NHS

Achieving World-Class Cancer Outcomes: Taking the strategy forward
Equality and Health Inequalities Analysis

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1 Equality Analysis

Title
Achieving World-Class Cancer Outcomes: Taking the strategy forward

What are the intended outcomes of this work?

The implementation programme outlined in the plan takes forward the independent Cancer Taskforce's five-year cancer strategy. The strategy sets clear ambitions for the work:

- fewer people getting preventable cancers, with national adult smoking rates falling to 13% by 2020
- more people surviving for longer after a diagnosis, with 75% surviving one year or more by 2020, 57% of patients surviving ten years or more, a reduction in CCG variation and a reduction in the survival deficit for older people
- more people having a positive experience of care and support; and,
- more people having a better long-term quality of life.

Who will be affected by this work?

People affected by cancer – those living with it and those supporting relatives or friends with a diagnosis – are the driving force for the change. Every part of the health and care service will need to step up its effort, dedication and passion to achieve the very best cancer outcomes as set out in the strategy and implementation plan.

Evidence

What evidence have you considered?

- National Cancer Intelligence Network: Cancer and equality groups: key metrics – 2015 report, Public Health England

Data included in the NCIN key metrics reports are taken from a variety of different sources, including analysis produced within the NCIN, PHE Knowledge and Intelligence Teams, Cancer Research UK, Macmillan Cancer Support, and the Office for National Statistics, with data from the Health and Social Care Information Centre, NHS Cancer Screening Programme, and the Cancer Patient Experience Survey. NCIN (now the National Cancer Registration and Analysis Service) has said that the value of bringing these data together presents an overall view of data on cancer and equalities. Some of the data highlight where there are differences between equality groups, whilst others show that differences do not exist.

Age

Screening: In cervical screening, coverage is lowest in the youngest age group (25-29) and highest in the 50-54 age group. In breast screening, coverage generally increases with age until women aged 60 to 70, and is lower in 70-74 year olds. Much of this will be due to the changing age range of women routinely invited for screening appointments.

Routes to diagnosis: Very low proportions of breast and prostate cancer are diagnosed through an emergency route in patients aged under 80 years, with the proportion increasing with age, being highest in the 85 and older group. Lung cancer patients have the highest proportions of emergency presentations (38% overall), increasing with age with 57% of patients aged 85 or older diagnosed through this route.

Patient experience: In the Cancer Patient Experience Survey (CPES), the youngest age groups are generally the least positive about their patient experience. For example, in the 2014 survey 51% of the youngest age group said they completely understood the explanation as to what was wrong with them compared to 75% of the oldest age group.

Treatment: For all cancer types assessed, older patients were less likely to have had surgery, and this decline often started from the youngest age group. The number of patients undergoing chemotherapy for bowel cancer increases with age until a peak in the 65-69 age group. While cases then decline slightly, the number of patients receiving chemotherapy rapidly drops to much lower numbers in the 85 years and older age group. There is an early peak in the proportion of patients having radiotherapy in the five to nine age group, reflecting childhood cancer treatment. After decreasing in teenagers and young adults, the proportion increases again, reaching a peak in patients aged 50 to 69 and decreases for older patients.

Patient-reported outcome measures: Patients aged 65 to 74 had the highest proportion in 'perfect health' (40%) with the lowest proportion in patients aged 85 and over (21%).

Disability

Patient experience: The CPES asked patients to state whether they had any long-term conditions (LTCs), other than cancer. Patients were able to select multiple items from: deafness or severe hearing impairment; blindness or partially sighted; a long standing physical condition; a learning disability; a mental health condition; or a long standing illness such as HIV, diabetes, chronic heart disease, or epilepsy. Responses are shown for patients who had no long-term conditions and those who selected at least one. Patients with long-term conditions were less positive about their cancer care than patients without such conditions across a wide range of issues measured in the survey. Figure 8.6.1 shows three of these questions, where those with at least one long-term condition were less likely to say they were given easy to understand written information about their type of cancer or their operation, or given information on financial help or benefits by hospital staff.

Gender reassignment (including transgender)

There is very little information on differences in cancer incidence, treatment or outcomes by gender reassignment, and none at a national level.

Marriage and civil partnership

There is very little information on differences in cancer incidence, treatment or outcomes by marital or civil partnership status, and none at a national level.

Pregnancy and maternity

There is very little information on differences in cancer incidence, treatment or outcomes for pregnant women or mothers, and none at a national level.

Race

Incidence: Black people have higher rates of myeloma and stomach cancer, and black males have higher rates of prostate cancer. Incidence rates of liver cancer are highest amongst Asian people compared with white people. Rates of mouth cancer are higher in females and rates of cervical cancer are higher in the over 65s.

Patient experience: In 2014, there were 21 questions where different ethnic groups had significantly different responses. White patients were least likely to agree that they had been asked to take part in research and been given a written assessment and care plan. A lower proportion of patients from Asian groups reported that they did not feel like they were treated as a 'set of symptoms'.

Religion or belief

There is very little information on differences in cancer incidence, treatment or outcomes by religion or belief, and none at a national level.

Sex

Incidence: For the majority of common cancer types, males have higher incidence rates than females. With certain causes of cancer being higher in males, such as smoking and exposure to asbestos, it is to be expected that lung, bladder and other smoking related cancers are higher in males. However, higher rates for males are also seen for many other cancer types.

Mortality: For the majority of common cancer types, males have higher cancer mortality rates than females. Mortality rates for bladder and oesophageal cancers were more than two and a half times higher for males than females.

Survival: Survival is higher for females than males with lung cancer and malignant

melanoma, while male colorectal cancer patients have better survival than females.

Prevalence: At the end of 2010 there were over 1.8 million people alive who had been diagnosed with cancer in the previous 20 years. Over a million of these were females. There were just under 600,000 people aged 75 or over, and around 240,000 aged under 50 who had a diagnosis of cancer in the previous 20 years.

Screening: In bowel screening, for men and women aged 60-69 uptake is slightly higher amongst women than men.

Routes to diagnosis: Males have a higher proportion of emergency presentations for melanoma, non-Hodgkin lymphoma and thyroid cancer. Females had a higher proportion for chronic lymphocytic leukaemia, oesophagus, stomach, bladder and brain cancer.

PROMs: Males (37%) were more likely to report being in 'perfect health' than females (32%)

Sexual orientation

Incidence: Data from the Integrated Household Survey shows that lesbian and gay people are much more likely to smoke than the general population (25.3% compared to 18.4%)[i]. Whilst there is a lack of research on smoking among bisexual and trans people, surveys do show both bisexual and trans people are more likely to smoke (Stonewall, 2012[ii]; Rooney, 2012[iii]). Young LGB people are also more likely to smoke, to start smoking at a younger age and smoke more heavily (Corliss et al, 2013)[iv].

MSM are at increased risk (compared to heterosexual men and women) of anal HPV40 and anal cancer (associated with HPV), and may be at increased risk of other HPV-associated cancers (penile, oral and throat). MSM are also at risk of hepatitis B and C41 (associated with liver cancers.[v]

Patient experience: In the most recent Cancer Patient Experience Survey report, there were 24 questions where there was a difference in the response by sexual orientation. For all of those, the heterosexual group reported a more positive experience. LGBT groups were less likely to report being given enough privacy when discussing their condition or treatment, not feeling treated like set of symptoms and being able to discuss their worries or fears with staff.

Carers

There is very little information on differences in cancer incidence, treatment or outcomes for carers, and none at a national level.

Engagement and involvement

A six-week consultation on the new cancer strategy was launched by the independent Cancer Taskforce on 14th January 2015 and closed on 27th February 2015. 226 formal written responses were received.

The 226 responses were predominantly comprised of members of the public, including people who self-defined as having been affected by cancer (99 responses, 44%) and responses received from an organisation (94 responses, 42%).

A summary of the written responses can be seen here.

In addition, nearly 100 workshops and meetings were held, involving around 600 participants, the proactive involvement of patients, consultation with around 30 cancer charities, and professional groups.

Across all of this stakeholder engagement, reducing inequalities and promoting equality were seen as a key over-arching theme, along with variation between services, workforce and data.

Moving forward from the strategy, the National Cancer Advisory Group, which is chaired by Sir Harpal Kumar, Chief Executive of Cancer Research UK, and is comprised of cancer charities, Royal Colleges and patient representatives, have informed the development of the implementation plan. There will be continued engagement and involvement of stakeholders through the programme to implement the strategy.

Summary of Analysis

The intended impact of the cancer strategy is to reduce preventable cancers, increase survival and improve patient experience and long-term quality of life for all cancer patients, regardless of their background or where they live.

Cancer does not discriminate; it can affect anybody at any point in their life. However, as shown in the evidence above, one, some or all of the protected characteristics can impact on cancer incidence, mortality, survival, experience and other outcomes.

The implementation plan puts local clinical leadership at the heart of delivering the Cancer Taskforce strategy. Working together in Cancer Alliances, clinical leaders from across different health and care settings in a local community will look at whole pathway data and information in the new Cancer Dashboard – including survival, early diagnosis rates, treatment outcomes, patient experience and quality of life – and use it to pinpoint areas for improvement locally through pathway redesign and changing clinical behaviours.

It is expected that in looking at the data and information about local outcomes and services across cancer pathways, Cancer Alliances and their constituent members consider the specific outcomes of different protected groups and inclusion health groups where the data are available, and consider their specific needs when planning to improve cancer outcomes across their communities. In this way, they should work to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Promote good relations between groups

The implementation plan sets out the support that local clinical leaders will have from national initiatives and transformation programmes to make real the pathway improvements they determine are necessary from the data, information and experience they have in their local areas, to turn the Cancer Taskforce ambitions into reality.

To support clinical leaders in Cancer Alliances to understand the cancer outcomes of those within different protected groups, at a national level we will seek to improve the availability of such data within the Cancer Dashboard.

Evidence based decision-making

To support clinical leaders in Cancer Alliances to understand the cancer outcomes of those within different protected groups, at a national level we will seek to improve the availability of such data within the Cancer Dashboard.

In order to share findings of our equality analysis, we will publish this document alongside the implementation plan.

2 Health Inequalities Analysis

Evidence

1. What evidence have you considered to determine what health inequalities exist in relation to your work?

National Cancer Intelligence Network: [Cancer and equality groups: key metrics](#) – 2015 report, Public Health England.

This includes evidence on socio-economic deprivation:

Incidence: A joint NCIN/Cancer Research UK (CRUK) report showed that incidence rates of some cancers (oral cavity in males, larynx, liver in males and lung cancer) in the most deprived group were at least double those of the least deprived group.

Mortality: The joint NCIN/CRUK report showed that mortality rates for many cancers (eg oral cancer, stomach, anus, lung, cervix and penis) were at least double in the most deprived group compared to the least deprived group. Only malignant melanoma showed higher mortality rates for the least deprived compared to the most deprived group.

Survival: Patients resident in more deprived areas have worse survival for colorectal, lung and ovarian cancer, with small differences between the deprivation groups for breast and prostate cancer.

Diagnosis: As many cancers are more commonly diagnosed in more deprived areas, the lower numbers of one-year survivors in the more deprived groups partially reflect the worse survival for these patients

Routes to diagnosis: For many cancer types, differences were observed by deprivation with a higher proportion of emergency presentations in the most deprived group. A clear gradient is observed for female breast, colorectal, lung and prostate cancer.

Patient experience: Of the 37 questions in the 2014 survey with a statistically significant difference in responses between the least and most deprived groups, patients living in less deprived areas reported a better experience in 25 questions. This included reporting health getting worse whilst waiting to see a hospital doctor and receiving written information about tests.

Patient-Reported Outcome Measures (PROMs): The proportion of patients in 'perfect health' decreased with increasing deprivation, from 39% in the least deprived group to 28% in the most deprived group

Impact

2. What is the potential impact of your work on health inequalities?

The intended impact of the cancer strategy is to reduce preventable cancers, increase survival and improve patient experience and long-term quality of life for all

cancer patients, regardless of their background or where they live.

3. How can you make sure that your work has the best chance of reducing health inequalities?
Through Cancer Alliances, as set out above.

Monitor and Evaluation

4. How will you monitor and evaluate the effect of your work on health inequalities?
Through the Cancer Dashboard, as set out above.

For your records

Name of person(s) who carried out these analyses:

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Name of Sponsor Director:

Cally Palmer, National Cancer Director

Date analyses were completed:

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