



**MSD**  
INVENTING FOR LIFE

# Driving health equity in cancer: Practical examples from Cancer Alliances





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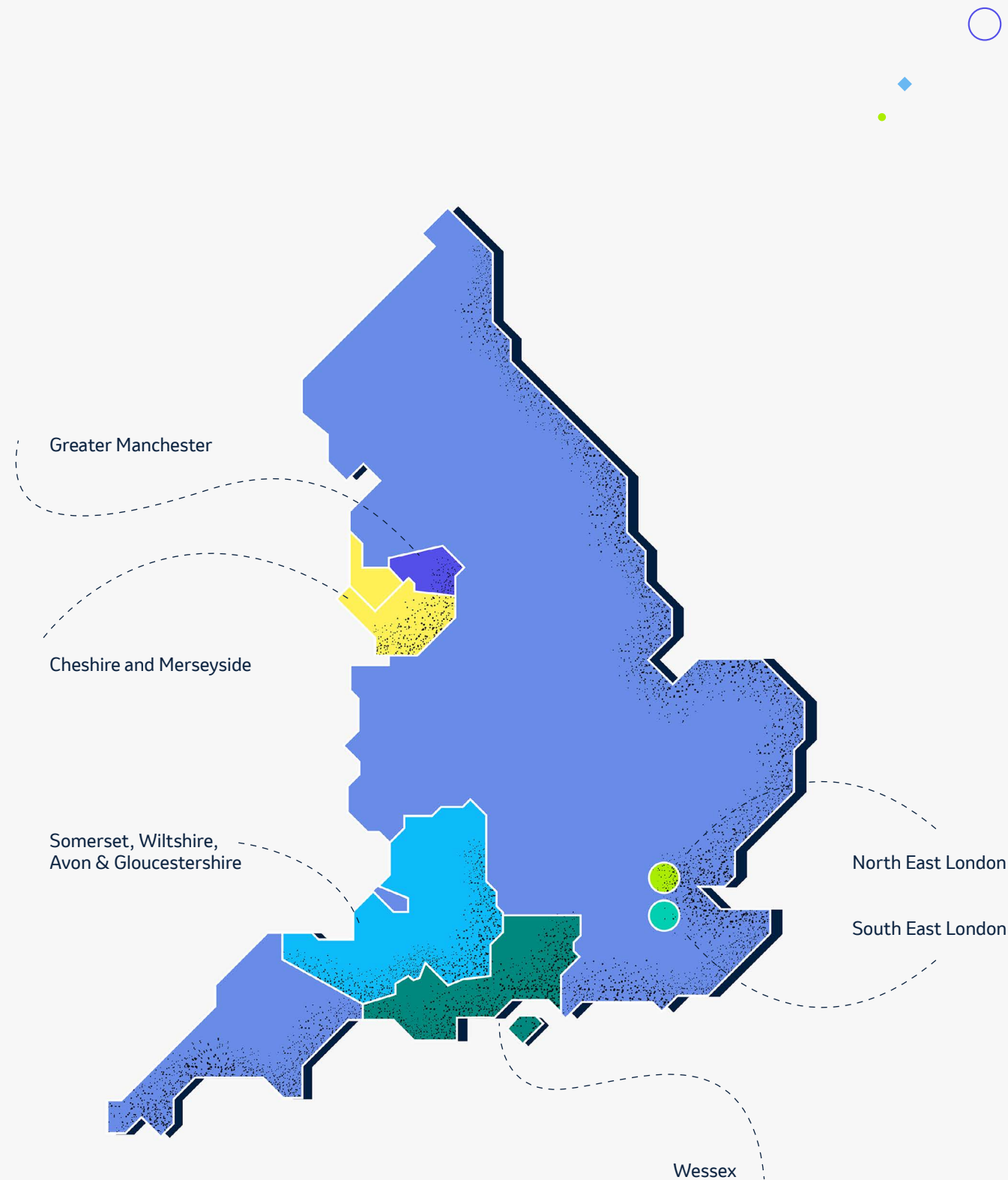
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DISCLAIMER

This report was funded and developed by MSD The case studies included in this report have been collated following desk research and interviews with Cancer Alliances inequalities leads. All Cancer Alliances across England were invited to participate in the project and those included in the report responded to our calls for evidence. Please be aware that all external hyperlinks will take you to an external website.

# Cancer Alliance case study locations



# Foreword – NHS England

**Professor Peter Johnson, National Clinical Director for Cancer & Professor Bola Owolabi, Director of the National Healthcare Inequalities Improvement Programme**

Health inequalities affect many different groups within our society, resulting in some people facing greater difficulties accessing health services and experiencing poorer levels of care and outcomes.

NHS England's National Healthcare Inequalities Improvement Programme was set up to address the underlying issues that cause health inequalities and drive solutions to reduce them where they exist. Through our Core20PLUS5 approach, we are supporting NHS England and local systems to identify and reduce health inequalities and improve the experiences of some of the most vulnerable and disadvantaged communities. We are delighted to see this programme of work drive NHS action.

The case studies in this report provide powerful insights into this work using the important example of cancer, which is a key priority for the NHS and within Core20PLUS5. They demonstrate the innovative and responsive ways Cancer Alliances and other organisations are implementing Core20PLUS5 in their local communities, shaping their work around a community's specific needs. They exemplify the types of projects we hoped a more local, joined-up approach to health service organisation would deliver. We have enjoyed hearing about these case studies throughout the project and hope they inspire others, as they have inspired us, to continue our life-saving and important work in addressing health inequalities in cancer care across England.

# Foreword – Macmillan Cancer Support

**Claire Taylor MBE, Chief Nursing Officer & Professor Richard Simcock, Chief Medical Officer**


Eliminating health inequalities is becoming an increasing priority in the UK as we continue to see widening variation in cancer outcomes. This report offers positive and practical ways to improve health equity with useful insights from others' key learnings and provides further resources you may wish to access. The case studies highlight why a multi-stranded approach is needed to reach the intersecting drivers of these stark differences in health. Collectively, they demonstrate how through collaboration, education, commitment to service improvements, small steps build to meaningful changes across the system. At Macmillan, we have seen this materialise through our work with the Cancer Champions project, an example of which is mentioned here. We hope this report inspires you to replicate some of this good work.


# Introduction

## What is health equity?

Health equity is defined as “the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.”<sup>1</sup> Health equity can only be achieved by eliminating health inequalities. The Government and NHS have both committed to tackling health inequalities, and this shapes policy and practice at both a national and a local level.


Health inequalities can be driven by a number of factors including, but not limited to:<sup>2</sup>


Socio-economic factors – such as income


Geography – such as regional, urban or rural areas


Specific characteristics (including those protected in law) – such as race, disability, and sex

As there are many drivers, which can all intersect with one another, people experience health inequalities differently.<sup>3</sup> For example, health inequalities may manifest as differences in:<sup>4</sup>

Health status – such as life expectancy

Access to care – such as availability of services

Quality and experience of care – such as levels of patient satisfaction

Behavioural risks – such as smoking rates

## How do health inequalities impact on cancer?

Health inequalities have a direct impact on the risk of getting cancer, the speed with which someone is diagnosed, and their likelihood of surviving. For example, a report by Cancer Research UK found that more than 30,000 extra cases of cancer in the UK each year can be attributed to “socio and financial deprivation, and survival is worse for the most deprived groups.”<sup>5</sup>

Other research has highlighted that deprivation and lifestyle behaviours, which are often closely linked, are the most significant contributors to cancer diagnoses – with an estimated 40% of cancers being caused by risk factors, such as smoking and obesity.<sup>6</sup>

People from the most disadvantaged socioeconomic backgrounds are also less likely to attend screening appointments,<sup>7</sup> tend to have lower awareness of cancer symptoms and experience greater challenges in accessing help – including difficulty taking time off work and arranging transport to appointments. Unfortunately, this can contribute to delayed diagnosis, often through emergency routes, which in turn impacts their treatment options.<sup>8</sup> National data show that only 49% of people living in the most deprived quintile are diagnosed with cancer at an early stage (stage 1 or 2), compared to 58% of people from the least deprived quintile.<sup>9</sup> Colorectal cancer is a good example of why stage of diagnosis matters: patients diagnosed at stage 1 have a 90% chance of surviving five years after diagnosis, versus less than 10% of patients diagnosed at stage 4.<sup>10</sup>

While much of the evidence focuses on deprivation, there are many other health determinants that may influence the care that patients with cancer receive. For example, structural, gender, racial and educational inequalities can result in mistrust and fear among communities when it comes to accessing healthcare.

As recognised in *Levelling up: what does it mean for the less survivable cancers in England*,<sup>11</sup> it is vital that more work is undertaken to understand how deprivation, and other health inequalities, drive variation in cancer care.<sup>12</sup> What is clear is that it will not be possible for the Government and NHS to deliver on their early diagnosis and survival ambitions without a strong focus on tackling health inequalities.

## What are the Government and NHS doing about health inequalities?

The Government and NHS have made a number of commitments to addressing health inequalities. The [NHS Long Term Plan](#), published in 2019, made health inequalities a central focus, for example by stating an intent to “target a higher share of funding towards geographies with high health inequalities.”<sup>13</sup> A review in 2022 by the Advisory Committee for Resource Allocations (ACRA) found this adjustment to be worthwhile and recommended that it be maintained.<sup>14</sup>

More recently, in response to the inequalities starkly highlighted by the COVID-19 pandemic, NHS England established the [National Healthcare Inequalities Improvement Programme \(HiQiP\)](#), which works across programmes and policy areas across the NHS to deliver “exceptional quality healthcare for all.”<sup>15</sup> A key responsibility of HiQiP is driving forwards [Core20PLUS5](#), the NHS England approach to tackling health inequalities at a national and system level.<sup>16</sup> One of the clinical areas of focus is the need to diagnose cancer early – the framework reiterates the commitment made in the [NHS Long Term Plan](#) to diagnose 75% of cancers at stage 1 or 2 by 2028. As part of the NHS 2024/25 priorities and operational planning guidance, there is a commitment to publish “joined up action plans to address inequalities and implement the Core20PLUS5 approach” by June 2024.<sup>17</sup>

Tackling and eradicating inequalities is also integral to the Government’s [Major Conditions Strategy](#). Cancer is one of the major conditions included in the Strategy, and the Government has specifically committed to ensuring that better use of data will help to increase understanding of where health inequalities are arising and how they can be best tackled.<sup>18</sup>

## What role do Cancer Alliances have to play in tackling health inequalities?

Cancer Alliances are expected to deliver against the Government’s and NHS’s national priorities for cancer, including getting more people diagnosed with cancer quicker, and improving access to and experiences of cancer treatment.<sup>19</sup> Specifically on health inequalities, Cancer Alliances have been explicitly asked to “reduce health inequalities in cancer services, using latest data and working with partners to identify solutions.”<sup>20</sup>

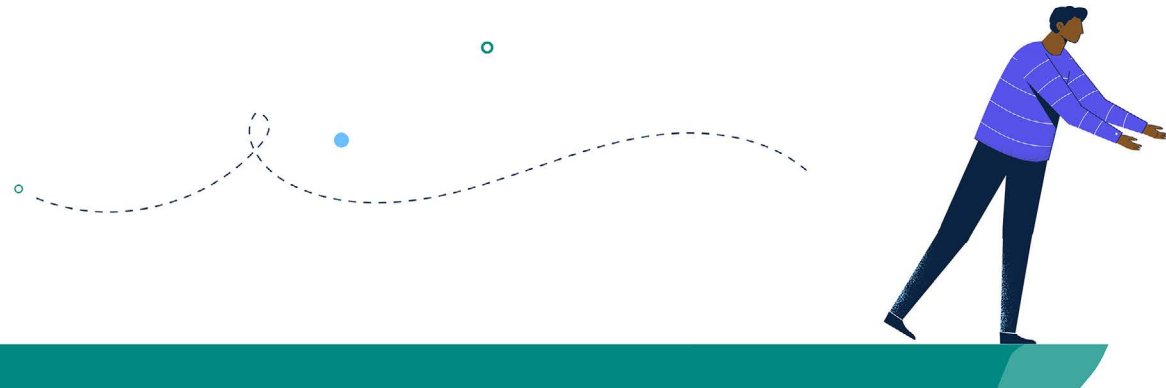
More broadly, Cancer Alliances are responsible for leading the “whole-system planning and delivery of cancer care” on behalf of their constituent [Integrated Care Systems \(ICSs\)](#), as well as providing clinical leadership and advice on commissioning.<sup>21</sup> This involves supporting ICSs to deliver on their statutory duty to reduce inequalities of “access and outcome”,<sup>22</sup> recognising the role that Cancer Alliances play in reducing health inequalities.

## What is this project and what does it seek to achieve?

Following on from MSD’s October 2022 report, *Levelling up: what does it mean for the less survivable cancers in England?*,<sup>23</sup> MSD engaged with Cancer Alliances to learn more about the significant progress that has already been made in tackling health inequalities, across all cancers, and where further support might be helpful. A recurring theme was that access to detailed examples of impactful projects would be a useful resource for Cancer Alliances to enable peer-to-peer learning.

This compendium has been informed by a number of interviews with Cancer Alliances, as well as an open call for written submissions. The final seven case studies are intended to inspire Cancer Alliances and other stakeholders within the cancer community by showcasing practical, meaningful steps that can be taken to reduce health inequalities in cancer.

The case studies presented here are just a snapshot of the incredibly important and vital work that Cancer Alliances have been undertaking, over the course of many years, to tackle health inequalities. This compendium is by no means exhaustive, but hopefully provides food for thought that can help Cancer Alliances think differently about the opportunities to support their local populations.





# Case studies

## Macmillan Cancer Support: *Pioneering local and community action on health inequalities*

Before Cancer Alliances were established, Macmillan Cancer Support was working with communities and local organisations to tackle health inequalities and variation in cancer. In 2016, Macmillan began working with South Reading Clinical Commissioning Group and Rushmoor Healthy Living (RHL) – a charity set up to remove barriers and provide support for residents in the borough of Rushmoor, South Reading and Basingstoke.<sup>24</sup> The CCG was previously identified as the sixth lowest area for one-year cancer survival.<sup>25</sup>

Working with South Reading CCG and RHL, Macmillan aimed to raise awareness of cancer signs and symptoms, offer support, and promote patient education among less engaged groups including: Nepalese, Polish, Pakistani, Sudanese, Afro-Caribbean, the deaf community, and the LGBTQ+ community.<sup>26</sup> South Reading CCG were given funding from Macmillan to run this project for two years, the CCG then commissioned RHL to deliver the project.

In order to deliver the project, Macmillan developed a new 12-week training programme, to upskill community members to educate, support, and advocate for people in their own communities – creating local ‘Cancer Champions’ from community volunteers. The Cancer Champions went on to work with patients by:

- Providing cancer patients with verbal information in the patient’s native language
- Help with informed translation at outpatient, chemotherapy, and radiotherapy appointments
- Liaise with hospital transport
- Help to book hospital appointments
- Check up on those living with cancer by phone and with home visits
- Raising awareness of cancer symptoms/educating their local community
- Support local people beyond cancer care by building trust in local services

### Outputs:

- 35 Cancer Champions were recruited, trained and worked in most of the identified communities
- 48 in-person cancer awareness sessions were delivered to over 1,800 people in South Reading. These events were tailored depending on the community, for example for the Polish community, events were held in a local Roman Catholic church
- Over 70 health awareness talks were delivered by a Nepalese Cancer Champion on BFBS Ghurkha Radio (an international radio station that is seen as a vital link for the Nepalese and Ghurkha communities)
- More than 280 requests for the support of a Cancer Champion were received over the two year period. This included requests from GPs, community leaders, and from local Macmillan Information Centres
- Cancer Champions also helped to educate healthcare professionals and clinicians on some of the barriers faced by certain communities in accessing health and care services
- As a result of the success of the project, Macmillan expanded their Cancer Champion project, and it has continued to this day<sup>27</sup>

### Outcomes:

The evaluation of the project reported an anecdotal increase in the number of referrals and in the take-up of bowel screening, breast screening, and cervical screening. The project helps to highlight the possibilities of partnership working, engaging with the local community, and ensuring services are co-created.

### For more information

For more information about this case study or if you have any questions please contact Julian Backhouse, Cancer Champions Project Implementation Lead, Macmillan Cancer Support, [JBackhouse@macmillan.org.uk](mailto:JBackhouse@macmillan.org.uk).

## Somerset, Wiltshire, Avon & Gloucestershire Cancer Alliance case study: *Addressing the potential causes of liver cancer before it develops*



### Key points:

- By identifying people at risk of developing liver cancer, the *Alright My Liver?* initiative in Somerset, Wiltshire, Avon & Gloucestershire (SWAG) sought to address inequalities in referrals and cancer outcomes by improving early diagnosis – and therefore survival – in an increasingly common form of cancer<sup>28</sup>
- Through a continuous review process, SWAG have been able to target and adapt their pilot to reach more people in need

### Health inequalities in Somerset, Wiltshire, Avon & Gloucestershire:

The COVID-19 pandemic had a significant impact on referral and treatment in the Somerset, Wiltshire, Avon & Gloucestershire (SWAG) Cancer Alliance – and referral and treatment rates recovered more quickly in those from the least deprived backgrounds compared with those from the most deprived backgrounds.<sup>29</sup>

### The challenge:

Liver cancer is the one of the least survivable cancers in the UK – with approximately 19% of those diagnosed surviving five years or more in the SWAG region.<sup>30</sup> Since the early 1990s liver cancer rates have increased by 167%,<sup>31</sup> and incidence is 78% higher in the poorest populations.<sup>32</sup>

Hepatocellular carcinoma (HCC) is the most common form of liver cancer.<sup>33</sup> The main risk factor is cirrhosis, or scarring due to previous liver damage.<sup>34</sup> Cirrhosis itself can be life threatening – with 75% of cases of cirrhosis first diagnosed following an emergency admission to hospital, during which 1 in 6 people will die.<sup>35</sup> People in the most deprived communities have a four-fold increased risk of premature death from liver disease.<sup>36</sup>

There can be an asymptomatic phase in cirrhosis or liver disease<sup>37</sup> which provides an opportunity for healthcare providers to diagnose the condition and intervene before the disease progresses. Diagnosis can facilitate lifestyle changes and allow ongoing surveillance for liver cancer.

### The solution:

With this context in mind, and with liver cancer rates increasing faster than most other cancers across the UK,<sup>38</sup> in April 2022 SWAG began a 12 month pilot of screening for cirrhosis, titled *Alright My Liver?*, in partnership with the Bristol & Severn Hepatitis C Operational Delivery Network. By targeting people at risk of cirrhosis, the team at SWAG identified an opportunity to prevent and diagnose liver cancer at its earliest stage.

The team identified locations for screening ‘events’ that might reach people experiencing risk factors for liver disease. These included drug and alcohol services,

primary care services in areas with high levels of deprivation, and homelessness health services. They also worked with Caafi Health,<sup>39</sup> a local organisation seeking to reduce health inequalities among people from Black and other ethnic backgrounds.

The pilot programme operated on a drop-in basis. During the *Alright My Liver?* screening events, attendees are asked about their behaviours relating to risk factors for cirrhosis and may be offered viral hepatitis testing and a FibroScan, which is a quick, non-invasive scan for liver scarring. This is performed by a specialist nurse who can offer specific advice and signposting to services if cirrhosis is detected.

If a person is found to have probable cirrhosis, an NHS patient pathway navigator will phone to organise blood tests, a liver ultrasound, a hospital appointment and offer a prepaid taxi. The pathway navigators will also provide reminders and involve any support workers or family that the patient wishes.

To facilitate the pilot, the SWAG team sought advice from the region’s Drug and Alcohol Health Integration Team, who were able to identify a number of charities and services where their screening and information events could be co-located. Collaborators have included addiction services, health promotion charities, homelessness charities, GP practices, prisons, sports clubs, and diabetic eye checks. A pathway to identify people with alcohol use disorder attending a major emergency department was also developed, and this allowed for opportunistic testing at the hospital in conjunction with Alcohol Specialist Nurses.

It was important to the team at SWAG that this service was co-developed with people who would benefit most from it. During the development of the service, discussion groups were arranged and people with liver disease or those most at risk were invited to attend. By working closely with these potential service users, SWAG were able to improve their strategy, promotional materials and patient resources. They also produced a video outlining the service to aid engagement: *Alright My Liver* – community liver screening programme.<sup>i</sup>

### Barriers to implementation:

As alluded to above, the SWAG team's approach sought to identify and proactively address barriers to engagement from the public, through a flexible, patient-centred approach without judgement. However, they also faced a number of additional challenges:

#### • Primary and secondary care capacity

The SWAG team were very aware of the strain that primary and secondary care health services are already under and mindful that the project could potentially increase the workload for these services. This meant the team undertook careful engagement with stakeholders within primary and secondary care to ensure that they communicated the goals of the pilot service and what it could provide as well as exploring the concerns and ideas from all parties. Overall, the team found that the pilot was met with enthusiasm and that it was widely accepted that the potential short term increase in workload would be offset by its benefits in the medium to long term. The assumption is that a new diagnosis of cirrhosis might lead to a flurry of appointments and investigations, but the potential health benefits of these interventions would save a similar cycle in the future – if cirrhosis was not detected early – with a likely worse outcome.

SWAG worked with local GPs to produce a letter template to concisely communicate the potential benefits of attending screening events and provided specialty education sessions at participating GP practices as well as providing updates at local GP network meetings, and to the Drug and Alcohol Health Integration Team.

### Key learnings:

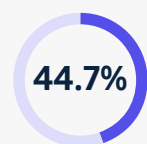
The SWAG team attribute much of the success of the pilot to working with community partners. Through this community network, already trusted services and contacts, the SWAG team have been able to reach groups most at risk of cirrhosis, and those that were unlikely to engage with health services including people with experience of homelessness, people who had been in prison, people who self-reported harmful drinking, and people from a non-white background, which make up some of the most marginalised people in the region. They describe this model of operating as invaluable.

As part of their review process SWAG have been conducting an evaluation of *Alright My Liver?* in real-time, to allow for live improvements to be made to the service as we gather information. With support from the University of Bristol, they have conducted short interviews with service users and providers to explore their experiences of *Alright My Liver?* including barriers and enablers to engaging with the service.

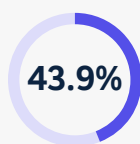
These interviews allowed the team to understand the previously described challenges facing the population and make improvements to the patient experience. They observed that the positive relationship building previously done with healthcare services has helped to build overall trust and improve engagement from seldom heard from groups of society. The pilot has led to onward referrals into other specialist services and may have wider health implications as people have gone on to access further health services.

SWAG have collected quantitative data for *Alright My Liver?* screening events, which have allowed them to

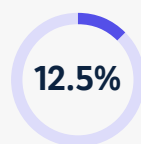
Within their first year of operation, the SWAG Cancer Alliance team have screened more than 2000 people at high risk of cirrhosis. Of these:<sup>40</sup>



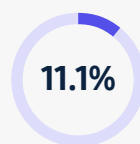
of attendees were female



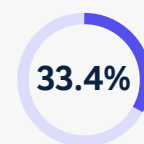
of attendees were from a non-white background



of attendees had experienced homelessness



of attendees had been in prison



of attendees had self-reported harmful drinking

#### • Accessibility to participants

As well as barriers in the system, the team identified two key barriers for participants, or potential participants – people not being able to attend sessions due to work, and information not being provided in their language. To overcome these barriers, SWAG increased the frequency of evening and weekend events, as well as co-producing a translated leaflet which helped explain the process.

### Outcomes to date:

Attendance rates at hepatology clinic and liver ultrasounds organised through the service are being monitored to allow measurement of engagement with follow up. SWAG plan to review the clinical progress of patients identified through the *Alright My Liver?* pilot to try to understand how earlier detection may have altered their outcomes.

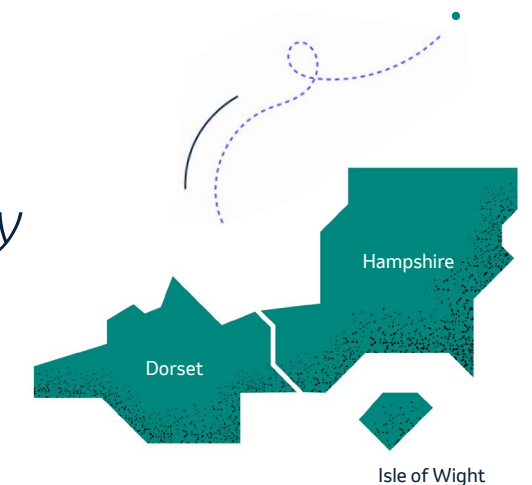
extrapolate the diagnoses from each event type.

For example, they found that at an inpatient detox unit roughly 12% of people will have cirrhosis, whereas at a diabetic eye check the yield is around 5%. This has allowed them to consider their focus and adapt their screening events in order to ensure populations most at risk both geographically and demographically are targeted and reached.

### For more information:

For more information about this case study or if you have any questions please contact Dr Annie Archer, NIHR Academic Clinical Fellow in Hepatology at University Hospitals Bristol & Weston, [ann.archer@uhbw.nhs.uk](mailto:ann.archer@uhbw.nhs.uk).

## Wessex Cancer Alliance case study: Empowering community organisations to address barriers to earlier diagnosis



### Key points:

- Through its *Communities Against Cancer* initiative, Wessex provides grants and cancer awareness training to community organisations and leaders
- This has allowed Wessex to raise awareness of cancer risk factors and symptoms among groups it had previously found hard to reach, such as people from ethnic minority backgrounds and those living in more deprived areas
- Independent evaluation shows that, in some cases, these groups have become more likely to access cancer screening and seek appropriate advice from healthcare professionals

### Health inequalities in Wessex:

Wessex Cancer Alliance covers the Hampshire and Isle of Wight and Dorset *Integrated Care Systems*. While many people in the area have good health and relative affluence, there are some areas, within some towns and cities and along the coastline, where people live in areas of entrenched multiple deprivation.<sup>41</sup> Only around 4% of the population is from an ethnic minority in Dorset,<sup>42</sup> and the area has a range of challenges in delivering equitable access, outcomes and experiences in cancer care including:

- Rural communities poorly served by transport infrastructure and an island
- An increasing number of over-65 year olds<sup>43</sup> requiring coordinated responses from multiple health and care partners
- Coastal communities with issues related to poverty, low health literacy, poor housing and homelessness, substance misuse

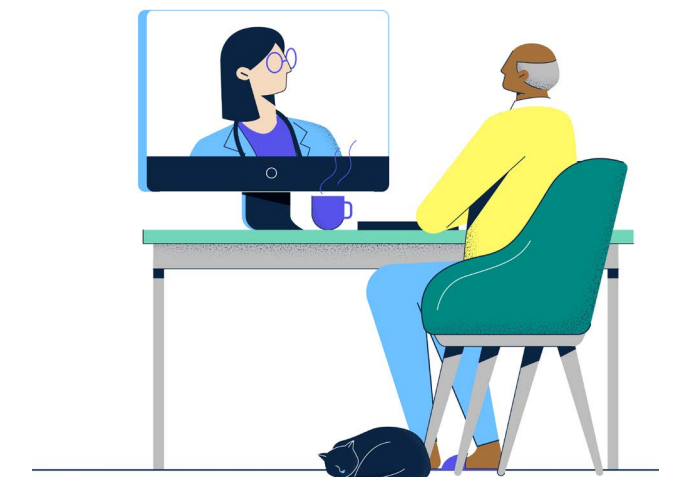
The 'pockets of deprivation' in Wessex, including areas within the most deprived 10% of neighbourhoods nationally, are often masked by more affluent neighbouring areas, which can affect the resources available to support these populations with healthcare that meets their needs.

### The challenge:

Wessex Cancer Alliance has identified that certain groups – including people from ethnic minority backgrounds, those living in more deprived areas and people with a learning disability – are more likely to have low awareness of cancer risk factors and symptoms, less likely to take part in cancer screening programmes and less likely to have access to appropriately written health information (instead often relying on personal sources of health information, such as friends and family).<sup>44</sup> The Wessex Cancer Alliance team stated, "there is a difference in experience of people in Wessex from ethnic minorities as compared to white counterparts."<sup>45</sup> This can contribute to late diagnosis and, ultimately, poorer survival outcomes.

Wessex Cancer Alliance also has unique geographical challenges, which further compound the above inequalities. These geographical inequalities include:

- **Navigating the coordination of care to the Isle of Wight:** For patients living on the Isle of Wight who require an oncology centre, the closest hospitals are on the mainland in Southampton or Portsmouth, requiring a ferry crossing. While some financial support is available, the cost, and additional stress of the crossing can affect people's wellbeing
- **Accessibility of public transport for some rural communities:** This can create a barrier to accessing health services as patients have to be within accessible public transport of hospitals and other healthcare settings. Additionally, for some patients, public transport has to be paid for, which can make it difficult for some patients to access regular care





### The solution:

The Wessex team looked to utilise the power of peer education as a means to increase health literacy and trust in the health system among underserved groups, stating: “peers are a trusted source and can express things in a more understanding way that takes into account a person’s circumstances.”<sup>46</sup>

Working with Action Hampshire – an organisation that strengthens and connects thousands of organisations across Hampshire – the *Communities Against Cancer* initiative was created,<sup>47</sup> first launching in 2019, with the central aim of, “reaching communities and raising awareness of cancer to help improve their health outcomes.”<sup>48</sup> The two main pillars of the initiative are:

- Providing grants to community organisations to support activities that help people reduce their risk of cancer, be aware of signs and symptoms and seek help at an earlier stage
- Delivering cancer awareness training to support community leaders to have conversations about cancer with people in their local communities

Building meaningful partnerships with community organisations was central to the Cancer Alliance’s approach to get “vital cancer messages across in creative and engaging ways.”<sup>49</sup> Working with Action Hampshire allowed the Cancer Alliance to capitalise on the links that Action Hampshire already had with community organisations, building trust and capacity through peer led approaches.<sup>50</sup>

### Barriers to implementation:

There were 53 grant recipients who received funding in the 2021/22 funding period, 52 completed their activities successfully. Several projects have had to change their activities due to circumstances beyond their control, such as volunteer or attendee availability.<sup>51</sup> Only one was unable to complete the activity due to a change of staff and in this instance the money was returned.<sup>52</sup>

The chief barrier to the programme as a whole was the lack of data the team was able to gather on the impact of the *Communities Against Cancer* initiative: specifically, data on the levels of early diagnosis of cancer that the programme has had, which would allow them to better and more confidently track the interventions communities and the third sector organisations are delivering. Information regarding people who are not regularly ‘in touch’ with health and care services is particularly important to uncover, to understand whether or not they are receiving the care they deserve.

### Outcomes to date:

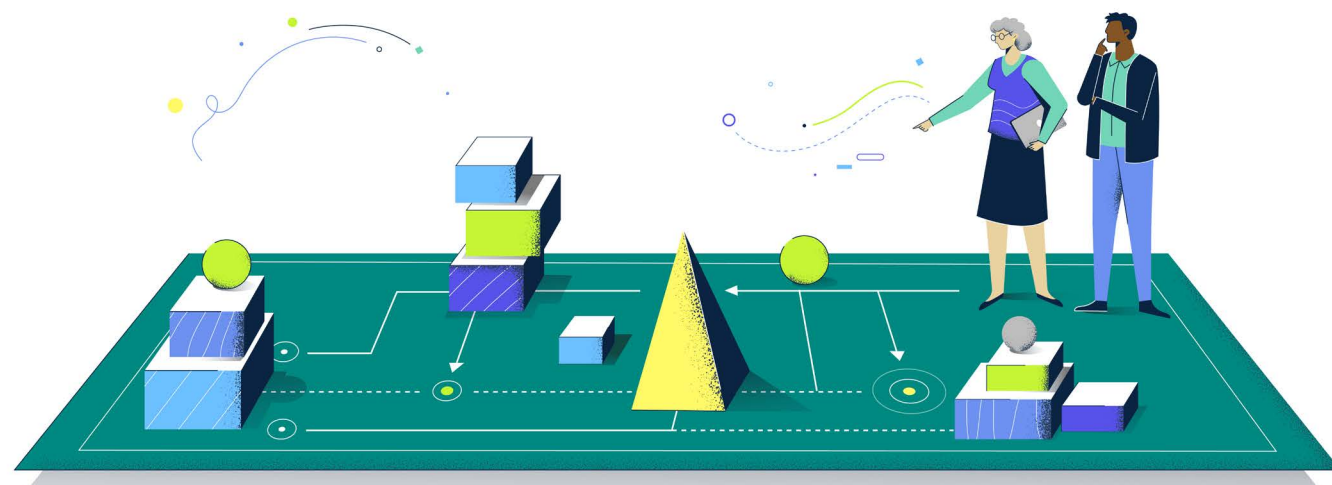
The *Communities Against Cancer* initiative has demonstrated the value in working with community organisations and leaders in extending cancer awareness messaging to groups that Wessex has previously found hard to reach. As the Wessex Cancer Alliance team themselves have said, “the benefits of being led by the third sector are immediate. This work is not possible to do within the NHS.”<sup>53</sup>

During 2019/20 and 2021/22, more than 93 grants were awarded to 83 separate organisations, totalling £307,311.<sup>54</sup> It is estimated that in Wessex alone, 7.2 million contacts have been made through various means including radio, television, social media, leaflets, and face-to-face attendance at events. For one project, the reach extended beyond Wessex as the grant-holders delivered a suite of cancer-focused radio programmes broadcast to Birmingham.<sup>55</sup> Some 200 community leaders have also received cancer awareness training as part of the initiative.<sup>56</sup>

Evidence of impact on outcomes has been harder to demonstrate, but early evaluation data suggests that some projects have helped to:<sup>57</sup>

- Increase healthy behaviours/decrease risky behaviours
- Increase screening uptake and related health checks
- Increase help seeking behaviour
- Embed/spread knowledge

Wessex is in the process of working with the Centre for Psychosocial Research in Cancer to conduct an independent evaluation of the *Communities Against Cancer* initiative, with the final report due for publication in late 2023<sup>58</sup> (this has since been delayed).



Some key examples of projects that were given grant funding through *Communities Against Cancer* are as follows:

### Something’s Not Right - Dorset Campaign (Mission Remission)<sup>ii</sup>

**Grant amount:** £4,965

**Reach and project:** An online campaign to increase early diagnosis of cancer and help people become champions of their own health. The campaign raises awareness that while bodily changes do not always mean cancer, it is still important to get any unusual symptoms or changes checked out. The campaign also provided a number of resources for patients and the local community. These include:

- **A symptom diary**<sup>iii</sup> which can help patients make sense of their symptoms
- **A diagnosis guide**<sup>iv</sup> which sets out the process of being diagnosed with cancer, or any illness, and how patients can advocate for themselves
- **Testimonials and advice area**<sup>v</sup> from those who have already received a diagnosis

The online campaign reached 145,000 people and 1,237 people used the resources. Furthermore, The Dorset Echo wrote about the campaign, which was subsequently picked up by BBC Breakfast reaching an audience of 6 million.<sup>59</sup>

### Chat Café

**Grant amount:** £4,700

**Reach and project:** Loneliness has a huge impact on people’s health and confidence. This can affect their ability to come forward with any health concerns. Chat Cafés held in Bournemouth and Poole brought people together to have discussions about cancer and answer questions. The sessions were attended by a total of 106 people. Of those who completed feedback forms, 91% said they would make a change to their lifestyle as a result of the session and 95% said they felt better informed about the importance of early testing.<sup>60</sup>

### The Silk Route<sup>vi</sup>

**Grant amount:** £2,000

**Reach and project:** The Silk Route is a charity in Hampshire which aims to raise Islamic awareness, promote good health, and provide a community for local residents. As part of the *Communities Against Cancer* initiative, The Silk Route was given funding to run a family health and cancer awareness day. During the day a number of topics were covered, including early diagnosis of cancer – with a focus on lung, prostate, breast, and bowel – cancer information and support, and the value of exercise to health and cancer survival. In 2022, over 400 people attended the day<sup>61</sup> and this session was then repeated in 2023 with over 150 attendees.<sup>62</sup>

More information on other projects that were given grant funding through *Communities Against Cancer* can be found on the following external website: <https://wessexcanceralliance.nhs.uk/wp-content/uploads/2023/08/3.0-WCA-report-Communities-Against-Cancer.pdf><sup>63</sup>

### Key learnings:

Based on its experiences in 2019/20 and 2021/22, Wessex has identified that the following changes would be beneficial for future iterations of the programme:<sup>64</sup>

- **Encouraging targeted applications:** To date, the initiative has supported a wide range of projects. Moving forward, Wessex intends to focus on projects that are specifically designed to increase early diagnosis in underserved communities, for example by promoting opportunities to access cancer screening. This is to ensure greater strategic direction and more consistent impact
- **Introducing milestone-based funding:** In response to some grant-funded projects not fulfilling their aims and objectives, Wessex is considering introducing a milestone-based funding system, which means funding would be released in intervals on the condition that pre-agreed milestones had been successfully delivered. In addition to guarding funds, this system is expected to help Wessex have access to improved reporting and insights data

- **Developing a ‘community’ for grant recipients:** Following feedback from the previous years’ programmes, Wessex identified that grant recipients can feel isolated. As the most effective projects tended to be the most reflective, it is hoped that a community for grant recipients will allow sharing of insights and peer support opportunities, in turn driving up quality
- **Active engagement of advocates:** Using advocates which have the trust of the local communities which have been highly active and engaged across the multiple years of the *Communities Against Cancer* programme and these will ensure support for the future
- **Investment of additional project officers:** By investing in further project officers it would allow for enhanced community outreach training, and support
- **Revising the Grant Making panel:** There was feedback that not all communities that the Cancer Alliance represented were reflected in the Grant Making panel. To reflect this feedback they are revising the panel to ensure that all communities are included

### For more information:

For more information about this case study or if you have any questions, please contact Emma Leatherbarrow, Equality & Involvement Strategic Lead, [emma.leatherbarrow@wca.uhs.nhs.uk](mailto:emma.leatherbarrow@wca.uhs.nhs.uk).

<sup>ii</sup> Mission Remission, *Something’s not right- Dorset campaign*, accessed April 2024. Available: <https://www.mission-remission.com/dorset-something-not-right>

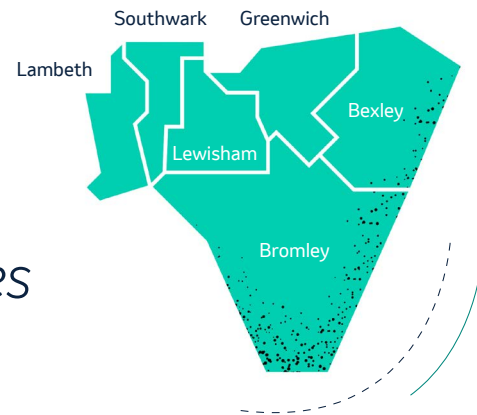
<sup>iii</sup> Mission Remission, *Create a symptom diary*, accessed April 2024. Available: <https://www.mission-remission.com/symptom-diary>

<sup>iv</sup> Mission Remission, *Diagnosis support*, accessed April 2024. Available: <https://www.mission-remission.com/diagnosis>

<sup>v</sup> Mission Remission, *Something’s not right*, accessed April 2024. Available: <https://www.mission-remission.com/Somethings-not-right-stories>

<sup>vi</sup> The Silk Route, *About our charity*, accessed April 2024. Available: <https://www.tsrc.org.uk/>

# South East London Cancer Alliance case study: *Improving clinical information for cancer patients with learning difficulties*



## Key points:

- People with learning disabilities who are diagnosed with cancer have worse outcomes, and often report a poorer experience of cancer care, compared with other patient groups<sup>65</sup>
- South East London Cancer Alliance partnered with a charity who support people with learning disabilities and autism through performing arts, to develop workshops, training and patient information materials to help improve the experience of this important group of cancer patients

## Health inequalities in South East London:

South East London has some of the most deprived boroughs in London, including Lewisham (7th most deprived out of 33), Southwark (9th), Greenwich (11th), and Lambeth (12th), and also some of the least deprived boroughs which include Bromley (22nd) and Bexley (23rd).<sup>66</sup>

## The challenge:

The National Cancer Patient Experience Survey (NCPES) results showed that patients with learning disabilities report among the poorest experience of cancer care compared to other patient groups.<sup>67</sup> For example, patients with learning disabilities felt that they were not provided with the relevant information on available support, with a score 40% (compared to 67% average). 20% of people completing the NCPES with learning disabilities also reported not having access to support but needing it (compared to 4% average).<sup>68</sup> The data also showed that those with cancer and a learning disability are less likely to be informed of their diagnosis and prognosis; be given pain relief; be involved in decisions about their care; receive palliative care.<sup>69</sup> Additional national data also show that patients with a learning disability have lower uptake rates across all screening programmes.<sup>70</sup>



**58.3%** of the population aged 16-64 would likely have difficulties in understanding or interpreting health information (health literacy and health numeracy)<sup>71</sup> – therefore

any improved care and support offered to cancer patients with learning difficulties will further benefit a much larger group of cancer patients within services.

## The solution:

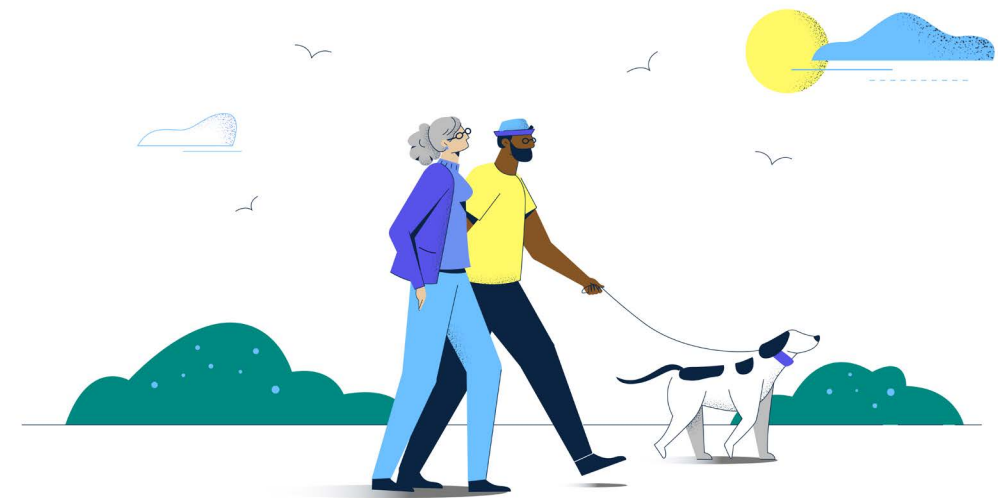
To understand the existing situation, the South East London Cancer Alliance initially had informal conversations with clinical colleagues across South East London Trusts, particularly cancer nurse specialists who have regular contact with patients. This revealed that staff felt unable to adequately communicate and support patients with a learning disability, assess their capacity, or know when, and how, to communicate with accompanying carers or family members.

Subsequently a larger group of Trust staff – including allied health professionals, nurses, doctors, administrators, and booking staff to further understand the potential need for education and training. The responses received clearly stated a huge appetite for more training and support in order to care for this patient group.

While exploring opportunities for staff training, it was clear that interactive communication training sessions for staff to support patients with learning disabilities and/or autism did not currently exist. This gap of provision led the Cancer Alliance team to approach the Baked Bean Charity a charity based in South West London, providing performing arts education for about 150 students with a learning disability and autism. Following their initial scoping phase, the South East London Cancer Alliance commissioned the Baked Bean Charity and their students, to help them develop bespoke and cancer-specific training sessions for a variety of staff across the cancer field.

As part of this programme development, they held workshops which were 1.5 hours in length, face to face, and for a maximum of 10 people at the time. The workshops were expertly facilitated by teachers and students from the Baked Bean Charity, with some context and scene setting provided by Cancer Alliance staff around some of the issues that had previously been reported by cancer patients with learning disabilities and autism, mainly through surveys.

Over the first year of operation, six workshops were commissioned. The partnership with the Baked Bean Charity was further extended to develop further training opportunities, also including in primary care, and to co-develop appropriate information resources for this patient group.



## Barriers to implementation:

### Tailoring sessions:

- Every medical or administrative profession and individual staff member has unique needs and experiences when trying to support patients with learning disabilities. To ensure South East London Cancer Alliance catered correctly for the workshop attendees, they grouped staffing professions together – for example, information and support workers, the bowel cancer screening team etc
- Before each workshop was run, the team made sure questionnaires were sent to all attending, enquiring what previous experience they had and if key situations came to mind they could play out in the workshop. These were then reviewed for any themes that could be used in the workshop and shared with the facilitator of the event to help shape the session to their requirements

### Protecting staff time:

- Some staffing groups were more difficult to schedule for training than others, due to their clinical workload. Where possible the team tried contacting department leads and working with them to integrate training into employee protected time for learning
- South East London Cancer Alliance includes three Trusts, but since the Cancer Alliance team are based at Guy's and St Thomas', they have limited involvement from other staffing teams from Lewisham and Greenwich NHS Trust and King's College Hospital. To resolve this, they worked with the lead cancer nurses to book in spaces within their Trust, to encourage wider groups of staff across South East London to attend the sessions

### Measuring improvement:

- Although the Cancer Alliance team have data sources to show people with learning disabilities have a more negative experience than people without in the health service, they do not have access to any live local cancer-focused experience data – even if it was available, the sample size would be quite small. To overcome this, the team tried to gather proxy data from staff instead (more details below) on their understanding following the workshop sessions

## Outcomes to date:

Trying to measure impact directly from patients with learning disabilities would have also pushed the scope of the project outside of what the small team had the capacity for. To overcome this, they instead gathered data from members attending workshop sessions, by creating a short pre- and post-training questionnaire. This helped identify if each staff member felt that after the training they were more knowledgeable about supporting and understanding the needs, and better prepared for communicating with, patients that have a learning disability.

## Key learnings:

While the team identified there was a benefit to curating a list of people to invite to join each event, it was time consuming and may have excluded some staff members who would be interested in joining but didn't know about the event. In the future, the team realised that automating tickets to the event would save capacity and improve spread of the workshop across oncology.

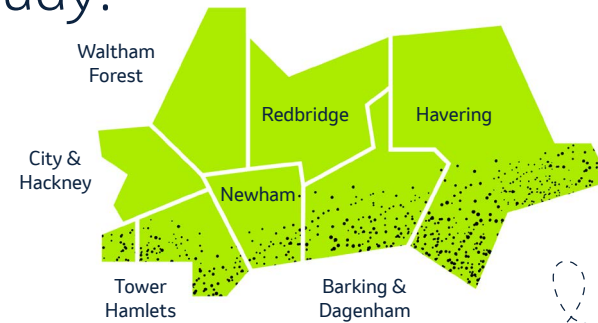
The team also made the training sessions part of a larger event, i.e. team away days as this ensured staff were guaranteed to attend without getting caught up in other work priorities on the day. The face-to-face aspect of the training is something that the Cancer Alliance team felt worked very well and changed the dynamic of the workshops – and they would suggest sticking to this format as much as possible for future events.

## For more information:

For more information about this case study or if you have any questions please contact Jannike Nordlund, Patient Involvement Lead, [Jannike.Nordlund@gstt.nhs.uk](mailto:Jannike.Nordlund@gstt.nhs.uk) or Chris Wanstall, Cancer Improvement Manager – Inequalities and Early Diagnosis, [Chris.Wanstall@gstt.nhs.uk](mailto:Chris.Wanstall@gstt.nhs.uk).



# North East London case study: *Working with community and charity partners to address low awareness of womb (uterine) cancer*



## Key points:

- Reacting to data that highlighted poor outcomes, North East London Cancer Alliance developed the *You Need to Know* campaign to tackle low awareness of womb cancer, particularly in more diverse and deprived communities
- Ensuring the programme and materials were co-created with the identified communities has enhanced engagement and results across the programme

## Factors influencing health inequalities and cancer in North East London:

Almost 40% of the population of North East London is of Black African or Caribbean and South Asian heritage.<sup>72</sup> The area has some of the highest obesity rates in the country;<sup>73</sup> and it hosts some of the most deprived local communities in London, particularly among over 60-year-olds.<sup>74</sup>

## The challenge:

Due to the local demographics described above, North East London has a high prevalence of women at risk of womb cancer. Incidence rates for womb cancer are higher amongst Black and Asian women than White women<sup>75</sup> and mortality rates are higher in people of non-white ethnicities and from more deprived communities.<sup>76</sup> Risk factors for womb cancer also include age (it is more common in post-menopausal women), obesity and genetics.<sup>77</sup>

Early diagnosis of womb cancer, the most common gynaecological cancer,<sup>78</sup> significantly improves survival – around 90% of women diagnosed with womb cancer at stage 1 will survive their cancer for more than five years, compared to only 15% if diagnosed at the stage 4.<sup>79</sup>

Data collected locally found a lack of awareness of womb cancer, health literacy challenges, and inequalities in stage at diagnosis and survival outcomes for people diagnosed with womb cancer in North East London:



Between 2011 and 2015, North East London had the worst one-year survival rate in the UK at **86.3%** vs **89.5%** over England as a whole<sup>80</sup>

- Anecdotal evidence from a gynaecology consultant at Homerton University Hospital suggested Black African women were diagnosed late and saw post-menopausal bleeding as a sign of fertility

## The solution:

Led by their data on health inequalities, North East London Cancer Alliance began creating an education and awareness campaign to be delivered at grassroots level, across North East London, to raise awareness of the signs and symptoms of womb cancer in the local population, called *You Need to Know*.

The campaign would work with local community groups and organisations to deliver educational events during existing community group meetings in addition to stand-alone events. Social media was also used to raise awareness of womb cancer, and of the details of the educational sessions to promote attendance.

The team identified that clinical leadership would be essential to the success of the campaign. This was provided by a Consultant Gynaecological Oncologist at Barts Health, Miss Alexandra Lawrence, who is also the Chair of North East London's Gynaecology Expert Reference Group (ERG). The ERG is made up of gynaecology surgeons, oncologists, radiologists, nurses, as well as operational managers, who were able to ensure buy-in from the wider health system, along with providing a source of expert advice.

With the Clinical Lead in place, the Cancer Alliance team then approached the Eve Appeal, as a trusted charity in this field, to be a partner in the delivery of the project. The Eve Appeal worked with the team to set the project scope and led on the development of the session content. In partnership with the Eve Appeal and a marketing agency, the team created the project assets, including posters, leaflets, and social media content in appropriate languages.

The Cancer Alliance team deemed it crucial to co-produce the *You Need to Know* campaign and related assets with local women from the target communities. The marketing agency facilitated workshops with post-menopausal Black Caribbean, Black African, and South Asian women from North East London – including a woman with lived experience of womb cancer and another whose close relative was undergoing treatment. The workshop focussed on elements that

the women could influence, to provide value to their input, and ensure that the campaign would resonate with the intended audience. This included aspects of the campaign that might make them take notice i.e. the tag line, the messaging including cultural aspects of words that might be taboo or would not translate well, and where the sessions should be held.

## Barriers to implementation:

North East London Cancer Alliance experienced several challenges during this project:

- **Identifying attendees** of focus groups, including someone with a lived experience, or someone who had a family member with a lived experience. To overcome this, the team used their internal networks and external stakeholder contacts to help identify attendees
- **Time constraints** meant that some of the feedback following the education sessions could not be captured in detail. Ensuring sessions were as streamlined as possible helped make efficient use of time
- **Language barriers** hindered both comprehension of those for whom English was not their first language, and the completion of feedback forms. To overcome this challenge, the team made sure there were bilingual speakers at sessions for the most commonly spoken languages, provided additional information leaflets in other languages highlighting signs and symptoms to be aware of, and produced feedback forms in the same languages as the leaflets

## Outputs and outcomes to date:

Evaluation of the campaign, undertaken by the University of Leicester, will be completed by May 2024. Interim, qualitative measures have been used to assess impact to date, utilising feedback forms given to attendees at the education delivery sessions, as well as social media reach.

In total, ten sessions have been delivered across six of the seven North East London boroughs, with 227 attendees, both men and women. These have all been in community groups, with some women-only groups and some mixed. Eight sessions were in person and two were conducted virtually, via Zoom. The accompanying social media campaign had 348,669 impressions.

Feedback indicated that responses to the outreach activity and engagement were very positive. The Eve Appeal presenter was able to engage the diverse audiences at each session, adapting their delivery of the information to each unique group.

Early quantitative evidence demonstrates that the project is delivering its objectives. Some of the responses recorded on the evaluation forms, showing the key messages taken from the sessions from attendees, were to:

- Be aware of changing symptoms and the need to make an appointment with a GP where necessary
- Taking note of what was normal for them and the signs and symptoms of womb cancer

Milestones achieved as part of the *You Need to Know* campaign included:

- Appointment of a marketing agency
- Delivery of a co-production workshop
- Production of assets
- Partnership working with community organisations
- Campaign launch
- Delivery of outreach sessions
- Ongoing monitoring
- Project evaluation

## Key learnings:

North East London have been fortunate to have additional interest from community groups not previously engaged in the project. As a result of this, they have decided to run a further phase of activity. This next phase will consider lessons learned to date, such as:

- **Avoiding online sessions:** It was felt that these were less conducive to an interactive session and fewer questions were asked
- **Using existing resources:** Holding educational sessions during existing regular meetings of community groups and other organisations optimised efficient use of resources, community engagement, and increased attendance
- **Ensuring a broad focus:** In North East London, the borough of Havering was not initially considered for the *You Need to Know* campaign as it is less ethnically diverse and less deprived than other areas of the Cancer Alliance. However, the team recognised that as a result they did not consider the small pockets of diversity and deprivation in all areas which should be included in the future to ensure equity

## For more information:

For more information about this case study or if you have any questions please contact Caroline Cook, Early Diagnosis Programme Lead, [caroline.cook9@nhs.net](mailto:caroline.cook9@nhs.net).



# Greater Manchester Cancer Alliance case study: *Using community engagement to implement a national pilot*



## Key points:

- Through their adoption of the national prostate cancer pilot of *This Van Can*, Greater Manchester Cancer Alliance (GMCA) aim to return prostate cancer diagnoses to pre-COVID-19 levels by offering convenient and available appointments to communities
- Working with community groups has allowed GMCA to have a greater impact and reach with the pilot programme

## Health inequalities in Greater Manchester:

Greater Manchester Cancer Alliance has the lowest rates of cancer in the Northwest of England, largely due to its young population.<sup>81</sup> However, rates of cancer remain higher than the national average,<sup>82</sup> and deprivation across Greater Manchester is thought to be one of the main reasons for this.<sup>83</sup>

## The challenge:

Prostate cancer is the second most prevalent cancer<sup>84</sup> and the fourth highest cause of cancer deaths in the North West.<sup>85</sup> Nationally, prostate cancer diagnoses have still not recovered back to pre-COVID-19 pandemic levels.<sup>86</sup> A national pilot was therefore implemented to raise awareness of the condition in at-risk groups and improve early diagnosis<sup>87</sup> – and Greater Manchester was invited to take part.

## The solution:

*This Van Can* is a mobile health clinic – in a van – aiming to raise awareness of prostate cancer, increase early prostate cancer diagnoses, and ultimately to save lives. The initiative specifically targets groups at higher risk of prostate cancer, including men and people with a prostate who either have a family history of prostate, breast, or ovarian cancer or are of Black ethnicity, and who are over the age of 45.<sup>88</sup> The team at GMCA were keen to also targeted the Jewish community due to the large Jewish population within their geography.<sup>89</sup>

These groups were instrumental in helping Greater Manchester Cancer Alliance reach out into the community and ensure that conversations with patients and service users were reflected in the service offering. These groups attend regular stakeholder meetings with the project operational team and played an integral role in the design and running of the project.

As the van is a mobile unit, the Greater Manchester Cancer Alliance worked closely with [Primary Care Networks \(PCNs\)](#) to identify eligible men/people with a prostate and ensure that text messages reach men ahead of the van arriving in their local area so they can book an appointment.

During the appointments, staff discuss the risks of prostate cancer, answer any questions and provide information about the condition. Attendees are able to choose whether to have a free Prostate Specific Antigen (PSA) blood test – this is not mandatory – which can be performed while attendees are in the van.

Following the appointment, attendees are given an information leaflet and should receive results within 14 days if they chose to have a PSA test. If attendees were found to have symptoms such as, lower urinary tract symptoms, blood in the urine, lower back or bone pain or unexplained weight loss, they are asked to contact their GP for a more in-depth assessment.

To help deliver the *This Van Can* roadshow, the Greater Manchester team worked with local voluntary and community based groups, as well as wider charities and organisations such as:

**Prostate Cancer UK** – a national charity raising awareness of prostate cancer<sup>90</sup>

**CAHN Survive** – a Black-led organisation to address the social determinants and to eradicate health disparities for Caribbean and African people in the UK<sup>91</sup>

**The BHA** – an organisation that challenges and addresses health and social care inequalities across Manchester<sup>92</sup>

**The FED** – a Greater Manchester based social care charity for the Jewish Community<sup>93</sup>

## Barriers to implementation:

GMCA faced several barriers in rolling out *This Van Can*. These were mainly operational, which they were able to overcome for the most part.

### • Appointment-only set-up:

Due to the nature of the service being offered (open conversations about the condition, the person's risk, the tests available, and offering a PSA blood test), *This Van Can* appointments can be lengthy (c. 15 mins). The team therefore offered an appointment-only service, so people weren't having to queue for long periods waiting to be seen.

Drop-in appointments for this service would be preferable for people with limited or no access to healthcare, such as the homeless community, or Gypsy, Roma, and Traveller communities due to a well-recognised reluctance from these groups to traditionally attend more formal healthcare settings or difficulty in accessing services.<sup>94</sup> This drop-in service is something that the team would like to explore in future.

### • GP registration:

Attendees to the van do not require an ID, address, or immigration status but they do need to be registered with a GP. Since the patients receive a PSA blood test as part of the appointment – which requires the sample to be tracked using an NHS number as it travels to the lab for testing, and patient receive a follow up appointment to find out their results – registration is necessary as and a follow up appointment.

Again, this may limit attendance of the aforementioned groups who are more reluctant to formally engage with the health system. Registering attendees can be a lengthy process, so there would need to be infrastructure built-in to the programme to support new registrations if this barrier is to be overcome.

### • Staffing:

The team aimed to ensure the van is staffed three times a week with two staff, including the following:

- Two consultants or;
- Two urology-specialist nursing staff or;
- One urology-specialist nursing staff and one consultant and;
- A phlebotomist is usually also present

In order to help achieve these staffing levels, there was an ongoing offer to all urology trained clinical staff across the region to work on the van. However, achieving these levels is not always possible due to ongoing capacity challenges across the NHS.

### • Text messaging service

A further barrier faced by the team has been the text messaging service used by GPs to advertise the van to their local patient population. Texts should go to a targeted group including men from a Black/African or Caribbean ethnic background over 45 years of age and men over 45 years of age with a family history of prostate cancer. On some occasions, text messages have been sent to all men over the age of 45, leading to admin teams for *This Van Can* becoming overwhelmed, and to confusion over eligibility in the community, which the team have had to correct.

## Outcomes to date:

While the pilot in Greater Manchester Cancer Alliance has not yet reported results, they have been met with a much larger demand than they expected.

A similar pilot in London with RM Partners Cancer Alliance found that more than 600 men visited the mobile clinic, with around 14 diagnosed with prostate cancer.<sup>95</sup> In RM Partners Cancer Alliance, Black men, who were specifically targeted for this pilot – as with the pilot in Greater Manchester – made up more than a quarter of those seen (29%) and 71% of those diagnosed with prostate cancer.<sup>96</sup> These results highlight the impact pilots like these are having on tackling health inequalities across Cancer Alliances.

The team in Greater Manchester have identified KPIs that they will monitor themselves to assess whether they are achieving their goals. These include:

- Number of visits to the website listing van sites and how to book
- Number of bookings
- Number of appointments held in the van
- Number of positive diagnoses of prostate cancer found
- Number of patients successfully treated
- Engagement on social media
- Qualitative feedback from community engagement work

The results will be available from Greater Manchester Cancer Alliance in March 2024.

## Key learnings:

While the pilot programme is still ongoing, the team have identified a number of areas where they could make improvements. This includes:

- A larger administrative team as the uptake has been greater than expected. This would also help resolve any issues caused by the messaging service
- An increase in the role and hours of the lead nurse, as the four contracted hours have not been enough
- Ensure there are a core group of staff on a rota; the team has occasionally lacked consistency to ensure efficiency and understanding of the process

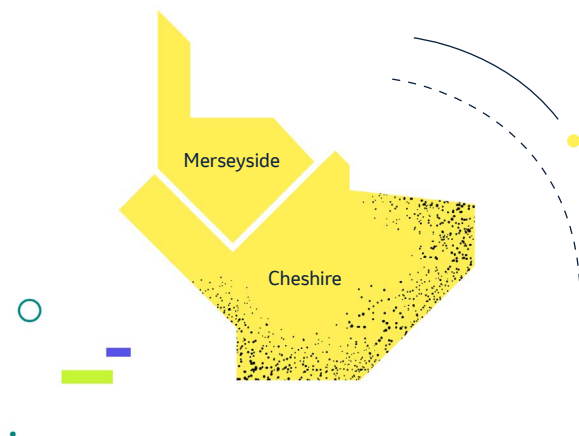
With these changes, the team at GMCA are positive they will have a greater impact on tackling inequalities across their Cancer Alliance.

## For more information:

For more information about this case study or if you have any questions please contact Millie Wadley, Project Manager, Prostate Cancer Pilot, [Millie.wadley1@nhs.net](mailto:Millie.wadley1@nhs.net).



# Cheshire and Merseyside Cancer Alliance case study: *Making health inequalities everyone's business*



## Key points:

- The importance of tackling health inequalities needs to be embedded in every aspect of the Cancer Alliance's work
- Cheshire and Merseyside have developed and delivered its own suite of training on health inequalities to empower staff to do this

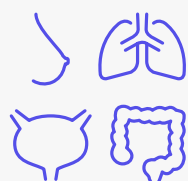
## Health inequalities in Cheshire and Merseyside:

Cheshire and Merseyside has stark levels of deprivation across their geography, with around 25% of the neighbourhoods in Cheshire and Merseyside identifying as being in the top 10% of deprived neighbourhoods in England.<sup>97</sup> Residents in Cheshire and Merseyside are also more likely to be affected by health deprivation and disability (a domain within the IMD) than any other type of deprivation.<sup>98</sup>

The impact of cancer in Cheshire and Merseyside is significant:<sup>99</sup>

Around **7,000** deaths a year

Over half of all new diagnoses each year are made up of the four most common cancers: breast; lung; prostate; and colorectal



The National Cancer Patient Experience Survey has shown that people with cancer in Cheshire and Merseyside who describe themselves as being from an Asian, Black, Mixed, Other White or Other Background

are likely to report a poorer experience as reported in the National Cancer Patient Experience Survey

These insights have shaped the Cancer Alliance's approach to tackling health inequalities, with the main focus being on deprivation.

## The challenge:

Cheshire and Merseyside recognised that it was not enough to simply address health inequalities at the point of access to health services, rather there needed to be work done in communities and with partner organisations to both address and prevent inequalities before the start of the cancer pathway.

The Cancer Alliance identified that health inequalities were not being fully considered across every aspect of the Cancer Alliance's work and sought to make this change across the Alliance. They recognised that it was important to ensure all staff were working towards the same goals. As a group that commissions and encourages work to tackle inequalities rather than deliver care, they were aware of their need to consider inequalities on a wider, Cancer Alliance scale, while working with local partners to deliver local change.

## The solution:

There were several actions to creating change through the Cancer Alliance, however the wholesale organisational change was highlighted as the most impactful, and vital, part of their strategy. This change can be summarised by Cheshire and Merseyside Cancer Alliance's nine pillars of health inequalities (which were evolved through bringing together workstreams and the Health Inequality champions) strategy which are:<sup>100</sup>

- **Understanding health inequity** – both building and signposting to reliable data sources
- **Building confidence and awareness** – developing and delivering all-staff mandatory workshops on health inequity
- **Adapting process** – adapting frameworks across the Cancer Alliance, including the governance framework, to ensure all programmes are addressing health inequalities
- **Accessibility to information** – all materials available from the Alliance have been made accessible to all, through translations into five common languages and British Sign Language – to achieve this the Alliance has protected budget
- **Building a community against cancer** – the Alliance works with over 200 community organisations which assist with a number of key asks, including co-producing services
- **Sharing individual experience** – a patient experience library has been created with statements, quotes, stories and podcasts to offer a range of lived experience

- **Sharing group experience** – a resource of experiences from groups with protected characteristics, developed with communities and support groups
- **Making health inequalities everyone's business** – the health inequalities team work alongside Cancer Alliance staff, to support, upskill and facilitate conversations to address inequity
- **Creating and sharing resources** – the Alliance maintain an up-to-date library of resource, both from national materials to specifically-created localised materials

As can be seen by the scope of the above nine pillars, the Cancer Alliance overhauled its framework to ensure all decisions made across the Alliance are done with health inequalities in mind. Jo Trask, the Health Inequalities and Patient Experience Lead for Cheshire and Merseyside Cancer Alliance, highlighted that this was only possible with management buy-in. Without this buy-in and support, the team would not have been able to make as much headway as they have. While this is obviously team dependent, Cheshire and Merseyside have a number of resources to support any Cancer Alliance wishing to make similar changes.

Cheshire and Merseyside have also set up a staff network to address health inequalities, which is open to anyone who works in cancer services and has an interest in health inequalities. The group meets for one hour on a monthly basis to share best practice, seek feedback, and offer support.<sup>101</sup> The support network at Cheshire and Merseyside has been so successful they are hoping to expand into wider trust-level teams.

A portion of Cheshire and Merseyside Cancer Alliance's health inequalities budget is ringfenced for the voluntary, community, faith, and social enterprise (VCSE) sector. This pot of money supports the Cancer Awareness Community Engagement project, which is delivered by three groups (One Knowsley, St Helens and Halton Community and Voluntary Action, and Warrington Voluntary Action) from across the Cancer Alliance geography. This project funds small grants to organisations delivering cancer awareness initiatives within their communities – particularly those in areas of high deprivation or those who are identified as underserved.<sup>102</sup>

## Barriers to implementation:

The greatest barrier encountered by Cheshire and Merseyside Cancer Alliance is ensuring staff across the Alliance see health inequalities as the 'golden thread' for achieving cancer diagnosis and treatment targets. This has been addressed by support from management and in-house delivery of training on health inequalities, as part of Cheshire and Merseyside's nine pillars.

Availability and access to accurate and local data has also been a barrier to developing more robust actions. While *FutureNHS* and the national inequalities tool offers an important starting point, only local data can help Cancer Alliances address local inequalities. While the Cancer Alliance have developed their own health inequalities dashboard, they admit that the national dashboards are better – so they are using those and every member of staff is receiving training on how to use these.

## Outcomes to date:

The Cheshire and Merseyside Cancer Alliance has been very successful with their approach and has been externally recognised for their innovative work.<sup>103</sup> They have acknowledged that they are not going to be able to close the gap by addressing health inequalities at the point of access to health services, but they will have to work with communities across organisations to address and prevent "inequalities upstream".<sup>104</sup> All staff across the Alliance now receive training on health inequalities, which is making a positive impact on their ability to embed health inequalities across the entire Cancer Alliance.

## Key learnings:

Through the work across the Cancer Alliance, Cheshire and Merseyside have understood and developed a number of key learnings which include:

- Starting small, which ensures that changes can be delivered to drive momentum. These could be a recurring agenda point in meetings or streamlining the process to claim expenses
- Engage any recruited champions, both staff and external champions, to ensure the process is not met with resistance
- High level strategic changes can only be achieved through evolution and the engagement and buy in of staff and the community

## For more information:

For more information about this case study or if you have any questions please contact Jo Trask, Health Inequalities and Patient Experience Lead, [jo.trask@nhs.net](mailto:jo.trask@nhs.net).





# Appendix 1: Resources

This section pulls together a number of resources which have been identified as helpful to anyone trying to address the inequalities in cancer. Please be aware that all external hyperlinks will take you to an external website.

## Breast Cancer Now (formerly Breast Cancer Care), Breast cancer and inequalities: a review of the evidence

Summary: A literature review of findings on breast cancer inequalities in the UK  
[Link to resource](#)

## Cancer Research UK, Cancer in the UK 2020: Socio-economic deprivation

Summary: A report which sets out the impact of socio-economic deprivation on cancer in the UK  
[Link to resource](#)

## Inequalities in cancer out comes network (ICON)

Summary: ICON aims to understand through research why cancer outcomes are poorer in some population groups and to reduce these inequalities  
[Link to resource](#)

## NHS England, What are healthcare inequalities?

Summary: A short webpage from NHS England setting out what health inequalities are and a brief explanation on steps NHS England are taking to address them  
[Link to resource](#)

## NHS Confed and ABPI, An examination of health inequalities in cancer care in Kent and Medway

Summary: A long-form case study on work by Kent and Medway ICS to improve health inequalities in cancer  
[Link to resource](#)

## The Health Foundation, Health equity in England: The Marmot review 10 years on

Summary: An update to the 2010 Marmot Review: Fair Society, Healthy Lives assessing progress in addressing health inequalities in England  
[Link to resource](#)

## The King's Fund, What are health inequalities?

Summary: An explainer setting out an overview of how health inequalities are shaped and experienced in England  
[Link to resource](#)

## United Kingdom Lung Cancer Coalition, Bridging the gap

Summary: A report based on the opinions of the UKLCC's Clinical Advisory Group to increase equitable access to diagnosis, treatment, and lung cancer care  
[Link to resource](#)



# Appendix 2: Glossary

This section sets out definitions of terms and phrases used throughout this report and each definition is hyperlinked in the text of the report.

## Core20PLUS5:

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. It is made up of the following aspects: Core20 is the most deprived 20% of the population as identified by the national Index of Multiple Deprivation; PLUS is the population groups identified at a local level, while these are not defined by NHS England they would expect to see groups that share protected characteristics and groups experiencing social exclusion; 5 refers to five areas of clinical focus that require accelerated improvement (maternity severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding and optimal management and lipid optimal management).<sup>105</sup>

## Index of Multiple Deprivation:

Indices of Deprivation are a unique measure of relative deprivation at a small local area level and provide a set of measures across England, based on seven different domains of deprivation: income deprivation, employment deprivation, education, skills and training deprivation, health deprivation and disability, crime, barriers to housing and services, and living environment deprivation. These seven domains are combined to produce the Index of Multiple Deprivation (IMD). IMD ranks every small area in England from 1 (most deprived) to 32,844 (least deprived).<sup>106</sup>

## Integrated Care Systems (ICSs):

42 Integrated Care Systems, or ICSs, were legally established in 2022 with an aim to join together with local partners and improve health and care services with a focus on prevention, better outcomes and reducing health inequalities. They are formed by NHS organisations and upper-tier local councils, and also include the voluntary sector, social care providers and other partners to improve health and wellbeing.<sup>107</sup>

## Health deprivation:

Health deprivation and disability is a domain of the Index of Multiple Deprivation, and it measures the risk of premature death and the impairment of quality of life throughout poor physical and mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviours or environment that may be predictive of future health deprivation.<sup>108</sup>

## Major Conditions Strategy:

The UK Government Department for Health and Social Care's strategy which will aim to improve health outcomes and better meet the health and wellbeing needs of local populations. It seeks to contribute to the broader government goal to narrow the gap in healthy life expectancy between areas where it is highest and lowest by 2030 and raise healthy life expectancy by 2035. The strategy recognises the challenges facing an ageing population with multiple conditions. The strategy focuses on six major conditions: cancers, cardiovascular disease, musculoskeletal disorders, mental ill health, dementia, and chronic respiratory disease.<sup>109</sup>

## National Healthcare Inequalities Improvement Programme (HiQiP):

The National Healthcare Inequalities Improvement Programme was established in January 2021 to work with other NHS programmes and policy areas as well as wider partners, patients and communities to ensure quality healthcare for all. HiQiP is responsible for setting the direction for tackling healthcare inequalities and used data to target action to reduce and prevent healthcare inequalities.<sup>110</sup>

## NHS Long Term Plan:

Introduced in 2019, the NHS Long Term Plan was introduced to set out key ambitions for the NHS over the following 10 years and to improve the quality of patient care and health outcomes. It was accompanied by a five-year funding settlement.<sup>111</sup> The Long Term Plan has since been supplemented by the [Major Conditions Strategy](#) (mentioned above).

## Primary Care Network (PCN):

Primary Care Networks (PCNs) are formed when a GP practice, or multiple GP practices, work together with community, mental health, social care, pharmacy, hospital, and voluntary services in their local areas. PCNs aim to build on existing services primary care services to ensure greater provision of integrated health and care for people closer to home. PCNs are led by clinical directors working across general practice.<sup>112</sup>

## Voluntary, community, faith, and social enterprise (VCFSE):

Voluntary, community, faith, and social enterprise sector plays an important role in the wider health and care sector. Numerous legislative and strategy documents, including the NHS Long Term Plan, have recognised the important role these organisations play in improving health outcomes. The role the VCFSE sector can play in tackling health inequalities is through shaping the design of services and advocating for, and amplifying the voices of service users, patients, and carers.<sup>113</sup>

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