Greater Manchester Tackling Inequalities in Cancer Strategy

We will tackle inequalities in cancer incidence and outcomes and improve equity in access and experience of cancer care.

Vision and purpose

This strategy will set out how the Cancer System in Greater Manchester (GM) will tackle inequalities in incidence and outcomes and improve equity in access and experience of cancer care.

It will identify the areas in which inequalities exist in the cancer pathway and comit to high-level objectives the GM Cancer Health Inequalities Programme Board will action through a robust implementation plan and the areas the Board will look to influence in the wider GM System.

Strategic Context

The NHS long-term plan sets out the ambition to have a 'more concerted and systematic approach to reducing health inequalities. This has been furthered by the Core20Plus5 approach, which is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. This recognises early cancer diagnosis as one of the five clinical areas of focus for adults which requires accelerated improvement.

This strategy will support delivery of the Greater Manchester ICP Strategy and coordinated work across the system to reduce inequalities across the lifecourse to create a greener, fairer, and more prosperous city-region. This will enable the GM Integrated Care System to ensure:

- Everyone has an opportunity to live a good life
- Everyone has improved health and wellbeing
- Everyone experiences high quality care and support where and when they need it
- Health and care services are integrated and sustainable

The NHS People Plan[1] cites strong evidence for promoting an NHS workforce being representative of the community that it serves, as findings suggest patient care and the overall patient experience is more personalised and patients have better outcomes. It pledges to increase diversity and inclusivity amongst the workforce which will be a key factor influencing how we achieve the ambition and especially the principles of embedding equalities through thinking inclusively.

Governance

The contents of this strategy will be led and implemented by the GM Cancer Health Inequalities Programme Board, which is a collaborative of partners across the cancer system chaired and managed by the Great Manchester Cancer Alliance.

The Health Inequalities Programme Board reports to and is held accountable by the GM Cancer Alliance Programme Assurance Board and the GM Cancer Board.

This strategy also recognises the work of the GM Population Board and the wider GM systems governance of the tackling health inequalities agenda. It is important to ensure that worked developed to tackle inequalities in cancer aligns to efforts in the wider system.

The Health Inequalities Programme Board oversee the development and delivery of the strategy through a robust implementation plan and supported by a number of subgroups and task and finish groups as and when needed.

Principles

This strategy supports the principles as set out in the Greater Manchester ICP Strategy to reduce inequalities, which also incorporate those set out by the GMCVO report[2]

People Power

We will work with people and communities, and listen to all voices including people who often get left out. We will build trust and collaboration and recognise that not all people have had equal life opportunities.

Proportionate Universalism

We will co-design universal services but with a scale and intensity that is proportionate to levels of need.

Health Inequalities are everyone's business

We will think about inclusion and equality of outcome in everything that we do and how we do it. Developing an institutional habit of thinking inclusively enables us to go

[1] We are the NHS: People plan 202/21 – action for us all. NHS England
[2] Inequalities in cancer prevention, diagnosis, treatment and care, 2022. GMCVO

beyond the minimum requirements of legislation and service standards, and supports universal design, creativity and innovation.

Representation

The mix of people who work in our organisations will be similar to the people we provide services for.

Health Creating Places

As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies.

Health Inequalities

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They exist as a result of systematic variation in (i) the accessibility, quality and experience of health and care services, (ii) individual behaviours and, most importantly, (iii) the wider determinants of health, such as employment, education and income[3].

There is not just a moral imperative to address health inequalities but also a financial one with health inequalities costing the NHS £4.8 billion a year in hospitalisation alone[4].

Health inequalities in the cancer system can represent themselves as differences between groups in:

- the risk of getting cancer
- the proportion of people diagnosed at an early stage
- access and experience of diagnosis, treatment, and care
- access to and representation within research
- representation within the workforce

This strategy, although it will reference single issue/identity inequalities, recognises the intersectionality of inequalities within the cancer sector, it will therefore be the responsibility of action leads within the implementation plan to move away from a siloed approach to health inequalities.

Risk Reduction

Inequalities in cancer incidence can largely be attributed to variation in the wider social and commercial determinants of health, a higher prevalence of behavioural

[3] Maguire, D. and Buck, D., 2015. Inequalities in life expectancy-Changes over time and implications for policy.
[4] Asaria, M., Doran, T. and Cookson, R., 2016. The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation. J Epidemiol Community Health, 70(10), pp.990-996.

risk factors in some populations, such as; smoking, obesity, alcohol and sun safety, and environmental risks such as; exposure to air pollution.

Smoking remains the leading cause of cancer deaths, being responsible for 3 in 20 cases[5], while the second is being overweight and obese, which accounts for 6.35% of all Cancers[4], with prevalence of both following the deprivation gradient[6,7].

Prevalence of behavioural risk factors not only differ by level of deprivation but also by personal characteristics such as sex, ethnicity, and other protected characteristics.

These inequalities also exist in preventative programmes such as cervical screening and HPV vaccination, with those from socially deprived groups and ethnic minorities less likely to take up the offer.

We will work with partners to reduce the inequalities in prevalence of behavioural risk for cancer and tackle inequalities in access and outcomes to preventative programmes.	
We will influence… • the wider programmes of work in GM that are addressing the wider social and commercial determinants of health (i.e. air quality, housing quality, good employment etc) • support delivery of the Greater Manchester ICP Strategy and coordinated work across the system to reduce inequalities across the life course to create a greener, fairer, and more prosperous city-region • GM prevention programmes such Make Smoking History and support them to move at scale and pace	We will… • reduce inequalities in access HPV Vaccination • amplify and support local, regional, and national prevention campaigns, ensuring they reach the right communities • implement upstream models of care within cancer pathways, ensuring they are preventative, person-centred, integrated with wider welfare and support

[5] Brown, K.F., Rumgay, H., Dunlop, C., Ryan, M., Quartly, F., Cox, A., Deas, A., Elliss-Brookes, L., Gavin, A., Hounsome, L. and Huws, D., 2018. The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. British journal of cancer, 118(8), pp.1130-1141.
[6] Marmot, M., 2013. Fair society, healthy lives. Fair society, healthy lives, pp.1-74.
[7] Conolly, A. and Davies, B., 2018. Health survey for England 2017: adult and child overweight and obesity. NHS Digital, 1, pp.1-30.

Early Diagnosis

Early diagnosis of cancer is when a cancer is diagnosed at stage 1 or 2 and which leads to much improved outcomes. The NHS Long Term Plan set the target of 75% of people with cancer will be diagnosed at an early stage by 2028. Research shows that eliminating socioeconomic inequalities of stage at diagnosis could result in a 4% shift to early stage cancer diagnosis across 10 cancer sites[8].

Inequalities in early diagnosis, can be attributable to a number of factors, including but not limited to:

- lower uptake of cancer screening programmes[9]
- lower recognition of the signs and symptoms of cancer[10]
- increased barriers to seeking help[11]

Although likely linked to the above factors we know that risk of emergency presentation varies notably by sex, age and deprivation group[12]. Those diagnosed this way are more likely to be late stage diagnoses.

We will work to improve equitable access to healthcare and cancer screening and reduce inequalities in signs and symptom knowledge.	
We will influence… • the wider primary care sector to reduce the inequalities in access to seeking help • support the wider system to be more aware of cancer signs and symptoms including those working with and supporting health inclusion groups	We will… • reduce inequalities in access, experience and outcomes of the three cancer screening programmes • support any innovations in case finding to ensure they are targeted to the most need • amplify and support national signs and symptoms awareness

[8] Barclay, M.E., Abel, G.A., Greenberg, D.C., Rous, B. and Lyratzopoulos, G., 2021. Socio-demographic variation in stage at diagnosis of breast, bladder, colon, endometrial, lung, melanoma, prostate, rectal, renal and ovarian cancer in England and its population impact. British Journal of Cancer, 124(7), pp.1320-1329.
[9] Cancer in the UK 2020: socio-economic deprivation, 2020. Cancer Research UK.
[10] Niksic, M., Rachet, B., Warburton, F.G., Wardle, J., Ramirez, A.J. and Forbes, L.J.L., 2015. Cancer symptom awareness and barriers to symptomatic presentation in England—are we clear on cancer?. British journal of cancer, 113(3), pp.533-542.
[11] Moffat, J., Hinchliffe, R., Ironmonger, L. and Osborne, K., 2016. Identifying anticipated barriers to help-seeking to promote earlier diagnosis of cancer in Great Britain. public health, 141, p.120.
[12] Abel, G.A., Shelton, J., Johnson, S., Elliss-Brookes, L. and Lyratzopoulos, G., 2015. Cancer-specific variation in emergency presentation by sex, age and deprivation across 27 common and rarer cancers. British journal of cancer, 112(1), pp.S129-S136.

	campaigns and create, design and develop our own, ensuring we are targeting symptoms and communities were inequalities exist • develop a Cancer Charter to increase confidence in those who wish to seek help for cancer symptoms • work to better understand and reduce emergency presentations in GM

Diagnosis Treatment and Care

Diagnosis & Treatment

Inequalities in diagnosis and treatment can lead to differing outcomes for patients and differing experiences of care.

There are many factors that can contribute to the differing speed of diagnostics and treatment options but there is evidence that deprivation, age and protected characteristics can play a role.

Evidence shows varying treatment by deprivation and age with some suggesting some of the differences in international cancer survival can be attributed to this[13,14].

Personalised Care

There is difference in experience of care for a number of health inequality groups, in particular socioeconomic background is a key determinant of the gap between people's social care needs and the provision they receive. Those in our most deprived communities are:

- Twice as likely to report a need for emotional support
- Twice as likely to want practical support inside the home
- Three times more likely to need support outside the home[13].

While the National Cancer Patient Experience Survey 2021[15] found that set against this context of high levels of overall care experienced and gratitude, there was a difference noted in the following groups:

[13] Health inequalities: time to talk, 2019. Macmillan Cancer Support.
[14] The age old excuse: the under treatment of older cancer patients, 2012. Macmillan Cancer Support.
[15] National Cancer Patient Experience Survey 2021: Qualitative Deep Dive Report, 2023. NHS England.

- People living in the most deprived areas
- People from ethnic minorities
- People reporting a mental health condition
- People with a Learning Disability
- People aged 16-44

We will work to tackle inequalities in access and experience of diagnosis, treatment, and care.	
We will influence… • our partners to record, analyse and take action, on a trust level, on performance differences in patient cohorts • our partners to ensure innovations in diagnosis, treatment and care are focussed on tackling existing health inequalities	We will… • undertake work to better understand the health inequalities that exist in time to diagnosis • target inequalities in treatment as identified through the pathway boards • lead work on patient empowerment and person centre care • ensure cancer services are accessible to all, including services, information and support • ensure personalised care in GM is both universal and targeted to those that need it most

Research

People from our most deprived areas receive half the number of referrals to early phase cancer trials compared to those living in the least deprived areas. Participants in trials are also less likely to be non-white[16] with older patient also under-represented[17].

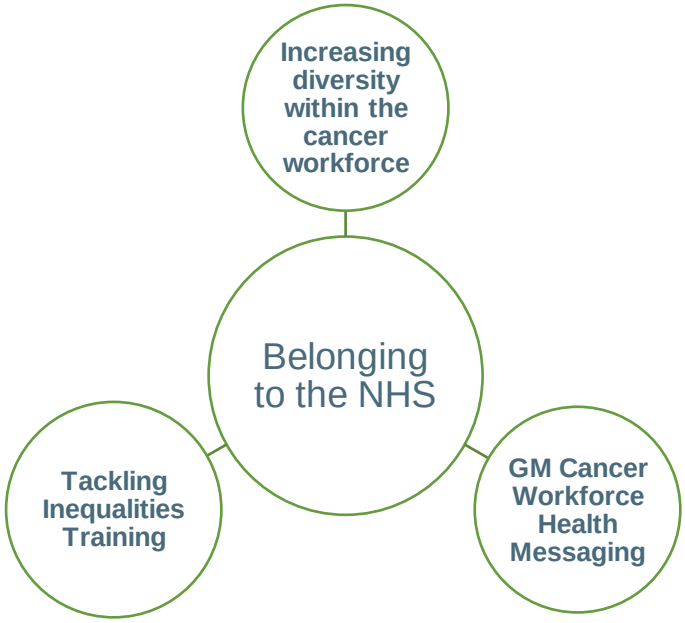
Inequalities in research are impacted by the cancer workforce's ability to advocate for trial inclusion. At present in GM the is an inequity in the distribution of our research nurse workforce.

[16] Godden, S., Ambler, G. and Pollock, A.M., 2010. Recruitment of minority ethnic groups into clinical cancer research trials to assess adherence to the principles of the Department of Health Research Governance Framework: national sources of data and general issues arising from a study in one hospital trust in England. Journal of Medical Ethics, 36(6), pp.358-362.
[17] Longevity, T.L.H., 2021. Older patients with cancer: evidence-based care needs evidence. The Lancet. Healthy longevity, 2(11), p.e678.

We will make sure our research is representative of the population of Greater Manchester and be a leader in health inequalities research.	
We will influence… • and support the research community in GM to increase funding into Health Inequalities focussed research projects	We will… • seek to understand the health inequalities that exist in research in GM • act to increase access to clinical trials for those that are currently underrepresented • scope the inequity in research nurse representation across organisations

Workforce

The GM Cancer Alliance Workforce and Education Team has established a Cancer Workforce Inequalities Working Group for Cancer, which feeds directly into the GM Cancer Inequalities Board and into the relevant ICB EDI function with a focus on 'Belonging to the NHS'.



We will work collaboratively with key stakeholders to promote 'Belonging to the NHS' focusing on inclusion and reducing inequalities within the cancer workforce.	
We will influence… • the cancer system to recognise the importance of workforce EDI by ensuring that inequalities is a cross cutting theme across all	We will… • work with key stakeholders to understand the current cancer workforce demographic and increase workforce

activity within the Workforce & Education Strategy	representation through inclusive recruitment practices • increase staff confidence through upskilling education packages • advocate for our workforce to prioritise their health and wellbeing to live well

GM Cancer Alliance

Greater Manchester Cancer Alliance is one of 21 Cancer Alliances across NHS England and as a public body, GM Cancer has a legal requirement to promote equality and set out how to meet 'general' and 'specific duties' specified in the Public Sector Equality Duty (PSED). PSED give public bodies legal responsibilities to demonstrate that they are taking action to promote equality in relation to policy making, the delivery of services and employment. To meet the PSED all projects will have reducing health inequalities as a core principle and monitored through the Equality Impact Assessment process.

Greater Manchester Cancer Alliance has an extensive User Involvement programme in place currently with a significant number of members. As set out in the principles it is critical in tackling health inequalities to listen to all voices and co-design with our patients and communities.

Our qualitive and quantitative understanding of health inequalities in cancer in GM will be closely linked to the Health Inequality Programme Board's ability to act and make a difference. The GM Cancer Alliance Business intelligence team will support the Cancer health inequality work creating a dashboard the helps us to understand:

- Inequalities in access – what inequalities exist at referral
- Inequalities in process – what inequalities exist along the cancer pathway
- Inequality in outcomes – impact that access and process have on outcomes

The GM Cancer Alliance leads the Digital and Innovation work for the GM Cancer System. This strategy recognises the ambitions and objectives of the Digital and Innovation Strategy in ensuring reducing health inequalities is a core principle of that work.

We will ensure everything we do at the Greater Manchester Cancer Alliance supports the reduction in health inequalities across the cancer system in Greater Manchester.	
We will influence…	We will do

• others in GM and there work on inequalities to support the work we are doing in Cancer, including the ICB, Population Health and the VCSE sector • influence others to capture data in a way that makes it useable	• meet all health inequalities asks as to set out in the cancer planning pack • develop a Health Inequality data dashboard • ensure all projects have reducing health inequalities as a core principle and monitored through the Equality Impact Assessment process. • develop a representative user involvement programme

Implementation Plan and Next Steps

This strategy will be accompanied by an implementation plan which will be a live document. The implementation plan will be developed and overseen by the Health Inequalities Program Board and led by the GM Cancer Alliance with the aim of tackling inequalities in incidence and outcomes and improve equity in access and experience of cancer care by:

- working with partners to reduce the inequalities in prevalence of behavioural risk for cancer and tackle inequalities in access and outcomes to preventative programmes
- working to improve equitable access to healthcare and cancer screening and reduce inequalities in signs and symptom knowledge
- working to tackle inequalities in access and experience of diagnosis, treatment, and care
- making sure our research is representative of the population of Greater Manchester and be a leader in health inequalities research
- working collaboratively with key stakeholders to promote ‘Belonging to the NHS’ focusing on inclusion and reducing inequalities within the cancer workforce
- ensuring everything we do at the Greater Manchester Cancer Alliance supports the reduction in health inequalities across the cancer system in Greater Manchester