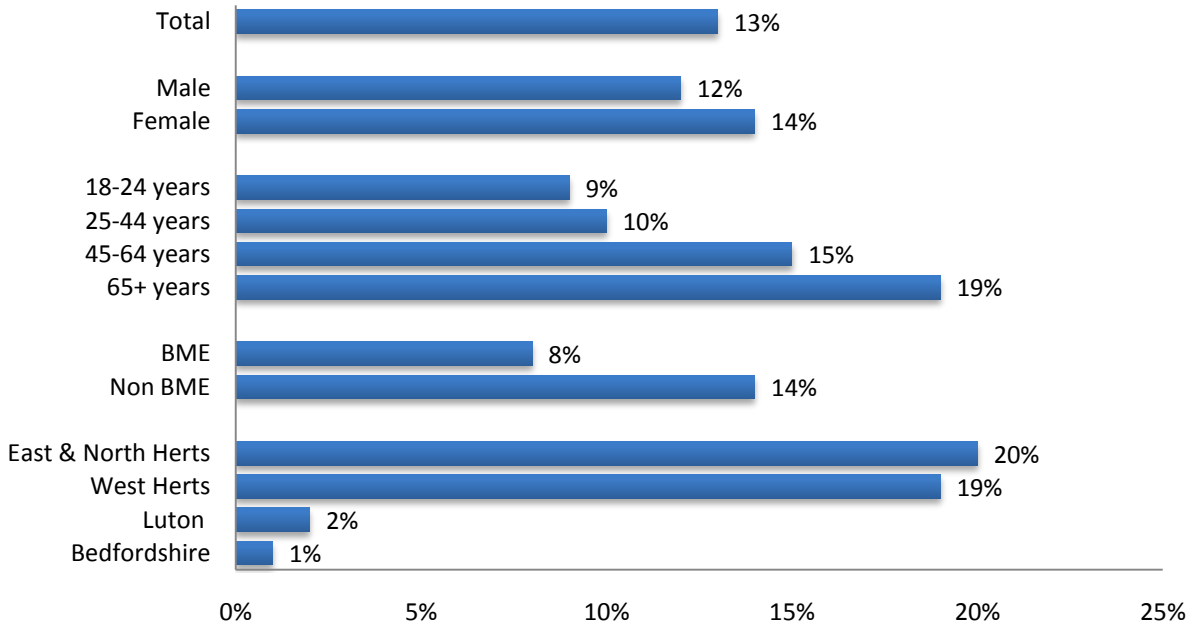
* denotes <o.5%

6.4 NHS bowel cancer screening programme

The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 58 to 69.

One in eight (13%) respondents was aware of the NHS screening programme for bowel cancer. Men and women had a similar level of awareness of the screening programme (12% c.f. 14%) and awareness was higher amongst people aged 65 years plus (19%) and non BMEs (14%). There is a significant variance in the awareness levels of the bowel cancer screening programme across the PCT areas with residents in East and North Hertfordshire (20%) and West Hertfordshire PCTs (19%) showing ten times the level of awareness of residents in Luton and South Bedfordshire PCTs.

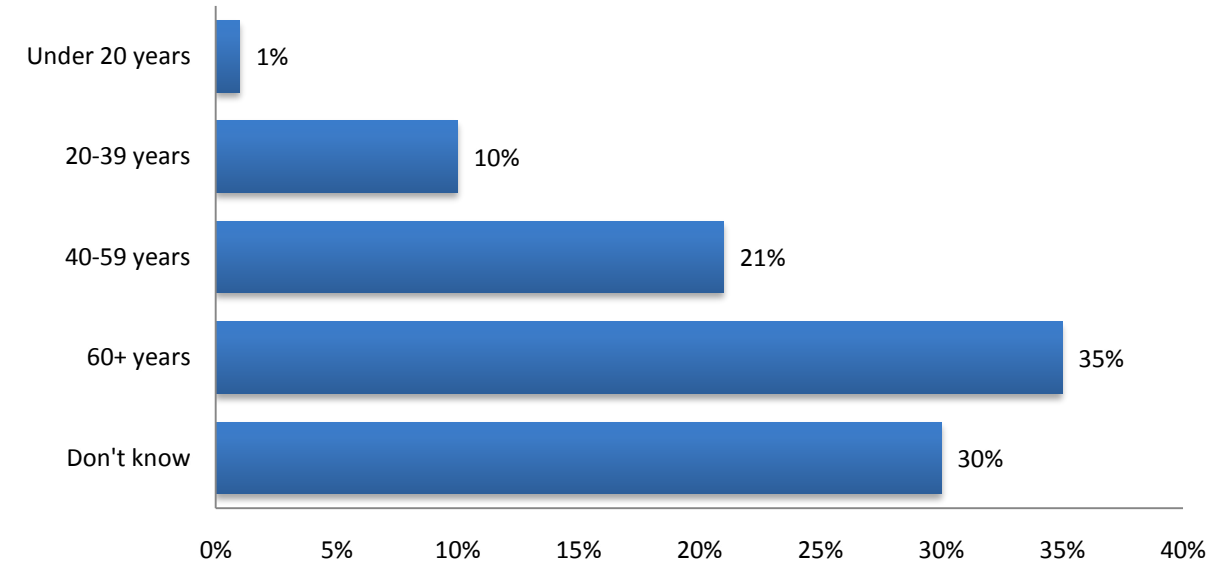
Figure 17: Is there an NHS bowel cancer screening programme? % yes (All respondents)



Unweighted bases = 1251

Just over half (56%) of those who are aware of the bowel cancer screening programme state that people are first invited for screening once over the age of 40 years.

Figure 18: At what age are people first invited for bowel cancer screening? (All respondents that state there is a bowel cancer screening programme)



Unweighted bases = 1251

7 Conclusions

In summary, the following key points are evident:

- Residents of East and North Herts demonstrate less knowledge of cancer symptoms and risk factors. Therefore, they are least likely to seek help as a result of identifying a possible symptom;
- Knowledge of diet and exercise and obesity as risk factors of cancer is poor, but less so amongst residents of Luton. Regarding knowledge of alcohol as a risk factor, this is also low, especially amongst men and those living in East and North Herts;
- The incidence of cervical and testicular cancer is over estimated;
- Awareness of the cervical cancer screening programme is poor amongst BME residents. In addition, 30% of females within the target 25-44 age range are unaware of the cervical cancer screening programme;
- Detailed analysis of responses in each of the localities with reference to age, sex and ethnicity status may help the cancer network and PCT public health teams to target specific health promotion messages as clear knowledge gaps have been identified.

8 Cancer awareness campaign effectiveness

This section of the report will briefly review the potential effect of the 'Cancer caught early can be cured' leaflet produced by the NHS Mount Vernon Cancer Network (see Appendix 1 for copy of the leaflet).

Mount Vernon was interested in exploring the impact of sending out an information leaflet to residents in advance of the survey taking place. This leaflet informed residents of the symptoms of cancer, how changing your lifestyle could help to prevent cancers and reminded of the vaccination and screening programmes available

The Mount Vernon Cancer Network defined a postcode area for distributing these leaflets and a total of 507 interviews were conducted in this area. For the purposes of analysis, this area will be called the Intervention Area.

Two further areas were then put in place to enable exploration of the impact of the leaflet:

- The Control Area 1 had no cancer awareness leaflet activity and was selected to closely reflect the attributes of the intervention area (for example, by deprivation, education attainment levels and type of area). 5 SOAs were selected for inclusion in the sample, all of which were located in Luton and a total of 249 interviews were conducted[3].
- The Intervention area 2 was similarly selected to closely reflect the attributes of the intervention area and within this area an information leaflet was distributed to residents, along with a covering letter signed off by the Network Director and the primary care lead. This was to test whether a covering letter made residents more inclined to read the leaflet and hence demonstrate higher levels of awareness. A total of 254 interviews were conducted in this area.

Control area 1 was established on the basis of SOAs comparable on the parameters of deprivation, educational achievement and economic status. However, the results have indicated that the difference between Luton (the control area) and Watford (the intervention area) goes beyond these factors, perhaps as a result of local awareness raising campaigns or other factors. This means that Luton is perhaps not a fair control group and so we also compare results in the interventions (in the tables) with West Herts as a whole.

The questionnaire utilised was the standard Cancer Awareness Measure (CAM). As such the leaflet itself was not shown during the course of the interview to gain a measure of awareness of this particular cancer awareness campaign. An assumption has been made that there was no other cancer awareness building mechanisms in place within each area during the course of the survey and as such differences between the three areas can be attributed to the leaflet.

[3] Some caution is required when drawing comparisons between the intervention area and the control area. Although every effort was made to identify an area with similar characteristics, the control area is in a different location, so may face other varying factors.

8.1 Spontaneous awareness of warning signs

Within the leaflet, warning signs that could indicate early symptoms of cancer were listed as: lumps; pain; cough; ulcers; changing moles; bleeding; and, skin sores.

Respondents within the Intervention Area (leaflet only) have spontaneous awareness levels of cancer warning signs that are largely in-line with the Control Area with the exception being the changing appearance of moles, which is significantly higher in the leafleted area (25% c.f. 16%).

Interestingly, residents of the Intervention Area 2 (letter / leaflet) has a similarly significantly higher level of awareness of the changing appearance of moles as a cancer symptom than the Control Area (24% c.f. 16%), but also significantly higher levels of a cough/hoarseness and changing bowel or bladder habits as cancer indicators than either the Control Area or Intervention Area.

- Cough/hoarseness - 10% Letter/leaflet c.f. 3% Control, 2% Leaflet
- Change in bladder/bowel habits – 10% Letter/leaflet c.f. 4% Control, 6% Leaflet

Calculating the average number of cancer warning signs spontaneously recalled increases from 2.47 in the control area to 2.57 in the area with the leaflet to 3.06 in the area with both the letter and the leaflet.

Table 8: Spontaneous recall of warning signs / symptoms of cancer (All mentions by survey area – All responses)

	Control area	Intervention area	Intervention area 2	West Herts
	None	Leaflet	Letter & Leaflet	None
AVERAGE NO. OF MENTIONS	**2.47**	**2.57**	**3.06**	**2.67**
Lump / swelling	65%	67%	69%	65%
Pain	35%	25%	**42%**	33%
Bleeding	22%	20%	16%	25%
Change in appearance of a mole	16%	**25%**	**24%**	24%
Weight loss	13%	15%	18%	14%
Tiredness / fatigue	7%	7%	8%	9%
Generally unwell	7%	6%	9%	5%
Feeling weak	5%	4%	6%	1%
Nausea / sickness	5%	4%	3%	5%
Change in bowel / bladder habits	4%	6%	**10%**	17%
Loss of appetite	4%	1%	1%	3%
Sore that does not heal	3%	4%	4%	9%
Cough / hoarseness	3%	2%	**10%**	7%

	Control area	Intervention area	Intervention area 2	West Herts
Difficulty swallowing	3%	2%	3%	4%
Bruising	3%	1%	*%	*%
Blurred vision	1%	1%	1%	0%
Other	1%	1%	0%	1%
Don't know/nothing	20%	26%	27%	16%
Unweighted base	**249**	**507**	**254**	**380**

8.2 Prompted awareness of warning signs

Comparing the prompted awareness results across the Control Area and the Intervention Area (leaflet) shows little variance. Those in the leafleted area have a significantly higher level of prompted recognition of the change in the appearance of a mole as a potential warning sign of cancer (77% c.f. 70%).

Similarly the Intervention Area 2 (letter/leaflet) varies little when compared to the Control Area, awareness of a persistent cough or hoarseness as a cancer indicator is however significantly higher within the Control Area (65% c.f. 54%).

Interestingly, Intervention Area 2 (letter / leaflet) has significantly lower levels of prompted awareness of unexplained bleeding, changes in bowel/bladder habits, changes in the appearance of a mole and unexplained weight loss as cancer symptoms than noted in the Intervention Area (leaflet).

Table 9: Prompted recognition of warning signs / symptoms of cancer

By survey area (All respondents)

	Control area	Intervention area	Intervention area 2	West Herts
	None	Leaflet	Letter & Leaflet	None
Lump or swelling	82%	87%	83%	93%
Persistent unexplained pain	78%	77%	71%	78%
Unexplained bleeding	74%	**80%**	71%	86%
Persistent cough or hoarseness	**65%**	61%	54%	71%
Persistent change in bowel or bladder habits	77%	**82%**	75%	91%
Persistent difficulty swallowing	56%	58%	52%	65%
Change in the appearance of a mole	70%	**77%**	69%	90%
A sore that does not heal	67%	66%	59%	75%
Unexplained weight loss	66%	**71%**	61%	82%
Unweighted base	**249**	**507**	**254**	**380**

8.3 Recognition of risk factors for cancer (prompted)

Comparing the recognition of the risk factors for cancer across the Control Area and Intervention Areas, a clear pattern of data emerges, whereby those within the 2 Intervention Areas that have received the cancer awareness campaign leaflet have higher levels of recognition of the cancer risk factors than those within the Control Area.

Note that those in the Intervention Area (leaflet) have a significantly higher recognition that having a close relative with cancer can present a cancer risk when compared with Intervention Area 2 (letter/leaflet), but this message is not included within either the leaflet or letter/leaflet activity.

Table 10: Recognition of risk factors for cancer

% agree by survey area (All respondents)

	Control area	Intervention area	Intervention area 2	West Herts
	None	Leaflet	Letter & Leaflet	None
Smoking any cigarettes at all	80%	87%	**88%**	**92%**
Exposure to another person's cigarette smoke	74%	**87%**	**91%**	**84%**
Drinking more than 1 unit of alcohol a day	**50%**	**60%**	**61%**	32%
Eating less than 5 portions of fruit and vegetables a day	**31%**	**30%**	**28%**	7%
Eating red or processed meat once a day or more	**39%**	**47%**	**45%**	19%
Being overweight (BMI over 25)	46%	**55%**	50%	**56%**
Getting sunburnt more than once as a child	71%	**83%**	**81%**	75%
Being over 70 years old	**51%**	**54%**	**61%**	34%
Having a close relative with cancer	50%	**63%**	48%	**63%**
Infection with HPV (Human Papillomavirus)	19%	**29%**	22%	**28%**
Doing less than 30mins of moderate physical activity 5 times a week	**28%**	**31%**	**32%**	9%
Unweighted base	**249**	**507**	**254**	**380**

8.4 Awareness of cancer screening programmes

The back page of the leaflet provided details of the vaccinations and screening programmes available to each age-group.

Awareness of both breast cancer screening and cervical cancer screening is higher within both the Intervention Areas than within the Control Area, but is significantly higher within the Intervention Area (leaflet).

Awareness of bowel cancer screening however remains consistent across both Control and Intervention areas.

Table 11: Awareness of cancer screening programmes

% yes by survey area (All respondents)

	Control area	Intervention area	Intervention area 2	West Herts
	None	Leaflet	Letter & Leaflet	None
NHS breast cancer screening	42%	**60%**	50%	58%
NHS cervical cancer screening	43%	**56%**	45%	55%
NHS bowel cancer screening	21%	22%	19%	19%
Unweighted base	**249**	**507**	**254**	**380**

8.5 Lifestyle as a cancer contributing factor

Lifestyle (smoking, diet, physical activity) was recognised by the total sample as the most important factor in contributing to the incidences of cancer within the UK. A page of the leaflet provided detail on how over half of all cancers would be prevented by changing your lifestyle and so the table below compares the proportion of respondents within each area who selected 'Lifestyle' as the most important contributor to cancer.

The Intervention Area 2 (letter/leaflet) can be seen to rank lifestyle as a cancer contributor at a significantly higher level (66%) than either the Control Area (53%) or the Intervention Area (55%).

Table 12: Lifestyle as a cancer contributor

By survey area (All respondents)

	Control area	Intervention 1 area	Intervention area 2
	None	Leaflet	Letter & Leaflet
Ranked as most important	53%	55%	**66%**
Unweighted base	**249**	**507**	**254**

8.6 Conclusion

- The cancer awareness campaign within both the Intervention Areas would appear to be impacting on spontaneous recall of cancer warning symptoms, increasing the range of early warning signs recognised in line with those promoted within the leaflet.
- Prompted awareness remains similar across the three areas, but this would be expected with a low-level advertising campaign.
- Recognition of risk factors increases notably in the areas of intervention, but there is little difference between the impact of the leaflet alone and the leaflet and letter combined.
- Awareness of breast and cervical cancer screening programmes are significantly higher in the intervention area with the leaflet only. The cancer screening information is on the back page and this effect may be a result of how the leaflet was picked up, further qualitative research could aid understanding.
- Awareness of lifestyle as a cancer contributor is significantly higher in the intervention area with the letter and leaflet. This result could support the hypothesis that the covering letter from the Network Director may encourage a more detailed reading of the leaflet;
- Following analysis of the main sample group, it appears that the PCT localities have significantly different levels of awareness, which was a surprise to the study group. This means that the control area (in Luton), although matched by SOA, is not a fair comparison with the intervention areas (in Watford). Drawing conclusions from this data is therefore more difficult and a repeat intervention project with closer matched controls from the same PCT locality would provide a more valid comparison.

9 Profile of sample

The following tables provide details of the profile of the sample (main sample).

Table 13: Demographic profile (main sample)

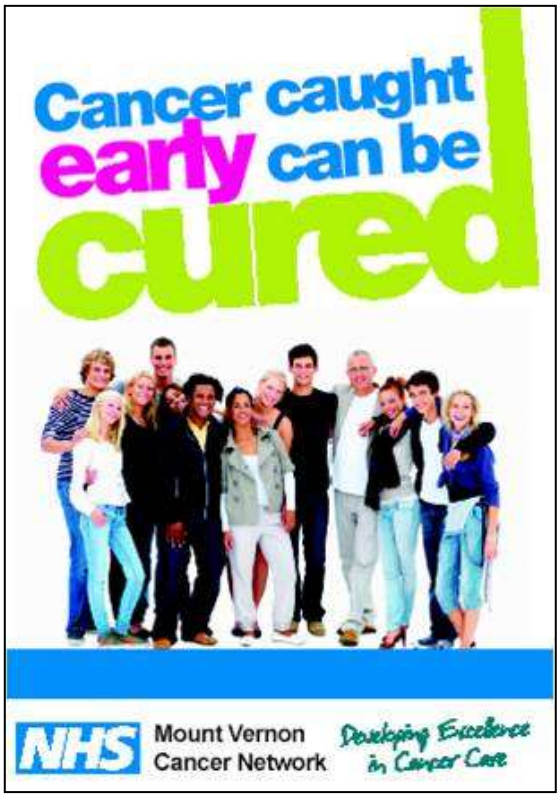
Demographic	Unweighted base	%
Age		
18-24	125	10%
25-44	411	33%
45-64	362	29%
65+	290	23%
Not provided	63	5%
Gender		
Male	591	47%
Female	660	53%
Ethnicity		
White	1009	81%
Mixed	17	1%
Asian or Asian British	37	3%
Black or Black British	161	13%
Chinese / other	18	1%
Not provided	9	1%
Marital status		
Single / Separated / Divorced / Widowed	430	34%
Married / Living with partner / Civil Partnership	773	62%
Not provided	48	4%
Education achievement		
More than O Levels	518	41%
O Levels or less	642	51%
Other	16	1%
Not provided	75	6%
Tenure		

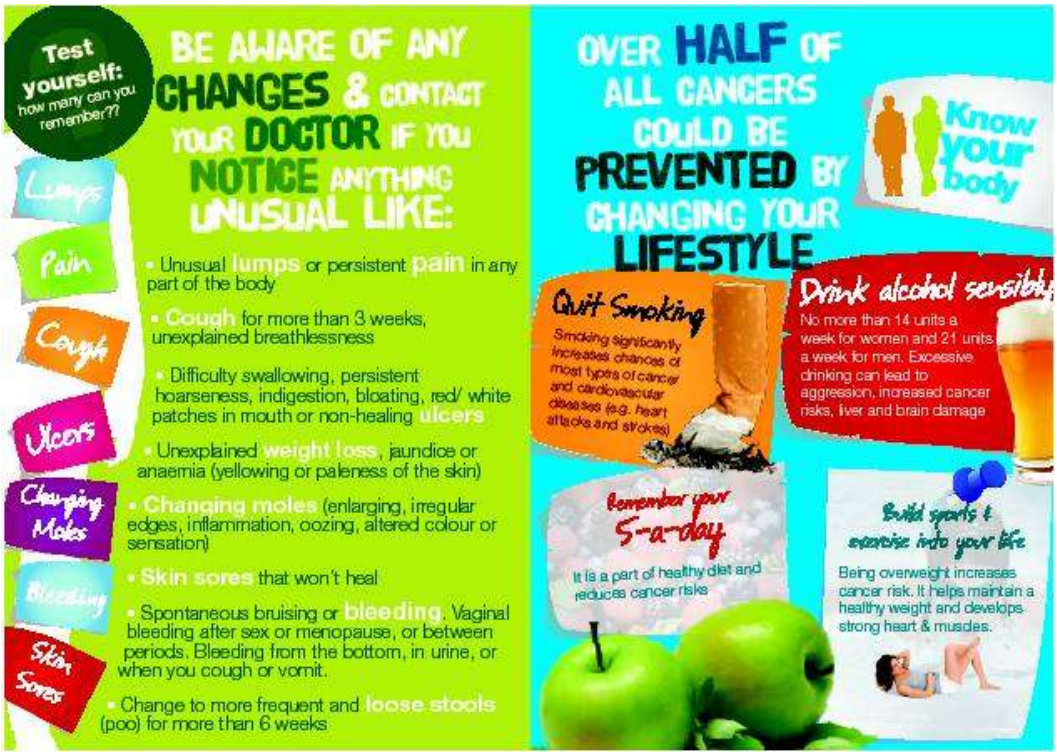
Owner Occupier / Leaseholder	834	67%
Renting	322	26%
Other	23	2%
Not provided	72	6%
Employment status		
Economically active	640	51%
Economically inactive	575	46%
Not provided	36	3%
Language spoken at home		
English	1102	88%
Other	139	11%
Not provided	10	1%

Table 14: Have you or your family or close friends had cancer? (All respondents)

	Yes	No	Prefer not to say	Not sure
You	5%	90%	5%	*%
Partner	5%	88%	6%	1%
Close family member	44%	51%	5%	*%
Other family member	30%	64%	5%	1%
Close friend	24%	70%	6%	*%
Other friend	24%	70%	6%	1%
Unweighted sample bases vary			***% denotes < 0.5%**	

10 Appendix 1: Leaflet






Keep yourself up-to-date
with all vaccinations and screening programmes:
Breast: ages 50 – 70 years,
Cervical: ages 25 – 64 years
Bowel cancer: ages 60 – 69 years
HPV vaccination : 13 – 18 years
started from September 2008
www.cancerscreening.nhs.uk
Protect your skin
Avoid excessive sun exposure, spend time in the shade between 11am to 3pm. Sun Damage causes skin cancers
information on prostate cancer
visit www.prostate-link.org.uk
Practice safe sex
and report any infections. Sexually-transmitted wart virus is the main cause of cervical cancer.
Remember-
Consult your doctor EARLY
More information on staying healthy is available on www.nhs.uk

11 Appendix 2: Covering letter

March, 2010

NHS
Mount Vernon
Cancer Network

Royalty House
10, King Street
Watford
WD18 6NT
Tel: 01923 281600

Dear Householder

The Mount Vernon Cancer Network is keen to ensure that our residents stay as healthy as possible.

One way we can do this is to encourage you to speak to your doctor (GP) or practice nurse if you notice any changes in your health or symptoms that might indicate that you have cancer.

It is really important that people who show any symptoms are assessed as quickly as possible. As with many illnesses, early detection, diagnosis and treatment of symptoms reduce the risk of the condition becoming more serious.

To help with this, we are enclosing a leaflet that gives important information about the early symptoms of cancer and what can be done to reduce your risk of getting cancer. We hope that you read this leaflet, show it to your family and friends and keep it in case you need to look at it again in the future.

If you think you already have any of these symptoms then please talk to your GP or nurse about them right away. For more information on a range of health matters – including cancer, take a look at www.nhs.co.uk.

We would like to take this opportunity to wish you the best of health now and in future.

Yours sincerely

Barbara Gill
Network Director

Dr Philip Sawyer
Primary Care Lead

Working in partnership to ensure continual excellence in cancer care for the benefit of all in Hertfordshire, Luton and South Bedfordshire.

12 Appendix 3: Probability of developing cancer (out of 100)

Respondents were asked to specify, out of 100 people, how many they think would develop cancer at some point in their life. The full range of responses is shown in the table below:

Number of people out of 100	Proportion
1	1%
2	1%
3	*%
4	*%
5	3%
6	*%
7	*%
8	*%
10	10%
12	*%
13	*%
15	3%
16	*%
17	*%
18	*%
19	*%
20	16%
23	*%
24	*%
25	10%
26	*%
29	*%
30	18%
32	*%
33	5%
35	2%
38	*%
40	5%
45	1%
47	*%
48	*%

50	9%
55	*%
56	*%
60	4%
65	1%
67	*%
70	1%
74	*%
75	1%
80	1%
85	*%

Because people matter, we listen.

With some 20 years' experience, BMG Research has established a strong reputation for delivering high quality research and consultancy.

Our business is about understanding people; because they matter. Finding out what they really need; from the type of information they use to the type of services they require. In short, finding out about the kind of world people want to live in tomorrow.

BMG serves both the social public sector and the commercial private sector, providing market and customer insight which is vital in the development of plans, the support of campaigns and the evaluation of performance.

Innovation and development is very much at the heart of our business, and considerable attention is paid to the utilisation of technologies such as portals and information systems to ensure that market and customer intelligence is widely shared.

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