

NCL Cancer Inequalities Strategy 2024-2028



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Mrs Lee's experience



Mrs Lee is 61 years old; she is non-English speaking and originally from China. She develops abdominal pain and constipation.

Accessing healthcare:

Mrs Lee's friend, Elsie, rings her GP surgery on several occasions to make her an appointment. After several days of calling at 8am, she manages to book a telephone appointment for Mrs Lee with Dr LB, a GP. It is very quickly converted to a same day face-to-face appointment. Mrs Lee attends with her friend Elsie to translate.

Initial face to face consultation

Social and Medical History: Mrs Lee lives with her family and is employed, working in a factory. She smokes approximately 15 cigarettes a day and has no known underlying medical conditions.

Symptoms: She has experienced generalised abdominal pain, with intermittent constipation for months. She puts it down to irregular eating habits and long work hours. She thinks there may be weight loss but hard to quantify. GP records have no previous weights recorded.

GP Assessment: Dr LB takes a detailed history, examines her, and recommends further tests. Through Elsie, she runs through the process of booking blood tests and where to go. She explains about the qFIT stool test and how to do it.

Diagnostic journey

- 1 **Blood screening and stool test**
A full blood screen, including full blood count, qFIT test requested.
- 2 **Incomplete qFit test**
Bloods are back, but no qFIT result. Mrs Lee is called but no English speaker is present. Rang again with a translator and reiterated instructions for conducting qFIT test.
- 3 **Repeat attempts**
The qFIT report says 'bottle unlabelled'. Sample not processed'. Further contact made to repeat the test.
- 4 **The qFIT result**
Significantly positive - concern regarding underlying bowel cancer.

Follow-up and discussion

Positive qFIT Result: Mrs Lee booked into a follow-up appointment with GP. Elise attends to help with interpreting and support. Dr. LB discusses the findings related to suspected cancer.

Referral Options: They discuss referral sites and waiting times. Trust Y is closer, but trust Z has shorter waiting times. Mrs Lee doesn't have access to a car and prefers to stay with trust Y, as she has a known bus route. The referral process is discussed and agreed including the safety netting information.

Referral Process: Dr LB completes the fast-track referral form, emphasising the need for language and comprehension adjustments.

Direct Access Pack: Mrs Lee receives a pack with instructions and laxatives but requires further guidance. She is unable to find a hospital contact to query this pack, so seeks clarification from her GP.

Missed appointment: In the process of waiting to speak to her GP, she misses her appointment for the colonoscopy. Dr LB advocates for her to be rebooked as soon as possible.

Post-colonoscopy and follow up

New symptoms: Mrs Lee has her colonoscopy but develops rectal bleeding soon after this. She gets worried about this and asks her friend to ring the hospital.

Difficulty contacting the hospital: They are unable to get through despite several tries. Elsie emails the GP practice to find out if they can help.

Challenges experienced by Mrs Lee:

- accessing GP appointments
- consultation options
- language
- comprehension
- communications
- health service navigation.

Introduction – what we know about inequalities in cancer care and outcomes

Inequalities can be experienced at any point in the cancer pathway

In this strategy, we begin by telling the story of Mrs Lee on page 3. Her story illustrates the multiple challenges patients can experience as they navigate the cancer pathway and the wider health and care system, which can influence their outcomes.

In Mrs Lee's case, we see the difficulties she experienced in accessing an appointment in primary care, her language support needs, understanding of the information provided by services and other factors that influenced her care options e.g. distance and transport routes to hospitals. Identifying and addressing these issues is important in helping to address health inequalities for our population.



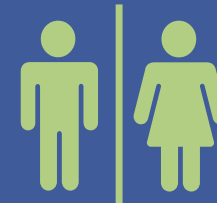
National data shows that people living in the most deprived areas are more likely to have their cancers diagnosed at a later stage which reduces their chances of having successful treatments.



Socioeconomic background is also linked to a lower likelihood of receiving some treatments.



One and five-year survival rates are lower amongst patients living in the most deprived areas for the majority of cancer types.



A difference in survival outcomes is also seen between sexes, for instance a higher survival rate amongst females in lung cancer (see Appendix 1).

Sources: Cancer Survival in England - NHS England Digital; Cancer inequalities: The problem of unwarranted variation in access to treatment.

The national and local calls to action

The NHS Long Term Plan sets out two ambitions for cancer by 2028:

- diagnose 75% of people with a cancer at stage 1 and 2 to improve survival outcomes, and each year, 55,000 more people survive for 5 years or more following their cancer diagnosis.
- **It also calls for stronger NHS action to address health inequalities, to improve overall outcomes for the whole population.**

The call for greater action to reduce health inequalities is also reflected in NCL's Population Health and Integrated Care Strategy, NCL Cancer System Strategic Aims and Objectives and the Core20PLUS5 framework (which NCL has localised and features cancer as a key population health risk). In addition to these NCL-wide strategies, organisations across the sector are committed to addressing health inequalities. This is reflected in many of their equality, diversity and inclusion strategies and the services being delivered.

Addressing health inequalities in cancer care is key in helping to achieve the two ambitions.

NCL Cancer System Strategic Aims and Objectives

Mission statement	Our mission is to continuously improve cancer outcomes for the whole of our population through a high performing, innovative and sustainable cancer system that delivers the best patient and staff experience		
Strategic Aims	SA1. Improve survival, focusing on early diagnosis, and prevention	SA2. Deliver the highest standards of patient experience and improve quality of life	SA3. Support the operational delivery of high performing, innovative and sustainable cancer diagnostic and treatment services
	SA5. Ensure we have the right workforce in place and that we deliver the highest standards of staff experience		
	SA6. Foster innovative approaches and practice in cancer diagnostics, care and treatment		
Strategic Objectives	SO1a. Consistently improve five year survival, in line with the 2028 NHS Long Term Plan ambition	SO2a. Continually improve our performance in the CPES to be in the top quartile nationally by 2028	SO3a. Deliver and sustain compliance with the 62 day standard by 2028, and 28 day standard by March 2024, with continuous improvement up to then
	SO1b. Detect 75% of cancers at Stage I or II by 2028	SO2b. Consistently improve quality of life for all cancer patients	SO3b. Reduce variation in clinical practice across the whole pathway
	SO1c. Reduce smoking rates, rates of alcohol consumption and the number of people who have excess weight in NCL	SO4a. Continually reduce inequalities across the whole cancer pathway until services are on par across our population	
	SO4b. Deliver year on year improvement in our staff satisfaction survey and retention		
	SO4c. Identify, support and evaluate a suite of clinical innovations with the aim of contributing to improved outcomes		

About this strategy

Addressing health inequalities is everyone's business.

Why do we need an inequalities strategy that focuses on cancer?

Addressing health inequalities is complex, multi-layered and requires action from every part of the system, not just health services. This complexity can make it challenging to take bold action.

In NCL, we already have a lot of impactful work happening that is either focused on addressing health inequalities or is an integral part of service delivery. Some examples of this work in cancer are highlighted on pages 14, 16 and 18 – Spotlight. This is a strong starting point for the NCL cancer system to build on.

Cancer pathways are also complex. To ensure there is collective action to address inequalities in cancer care, it is important to have common areas of focus, where we have gaps. This strategy helps to address the gaps by bringing together our cancer system to collaboratively focus on key priorities so that we can learn what works and gradually scale them up where appropriate.

We need to start off with some 'small' steps to make in-roads for bigger action in the future. Although it is not listed as a specific priority, one of our aims in delivering this strategy is to help embed a strong culture of addressing inequalities as a key aspect of all the work we do.

...About this strategy

To inform the strategy, an examination of both quantitative and qualitative data was conducted.

How was the strategy developed?

Our analysis of the quantitative data aimed to identify areas where there may be variation in different parts of the cancer pathway, which could highlight potential inequalities. Although the data being captured enables us to better understand inequalities better and is gradually improving, significant gaps still exist. For instance, the data available on accessing personalised cancer care interventions is limited; therefore, no analysis of potential inequalities in this specific area was included in the strategy. Similarly, the analysis could not include factors such as language preferences due to limited data. The inability to link the data means we do not have patient level data across pathways or any disparities in outcomes. This limits the conclusions we can draw regarding possible areas of inequality.

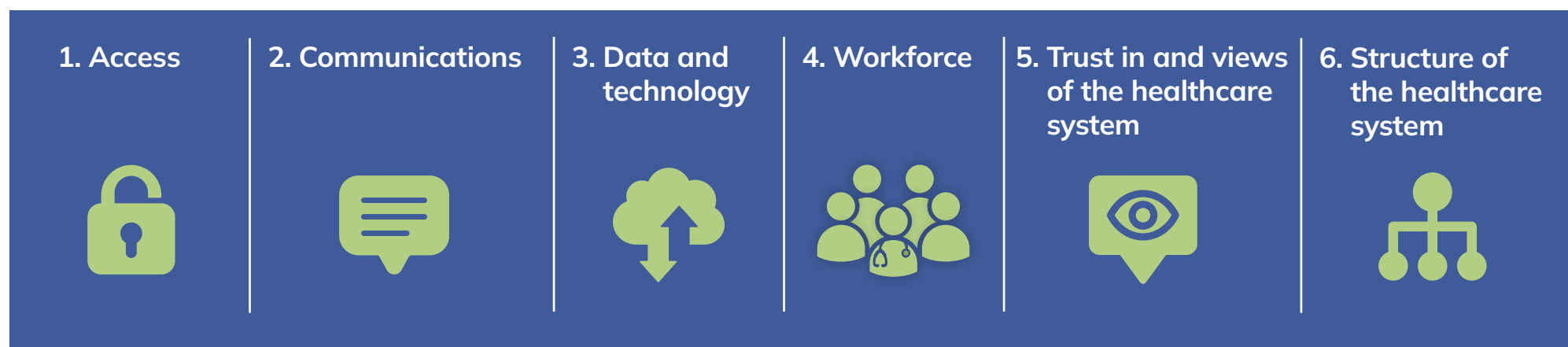
Gathering qualitative data from service providers and patients who access the services is vital. Insights were collected to identify where inequalities may exist in various stages of the cancer pathway and to identify potential solutions to address them. The qualitative insights do not attempt to directly provide context to help explain the quantitative data, but they do shed some light on why we see differences in outcomes and experiences within the population. The insights were gathered through a strategy kick-off workshop and follow-up meetings with various partners from primary care, secondary care, community services and patients, to capture diverse views. Individuals and teams who contributed into these sessions are listed on page 30.

...About this strategy

What does the strategy focus on?

The strategy sets out key priorities to help address inequalities that the NCL cancer system will focus on between 2024 to 2028. As noted, it aims to concentrate on areas where we have gaps, to avoid duplication. This is mainly in diagnostics, treatment and patient experience, where further development on addressing inequalities is needed.

Ten priorities have been selected to focus on which fall under the six themes below:

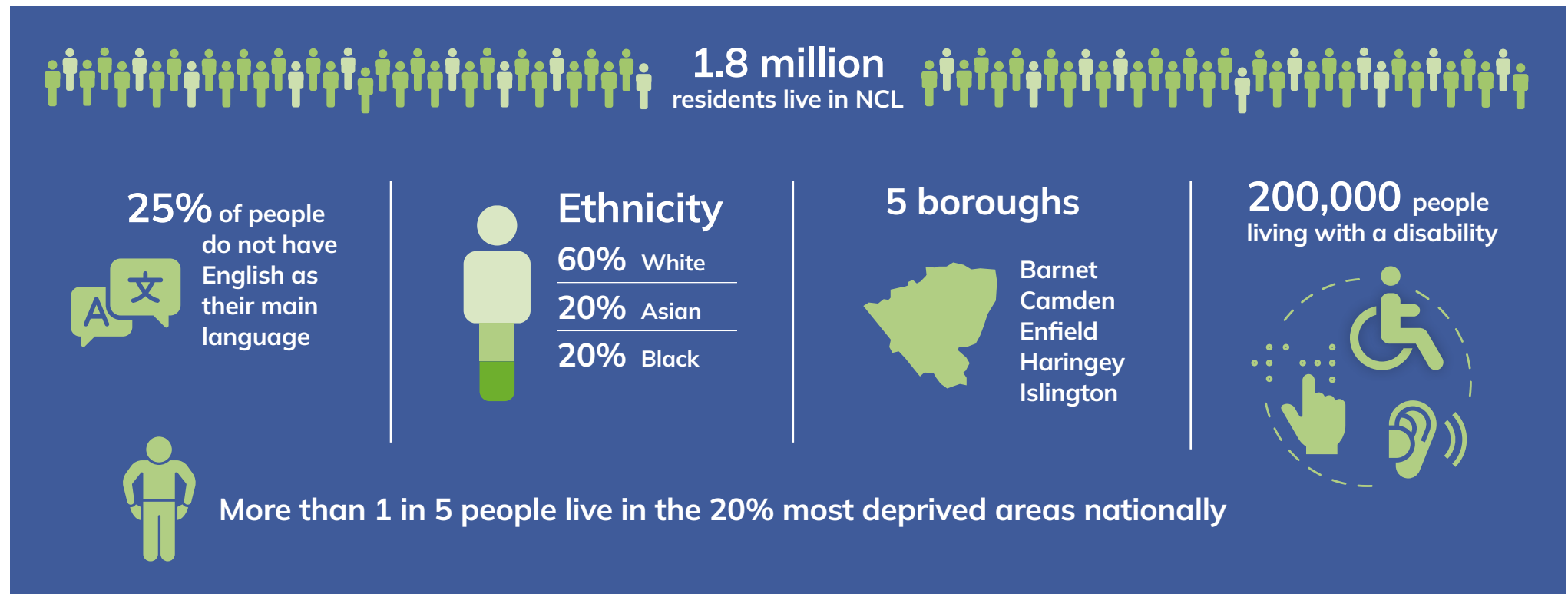


Throughout the delivery of the strategy, there will be an emphasis on sharing and learning from the wider health and care system to implement good practices locally, and champion the development of creative solutions to address identified challenges. Where it is possible to deliver activities at an NCL-level, these will be prioritised.

CONTEXT:

A snapshot of the NCL population

NCL has a diverse and relatively young population of just under 1.8 million residents, with a similar number of individuals registered with our GPs. Despite large overlap these are not the same populations, and some of our residents remain unregistered anywhere, including from our inclusion health groups*.



*Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes for example people experiencing homelessness, refugees and asylum seekers, sex workers, Irish Traveller and Gypsy, Roma and Traveller communities, transgender people and (ex)offenders.

Data source: Census 2021

CONTEXT:

What the cancer inequalities data is telling us

To gain a better understanding of the landscape and areas to prioritise in the strategy, we analysed recent quantitative data on urgent suspected referrals, waiting times, treatment, stage of diagnosis, survival outcomes, patient experience and quality of life at NCL-level where available.

We excluded data with insufficient quality (e.g. holistic needs assessment). In some of the analysis, we sought to understand any variations across the pathway relative to the overall population, to identify potential inequalities.

Most of the analysis is split by ethnicity and deprivation. Gender and age were excluded from most of the analysis due to the prevalence of certain cancers in specific genders and the increased incidence of cancer with age. However, we included an analysis of gender in relation to one-year survival outcomes.

Urgent suspected cancer referrals by ethnicity

For entry into the cancer pathway, the analysis was focused on urgent suspected cancer referrals as most diagnoses are via this route, and it represents the largest number of patients that require diagnostic follow-up. A few cancer types are highlighted below and in Appendix 2, showing the difference in referral levels across each ethnic group.

- A slight under-representation of breast cancer referrals is seen in patients of Asian background and an over-representation amongst White ethnicity.
- Gynaecological, haematological, and lower gastrointestinal cancers show a slight under-representation of patients from Asian and Mixed backgrounds.
- Lung cancer referral rates show an over-representation amongst White patients.
- Skin and urology cancers were excluded from this analysis due to a known higher incidence in some ethnicities.

Patients from the most deprived areas of NCL are over-represented in referrals and new cancer diagnoses.

Stage of diagnosis



People from an Asian, Mixed and Other ethnic background have lower rates of early-stage (stage 1 and 2) diagnoses for haematological cancers as shown in Appendix 3. Similarly, for oesophago-gastric cancers, people from Asian backgrounds have a lower rate and for other upper gastrointestinal cancers, people from Black ethnicity have a lower early-stage diagnosis rate. Appendix 4 provides a breakdown of cancer diagnosis by borough.

Waiting times



People living in the most deprived areas have a longer wait to be informed whether they have or do not have cancer (FDS Faster Diagnosis Standard performance) as shown in Figure 2, Appendix 5. Individuals from a Black background also wait longer, only 65% are given their diagnostic results within 28 days which is 3% below the combined patient cohort for this standard (graph not shown). Patients from a Black ethnic background equally have a longer wait to begin treatment (62-day performance) compared to other ethnicities as shown in Figure 3, Appendix 5.

Experience of care



In the 2023 National Cancer Patient Experience Survey (NCPES), White respondents were over-represented at 75.6%, compared to the NCL population (59%), and cancer prevalence (69.5%). Asian, Mixed, and Black ethnic groups were under-represented in terms of the NCL population as shown in Figure 4, Appendix 6, but not under-represented in terms of cancer prevalence levels. Respondents from the most deprived areas were under-represented, but not significantly as shown in Figure 5, Appendix 6.

Quality of life



There is an under-representation of survey respondents living in the most deprived quintile and those from Asian, Black and Mixed backgrounds as shown in Appendix 7.

Data source: Pseudonymised pathway level Cancer Waiting Times data linked to patient demographics . Analysed by the Centre for Cancer Outcomes.

CONTEXT:

What people receiving or providing cancer care tell us

People delivering or receiving care provided qualitative insights on the potential inequalities/challenges across the cancer pathway. These have been illustrated in the graphic from pre-referral through to living with and beyond cancer.

Details of staff and patient partners that contributed to building these insights are listed on page 28. We thank them for their invaluable contribution.

Pre-referral	Referral	Diagnostics	Treatment	Treatment	Living with and beyond cancer
<ul style="list-style-type: none"> Some people have language barriers including lack of awareness of how to access help to address any health issues. There is low literacy levels amongst some patients which means they may not understand written information provided. There is a lack of trust in the system in some communities and people feel they will not be taken seriously when they access health services. 	<ul style="list-style-type: none"> There is a low availability of out of hours appointments which may not suit people that work during the day and are unable to take time off to attend appointments. Data collection is patchy and does not always capture all communities. Categories are too broad e.g. ethnicity, which limits analysis that can be carried out. 	<ul style="list-style-type: none"> Economic issues may affect attendance at appointments. Automated reminders are not configured/facility is unavailable for some providers. Access to diagnostics is fragmented. Patients must attend several different services and appointments for tests. 	<ul style="list-style-type: none"> Cultural beliefs may influence health care decisions. Inequity in clinical trials participation (low participation in ethnic minority groups). Health services have limited understanding of the reasons why people choose to receive treatment in other countries. 	<ul style="list-style-type: none"> Patients unable to absorb all information provided to them particularly once a diagnosis has been made. Inadequate amount of time given to patients to process information about their diagnosis and treatment options. Effects of cancer treatment not communicated well, so some patients are unaware of how it may impact their lives. 	<ul style="list-style-type: none"> Low understanding of inequalities that exists in patient-initiated follow-up. There is a lack of outcomes data on people living with and beyond cancer to inform improvements. Transfer of information from secondary to primary care has gaps i.e. needs to include detailed advice to GPs from cancer team regarding follow-up care required.
<ul style="list-style-type: none"> Some individuals may feel hesitant to ask clinicians questions, due to low self-worth or lack of awareness of the scope of questions they can ask clinicians. Misinformation on social media about the healthcare system can influence people's decisions about care. Some people lack confidence to explain health issues or to ask questions if unsure about information provided. 	<ul style="list-style-type: none"> Referral forms do not always contain additional information that is useful to clinical teams e.g. key worker contact details. Codes on EMIS are not always utilised to highlight that a patient has additional needs e.g. language or disability. Some people have difficulty navigating the healthcare system. 	<ul style="list-style-type: none"> Patients with low levels of English find it difficult to communicate or advocate for themselves which may lead to appointments being missed. Patient anxiety and lack of understanding about diagnostic tests may contribute to non-attendance of appointments. Gaps in information exist relating to rebooking DNA appointments. This makes it unclear if patients require additional support to facilitate attendance. 	<ul style="list-style-type: none"> Providers have a limited understanding of the demographic information (e.g. ethnicity and deprivation) of individuals who miss appointments to help analyse and understand trends. Not all patients are confident using technology e.g. for online appointments. Different wait times at hospitals causes disparities. 	<ul style="list-style-type: none"> Format of information materials and language used is not always suitable for all patients. Clinical Nurse Specialist capacity constraints in services impacts on the delivery of personalised care and support for people with cancer. Patients who do not have a fixed address, do not have joined up care from treatment through to follow-up. 	<ul style="list-style-type: none"> Clearer coordination needs to happen between public health and clinical teams. Acute and community healthcare professionals are not always aware of support services close to home for patients/carers.

There are some inequalities/challenges that are relevant to multiple parts of the pathway but have been shown only once in the graphic (e.g. low literacy levels amongst some patients to understand written information provided).

Bringing the insights together

The information gathered from service leads and patients does not attempt to explain the quantitative data however, it does offer some insights on what may influence the access, experience and outcomes of NCL patients.

Some of the areas of potential inequalities identified through engaging staff and patients are relevant to different parts of the cancer pathway e.g., patients with low levels of English find it difficult to communicate with providers. All the insights have been grouped into the six themes below which will help ensure that actions taken to address them are holistic and influence the whole cancer pathway.

Strategy themes priorities

1. Access



2. Communications



3. Data and technology



4. Workforce



5. Trust in and views of the healthcare system



6. Structure of the healthcare system



For each of the six themes, one to two priorities have been set. Some priorities will require longer to deliver compared to others and this will be fully scoped out when developing the action plan. Selection of the priorities was informed by feedback from service leads about its importance to patients and to improving services. Additionally, they were selected as they will help address gaps that other existing strategies will not focus on. As mentioned, particular attention has also been paid to existing work, to avoid duplication e.g., public awareness raising activities on accessing services will be delivered through the Cancer Prevention, Awareness and Screening Strategy, therefore this strategy will not focus on that area.

Our priorities

1. Access



Priority 1: Work with service leads to improve access to and design of hospital transport facilities, to help patients and carers attend all appointments.

Priority 2: Improve access to and participation in clinical trials particularly amongst people from ethnic minority groups, who are typically under-represented in trials.

Why are these priorities important?

Financial constraints can influence patients' and carers' ability to attend hospital appointments which impacts their cancer experience. Facilitating transport for those in need will improve their experience and potentially outcomes too. It is important for participation in clinical trials to reflect the demographics of the population to ensure that the benefits are realised for all communities.

2. Communications



Priority 3: Develop and implement an NCL-wide approach to providing information to patients and carers in multiple formats and accessible language, to meet the diverse needs of our population.

Priority 4: Pilot the use of different technologies during consultations, to enable patients and carers to access the information at any time to support their ongoing care needs.

Why are these priorities important?

Approximately 25% of the NCL population does not speak English as a main language. The national reading age is 9 years. Therefore, it is crucial to adapt our communication style to meet people's requirements. Additionally, feedback from patients highlights the importance of having enough time to understand the information provided during consultations, beyond printed materials. Therefore, we need to consider the use of different technologies to address this gap.

SPOTLIGHT:

Improving breast screening for people with a learning disability

What was the case for change?

Participation in breast screening amongst women with a learning disability (LD) is 14.6% below the rest of the population. There is a need to improve uptake to ensure people with cancer get identified early.

What was delivered?

The Royal Free London (RFL) Hospital breast screening service worked with community learning disability teams to put in place a data sharing agreement which allowed them to identify people with LD who did not respond to their breast screening invitation. They worked with the community teams to raise awareness of breast screening, encouraged people to book an appointment and put in place reasonable adjustments according to the needs of the individuals to facilitate their attendance. An example of an adjustment includes offering the opportunity for people with LD and their carers to carry out a pre-visit to the screening site. This enables people with LD and their carers to familiarise themselves with the environment and understand what happens at the appointment. Another adjustment is the provision of easy read breast screening information to help people make an informed choice about attending their appointment. Breast screening information was provided in easy read format to help people make an informed choice about attending their appointment.

What was achieved?

To date **657** people have been contacted

342 engaged, **169** booked an appointment

68 attended.

As a result of this work, one woman with a learning disability was diagnosed with breast cancer.

This work is now being delivered routinely in the service. The next step is to develop easy read information for the whole breast cancer pathway.

...Our priorities

3. Data and technology



Priority 5: Integrate granular demographic and geographic data into routine reporting across the entire cancer pathway. This will enable continuous monitoring of disparities and support data-driven service development and delivery.

Priority 6: Work collaboratively with NCL ICB, primary and secondary care, to establish new data sources, improve data quality, adopt advanced analytical methods and ensure information is available in appropriate formats to help identify unwarranted variations in care and guide service delivery.

Why are these priorities important?

Improving the completeness of the data available will make it easier to monitor inequalities across the pathways. Analysing the available data is equally important and ensuring it can be accessed by all staff will help move us closer to addressing inequalities across the system.

4. Workforce



Priority 7: Invest in the development and continuous improvement of action-oriented training on addressing health inequalities for all clinical and non-clinical staff.

Priority 8: Collate and promote available resources about services in the community that primary and secondary care can refer patients to for additional support.

Why are these priorities important?

Providing all staff with training on the role they can play in tackling inequalities is vital in making it everyone's business. Regular training updates help ensure that inequalities remain a priority. Staff awareness and up-to-date knowledge about the additional support available for patients and carers are very important in improving patient experience and quality of life.



SPOTLIGHT:

PREPARE

What was the case for change?

The NHS Long Term Plan requires every person diagnosed with cancer to have access to personalised care, including health and wellbeing information and support from the moment they receive their diagnosis. Current data shows that cancer patients are not receiving sufficient wellbeing information and support at the pre-treatment stage of the cancer pathway, resulting in them not receiving optimal support and expertise to manage their care.

What was delivered?

Royal Free London (RFL) Hospital launched PREPARE, a pilot pre-treatment health and wellbeing event for all patients diagnosed with cancer, whether that be curative or palliative treatment, to help them prepare and manage diagnosis and treatment.

Two-hour appointments were delivered twice per month at alternating clinical and non-clinical venues. Patients could self-register or be referred by a clinical nurse specialist (CNS)/cancer support worker. Patients could bring along a 'plus one' relative/carer. Sessions were also attended by CNSs and cancer support workers.

The interactive sessions covered Personalised cancer care, Reacting to cancer, Eating well, Physical activity and exercise, After effects of treatment, Resources to help attend cancer information services, and Extra help with living costs. Sessions included peer support, Q&A, and refreshments.

What was achieved?

101 patients and 90 plus one's attended

**97% scored 8 out of 10 or higher
on the satisfaction survey**

People with a variety of tumour types and from diverse ethnicities representative of the RFL population attended. The accompanying course booklet is being translated and a video version is being developed with subtitles in the top ten RFL languages.

...Our priorities

5. Trust and views of the healthcare system



Priority 9: Strengthen partnership working with the voluntary, community and social enterprises (VCSE) sector across the whole cancer pathway to better target underserved communities and health inclusion groups, to improve trust and encourage engagement with healthcare services.

Why is this priority important

Some communities lack trust in the health and care system. As a result, they may delay seeking help for concerning symptoms or adhering to cancer treatment, which can result in poor outcomes. Building trust and encouraging people to access care early through working with VCSE which support these communities is essential. Stronger partnership working will enable VCSE to directly contribute to the development and improvement of projects and services.

6. Structure of the healthcare system



Priority 10: Take an inclusive, user experience approach to quality improvement and service design to ensure barriers across the cancer pathway are considered and addressed.

Why is this priority important?

It is crucial to adopt a patient-centred approach when designing and improving services, as it helps identify potential barriers early on. Taking into account the diversity of the population's needs is key. There are various tools available that can support this process, including the example provided in Appendix 4 – designing for diversity.

SPOTLIGHT:

C Factor

What was the case for change?

Many patients are hesitant to attend 1-2-1 psychological support services, especially those who lack confidence in mental health services and have low levels of literacy. Patient feedback shows the need for more inclusive, accessible and creative approaches to emotional wellbeing support, to encourage those who do not attend 1-2-1 appointments but still require emotional support.

What was delivered?

Macmillan, in collaboration with Whittington Hospital and local psychology teams, developed C Factor, group emotional support sessions, combining psychology, storytelling and applied theatre approaches to create a safe space for participants to share their experiences.

Eight 2-hour sessions were piloted with two in-person groups. The content revolved around the story of fictional characters, Ricky and his friends narrated by an actor. Most of the stories were based on real experiences and words of Whittington patients to lend authenticity. The topics included the shock of diagnosis, talking to friends, and family about cancer, the effects of treatment, ending treatment, feedback and celebration.

What was achieved?

16 participants attended an average of 4.2 sessions and at least 1 session.

Participants ranged from 37–80 years, 75% female and 25% male, and from diverse ethnic backgrounds and tumour groups representative of the NCL population.

7 participants provided written (some with the help of family members) and verbal feedback including 2 participants who had been under mental health services and 2 with low literacy levels

Additionally, satisfaction survey scores showed improvement in participants' overall wellbeing, greater confidence in talking with friends and family about cancer, improved confidence in managing the emotional effects of cancer, and feeling less alone with cancer. Funding is being explored to develop a film, handbook and to run further pilot sessions.

Delivering the strategy

Each system partner (mostly secondary care providers) will develop an action plan for their organisation that aligns with the priorities they will take forward over the short, medium and long term.

This process will be supported by the NCL Cancer Alliance and key governance groups to ensure there are opportunities for joint working, delivery oversight and ability to track outcomes and impact of the strategy.

The principles that will shape delivery of the strategy will include:



- **Close partnership working** to maximise resources available across the system and ensure pathway learnings can be shared. This will include working closely with patients, the public and other organisations embedded in the NCL community, to address multiple health conditions including cancer. Where activities can be delivered at NCL level, they will be prioritised.



- **Spreading good practice** where there is evidence that interventions will have a positive impact on patients and improve service delivery.



- **Being innovative** and trialling new ways of doing things, to scale up activities that are effective.



- **Building ways to sustain what we do**, to ensure that good work does not get lost.

This process will be supported by the NCL Cancer Alliance and key governance groups

APPENDICES

APPENDIX 1:

What the cancer inequalities data is telling us

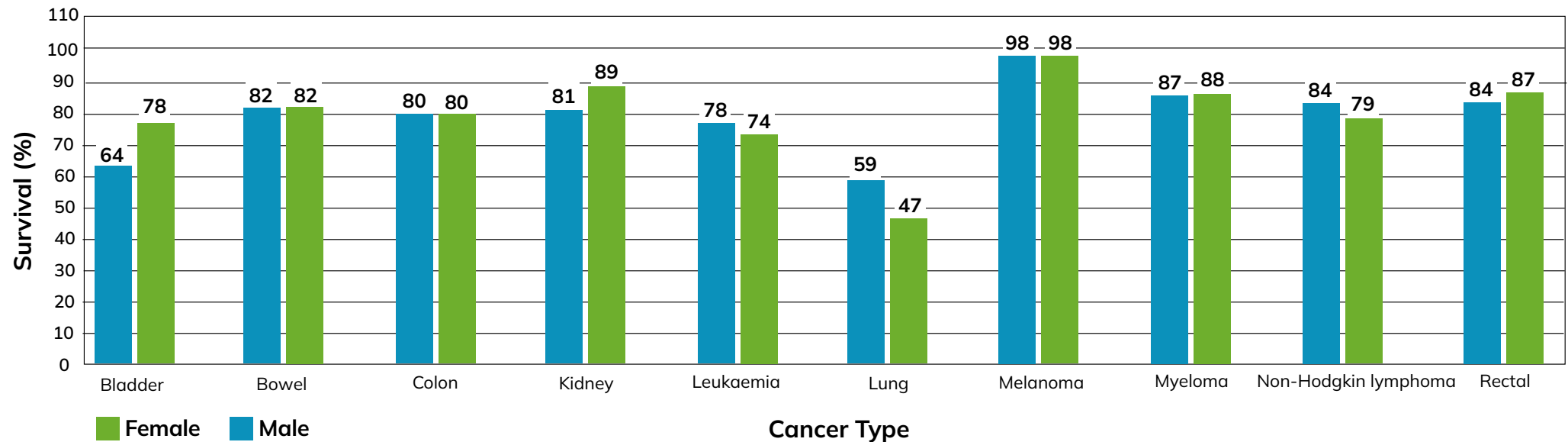
Survival outcomes between sexes

In NCL, a great difference in survival outcomes is seen in bladder, kidney, Non-Hodgkin lymphoma and lung cancers. In the former three cancers, survival is worse in females and in the latter, it is worse in males, as shown in Figure 1. This is survival data for patients diagnosed in 2020 and followed up in 2021.

Survival by deprivation

Data on survival by deprivation quintile is unavailable at NCL level. Available national figures show that people living in the most deprived quintile have a lower one-year survival compared to those in the least deprived for almost all cancers.

Figure 1. NCL one-year survival by sex



Data source: Cancer Survival in England - NHS England Digital. Analysed by the Centre for Cancer Outcomes.

APPENDIX 2:

What the cancer inequalities data is telling us

Table 1. Variation in urgent suspected cancer referral rates by ethnicity (2023)

Urgent suspected cancer referral type	Asian	Black	Mixed	White
Suspected brain or central nervous system tumours	-0.6%	1.9%	-1.7%	0.4%
Suspected breast cancer (including Symptomatic)	-6.7%	1.6%	-2.2%	7.3%
Suspected cancer - non-specific symptoms	-1.2%	2.5%	-3.9%	2.5%
Suspected gynaecological cancers	-5.6%	2.1%	-2.9%	6.4%
Suspected haematological malignancies excluding acute leukaemia	-4.6%	3.1%	-3.7%	5.3%
Suspected head and neck cancers	-1.8%	-0.6%	-2.3%	4.7%
Suspected lower gastrointestinal cancers	-3.5%	-0.9%	-4.0%	8.4%
Suspected lung cancer	-4.3%	-4.5%	-4.3%	13.1%
Suspected sarcomas	-2.7%	0.7%	-0.7%	2.7%
Suspected upper gastrointestinal cancers	-0.4%	0.5%	-3.6%	3.5%

Skin and urological cancers were excluded from this analysis due to a known higher rate of referral in some ethnicities.

Key:

RED denotes an under representation within urgent suspected cancer referrals compared to NCL population.

GREEN denotes over representation within urgent suspected cancer referrals compared to NCL population

Data source: Pseudonymised pathway level Cancer Waiting Times data linked to patient demographics. Analysed by the Centre for Cancer Outcomes.

APPENDIX 3:

What the cancer inequalities data is telling us

Table 2. Difference in early-stage diagnosis vs all diagnosis by ethnicity (2022)

Cancer type	Asian	Black	Mixed	White
Breast	-0.1%	-1.0%	1.5%	-0.4%
Colorectal	-1.5%	-0.9%	0.0%	2.5%
Gynaecological	2.8%	-1.2%	-0.4%	-1.2%
Haematological	-7.1%	1.5%	-7.1%	12.8%
Lung	0.6%	-1.8%	0.4%	0.8%
Melanoma	0.1%	0.1%	-0.2%	-0.1%
Oesophago-gastric (OG)	-9.6%	-3.5%	4.8%	8.4%
Prostate	-0.4%	2.5%	0.2%	-2.3%
Upper Gastro-intestinal (GI) excl. OG	0.4%	-9.6%	-0.4%	9.6%
Urological excl prostate	0.9%	0.3%	-2.1%	0.9%

Key:

RED denotes an under representation within early diagnosis compared to all diagnosis.

GREEN denotes an over representation within early diagnosis compared to all diagnosis.

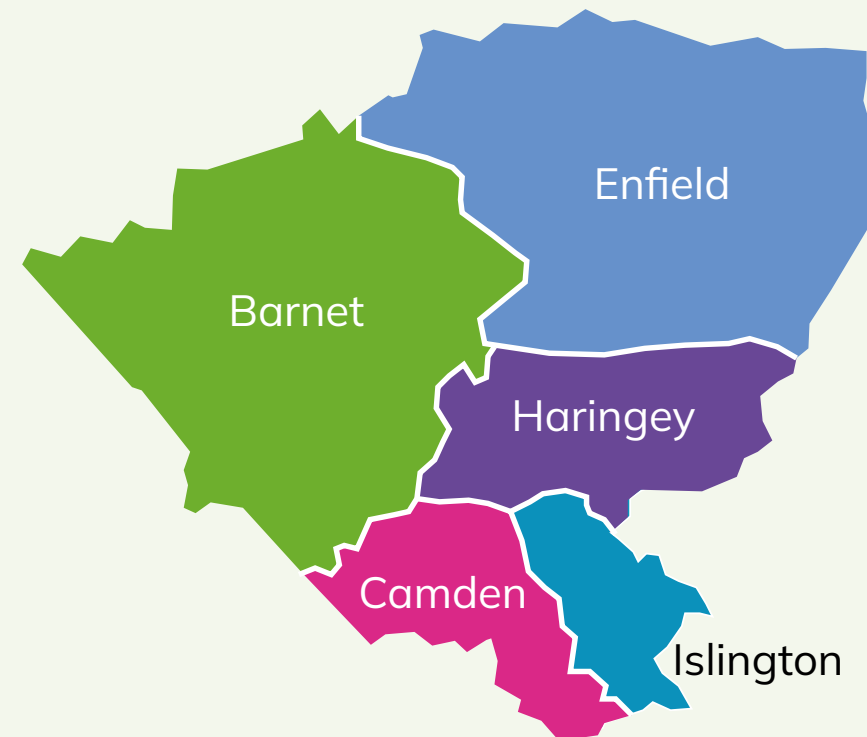
Data source: Rapid Cancer Registration and Treatment Data. Analysed by the Centre for Cancer Outcomes.

APPENDIX 4:

What the cancer inequalities data is telling us

Cancer diagnosis by borough

- In **Barnet**, there is an over-representation of White patients in diagnoses for haematology, skin, lower GI, lung, and urology (excluding prostate) cancers compared to the population level.
- In **Camden**, there is an over-representation of White patients in lung, haematology and lower GI cancer diagnoses and an under-representation of Asian patients in prostate diagnoses.
- In **Enfield**, there is over-representation of White patients in lower GI, skin and lung diagnoses.
- **Haringey** shows the best correlation between cancer referrals and diagnoses compared to the overall NCL population.
- In **Islington**, there is an over-representation of White patients in lower GI, lung and urology (excluding prostate) diagnoses.



Data source: Pseudonymised pathway level Cancer Waiting Times data linked to patient demographics. Analysed by the Centre for Cancer Outcomes.

APPENDIX 5:

What the cancer inequalities data is telling us

Cancer Waiting Times – Faster Diagnosis Standard and 62-day Performance (2023)

Figure 2. Faster Diagnosis Standard (FDS) performance by deprivation

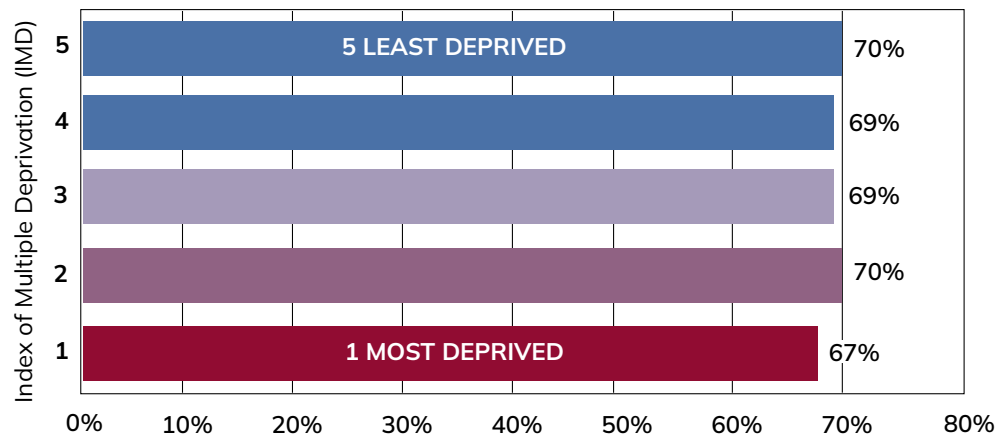
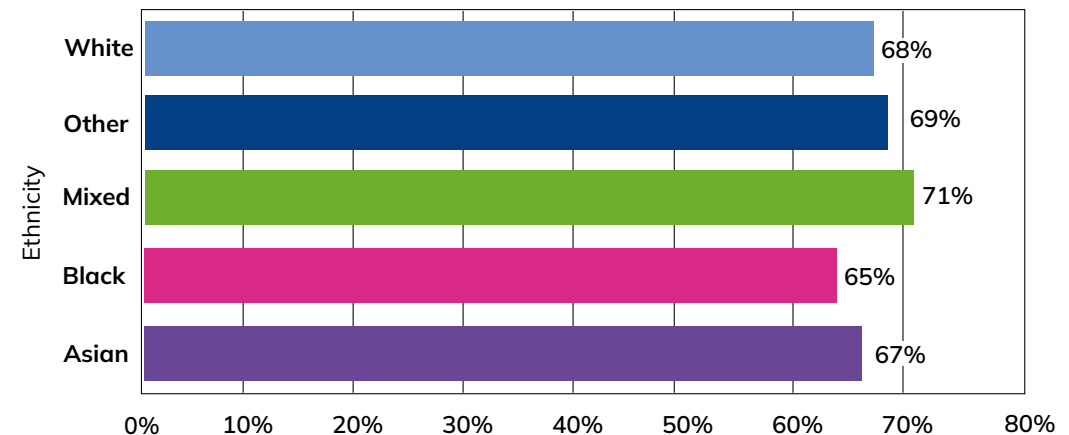


Figure 3. 62-day performance by ethnicity



Data source: Pseudonymised pathway level Cancer Waiting Times data linked to patient demographics . Analysed by the Centre for Cancer Outcomes.

APPENDIX 6:

What the cancer inequalities data is telling us

National Cancer Patient Experience Survey

Figure 4. 2023 NCPES respondents by ethnicity

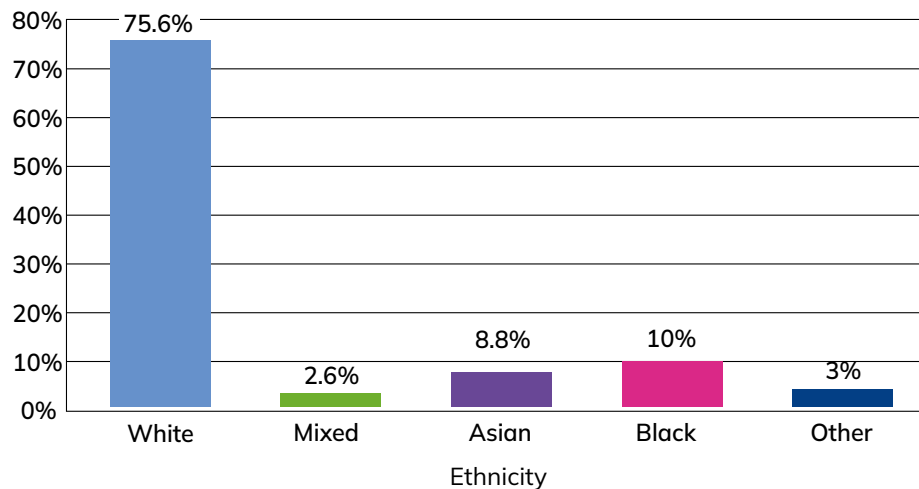
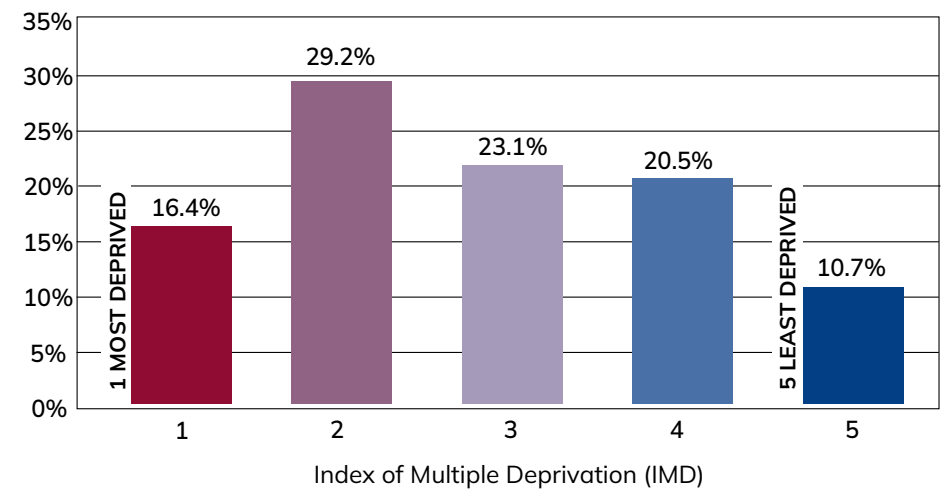


Figure 5. 2023 NCPES respondents by deprivation



Data source: National Cancer Patient Experience Survey. Analysed by the Centre for Cancer Outcomes.

APPENDIX 7:

What the cancer inequalities data is telling us

Quality of life

The Cancer Quality of Life Survey measures overall health and quality of life. Analysis of respondents from 2020 to 2023 shows that there is a consistent under-representation in patients from the most deprived quintiles (IMD 1 and 2), suggesting that more deprived individuals are less likely to participate, or be represented in the survey.

There is a notable under-representation of ethnic minorities (Asian, Black, and Mixed) in the survey respondents, whereas White populations are consistently over-represented, suggesting a bias or discrepancy in survey reach or participation.

Table 3 shows the difference in responses compared to the NCL population, broken down by deprivation and ethnicity for breast, prostate and lung, as there are sufficient respondents for these tumour groups to analyse.

Table 3. Difference in responses by deprivation and ethnicity (2020 to 2023)

Cancer type	Ethnicity type				
	Asian	Black	Mixed	Other	White
All cancers	-7%	-8%	2%	7%	7%
Breast	-8%	-6%	0%	7%	7%
Prostate	-8%	-12%	2%	9%	9%
Lung	-7%	-3%	9%	10%	

Cancer type	Ethnicity type				
	Asian	Black	Mixed	Other	White
All cancers	-10%	-5%	-5%	1%	13%
Breast	-9%	-4%	-6%	5%	14%
Prostate	-10%	-1%	-6%	-1%	19%
Lung	Unavailable				

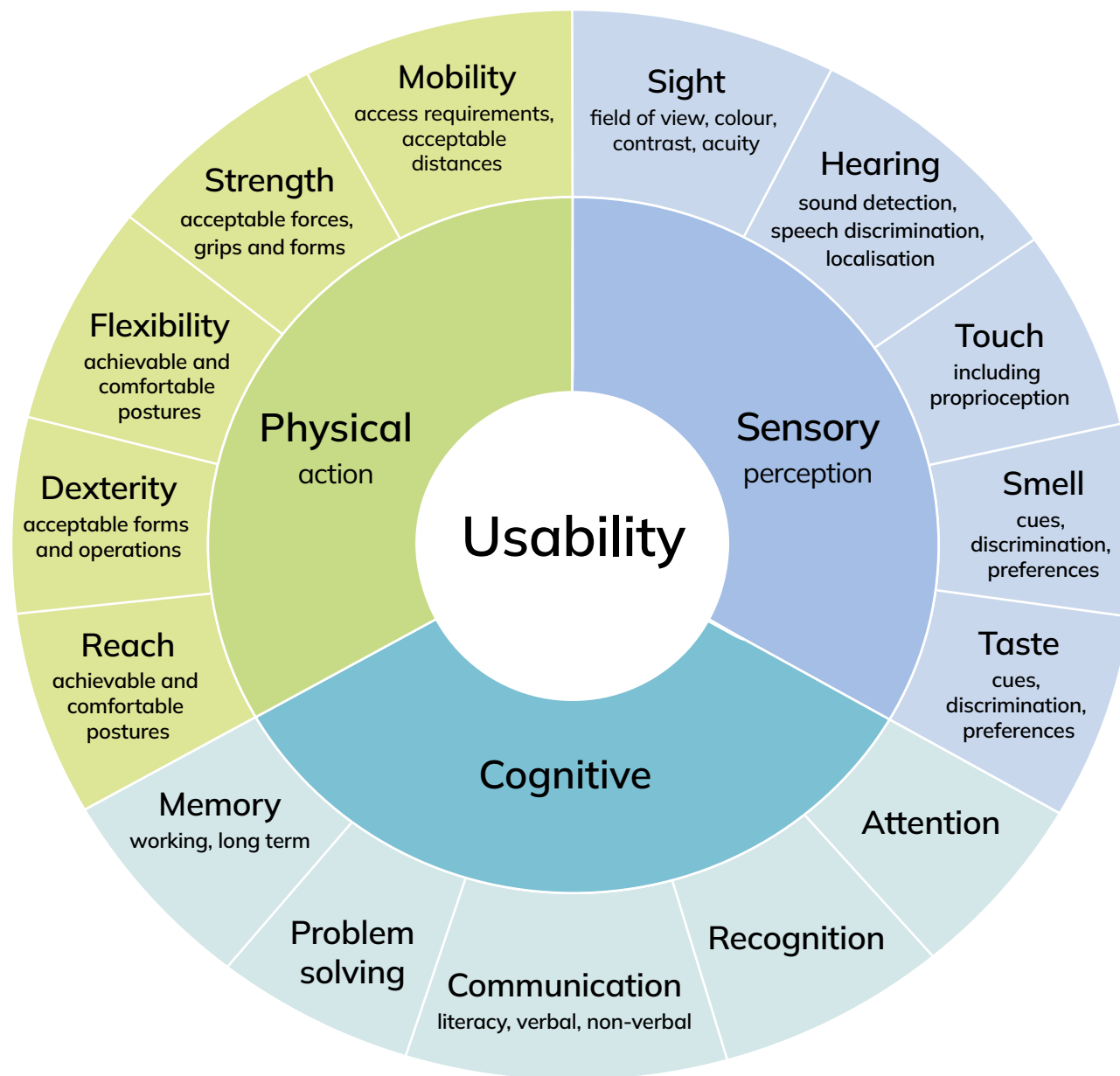
Key:

RED denotes an under representation of respondents compared to NCL population.

GREEN denotes over representation of respondents compared to NCL population.

APPENDIX 8: Inclusive design

Inclusive design is about designing for as diverse a range of people as possible. It is a philosophy that encourages us to consider how size, shape, age, sex, sexuality, ethnicity, education levels, income, spoken languages, culture and customs, and even diets shape the way we interact with the world. More importantly, it is about designing products and services in light of this understanding.



Source: DCA - Designing for Diversity | DCA Design International (dca-design.com)

GLOSSARY

Word	Definition
62-day performance standard	The standard states that people who have been referred for suspected cancer and go on to receive a diagnosis should start treatment within 62 days of their referral.
Faster Diagnosis Standard (FDS)	The Faster Diagnosis Standard states that people should have cancer ruled out or receive a diagnosis within 28 days of an urgent suspected cancer referral.
Incidence	The occurrence of new cases of disease, injury, or other medical conditions over a specified time period, typically calculated as a rate or proportion.
Indices of Multiple Deprivation (IMD)	The IMD datasets are small area measures of relative deprivation across each of the constituent nations of the United Kingdom. Areas are ranked from the most deprived area (rank 1) to the least deprived area. Each nation measures deprivation in a slightly different way but the broad themes include income, employment, education, health, crime, barriers to housing and services, and the living environment.
Prevalence	The proportion of a population with a disease or a particular condition at a specific point in time (point prevalence) or over a specified period of time (period prevalence).
Urgent Suspected Cancer (USC) referral	Urgent Suspected Cancer (USC) referrals are used for people with possible cancer symptoms, to refer them to secondary care for investigation and possible diagnosis.

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