Improving cancer screening for people experiencing homelessness

Interim evaluation report for North Central London Cancer Alliance

July 2024

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Produced by Homeless Link, 2024

Acknowledgements:

Thanks to all who have given their time to feed into the evaluation to date, including North Central London Cancer Alliance, Dr Jasmin Malik (Clinical Lead, Health Inclusion (NCL ICB) and London Region Clinical Lead, Homeless Health Programme (TPHC), NHSE (London Region) Cancer Screening Commissioning Team, delivery partners, patient partners, alongside all stakeholders who have contributed to the project.

0. Executive summary

This interim report provides a snapshot of the ongoing evaluation of the Improving Access to Cancer Screening for People Experiencing Homelessness (PEH) project delivered by NCL Cancer Alliance (NCL CA) and partners, alongside initial findings and reflections from the project to date. The project aims to identify barriers and implement reasonable adjustments to enhance cancer screening participation among PEH in North Central London (NCL), with the broader goal to capture learnings and, if successful, influence best practice regionally.

Early insights from the evaluation highlight the project's success in leveraging collective expertise to understand barriers and develop sustainable adjustments across the three national cancer screening pathways. Stakeholder engagement, involving over 80 representatives including screening providers and commissioners, local authorities, and homelessness services, has been instrumental in shaping strategic direction and ensuring alignment with broader health inclusion agendas. Integrating lived experiences of PEH in the project design provided invaluable insights, grounding the initiative in practical realities.

The project has successfully piloted a diverse range of initiatives of varied nature and has begun to influence practices and systems related to cancer screening. While many of these initiatives are still ongoing, initial progress indicates promising outcomes that will be further reviewed in the final evaluation stage. Implementing these changes, however, is a gradual process that requires time to achieve meaningful impact. It involves embedding adjustments across all stakeholders involved in the screening pathways.

While engagement from strategic and clinical staff was robust, representation from frontline homelessness staff was limited, crucial for supporting PEH in accessing screening.

Theme 1. Develop resources • Produce and disseminate comprehensive resources to raise awareness of cancer screening for PEH and people in frequent contact with PEH.	**Theme 2. Train and share knowledge across cancer and health inclusion teams** • Support test completion and investigations. • Develop and deliver trauma-informed care and cancer screening awareness sessions to those involved in the screening pathways and those working closely with PEH.
Theme 3. Work closely with primary care/screening providers and commissioners • Improve and promote better use of existing support pathways.	**Theme 4. Health Promotion** • Design, develop and deliver a targeted public awareness campaign to raise awareness of cancer screening and facilitate cancer screening information shared with PEH.

↑ Reasonable adjustments are being piloted under 4 key themes.

Overall, the project demonstrates positive potential for sustainability and replication beyond NCL. The next phase of the evaluation will delve deeper into barriers, opportunities, and needs to better support PEH in accessing and participating in screening in primary care settings. It will also focus on capturing the impact of piloted adjustments where possible, and further assessing the sustainability and replicability of these adjustments.

1. Introduction

The project

Aim: To improve awareness, access and participation into all three screening programmes for people experiencing homelessness across five boroughs in North Central London (NCL).

Objectives:

1) To identify barriers and what reasonable adjustments are required for people experiencing homelessness to participate in cancer screening
2) To pilot the agreed reasonable adjustments in NCL
3) By drawing on the learnings and successes from the pilot phase, the project hopes to influence and inform best practices that can be implemented across London, and beyond.

Project timeline: July 2022-March 2025

About the evaluation

NCL CA commissioned Homeless Link to carry out an evaluation of the project to date to generate insight into the processes undertaken, successes and learning, with a view to sharing findings regionally with screening commissioners, providers and other London cancer alliances. If the evaluation provides evidence of project success, it is hoped that it will help to influence key cancer screening and homeless health providers to collaborate more effectively to improve access and participation to cancer screening for PEH. as well as inform good practice, successfully implement reasonable adjustments, and provide equity of care for PEH across London and beyond. The evaluation began in March 2024.

About this interim report

This interim report's objective is to provide an update on the progress, findings, and initial insights of the project. It should be considered a working document. It will serve as a tool to facilitate further discussions and engagement with strategic and delivery partners to identify key areas that require further exploration through additional research, before the finalisation of the evaluation report in October 2024.

The information and initial findings presented in this interim report derive from a review of existing literature and evidence on the topic; a review of all project materials, outputs and monitoring documents; 1-2-1 interviews with key strategic and delivery partners involved in the project and an initial review of monitoring and impact data for some of the adjustments.

2. Project background and context

2.1 The need

Health and homelessness

People experiencing homelessness (PEH) are more likely to have poor physical and mental health than the general population. Evidence shows that they have worse health outcomes than the general

population largely due to inadequate access to routine and preventative care and treatment[1]. The average age of death for men and women experiencing homelessness is 45 and 43, respectively, and previous research suggests that nearly one in three of these deaths could have been prevented with timely medical intervention[2].

There are multiple barriers for the homeless population to accessing healthcare, from having to provide proof of address at registration with a GP, to the rigidity of appointments, stigma, and a lack of awareness by healthcare practitioners of their complex healthcare and social needs[3]. People may miss communications due to their lack of stable housing and may also avoid medical settings because of previous traumatic or stigmatising experiences. Therefore, many homeless people wait for their health to deteriorate to the point of needing emergency medical care at A&E before seeking help.

Mainstream healthcare services often fail to provide effective care for individuals facing multiple disadvantages. A recent report warns that homeless individuals are 'at the bottom of the pile' when it comes to accessing healthcare and are frequently discharged from hospitals back to the streets with unmet health needs.[4] Existing pressures on the NHS have also been identified as creating further barriers to care for those in inclusion health groups, including PEH. Health exclusion extends beyond healthcare systems, as homelessness negatively impacts overall health and wellbeing, making it difficult for individuals to engage in health-promoting behaviours[5]. PEH also face higher exposure to cancer risk factors such as substance abuse, risky sexual practices, and environmental pollutants.

Cancer and homelessness

PEH are particularly affected by cancer, and the incidence and mortality rate is higher than in the general population[6]. Figures around the prevalence of cancer death for people experiencing homelessness in England vary between studies. One study found cancers accounted for 19% of underlying causes of death for people experiencing homelessness between 2013 and 2016[7]. The Office for National Statistics (ONS)'s statistics on homelessness deaths puts deaths specifically attributable to cancers at 5% in 2019; however, when controlled for accidental death and suicide, this number rises to 11%.

Screening and early detection dramatically increases the likelihood that cancers can be treated and resolved[8]. However, evidence shows that cancer screening rates are much lower for PEH than the

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[1] Hertzberg D., Boobis S. (2022). *The Unhealthy State of Homelessness: findings from the Homeless Health Needs Audit.* Homeless Link https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf

[2] Office for National Statistics (2021). Deaths of homeless people in England and Wales: 2021 registrations. Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)

[3] McNeill S., O'Donovan D., Hart N. (2022*). Access to healthcare for people experiencing homelessness in the UK and Ireland: a scoping review*. BMC Health Services Research.

[4] Jackson T., Dr Nadicksbern JJ., O'Connor D., Page E. (2024). *'Always at the bottom of the pile': The Homeless and Inclusion Health Barometer 2024.* Pathway and Crisis. file:///C:/Users/lili.laine/Downloads/ALWAYS-AT-THE-BOTTOM-OF-THE-PILE%20(2).pdf

[5] [5] Leng G. (2021). *The impact of homelessness on health.* Local Government Association. https://www.local.gov.uk/sites/default/files/documents/22.7%20HEALTH%20AND%20HOMELESSNESS_v08_WEB_0.PDF

[6] Lawrie K., Charow R., Giuliani M., Papadakos J., *Homelessness, cancer and health literacy: a scoping review*. J Health Care Poor Underserved, 2020; 21:81-104

[7] Aldridge RW *et al*. (2019). *Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England*. Open Research.

[8] Institute of Medicine (US) and National Research Council (US) National Cancer Policy Board; Curry SJ, Byers T, Hewitt M, editors. *Fulfilling the Potential of Cancer Prevention and Early Detection*. Washington (DC): National Academies Press (US); 2003.

general population[9]. Inequalities in cancer screening means that cancer is often detected much later, when it is likely to be in a more advanced stage and with a higher chance of mortality.

Data from Homeless Link's Unhealthy State of Homelessness report (2022) shows that just 37% of eligible homeless women had attended a breast screening in the previous three years, in contrast to 62% of the general population. Cervical screening rates were comparably reduced, with 54% of eligible people accessing screening in the previous three years as compared to 70% of the general population.

The UK National Cancer Screening Programmes

In the UK there are national screening programmes for breast, cervical and bowel cancer. Eligible individuals are invited for screening if registered with their GP or have an NHS number provided their contact details are up to date.

Cervical screening	Bowel cancer screening	Breast screening
Offered to women and people with a cervix : - Aged 25-49 every three years and; - Aged 60-64 every five years. Test: HPV/Cytology Location: GP practice (some sexual health services)	Home Faecal Immunochemical Test (FIT) screening test offered to men and women aged 54-74 every two years. This will reduce to age 50 by March 2025. Test: Stool test Location: Kit sent to registered address	Offered to women aged 50-71 every two years. Test: Mammography Location: Various screening sites

Table 1. Overview of UK National Cancer Screening Programmes

Barriers to accessing cancer screening

Numerous studies have explored the universal barriers to cancer screening in the general UK population. Existing literature identifies several barriers preventing people from accessing screening. This includes practical challenges like difficulty booking or attending appointments, and inaccessible screening locations[10]. Informational barriers, such as inadequate health information in appropriate languages and unanswered questions about the screening process, lead to fear and anxiety[11]. Social and cultural factors, including myths about cancer, fear of social isolation, and cultural beliefs about modesty, further deter people from attending screening[12]. Misconceptions about the necessity of screening when asymptomatic further contribute to low uptake[13]. For bowel cancer screening, cultural taboos around collecting and storing faecal samples cause shame and discomfort[14]. For breast and cervical screening, there are also discomfort, or embarrassment associated with the procedure.

[9] Homeless Link., (2022). The Unhealthy State of Homelessness: Findings from the Homeless Health Needs Audit. https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf

[10] Kerrison RS, Travis E, Dobson C, Whitaker KL, Rees CJ, Duffy SW, von Wagner C. Barriers and facilitators to colonoscopy following faecal immunochemical test screening for colorectal cancer: A key informant interview study. Patient Educ Couns. 2021 Sep 17:S0738-3991(21)00631-5.

[11] Jones CEL, Maben J, Lucas G, et al. Barriers to early diagnosis of symptomatic breast cancer: a qualitative study of Black African, Black Caribbean and White British women living in the UKBMJ Open 2015;5:e006944.

[12] Ponce-Chazarri L, Ponce-Blandón JA, Immordino P, Giordano A, Morales F. Barriers to Breast Cancer-Screening Adherence in Vulnerable Populations. Cancers (Basel). 2023 Jan 18;15(3):604. doi: 10.3390/cancers15030604.

[12] https://www.nelcanceralliance.nhs.uk/news/new-research-reveals-lack-understanding-about-cervical-screening-and-why-some-dont-attend

[13] Kerrison RS, Travis E, Dobson C, Whitaker KL, Rees CJ, Duffy SW, von Wagner C. Barriers and facilitators to colonoscopy following faecal immunochemical test screening for colorectal cancer: A key informant interview study. Patient Educ Couns. 2021 Sep 17:S0738-3991(21)00631-5.

[14] Palmer CK, Thomas MC, von Wagner C et al. Reasons for non-uptake and subsequent participation in the NHS Bowel Cancer Screening Programme: a qualitative study. Br J Cancer. 2014;110(7):1705-11.

While improvements have been made to inclusion health outreach in recent years, tailored cancer prevention services are limited to the point of being 'effectively non-existent'.[15] Qualitative work with people with experience of homelessness shows very few recall invitations for cancer screening[16]. This means 'opportunities for the early diagnosis among PEH were often being missed'. Everyone who is registered with a GP and within the screening age will be invited based on the contact details given to their GP practice. However, for PEH, cancer screening invitations might be 'non-existent' not only due to these structural and service-level barriers, but also because this population often faces difficulties in registering with a GP or keeping their contact details up to date.

The impact of systemic barriers on cancer outcomes is significant. Early diagnosis is an indicator of better long-term outcomes in cancer care. The combined risks of 'unequal access and utilisation of cancer screening services as well as advanced stages of cancer when diagnosed' mean outcomes for PEH are significantly worse[17]. Late diagnosis in acute healthcare settings such as emergency hospital departments mean treatment options are likely to be much more limited and chances of mortality are significantly higher.

2.2 Strategic alignment

The big picture

The NHS Long Term Plan (2019) sets out how health services will improve care, prevent ill health, and reduce inequalities over the next decade. It sets out two major ambitions for cancer care:

- Early Diagnosis: By 2028, the goal is to increase the proportion of cancers diagnosed at stages 1 and 2 from around 50% to 75%.
- Survival Rates: Achieving earlier diagnosis is expected to result in 55,000 more people each year surviving their cancer for at least five years after diagnosis.

Delivering on these ambitions means improving diagnosis across the system, creating more capacity and helping people to understand what signs to look out for and encourage them to get checked promptly.

NHS England (NHSE), the Office for Health Improvement and Disparities (OHID), and the UK Health Security Agency (UKHSA) have all identified inclusion health groups as priority populations to address in efforts to reduce health inequalities. Reduction of health inequalities among PEH and early cancer detection are also targeted under the Core20Plus5 framework and the NHS Long Term Plan.

In London, The Homeless Health London Partnership brings together London's NHS Integrated Care Boards (ICB), regional partners and third-sector organisations to improve access to, experience of, and outcomes from health care, for people at risk of, or experiencing homelessness. Improving access to screening was a key objective of the programme in 2022/23.

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[15] Schiffler T, Carmichael C, Smith L, Doñate-Martínez A, Alhambra-Borrás T, Varadé MR, Barrio Cortes J, Kouvari M, Karnaki P, Moudatsou M, Tabaki I, Gil-Salmeron A, Grabovac I. Access to cancer preventive care and program considerations for people experiencing homelessness across four European countries: an exploratory qualitative study. EClinicalMedicine. 2023 Jul 20;62:102095.

[16] Farrugia AM., (2023). Improbability or impossibility? A qualitative study exploring the stakeholder's perception of barriers homeless populations face within cancer screening.

[17] A Gil-Salmerón, C Gutiérrez-Schiavon. (2020) Cancer care for the homeless population: a literature review, European Journal of Public Health, Volume 30

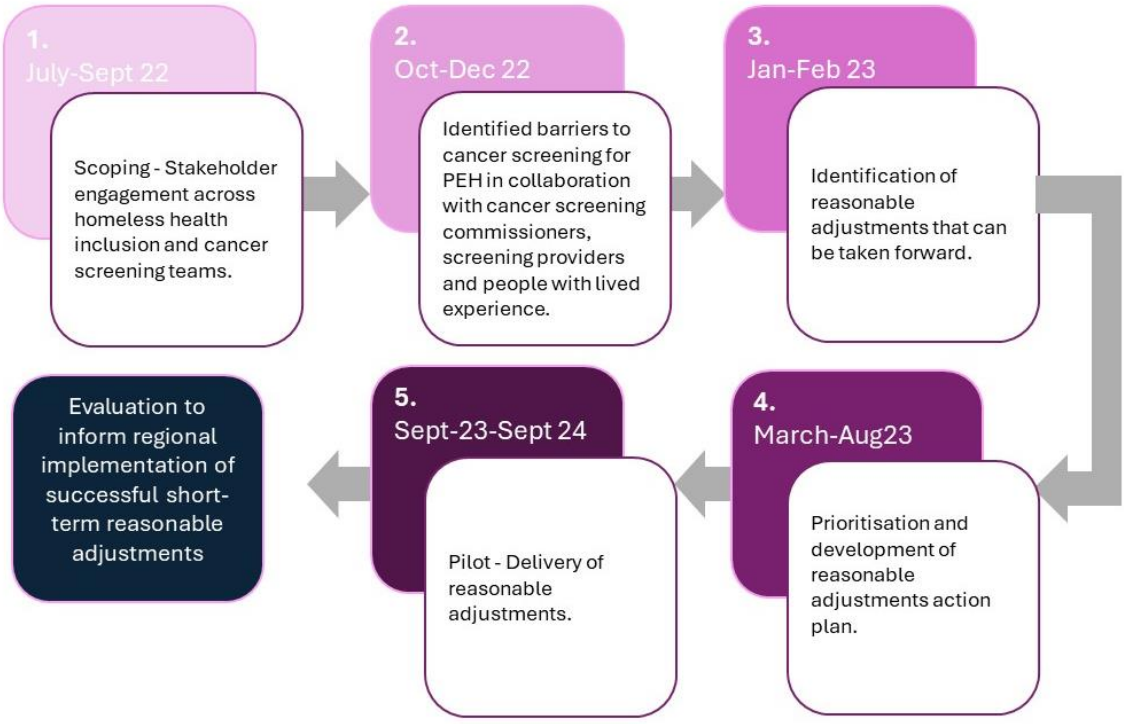
This project also draws on general principles and recommendations outlined in the Integrated health and social care for people experiencing homelessness NICE guidelines [NG214].

North Central London

The NCL Health Needs Assessment identified a range of needs and healthcare access barriers for PEH including fear of stigma and discrimination, lack of identification or proof of permanent address, lack of awareness of the healthcare system and entitlements, trauma triggers, language and digital exclusion[18].

Improving survival, focusing on early diagnosis and prevention and reducing health inequalities across the whole NCL population is two of the key strategic objectives of NCL CA. As a system partner, NCL CA has been working in partnership with NCL ICS colleagues on its mission to improve cancer outcomes for the whole of the NCL population (covering the London boroughs of Barnet, Camden, Enfield, Haringey and Islington), through a high performing, innovative and sustainable cancer system that delivers the best patient and staff experience, which this project is hoped to contribute towards.

3. The project process



➔ **Details on the activities delivered at key stages of the project can be found in Appendix A**
➔ **The barriers identified through the project can be found in Appendix B**

[18] The NCL Health Needs Assessment and Commissioning Strategy built upon a range of source and evidence, including an epidemiological analysis carried out by Camden and Islington's Public Health Intelligence teams.

4.The short-term reasonable adjustment pilots

The process of identifying and implementing reasonable adjustments was driven by stakeholders' engagement and their insights into feasibility. Those deemed feasible i.e., can be delivered in the next 12-months were incorporated into a delivery plan, supported by a quarterly delivery framework to track progress. For adjustments deemed medium/long-term and not feasible, clear rationales were documented to facilitate shared learning and inform future initiatives. Below are the main themes arising from the workshop and a summary of the reasonable adjustments identified within each theme, and the progress made as of May 2024.

Theme 1. Develop resources	**Theme 2. Train and share knowledge across cancer and health inclusion teams**
Theme 3. Work closely with primary care	**Theme 4. Health Promotion**

Theme 1: Develop resources

- Produce and disseminate comprehensive resources to raise awareness of cancer screening for PEH and people in frequent contact with PEH.

Screening	Delivery partner	Short-term reasonable adjustment	New or already in place	Progress update (May 2024)
Cross-cutting	NHSE (London Region) Cancer Screening Team	Development and publication of a directory of cancer screening resources for use by healthcare professionals and staff in frequent contact with PEH (including invitation and decision making in easy read and other languages available).	New	**Complete**
Cross-cutting	Groundswell	Development of cancer-screening leaflet for PEH		**Ongoing**

Table 2. Reasonable adjustments – Theme 1: Develop resources

Overview of progress

— NHSE (London Region) Cancer Screening Commissioning Team with inputs from NCL CA and Transforming Partners in Health and Care (TPHC), developed a comprehensive directory of cancer screening resources, providing information, advice, and guidance for health and social care professionals and people in caring and supporting roles to aid conversations with their patients and service-users across London.

Resource directory traffic analytics (15th May – 30th June 2024)

— 525 views from 238 unique users, including 60% through direct URL link, 30% though organic search and 10% through website referrals, emails/e-newsletters and social media.
— The average view time was 1min15.
— The cervical screening page was viewed more (152) than the bowel (90) and breast (37) screening pages.

Engagement is considered promising, and higher than the overall TPHC website.

— Groundswell was commissioned to produce leaflets for each of the national cancer screening programmes. Funded by the four London cancer alliances, these leaflets aim to promote trauma-informed practice and encourage screening participation and informed-decision making by providing tailored information to PEH. The leaflets were co-developed with people with lived

experience, cancer screening providers and commissioners, specialist and mainstream GP practice and sexual health clinicians, and homeless services. The leaflets are currently being finalised and work will begin to translate these resources.

Theme 2. Train and share knowledge across cancer screening and health inclusion teams

- Ensure a shared understanding of health inclusion issues and existing barriers for accessing cancer screening for PEH; trauma-informed practices and how best to support this cohort.
- Ensure that those supporting PEH are aware of the screening pathways and adjustments available for this cohort; and improve communications pathways between homeless services and screening centres.

Screening	Delivery partner	Short-term reasonable adjustment	New or already in place?	Progress update (May 2024)
Bowel & Breast	Groundswell	Upskilling the Health Promotion Lead and Specialist Screening Practitioners at UCLH Bowel Screening Centre on inclusion health, tips to engaging with this cohort and what reasonable adjustments can be offered. Training to mammographers and queries team on inclusion health, tips to engaging with this cohort and what reasonable adjustments can be offered.	New	**Ongoing**
	Bowel screening centre (UCLH)	UCLH screening team to provide health promotion sessions to staff who are in frequent contact with PEH		**Ongoing**
	Breast screening centre (RFL)	Breast Screening Service to provide health promotion sessions to staff who are in frequent contact with PEH		

Table 3. Reasonable adjustments – Theme 2: Train and share knowledge across cancer screening and health inclusion teams

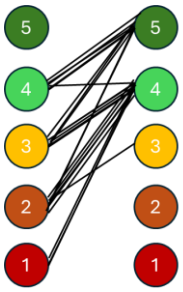
Overview of progress

— Groundswell, commissioned by NCL CA, provided trauma-informed training to screening teams. This training focused on enhancing understanding of homelessness, addressing barriers and stigma, and developing staff capability to support PEH effectively.
— After this initial training, screening centres' health promotion teams used their learnings to create a tailored cancer screening awareness session package for local homeless organisations and support workers. This package covers the importance of screening, raises awareness about screening pathways, and educates on implemented reasonable adjustments.
— All local authorities in NCL have assisted in identifying and inviting participating organisations.

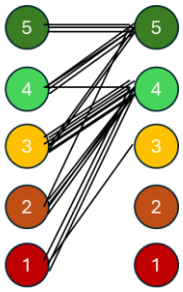
Initial cancer screening awareness sessions were delivered in May and June 2024, bringing together 40 staff (health inclusion, hostel project workers, support workers). Feedback was gathered from participants via a survey and e-certificates shared upon receipt:

- Overall feedback was positive. Key takeaways for participants included a better understanding of the barriers that PEH may face, pathways and processes and learning about the available adjustments.
- When asked about what they will implement as a result of the cancer awareness sessions, participants indicated that they will be more vigilant in ensuring their eligible clients receive invitations for screening and are supported in accessing services; utilise pre-visits; and encourage discussions around screening with their clients.

➔ **Full findings can be found in Appendix C**



Knowledge around screening and pathways
Before/after training (1 – 5 rating)



Confidence in discussing screening with clients
Before/after training (1-5 rating)

Theme 3. Working with primary care/screening providers and commissioners

- Introduce reasonable adjustments to support test completion and investigations.
- Improve and promote better use of existing support pathways.

Screening	Delivery partner	Short-term reasonable adjustment	New or already in place?	Progress update (May 2024)
Bowel	Bowel screening centre (UCLH)	Flexibility in pre-diagnostic test support e.g., to discuss how to do bowel prep	Already in place	**Complete**
		Flexibility in follow up appointments at preferred times of the day for the individual. Provide follow up / drop-in clinic to discuss abnormal results		
		Allow admission to support bowel preparation (3 day in-hospital stay) - by exception only		
		Alternative test to colonoscopy offered – CT Colonoscopy		
Breast	Breast screening centre (RFL)	Provide hub number and email address in FAQs to support key workers and hostel staff to help answer any queries relating to clients.	New	**Complete**
		Provide longer appointment times		
		Allow for pre-visits		
		Ask clients for 2nd contact/address when accessing breast screening service to follow up results	Already in place	**Complete**
		Provide changing facilities that allow patients a chance to 'freshen up' before their scan, and provision of wipes.	New	**After exploring further, this was not deemed feasible due to financial constraints**
Cross-cutting	Islington GP Hostel Outreach Service	Review of EMIS template - Include cancer screening when new patient registration consultation takes place for eligible patients.	New	**Ongoing**

	Enfield Homeless Health Service Haringey Homeless Health Inclusion Team	Provide key contacts in the community to provide support with test completion – links to screening awareness sessions with key workers and staff in frequent contact with PEH.		

Table 4. Reasonable adjustments – Theme 3: Working with primary care/screening providers and commissioners

Overview of progress

- The project has raised awareness of these adjustments among screening staff and embedded into official protocols:
- For bowel cancer screening, this includes offering 3-day hospital admission for PEH to ensure good bowel preparation prior to a colonoscopy and offering an alternative test to colonoscopy (CT scan) which is less invasive, requires less preparation and does not involve sedation.
- Both screening centres in NCL now offer longer appointments alongside pre-visits and pre-diagnostic test support for PEH, enhancing accessibility and support during the screening process.

As part of the scoping work for the project and to identify potential improvements and adjustments in primary care settings, NCL CA engaged with specialist primary care services for PEH in NCL to understand their care model and scope whether they could pilot some of the identified reasonable adjustments. Specialist primary care services including Camden Health Improvement Practice (CHIP) are aware of the unique needs of this cohort. Most incorporate certain adjustments in routine care such as flexibility in appointment times and additional support. However, for the services outlined, specific adjustments in relation to supporting and encouraging clients in cancer screening were not formally embedded.

Overview of progress

- As part of a wider piece of work, the integration of cancer screening within the Homeless EMIS template, aiming to systematically consider screening for all eligible patients right from their initial GP registration was drafted with support from London Homeless Health TPHC team. Considering the opportunity for embedding cancer screening within the Homeless EMIS template across primary care practices and local areas beyond NCL, the proposed template is in the hand of TPHC, which is awaiting the next funding cycle to determine if this can be taken forward as a priority.

London primary care survey: Understanding further barriers and opportunities for improving access to cancer screening in primary care settings

As part of the evaluation, further insights are being gathered on barriers, existing processes and opportunities within primary care settings that aim to improve access and participation in cancer screening for PEH via a survey targeting London's primary care GP practices, including both specialist and mainstream practices. The survey will run until 31st July 2024. **Detailed survey findings as of June 24th can be found in Appendix D.**

As of June 24th, 2024, the survey has garnered 12 responses from 8 mainstream GP practices and 4 specialist homeless GP practices, involving 11 GPs and 1 service operational lead across London.

- The survey reveals that specialist GP practices tend to discuss cancer screening with PEH more frequently than mainstream GP practices. Cervical cancer screening is the most frequently discussed, followed by breast and bowel.
- Mainstream GP practices feel less confident (6/10) than specialist practices (9.5/10) in discussing cancer screening with PEH.
- Shared successful practices or adjustments implemented to improve access to PEH include drop-in weekend clinics for cervical screening; use of care navigators to reach out to eligible patients and support with appointment booking; health education events at day centres.
- Practices also said that direct access to FIT kit and additional resources to do some targeted support to known eligible patients and outreach would help them in supporting clients in accessing screening.

Theme 4. Health promotion

— Raise awareness of cancer screening importance of keeping contact details up to date.
— Help facilitate cancer screening information shared with PEH

Screening	Delivery partner	Short-term reasonable adjustment	New or already in place?	Progress update (May 2024)
Cross-cutting	Claremont	Co-design, develop and deliver cancer screening campaign with PEH and homeless health providers	New	**Ongoing (September launch)**

Table 5. Reasonable adjustments – Theme 4: Health Promotion

Overview of progress

— Communication agency Claremont was appointed by NCL CA in March 2024 to design and deliver a campaign which aims to increase awareness of cancer screening among PEH and encourage eligible individuals to participate when invited.
— The launch of the campaign is expected for September 2024 in line with the next annual Streets Fest which NCL CA and the screening Health Promotion Leads have participated in for the last two years.

Key insights from work to date

As part of the audience-research phase, Claremont engaged with a range of stakeholders including homelessness and inclusion health services together with 23 people with lived experience of homelessness in Haringey and Islington who were involved in focus and co-design groups.

Key findings from these sessions include:

- A need for clear information about the NHS system and the screening process
- The importance of translated materials
- Retaining information is a challenge so reminders are important (e.g., texts)
- Peers and support workers are the most trusted people in PEH lives
- Positive stories about screening are an important driver – there is a desire for information to come from people they can relate to in terms of what they have been through.

5. Longer-term adjustments and system barriers

Medium and long-term adjustments were also identified during the project's cross-sector consultation and workshop. These adjustments were identified as not immediately implementable or pilotable within the next year, requiring further scoping, exploration and consultation. The longer-term adjustments typically relate to broader systemic barriers that hinder access to cancer screening for PEH. **These are detailed in Appendix E.**

Evidence indicates that assertive, targeted support is best practice for engaging PEH in healthcare. However, current information systems and technology used by healthcare practitioners limit their ability to target excluded populations and effectively use non-postal contact methods like text, phone, or email. More broadly, maintaining consistent communication between PEH and healthcare practitioners is a challenge, and the lack of capacity and increasing pressures in homelessness services, primary care, and screening services further exacerbates this issue.

While the short-term adjustments piloted in screening centres, such as providing more flexible appointments, are a step in the right direction, rigidity in screening pathways remains. For cancer

screening, targeted initiatives and outreach activities are restricted by the need for patients to be registered with a GP, preventing opportunistic screening. For example, FIT kits (bowel cancer screening) are individualised via a barcode, each linked to a patient's GP record. The test is reliant on patients keeping their contact details up to date on their GP records and access to kits in the community or frequently visited sites is currently not feasible.

At current, cancer screening continues to rely on patients accessing support on-site which can prove challenging for people who cannot travel or feel anxiety in medical settings. Breakthroughs in self-testing for cervical screening for example could be of enormous benefit to PEH, giving people the opportunity to conduct testing in their own time and space. Such approaches may also allow key workers to more easily integrate conversations around screening into their support planning.

6. Preliminary insights

The following insights represent interim findings in the evaluation process. As efforts continue, the aim is to delve deeper into the nuances of these insights over the coming months. The goal is to capture more detailed perspectives and impact data to inform comprehensive conclusions and recommendations.

Leveraging collective expertise and capacity – The project successfully brought together partners working across the system, leveraging collective expertise to understand barriers and explore feasible adjustments that could be embedded sustainably into practices and systems. It fostered a cross-system environment conducive to developing targeted solutions.

Stakeholder engagement played an important role throughout the project. The consultation period to identify barriers and adjustments spanned almost a year and involved more than 80 people with representation from regional cancer screening and homeless health colleagues, screening centres (both clinical and health promotion staff), local authorities' public health teams, specialist primary care, and homelessness / rough sleeping teams. From a strategic perspective, the engagement efforts were designed to extend the project's impact beyond NCL and London cancer alliances played a crucial role in developing resources, providing content and feedback to ensure their relevance and usability across regions beyond NCL. Strategic input from health inclusion leaders also guided the project ensuring alignment with broader inclusion health agenda, likely enhancing the project's impact.

Effective project management – Effective project management drove initiatives forward by streamlining communication channels and ensuring timely dissemination of information, which kept stakeholders informed and engaged. This approach facilitated transparency and enabled efficient decision-making. The project's processes allowed adjustments to be piloted in a co-produced manner by delivery partners. This approach meant that delivery partners took ownership of the identified adjustments, tailoring them to fit their specific contexts and capabilities.

Lived experience input – Integrating the lived experiences of PEH in the project design provided invaluable insights and grounded the initiative. Patient partners were involved at all key stages, shaping the project's direction and ensuring interventions were practical and responsive to PEH needs.

Influencing practices, processes and systems – The project's goal was to identify straightforward adjustments replicable beyond NCL to enhance screening access for PEH. It

sparked valuable conversations, leading to small but impactful changes, such as making aware of adjustments already available and establishing dedicated processes within screening centres for PEH.

The project has made good strides in influencing practices, processes, and systems related to cancer screening for people experiencing homelessness. It has successfully piloted a diverse range of interventions of varied nature from raising awareness about the importance of screenings to implementing changes in practices and systems within healthcare settings. While many of these initiatives are still ongoing, initial progress indicates promising outcomes that will be further reviewed in the final evaluation stage. Implementing these changes, however, is a gradual process that requires time to achieve meaningful impact. It involves embedding adjustments across all stakeholders involved in the screening pathways. For instance, while adjustments have been made at screening centres to accommodate PEH, the effectiveness of these changes depends on PEH and the people supporting them to be aware of these available adjustments.

Replicable adjustments – The adjustments piloted within this project, aimed at enhancing cancer screening accessibility for PEH, demonstrates potential applicability to other regions and health inclusion groups.

Gaps and remaining considerations – While engagement from strategic and clinical staff was robust, non-healthcare sector representation was limited. Key workers, crucial for supporting PEH in facilitating access to health and social care services, were underrepresented, missing valuable insights into barriers faced by PEH. In terms of piloted reasonable adjustments, the screening awareness initiatives developed for frontline staff is a positive step forward and a key consideration for the next phase of the evaluation will be to understand its impact and explore how this may be scaled up and integrated within broader health integration training frameworks.

Specialist primary care services, which typically include outreach components, play a crucial role in engaging with PEH with healthcare and supporting them in accessing screening. Outreach health services are particularly valued, with one inclusion health practitioner emphasising that conducting screenings within hostels boosts attendance rates, whereas requiring individuals to travel elsewhere often results in disengagement. However, primary care providers, like other healthcare sectors, face challenges such as information overload, which can impact the prioritisation of new initiatives. There is a shared understanding that for adjustments to be sustainable, they must integrate seamlessly into routine practices. Building on the ongoing primary care survey findings, the next phase of the evaluation will explore further the role of primary care can play and the support that they need to better support PEH in accessing cancer screening.

7. Next steps

The evaluation will continue in the coming months, and a finalised evaluation report will be ready for dissemination in October 2024. Until then, evaluation activities will focus on:

- **Capturing impact:** We will seek to capture activity and impact data for all the piloted adjustments to further understand their effectiveness and their impact in improving access to cancer screening for people experiencing homelessness (PEH). This will also include capturing any key delivery considerations and learnings if these adjustments are to be replicated.
- **Exploring the role of primary care:** To further develop our understanding of the barriers, existing processes, and opportunities within primary care settings that aim to improve access

and participation in cancer screening in London, we will organise a focus group with interested primary care stakeholders in September. This will build upon the insights gathered as part of the ongoing survey, which closes at the end of July.

- **Assessing sustainability and replicability:** We will explore the sustainability of the tested adjustments and the feasibility of replicating them beyond NCL.

The final evaluation report will particularly seek to highlight processes that have been effective and could be replicated elsewhere, pinpoint any gaps and key learnings from the projects, and finally articulate the project's impact on improving access to cancer screening for PEH and therefore its role in reducing health inequalities.

For any questions or queries relating to the project or evaluation, please contact Ekta.Patel9@nhs.net, Senior Project Manager - NCL Cancer Alliance.

Appendix

Appendix A: Project process

1 Project initiation

- The Improving Cancer Screening for PEH project by NCL CA emerged from strategic planning and local need:
    - Cancer screening is part of the NCL CA programme, aimed at reducing health inequalities.
    - Local authorities and specialist GP practices identified a need to increase access to bowel cancer screening for PEH via an adjusted pathway. Previous efforts to scope an adjusted pathway for bowel cancer screening was halted due to lack of engagement.
- Adjusting existing pathways required consultations with all involved, including PEH, to understand needs, identify barriers, and determine effective adjustments.
- Initial stakeholders' engagement took place across homeless health inclusion teams and cancer screening teams to scope the project.

2 Identifying barriers

- NCL CA reviewed existing evidence and partnered with Groundswell Homelessness Charity UK to facilitate a session with volunteers with lived experience of homelessness to gather insights into existing barriers to accessing cancer screening. This led to 3 volunteers to become patient partners for the project, guiding project development and implementation.

3 Identifying reasonable adjustments

- NCL CA held a workshop over 80 stakeholders with representation from regional cancer screening and homeless health teams, NCL ICB, London Cancer Alliances, screening centres, local authorities' and health inclusion teams, homelessness charities and the patient partners.
- The workshop aimed to understand the complexities PEH face, review healthcare and screening barriers, and explore feasible, sustainable adjustments for better access and ongoing participation.

4 Prioritisation and delivery plan

- Adjustments identified were prioritised by feasibility and timeline. Potential delivery partners were identified and engaged to assess their capacity for piloting short-term adjustments. Action plans were developed.
- A collaborative delivery plan was developed. A second workshop was subsequently organised to consolidate commitments and the delivery plan, ensuring unified alignment across all participating teams for the effective implementation of the reasonable adjustments.

5 Piloting the reasonable adjustments

- The action plan included specific steps for each adjustment, delineating responsibilities, timelines, and milestones. Mechanisms for tracking progress were established to ensure accountability and transparency throughout the implementation phase.

6 Evaluation to inform regional roll-out

Homeless Link appointed to deliver an evaluation of the project in order to inform the regional roll-out of successful reasonable adjustments within the 2025/26 London cancer screening commissioning plans.

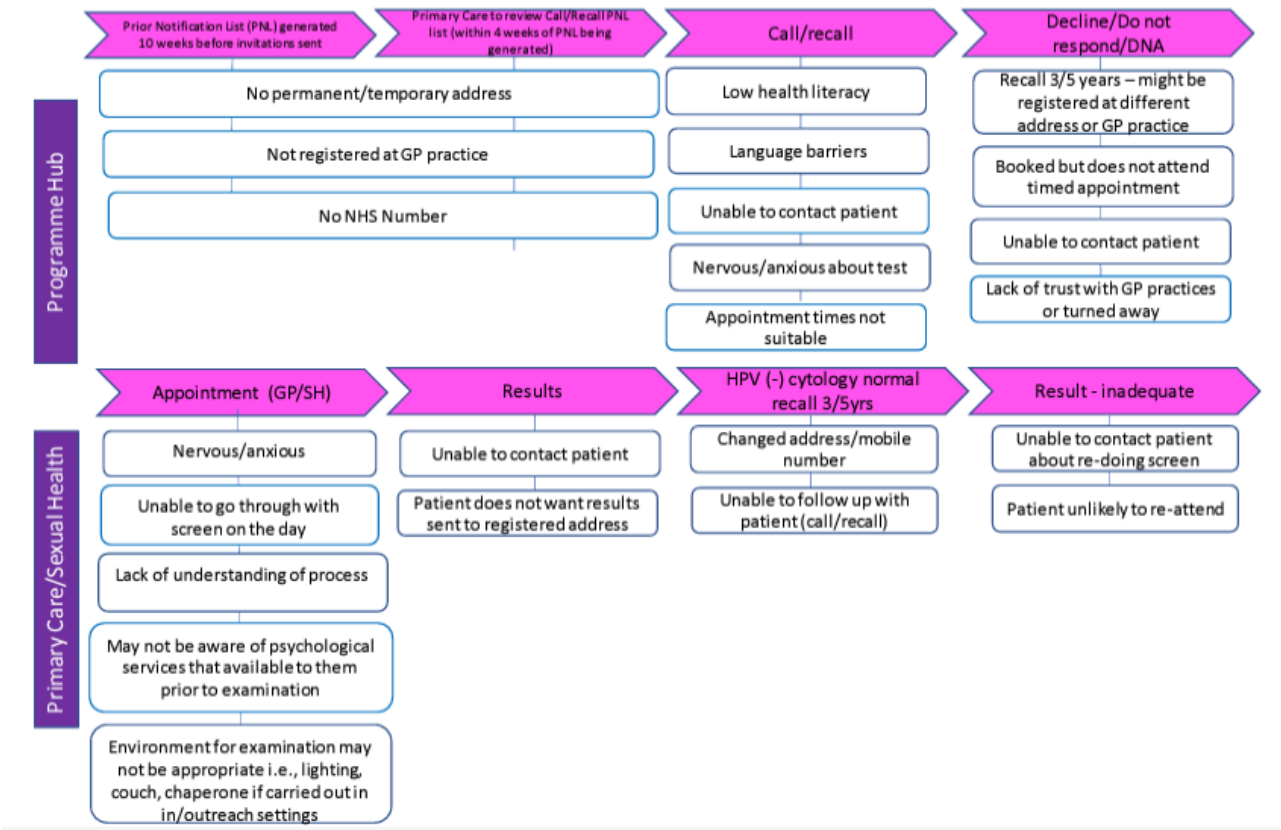
Appendix B: Barriers to accessing cancer screening for PEH

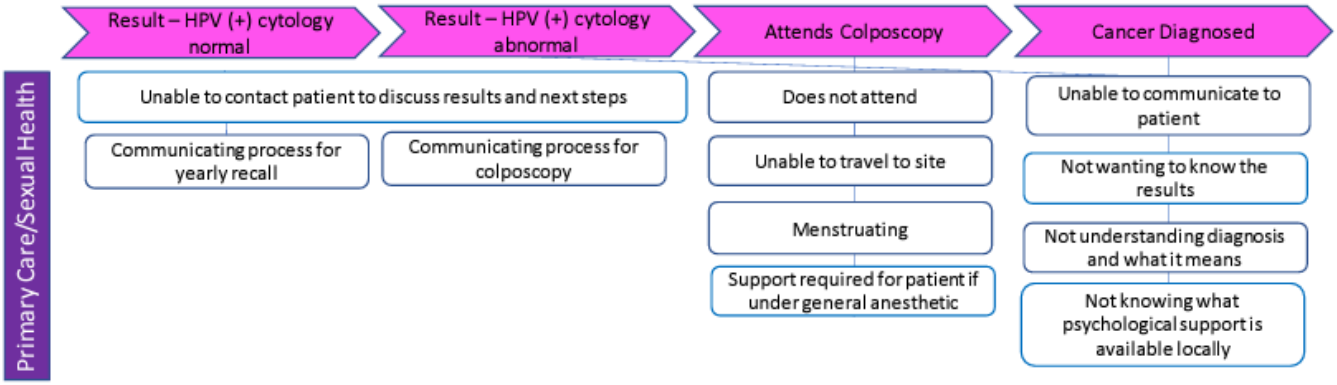
The process of identifying barriers for people experiencing homelessness (PEH) involved engaging with stakeholders across the screening pathway (including screening centres, practitioners, and primary care providers) and individuals with lived experience of homelessness. This process includes mapping out barriers at critical stages of the screening pathways to understand and address the challenges faced by PEH effectively.

Overall, multi-stage processes involving screening and follow-up testing present specific barriers such as fragmented care and the need for multiple appointments, which can be particularly daunting and impractical for individuals without stable housing. Moreover, previous negative experiences with healthcare providers or institutions may foster mistrust, discouraging PEH from participating in screening initiatives altogether. Even when screenings are initiated, logistical challenges such as transportation barriers and lack of consistent contact information can hinder follow-up care and subsequent diagnostic procedures. These complexities highlight the need for tailored interventions and support mechanisms to ensure equitable access to cancer screening and throughout the screening pathway for this cohort.

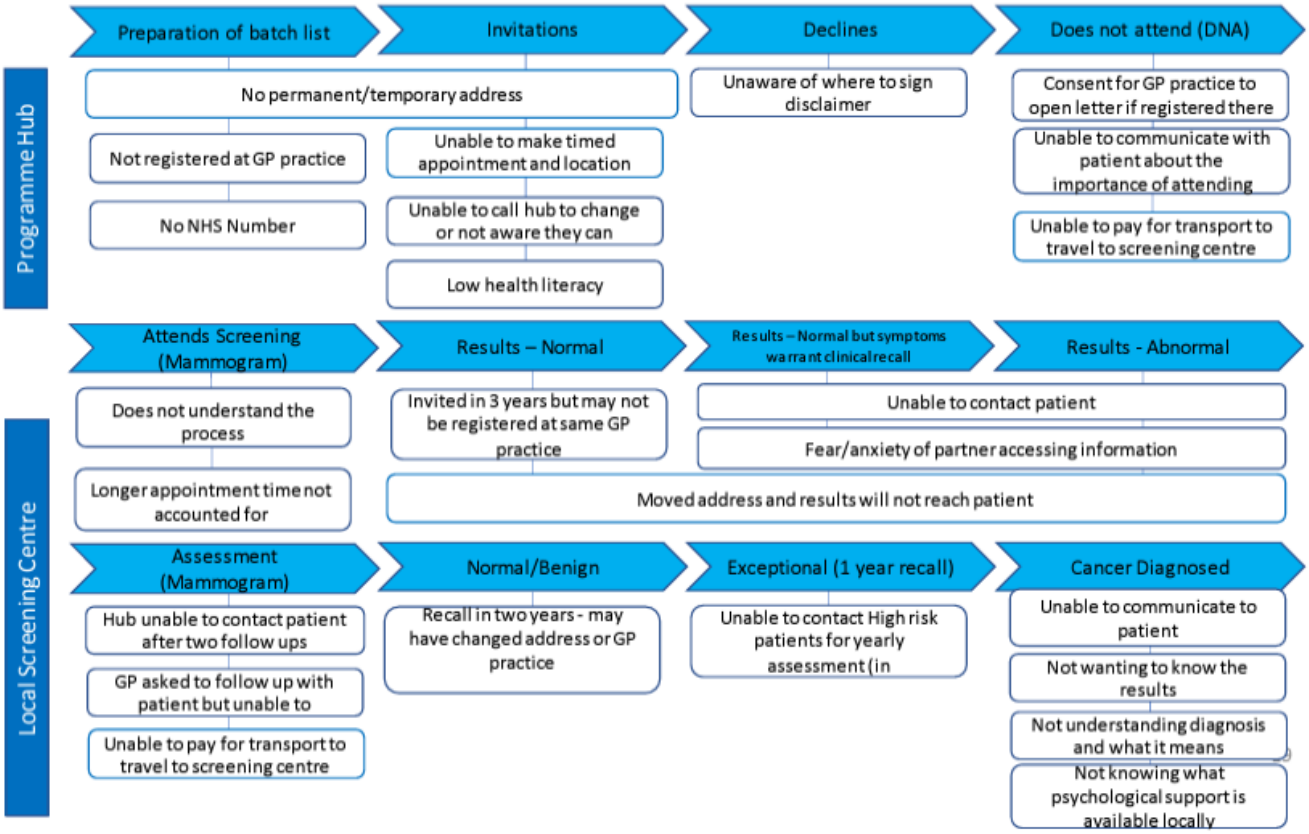
Below is an overview of the barriers encountered by the general population and PEH at each stage of the screening and diagnostic process for each screening programme. The diagram was developed by NCL CA with inputs from all partners stakeholders during initial consultation alongside people with lived experience.

Cervical screening

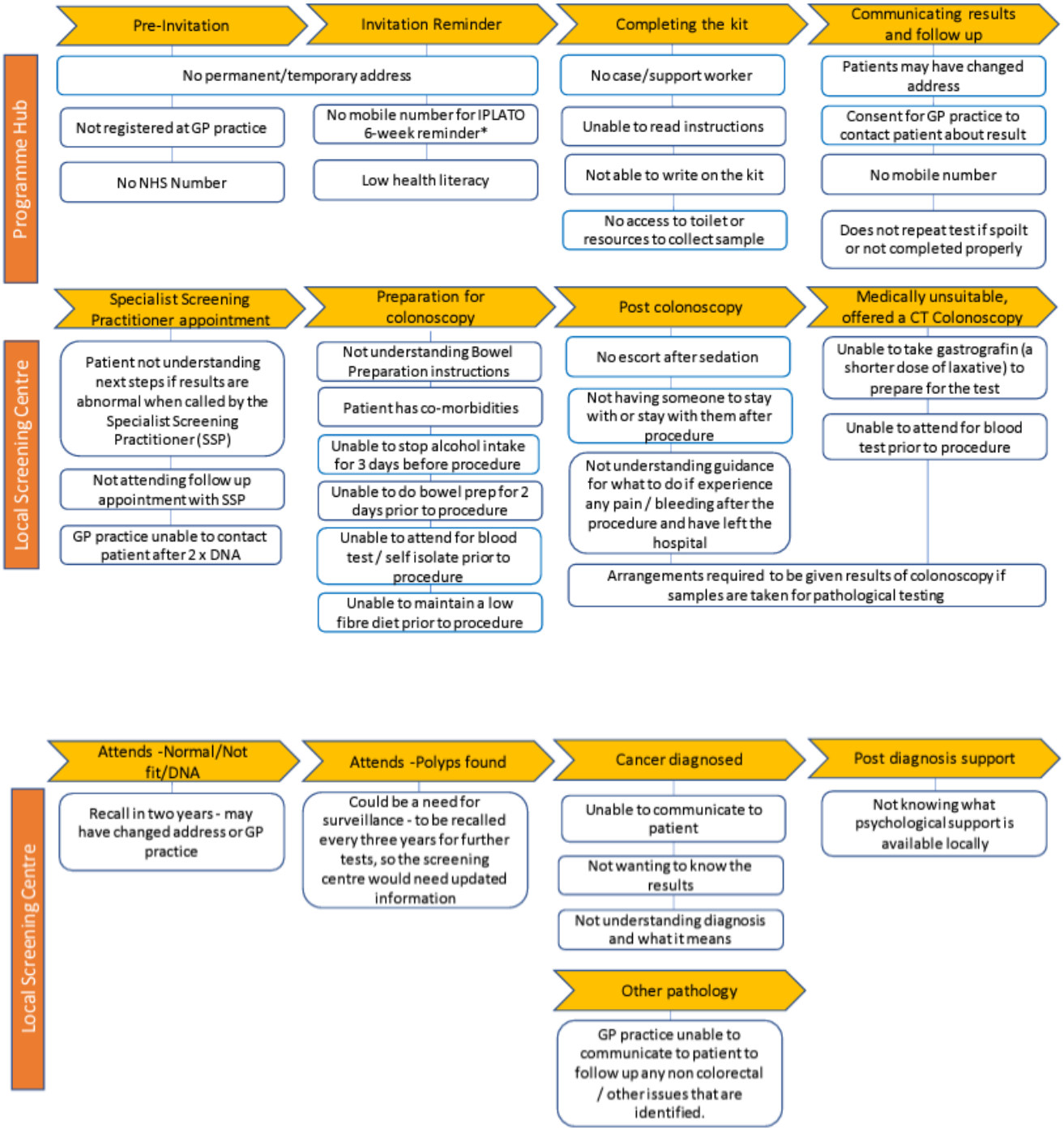




Breast screening



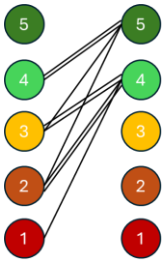
Bowel cancer screening



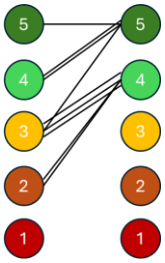
Appendix C: Cancer screening awareness session feedback

Bowel screening

- 12 participants to date (June 2024)
- The feedback was positive. Participants expressed that the training was practical and informative, giving them the right tools to engage a conversation with their clients about screening.
- When asked about what they will implement as a result of the training, participants indicated they would be more vigilant in ensuring their eligible clients receive invitations for cancer screening and are supported in accessing these services. Some participants also mentioned planning discussions with their clients to talk about the importance of screening and breaking the stigma around bowel cancer screening.
- When asked to rate the quality and usefulness of the training received, participants gave an average rating of 9/10.



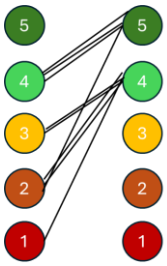
Knowledge around bowel screening and pathways
Before/after training (1 – 5 rating)



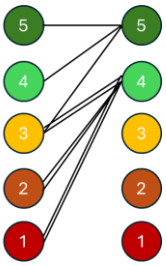
Confidence in discussing bowel screening with clients
Before/after training (1-5 rating)

Breast screening

- 15 participants to date (June 2024)
- The feedback was positive, with participants expressing that understanding pathways and processes (such as what happens during appointments), and the implemented adaptations would facilitate conversations with the people they support.
- When asked about what they will implement as a result of the training, participants indicated they would utilise pre-visits, make sure that their clients are aware of the service and raise awareness amongst their team and colleagues.
- When asked to rate the quality and usefulness of the training received, participants gave an average rating of 9/10.



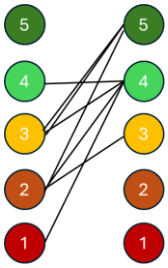
Knowledge around breast screening and pathways
Before/after training (1 – 5 rating)



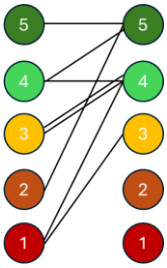
Confidence in discussing breast screening with clients
Before/after training (1-5 rating)

Cervical screening

- 10 participants to date (June 2024)
- Key takeaways for participants included learning about risks, gaining insight into symptoms and screening processes and understanding better the barriers that PEH may face.
- When asked about what they will implement as a result of the training, participants indicated that they would disseminate the information learnt to their team, encourage open discussions around screening with their clients and advocate for attending appointments.
- When asked to rate the quality and usefulness of the training received, participants gave an average rating of 9.5/10.



Knowledge around cervical screening and pathways
Before/after training (1 – 5 rating)



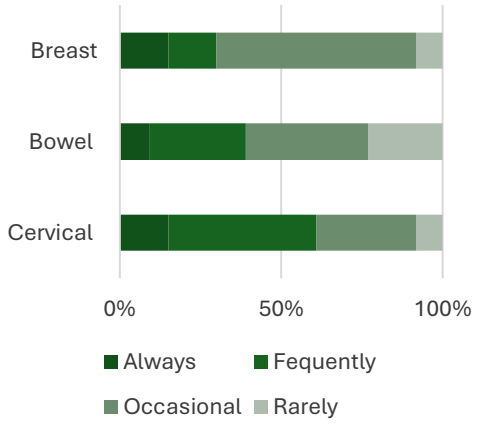
Confidence in discussing cervical screening with clients
Before/after training (1-5 rating)

Appendix D: London primary care survey: early findings

Whilst the project has captured information regarding processes and explored adjustments that could be implemented in primary care settings in three London boroughs, it hasn't provided a comprehensive understanding of the role that primary care services play or could play in supporting PEH in accessing screening.

As part of the evaluation, insights are being gathered on barriers, existing processes and opportunities within primary care settings that aim to improve access and participation in cancer screening for PEH via a survey. Targeting London's primary care GP practices, including both specialist and mainstream practices, the survey was distributed via communication channels of the four London Cancer Alliances, London Homeless Health Care Practitioners Network (HHCPN), NCL GP bulletin and NCL community of practice for homeless health. It launched in early June 2024 and will remain open until July 31st, 2024.

How often do you take the opportunity to discuss cancer screening during your interactions with PEH?



As of June 24th, 2024, the survey has garnered 12 responses from 8 mainstream GP practices and 4 specialist homeless GP practices, involving 11 GPs and 1 service operational lead.

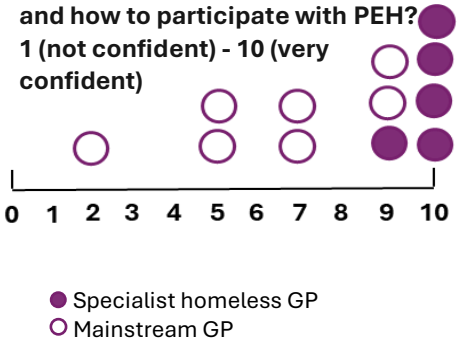
When asked how often the practices take the opportunity to discuss cancer screening during their interactions with PEH, responses vary greatly among practices and types of cancer screening.

Cervical screening is the most frequently discussed, with 61% of responding practices reporting frequent or always engagement on the topic, which is expected given its administration in primary care settings. Breast and bowel cancer screening are less commonly discussed, with 62% of practices reporting discussing breast screening occasionally and 8% rarely. Those figures are 38% and 23% for bowel cancer screening respectively.

Specialist GP practices indicated more frequent engagement across all three types of cancer screening than mainstream GP practices.

When asked to rate their confidence about discussing the importance of cancer screening and how to participate with PEH, practices showed varied ratings overall. The average rating was 7.5 out of 10, with some practices rating significantly lower. Conversely, higher confidence ratings were consistently given by specialist homeless GPs.

How confident are you in discussing the importance of cancer screening and how to participate with PEH? 1 (not confident) - 10 (very confident)



Practices were asked to share successful practices or adjustments implemented to improve cancer screening access for PEH or other groups. Responses highlighted various strategies and initiatives, including:

- Mainstream GP practice: Drop-in weekend clinics for cervical screening (opportunistic offer) targeting all eligible women including PEH but not only.
- Specialist GP: Use of care navigators calling women on a quarterly basis to organise cervical and breast clinic and helping with booking; women health education events at day centres; admin team regularly contacting individuals for bowel cancer screening and offering cancer screening packs.

Case study (Great Chapel Street Medical Centre, Westminster)
A 64-year-old Eritrean woman experiencing homelessness attended a women's day centre in Westminster where health education sessions on cancer screening were conducted. She was unaware that breast screening was available in the UK and was referred to the care navigator which supported her with booking a mammogram at the local breast screening centre. The care navigator also supported the patient to attend her appointment, advocating for the clients and ensuring translation was available.

Practices also reflected on the type of support that would help them in increasing cancer screening uptake for PEH. Feedback included:

- The ability for GP practices to perform bowel cancer screening directly at their practice (direct access to FIT kit)
- More appointment flexibility in screening centres
- Resources to do some targeted support to known eligible patients
- The ability to use GP address for FIT kits
- Outreach in hostels and day centres

Appendix E: Medium and long-term adjustments

Cancer screening	Theme	Barrier(s)	Adjustment	Outcome
Breast	Supporting test & investigations	Challenges for PEH to attend fixed appointments	Dedicated sessions/walk in clinics for PEH in breast screening centre	**Not feasible** due to limited appointments and staff capacity.
		Invasive nature of the test creating shame, worries, and stigma	Offer an alternative test to a mammogram e.g., Ultrasound	**Not feasible** as mammogram is the national standard for investigations.
Bowel		Invitation letters can be missed due PEH lack of permanent address.	Digital resource/portal to access screening	**Medium-term** NHS Digital Transformation Team are working on digital resources for breast and diabetic eye screening. Further scoping on bowel cancer screening logistic need exploring with local screening centres to look into providing SSP appointments online to book into. Most trusts have portals. Bowel cancer screening appointments are sent by the London Hub.
		Kits individualised and sent directly to eligible GP registered patient	To be able to order a kit online and provide key contact details when ordering a kit	**Medium-term** Existing pilot project to promote the use of FIT kit in hospital emergency departments in NEL.

		address / PEH not receiving.	Provide unlabelled FIT kits in PEH frequently visited locations., day centres and hostels and roaming buses	**Long-term** Feasibility needed - to be completed under a research context with national approval from Research Advisory Committee. Complex logistics –agreement with kit supplier needed to proceed.
Cervical		PEH not always able to attend cervical appointment at GP practice due to lack of flexibility or confidence/stigma	Offer cervical screening in sexual health clinics	**Medium-term** This is available in NCL. Promotion to be agreed with trusts (managing demand/capacity). London– various conversations taking place 50-60% coverage. Change in service delivery model means that opportunistic screening is limited. Barriers to setting up service including time, capacity and priority.
Breast & Bowel	Transport	PEH not always able to get to screening centres for their appointments.	Issue vouchers for homelessness services to give to eligible clients to use taxi firms to take clients to their screening appointments.	**Medium-term** Would require further scoping and resources. A similar services peer-advocacy is already in place. It enables PEH to be taken to hospital appointments. This only covers 12/13 boroughs in London (Camden only in NCL)
Cross-cutting	Supporting test & investigations	Primary care not necessarily aware of patients' homelessness situation hindering targeted engagement.	Setting up a digital solution to help identify patients on system who may be experiencing homelessness to offer a different approach to inviting them for screening	**Medium-term** EMIS clinical system can be used but unless notified by partners, difficult to identify.
Bowel		Targeted engagement and follow-up needed to encourage PEH to take up screening.	Implement safety netting process for PEH to be followed up and reviewed annually for cancer screening.	**Medium-term** Further discussion required.
Cervical		Improve communication between hostels and GP practices	With person's consent, practices can inform hostel via office number of appointments or to call back practice for results	**Long term** GDPR concerns re sharing patient identifiable data with third party. Would require governance, consumables, IT logistics, lead practice and a data processing agreement.
		Range of barriers existing for PEH to access screening at GP practices	Deliver cervical screening in the community	**Long term** Would require governance, consumables, IT logistics, lead practice and a data processing agreement. Look into HPV self-sampling for this population.