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ARTICLE

Uptake of Bowel Scope (Flexible Sigmoidoscopy) Screening in the English National Programme: an analysis of the first fourteen months.

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ABSTRACT

Objective: To examine uptake in the first six pilot centres of the English Bowel Scope Screening (BSS) programme.

Setting: Roll-out of the BSS programme, which invites adults aged 55 for a once off Flexible Sigmoidoscopy (FS), began in early 2013. This analysis covers 21,187 invitations sent by the six pilot centres during the first 14 months of the programme (March 2013 - May 2014).

Method: We used multivariate logistic regression analysis to examine variation in uptake by gender, socioeconomic deprivation (using the Index of Multiple Deprivation), area-based ethnic diversity (proportion of non-white residents), screening centre, and appointment time (routine: daytime vs out of hours: evening/weekend).

Results: Uptake was 43.1%. Men were more likely to attend than women (45% vs 42%; OR 1.136, 95% CI 1.076, 1.199, $p < 0.001$). Combining data across centres, there was a socioeconomic gradient in uptake, which ranged from 33% in the most deprived to 53% in the least deprived quintile. Areas with the highest level of ethnic diversity also had lower uptake (39%) than other areas (41-47%) (all $p < 0.02$), but there was no gradient. Individuals offered a routine appointment were less likely to attend than those offered an out of hours appointment (42% vs. 44%; OR 0.931, 95% CI 0.882, 0.983, $p = 0.01$). Multivariate analyses confirmed independent effects of deprivation, gender and centre but not ethnic diversity or appointment time.

Conclusion: Early indications of uptake are encouraging. Future efforts should focus on increasing public awareness of the programme and reducing socioeconomic inequalities.

Key Words: Colorectal Cancer, Screening, Flexible Sigmoidoscopy, Bowel Scope, Uptake, Appointments, Socioeconomic Deprivation.

INTRODUCTION

Colorectal cancer (CRC) is the third most frequently diagnosed cancer worldwide (700,000 deaths worldwide per year), and the fourth leading cause of cancer deaths.^{1,2} In the UK, it is the second most common cause of cancer death.³ In 2006, the National Health Service (NHS) set up an organised CRC Screening Programme (called the Bowel Cancer Screening Programme; BCSP) in England. The programme is based on biennial guaiac-based Faecal Occult Blood testing (gFOBt) which is now offered to all adults aged 60-74 years. Trial data on gFOBt show a clear benefit in CRC mortality, but no evidence of a reduction in incidence;⁴ so the test is excellent in terms of earlier diagnosis but not contributing to prevention.

In contrast, endoscopic screening, through its capacity to detect and remove polyps, has been shown to reduce CRC incidence as well as mortality. In the UK Flexible Sigmoidoscopy (FS) Trial, a single FS exam (between age 55 and 64 years) reduced incidence by 23% and 33% and mortality by 31% and 43% in the total and the screened population respectively.⁵ Other quality studies have also found positive results with a subsequent meta-analysis concluding that offering FS screening can reduce CRC incidence by around 18% and mortality by 28%, increasing to 32% and 50% respectively when screening is adhered to, and thereby supporting its potential use as a strategy to prevent CRC.^{6,7} Indeed, a more recently published population-based trial from Norway provides

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further evidence of how screening using FS can help significantly reduce CRC incidence and mortality with an 11 year follow-up.⁸

The English BCSP started the national roll-out of the 'Bowel Scope Screening (BSS) Programme', offering a once-off FS to everyone aged 55, in March 2013. A phased roll-out to ensure workforce capacity is in progress and began with six screening centres (South of Tyne, West Kent, Norwich and Norfolk, London (St Mark's), Wolverhampton, and Surrey). The BSS programme is expected to be rolled out across all centres by 2016 (see Figure 1) with full population coverage from 2018.⁹

Like all screening programmes, reaping the full public health impact of BSS depends, to a large degree, on high uptake, but wherever CRC screening has been implemented, and whatever the modality, it has always underperformed compared to breast or cervical screening. In the gFOBt programme, uptake of the first 2.6 million invitations was 54% overall; however, this varied from less than 35% uptake in the most socioeconomically deprived quintile of areas in England to more than 60% in the least deprived quintile.¹⁰ A meta-analysis of uptake data from 14 RCT's of BSS has indicated that uptake rates for BSS is likely to be lower than what is seen for gFOBt:¹¹ one Dutch study found BSS uptake to be only 32.4%, compared to 49.5% for gFOBt.¹² Other studies within this meta-analysis, however, have found BSS uptake to be higher e.g. a

RCT conducted in Italy showed a BSS uptake of 58.3%.¹³ However, methodological heterogeneity among the trials included in the meta-analysis (for example, with some recruiting from the general population, while others, including the UK FS trial, inviting individuals who had already indicated interest in screening), made it difficult to extrapolate to likely uptake in the national BSS programme. A recent population-based RCT conducted in Norway found BSS uptake to be 63%, but again with variation in methodology, direct comparisons with the UK national programme is difficult.⁸

There have also been some small-scale evaluations of uptake. Two London-based feasibility studies of nurse-led BSS had uptake rates of 45% and 55%..^{14,15} However, both were delivered through a single screening centre known for its excellence in endoscopy, and served a population who may have been familiar with BSS screening due to the centre's involvement in the UK FS trial.^{14,15} In 2011, a pathfinder study of BSS in three centres in England reported uptake of only 29%;¹⁶ however, none of these sites used reminder letters for non-responders. With no publicity or marketing strategies in place, projection to uptake in the national programme is limited.

Similarly, there is uncertainty with regard to gender differences in uptake of FS screening uptake. Women are more likely to return completed gFOBt kits,^{9,17,18} but the opposite has been found for endoscopic screening. While the London-based feasibility studies indicated either similar or higher uptake for women,^{14,15} that was contrary to the UK FS trial data^{19,20} and other BSS uptake reports.¹²

The present study is the first multi-centre examination of uptake in an organised BSS programme. The primary objective was to give an indication of overall uptake of BSS and examine differences by gender, socioeconomic status (SES) and ethnicity. A secondary aim was to compare uptake across the six participating centres, and assess the extent to which differences could be attributed to the demographic composition of the catchment populations.

Finally, previous research has indicated that flexibility with regard to appointment day and/or time can influence attendance at various health-related appointments.^{21,22} We therefore also explored the extent to which the six centres offered out of hours appointments and whether offering these appointments was associated with increased uptake.

MATERIALS AND METHODS

Participants and setting

The study population was all men and women who turned 55 during the study period (March 2013 – May 2014) and were registered at a general practice linked with the six screening centres (South of Tyne (Queen Elizabeth and South Tyneside); West Kent (West Kent and Medway); Norwich; London (St Marks); Wolverhampton, Surrey (Guildford)). Ethical approval for this study was not required.

Invitation process

The English BSS Programme sends a pre-invitation letter to all eligible individuals, informing them about the forthcoming BSS opportunity. A screening invitation letter, that offers a dated and timed screening appointment with approximately six weeks' notice, is then sent 8-10 days later. During the invitation period covered in this study, of the six centres, five offered both weekday routine and evening/weekend (termed out-of-hours) appointments, while one (Wolverhampton) offered only weekday routine appointments. Invitees are asked to either return a slip attached to

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their invitation letter to confirm or decline attendance, or call the centre to confirm, rearrange, or cancel the appointment.

Enclosed with the screening invitation is an information booklet about the programme and a freepost return envelope for the confirmation slip. After two weeks, an appointment reminder is sent to people who have not responded. For those who confirm the appointment, a confirmation letter is sent along with a consent form, which is followed shortly by a mailed enema with instructions for self-administration on the day of the appointment.

Measures

The data used in this analysis were extracted and modified from data routinely collected within the BCSP. Data were anonymised before being transferred to the research team.

Individual-level demographics. The gender of each invitee was added to the study dataset.

Area-level deprivation. The postcode sector of each invitee was converted to a score for area-based socio-economic deprivation before being added to the study dataset. This score was derived using the 2010 Index of Multiple Deprivation (IMD).²³ The IMD uses census-derived indicators of income, education, employment, living environment, health and disability, barriers to housing and services, and crime, at small-area level to generate a scale from 0 (least deprived) to 80 (most deprived). For analysis, the IMD scores were categorised into quintiles of the national distribution.²⁴

Area-level ethnic diversity. An area-level index of ethnic diversity was produced using Census 2010 data based on the proportion of 'non-white' residents (all self-reported ethnic groups other than 'White British', 'White Irish', and 'White other') in each postcode sector. For analysis, area-based ethnic diversity was grouped into quintiles based on national census information.

Appointment slot offered. The appointment date/time offered in the initial invitation letter was documented for each person. For analysis, appointments offered on weekday mornings and afternoons were categorised as 'routine', while appointments offered on weekday evenings (after 5pm) and Saturdays were categorised as 'out-of-hours'.

Uptake. The date of attendance for individuals who attend is included in the programme database. Individuals with an entry for 'date attended' were classified as attending, and those with no date were classified as 'Did not attend' (DNA).

Statistical analysis

We categorised the continuous predictors (area level deprivation and ethnic diversity) using national quintiles of distribution. We used univariate logistic regression to examine differences in uptake by gender, deprivation quintile, ethnic diversity quintile, centre, and type of appointment offered. We used multivariate logistic regression to examine the independent effect of each predictor controlling for all others. Age group was not a variable in the analysis, as only 55 year olds are sent a BSS invitation. We report the results using odds ratios (ORs) and 95% confidence intervals (95% CI's) (Table 1). Data were analysed with SPSS version 22.

RESULTS

Over the study period, 21,187 screening invitations were sent out across the six centres (see Appendix Table 1) with an overall uptake rate of 43.1% (N = 9,123).

Differences by gender, deprivation, ethnic diversity, centre, and type of appointment offered are shown in Table 1. Uptake varied between the six centres (36.8% - 52.0%); four centres had uptake significantly higher than the centre with the lowest uptake (South of Tyne). Men were more likely to attend BSS than women (44.6% vs 41.5%).

Uptake in the least deprived quintile was 53.2% and only 32.7% for the most deprived quintile, with an almost linear trend across deprivation quintiles. This pattern was observed in all six centres, although the distribution of deprivation varied by centre (see Appendix Table 2). For example, Surrey had no invitees from the most deprived quintile while the majority of Wolverhampton's invitees were from the most deprived quintile. Overall, uptake was significantly higher in the least ethnically diverse areas compared with the most ethnically diverse areas (44.9% vs. 38.7%), but there was no evidence of a gradient in relation to area ethnic diversity (see Table 2).

Of the 21,187 appointments offered across the six centres, 49.7% (n = 10,533) were routine appointments (weekday morning and afternoons) and 50.3% (n = 10,654) were subsequently 'out-of-hours' (weekday evenings and Saturdays mornings and afternoons). The proportion of people who went on to attend an appointment and have the BSS procedure was significantly lower in the group originally offered a 'routine' appointment compared to those originally offered an 'out-of-hours' appointment (42.2% vs. 43.9%) (see Table 1). Closer inspection of the appointment data found attendance

at the exact appointment time and day offered was only 16.5% and 19.8% for 'routine' and 'out-of-hours' appointments respectively (see Table 2).

A multivariate analysis confirmed that area-level deprivation remained the strongest independent predictor of uptake (OR for quintile 1 vs quintile 5 = 2.046, 95% CI 1.848, 2.266) (see Table 1). Screening centre was also predictive of uptake with four centres achieving uptake levels significantly higher (15% to 38% higher) than the centre with the lowest uptake (South of Tyne). Gender also remained a significant predictor (OR = 1.149, 95% confidence interval (CI) 1.087, 1.214). There was no independent effect of area-based ethnic diversity or the type of appointment offered.

DISCUSSION

England is the first country to begin to deliver a nationwide organised, population-based, Bowel Scope Screening (BSS) programme, involving

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flexible sigmoidoscopy examinations. Since the start of the programme in 2013, the six pilot centres have invited 21,187 people invited for BSS, of whom 43% attended. This was considerably higher compared with a recent Dutch trial comparing different screening modalities and the recent English pathfinder study.^{12,16} However, uptake was

lower than was reported for the two single-centre feasibility studies (45% and 55%) in the London area,^{14,15} and the early uptake for gFOBt screening (54%).¹⁰

As documented in previous studies, uptake was strongly socioeconomically graded. Stratifying by quintile of area-level deprivation based on home address, uptake was almost twice as high in the least compared with most deprived areas (Table 1), and a similar gradient in uptake was seen in all six centres (see Appendix Table 2). Given the potential benefits of BSS in reducing CRC incidence as well as mortality, such striking inequalities are a major concern. If strategies are not implemented to reduce the gradient, it is likely that inequalities in CRC incidence will be created and inequalities in CRC mortality will be exacerbated.¹⁰

Similar to other studies investigating uptake of FS screening we found that women had lower uptake than men.^{12,19} This is surprising given that women are more

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likely to participate in CRC screening using the guaiac based FOBT kit,¹⁰ especially in the first invitation round.¹⁸ The reasons why this difference reverses for endoscopic screening tests is not well understood. Perhaps more importantly, very little is known about why there is an almost two-fold difference between uptake of BSS (41.5%) and coverage of breast and cervical screening (75.9 and 77.8%, respectively).^{25,26} A better

understanding of why women accept one invitation and decline the other could help to highlight the barriers to CRC screening.

There were significant differences in uptake rates by centre after adjusting for differences in gender, SES, and area-based ethnic diversity. Furthermore, centre-specific differences were not attenuated by adding a potentially modifiable service-related variable (use of 'out-of-hours' appointments). While offering out-of-hours appointments was associated with slightly higher uptake in univariate analyses, the multivariate analysis suggested that it was not the offer of out-of-hours appointments *per se*, but the fact that they were preferentially offered to people who would have been more likely to attend on the basis of their demographic background (gender, area-based deprivation and centre). Importantly, there was large variation between centres in the type of appointments they offered. While the difference between routine and out of hours appointments was small it might be advisable for individual centres to offer a broader range of appointments (at least to begin with) to monitor whether there is a preference for specific appointment times or days among their target population.

It is important to acknowledge that our analysis was restricted to the first six pilot centres, which covered only a fraction of the total population that will be eligible for BSS. The six pilot centres included in this analysis covered a population with a comparable level of deprivation to the rest of England (average IMD 2010 score 21.6 vs 21.7 respectively). In contrast, our analytic sample contained a higher proportion of

ethnically diverse individuals compared with the general population (20.8% vs 12.9%). Given the higher propensity of invitees from ethnically diverse areas, it is probable that uptake might increase slightly once the programme invites the entire eligible population.

The finding that all our variables together have relatively low predictive power highlights the fact that there must be other important factors that could be targeted to improve uptake. These could include other service-related variables such as offering single-sex lists (i.e. endoscopy sessions inviting men or women only) and a choice of practitioner gender, and individual-level psychosocial variables (e.g. test-specific beliefs and attitudes, beliefs about CRC). Larger-scale data analysis will enable us to investigate other sources of centre differences, such as geographical variables while a mixture of prospective and retrospective interview studies and surveys will identify psychosocial determinants of uptake. Recent projections for the national programme in England suggest that adding once-only FS to the NHS BCSP will prevent an additional 2000 CRC deaths and prevent 10,000 CRC cases in England by mid-2030. Importantly, this projection was based on 50% uptake of BSS and 57% uptake of gFOBT highlighting the potential benefits of increasing BSS uptake.⁹ Incentive to better understand predictors of BSS uptake and to incorporate this knowledge into the development of interventions to increase uptake is therefore high.

Because of the gradual roll-out of the programme there are currently no campaigns to encourage public awareness of BSS, unlike with other screening programmes. However, in light of the substantial health benefits of BSS screening, it is imperative that messages and communication channels are established to inform the public about BSS with a key objective being to narrow inequalities along with improving overall uptake.

CONCLUSION

The UK is a pioneer in delivery of organised endoscopic screening. Programme coverage is already good for a test that is intrusive and unfamiliar in the UK. Nevertheless, more than half of those invited do not attend, and this rises to two thirds for screening centres serving a predominantly socioeconomically deprived area. The huge health gain associated with preventing a common cancer that carries such high morbidity and mortality, makes a strong case for investment in strategies to both increase uptake and reduce social inequalities.

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Declarations of Interest

All authors declare they have no conflicts of interest.

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Table 1: Demographic and service-level variation in screening uptake.

	Univariate analysis			Multivariate analysis*	
	% Uptake (n)	OR (95% CI)	P value	OR (95% CI)	P value
Centre					
South of Tyne (n = 2858)	36.8 (1052)	1.000		1.000	
West Kent (n = 3689)	47.4 (1747)	1.544 (1.398, 1.706)	<0.001	1.184 (1.049, 1.336)	0.006
Norwich (n = 3776)	50.6 (1909)	1.755 (1.590, 1.938)	<0.001	1.376 (1.238, 1.529)	<0.001
London (St Mark's) (n = 4933)	40.5 (1997)	1.168 (1.062, 1.284)	0.001	1.173 (1.034, 1.332)	0.013
Wolverhampton (n = 4551)	37.4 (1700)	1.024 (0.929, 1.128)	0.636	1.012 (0.890, 1.151)	0.857
Surrey (n = 1380)	52.0 (718)	1.862 (1.635, 2.121)	<0.001	1.149 (1.052, 1.437)	0.009
Gender					
Women (n = 10619)	41.5 (4407)	1.000		1.000	
Men (n = 10568)	44.6 (4716)	1.136 (1.076, 1.199)	<0.001	1.149 (1.087, 1.214)	<0.001

Area-based deprivation quintiles

Quintile 1, mMost deprived (n = 4336)	32.7 (1416)	1.000		1.000	
Quintile 2 (n = 4413)	37.8 (1669)	1.254 (1.149, 1.370)	<0.001	1.198 (1.094, 1.312)	<0.001
Quintile 3 (n = 4100)	43.0 (1765)	1.559 (1.427, 1.703)	<0.001	1.443 (1.315, 1.584)	<0.001
Quintile 4 (n = 4016)	49.1 (1973)	1.991 (1.823, 2.176)	<0.001	1.766 (1.602, 1.947)	<0.001
Quintile 5, lLeast deprived (n = 4303)	53.2 (2289)	2.344 (2.148, 2.557)	<0.001	2.046 (1.848, 2.266)	<0.001

Area-based ethnic diversity quintiles

Quintile 1, mMost diverse (n = 4608)	38.7 (1783)	1.000		1.000	
Quintile 2 (n = 4462)	41.2 (1838)	1.110 (1.020, 1.207)	0.015	1.065 (0.959, 1.182)	0.241
Quintile 3 (n = 4292)	44.1 (1892)	1.249 (1.148, 1.359)	<0.001	1.025 (0.915, 1.149)	0.666
Quintile 4 (n = 3976)	47.3 (1879)	1.420 (1.303, 1.547)	<0.001	1.115 (0.991, 1.255)	0.071
Quintile 5, lLeast diverse (n = 3830)	44.9 (1720)	1.292 (1.184, 1.409)	<0.001	1.064 (0.942, 0.201)	0.316

Type of appointment offered

Out-of-hours (n = 10654)	43.9% (4680)	1.000		1.000	
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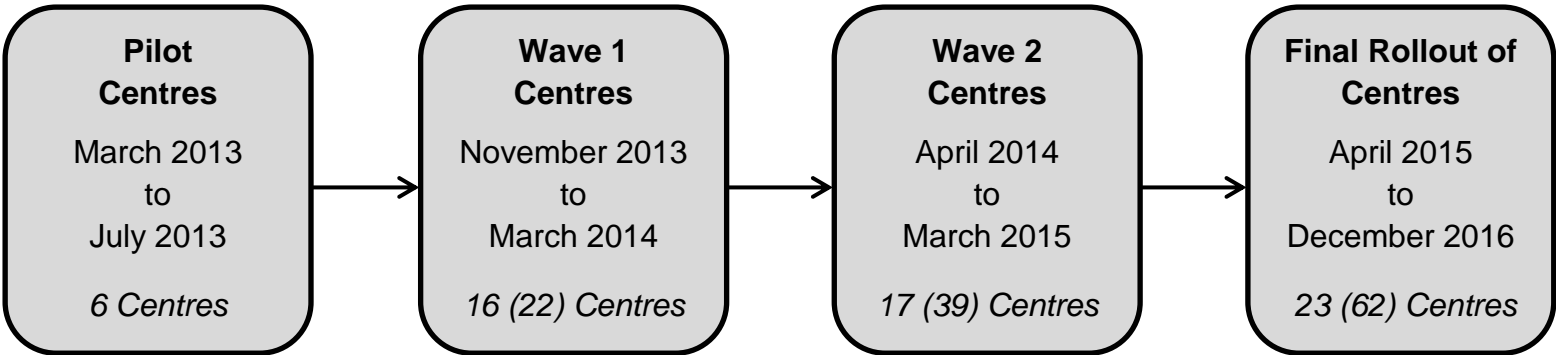
Routine (n = 10533)	42.2% (4443)	0.931 (0.882, 0.983)	0.010	1.062 (0.981, 1.149)	0.138
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*Controlled for all variables

Table 2: Proportion of appointment times offered, attended and re-scheduled

Appointment slot offered	Offered	Overall Attendance	Attendance at exact appointment offered	Changed appointment	
				Attended appointment within slot	Attended a different appointment slot
Routine	10533 (49.7%)	4443 (42.2%)	1737 (16.5%)	2301 (51.8%)	405 (9.1%)
Out-of-hours	10654 (50.3%)	4680 (43.9%)	2107 (19.8%)	2090 (44.7%)	483 (10.3%)
Total	21187	9123 (43.1%)	3844 (18.1%)	4391 (48.1%)	888 (9.7%)

Figure 1: Flowchart of proposed national roll-out of centres offering Bowel Scope screening



Appendix Table 1: Proportion of people invited across each centre by area-based deprivation quintile (row percentages) and proportion of people invited for each deprivation quintile by centre (column percentages).

		IMD Quintile					
		Q1	Q2	Q3	Q4	Q5	Total
		(Most deprived)				(Least deprived)	
<hr/>							
South of Tyne							
	% within centre	38.1	23.2	18.0	10.0	10.7	100.0
	% within IMD Quintile	25.1	15.0	12.5	7.1	7.1	13.5
	(n)	(1087)	(662)	(514)	(287)	(306)	(2856)
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West Kent							
	% within centre	4.5	16.4	17.5	27.6	34.0	100.0
	% within IMD Quintile	3.8	13.7	15.8	25.3	29.1	17.4

	(n)	(165)	(604)	(646)	(1017)	(1252)	(3684)
<hr/>							
Norwich							
% within centre		6.0	9.2	21.6	33.7	29.6	100.0
% within IMD Quintile		5.2	7.8	19.9	31.7	25.9	17.8
	(n)	(225)	(346)	(815)	(1272)	(1115)	(3773)
<hr/>							
London (St Marks)							
% within centre		18.3	37.4	25.1	12.3	6.8	100.0
% within IMD Quintile		20.8	41.8	30.2	15.1	7.8	23.3
	(n)	(903)	(1843)	(1238)	(607)	(337)	(4928)
<hr/>							
Wolverhampton							
% within centre		43.0	19.9	16.2	13.5	7.4	100.0
% within IMD Quintile		45.1	20.5	18.0	15.3	7.8	21.5

	(n)	(1956)	(904)	(736)	(616)	(337)	(4549)
<hr/>							
Surrey							
	% within centre	0.0	3.9	11.0	15.7	69.4	100.0
	% within IMD Quintile	0.0	1.2	3.7	5.4	22.2	6.5
	(n)	(0)	(54)	(151)	(217)	(956)	(1378)
<hr/>							
Total							
	% within centre	20.5	20.8	19.4	19.0	20.3	100.0
	% within IMD Quintile	100.0	100.0	100.0	100.0	100.0	100.0
	(n)	(4336)	(4413)	(4100)	(4016)	(4303)	(21168)*

*IMD scores were not available for 19 participants across 4 centres

Appendix Table 2: Demographic and service-level variation in screening uptake in the six pilot centres.

	South of Tyne % (n=2,858)	West Kent % (n=3,689)	Norwich % (n=3,776)	London % (n=4,933)	Wolverhampton % (n=4,551)	Surrey % (n=1,380)
Overall uptake	36.8	47.4	50.6	40.5	37.4	52.0
Gender						
Men	39.4 (564/1432)	48.3 (878/1,817)	52.6 (974/1,853)	41.1 (1,007/2,449)	39.7 (912/2,300)	53.1 (381/717)
Women	34.2 (488/1426)	46.4 (869/1,872)	48.6 (935/1,923)	39.9 (990/2,484)	35.0 (788/2,251)	50.8 (337/663)
Area-based deprivation quintiles						
Quintile 1 (Most deprived)	29.5 (321/1,087)	38.2 (63/165)	38.2 (86/225)	35.3 (319/903)	32.1 (627/1,956)	0 (0)

Quintile 2	35.3	39.9	45.7	37.5	35.5	42.6
	(234/662)	(241/604)	(158/346)	(692/1,843)	(321/904)	(23/54)
Quintile 3	41.6	43.0	46.3	42.7	41.4	41.1
	(214/514)	(278/646)	(377/815)	(529/1,238)	(305/736)	(62/151)
Quintile 4	46.3	49.3	52.4	47.0	46.6	46.1
	(133/287)	(501/1,017)	(667/1,272)	(285/607)	(287/616)	(100/217)
Quintile 5 (Least deprived)	49.0	52.7	55.5	50.1	47.5	55.5
	(150/306)	(660/1,252)	(619/1,115)	(169/337)	(160/337)	(531/956)

Area-based ethnic diversity quintiles

Quintile 1 (Most diverse)	48.3	42.1	44.4	38.9	34.6	50.0
	(28/58)	(51/121)	(40/90)	(1,418/3,644)	(229/661)	(17/34)
Quintile 2	34.3	45.3	52.2	41.8	36.9	52.6

	(92/268)	(340/751)	(107/205)	(269/643)	(788/2,135)	(242/460)
Quintile 3	32.4	46.9	54.7	43.8	36.8	51.7
	(119/367)	(757/1,614)	(237/433)	(84/192)	(437/1,187)	(258/499)
Quintile 4	39.4	49.7	50.5	47.6	45.1	52.2
	(370/939)	(448/901)	(658/1,303)	(91/191)	(148/328)	(164/314)
Quintile 5 (Least diverse)	36.2	49.5	49.7	51.2	41.2	49.3
	(443/1,224)	(147/297)	(865/1,742)	(132/258)	(98/238)	(35/71)
Type of appointment offered						
Out-of-hours appointment	36.1	44.8	50.6	40.5	0	56.5
	(896/2,480)	(499/1,115)	(1,887/3,730)	(1,225/3,023)	(0)	(173/306)
Routine appointment	41.3	48.5	47.8	40.4	37.4	50.7
	(156/378)	(1,248/2,574)	(22/46)	(772/1,910)	(1,700/4,551)	(545/1,074)

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