Testing approaches to increase Cancer Screening in the Clyde Gateway area

Evaluation of Clyde Gateway's Enhanced Screening Opportunities Project

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CLYDE GATEWAY

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Executive summary

Background

Over a two-year period (April 2018 to March 2020), Clyde Gateway have been working with various partners to “narrow the cancer screening gap between Scotland’s most deprived communities, specifically within the Clyde Gateway area, and the Scottish average”. This work has involved the formation and delivery of five project strands in order to raise awareness of cancer screening opportunities, to engage with marginalised groups and to implement new approaches that encourage increased participation in screening. This evaluation been undertaken to highlight the main lessons from the project and to propose how this learning could shape future approaches to increasing cancer screening uptake rates at a local or a national level.

Key findings

Project members shared many short, medium and long-term perspectives on what the project was aiming to achieve. Specifically, interviewees commented on the need to: reduce inequalities in cancer screening; raise awareness about cancer screening opportunities; allow people to make informed choices about screening opportunities; explore new ways of working; better understand and address the barriers to screening in the area; understand and address the barriers to screening for identified population groups; and increase uptake in cancer screening.

Despite some personal and organisational differences, project partners shared many common perspectives. These included the rewarding and worthwhile nature of the work, the value of including local voices and the need to tackle an avoidable inequality. In addition, reducing inequality around cancer screening was seen to be dependent on various organisations with different perspectives and expertise working together effectively.

The exploratory and multi-strand approach was ambitious and unique, providing useful learning around partnership working, influencing services and how to engage more effectively with the local population. As one of several projects funded by the Scottish Government to address inequalities in access to screening, the approach was one of the more ambitious and complex projects. While this allowed greater scope for impact, it meant that persistence and problem solving were needed, as well as a commitment to partnership working and an acceptance that some approaches might not be as successful as intended. The coordination of the project by a regeneration organisation was seen to be unusual but

commendable. Multi-agency partnership working within communities is in keeping with the commitments set out by Scotland's new public health body, Public Health Scotland.

Several inherent or unavoidable tensions tested the delivery and impact of the project. These differences were both internal (within the project team) and external (relating to the services that the project team were seeking to influence), and related to:

1. ***Time and resources***: Availability of the skills required to deliver the project, limitations on the scale of impact achievable.
2. ***Organisational differences***: Working culture, practice and professional boundaries
3. ***Geographical and demographic factors***: working across different health and local authority boundaries, the eligibility of the population for screening with the project timescales.
4. ***Measurement***: The challenge of attributing project activity to increases in cancer screening rates.
5. ***Language differences***: Different preferences around how to communicate cancer screening messages between community members and health organisations and encouraging participation from people whose first language is not English.
6. ***The capacity of services***: The time it takes to influence services, whether they have the resources to initiate change and other aspects of service provision that were outwith the control of project members.

Meanwhile, the following enabling factors were described:

1. Developing a realistic theory of change to establish what would be possible and realistic within the two-year timescale.
2. Project activities aligned with, or supported, existing practice or services.
3. There was a willingness on the part of community members to take part and support the project.
4. Skills and resources were available to deliver project activities.
5. There was a willingness to work collaboratively and share information with other organisations involved.

Local context was recognised as an important factor in shaping the rate of screening uptake in the area and was used positively to engage the local population. In particular, it was felt that national cancer screening messages did not always resonate with people from the

Clyde Gateway area. Targeted messaging, which was delivered by residents at local landmarks were therefore used as a means of engaging with the local population more effectively. There was strong local support for the project and a willingness to be involved.

The project's sustainability and legacy are fundamental to its success. This will not be through the continuation of the project beyond the funding period. Several aspects of the project should continue to be developed and pursued independently by partners involved, however, it is arguably more important that the learning can be effectively applied elsewhere to help shape the delivery of services and approaches around screening, to raise public awareness of cancer screening, to illustrate how statutory, health and community services can work together effectively despite organisational and cultural differences, and to support national cancer screening policy.

Recommendations are offered on the possible benefit of revisiting the learning and communication messages at a later date, the need to understand the socioeconomic and demographic circumstances that shape screening attendance across different areas, the potential value in adopting localised approaches to communication around screening, and the value in continuing to deliver multi-agency partnerships to meet public health goals. Finally, this report recommends supporting increased or improved screening provision where it is sustainable and can be embedded within existing services.

1. Background and context

1.1 Project origins and development

Since January 2017, the Clyde Gateway led Population Health Joint Working Group have been meeting regularly to support partnership working between public bodies in the local area. The group aims to support actions to improve population health by sharing relevant information and through taking collective action. In June 2017, the 'working group' agreed to establish a Cancer Screening Inequalities Steering Group in order to take forward ideas that could support the delivery of one of their ten priority actions: "*Increasing cancer screening rates towards the city average*". To realise this ambition, the group submitted a project proposal to the Scottish Government's Cancer Screening Inequalities Fund, which was created to tackle inequalities in access to screening through financial support for localised approaches.

1.2 Project approach and aims

Having successfully secured Scottish Government funding, the group agreed to develop a two-year project to understand the relative low uptake of cancer screening (bowel, breast and cervical) among residents living in the Clyde Gateway area. The overall project aim was agreed as follows: "to narrow the cancer screening gap between Scotland's most deprived communities, specifically within the Clyde Gateway area, and the Scottish average". A set of objectives to support this aim were also agreed, as follows:

- To increase knowledge and awareness of screening programmes with a focus on specified target groups.
- To reach marginalised groups, for example adults with learning disabilities.
- To increase screening uptake for newly invited or individuals who haven't previously attended.
- To increase understanding of the barriers to attend screening faced by people in the Clyde Gateway area.
- To find effective interventions to address the barriers resulting in low screening rates in the Clyde Gateway area across all screening programmes.
- To assess the impact of the individual strands and overall approach of the project.

Achieving outcomes beyond the funding period were also incorporated with a view to:

- increase co-production and sustainable interventions
- facilitate involvement and engagement through working *with* people, rather than 'doing to' people, in order to increase community empowerment

- facilitate opportunities to develop social capital, through self-directed solutions to the issues faced by people within the community and target groups
- secure holistic regeneration of an area through improving the potential for long-term positive health outcomes.

To help meet these objectives and longer-term ambitions, five project strands were developed. This included two overarching strands called ‘Evaluation’ and ‘Communication’ and three distinct strands called ‘Community Health Pathways’, ‘Sandyford pop-up Clinics’ and ‘Adults with Learning Disabilities’ (AWLD). The Evaluation strand was included to support each strand to articulate their contribution towards the long-term ambitions of the project and to help them identify any data to help them describe what they did (activities), and what difference they made (outcomes). This process was shaped by available evidence and a theory of change methodology. The Communication strand, meanwhile, involved developing a strategy to engage with local people about screening attendance. This strategy was designed to support each of the three distinct strands, which were developed to test new approaches to raising public awareness of cancer screening (bowel, breast and cervical), to increase uptake and to raise awareness of the importance of attending among adults with learning disabilities; a population group that is less likely to attend screening than the general population. A summary of the approach taken and the key learning from each strand is provided in chapter 2.

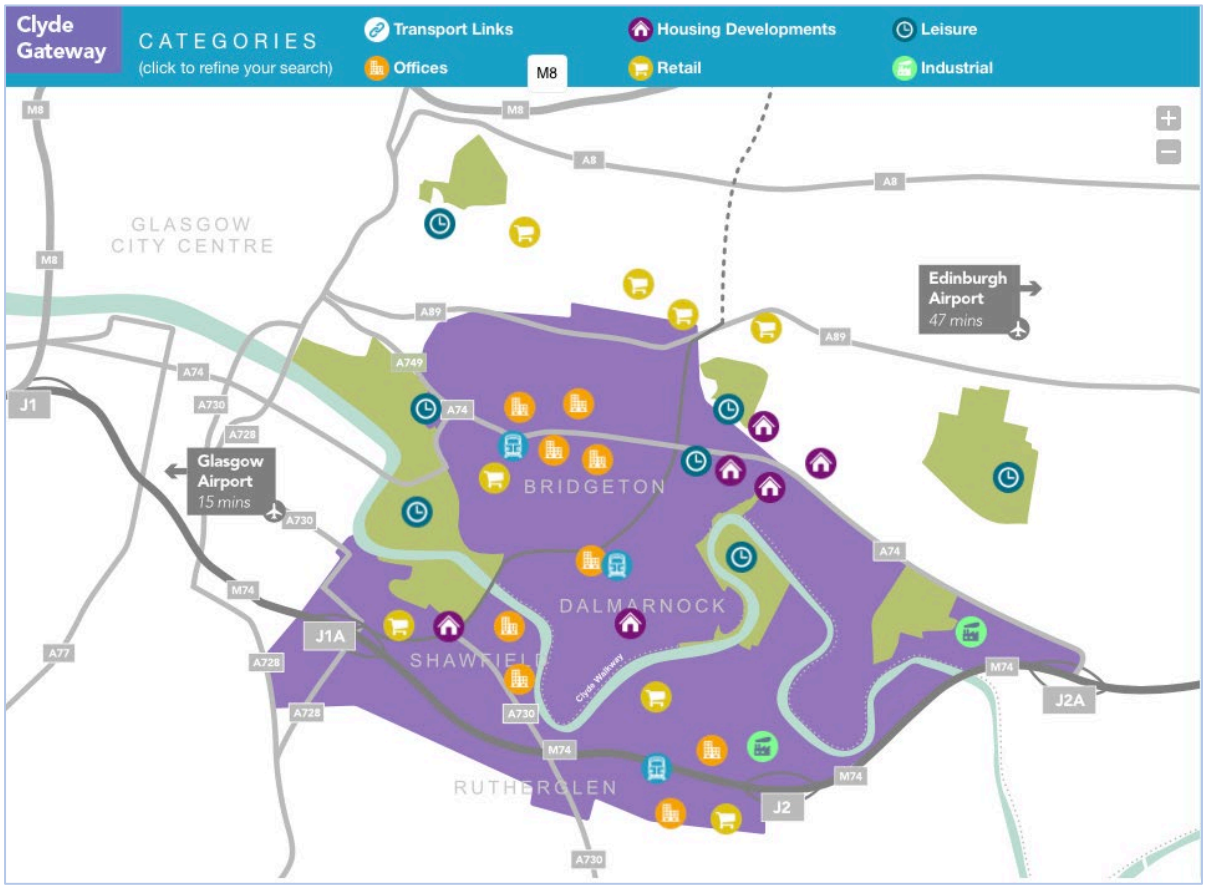
Three evaluation reports for the programme were completed in October 2018, April 2019 and April 2020 as a condition of funding. Additionally, each project strand was supported to develop their own outcomes framework and more detailed evaluation reports to inform the six-monthly programme report. Across the five project strands, activities have included engagement work to increase knowledge and awareness of screening programmes, exploring the barriers for local people to participate in screening, supporting people with certain protected characteristics (in this case people with a learning disability), developing service interventions to increase uptake and assessing the effectiveness of these projects. The project has involved partnership working between public, private and third sector organisations, by testing approaches that have the potential to be scaled up or embedded within mainstream service provision.

1.3 Clyde Gateway Urban Regeneration Company

The Clyde Gateway area covers 840-hectares within two Health Boards (NHS Greater Glasgow and Clyde (GGC) and NHS Lanarkshire) and two Local Authority areas (Glasgow City Council and South Lanarkshire Council). More specifically, it covers a large area in the

East End of Glasgow, including Bridgeton, Dalmarnock and Parkhead in Glasgow City, and Rutherglen and Shawfield in South Lanarkshire. The area has a strong industrial heritage, providing mass employment in industries like engineering, textiles, pottery, shipbuilding and printing until the 1960s. However, de-industrialisation and subsequent de-population took a heavy toll on the area, with the demolition of factories creating large swathes of contaminated land, while the loss of local facilities and employment meant that the remaining population lacked the necessary resources to live prosperously. Despite efforts to reverse these trends through projects like GEAR (Glasgow Eastern Area Renewal), the scale of the challenge and the state of the local economy[1] meant that a comprehensive and long-term approach would be needed.

Figure 1: Map of the Clyde Gateway area.



Source: http://www.investinclydegateway.com/location/clyde-gateway-map

In 2007, Clyde Gateway Urban Regeneration Company (URC) was established to deliver a 20-year programme of holistic regeneration. Three strategic aims were agreed:

- **Sustainable Place Transformation** – to focus on the overall infrastructure and environment of the area which in turn will increase its attractiveness as a place to live and work.
- **Increase Economic Activity** – to target major employers into the area and work with existing businesses to maximise growth which in turn will generate employment opportunities for local people.
- **Develop Community Capacity** – to ensure there is long-term investment in the community which will lead to increased levels of both community participation and private sector investment[2].

These strategic aims continue to be used as Key Performance Indicators for the organisation, and have been demonstrated through the delivery of several key infrastructure projects alongside economic and social interventions. Examples of which include the remediation of nearly 250 hectares of vacant land[3], building 2,700 new homes, the relocation of several businesses to the area including the refurbishment of the Olympia Building, where both Clyde Gateway and Glasgow Centre for Population Health (GCPH) occupy office space, significant improvements to public realm within town centre areas, support for local employment through the inclusion of procurement clauses, opening a new international sports arena to coincide with the delivery of the 2014 Glasgow Commonwealth Games, the development of major new transport infrastructure and a major new park development[4].

However, despite several positive developments, the local population continues to face many health-related challenges, including high unemployment and child poverty, a high proportion of single parent households, low educational attainment and the continued presence of vacant land[5,6,7]. These long-term challenges illustrate the complexities involved in shaping health on a population scale. Indeed, when considering the role of Clyde Gateway in shaping these indicators, it is important to note the impact of wider external factors such as political decisions, demographic changes, past individual experiences and behaviours, deeply embedded cultural factors and the reality that the impact of change within a population can take considerable time.

1.4 Cancer prevalence, incidence and screening uptake

Recent estimates show that 41% of the population of Scotland will develop some form of cancer during their lifetime[7]. New cases of cancer (excluding non-melanoma skin cancer) are predicted to rise by 33% between 2008-2012 and 2023-2027[8]. However, this is mainly due to an ageing population, with recent data showing that three quarters of new cases were aged 60 or older[9]. For all cancers combined, incidence rates are nearly a third (32%) higher in the most deprived quintile of the Scottish population compared with the least deprived quintile[10]. Meanwhile, mortality rates are 74% higher in the most deprived areas in Scotland than they are in the least deprived areas.

Uptake in screening is recognised as an important factor in shaping mortality from cancer because early detection is more likely to result in positive outcomes for patients. Across Scotland, uptake tends to be lower in areas of socioeconomic deprivation. Within NHS Greater Glasgow and Clyde, uptake for bowel screening follows this deprivation pattern, and is also lower among men, younger people (aged 50-54 years), people with learning disabilities and ethnic minority groups. Uptake for cervical screening is lowest among women aged between 25-29, women with learning disabilities and women from ethnic minorities[11]. Recent uptake rates for breast screening are not currently available due to a new IT system being implemented, however the most recent available data (2016) showed that women with learning difficulties were less likely to be screened than the rest of the population, with the lowest rates being found in the North East Health and Social Care Partnership (HSCP) of the city. Breast screening uptake was also lower in more deprived areas and among non-White women[12].

1.5 Scottish cancer screening policy

The 2016 Scottish Cancer Plan Beating Cancer: Ambition and Actions[13] includes a commitment to reduce inequalities in cancer screening (breast, bowel and cervical screening) through the allocation of £5 million for initiatives to help address barriers and issues for people who are less likely to engage. The strategy outlines the opportunities to tackle cancer through improvements in prevention, detection, diagnosis, treatment and after care. This includes a success indicator of *'a reduction in cancer health inequalities'* with ambitions to *reduce variation in survival rates among the least affluent and most affluent areas across Scotland'* and *'to empower people to make balanced and informed decisions around participation in national cancer screening programmes'*.

National Cancer Screening Fund

The project has been funded by the Scottish Government's National Cancer Screening Fund, which aims to tackle inequalities in access to screening projects, to support the development of innovative strategies and share learning to increase participation among those least likely to take part in the cancer screening programmes. To date (April 2020) more than £2.7 million of funding has been awarded to over 30 projects to tackle inequalities of access to screening in Scotland. These projects vary in nature and scale, from small projects targeted at individual groups, to larger projects supporting the wider aims of improving knowledge and understanding to promote increased uptake and accessibility. The Fund is running for a period of five years, from 2016/17 to 2020/21.

1.6 Evaluation of 'Enhanced Screening Opportunities in Clyde Gateway' project

In May 2019, Clyde Gateway approached the GCPH to undertake an independent evaluation of the 'Enhanced Screening Opportunities in Clyde Gateway' project. This work sits within the evaluation strand of the project and is intended to supplement existing information collated by Clyde Gateway and the various organisations involved in the project. This report presents findings from interviews with staff involved in the delivery of the project and learning derived from attending project advisory group meetings. It also draws on information already collated by partners, including each strand's theory of change, as well as the inputs, activities undertaken, levels of participation/engagement and any outcomes that have been possible to measure with the two-year timescales. In addition, six monthly reports to the Scottish Government have also been considered.

1.7 Evaluation aims and methodology

The purpose of this evaluation is to inform stakeholders, partners and practitioners of the outcomes and lessons learned from this programme of work and to propose how this learning could shape future approaches to increasing cancer screening uptake rates at a local or a national level. To meet this expectation, the GCPH agreed to collate monitoring information from the five project strands and to expand on the reporting currently provided to Scottish Government. In addition, interviews took place with project leads and other identified stakeholders to explore the challenges and successes. In total, 11 interviews took place with 14 participants. Where agreed, joint interviews took place with two members of staff working on the same project strand. With the exception of 'Evaluation', the interviews included at least two representatives from each project strand. A topic guide was developed

based on conversations with staff involved in the delivery and evaluation of the project (see appendix). The semi-structured topic guide afforded the interviewer some freedom to explore emerging ideas and to tailor the interview to the project strand being discussed. Interviews took place at a location that was convenient to the interviewee between August and September 2019.

2. Description of project strands and key learning

This chapter includes a brief summary of each project strand, including what each aimed to achieve, what activities took place, who they reached and what impact it had. Each strand summary has been developed by drawing on learning from the interviews and by reviewing the evaluation reports submitted to the Scottish Government.

2.1 Evaluation

The evaluation strand of the programme – one of two overarching project strands – was developed to provide evaluation support to Clyde Gateway URC to coordinate and deliver the project, as well as to support each of the individual strands within it. With input from a Public Health Intelligence Adviser from NHS Health Scotland, the strand developed a programme theory of change and an outcomes framework template for each strand. Project members were supported to develop and populate these documents. Staff from each strand were asked to describe their contributions to the overall aim of reducing screening inequalities, to articulate feasible outcomes within a two-year funding period and to identify dependencies on activities outwith the scope of the project. Support was provided through workshops, *ad hoc* evaluation advice, input at steering group meetings and/or on a 1:1 basis. This report also sits within the evaluation strand of the project. The addition of an independent evaluation is intended to bring together project learning in an impartial way. It has allowed project members to offer confidential feedback on what worked well, the challenges and if/how they were overcome, what should be sustained beyond the project timescales and whether this type of project could be delivered elsewhere.

Key findings

The interim work undertaken in this strand provided the basis from which the project could be delivered. Unlike other strands which involving testing or delivering approaches or engaging with the local population, this strand cannot be assessed through measures of reach or impact. Instead it involved supporting several organisations across various sectors to strategically plan and deliver their strand of work. Feedback from these members shows that it was highly valued as a means of framing the project, understanding its likely impacts on the population and for setting realistic targets and ambitions. For some, this was helpful for considering the difference between population level impacts and individual impacts. Feedback on this aspect of the project was largely determined by the type of organisation that a project member worked for. Those working for community organisations were more likely to describe the process as complicated and not in keeping with how they usually planned projects.

2.2 Communication

Communication – the second overarching project strand – was coordinated by Clyde Gateway URC to support the delivery of the other three operational strands: Sandyford Pop-up Clinics, Adults with Learning Disabilities and Community Health Pathways. Local organisations in the Clyde Gateway area were also encouraged to support the communication campaign, including a local housing association and a major sports organisation. This work involved procuring a specialist communications company to review existing national screening messages, the development of a communications strategy (which included a locally tailored campaign and dedicated website), testing the strategy with local residents and groups and establishing which social media platforms would be most effective at engaging the local population. Local residents also engaged with the 'don't skip your screening' campaign by volunteering to be photographed holding up a screening message in various locations throughout the Clyde Gateway area. The website includes advice on cervical, bowel and breast cancer screening regarding why it is important and what it will involve, as well as information to alleviate concerns and support on where to go to get screened. User behaviour on Facebook, Twitter and the dedicated website was monitored to assess reach and impact. Thenue Housing Association also contributed to the delivery of the strand by embedding screening messages within their core service provision, by using their media channels to share screening messages and by supporting their new drama group to consider the issue of screening.

Key findings

The website developed for the project received almost 3,000 unique visitors between November 2018 and March 2020, with most of these (75%) arriving via social media. Meanwhile, radio adverts aired on CamGlen Radio were estimated to have been played around 375 times since October 2019, reaching around 16,000 people.

Thenue supported the delivery of this strand by embedding screening and wider health and wellbeing messages in their community development courses, as well as by publishing social media posts (over 900 people viewed the Facebook material). Participants involved in community development courses were said to have engaged well with the screening material and had used this learning positively through their own actions or by encouraging others to be screened. Meanwhile, the success of the Nae Drama performance has led to further funding to deliver performances in five new locations.

2.3 Adults with learning disabilities

Adults with learning disabilities were identified as a population group with low uptake of cancer screening within Greater Glasgow and Clyde. To address this inequality, People First were commissioned, through a tendering process, to co-produce and deliver a course on cancer screening awareness. The process was informed by a course developed in Ireland called EMBRACES-ID (Early Monitoring of Breast and Cervical Screening: Intellectual Disabilities), which is a tested and validated course to raise awareness of screening among Adults with Learning Disabilities. The project was developed to support the adaptation and delivery of a programme by peer educators (People First members) to suit a Scottish context. A core group of adults with learning disabilities were recruited and were trained by the North East Glasgow Health and Social Care Partnership as cancer coaches. A key objective for this strand was to increase awareness of cancer screening among this population in the North East Glasgow; an area of the city where cancer screening rates in this population group are particularly low. Through the development and delivery of the course by peer educators, it was hoped that that more adults with a learning disability would be able to make an informed choice about their screening attendance.

Key findings

Seven female People First members developed their knowledge of cancer screening by attending First and a number of external agencies including the EMBRACES-ID programme. This involved four, two-hour sessions. Five two-hour facilitated sessions with NHS Health Improvement and the University of Glasgow then took place to co-design the sessions and alter the course content in a co-productive way. The project has had interest from other female members at People Mainstay, Enable and PAMIS. Unfortunately some organisational differences prevented this strand from being delivered as intended and partners ultimately decided to pursue separate approaches to the development and use of the learning resource. This will allow both organisations to take forward ideas that are in-keeping with their organisational identities and values. It is intended that a version of the course will be developed by People First to be delivered by its members. This version will be adapted for a Scottish context using activities that are deemed appropriate and useful to its members. Meanwhile, the HSCP intend to develop a version for use in a health setting, to be delivered by health staff.

2.4 Sandyford pop-up clinics

Pop-up cervical screening clinics were developed to engage women aged between 25 and 64 living in the Clyde Gateway area who had previously defaulted from attending screening. Partner organisations for this strand include Sandyford Sexual Health Central Services, NHS GGC Primary Care Development, Jo's Cervical Cancer Trust, Cancer Research UK and the North East Glasgow HSCP. Sandyford delivered monthly Saturday clinics for a year (with an additional two evening clinics toward the end of the project). Cancer Research UK and NHS GGC Primary Care Development engaged with 15 GP practices to encourage them to identify and recruit defaulters within their practice to attend these clinics. Jo's Cervical Cancer Trust and the North East Glasgow HSCP provided social support to women attending the clinics.

Key findings

Final data for the project shows that 105 people attended 12 clinics between August 2018 and November 2019. Of these, 93 women were screened with no cytology in the past three years. For those who provided postcode data, (n=72), 64% were from an area designated as within the 20% most deprived in Scotland. Women who attended the clinics stated that their experience at clinic was good and they would attend their GP on the next occasion that they were called for screening. They also stated they would encourage family and friends to do so. However, feedback from nursing staff was that new/pilot clinics have taken time to become busy and many were underutilised. Some nursing staff thought that word of mouth would be important for new/pilot clinics to become busy. However, another view was that there was potentially less buy-in from GP practices (because staff were less invested in the outcomes) when the cervical screening was conducted by an external organisation away from the practice recruiting attendees. These findings suggest that although the right women were reached and the experience for those attending was generally positive, this strand of the project has not significantly increased participation in screening within the Clyde Gateway area.

2.5 Community Health Pathways

'Healthy n Happy' is a community development trust located in Rutherglen, North Lanarkshire. The trust has been responsible for taking forward the Community Health Pathways strand of the project, with support from NHS Lanarkshire. The strand has been developed to generate learning on how to effectively deliver cancer screening services in the areas of Burnhill and Rutherglen. The project aimed to increase awareness of cancer screening opportunities, the process involved in being screened, and the offer provided by services. As a first step, community engagement and consultation took place with residents to gather local intelligence on their screening habits, the barriers to screening and what could encourage them to attend more regularly. This work revealed that many local people found it difficult to attend screening programmes and that there was a preference for more flexible options to be introduced. This feedback was taken on board and used to shape the next phase of the project, which involved working with GP surgeries to offer more locally appropriate solutions. Latterly, team members worked with services to align them with community needs, while grassroots community work took place to encourage local people to attend screening.

Key findings

337 local residents completed a grassroots engagement survey at the beginning of the project. This was completed through door to door engagement, street interviews and in activity groups in the local community of Burnhill. The survey achieved more responses from females than males (69% vs. 31%), 72% were registered at a GP practice at the Rutherglen Health Centre and a large proportion stated that they always attended screening appointments. The survey provided useful information on screening attendance, with 33% stating that they struggled to make appointments. There was a strong preference for more flexible options to be offered across the day, evening and weekends. Ongoing work with GP practices has focussed on engaging more effectively with screening defaulters and offering more flexible appointments. This has been limited to some extent by the availability of funding to deliver these options, although the need to go through a Quality Improvement process has provided a means to secure funding for some. An information campaign delivered by Healthy and Happy was supported by 47 residents involved in local activity groups, with 27 local residents initially being recruited and 8 becoming 'faces of the campaign'. COVID-19 has put this work on hold while Healthy and Happy support the community during this challenging period.

3. Findings

The following section principally includes findings from interviews with project stakeholders (11 interviews with 14 project members). The project advisory group, which has been chaired by Clyde Gateway staff and includes representation from each of the five project strands, was also attended to keep up to date with ongoing project developments. Although these meetings were not recorded and members are therefore not quoted here, our attendance was important for assessing project developments at different time points, observing relationships and for monitoring changes in opinion over time. The findings are presented under headings that were derived from the thematic analysis of the interview transcripts.

3.1 Project purpose

Interviewees were initially asked to comment on the overall purpose of the project. Responses to this question could be categorised as short term (e.g. awareness raising and testing new approaches to service delivery), medium term (e.g. increasing screening uptake) or long term (e.g. reducing inequalities in cancer screening).

Given the short timescales involved, raising public awareness was felt to be an important and realistic ambition. This was seen to be a necessary precursor to the longer-term ambitions already described.

> *"For our part, it's definitely been about raising awareness and informed choice."*

> *"To raise awareness of future opportunities to participate in screening, whether that's cervical, bowel, breast, and you would know where to go and questions to ask, and it would reduce some of the fear factor. It had to be one of the main objectives, as opposed to the uptake of screening."*

> *"Awareness raising and trying out different ways of working and new services to see if they can make a difference in knowledge and awareness, and ultimately improve uptake."*

However, one interviewee felt that although awareness of cancer screening opportunities had increased, they were unconvinced that this had led to an increase in the uptake of screening. Another, meanwhile, felt that it would be difficult to demonstrate a considerable increase in uptake within the project timescales, and that raising awareness was therefore a more realistic ambition.

"I can see that awareness has gone up. There's no doubt about that. But what is probably more difficult, the NHS I'm sure can track it, what's happened in terms of the amount of people actually going. How is this affecting the bottom line?"

"I suppose to improve uptake rates was one of the aims. However, in the short period of time you'll not be able to demonstrate that… I think awareness raising is probably an important aspect."

Testing new ways of working or approaches to service delivery were also described as important pathways to increasing screening uptake.

"It seems to me that the purpose is to try lots of different things in a concentrated area to increase not only screening, but people's knowledge of screening and why it's important."

"Trying out different ways of working and new services to see if they can make a difference in knowledge and awareness, and ultimately improve uptake."

Others, meanwhile, commented on the longer-term ambition of tackling inequalities in cancer screening.

"The purpose of the project is essentially to explore methods, opportunities, and other things… that would actually reduce the inequality gap for screening."

"I understand the whole project is about looking at reducing the cancer screening gap, the inequality, in the area of Clyde Gateway, as opposed to the national average."

3.2 Targeting attendees

The ambition to reduce inequalities in screening attendance raised an important question around how inequalities are measured and who should be targeted for attendance. On the one hand, a universal approach to increasing screening attendance might help to reduce area-based measures of inequality (e.g. SIMD). However, to ensure that those furthest removed from screening are reached, it was expressed that a targeted approach is needed. This included identifying under-represented population groups and people who had defaulted from past screening appointments.

"The approach we've taken has been shaped on the evidence about reducing inequalities and targeting defaulters."

"We decided quite early on to target… a practice or a number of practices each month so that they could letter or text the women who were on their defaulters list, and try and encourage them to come, rather than having it as a big, wide, open drop-in."

Adults with learning disabilities were selected for inclusion because of the barriers they faced to attendance and their subsequent low uptake in screening programmes.

"Adults with learning disabilities have a really low uptake for cancer screening compared to the general population, so we wanted to do some work to address that."

"Women with a physical disability don't really have access to screening because if you go to the GP they don't have the equipment to carry out that. So, they're kind of a hidden and forgotten population, really."

Other screening defaulters or population groups with low screening attendance were identified and targeted in some practices through using a more personalised approach. For example, Polish residents were identified as having high defaulting rates through analysis. Therefore, targeting Polish residents by translating attendance letters into their first language was seen to have been a simple but important 'opportunistic win' for the project, and an indication that population-specific approaches could be effective.

"Actually, one of our biggest successes was a particular practice that has a large Polish community, and we provided a translator, and the letters actually went out in Polish."

"A big Polish contingent turned up to that space, so that obviously worked."

3.3 Personal barriers to participation

Feedback on the need to improve public awareness on screening led to comments about the barriers to participation in the area. These comments reflected the survey feedback from local residents as part of the Community Health Pathways strand (already provided in chapter 2). Debunking out-dated myths around what the process would involve was felt to be important, as was the need to provide a positive experience that could encourage future attendance.

> *"Some of that has been about myth-busting."*

> *"The main thing is embarrassment, the fear that it's going to cause any pain."*

> *"With many of them, it's been a fear of coming, and if they come and the nurses are kind and gentle and nice and it's not as bad as they thought, then maybe they will come the next time."*

Another barrier was the fear of bad news. This issue was conflated with other everyday worries and the impact of poverty on people's resilience to cope with multiple challenges.

> *"I don't want to know the outcome, what if it's terrible?"*

> *"It's not their priority at that moment if they're trying to pay for their food shopping or the electric, they're not wanting to add another fear about cancer into their lives."*

Other logistical barriers were transport, childcare and other competing priorities.

> *"I don't have transport, it's too far away, I don't have time…"*

> *"We know the pace of life has changed and women more often than not are possibly working or have childcare commitments. So, they're trying to juggle lots of things."*

Finally, and not necessarily mutually exclusive from the other reasons, getting screened was described as simply not being on people's radar. Although other worries could be a factor in this, it was also felt that national screening messages were not effective at encouraging attendance in this part of the city.

"If the intention of the national campaigns was to increase the uptake of screening, awareness of the signs and symptoms, etc. then weren't they being as effective in this area?"

"I feel that there's a lot of money invested in… campaigns and things, but from the local community perspective, they're not working.

3.4 Encouraging local participation

As an acknowledgement of the importance of local context to screening uptake, an overarching communication strand was established. This allowed project members to explore ways of engaging more effectively with the local population, both through encouraging participation in the campaign and by reaching people through screening messages.

"I think that the whole point of the fund was to look at local solutions to it… And I was quite interested, actually, when they specifically took a comms strategy that was changing the national messages for that local population."

When offered the chance to support the project through the *'Don't skip your screen'* campaign, several local people expressed an interest in supporting the cause.

"We had local people, we had 17 local people who volunteered to say: I will stand up with a sign in front of me. You can put whatever you like on it. I want to be part of this."

Involving local people in the campaign was said to be important for engaging the wider population and ensuring that people could identify with it.

"So, by getting buy-in through having local people, local faces, led by local people, staff living in the area, I think that's fundamental to then create this momentum where people start to care and engage with it."

"It was important that we spoke to that local audience, and through speaking to that local audience, it was having local people telling their story. Almost being ambassadors for the project."

"You feel that sense of belonging and it's not some wide strategy that's way up here, no, this is for me, I live here, this is my locality. And I think that was quite genius of them to recognise the importance of that."

Community members also played an important role in the delivery of the AWLD strand. Local 'cancer coaches' were recruited to help shape and deliver a cancer screening awareness course, which was adapted from a training course previously developed and delivered in Ireland. For this strand, local people with a learning disability were asked to attend the course with a view to becoming peer educators. The peer delivery approach was felt to be important in changing the power dynamic between those delivering and attending the course, as well as for breaking down barriers in relation to the subject matter.

"It reduces the feeling that they're in a classroom, the fear of the teacher, don't ask any stupid questions, that just goes. The embarrassment also goes, given the nature of the topic, there can be a bit of embarrassment, a bit of red faces, a few giggles here and there, that kind of thing. But that's definitely less when you take away the power dynamic, the teacher-pupil thing, and just make it more like a peer session."

Another important aspect of local identity was the use of recognised locations and landmarks within the Clyde Gateway area. These locations provided the backdrop for local people to be photographed while holding up messages that were intended to encourage screening attendance.

"What we also then did was looked at various iconic or well-known buildings in the area, so when you look at the images, you'll see they're standing outside Bridgeton train station, or the umbrella, or Shawfield stadium, or whatever, so that you're seeing a local person and a local venue."

However, despite the positive role of local people and landmarks in supporting the project's delivery and ensuring that messages were received, challenges arose when feedback from local people was used to shape some of the marketing messages. For example, some healthcare staff felt that the preference to use colloquial language – including the use of humour and slang terms – to describe body parts or the screening process was not felt to be appropriate for use in a healthcare setting. While local people argued that this could be an effective way of breaking down personal barriers to screening attendance, staff highlighted the need to use anatomically correct language in order to ensure accuracy and avoid sensitivities (particularly in relation to sexual health).

"One of the most significant challenges early doors was that {name of organisation} would not approve any language that was not anatomically correct."

"They were using colloquial language, which they said they had worked in the community and that's the kind of terms that people recognised and wanted to hear, but {name of organisation} were saying 'we will not use language that is not proper terms for body parts'."

"This is the feedback from the community, we've tested these messages, and these are the people that are saying this is what they want."

This highlighted an important tension between community aspirations and the NHS professional duty of care to provide clear, accurate and relevant healthcare information that is based on up-to-date clinical guidance[14]. Indeed, although bringing together third sector, public sector and clinical organisations was felt to have been beneficial in many ways, inherent challenges arose. These challenges manifested as a result of different ways of working, the time it takes to influence services or practice and the complex nature of the work involved.

"The relationships were, as any other relationships can be, they're sometimes strained and sometimes not. But that's partnership working."

"What I've found is that organisations have different ways of working and different objectives and things like that, but this has been quite complex, quite a complex bit of work, for people involved."

"I probably would have liked to have seen more dovetailing of community with what the practices were doing, but it's just the age-old nature of the way life is very fast for GPs, and they're just getting on with it."

3.5 Project coherence and partnership working

The inclusion of five project strands was said to be ambitious compared with other nationally funded screening projects. Despite working to the same overall objectives and providing regular updates at advisory group meetings, the three distinct stands were reported to have largely worked independently. It should be noted that these strands were not created with the intention that they would work together; instead they were designed to test the effectiveness of different approaches.

> *"I wouldn't say we worked closely with them [the other project strands]."*

> *"I did feel it was a series of separate projects, and I would have liked to have seen a wee bit more linkage."*

> *"They've worked as intended… whether there's linkage between them, it's limited."*

> *"So, operationally, no, because the remits are geographically different. But where there are opportunities to share practice, resources, that has happened."*

The Adults with Learning Disabilities (AWLD) strand was described as taking a slightly different approach to the other distinct strands in that it had a population group focus rather than a geographical one (i.e. testing approaches within the Clyde Gateway area).

> *"Our focus has been on learning disability which, for want of a better way of explaining it, doesn't vary by locality."*

> *"we've not had a huge involvement with the other strands, so our focus has definitely been much more on the adults with learning disabilities."*

Organisational differences were notable within this strand. In particular, disagreement over the content of the course being delivered could not be resolved by a solution that suited both parties. Although based on an existing course that had been tested and validated in another country, aspects of it were felt to be unsuitable for use in a Scottish context. In addition, as levels of learning disability could vary widely, it became difficult to create a set of course materials that could meet a range of learning needs. It is important to note that it may not always be possible to ameliorate personal or organisational differences. However, it was felt that establishing expectations at the outset may have led both parties to consider whether it would be possible to find common ground.

"I think maybe having had clearer objectives at the very beginning, knowing exactly, almost like a working agreement type of thing at the very beginning would have been helpful."

3.6 Influence and attribution

The evaluation strand of the project involved setting realistic and evidence-based objectives by developing a theory of change. For community organisations involved, this process was reported to be quite complicated as it was not in keeping with how they would usually approach a new project or piece of work.

"I'm thinking community-based organisations, that might not be as used to dealing with logic models as a way of reporting or planning their work, then that could be a bit intense."

"Sometimes I think it was a bit complicated for people."

For others, meanwhile, the process was said to be valuable in providing coherence, ensuring accountability and establishing what might be feasible with the resources and time available.

"I think it's just helpful, particularly when you've got so many strands and so many partners, it's a good way of everybody being accountable for what they're saying they're doing."

"That was really useful … The driver diagrams and stuff were really good, and I've used that stuff for different projects."

"I think you have to know these parameters and have that research as your starting point to build the campaign around that and make sure you're hitting the right message. That's vitally important, actually."

Importantly, this process helped to set realistic parameters and expectations by highlighting what would be required to increase screening in the population by just 1%. This allowed project members to realise that tackling health inequalities would be beyond the scope of a small-scale two-year project.

"It still is a concern, that we're not going to shift the curve, that 1% shift, on a significant population level. And we recognise that in the framework in that we're

talking about micro activity, and it's the idea of testing something at that level to establish what could then, if you were able to resource and shape and support that approach, get that shift."

"I think there's often a lot of pressure from funders or other stakeholders to see a massive difference, so if screening uptake is 40%, they want to see it at 80% or the expected national levels, and that's just not realistic for the timeframe and the numbers of people they're working with."

"If we're looking at being able to really tackle the screening inequalities, it's going to take a generational change. I don't think these things can be done over a year or two year or five-year period."

Additional concerns were raised around the ability to attribute project activity directly to uptake and whether the right people were attending the clinics (i.e. those who faced the greatest barriers to screening or had not attended recently).

"Are you increasing inequalities by getting the wrong groups in there? Are you providing the service to people that would have gone to their GPs normally?"

"We didn't want to open the doors up and have lots of women coming in, if that meant that the targeted women then weren't getting a slot."

"When you start to look at the uptake of the programmes, from where we get our stats from, you can't attribute it to this project. But what we will be able to say is "this is what we've done in this area."

3.7 Working with service providers

Where attempts to influence service provision had been made (either through the Sandyford Strand or through Community Health Pathways), a number of challenges were described, such as competing demands, the time it took to implement change and the difficulty of changing long-standing practice.

"Even while GPs are up for it, it's really hard to engage with them and to look at how they're going to do things differently. But that isn't unique to the screening and inequalities fund."

"Just the length of time when it comes to trying to affect service change."

"When you've got a system that runs forever, people just don't think about going in and looking at that and seeing how it can be tweaked or changed, or looking at any of the barriers."

"I'm not saying that GPs aren't interested in their patients, but it depends where it sits on their list of priorities and how much they believe in the screening process, what benefits and drawbacks they see."

Where changes had been achieved, these generally came about when a practice was sufficiently resourced to take on additional work, where there was a strong will to do so or they were required to do so for Quality Improvement [QI] reasons.

"I think {name of area} will get that level of detail because the GPs are doing a quality improvement project."

"The fact that they have this quality improvement process, the GPs are kind of familiar with the fact that they need to go through that and then will package an offer… you usually have to try and convince GPs without any resource to go through that process, so we were able to offer that as an incentive."

"It was an incentive for GPs that they needed to do a QI, basically do a plan around something that they want to improve, and this could be an easy win for them because they could use this project to basically achieve that outcome for them and there was some resource attached to it."

Positive relationships with GPs and other practice staff were said to have been developed and could be built on further in the future.

"I think that's probably the best part of it, the physical engagement with practices who are keen to be involved, so we get invited to the practice meeting to talk about it for ten minutes so that GPs understand the context and the rationale for it, see what they can get out of it."

"I built really good relationships with a few GPs, a few practice managers, and so our objectives are the same, as the project objectives, that is to increase uptake, and

also to upskill primary care staff in terms of their engagement approaches rather than just looking at the list and okay, must do better."

3.8 Project impact and sustainability

The project's impact was mainly expressed in terms of process learning (i.e. learning derived from the approach taken). The ambitious, exploratory and co-productive nature of the project, which brought together third and public sector organisations, was felt to be commendable. This approach was not without challenges and it was recognised that important learning could also be derived from what did not work.

"It really depends on how this all comes together and what it's telling us, or we might find that it hasn't worked, and we need to explore why."

"I think it probably has been a really good example that actually all these organisations are working together with a similar aim. So, I think that has been really good as well… we've probably managed to do quite a lot in the timeframe."

"Would it have been easier for us just to do one thing? Just any one of those strands? Yeah, probably it would have. Would we have got as much learning out of it? Probably not."

However, despite providing useful learning for those involved, concern was expressed around how this was being captured and whether the funder's feedback requirements were sufficiently detailed to be able to evidence the impact of the project.

"I think the reporting is more of a tick-box at the moment. It's not really an evaluation at all, it's just "tell us how you spent the money", it's an accountability thing rather than really critiquing what's been done."

Impact was also considered in the context of being able to scale-up the approach. Some project members were optimistic that aspects could be scaled up, while others were more cautious.

"This has been done on a small-scale budget in a small geographic demographic area. But there's no reason this couldn't be used as a bit of a blueprint for other areas to adopt."

"It's very micro-level, but it's about piloting types of practice that actually could make a difference, and getting a sense of what worked and what didn't work."
"I suppose everything we've tried to look at is whether we can make it a sustainable change. I'm just not sure we're doing it to a scale that it would actually really upscale immediately after the project."

Influencing local practice and capturing learning that could be replicated or scaled up in the future were described as the main priorities for the project in its final stages, as opposed to trying to secure additional funding to continue the project. The sustainability of the project was said to be dependent on the learning being used or existing work being taken forward by the Scottish Government, community organisations and health providers.

"It's not our intention to continue with the project. It was never about that; it was about gathering this data on what works, what we collectively or as a community think doesn't work, and what could be embedded within core service provision."

The sustainability of the Sandyford strand of the project was questioned due to the use of pop-up clinics and the reliance on funding.

"I think there are a whole load of ways that the project could have been more sustainable that we've perhaps missed the boat on at this point."

"I think this is not a sustainable model (pop-up clinics), and there are women that are benefiting from it but once the money runs out, what's going to happen to those women?"

"I think there does seem to be a bit of reliance on government funding to stimulate this work… If it was going to be sustainable, you kind of want the business as usual people to reconsider how they deliver their current services and take these lessons on board."

Comments from interviewees involved in the Sandyford pop-up strand and Community Health Pathways advocated a practice-led approach, whereby GPs would seek to improve their screening offer by drawing on learning from specialist services.

> *"For it to be sustainable, it has to be practice-led, in my view. And I'm basing that on the fact that when other practices have done this as a practice-led initiative, it has been successful."*

> *"The money could have been used for these nurses to come out and help GP practices."*

However, despite not being sustainable, a counter argument to this was that well-run and person-centred temporary clinics could encourage people to attend their General Practice in the future.

> *"I suppose the cervical screening pop-ups are not sustainable, you can't keep doing that. But it's about that learning that might filter through to the practices to change some practice."*

Indeed, perceptions on the long-term influence of the Sandyford strand appeared to change over the course of the project. This was largely because people furthest removed from screening were being reached and having a positive screening experience. Advisory group members commented that this might encourage people that were furthest removed from the screening process to attend their GP for screening again in the future. Overall, however, embedding change within mainstream services was regarded as the most effective and efficient way of ensuring that the project had a lasting impact.

> *"The beauty of our part of it, if you like, was that this wasn't a stand-alone project, we were just embedding that message in things that we already do."*

> *"The other thing for me, and I'm not just relating it to this but other strands of health that I've worked on in the past, is the more you can embed this in what an organisation already does, the more likely you are to have success because the staff are already trusted."*

For the AWLD stand, partners ultimately decided to pursue separate approaches to the development and use of the learning resource. This will allow both organisations to take forward ideas that are in-keeping with their organisational identities and values. It is intended that a version of the course will be developed by People First to be delivered by its members. This version will be adapted for a Scottish context using activities that are deemed appropriate and useful to its members. Meanwhile, the HSCP intend to develop a version for use in a health setting, to be delivered by health staff. As of January 2020, it was agreed that this strand of the project would finish and any future developments would be taken forward independently of the project.

4. Discussion

This section considers what these findings could mean for future policy and practice in relation to screening, as well as how they sit alongside wider contextual factors. It covers the important enabling factors for the project, the inherent challenges, the value of the partnership approach, how local identity shaped the project and how sustainable the approach has been. Beyond this, consideration is given for the potential for investment in projects like this to shape health inequalities and how the impacts of Covid-19 might influence future screening attendance.

Enabling factors

Learning from this project has shown that several enabling factors were important to its delivery. These factors were not necessarily unique to the project; instead they are principles of good practice that we would recommend following if a similar project was delivered elsewhere. For example, developing a theory of change was important to establish what would be realistic and possible within the two-year timescales. Meanwhile, encouraging community members to take part and support the project helped to generate momentum and buy-in, while the willingness to work collaboratively and share information was important for building transparency and trust between project members from different organisations. Finally, and although the project wasn't entirely developed on this principle, ensuring that project activities aligned with or supported existing practice was important for sustaining them in the long term.

Inherent challenges

Several inherent or unavoidable challenges tested the delivery of the project. This included the capacity of services and the time it can take to influence them, organisational differences such as working culture and practice, geographical and demographic factors such as working across different health and local authority boundaries, the eligibility of some members of the population for screening within the timescales (i.e. screening typically takes places every three years), the ability to influence change on a significant scale and the availability of the skills and expertise required to deliver the project. Measuring success was another important challenge across strands, and in particular attributing project activity directly to cancer screening rates. Finally, language differences presented a challenge, both in terms of engaging people whose first language was not English, but also between local people and health professionals regarding the communication of cancer screening messages.

Place-based multi-agency approaches

This project, and the multi-agency approach of the wider Public Health Joint Working Group, aligns well with Public Health Scotland's commitment to supporting local partnerships and adopting a whole systems approach, which supports and enables others to take action across organisational boundaries[15]. Although not without challenge, the project has also highlighted the benefit of bringing together public, private and third sector organisations to meet local needs.

Embedding local considerations in national screening policy

Local context has been an important factor in shaping how the project was designed and delivered, with local people engaging positively throughout the process. This serves not only to raise awareness of screening and the importance of attending; it also helps to build community cohesion around an issue that affects everyone. Taking a locally specific approach to how messages are communicated may be particularly important in areas with a distinct identity or where local people feel disconnected from decision-making processes.

Sustainability

The project's sustainability and legacy will determine whether the resources assigned to it were well spent. This will not be through the continuation of the entire project beyond the funding period. However, there is clearly value in continuing to develop and pursue some aspects of the project independently where good relationships have been forged and practice can be shaped to meet local needs more effectively. It is also important that project learning can be effectively applied elsewhere (either at a local or national level) in order to raise public awareness of cancer screening, to determine how screening services can be delivered in ways that reflect public needs and to better understand how statutory, health and community services can work together more effectively.

Understanding and tackling health inequalities

Health inequalities result from the unequal distribution of income, power, resources, knowledge and opportunities. Although several factors are known to shape health, transformative public health responses generally require investment in a large population over a prolonged period and/or significant legislative changes. Notwithstanding this, the specific pathways from an intervention to a health outcome can be difficult to quantify. Here, the intention has been to raise awareness and increase opportunities for people to exhibit a positive health behaviour (i.e. attending screening more regularly). With sufficient engagement and resources, this could eventually result in a reduction in cancer mortality rates. However, while this project has been effective at engaging people with no cytology

(tests used to detect cancer) in the past three years and has predominantly engaged with people from socioeconomically deprived areas, new screening attendance has been insufficient to considerably affect population statistics. This is not to suggest that this aspect of the project has not delivered benefits, but instead that it is important to understand what is realistic within the confines of a resource-limited and short-term project. Given the concerted effort to raise awareness of screening through the project's communication campaign, it will be beneficial to monitor screening attendance (cervical, bowel and breast) across GP practices within the Clyde Gateway area for at least the next three years, using the start of the campaign as a baseline for measurement.

Providing flexible screening options

Unlike some health behaviours that involve addiction or are shaped by deeply embedded cultural norms, screening attendance is more likely to be shaped by an individual's personal circumstances (e.g. access to a car, existing health conditions, their experience of poverty, family commitments and their personal sense of control) or demographic characteristics. It is therefore reasonable to assert that some evidence informed practical actions (based on local preferences for screening in the area) could be an effective way of directly reducing a key health inequality between deprived and affluent parts of Scotland.

The impact of COVID-19

This project took place prior to the COVID-19 pandemic. During the pandemic many screening programmes were put on hold in order to focus resources on the crisis. The prioritisation of certain healthcare services underlines the pressure placed on NHS services during this critical time. As organisations come to terms with the immediate and longer-term impacts of COVID-19, it is possible that previous plans will be delayed or abandoned in order to meet new challenges. Although screening programmes will return as a vital means of detecting illness early and providing treatment, the circumstances of the population will be very different. With resources across all sectors likely to diminish and unemployment on the rise, increased poverty and inequality are likely outcomes. Some health behaviours and indicators are likely to suffer as a result, but it is important to ensure that reducing inequalities in screening uptake continues to be prioritised. This evaluation has highlighted some of the reasons that people living in areas of disadvantage are more likely to default from screening appointments, including the wish to avoid an additional pressure on top of the stress of living in poverty. It will therefore be important to continue to raise awareness of the importance of screening, providing more flexible arrangements for attending and ensuring that the experience is positive.

5. Conclusions and recommendations

Findings from this report have implications for several organisations, including those involved in the project, those wishing to implement similar ideas elsewhere, and for the Scottish Government in determining future policy regarding screening inequalities.

Recommendations for these organisations are offered below:

1. The project should be revisited in the future to assess which aspects have been carried forward, how learning has been shared and what opportunities there are to re-use or re-enforce messages and approaches.
2. Inequalities in screening uptake across Scotland are shaped by a range of factors, including the demographic make-up of the population and wider socioeconomic and cultural factors. Approaches to screening should be appropriate to the population being targeted, with more flexible and person-centred approaches being offered in areas of low attendance.
3. Localised approaches to encouraging screening attendance – which facilitate local participation and draw on an area's unique identity – can be an effective way of raising awareness and building community cohesion. Future communication around screening should consider how local or national identity can be harnessed to engage the population.
4. While there may be value in using temporary measures to encourage screening attendance in some circumstances, the most cost-effective and sustainable approach is to embed more flexible practice within existing services.
5. Where useful, partnerships between the third sector (community and charity) and primary care should be encouraged. Link workers could help to facilitate conversations and the development of ongoing partnerships in some areas.
6. Place-based multi-agency partnerships between public health, regeneration and community organisations should be encouraged as a model for tackling common issues with an area.
7. Influencing screening behaviour across a population will require a consistent long-term effort. High levels of poverty in some areas mean that additional resources to raise awareness and facilitate attendance will be necessary.
8. Good practice guidance on how to effectively engage with different population groups to attend screening may be helpful if it is not already available. This may be particularly relevant in areas which have experienced high levels of in-migration from other countries.

9. Where resources permit, screening messages should continue to be used within the Clyde Gateway area and data should be monitored on screening rates across GP practices as an indicator of impact.

Appendix: Topic guide

1. Thinking about the overall project rather than the strand you are working within, I wonder if you might tell me in your own words what the purpose is?

2. Please provide a brief overview of the area/strand of the project you've been involved in and where it sits within the overall project.

3. To what extent did the area's (Clyde Gateway) local context shape the approach you took?
(Prompts: is it necessary to take local context into account, have the outcomes been shaped by this context?)

4. Thinking specifically about your strand of the project, what would you say have been the successes or things that have worked well?

5. Who do you think has/has not benefited from the work you've been involved in?

6. Thinking back, is there anything that you would have done differently?

7. Can you describe how closely you worked with the other strands of the project?
(Prompts: benefits, challenges, working towards the same goal or in isolation?)

8. How important has the evaluation support been in shaping what you've done?

9. What learning from your experience could help to shape similar projects in other areas?
(Prompts: components crucial to success, how to overcome challenges?)

10. What do you feel is important for the project to be sustainable/to continue in the long term?
(Prompt: confidence that it will continue beyond the current funding period)

11. Is there anything else you'd like to say about this project that hasn't already been covered?

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