Envoy Partnership

Screen, Detect, Protect

Process and Impact Evaluation of the first round of the NWL VHC Community Solutions Fund

August 2024

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This report and research was prepared by Hannah Barnett and Andy Gawin Warby, Envoy Partnership. With utmost thanks to the NWL Vibrant and Healthy Communities team, participating VCS organisations, and service users for participating in the research.

Executive Summary

Background

The Vibrant and Healthy Communities (VHC) programme fosters collaboration among the Voluntary and Community Sector (VCS), NHS, Local Authorities, Public Health, and other stakeholders to address health inequalities in the London Boroughs of Kensington & Chelsea and Westminster (the "bi-boroughs"). The Community Solutions Fund, a key element of the VHC programme, focuses on early intervention and prevention by empowering community-driven healthcare initiatives.

The fund's inaugural programme, Screen, Detect, Protect (SDP), aims to improve early cancer detection in marginalized communities through VCS-led projects. Between January and June 2024, nine VCS organisations were funded to implement community-specific interventions, targeting over 9,800 residents. The projects, ranging in grants from £19k to £40k, were designed in collaboration with NHS professionals, offering flexibility and support to the VCS organisations involved. The SDP also served as a pilot to evaluate the effectiveness of this collaborative approach in addressing health inequalities.

Nationally, early detection of cancer is critical for improving patient outcomes, reducing treatment costs, and enhancing the quality of life for individuals. Currently, only 54% of cancers in the UK are detected at early stages, with the NHS aiming to increase this to 75% by 2028. Early diagnosis initiatives, including screening programs for cervical, breast, and colorectal cancers, are vital in achieving this goal. However, challenges persist, including significant variations in screening uptake across different populations due to factors like socioeconomic status, ethnicity, gender, and medical mistrust.

Locally, in Kensington & Chelsea and Westminster, cancer screening rates are historically lower than both the national and London averages, particularly for cervical cancer. This low uptake reflects deeply entrenched health inequalities within these communities. The Community Solutions Fund's *Screen, Detect, Protect* (SDP) programme was specifically designed to address these disparities by targeting populations with the greatest need, such as ethnic minorities, older adults, people with learning disabilities, and those experiencing homelessness. By focusing on these underserved groups, the SDP programme aims to enhance early cancer detection in the bi-boroughs, contributing to the NHS's broader objectives and addressing critical local healthcare gaps.

Aims and Approach of Evaluation

Envoy Partnership was commissioned to conduct an external evaluation of the *Screen, Detect, Protect* (SDP) programme under the Vibrant and Healthy Communities (VHC) initiative. The evaluation had two main objectives:

1. **Process Evaluation:** To assess the effectiveness of the Community Solutions Fund model in addressing health inequalities through local partnerships.
2. **Impact Evaluation:** To evaluate the impact of nine community-led projects on increasing cancer screening rates among marginalised populations.

The evaluation employed a mixed-methods approach, combining qualitative and quantitative data from interviews, surveys, and focus groups with VCS organisations, health professionals, and service users. The findings aimed to provide a comprehensive understanding of the SDP programme's achievements and generate actionable recommendations for future funding rounds.

There are some limitations to the evaluation, such as inconsistent data collection and the inability to track individual cancer screening uptake. However, the findings still provide meaningful insights into the programme's impact on the targeted communities.

Summary of Findings

The evaluation captured key learnings in project design, delivery, partnerships, and outcomes, offering valuable insights into the strengths and challenges of the programme.

Process Evaluation

The SDP programme effectively harnessed collaborative efforts among community organisations, the NHS, Public Health, and Local Authority departments, which were crucial in advancing cancer screening initiatives. VCS-led interventions, supported by health professionals, combined community and clinical expertise to enhance workshop delivery. Their involvement in reviewing materials and leading sessions bolstered the confidence and effectiveness of the VCS organisations.

The SDP projects were largely consistent with the VCS organisations' previous interventions, as many leveraged established activities that had proven successful in the past. Most organisations brought prior experience in clinical topics and collaborations with health professionals, and many had conducted other cancer-related initiatives either shortly before or alongside their SDP projects. However, the programme's workshops and learning sessions were considered a particular benefit and distinguished it from other programmes. These sessions offered significant networking and resource-sharing opportunities, enhancing collaboration among VCS organisations and contributing to the programme’s overall success.

Several challenges were identified by stakeholders, including the six-month timeframe, which was deemed insufficient. Issues also arose with the programme’s structure, goals, evaluation requirements, and the availability of health professionals. Many organisations encountered unexpected staffing and resource limitations but managed to adapt by utilising internal expertise and external networks.

Impact Evaluation

The findings from the SDP projects reveal a complex landscape of cancer screening engagement across diverse communities. Collectively, these initiatives reached over 5,200 individuals through 709 events and activities, with an additional 421,000 residents engaged indirectly via digital campaigns and community outreach. The organisations involved adopted a wide array of approaches, from health workshops focused on cancer awareness to large-scale digital campaigns, each tailored to the unique needs and characteristics of the populations they served.

Our evaluation led to the identification of five primary barriers to cancer screening: Knowledge and Awareness, Cultural and Social Factors, Accessibility of Screening Appointments, Healthcare System Distrust, and Fear and Anxiety. These barriers are not only widespread but also deeply interconnected. Limited knowledge about cancer and screening processes, for example, often exacerbates cultural resistance and feeds into broader fears and anxieties, particularly among minority and immigrant communities.

Qualitative and quantitative feedback from service users demonstrated that SDP projects played a crucial role in breaking down these barriers by:

- Enhancing the understanding of target communities regarding cancers, their symptoms, risk factors, and the critical importance and process of cancer screenings.
- Fostering open discussions in safe and informal environments, thereby encouraging greater knowledge sharing and peer reinforcement within these communities.
- Empowering participants with self-advocacy skills and facilitating personalised support from trusted health professionals, which helped to build confidence and encourage participation in screening programs.
- Providing clear, accessible information in a positive tone to demystify the screening process and alleviate concerns of pain and anxiety.

Overall, the SDP projects made a notable impact on increasing knowledge and awareness about cancer screenings, with many participants reporting a higher likelihood of attending screenings in the future. However, the changes in actual screening rates were mixed, reflecting the complexity of these issues and current data limitations in attributing these outcomes directly to the interventions.

Learnings and Recommendations

These findings underscore the importance of continued, culturally sensitive engagement and tailored support to address the multifaceted barriers that hinder cancer screening participation in diverse communities. By bridging communication gaps, providing tailored information, and involving health professionals, the programme significantly raised awareness of earlier detection of cancer within the targeted communities.

However, the absence of individual or cohort-level tracking on systems such as SystmOne, EMIS, or WSIC has made it challenging to directly measure the programme's impact on cancer screening rates over the medium to long term. To better assess and enhance future Community Solutions Fund programmes, the VHC team should explore ways to integrate system data with service user data. This combined approach could offer a clearer picture of the impact of these initiatives. Additionally, feedback from stakeholders highlights the need for clearer communication, extended project timelines, and well-defined roles to optimise future efforts. Collaborations between VCS organisations and NHS clinicians present valuable opportunities for mutual learning and continuous improvement, and it is essential for the VHC team to incorporate structured mechanisms that facilitate practical adaptations and responsiveness to community feedback.

Moreover, the evaluation findings revealed several key opportunities to further address barriers to cancer screening and enhance early detection efforts within target communities and other marginalised populations:

1. **Enhance Accessibility**: Ensure that cancer screening invitations and healthcare interactions include materials that are easy to read and available in multiple languages. Improving digital translation tools on the NHS website will also support patient engagement.
2. **Improve Cultural Sensitivity**: Provide comprehensive training for NHS staff to better address the diverse cultural and physical needs of patients, including those with learning disabilities. Clear information about screening options should be provided to enhance patient comfort and decision-making.
3. **Expand Service Accessibility**: Consider investing in mobile screening units to reach underserved areas and employ data-driven methods to identify and address service provision gaps. This approach will make screening services more accessible to those who need them most.
4. **Targeted Engagement**: Utilise community feedback and population data to identify and engage hard-to-reach subgroups, such as men, who are currently underrepresented in screening programmes. Developing tailored strategies to address the specific barriers faced by these groups will improve their participation.
5. **Prioritise Early Prevention**: Focus on preventative measures by creating initiatives that educate about lifestyle factors and promote early intervention. Addressing misconceptions and encouraging preventative practices from a young age can significantly improve cancer outcomes.

By implementing these recommendations, the NHS and community organisations can enhance the effectiveness of cancer screening programmes, reduce health inequalities, and foster a more inclusive and supportive approach to early cancer detection.

1. Background

Community Solutions Fund

The Vibrant and Healthy Communities (VHC) programme brings together the Voluntary and Community Sector (VCS), NHS, Local Authorities, Public Health, and other stakeholders in collaborative partnerships aimed at addressing health inequalities across the London Boroughs of Kensington & Chelsea and Westminster (the “bi-boroughs”).

The Community Solutions Fund is a funding programme under the NHS NWL Inequalities fund, which forms one of the VHC workstreams. Emphasising early intervention and prevention, the Community Solutions Fund thus aims to leverage the transformative potential of community-driven healthcare interventions to bridge gaps on inequalities in delivery of healthcare where historical NHS initiatives may have fallen short.

The Fund departs from traditional funding approaches by fostering an interactive and collaborative model with the VCS sector built on partnerships and support. Unlike the usual prescriptive methods of NHS funding, which tend to be more directive, it encourages VCS organisations to propose their own solutions and strategies to specific health inequalities selected by the VHC team.

Screen, Detect, Protect

Screen, Detect, Protect (SDP) is the first applied programme under the Community Solutions Fund. The aim of the SDP programme is to achieve earlier detection of cancer among marginalised communities through community-designed and led activities and cross-sector collaboration and support.

In addition to increasing uptake of cancer screening among the targeted populations, the SDP project served as a pilot to test and evidence the effectiveness of the programme approach in working more effectively with local VCS organisations and communities.

Programme Approach

The VHC programme funded nine VCS organisations to deliver SDP programme activities between January and June 2024. Grants ranged from £19k to £40k, depending on the project’s scope and the number of organisations involved. Rather than issuing a general tender, the VHC team directly invited VCS organisations serving the targeted communities to apply for funding. To support the application process, the VHC team hosted a workshop where interested organisations received guidance and feedback on their project designs. The total number of residents engaged by the entire cohort of organisations, per their initial funding proposals, was projected to be 9,812.

A distinctive feature of the programme was its emphasis on cross-sector collaboration between the SDP projects and NHS health professionals on the VHC team. To ensure successful delivery, the programme provided robust support structures, allowing flexibility within each project’s approach and overall programme structure. The VHC team facilitated around seven sessions with the funded VCS cohort, both online and in-person, over the six-month period. This included a three-part “Learning Series” at the start, designed to help organisations develop their projects, train them on cancer screening resources, and provide support for project evaluation and monitoring. Additionally, two co-sharing sessions were held to encourage organisations to exchange lessons learned and resources.

Each funded SDP project was also paired with one or two "project buddies" from the VHC team, who served as the main point of contact for any queries or support needs throughout the project’s duration.

Earlier Detection of Cancer in the UK

Early detection and diagnosis of cancer are essential for expanding treatment options, improving long-term survival, enhancing patients' quality of life, and reducing treatment costs for the NHS. However, only 54% of cancers in the UK are currently identified at early stages (stages one and two).[1] In line with the NHS’s goal to increase this figure to 75% by 2028, extensive campaigns and early diagnosis initiatives have been rolled out in recent years to promote earlier cancer detection.

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[1] Health Education England. (n.d.). *Improving cancer diagnosis and earlier detection.* Retrieved August 19, 2024, from https://www.hee.nhs.uk/our-work/primary-care/improving-cancer-diagnosis-earlier-detection

NHS National Screening Programmes

Cervical screening

- Offered to females aged 25-64 every 3 years up to 49 years of age and every 5 years thereafter
- Conducted in-person by health care professional

Breast screening

- Offered to females aged 50-71 every 3 years
- Conducted in-person via x-ray (mammogram) test

Bowel screening

- Offered to males and females aged 60-74 every 2 years
- Conducted at home using a testing kit, which is sent to a laboratory for analysis

Screening is one key strategy proven to help diagnose cancer or risk of cancer earlier. The NHS currently runs three screening programmes in England for cervical, breast, and colorectal (bowel) screenings.[2] These programmes focus on entire populations within specific age groups, unlike screenings for cancers such as lung cancer, which target individuals at particularly high risk. Targeted lung health checks are currently being rolled out across England but are not yet available in Kensington & Chelsea or Westminster.

The average cost to the NHS for treating individuals aged 18–64 in the year of diagnosis is estimated at £28,767 for Stages 3-4 colorectal cancer, £19,963 for Stages 3-4 breast cancer, and £25,654 for Stage 2 or later cervical cancer (adjusted for 2024 inflation).[3][4]

Research published this year suggests that the annual cost of breast cancer alone could rise to £3.6 billion by 2034 from approximately £2.8 billion in 2024, with a further £17.5 billion in well-being costs to patients (i.e. a loss of well-being for cancer patients). Increasing screening rates to 80% is estimated to result in up to £111 million in savings for the NHS and £1.2 billion in well-being savings for patients.[5]

Variations in Screening Uptake and Diagnoses

The factors contributing to differences in cancer screening uptake are complex and varied. **They include perceived racial discrimination, racial residential segregation, stigma, sociodemographic and cultural influences, medical mistrust, and perceptions of susceptibility, benefits, and barriers.** For example:

- **Socioeconomic Status**: Generally, areas with higher levels of deprivation show lower participation rates across all cancer screening programs.
- **Ethnicity**: Ethnic background plays a significant role in cervical cancer screening participation, with South Asian women exhibiting lower participation rates compared to White British women.
- **Gender Disparities**: Despite their increased risk, men are less likely to participate in bowel screening programs.
- **Other Factors**: Lower uptake rates are observed among smokers, homeless individuals, transient populations, people with learning difficulties, and those with existing health conditions.

Increasing screening uptake is crucial for improving cancer detection rates, and various methods have been employed in the UK to promote screening. The NHS's 2019 "Cervical Screening Saves Lives" campaign, which utilised TV, videos, posters, media partnerships, and social media, significantly increased GP attendances for cervical screening tests and colonoscopy referrals, particularly among younger women and South Asian and Black women, who have historically shown lower screening uptake.[6] Similarly, a 2022 evaluation of the NHS's "Breast Cancer in Women Over 70" campaign noted increases in urgent GP referrals, breast cancer diagnoses, and mammograms, as well as improved knowledge, awareness, and comfort in discussing concerns with GPs.[7]

Localised, culturally sensitive approaches have also proven effective. For instance, a 2014 community-targeted campaign in Dudley successfully increased cervical screenings in South Asian communities through culturally relevant

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[2] NHS England. (n.d.). *Screening and earlier diagnosis.* Retrieved August 19, 2024, from https://www.england.nhs.uk/cancer/early-diagnosis/screening-and-earlier-diagnosis/

[3] Laudicella, M., Walsh, B., Burns, E., & Smith, P. C. (2016). Cost of care for cancer patients in England: evidence from population-based patient-level data. *British journal of cancer*, *114*(11), 1286–1292. https://doi.org/10.1038/bjc.2016.77

[4] Jo's Cervical Cancer Trust. (2021). Cervical screening in the spotlight. Retrieved from https://www.jostrust.org.uk/sites/default/files/cervical_screening_in_the_spotlight_-_final.pdf

[5] Bush, L., Misak, J., & Macdonald, S. (2024). *The cost of breast cancer: Modelling the economic impact to the UK.* Demos and Breast Cancer Now. Retrieved from https://breastcancernow.org/sites/default/files/files/the_cost_of_breast_cancer_report_final.pdf

[6] Stubbs, R. (2021). *Cervical screening saves lives: Evaluating the national campaign.* NHS. Retrieved from https://phescreening.blog.gov.uk/2021/09/28/cervical-screening-saves-lives/

[7] Smith, N. (2017). Bowel screening uptake project in Pennine Lancashire. NHS. Retrieved from https://www.cancerresearchuk.org/sites/default/files/6bowel_screening_uptake_project_in_pennine_lancashire_neil_smith_2017.pdf

communication, bilingual materials, and partnerships with community leaders.[8] Additionally, a 2016 evaluation of a Lancashire bowel screening programme demonstrated that a multilingual, face-to-face approach significantly boosted test kit completion rates, with 58% of participants completing the kit compared to only 11% via letter invitations.

Local Needs

The topic of earlier detection of cancer was chosen as the focus for this first round of funding due to historically low uptake of cancer screening services in the bi-boroughs compared to the larger area of Northwest London. Historically, participation rates for cancer screening programs in Westminster and Kensington & Chelsea are below both the national and London averages, with uptake of cervical cancer screening decreasing over the past decade.[9]

The VHC team targeted communities within the bi-borough with particularly low cancer screening attendance rates. This uneven uptake reflects historically entrenched inequalities in healthcare delivery experienced by these cohorts.

Tables 1-3 present data from Whole Systems Integrated Care (WSIC) on bowel and cervical cancer screening rates among the target community groups in the bi-boroughs as of December 2023, (prior to the project's implementation), and contrasts this with i) the estimated number of residents the organisations aimed to engage, as outlined in their funding applications; and ii) the actual number of residents in the bi-boroughs eligible for screening.

The final two columns indicate the additional number of screenings needed in each borough to meet Northwest London's screening rates for the specified population groups. The comparator rate in NWL was used due to the absence of existing targets for screening but the aim of the programme is to improve uptake across all areas.

*Table 1. Cervical Cancer Screening Rates in the Bi-boroughs, **Ages 25-49**, with SPD cohort comparisons*

VCS Organisation	Target Cohort	Estimated Residents to be Reached	Eligible Residents in Cohort (Bi-Borough)	Current Uptake - Central London (Westminster)	Current Uptake - West London (RBKC)	Additional Screenings Required to Achieve Comparator Rate in NWL	
						Central London (Westminster)	**West London (RBKC)**
Advocacy Project	People with learning disabilities	125	195	33.3%	28.2%	13	26
Age UK	Residents over 50	700	N/A	N/A	N/A	N/A	N/A
Almanaar	Men and women of Muslim faith	200	6,710	44.7%	53.0%	505	97
BME Health Forum	Resident BME population	1,200	53,675	44.6%	51.5%	2,720	825
Chinese Welfare Trust	Resident Chinese population	2,600	6,273	38.5%	43.7%	471	137
FAWA	Francophone African residents	2,500	3,990	53.1%	61.1%	70	-
Groundswell	People experiencing homelessness	360	300	39.7%	-	59	-

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[8] Sogi, P. (2014). *Using a social marketing approach to increase the uptake of cervical screening amongst women aged 25-29 in Dudley borough*. Dudley Public Health. Retrieved from https://www.jostrust.org.uk/sites/default/files/materials/JCCT_ParminderSogi_DudleyPublicHealth.pdf

[9] *Westminster City Council. (2024). Cancer screening and recovery: Cover paper. Retrieved August 19, 2024, from https://committees.westminster.gov.uk/documents/s42348/09%20-%20Cancer%20Screening%20and%20recovery%20-%20Cover%20Paper.pdf*

Mosaic Community Trust	BME women resident in Church Street ward	300	1,576	48.6%	60.9%	118	-
VCKC	Residents of North Kensington	2,150	1,712	57.9%	60.0%	1	-

*Table 2. Cervical Cancer Screening Rates in the Bi-boroughs, **Ages 50-64,** with SPD cohort comparisons*

VCS Organisation	Target Cohort	Estimated Residents to be Reached	Eligible Cohort (Bi-Borough)	Current Uptake - Central London (Westminster)	Current Uptake - West London (RBKC)	Additional Screenings Required to Achieve Comparator Rate in NWL	
						Central London (Westminster)	**West London (RBKC)**
Advocacy Project	People with learning disabilities	125	117	43.8%	43.5%	3	5
Age UK	Residents over 50	700	40,833	64.9%	67.8%	1,366	1,132
Almanaar	Men and women of Muslim faith	200	1,937	61.7%	72.1%	159	30
BME Health Forum	BME residents	1,200	18,236	63.4%	67.3%	777	529
Chinese Welfare Trust	Chinese residents	2,600	1,301	60.3%	64.5%	61	11
FAWA	Francophone African residents	2,500	2,024	72.3%	74.8%	26	11
Groundswell	People experiencing homelessness	360	242	48.8%	-	30	-
Mosaic Community Trust	BME women residents in Church Street ward	300	672	67.0%	73.2%	45	1
VCKC	Residents of North Kensington	2,150	892	66.7%	73.0%	1	-

Table 3. Bowel Cancer Screening Rates in the Bi-boroughs with SPD cohort comparisons

VCS Organisation	Target Cohort	Estimated Residents to be Reached	Eligible Cohort (Bi-Borough)	Current Uptake - Central London (Westminster)	Current Uptake - West London (RBKC)	Additional Screenings Required to Achieve Comparator Rate in NWL	
						Central London (Westminster)	**West London (RBKC)**
Advocacy Project	People with learning disabilities	125	158	42.4%	51.1%	5	-

VCS Organisation	Target Cohort	Estimated Residents to be Reached	Eligible Cohort (Bi-Borough)	Current Uptake - Central London (Westminster)	Current Uptake - West London (RBKC)	Additional Screenings Required to Achieve Comparator Rate in NWL	
						Central London (Westminster)	West London (RBKC)
Age UK	Residents over 50	700	39,755	53.5%	54.4%	1,346	1,511
Almanaar	Men and women of Muslim faith	200	2,487	43.6%	48.2%	262	139
BME Health Forum	BME residents	1,200	21,624	46.0%	48.4%	1,183	1,204
Chinese Welfare Trust	Chinese residents	2,600	1,116	51.0%	61.2%	120	28
FAWA	Francophone African residents	2,500	2,006	43.7%	51.5%	69	21
Groundswell	People experiencing homelessness	360	568	19.4%	-	107	-
Mosaic Community Trust	BME women residents in Church Street ward	300	800	49.0%	58.2%	8	-
VCKC	Residents of North Kensington	2,150	1,236	64.3%	55.5%	-	21

Summary of Funded SDP Projects

The following section describes the target community and project activities of the nine funded VCS organisations in this first round of the Community Solutions Fund.

(The) Advocacy Project

Target community: People with Learning Disabilities (LD)

Project activities: The Advocacy Project worked with health professionals to co-produce several videos, including one that shared positive screening experiences for service users and another that highlighted necessary accommodations for patients with LD during cancer screenings for health professionals. The organisation also collaborated with health professionals to create easy-read documents about cancer screenings and GP visits for service users.

The Advocacy Project presented these resources to service users across 6 different workshops.

Age UK (Westminster and RBKC, jointly)

Target community: Adults aged 50 years and older

Project activities: Age UK developed a leaflet containing cancer screening information and guidance, and trained staff and volunteers to disseminate these leaflets and hold face-to-face discussions on cancer and cancer screenings to service users during existing Age UK activities. They also promoted these materials in their newsletter and other digital communication channels.

Almanaar Muslim Cultural Heritage Centre

Target community: Residents of Muslim faith

Project activities: Al Manaar raised awareness of cancer and cancer screenings during both new and existing activities at their community centre. For example, community leaders held preventative health discussions after weekly elderly exercise classes and distributed leaflets on cancer screening after prayer sessions at the mosque. Al Manaar also delivered dedicated workshops on focused on cancer screenings to male and female community members.

BME Health Forum (HF)

Target community: Black and minority ethnic (BME) population

Project activities: BME HF collaborated with seven grassroots organisations across the bi-boroughs to deliver workshops on cervical, breast, bowel, and prostate cancer to their respective community groups. Each partner recruited ambassadors to act as points of contact for the community, addressing questions and potentially providing bilingual translation services during the workshops. Additionally, partners also recruited cancer survivors from the communities to share their experiences with cancer and cancer screenings during workshops.

Chinese Welfare Trust (CWT)

Target community: Chinese-speaking population

Project activities: CWT held three focus groups at the beginning of the project period to gather community opinions and assess awareness of cancer screenings and resources. Drawing from the feedback collected, CWT created communication materials in both Chinese and English for cross-promotion during dedicated workshops at existing community events and intersecting spaces, such as Chinese pharmacies and community centres.

French African Welfare Association (FAWA)

Target community: Black African population

Project activities: FAWA aired three 30-second radio advertisements on lung, prostate, and cervical cancer symptoms and screenings across three different local radio stations, five times a day for three months.

Groundswell Health

Target community: People experiencing homelessness

Project activities: Groundswell Health conducted sessions aimed at educating service users about recognising symptoms associated with different types of cancer and understanding what constitutes their own body's 'normal'. These sessions empowered participants to self-advocate for cancer screenings if they noticed any concerning symptoms.

Mosaic Community Trust (MCT)

Target community: BME female residents of Church Street Ward

Project activities: Alongside health specialists, MCT co-produced and co-facilitated a series of workshops, consisting of two each on bowel, cervical, and breast cancer. MCT also held several focus group sessions on cancer screening and awareness during their regular drop-in support group sessions.

Volunteer Centre K&C (Notting Dale Community Champions)

Target community: Residents of North Kensington

Project activities: Notting Dale Community Champions integrated cancer screening awareness into a broader approach to health activism through various community initiatives, including sessions for women focused on self-care and wellness, alongside medically-oriented workshops covering breast health, cervical cancer screenings, and the intersection of menopause and cancer.

2. Methodology and Underlying Framework

Objectives and Scope of Evaluation

Envoy Partnership was commissioned by the VHC team to conduct an external and comprehensive evaluation of the SDP programme. The main objectives of the evaluation were as follows:

- **Process Evaluation:** Identify the challenges and strengths of the Community Solutions Fund approach in addressing healthcare delivery inequalities through local organization and community partnerships.
- **Impact Evaluation:** Assess the impact of 9 community-designed and led projects on cancer screening uptake among communities with low screening rates and histories of marginalization.

These evaluation objectives were designed to present a coherent narrative of the Screen, Detect, Protect programme accomplishments while generating actionable recommendations for future rounds of the Community Solutions Fund.

Table 4. Summary of Research Activities

Research Type	#
Process Evaluation	
Interviews with the VHC team	9
Interviews with VCS organisations	9
Surveys for project delivery partners	7
Impact Evaluation	
Surveys for heath professionals	25
Interviews with service users	11
Interviews with VCS organisations	9
Surveys for VCS organisations	9
Focus groups with service users	3
Ethnographic observations of SDP project activities	2

Research Methods

Both the impact and process evaluations employed an overlapping mixed-methods approach. This methodology integrated primary qualitative and quantitative data collected by Envoy Partnership and VCS organisations from January to July 2024, alongside secondary clinical data on cancer screening attendance rates provided by the NWL ICB Business Intelligence Team for each target community group.

The table to the left summarises the primary research activities. The entire evaluation workplan is detailed in Appendix A.

Process Evaluation

The process evaluation intended to capture the learnings and successes of the SDP programme to create actionable recommendations for future Community Solution Fund programme approaches.

The research took place from May to July 2024, using a mixed-method approach to capturing feedback from stakeholders involved in the conception, design, and delivery of the SDP programme. This included nine interviews with the VHC team, nine interviews service providers from the nine SDP projects, as well as an online survey distributed to the seven delivery partners working with one of the SDP projects. Figure 1, below, expands upon the main areas of assessment:

Figure 1. Categories of Assessment, Process Evaluation

Conception and Design

- Understand the project’s purpose and motivation, including past collaborations.
- Compare the Community Solutions Fund with other funding models, noting strengths and challenges.

Project Delivery and Implementation

- Identify and assess internal barriers such as logistical issues or resource limitations.
- Analyse challenges such as language or mobility barriers.
- Evaluate participation rates and demand for activities.
- Assess the timeliness and adequacy of training and support provided.

Partnerships and Collaboration

- Evaluate collaboration quality with health professionals, NWL ICB, and VHC team.
- Assess benefits of partnerships for health information dissemination and resident support.
- Analyse cross-sector communication and knowledge-sharing effectiveness.

Impact and Outcomes

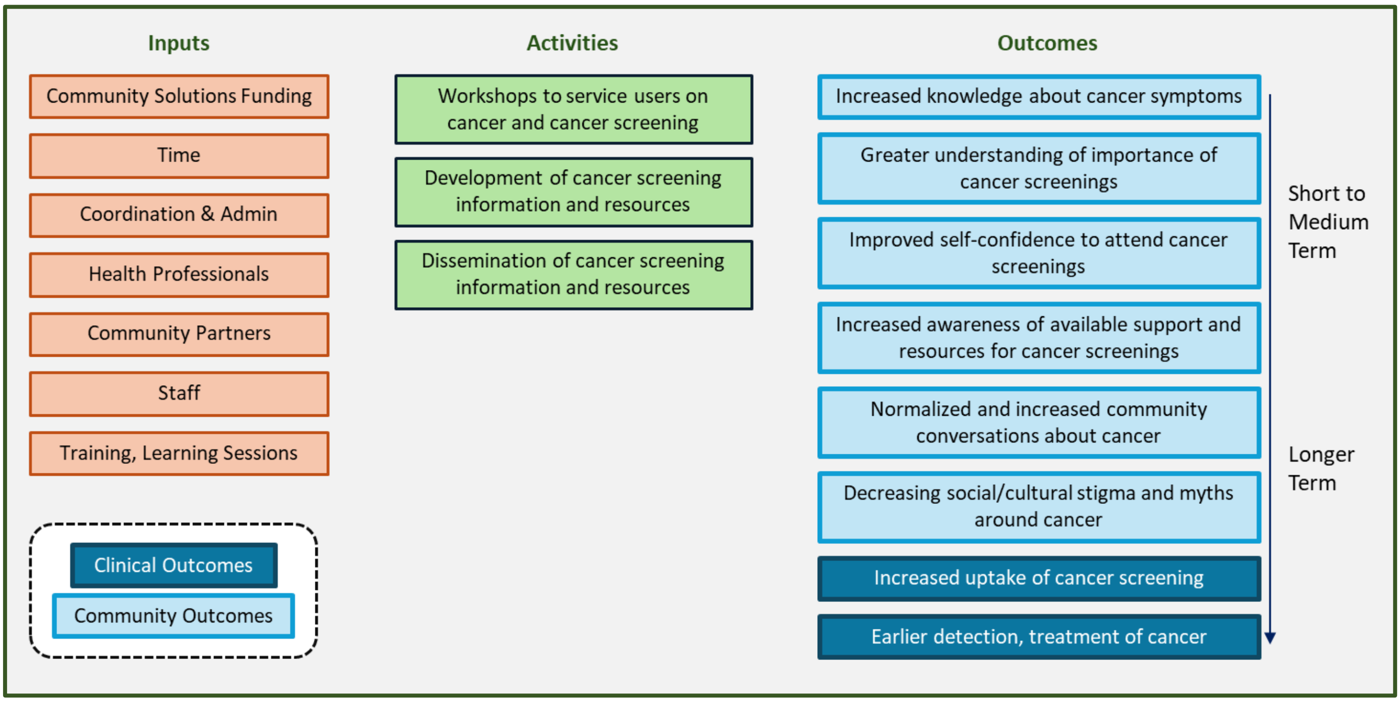
- Assess the impact of the funding model on achieving project goals and fostering partnerships.
- Measure project success and whether goals were met or criteria evolved.
- Consider the project’s long-term effects on the organisation, volunteers, and community.

Impact Evaluation

To effectively demonstrate the impact of the SDP programme on stakeholders, it is important to illustrate how project inputs, activities, and outputs contribute to outcomes and the processes facilitating this change. A Theory of Change (ToC) model serves as a roadmap by delineating why specific activities are expected to achieve desired outcomes. This approach ensures that the evaluation is grounded in established evidence and theory, linking programme effectiveness factors to individual activity types during the evaluation.

Envoy Partnership conducted nine interviews with the service leads from funded VCS organisations at the beginning of the evaluation to define the goals and anticipated outcomes of their projects within the communities they serve, and the project activities and inputs that would lead to the intended results.

Figure 2. Theory of Change



The SDP programme's primary clinical objective was to increase cancer screening attendance rates among the target communities, and did not set out to achieve a specific level of clinical impact within each target community. (The screening deficiencies in each community outlined above in *Local Needs* were not the primary focus of the project, but rather served to illustrate the magnitude of geographical gaps in uptake). The ToC (Figure 2) roadmaps these target clinical outcomes alongside the target community outcomes identified by service providers during interviews. For the latter, it illustrates the inputs, activities, and outcomes common across SDP projects; each section is likewise not inclusive of nor applicable to all SDP projects.

These clinical and community-defined target outcomes guided the selection of metrics to benchmark the impact of project activities. The participating VCS organisations were tasked with collecting their own primary data to showcase the impact of their projects, with Envoy Partnership supporting the development and refinement of data collection tools and methods as necessary.[10] The research methodologies and data capture types differed across organisations based on the specific needs of their service users (e.g., language, learning levels) and projects (e.g., frequency of activity).

Envoy Partnership also conducted 11 one-to-one interviews and two focus groups with service users from eight of the funded VCS organisations, as well as ethnographic observations of two SDP projects, to contribute to case study material for the report. Envoy Partnerships also distributed a survey to the VCS organisations to assess the overall demand for transport services among their service users, and a survey to health professionals who supported SDP projects to explore their perspectives on how the interventions may influence cancer screening rates and behaviours in the community.

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[10] Envoy Partnership joined as an evaluation partner several months into the SDP project period, by which time most VCS organisations had already established some form of feedback capture mechanisms. After establishing the ToC, Envoy Partnership reviewed any existing data capture tools to ensure alignment with the ToC framework.

Data Limitations

The evaluation of the SDP programme faced several data limitations that should be considered when interpreting findings.

Several organisations did not implement formal systems for collecting service user data until one or two months into the delivery period. Additionally, one organisation failed to collect any demographic or feedback data, while another did not gather consistent service user data. This absence of primary data limits the comprehensiveness of the analysis and may result in an incomplete understanding of the programme's impact and effectiveness. Furthermore, data collection forms were tailored to the individual needs (e.g., language, learning) of each target community group, which led to inconsistencies in the questions asked and required the researcher to use discretion in grouping similar question-types and responses.

Organisations that collected demographic data did so comprehensively enough to support a robust analysis and generalise findings to their entire participant cohort. However, the proportion of feedback gathered from the overall cohort varied significantly among organisations and was not adjusted for weighting. Consequently, the impact section presents aggregate-level insights based on the available data.

Moreover, it is not possible to track individual uptake of cancer screening services via NWL ICB Business Intelligence Data, and instead must rely on cohort-level, de-identified data that makes it difficult to quantify individual-level clinical impact. As such, changes in cancer screening attendance rates cannot be as accurately attributed solely to the SDP project, as they could be influenced by various other factors.

3. Findings: SDP Programme Approach and Process

One of the keystone elements of the SDP programme approach is its focus on collaborative working across community organisations, the NHS, Public Health, and other Local Authority departments. This section explores the way these collaborative structures were perceived and experienced by key stakeholders in practice.

Collaborations with Health Professionals

Most SDP projects involved health professionals in one or both of the following capacities:

- **Reviewing project materials and resources:** Several organisations worked with health professionals on the VHC team to review and ensure the medical accuracy and relevance of the cancer screening materials distributed to service users.
- **Delivering workshops to service users:** Six out of the eight organisations that delivered cancer screening workshops engaged health professionals to facilitate the sessions. Five of these organisations recruited health professionals from their own established networks or communities, rather than from the VHC team. For several organisations, this was necessary if their service users were likelier to trust health professionals from specific backgrounds. The few organisations that utilised health professionals on the VHC team did so with varying frequency.

VCS organisations valued these collaborations with health professionals specifically due to the technical and medical complexities of cancer and the screening process. Several service providers expressed greater confidence in their interventions when project materials were either reviewed or directly delivered by clinical experts.

Likewise, several VCS organisations were uncertain about their own abilities to absorb and communicate cancer-related information, a sentiment echoed by members of the VHC team. One health professional emphasised the difficulty of conveying accurate information about cancer screening, and at the beginning of the project stressed that all project materials needed to be reviewed by a clinical lead. Another member of the VHC team agreed, highlighting the challenge of equipping community organisations with the skills needed to effectively communicate clinical information aimed at promoting behavioural change.

Overall, VCS organisations who worked with health professionals on the VHC team had positive experiences, finding them supportive and eager to assist. Their reviews of project materials were considered helpful and timely, and those who delivered workshops were positively received by both VCS staff and service users. These health professionals likewise enjoyed collaborating with the VCS organisations, and were impressed by their technical and logistical capacities to deliver workshops and engage their service users.

> *“When I was working on this project, I never felt worried because it was so easy to get in touch with the VHC team. They helped us proofread our materials and guided us through what is accurate information. And they’ve showed immense trust in us. I really appreciate when commissioners are so supportive and understanding.”*
>
> *“When somebody has the resource, somebody has the expertise, and somebody has knowledge and trust with the community, this is where you can make impact and this is where you can deliver and sustain as well.”*
>
> **- Service providers**

Collaborations with the Wider VHC Team

VCS organisations varied in their direct interactions with the VHC team throughout the project delivery period. In particular, those whose projects aligned closely with their typical organisational activities and/or leveraged existing networks and resources reported minimal engagement. Many VCS organisations primarily sought assistance from the VHC team in recruiting health professionals to facilitate workshops or to review their project materials. Almost all of the organisations felt equipped to deliver their proposed activities without additional support or training.

Overall, the VCS organisations had positive experiences working with the VHC team during the project period. All service providers described the VHC team as supportive and constantly providing resources, and many felt comfortable approaching the VHC leads with questions. Only one organisation would have preferred more one-to-one check-ins with the VHC leads.

The core members of the VHC team felt they successfully delivered the intended support to the VCS organisations and fostered an environment of open dialogue and communication.

Project Buddies

The project buddy system was introduced at the start of the SDP programme to provide structured support and maintain open communication across sectors. Project buddies comprised of members of the VHC team, and included both health professionals and non-health professionals.

> *"I think everybody knew who to talk to if there was something that wasn't working or to celebrate things that have gone well."*
>
> **- VHC team member**

Most VCS organisations appreciated the project buddy system and having a designated contact to send project-related queries. The majority of project buddies were described as responsive and engaged. VCS organisations that buddied with health professionals gave particularly positive feedback, appreciating the direct access to clinical and health-related advice. On the other hand, VCS organisations paired with non-health professionals often found that their questions were eventually referred to a health professional, which added an extra step to the communication process.

Buddying with health professionals also oftentimes created unexpected enhancements to SDP project activities and reach. For example, one service provider's project buddy was eager to disseminate project materials to their clinical network. Several other service providers noted how their project buddies sent them helpful materials, such as cancer screening test kits and informational resources, which they used during SDP activities and also shared with other SDP projects.

Only a few VCS organisations described limited engagement with their project buddies, either due to perceived lack of need or preference to direct questions to the VHC team leads. These same organisations were also unclear on the project buddies' intended roles.

Workshops and Learning Sessions

As described earlier in *Program Approach,* the VHC team led numerous in-person and online sessions with VCS organisations across the six-month period. These included a "Learning Series" at the start of the project period and co-learning and sharing sessions at the middle and end.

Almost all VCS organisations enjoyed these workshops, particularly for the opportunity to network with other VCS organisations and share resources and lessons learned. Two service providers contrasted this with other grants, where funders often "just give [them] the money and leave."

These workshops were identified as a positive outcome of the programme by a member of the VHC team, who found it helped avoid working in silos and promoted intersectionality and self-sufficiency among VCS organisations.

> *"I liked receiving information but also talking to the other organisations. It's quite refreshing to hear other providers talk about the challenges that they're experiencing. Not specifically in their SDP programme but generally some of the broader challenges that we need to address as charities working with the community."*
>
> *"It's been great to work with other organisations as well. It's not something we've done with other projects, which is a huge bonus. Sharing of resources, learnings, has been great."*
>
> **- Service providers**

While two VCS organisations would have preferred even more meetings, one felt there were too many for the programme's short delivery period and that some of the information could have been communicated via email.

Divergences from Traditional Ways of Working

NHS Funding Approaches

Members of the VHC team who helped conceptualise and design the SDP programme were particularly enthusiastic about its potential to empower the voluntary sector and explore innovative ways to tackle health inequalities.

One NHS colleague mentioned that, although they had previously worked with VCS organisations on similar community-focused grants, this was the first time they had invited certain smaller grassroots organisations to submit tenders. The intention was to build the capacity of these smaller groups, who might have been put off by the scale of the grant. However, in hindsight, they were unsure whether this approach had a significant impact on the selection of the organisations that were ultimately funded.

VCS Organisational Interventions

Aside from the support structures provided from the VHC team during the project delivery period, the SDP programme’s activities and approach did not differ significantly from other interventions carried out by the VCS organisations. For example, most VCS organisations implemented activities they had previously used successfully. They often had prior experience with clinical topics and collaborating with health professionals, and several had run other cancer-related interventions either in the year before or concurrently with their SDP project.

Conversely, the few VCS organisations with less experience delivering clinical health topics typically offered "light touch" interventions, such as mindfulness sessions or fitness mornings, and practical social support activities like signposting to housing services. These organisations also lacked prior experience in working with health professionals.

Challenges Experienced

The following section outlines key challenges which emerged during the SDP programme, providing insights for the VHC to consider when designing future rounds of the Community Solutions Fund or other similar cross-sector public health interventions aimed at addressing health inequalities.

Length of Delivery Period

Almost all VCS organisations felt that the six-month timeframe was too short to effectively deliver their project activities. Many spent the initial months familiarising themselves with training materials, promoting events, and developing resources. Internal delays also pushed back in-person events or reduced the number of activities they could provide. Some organisations found that the scope of addressing multiple cancers within such a limited period strained their resources and scheduling, and also lead to perceived burnout among staff and service users.

Several VHC team members agreed that the timeframe was a notable challenge of the SDP programme. They recognised in hindsight that expecting organisations to launch events immediately after receiving funding was unrealistic, and should have included a mobilisation period before the delivery phase began. However, they flagged that issue was constrained by the requirement to spend project funds by the end of the six-month period to align with the financial year’s end.

Programmatic Structure and Goals

Scope and objectives

Several VCS organisations and members of the VHC team felt that the goals and scope of the SDP programme were not clearly communicated by the VHC team leads, particularly during the planning and application stages. Some VHC team members believed they were introduced to the project before a well-defined vision or collaboration strategy was established. This lack of clarity led to unstructured initial meetings and difficulties in understanding their roles and contributions.

One VCS organisation was unsure about how the VHC team defined a successful intervention, while another initially misunderstood the programme's focus, thinking it was only about raising general awareness rather than specifically increasing clinical uptake of screening. Additionally, there was confusion about whether the programme targeted only the cancers included in the NHS National Screening Programme (bowel, breast, and cervical) or any cancer that could be screened.

Reporting and evaluation

Nearly half of the organisations expressed a need for clearer guidance on their data collection responsibilities during the funding application stages. The VHC team did not communicate any monitoring requirements until later in the project timeline, requiring VCS organisations to reallocate resources towards data collection efforts once their projects were already underway. Additionally, organisations were not informed about the reporting templates until several months into the project, by which time many had already drafted their first reports.

In retrospect, several VHC team members acknowledged the impact of these delays on the VCS organisations. One team member noted that the late introduction of data collection requirements and reporting templates caused unnecessary challenges for the organisations, underscoring the need for more timely and detailed guidance in future projects.

VHC team roles and responsibilities

As touched upon above, members of the VHC team and several VCS organisations expressed a lack of clarity regarding the roles and responsibilities of VHC team members. For example, several VCS organisations were uncertain on the official purpose and function of the project buddy, and the best point of contact for different questions. One VHC team member retrospectively identified the need for clearer role definitions to enhance accountability across the project.

Several health professionals, in particular, felt that the scope of their role could have been better communicated to them by VHC leads. For example, they were unclear how they were expected to contribute at workshops, while one health professional felt the need to confirm with the VHC team whether certain requests from VCS organisations fell within their purview.

Technical Expertise

As previously noted, many VCS organisations felt it was crucial to collaborate with health professionals when addressing clinical topics, as they were uncertain about their capacity to independently absorb and communicate cancer-related information.

Similarly, Age UK, which trained its staff to incorporate cancer and screening discussions into their existing service activities, felt they lacked sufficient time and expertise for effective training. They struggled to prioritise the clinical information for their outreach materials and found that service users frequently posed specific clinical questions that staff were unprepared to answer. In hindsight, one service provider wished that the intervention had included direct engagement from health professionals at dedicated events to address these questions more effectively.

Support and Training

VCS organisations received training and information on cancer screening and symptoms after their projects had already been approved and funded. Several service providers and members of the VHC team felt this should have been delivered earlier in the project timeline to allow organisations to better align their intervention approaches with the clinical specifics of the subject. For example, Groundswell Health only learned after the training session that the majority of their service users were ineligible for cancer screenings, and thus needed to shift the focus and tone of their intervention.

Several VCS organisations identified the following other training needs:

- Two VCS organisations identified a need for training in report writing and evaluation methods to effectively meet the programme’s data collection requirements. One organisation emphasised this need particularly in light of the sensitivity surrounding the topic of cancer, expressing uncertainty about ensuring appropriate safeguards to protect their service users' confidentiality.
- Two organisations desired additional guidance on how to approach discussions about cancer with their service users. Notably, these were the organisations without previous experience delivering clinical health interventions. A health professional on the VHC team likewise reflected on the potential benefit of training VCS organisations on how to address cancer topics from a non-clinical perspective.

Cross-Sector Collaborations

Availability of Health Professionals

> *“Many of our services users did not feel they had a greater understanding of the pathway or experience of the prostate and testicular cancers as the NHS professional leading the workshop was unable to give a detailed and specific explanation that was requested due to her not being a specialist in the field.”*
>
> **- Service provider**

The VHC team provided approximately 3-5 health professionals from various clinical backgrounds to facilitate SDP workshops or sessions. However, VCS organisations that intended to use these professionals found their number, availability, and variety insufficient to meet demand. As a result, VCS organisations felt that they had to plan their SDP activities around the health professionals, which led to delays or complications in their project timelines. One organisation opted to recruit from their own network of health professionals only after encountering difficulties scheduling health professionals provided by the VHC team.

VCS organisations also encountered barriers to engaging health professionals besides those on the VHC team. For example, several organisations wanted to recruit more clinical specialists. While the VHC team provided the details of other potential speakers, VCS organisations felt that they had to expend considerable resources to contact these individuals, who were oftentimes unresponsive.

One member of the VHC team acknowledged the limited pool of health professionals available, but felt that they had clearly communicated this constraint from the project's outset. They pointed to the workshop sessions as a space for VCS organisations with their own health networks to share their contacts with others.

Stakeholder Communication

In addition to feeling uncertain about their roles, several health professionals experienced a general disconnect from the project outside of their expertise as project buddies and workshop facilitators. Most health professionals interviewed were less directly involved than originally intended due to competing work responsibilities, but felt that there was no centralised communication stream to keep them updated on both internal and external SDP events.

For instance, one health professional often had scheduling conflicts with the monthly SDP support group meetings and would have appreciated email recaps. Similarly, another health professional mentioned that with advance notice of SDP workshops and events, they could have informed local GP practices to offer support and possibly participate to increase cross-sector collaborations.

Another health professional found it difficult to communicate and coordinate schedules with VCS organisations. They would have preferred the VHC team to set up a more formal communication structure at the beginning of the project, as they felt unprepared when VCS organisations began emailing them. In contrast, members of the VHC team felt that they had a successful process for VCS organisations to request clinicians for sessions. They remarked that this coordination worked "quite well" and explained that they managed these exchanges themselves rather than providing VCS organisations with direct contact information for the clinicians.

Age UK’s SDP project offered service users the option to book transport services to cancer screening appointments, but after low uptake extended this offer to service users from other VCS organisations. Nonetheless, demand remained limited. In response, the VHC team engaged Envoy Partnership to consult with VCS organisations to investigate the relevancy of transport as a barrier to screening attendances among service users. One service provider mentioned they didn't promote the transport option because most users were local, and others could use public transport, indicating a misunderstanding of the transport’s purpose (i.e., to screening appointments versus their SDP events). Additionally, a different service provider noted they never saw the offer amid the daily influx of emails, highlighting the need for clearer, more targeted communication channels.

Variations in Delivery Expectations

Interviews highlighted several instances of potential misalignment between stakeholder target outcomes, priorities, and activities:

> *“People want to see numbers change on the WSIC dashboard. We have to be realistic. Unfortunately we don’t have a lot of that data that we want. As long as you’re getting 5 people to get a screen who would have never done it before, that’s saving lives.”*
>
> *“The community groups aren't specialists, and may not have the same agenda as us. So we might have a specific agenda around certain groups or certain screening programs or a particular message that we want to get across that could be missed.”*
>
> **- Health professionals**

Observable Impact on Cancer Screening Attendances: Stakeholders felt that the SDP programme’s short duration and intensity would not lead to significant increases in cancer screening rates. They viewed it as building community momentum but not as a catalyst for immediate behavioural change. A member of the VHC team underscored the disparity between this gradual, community-led approach and NHS governance and finance priorities, the latter which prioritises immediate and visible changes in clinical metrics over more nuanced project outputs such as "number of conversations held."

Clinical Focus: While all VCS organisations found the topic of earlier detection of cancer to be relevant to their communities, some opted to adopt a less clinical focus and instead to incorporate them into discussions on other health topics such as menopause, self-advocacy, and body positivity. While this strategy was chosen to boost engagement and attendance from service users who might be hesitant to participate in cancer-focused conversations, these “softer” intervention approaches ran the risk of diluting the programme's clinical objectives or approaches to measuring impact (e.g., increases in cancer screening attendances).

Internal Challenges

Nearly half of the VCS organisations faced challenges in delivering their original projects due to unexpected staffing or resource limitations. However, these organisations quickly adapted by leveraging their internal expertise and external networks to redesign parts of their interventions as needed. As a result, only one organisation's activities were delayed for more than two months after the start of the delivery period.

> Due to staffing challenges, VCKC was unable to produce cancer-focused podcasts as originally planned. Instead, the service provider developed and distributed breast screening leaflets that were perceived as “fresh and engaging” and sparked “many more conversations on cancer, screening and health in general.”

Engaging Service Users

VCS organisations found that their service users who attended their SDP activities were engaged and provided positive feedback. Approximately half of organisations however, experienced unexpected challenges in engaging service users in the first place. The attributed reasons ranged from cultural, social, and general disinterest in discussing the topic of cancer and preventative health topics more generally.

For example, the service provider from VCKC described a general disinterest among service users in activities with a medical focus, especially those concerning “long-term” issues such as cancer prevention. Several other organisations noted initial or enduring pushback from service users to discuss cancer due to the sensitive nature of the topic and its association with death, and likewise that service users did not choose to attend their activities to engage in heavy topics.

One service provider, BME HF, also noted that the taboo nature of the topic among their communities’ members made it initially difficult to recruit workshop attendees. However, attendance gradually increased, which this service provider considered suggesting that word-of-mouth and community engagement efforts were effective in overcoming initial reluctance.

Several VCS organisations struggled to engage men in their activities, with one organisation noting it to be a common issue around any health-focused discussions and events in the community. This organisation attempted to attract men by offering food during the sessions; however, they observed that after eating, many men would leave without fully participating in the workshop activities.

4. Findings: SDP Programme Impact

The following section explores the impact of the nine funded SDP projects on the programme's clinical and community target outcomes. As described earlier in *Methodology and Underlying Framework,* it draws on project-level inputs, activities, and outputs, quantitative and qualitative feedback from service users, and observations from service providers and Envoy Partnership.

Evaluating the impact of the SDP projects presents a challenge because project interventions were tailored to different demographic groups, each with unique needs and complex barriers. As a result, direct comparisons of the effectiveness of these projects can be difficult and tenuous. This complexity should be carefully considered when evaluating the influence of the entire programme cohort on early cancer detection within the targeted community groups.

Summary of Inputs, Activities, and Outputs

Table 5 below offers a project-level breakdown of the inputs and outputs of the SDP projects over the 6-month programme delivery period.

Table 5. Reach and Funding, by SDP Project

VCS Organisation	Residents directly reached	Individuals supporting the project	Staff and partner volunteer hours	Events / sessions / activities delivered	Total funding
Advocacy Project	60	72	N/A	6	**£16,917**
Age UK	2,570	179	1,486	548	**£40,758**
Al Manaar	95	15	70	7	**£19,980**
BME HF	1,011	102	2,642	46	**£40,000**
Chinese Welfare Trust	181	28	450	11	**£25,131**
FAWA	140	27	400	3	**£18,600**
Groundswell Health	137	26	120	11	**£27,906**
Mosaic Community Trust	125	15	404	16	**£20,000**
VCKC	900	17	360	61	**£19,920**

Figure 3. Summary of SDP Project Achievements

Individuals supporting the projects: 481

Staff / partner volunteer hours spent: 5,932

Events /sessions / activities delivered: 709*

Directly engaged residents: 5,219

Indirectly engaged residents: 24,288

*Does not include the 1,708 spot executions of cancer advertisements aired by FAWA

The greatest portion of project funding went towards project management (37%), followed by core costs and other staffing (15% and 13%, respectively). Please see Appendices B and C for cohort and project-level spend breakdowns.

Overall, SDP providers directly engaged a total 5,219 individuals across 709 events, sessions, and activities (Figure 3). The frequency and focus of these engagements varied greatly across SDP projects. As described in greater detail in the previous section, the majority of VCS organisations decided to take a more in-depth, focused approach to delivering clinical information to their service users, primarily through workshops and sessions. Several other organisations decided to adopt a less "intense" approach, but as a result could reach a greater portion of their target community.

For example, the six organisations which primarily delivered health workshops – Advocacy Project, BME HF, Chinese Welfare Trust, Mosaic Community Trust, Groundswell Health, and Al Manaar – delivered a total of 65 workshops on breast, cervical, bowel, and prostate cancer.

In contrast, FAWA,[11] Age UK, and VCKC delivered activities that did not centre on direct outreach sessions and workshops. FAWA ran a digital campaign featuring radio advertisements about cancer screening services across three French-African radio stations in the bi-boroughs. VCKC engaged service users in relatively light-touch activities, such as weekly sewing and clothes upcycling workshops designed to foster community and provide a supportive environment for sharing. These sessions featured printed materials on various cancer screenings and included informal discussions, but was not driven by any clinical agenda or message. Similarly, Age UK's two different borough-based locations integrated cancer conversations into existing activities, initiated through the distribution of a leaflet with cancer screenings information.

Due to the nature of these activities, these three SDP projects reported much higher reach numbers and events delivered than others. These variations underscore why the effectiveness of SDP projects should not be judged solely by their engagement and activity numbers and speak to the challenge of quantitively summarising the achievements of diverse intervention approaches.

Indirectly Engaged Residents

Several SDP projects also took additional measures to raise awareness about early cancer detection beyond their primary activities. These efforts included distributing informational flyers and brochures around the community, as well as promoting awareness through their own and community partners' social media channels. For a detailed breakdown of these activities and the estimated number of indirectly reached individuals, please refer to Appendix D.

The estimate of the total number of residents indirectly engaged by these efforts is 421,168. A substantial share of this figure is from FAWA, which estimates that their digital campaign indirectly engaged a total of 396,880 residents.

It's challenging to verify the exact number of residents reached by these outreach efforts, as many of the numbers provided by VCS organisations were only estimates, often based on metrics like total social media followers and newsletter subscribers. Moreover, the data does not indicate the degree of engagement, such as the proportion of newsletter readers who went on to open a link with additional information about cancer screening. Nevertheless, these efforts illustrate the potential for community-led interventions to leverage diverse networks and channels to amplify their messaging, reaching target residents beyond those directly involved in their core activities.

Demographics

As outlined earlier in the *Data Limitations* section, service providers differed in the types of demographic data they collected. The table below shows the total number of resident responses for each demographic category collected by each service provider. Nearly all organisations that collected demographic data gathered sufficient information to ensure robust analysis of their sample, allowing for accurate generalisation of the data to their entire participant cohort.

Table 6. Demographic Data Collected

VCS Organisation	Residents directly reached	Resident ethnicity responses collected	Resident gender responses collected	Resident age responses collected	Minimum no. of responses needed for 95% confidence at 5% margin of error
Advocacy Project	60	60	60	60	**53**
Age UK	2,570	361	438	455	**335**

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[11] FAWA estimated that the radio advertisements reached 17,000 unique residents, based on listener counts provided by each station. However, to avoid conflating these estimates with verified resident engagements provided by other projects, we will use the figure of 2,520 residents, based on a survey conducted by FAWA that identified 140 listeners over five days of random street surveying. Without knowing the total number of people surveyed, it is not possible to calculate a more accurate estimate of the total number of listeners. Our analysis will thus rely on the 140 confirmed listeners while acknowledging the 17,000 figure as an estimate. We will also use this number to calculate the ethnic breakdown of listeners, based on the ethnic composition of the radio audiences, to estimate the campaign's demographic reach.

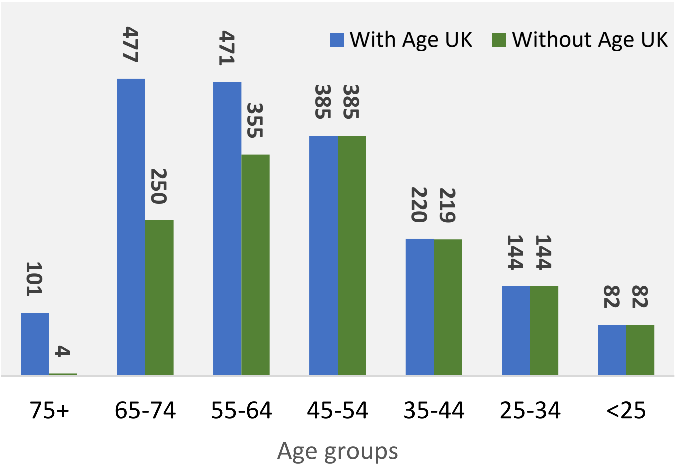
Al Manaar	95	22	95	20	**77**
BME HF	1,011	411	457	411	**279**
Chinese Welfare Trust	181	151	181	0	**124**
FAWA	140	140	0	0	**103**
Groundswell Health	137	0	0	0	**102**
Mosaic Community Trust	127	122	127	55	**95**
VCKC	900	900	900	900	**270**
Total	**5,221**	**2,167**	**2,258**	**1,901**	**358**

More than 75% of service users of the six VCS organisations that provided gender data and engaged both men and women (e.g., excluding FAWA, Groundswell Health, and Mosaic Community Trust) were female.

The majority of service users for whom demographic data was collected by the SDP projects identified as Black or Black British (35%), followed closely by Asian or Asian British (including Indian, Pakistani, and Bangladeshi) at 32%. The next largest group identified as White (17%). Please see Appendix E. for a detailed ethnic breakdown for each SDP project.

Among the six VCS organisations that provided age breakdowns of their SDP project participants, the largest age groups engaged were 65-74 and 55-64.[12] Age UK, which serves individuals aged 50 and above, accounts for nearly 25% of age data; when their data is excluded, the largest age group is 45-54 and 55-64 (Figure 4). Please see Appendix F. for a detailed age breakdown for each SDP project.

Figure 4. Age Breakdown of Service Users



Addressing Hidden Barriers to Uptake of Cancer Screening Services

The analysis of the qualitative and quantitative data led to the identification of five main barriers to participation in cancer screen services among the target groups: Knowledge and Awareness, Cultural and Social Factors, Accessibility of Screening Appointments, Healthcare System Issues, and Fear and Anxiety. These barriers are interconnected, often intensifying one another; for example, limited knowledge can exacerbate cultural resistance to cervical and breast screenings, while negative past experiences can heighten anxiety about future screenings.

These barriers align closely with the target service user outcomes identified by service providers at the beginning of the evaluation (see *Theory of Change*), highlighting the VCS sector's deep insights into community needs. The following section summarises these barriers and how SDP projects worked to address them to reach their target outcomes.

Knowledge and Awareness

Knowledge and awareness was one of the most prominent barriers to greater uptake of screenings across all community groups and cancer types. In qualitative interviews, nearly all service users struggled to recall receiving information about cancer screenings or symptoms in either community or clinical settings. This included individuals who had previously undergone screenings and felt that they had received minimal information from their GPs or screening nurses about the importance or what to expect during the process.

Many service users expressed a low understanding of cancer screening services. This included limited awareness about the importance of screenings, misconceptions about cancer risks, and confusion about screening procedures. While this issue affected all types of cancer screenings, it was especially impactful for bowel cancer, where understanding the use of home testing kits is crucial.

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[12] As an aggregate age breakdown, this does not reflect all organisations. For example, nearly half of the service users engaged by the Advocacy Project were less than 35. Please see Appendix X. for a project-level breakdown.

The perceived scarcity of accessible and easy-to-understand information exacerbated this issue, particularly for non-English speakers and people with learning disabilities. Non-English speakers often struggled to grasp the importance of cancer screenings or the instructions provided by the NHS, and were unaware of available translated resources. Individuals with learning disabilities were not provided with easy-read materials with their screening invitations, which made it difficult to understand the importance of the test or how to use it.

Misunderstandings about eligibility, particularly among older individuals regarding breast and bowel cancer screenings, were also prevalent, while misconceptions about the necessity and safety of screenings were common – particularly for breast and cervical cancers. For instance, some participants from Chinese Welfare Trust, BME HF, and Mosaic Community Trust believed that mammograms could increase cancer risk or thought that only sexually active women needed cervical screenings.

> *"I was invited by my GP to have a smear test, but I wasn't too sure if I should attend as I don't have any symptoms, but after attending the cervical cancer workshop I have learnt so much and how important it is to get checked. We need more health workshops that educate more women."*
>
> **- Service user, Mosaic Community Trust**

Quantitative and qualitative feedback indicates that the SDP projects significantly improved cancer awareness and knowledge among service users. Service users highlighted the benefit of having information tailored to their learning needs and styles to be able to effectively absorb the information. The SDPS activities worked to improve service users' health literacy to enable them to make informed decisions around cancer screening services and preventative behaviours.

- **Awareness of Early Detection**: 90% of those surveyed by BME Health Forum reported a greater awareness of the importance of early detection after attending workshops. Similarly, 72% of respondents surveyed by the Chinese Welfare Trust strongly agreed that they gained a better understanding of the importance of being screened.
- **Awareness of Symptoms**: 90% of BME Health Forum participants also reported increased awareness of cancer symptoms following the workshops. In addition, 78% of respondents from Mosaic indicated they are now more knowledgeable about cancer signs and symptoms.
- **Understanding of Screening Process**: 95% of those surveyed by BME Health Forum stated they now have a better understanding of the cancer screening process and pathways after attending the workshops. Moreover, 76% of Chinese Welfare Trust participants strongly agreed that they now have a better grasp of the contents of the national screening programme.
- **Knowledge of Treatment and Risk Factors**: 87% of Mosaic respondents said they are more informed about how cancer is treated and managed, and 84% reported a better understanding of cancer risk factors.[13]

Highlighting the value of having health professionals at workshops, a service user recently diagnosed with breast cancer shared that she struggled to understand her cancer diagnosis from the information provided by her doctor and couldn't find useful resources online. During the workshop, she was able to ask the health professional about the different stages of cancer, which she found extremely helpful in understanding the progression of the disease and preparing for future appointments.

Some organisations also chose to highlight the importance of preventative behaviours alongside screening services. For example, one of BME HF's delivery partners led a discussion about the HPV vaccination for children, discovering resistance from parents due to a lack of understanding about the connection between HPV and cancer and how the virus is transmitted. Due to interest from service users, other VCS organisations also led discussions on lifestyle habits that can reduce cancer risk factors, such as diet, smoking, and physical exercise.

> *"The workshops have taught me to be more mindful of what I consume, how I think, and focus more on my internal health."*
>
> **- Service user, Al Manaar**

Several organisations also highlighted the valuable knowledge gained by their staff and volunteers on cancer topics. As both learners and educators within their community, these VCS organisations remarked how intra-organisational trainings can foster a domino effect of information spreading among employees, friends, and families.

Cultural and Social Barriers

Cultural and social barriers emerged as significant obstacles, particularly affecting cervical and breast cancer screenings among women of Muslim faith and black and minority ethnic communities. Cultural and religious beliefs about

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[13] Quantitative findings were included for VCS organisations with sufficiently robust data. However, in cases where the data was less robust, the analysis relied more heavily on qualitative insights.

modesty and body exposure frequently clashed with the requirements of these screenings. For instance, concerns about virginity, privacy, and family honour led to familial and community pushback for women to participate in cervical screenings. Additionally, requests for same-gender healthcare providers were reportedly often unmet by the NHS, leading to reluctance to follow through with screening appointments.

Effectiveness of Intervention Approaches

- **Advocacy Project**: Among its participants, 62% felt that the videos were effective in increasing their knowledge about cancer screening, while 63% found that the easy-read information was similarly helpful.
- **FAWA**: In a survey of 140 people, 100% agreed that the radio campaign was an effective tool for encouraging action related to cancer screening.
- **Chinese Welfare Trust**: 89% of respondents strongly agreed that their event would help promote a positive understanding of cancer and reduce stigma.
- **Age UK**: 84% of those surveyed said that the information provided was clear and easy to understand.

Service providers noted resistance from men to discuss or participate in bowel and prostate screenings. Men often associated prostate screening with old age or as a threat to masculinity, exemplary of a larger reluctance to engage with the health system or pursue preventive measures.

The SDP projects created a supportive environment where service users could openly discuss stigmatised and taboo health issues with their peers. Workshops co-led by health professionals and service providers were especially valued, as the service providers enriched the clinical information with culturally and socially relevant insights, enhancing its relatability and accessibility.

By breaking down social and cultural barriers through knowledge sessions held in familiar community spaces, these interventions not only made participants feel heard but also encouraged broader knowledge sharing in the community. Many VCS organisations anticipated that fostering these community conversations would be key to sustaining participation in health screenings; likewise, familial and community encouragement emerged as a significant factor in promoting healthy behaviours, as service users expressed a strong desire to share the knowledge they gained with friends and family. Service providers often observed participants requesting extra copies of informational materials to share with their children or mentioned that they would advise their children to take screening invitations more seriously.

This ripple effect has the potential to positively influence those who may not be directly engaged with or impacted by SDP activities. For example, one service user mentioned that he only attended screenings due to insistence of his daughter and wife. He admitted that the SDP workshop didn't change his mind about the importance of screenings, but that he would continue to attend screenings due to his family. Similarly, during a focus group, women involved in Al Manaar's project highlighted the disengagement of men in their community regarding health screenings. They noted that men typically resisted taking control of their health and only sought medical attention when urged by their wives or female family members. These women stressed the importance of attending cancer screening workshops themselves so they could be better informed and, in turn, educate the men in their lives.

> *"I felt very comfortable asking questions during the workshop. I'm not shy to talk when I'm surrounded by people from [my home country] – no longer embarrassed by my accent."*
>
> **- Service user, BME HF**

Health System Issues

Widespread distrust of the healthcare system across community groups created significant resistance to and hesitancy around screening services. Many individuals felt that healthcare providers did not genuinely care about their well-being or accommodate their informational, cultural, or social needs during screenings or other interactions. This distrust was especially pronounced in more intimate screenings like cervical and breast cancer, where personal interactions with healthcare providers are crucial to increasing comfort. The lack of sensitive care and support for individuals with special needs, such as those with learning disabilities and trauma survivors, further impacted engagement with these screenings.

A 67-year-old woman showed interest in booking screening appointments after receiving an informational flyer from Age UK. When staff encouraged her to contact her GP, she expressed disappointment, citing difficulty in speaking to and booking appointments with her GP.

Feelings of being dismissed during appointments and a lack of continuity in care deepened this mistrust. Additionally, barriers like limited access to healthcare services and long waiting times discouraged many from taking the preventative steps promoted by the SDP projects. Some service users, already aware of their cancer risk factors, reported approaching the NHS for screening due to family history or other concerns, only to be turned away because they did not meet the eligibility criteria. These experiences often clashed with the messaging of the SDP programme and led service users to question its relevance.

In VCKC's self-advocacy session, a participant who was a past survivor of sexual abuse feared undergoing a smear test despite understanding its importance. After the session, she decided to book the test and share her concerns with the nurse. She later described it as the "best decision," noting that the nurse's gentle support made the experience far less daunting and ultimately empowering.

As it is unfeasible for VCS organisations to resolve these clinical barriers, they focused instead on equipping participants with the tools to overcome them through self-advocacy. For instance, only a small percentage of Groundswell Health's service users (individuals experiencing homelessness) met the age threshold for NHS cancer screening programmes. Consequently, the organisation adjusted their SDP project to concentrate on educating participants about cancer symptoms and empowering them with the skills to advocate for testing if they believed it necessary.

As mentioned earlier, the involvement of health professionals was highly valued for offering tailored advice and addressing the personal questions of service users. This personalised support played a key role in boosting their confidence and motivation to attend cancer screening appointments, and for building trust between the health system and community groups.

Fear and Anxiety

Fear and anxiety emerged as significant barriers to cancer screening across all target groups and cancer screening types. The fear of receiving bad news often led individuals to avoid testing altogether, preferring to remain unaware. This avoidance behaviour was observed across various community groups, highlighting the need for targeted interventions to address these fears.

A specific fear of the unknown and reluctance to ask questions emerged in communities where cultural, social, and language barriers obstructed clinical and community discussions about cancer screening and diagnosis.

> *"I wish more people came to the workshops because a lot of [our community] don't speak English. This is very good for them to be able to understand and to ask questions. They are frightened to ask questions, and they are frightened to go to their GP for information."*
>
> **- Service user, Chinese Welfare Trust**

Finally, a fear of pain associated with cervical and breast screening procedures deterred women who had never been screened before, and contributed to reluctance to return for subsequent screenings among those who had.

The SDP projects worked to overcome these fears by providing clear information about the high survival rates when cancer is detected early and featuring cancer survivors from the community to share their stories. Service users found these personal accounts particularly impactful, as they not only broke the typical community silence around cancer discussions but also demonstrated that a cancer diagnosis does not always lead to a fatal outcome, especially when caught early. Participants described feeling more empowered to take proactive steps, such as getting screened, despite lingering fears.

> *"It is better to feel uncomfortable for 2 minutes than to be whole your life suffering. Let us encourage each other to go and do it for our body."*
>
> *"I was scared to say the word 'cancer' and to talk about it, but now I feel less anxious and understand that with the right treatment it can be cured."*
>
> **- Service users, Mosaic Community Trust & BME HF (respectively)**

Additionally, when information was tailored to their learning needs and delivered in an intimate group setting, service users reported feeling more comfortable speaking up and asking questions.

To mitigate the fear of pain, several VCS organisations shared information that could alleviate potential pain during cervical cancer screenings, such as the patients' right to request specific speculum sizes and types and prescribed gels. Sharing this information empowered participants, making them more likely to respond to screening invitations and feel more involved in decisions regarding their health.

Accessibility of Screening Appointments

The accessibility of cancer screening appointments highlighted several practical barriers across communities and cancer types, with particular impact on breast and cervical screenings due to the need for in-person appointments. Common logistical challenges included difficulties with travel to screening locations, exacerbated by childcare responsibilities and financial constraints. Service users from Age UK (those aged 50 years and older) voiced particular hurdles with technology, such as navigating online booking systems and managing appointment schedules.

Distance to screening centres was a barrier for service users in some organisations but not for others. For instance, in a sample of 140 people surveyed by FAWA, only three indicated that they would need assistance accessing an appointment, and just one of these three mentioned transport as a specific barrier.

Following the positive response to their transport offer for COVID-19 vaccine appointments, Age UK's SDP project included the option of transportation to cancer screening appointments. However, they found that this transport option was not popular among their service users. This was confirmed in quantitative surveys with their service users in which 63% of respondents said it was "highly unlikely" that they would contact Age UK to book free transport for a screening appointment, while only 5% said that they required support with transport. Interestingly, Age UK also noted that several service users cited the lengthy distance of screening locations from their homes as a barrier to attending, suggesting that convenience and proximity to the screening service may play a larger role in screening uptake rather than financial barriers in this community group.

In response to the low demand, Age UK extended the transport offer to users of other SDP projects. However, the interest remained minimal, even among VCS organisations that serve populations who noted transport barriers. For example, BME HF's service users identified financial constraints, including the costs of travel and childcare, as major obstacles to attending screening appointments. After BME HF offered this transport opportunity to service users, however, only five out of 100-200 service users reportedly used the service to attend a cancer screening appointment.

Cancer Screening Attendances

Several organisations surveyed their participants about the likelihood of accepting a cancer screening invitation after attending their SDP activities. Please note that these responses do not indicate whether the participants already undergo screenings regularly or whether they were likely to attend a screening prior to the intervention.

> *"Yes, I will perform the bowel cancer screenings in the future if I receive it in the mail as I now know what it is."*
>
> **- Service user, BME HF**

- **BME Health Forum:** 95% of participants indicated they would attend cancer screening when invited after attending the workshop.
- **Advocacy Project:** Approximately 82% of service users stated they would seek cancer screening in the future after receiving information during the session.
- **Mosaic Community Trust:** 95% of participants reported they were more likely to take up bowel screening, and 90% were more likely to undergo cervical cancer screening.
- **Chinese Welfare Trust:** 75% of those surveyed strongly agreed that they were more likely to accept screening invitations after attending the session.
- **FAWA:** 100% of those surveyed stated that after hearing the radio advertisements, they were more likely to seek screening if they experienced symptoms.
- **Age UK:** 65% of those surveyed said they were likely to book a screening based on the information in the leaflet.

WSIC Data

Tables 7-9 below display the percentage change of screening attendances within each eligible population group prior to the commencement of the SDP programme and the end (December 2023-July 2024). Orange cells indicate a decrease in the percentage. Appendix G displays the data for the same proxy cohorts and time period but as compared to the NWL average for the equivalent cohort.

Several limitations should be considered when interpreting the tables below. In general, interventions aimed at changing community behaviour take time to build momentum. For this programme, an immediate increase in cancer screening attendance was not expected, as the SDP projects were primarily focused on encouraging individuals to accept screening invitations when they receive them. Given the infrequency of these invitations (every 3 or 5 years), it is still too early to identify any causative trends in the data.

Furthermore, as noted earlier (see *Data Limitations*), it is not possible to track service user uptake of cancer screening services through NWL ICB Business Intelligence Data. This means that analyses of longitudinal changes in screening attendance would be challenging to attribute to the SDP programme.

Moreover, percentage changes alone don't tell the full story when comparing groups of different sizes. The larger percentage increases in smaller populations are noteworthy and might indicate successful targeted interventions.

However, smaller percentage increases in larger populations shouldn't be undervalued, as they likely represent a larger number of additional screenings.

Overall, WSIC data indicates that screening rates increased among almost all target population groups and cancer screening types during the 6-month programme period. Decreases were observed for bowel cancer screening attendances among the Chinese population, people experiencing homelessness, and residents in the Notting Dale Ward. The only other decrease occurred for cervical cancer screenings for the 50-64 Black African age group.

Cervical Cancer Screenings

Ages 25-49 years

The most significant increases in screening rates for cervical cancer screenings among target populations aged 25-49 occurred among people with learning disabilities (The Advocacy Project; 15.77%) and Notting Dale Ward (VCKC; 10.26%). Most other groups saw modest increases in the 1-2% range. The Black African population (FAWA) had the highest uptake in both periods but the smallest percentage increase (0.96%).

*Table 7. Cervical Cancer Screening Uptake, **25-49 years**, Dec 23-July 24*

VCS Organisation	**WSIC Proxy Population**	**Total Residents reached by SDP Project**	**Dec 2023**		**July 2024**		**% Change**
			Eligible Bi-borough Population	Uptake (%)	Eligible Bi-borough Population	Uptake (%)	
Advocacy Project	People with learning disabilities	60	195	30.8%	257	35.6%	15.77%
Age UK	Over 50 population	2,570	N/A	N/A	N/A	N/A	N/A
Al Manaar	Indian, Pakistani, Bangladeshi population	95	6,710	48.9%	6,661	49.6%	1.54%
BME HF	BME population	1,011	53,675	48.1%	53,437	49.0%	1.98%
Chinese Welfare Trust	Chinese population	181	6,273	41.1%	6,261	41.8%	1.58%
FAWA	Black (African) population	140	3,990	57.1%	4,024	57.7%	0.96%
Groundswell Health[14]	Dr Hickey / Great Chapel GP Practices	137	300	39.7%	321	42.1%	6.05%
Mosaic Community Trust	BME & Church Street Ward	125	1,576	54.8%	1,548	55.6%	1.55%
VCKC	Notting Dale Ward	900	1,712	59.0%	1,675	65.0%	10.26%

Ages 50-64 years

Most groups showed modest increases in uptake, except for a substantial improvement seen among people with learning disabilities (The Advocacy Project; 36.43%). The Black African population (FAWA) was the only group to show

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[14] Central London only

a slight decrease in uptake (-1.02%). Dr Hickey / Great Chapel GP Practices (Groundswell Health), despite having the lowest uptake, showed the third-highest percentage increase (3.28%).

*Table 8. Cervical Cancer Screening Uptake, **50-64 years**, Dec 23-July 24*

VCS Organisation	WSIC Proxy Population	Total Residents reached by SDP Project	Dec 2023		July 2024		% Change
			Eligible Bi-borough Population	Uptake (%)	Eligible Bi-borough Population	Uptake (%)	
Advocacy Project	People with learning disabilities	60	117	43.7%	160	59.6%	36.43%
Age UK	Over 50 population	2,570	40,833	66.4%	40,749	67.1%	1.13%
Al Manaar	Indian, Pakistani, Bangladeshi population	95	1,937	66.9%	1,969	68.7%	2.62%
BME HF	BME population	1,011	18,236	65.4%	18,399	65.9%	0.84%
Chinese Welfare Trust	Chinese population	181	1,301	62.4%	1,332	63.8%	2.16%
FAWA	Black (African) population	140	2,024	73.6%	2,051	72.8%	-1.02%
Groundswell Health[14]	Dr Hickey / Great Chapel GP Practices	137	242	48.8%	133	50.4%	3.28%
Mosaic Community Trust	BME & Church Street Ward	125	672	70.1%	665	71.0%	1.28%
VCKC	Notting Dale Ward	900	892	69.9%	889	70.5%	0.93%

<u>Bowel Screenings</u>

Bowel screening rates varied across different population groups, with some showing significant improvements while others declined. The most significant improvement was in people with learning disabilities (The Advocacy Project), with a 20.75% increase. The Black African population (FAWA) showed the second-highest improvement at 3.36%. The two groups with the most notable declines was Dr Hickey / Great Chapel GP Practices (Groundswell Health; -16.49%) and Notting Dale Ward (VCKC; -8.85%).

Table 9. Bowel Cancer Screening Uptake, Dec 23-July 24

VCS Organisation	WSIC Proxy Population	Total Residents reached by SDP Project	Dec 2023		July 2024		% Change
			Eligible Bi-borough Population	Uptake (%)	Eligible Bi-borough Population	Uptake (%)	
Advocacy Project	People with learning disabilities	60	158	46.8%	233	56.5%	20.7%
Age UK	Over 50 population	2,570	39,755	54.0%	40,870	54.1%	0.2%
Al Manaar	Indian, Pakistani, Bangladeshi population	95	2,487	45.9%	2,467	46.0%	0.1%
BME HF	BME population	1,011	21,624	47.2%	22,186	47.5%	0.5%

Chinese Welfare Trust	Chinese population	181	1,116	56.1%	1,136	55.9%	-0.4%
FAWA	Black (African) population	140	2,006	47.6%	2,093	49.2%	3.4%
Groundswell Health[14]	Dr Hickey / Great Chapel GP Practices	137	568	19.4%	297	16.2%	-16.49%
Mosaic Community Trust	BME & Church Street Ward	125	800	53.6%	801	54.0%	0.7%
VCKC	Notting Dale Ward	900	1,236	59.9%	1,272	54.6%	-8.8%

Wider Stakeholder Effects

The VHC team and VCS organisations described in detail how the SDP programme transformed their internal capacities and ways of working, with the potential for sustained impact in the future.

Intra-Sector Learning and Development

Service providers highlighted how the SDP projects impacted their own organisations. Some identified a deeper disconnect with certain subgroups than initially recognized, as well as interests among service users in learning more about or needing support around other health topics.

> *"One of the projects that I'll think back in 5 years that this was really good. We were able to get the right kind of support and the voices of the residents, and developed really good resources to share for the next 5 years. I can see us doing this more in other boroughs too."*
>
> **- Service provider**

VCS organisations were also able to develop and refine new project approaches, and many expressed interest in applying these methods in the future. The Advocacy Network, for instance, reported a boost in confidence in producing quality easy-read materials and videos, hoping to use this format for other health topics such as sexual and mental health. Similarly, FAWA expressed interest in using the radio in the future to spread health messages to the community. Groundswell Health's SDP project enabled them to establish a formal approach to cancer screening and awareness, and they have since received external funding to continue providing sessions.

Cross-Sector Relationship Building

Stakeholders agreed that one of the programme's greatest strengths was its promotion of cross-sector relationships. A VHC team member highlighted how its open dialogue and one-to-one support enabled the NHS to better understand the VCS sector's support needs, and hoped that VCS organisations likewise gained insight into the NHS's perspective as a commissioner. Only one VCS organisation, however, described gaining an increased understanding of the NHS.

> *"We got to know some of the key people in the NHS. It becomes useful because they now know about our agency, capacity, and experience working with the community."*
>
> **- Service provider**

Most organisations noted how the programme laid a foundation for potential future partnerships. One service provider observed this impact on their smaller, less-resourced delivery partners who wouldn't have had opportunities to work across sectors. Similarly, one health professional valued the chance to establish new relationships with organisations and hopes to deliver more workshops.

Health professionals also recognised the value of knowing which organisations to approach with potential future research and public health opportunities. Likewise, several VCS organisations flagged the advantage of being known by NHS stakeholders for future programming collaborations.

5. Discussion: Impact of SDP Programme on Target Outcomes

Participants across the SDP projects gained new knowledge about cancer prevention, which service providers hope will positively influence short-term behaviours and embed a sustained attitudinal shift in the communities. The project also strengthened community bonds, with participants feeling a heightened sense of unity and support around topics that often go undiscussed.

Very few service users engaged in qualitative interviews were able to identify previous community or clinical settings where they had received information about cancer screenings or symptoms. The notable gap in knowledge across all target communities around the importance of cancer screening services suggests NHS and government public health efforts are not as effective as hoped in reaching large segments of the population. The SDP programme successfully bridged some of this gap by delivering information in a way that was both meaningful and actionable for these communities, empowering them to self-advocate to compensate for systemic oversights.

Strengths of Programme Approach for Addressing Health Inequalities

The following section reviews how the SDP programme engaged the strengths of each sector to achieve community and clinical health goals.

Community-Led

Feedback from service users underscores VCS organisations' nuanced understanding of the needs, concerns, and effective engagement strategies for their communities. They brought innovative and sensitive approaches to content and settings, ensuring that their interventions were both culturally appropriate and impactful to address the major barriers creating inequalities in care delivery. For example, organisations engaged health professionals from specific clinical and demographic backgrounds or from within their own community groups, knowing they would be more trusted by their service users.

Service users reported minimal prior exposure to NHS information about cancer screenings. The VCS sector leveraged its deep-rooted connections and integration within target communities to engage communities whose cultural, social, learning, physical, and language needs means they are missed by other outreach methods. For instance, a service user from Al Manaar shared that the only time she left her flat was to visit Al Manaar, highlighting the importance of these established relationships. Previous studies support these findings, showing that collaborating with established community organisations is crucial for reaching and supporting vulnerable populations for earlier detection of cancer.[15]

Tailored Approaches to Engaging Residents

- BME HF's delivery partner integrated Islam and spirituality into their project to increase engagement by inviting an Imam to their coffee group to lead a session on the Islamic duty to lead healthy lives. The Imam encouraged service users to seek medical attention when needed and not to neglect their health.
- As Mosaic Community Trust's community members are primarily mothers or caregivers of school-aged children, workshops were scheduled in the morning with lunch provided to fit their availability.

Even those who had previously attended cancer screenings reported a lack of clear communication about the process, leaving them uncertain about what to expect. This underscores the VCS sector's role in not only reaching underserved audiences but also addressing knowledge gaps that persist despite NHS efforts.

VCS organisations also leveraged intra-sector relationships to amplify the reach and duration of their impact. For instance, some distributed their materials through other health networks and VCS organisations, such as the Chinese Welfare Trust, which placed Chinese-language pamphlets in 12 locations across Westminster. Other organisations, such as BME Health Forum, trained up cancer survivors and ambassadors/champions who plan to continue sharing messages about cancer detection and SDP after the programme's conclusion.

Clinical Collaborations

VCS organisations highly valued the direct involvement of health professionals due to their own uncertainties around engaging service users in clinical conversations. Most service providers also anticipated that service users would perceive cancer information as more trustworthy and impactful when delivered by a health professional.

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[15] Lyon D, Knowles J, Slater B, Kennedy R (2009) Improving the early presentation of cancer symptoms in disadvantaged communities: putting local people in control. Br J Cancer 101(Suppl):S49–S54. https://doi.org/10.1038/sj.bjc.6605390

One-to-one conversations with health professionals in a safe, open discussion space were shown to boost service users' confidence and motivation to discuss stigmatised topics like cancer. Participants also valued the opportunity to ask questions and receive personalised attention from a health professional—something they felt was increasingly lacking in their regular clinical encounters, such as with their GP.

Moreover, several stakeholders highlighted the mutual learning opportunities created by the programme between the VCS sector and NHS clinicians. They valued how community insights and feedback on various topics could be shared with health professionals, enabling them to adapt their practices to encourage greater uptake. The Advocacy Project, for example, was connected by their project buddy to the NWL Nursing Forum and NWL PCN Webinar to help promote the top tips that service users want to share with health professionals, with presentations scheduled in August and September.

> *"Most of the attendees were extremely happy with the way the workshops were delivered by the healthcare professionals. They were given the opportunity to ask questions in private and this really helped them feel comfortable."*
>
> *"Having GPs and doctors from the same communities involved in delivering workshops helped a lot to build trust and feel related to the professionals."*
>
> **- Service providers**

Flexible Programme Approach

Some stakeholders noted that collaborating with community-led organisations can be more complex than working with NHS entities, necessitating a higher level of flexibility and understanding from the beginning. Although none of the organisations encountered major challenges during their SDP projects, the programme's flexible and open-ended approach allowed them to adapt and refine their interventions to address any obstacles that arose.

At the start of the project delivery, Groundswell Health discovered that a very low percentage of their client group was eligible for the standard cancer screening programme. Despite this, they knew from their close work with the community that late cancer diagnosis was still a significant issue. Consequently, the SDP project shifted focus to promoting awareness of cancer symptoms and empowering individuals with the skills to advocate for testing when needed.

Comparing Impact Across Project Approaches

The intervention approaches of the SDP projects varied in their reach (e.g., the number of residents engaged), depth (e.g., intensity and duration of interactions), and clinical focus (e.g., the extent to which activities disseminated information about cancer screening and symptoms).

By entrusting community organisations to design their own interventions, the SDP acknowledged that these organisations possess the best understanding of the needs and dynamics of the populations they serve. Consequently, SDP projects were customised to meet the unique cultural, educational, and accessibility requirements of specific target groups. While this customisation enhanced the relevance of each intervention, it also complicated cross-intervention comparisons and made it challenging to evaluate the overall programme effectiveness.

However, observations from the research suggest that interventions that leveraged health professionals to deliver clinical information in an intimate space via health sessions and workshops were especially impactful.[16] The positive effect was further amplified for certain community groups when these professionals were accompanied by trusted service providers or community members with lived experiences. The often informal nature of these workshops was appreciated by both service users and providers, as it encouraged open dialogue and allowed organic conversations about service barriers to emerge. The involvement of health professionals added credibility to the discussions, enabled participants to have their questions addressed directly, and fostered trust between the health system and the community. This approach also created a valuable feedback loop, where practical insights from the community could be relayed back to health professionals.

> *"Some women who are not digitally literate they said cannot read about cancers on internet and they have a short time at their GP appointments too. They also said they never been in a group to talk about cancer as this matter always was a taboo. By attending these workshops, they learned so much about cancers."*
>
> **- Service provider**

Likewise, SDP projects with a less clinical focus, although successful in creating safe spaces for participants to congregate and socialise, were less effective at communicating the core messages of the SDP programme. Initiatives

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[16] This is not applicable for every target community group; for example, Groundswell Health delivered workshops themselves due to their communities' distrust of healthcare professionals. However, Groundswell Health had nurses available during the workshops to answer any questions and order screening kits as needed.

that prioritised reach over depth may also not have provided the level of information needed to encourage behaviour change. For example, FAWA’s 30-second radio advertisements focused on recognising and seeking help for cancer symptoms, rather than regular screenings. One service user noted that it would have been helpful if the advertisement had also included contact information for screening services. Conversely, several Age UK focus group participants indicated that they would have preferred the project’s leaflet to include information about cancer symptoms, rather than just a telephone number to call if symptoms emerged.

Moreover, it is challenging to measure or ensure that this information was effectively delivered. For instance, Age UK conducted a feedback survey by contacting service users who should have received a leaflet about cancer screening during an Age UK activity or interaction. Of the 38 people contacted, 25 (65%) recalled receiving the leaflet, and 23 (61%) had read it. Similarly, during the evaluation, Envoy Partnership held focus groups with 18 Age UK service users who were likely to have received leaflets through other Age UK activities; approximately eight (44%) reported having received one.

These approaches also forfeit the safe spaces and learning opportunities that the evaluation shows are vital for uncovering and addressing barriers to behaviour change. For instance, during two focus groups conducted by Envoy Partnership with Age UK service users who had previously received cancer screening leaflets, participants showed great interest in discussing cancer when the topic was introduced, asking numerous clinical questions to the researcher. These discussions highlighted the value of having dedicated spaces for such conversations. One participant suggested that Age UK could offer a service or space for people to discuss health issues anonymously or organise monthly discussion groups led by volunteers with medical backgrounds. Another participant praised the focus group as a "safe space to discuss cancer and screening services among peers," recommending more sessions like it. When asked how people could be better encouraged to attend cancer screenings, one participant responded, "sharing information and holding more focus groups like the one I took part in." This feedback underscores the importance of providing tailored information through trusted organisations and creating supportive environments for discussing sensitive health topics.

Gaps in Engagement

Overall, interventions must balance efforts to reach as much of the population as possible with efforts to engage those who do not participate in community organisations or may be missed by traditional community outreach. These are oftentimes those within the target populations who are the most marginalised. With 75% of service users being female, all projects evidently struggled to reach men. This underscores the need for tailored strategies to target hard-to-reach subgroups within target communities.

6. Recommendations

Future Community Solutions Fund Approaches

One of the most frequently cited challenges by SDP programme stakeholders was the lack of collective clarity regarding the roles, objectives, and aims of both the broader programme as well as internal events and meetings. To address this issue in future rounds of the Community Solutions Fund, the VHC team should prioritise clearly defining and communicating distinct programmatic phases and roles from the very beginning.

The following sections, informed by stakeholder feedback, offer suggestions for organising and structuring future programs, while also highlighting opportunities to enhance existing activities and elements within each phase.

Stage 1 Recommendations: Brainstorming

After selecting the health topic for the next round of funding, the VHC team should collaborate with stakeholders from other NWL boroughs and the NWL engagement team to identify any similar recent or ongoing initiatives. By reviewing these past programmes and outputs, the team can avoid repeating known issues or duplicating resources, such as NHS materials already in use.

Stage 2 Recommendations: Programme and Application Design

The VHC core team should identify and invite relevant stakeholders, including clinical specialists and health professionals involved in similar projects in other boroughs, as identified in Stage 1. The core team should make clear the purpose of all events and how each member can contribute to both the overall programmatic approach and to each funded project. Other important actions to consider during this stage include:

Define Programmatic Scope

- Collectively brainstorm and define the programme's scope and goals, and how to meaningfully measure impact for all stakeholders. Address potential barriers to tracking progress, such as the availability and feasibility of collecting clinical data.
- Ensure programmatic goals are realistic and can be achieved within the proposed delivery period. Likewise, identify practical considerations that may influence impact in this period (e.g., the timing of cancer screening invitations limited observable changes in uptake during the 6-month SDP delivery period).
- The funding specification should:
    - Clearly articulate programme objectives and how applicants are expected to contribute. This should include any clinical considerations to help applicants assess their internal capacities to work with these topics.
    - Outline all expectations for data collection and ensure a proportionate portion of the funding is allocated to support these tasks.
- The funding application should:
    - Request that VCS organisations specify the potential support they'll need from the VHC team based on their experience with clinical topics and health professionals**.** This will help the VHC team prepare internally and determine the number of health professionals required for direct support.

Leverage Health Professionals

- Make available a sufficient number of health professionals with topical expertise to meet the potential demand of SDP projects.
- Consider identifying enough health professionals to serve as project buddies.

Offer Training and Capacity Building

- Before holding pre-planning workshops to discuss proposed SDP project designs, deliver training sessions on the clinical background of the programme topic to applicants. This will help VCS organisations align their proposed interventions with the clinical considerations and demands of the project topic, preventing readjustments during the delivery period. Moreover, it will allow them to identify if and when they may need greater support from the VHC team in their application.

Stage 3 Recommendations: Mobilisation

Aside from the pre-project application workshops, all VHC/VCS engagements occurred in the official project delivery period. Future Community Solutions Fund programmes should include a mobilisation phase between the programme design and delivery periods to provide time to identify any support and resource needs, project roles, and communication structures, and for projects to begin setting up their projects.

Introduce Programme Stakeholders

- Clearly articulate to the VCS organisations at the beginning of the mobilisation stage the roles of the VHC team, including that of the project buddy.
- Introduce evaluation partners during this period, to allow time to identify the clinical and community outcomes and design measurement tools before the SDP projects begin.
- Make clear the number and type of health care professionals available to support VCS organisations, and provide the time and space for organisations to share contacts and networks.

Identify Remaining Support Needs

- Work with the VCS organisations to identify and provide any training or support needs, including guidance on discussing potentially sensitive topics with their communities.
- The overlap between the SDP projects and previous initiatives by VCS organisations highlights the sector's ability to address clinical health topics with minimal support. However, the VHC team used a targeted recruitment strategy to engage known VCS organisations that are active and known across sectors. When funding future VCS projects, consider the level of upskilling required and how it aligns with the VHC team's own capacity to support.
- Similarly, if the intention is to upskill the VCS sector, revise the recruitment approach to invite less resourced VCS organisations.

Stage 4 Recommendations: Delivery

The mobilisation and delivery stages can overlap as needed, enabling projects that are prepared to start their SDP activities during the mobilisation phase.

Ongoing

Communication Channels

The VHC team should establish centralised and ongoing communication mechanisms to keep all stakeholders informed and engaged throughout the project period.

- For the funded projects:
    - Create a user-friendly online microsite or database to host project updates, key contacts, upcoming SDP activities, deadline reminders, and clinical resources.
    - Include a designated section where organisations can exchange lessons learned and share resources.
    - To ensure accessibility for all users, the platform must be easy to access and navigate, accommodating diverse technical capacities and learning styles.
- Within the VHC team:
    - Send summaries and action points of all meetings to the entire team.
    - Distribute a brochure or informational packet at the start of the programme, detailing the contact information, activities, and focus of the funded SDP projects.
    - Share upcoming SDP events and relevant resources with health professionals for their use and distribution within their clinical networks.

Feedback and Learning Exchange

Recognising health professionals as both experts and learners underscores the long-term, cross-sector effort needed to reduce health inequalities. The VHC team should not only continue facilitating resource sharing among VCS organisations but also prioritise deeper knowledge exchange between VCS organisations and health professionals. This includes strategising how to disseminate resources created by VCS organisations in clinical settings, while using service user feedback to modify clinical practice. Implementing structured feedback processes with health professionals throughout the programme, with clear and actionable strategies for incorporating lessons learned into clinical practice, will help bridge the gap between sectors and ensure that health professionals feel more connected and integral to the projects.

Sustaining Impact of *Screen Detect Protect* and Future Community Solutions Fund Programmes

Clinical and Community Target Outcomes

The intricate barriers to accessing information about cancer screening services and symptoms highlight the need for a multifaceted approach to earlier detection of cancer that engages multiple sectors. The analysis indicates that successful interventions must go beyond addressing practical and logistical challenges—they must also confront deeply ingrained cultural beliefs, enhance health literacy, and build trust in healthcare systems. Community-led organisations that involved health professionals to deliver clinical information in informal, adaptable, and supportive settings were identified as particularly effective in addressing these barriers.

Above all, stakeholders emphasised the critical need for ongoing education and community-level awareness initiatives to make earlier cancer detection a more ingrained and normalized health practice within the target communities. The NHS should consider allocating funds to support longer-term community projects and collaborate more closely with community sectors to develop sustainable intervention strategies.

The following recommendations outline how future interventions can build on the lessons learned from the SDP programme to promote earlier cancer detection. These recommendations are broadly applicable and should also be considered when developing interventions to decreasing inequalities in delivery of care in other health topics.

Address Clinical Barriers

Overcoming health inequalities in cancer screening requires efforts that go beyond individual behaviour change, recognising the broader systemic and structural issues that perpetuate these disparities. The following recommendations address the clinical barriers identified in our evaluation, which must be overcome to improve cancer screening attendance. These include the need for more technologically, logistically, and physically accessible healthcare services, culturally and linguistically tailored information, and healthcare professionals who are more attuned to the needs and experiences of their patients.

- <u>Improve Accessibility and Availability of Clinical Information</u>**:** Feedback from service users revealed that the information provided by GPs or via screening invitations does not often meet the language and learning needs of patients, and service users were unaware of the range of NHS resources available in different languages and formats until they participated in SDP activities.
    - The NHS should prioritise delivering accessible information directly to patients, including easy-read materials and language translations, within cancer screening invitations and during in-person healthcare interactions. For those who are digitally literate, improving access to translation tools on the NHS website could further enhance engagement. The Advocacy Project discovered that many service users did not receive easy-read information with their screening invitations, even though these resources are available. Ensuring such materials are consistently provided would significantly improve patient understanding and engagement.
- <u>Enhance Cultural and Social Awareness</u>**:** Many service users who had previously undergone screenings reported negative experiences due to a lack of cultural sensitivity, physical comfort, or clear communication from health professionals. To ensure sustained participation in cancer screening, NHS staff should make necessary cultural, physical, and communication adjustments. These improvements will help patients feel more comfortable and respected during their screenings, encouraging them to continue with regular screenings in the future.
    - The Advocacy Project service provider highlighted that health professionals are often unaware of the necessary adjustments for patients with learning disabilities. Facilitating collaborations between community experts and health professionals for joint training and development sessions and resource sharing can better equip healthcare providers to meet the needs of these populations.
    - Health professionals should inform patients about their options during screenings, such as choosing the appropriate size of a cervical screening speculum or requesting a prescribed gel. This knowledge empowers patients to make informed decisions and minimize their discomfort or pain.
- <u>Increase Accessibility of Screening Appointments</u>: Bringing screening services closer to underserved areas can help overcome barriers that contribute to healthcare inequalities. Investing in mobile breast screening units is one of

the most effective strategies, saving approximately 1,300 lives annually by detecting around 21,000 cancers.[17] The NHS should consider using business intelligence to identify areas with the greatest need and partnering with local VCS organisations to promote these services to encourage uptake.

Combine Business Intelligence Data with Community Insights

Integrating community expertise with population health data can greatly enhance intervention strategies and ensure resources are allocated effectively at the outset. Use Business Intelligence Data and community insights to identify the most marginalised subgroups within target communities, and collaborate with the VCS sector to develop tailored interventions that strategically target the hardest to reach individuals, particularly those who may be known or disengaged from community services.

The VHC team should explore how to incorporate these bespoke approaches to engage men, who were notably underrepresented in SDP activities, making up only 25% of total service users. Targeted strategies, which could include those which include men in the design of interventions, will not only reduce gender-based health disparities but also challenge any enduring cultural and social barriers. For instance, the evaluation revealed that some men discourage their wives from attending cervical screenings due to misconceptions about bodily exposure. By addressing these issues, the NHS and community organisations can achieve more inclusive and effective health interventions.

Shift Focus to Prevention

To effectively tackle health inequalities, it is essential to identify the earliest opportunities for intervention, which necessitates a strategic shift from focusing solely on clinical treatment to emphasizing early prevention. The SDP programme prioritized earlier detection and treatment, but future initiatives should consider supporting interventions that focus more on prevention.

This approach is particularly vital for cancer prevention, as many cancers are preventable. For example, nearly a quarter of breast cancer cases in the UK are linked to lifestyle factors such as obesity, alcohol consumption, and physical inactivity. [18] BME HF held workshops to educate their community about the link between the HPV virus and cancer, addressing misconceptions that contributed to vaccine hesitancy among children. This is one example of how directing interventions to earlier in the life course can maximize their impact.

Address Sensitivity Needs

For some women, especially survivors of trauma such as FGM or sexual violence, undergoing cervical or breast screenings can be incredibly difficult without additional support. To address these needs, the NHS should fund community organisations to offer counselling and emotional support before screenings or provide advocates to accompany individuals during their appointments. These tailored supports are crucial for helping vulnerable subgroups within target communities access and complete screenings with increased confidence and comfort.

Cross-Sector Collaborations and Capacity Building

The perceived impact of the programme approach articulated by the different stakeholders on cross-sector relationship building was conjectural. Likewise, the impact of the Community Solutions Fund on cross-sector relationships on future ways of working across the sectors cannot be accurately captured within timeframe of the evaluation period. To understand the true impact on these cross-sector relationships and future ways of working, the VHC team should consider funding a retrospective impact evaluation to consider which organisations experienced long-term benefits from their SDP collaborations and how NWL can likewise better encourage and sustain these collaborations in future programme approaches.

Similar to the clinical and community outcomes, cross sector collaborations require ongoing engagement and nurturing for meaningful impact. As a result, the impact of these collaborations on future ways of working will expect to increase in magnitude with further investments in these types of programmes.

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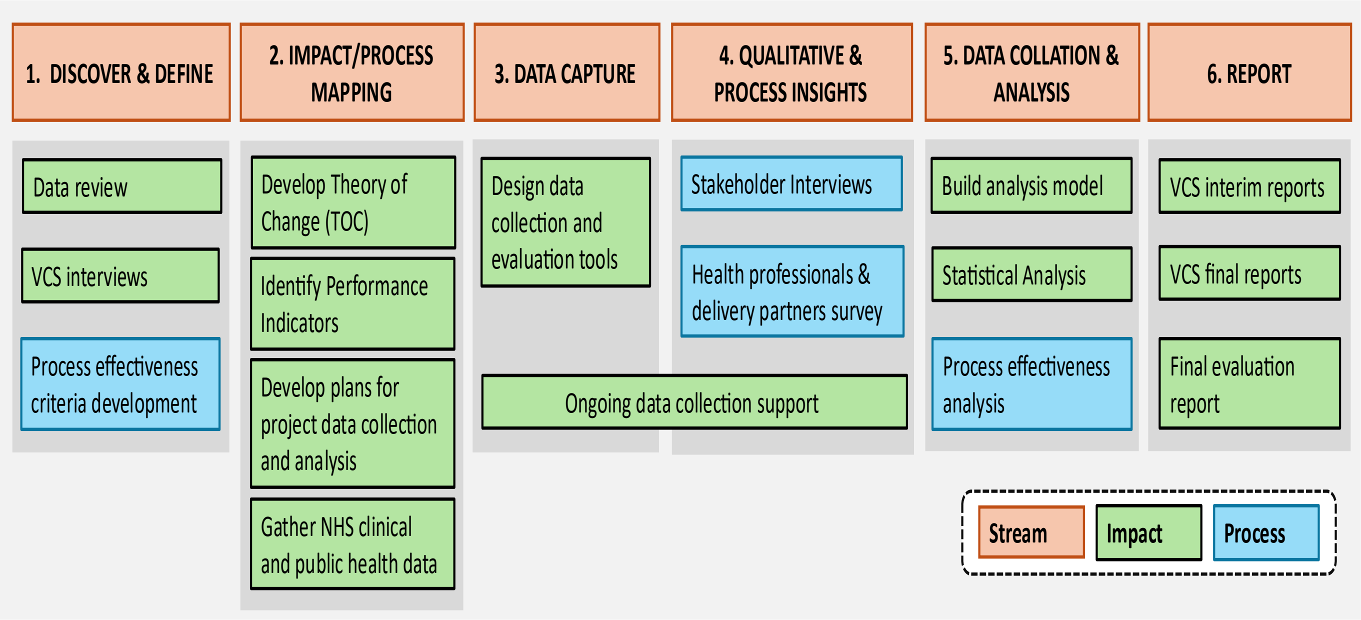
[17] UK Government. (2023, August 20). New breast cancer screening units to speed up diagnosis. GOV.UK. https://www.gov.uk/government/news/new-breast-cancer-screening-units-to-speed-up-diagnosis

[18] Gunn, T. Risk of dying from early invasive breast cancer down by around two-thirds in the last 20 years. 13 June 2023. https://news.cancerresearchuk.org/2023/06/13/breast-cancer-mortality-down-66-percent-since-the-1990s/

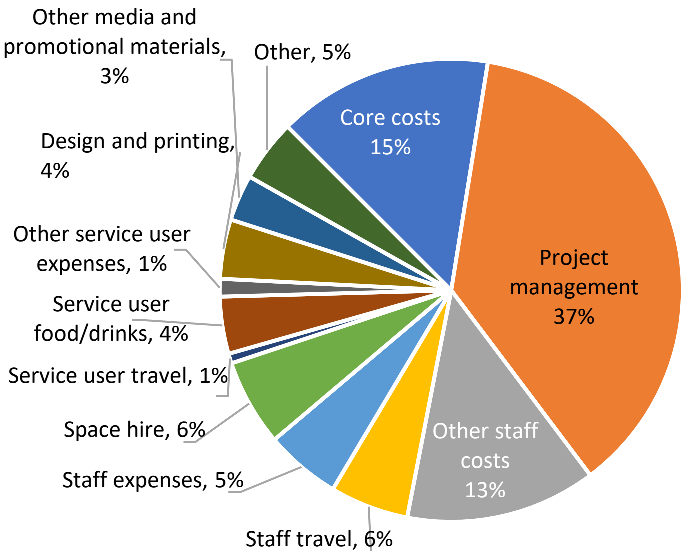
7. Appendices

Appendix B. SDP Evaluation Workstream



1. DISCOVER & DEFINE	2. IMPACT/PROCESS MAPPING	3. DATA CAPTURE	4. QUALITATIVE & PROCESS INSIGHTS	5. DATA COLLATION & ANALYSIS	6. REPORT
Data review	Develop Theory of Change (TOC)	Design data collection and evaluation tools	Stakeholder Interviews	Build analysis model	VCS interim reports
VCS interviews	Identify Performance Indicators		Health professionals & delivery partners survey	Statistical Analysis	VCS final reports
Process effectiveness criteria development	Develop plans for project data collection and analysis	Ongoing data collection support		Process effectiveness analysis	Final evaluation report
	Gather NHS clinical and public health data				

Appendix A. Summary of SDP Programme Spend



Appendix C. Project-level Spend

	Advocacy Project	Age UK	Al Manaar	BME HF	Chinese Welfare Trust	FAWA	Groundswell Health	Mosaic Community Trust	VCKC	Total
Core costs	£1,330	£4,132	£0	£6,280	£10,150	£0	£4,521	£5,000	£1,060	**£32,473**
Project management	£11,967	£20,866	£0	£15,516	£3,874	£2,500	£19,039	£3,000	£5,800	**£82,562**
Other staff costs	£2,750	£7,816	£0	£2,800	£2,332	£2,700	£286	£1,000	£7,440	**£27,124**
Staff travel	£70	£6,444	£0	£1,440	£680	£800	£1,350	£1,800	£0	**£12,584**
Staff expenses	£0	£1,500	£0	£870	£190	0	£0	£4,368	£0	**£6,928**
Space hire	£300	£0	£0	£3,130	£2,300	£1,800	£0	£600	£2,880	**£11,010**
Service user travel	£0	£0	£0	£570	£0	0	£0	£1,000	£0	**£1,570**
Service user food/drinks	£20	£0	£0	£2,970	£530	£240	£1,710	£720	£1,140	**£7,330**

Other service user expenses	£330	£0	£0	£1,280	£0	£0	£0	£720	£0	**£2,330**
Design and printing	£150	£0	£0	£3,650	£1,800	£410	£1,000	£388	£600	**£7,998**
Other media / promotional materials	£0	£0	£0	£1,494	£3,275	£215	£0	£1,404	£1,000	**£7,388**
Other	£0	£0	£0	£0	£0	£9,935	£0	£0	£0	**£9,935**
Total	**£16,917**	**£40,758**	**£19,980**	**£40,000**	**£25,131**	**£18,600**	**£27,906**	**£20,000**	**£19,920**	**£229,212**

Appendix D. Indirect Reach, by SDP project

VCS Organisation	Activities	Estimated no. of residents indirectly engaged
Age UK	• Newsletters (postal and digital) • Social media K&C life newsletter - 14/05/2024 – 14,000 • Age UK website	19,621
Al Manaar	• Social Media, • WhatsApp community group chats/broadcast list • Word of mouth • Announcements at Friday Prayer • Staff social media accounts	30
BME HF	• Dissemination of flyers and information on social media channels • Distribution of flyers and information about the cancer screening programmes in estates in the bi-boroughs	1,745
Chinese Welfare Trust	• Promotion of Chinese-language pamphlets on cancer screening/symptoms at 12 different locations in Westminster • Social media promotion of Chinese-language cancer screening information Via Facebook, X/Twitter, website, WhatsApp groups, and third-party internal comms	1,422
FAWA	• Digital campaign on Beats 103.6fm’s website, Instagram, Facebook, Twitter, Instagram, and digital streaming service for a period of 4 weeks.	396,880
Mosaic Community Trust	• Word of mouth, community advocacy, focus group discussions and outreach work	170
VCKC	• Social media • Flyers	1,300

Appendix E. Ethnic breakdown, by SDP project

Ethnic Category	Age UK	Advocacy Project	FAWA	Al Manaar	BME HF	Mosaic	Chinese Welfare Trust	VCKC	Total
Asian or Asian British	139	16	0	21	200	111	151	90	**725**
Unspecified	5	0	0	3	0	0	0	0	**0**
Indian	12	2	0	0	6	2	0	45	**0**
Pakistani	10	6	0	2	9	4	0	45	**0**
Bangladeshi	4	6	0	8	20	44	0	0	**0**
Chinese	2	2	0	0	0	4	151	0	**0**

Other	36	0	0	0	17	19	0	0	**0**
Middle East	70	0	0	8	148	38	0	0	**0**
Black or Black British	58	20	140	1	201	10	0	360	**790**
Unspecified	2	0	0	0	0	0	0	180	**0**
African	18	10	77	1	140	9	0	0	**0**
Caribbean	22	9	41	0	27	1	0	90	**0**
North African	14	1	0	0	34	0	0	90	**0**
Other	2	0	22	0	0	0	0	0	**0**
Mixed Ethnicity	6	2	0	0	2	0	0	135	**145**
Unspecified	1	1	0	0	2	0	0	135	**0**
White and Black Caribbean	1	0	0	0	0	0	0	0	**0**
White and Asian	1	1	0	0	0	0	0	0	**0**
Black and White African	1	0	0	0	0	0	0	0	**0**
Other	2	0	0	0	0	0	0	0	**0**
White	181	12	0	0	8	2	0	180	**384**
Unspecified	5	0	0	0	0	0	0	90	**0**
Eastern European	7	0	0	0	0	0	0	0	**0**
Southern European	0	0	0	0	1	0	0	0	**0**
Western European	13	0	0	0	2	0	0	0	**13**
White Irish	7	1	0	0	0	0	0	0	**0**
Gypsy or Irish Traveller	0	0	0	0	0	1	0	0	**0**
White English/Welsh/Scottish /Northern Irish/British	126	9	0	0	4	1	0	90	**0**
White Other	23	2	0	0	1		0	0	**0**
Unknown/Other	71	4	0	0	0	1	0	135	**210**
Declined to reply	1	6	0	0	0	1	0	0	**8**
Total	**139**	**60**	**140**	**22**	**411**	**124**	**151**	**900**	**2262**

Appendix F. Age breakdown, by SDP project

Age	**Age UK**	**Advocacy Project**	**Al Manaar**	**BME HF**	**Mosaic**	**VCKC**	**Total**
<18	0	0	0	16	0	0	**16**
18-24	0	11	0	37	0	18	**27**
25-34	0	20	0	89	8	27	**41**
35-44	1	8	2	113	6	90	**140**
45-54	0	9	5	92	9	270	**318**
55-64	116	5	13	52	15	270	**443**
65-74	227	0	0	11	14	225	**362**
75-84	29	0	0	1	2	0	**101**
85+	68	0	0	0	1	0	**69**
Unknown	14	7	0	0	0	0	**402**

Total	**455**	**60**	**20**	**411**	**55**	**900**	**1919**

Appendix G. Additional Screenings Needed to Reach NWL Cohort[19]

VCS Organisation	WSIC Cohort (or proxy) Measure	Total Residents reached by project	Cervical Screening (25 to 49 years)		Cervical Screening (50 to 64 years)		Bowel Screening	
			Change in screening rates	Changes needed to reach NWL Comparator (Dec ‘23 - July ‘24)	Change in screening rates Dec ‘23 - July ‘24	Additional screenings needed to reach NWL Comparator (July ‘24)	Change in screening rates Dec ‘23 - July ‘24	Additional screenings needed to reach NWL Comparator (July ‘24)
Advocacy Project	People with learning disabilities	60	2.63% +1	38	+8	0	+3	2
Age UK	Over 50 population	2,570	N/A	N/A	+232	2,266	-193	3,050
Al Manaar	Indian, Pakistani, Bangladeshi population	95	9.05% +50	552	+25	164	+3	398
BME HF	BME population	1,011	15.02% +463	3,082	+48	1,258	-90	2,477
Chinese Welfare Trust	Chinese population	181	7.23% +41	567	+9	63	-8	156
FAWA	Black (African) population	140	34.61% +18	52	-10	47	-3	93
Groundswell Health	Dr Hickey / Great Chapel GP Practices	137	5.35% +3	56	-2	32	-17	124
Mosaic Community Trust	BME & Church Street Ward	125	-13	131	+8	38	-42	50
VCKC	Notting Dale Ward	900	+1	0	+6	1	-12	33

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[19] Green cells indicate that fewer screenings are required to meet the NWL average, suggesting an increase in screenings. However, these figures do not account for population growth. Therefore, in areas where additional screenings are needed, it may be due to a larger eligible population in July 2024.