NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE quality standards

Equality impact assessment

Suspected cancer (update)

The impact on equality has been assessed during quality standard development according to the principles of the NICE equality policy.

### 1. TOPIC ENGAGEMENT STAGE

### 1.1 Have any potential equality issues been identified during this stage of the development process?

The following 4 issues were noted during development of [QS124](https://www.nice.org.uk/guidance/qs124) (published in 2016, updated 2017):

* Some people may need additional support to communicate effectively with professionals, and understanding information given, especially about the signs and symptoms of suspected cancer. This can be because English is not their first language or due to sensory difficulties.
* People with mental health conditions, dementia or learning disabilities may have specific needs and healthcare professionals should take into consideration communication issues when offering advice and information to people.
* Tests in primary care: healthcare professionals asking people to conduct a test for blood in the faeces should consider additional support for people with learning difficulties, physical impairments and loss of cognitive functions, as well as cultural issues.
* Information given to a person with suspected cancer should be appropriate in terms of language and culture, because there may be different cultural meanings associated with the possibility of cancer.

Additionally, identified for this update:

* Deprivation: cancer is one of the biggest contributors to inequalities in life expectancy, with people from the most deprived communities more likely to be diagnosed at a late stage for certain types of cancer and to die from the disease. Further information is provided in [NHS England & Improvement’s Core20PLUS5 (adults) – an approach to reducing healthcare inequalities](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/evidence-for-the-five-clinical-priorities/) including [the summary of evidence for the 5 clinical priorities.](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/evidence-for-the-five-clinical-priorities/) [Cancer Research UK (CRUK)’s Cancer in the UK 2020: socio-economic deprivation](https://www.cancerresearchuk.org/sites/default/files/cancer_inequalities_in_the_uk.pdf?_gl=1*16j0s4f*_ga*MjAzOTY3MDU2My4xNjQ1MjAyMjg1*_ga_58736Z2GNN*MTY1NjY3NjM0MC40LjEuMTY1NjY3NjM2Ni4zNA..&_ga=2.208526097.269631211.1656672614-2039670563.1645202285).
* Age: [Public Health England, 2020, Routes to Diagnosis 2006 to 2017 results](https://www.gov.uk/government/statistics/routes-to-diagnosis-2006-to-2017-results/routes-to-diagnosis-2006-to-2017-results), citing a paper by [Herbert et al, 2019](https://doi.org/10.1136/jech-2017-210371) which highlights that older people continue to make up the bulk of those diagnosed as an emergency presentation. Those who are living in more deprived areas are also more likely to be diagnosed through this route. Younger people are more likely to report barriers to help-seeking from a doctor to promote earlier diagnosis in Great Britain ([Moffat, Ironmonger and Osborne, 2014](https://doi.org/10.1016/j.puhe.2016.08.012)).
* Ethnicity: Caribbean, African and Asian women with breast or ovarian cancer, Caribbean and African women with uterine or colon cancer, Caribbean women with non-small cell lung cancer and Caribbean men with colon cancer had increased odds of late-stage disease at diagnosis compared with the white British cohort, using data from 2012 to 2016 ([Fry et al, 2023](https://bmjopen.bmj.com/content/13/1/e062079.info)).
* Gender: Women are more likely to report barriers to help-seeking from a doctor to promote earlier diagnosis in Great Britain ([Moffat, Ironmonger and Osborne, 2014](https://doi.org/10.1016/j.puhe.2016.08.012)).

### 1.2 Have any population groups, treatments or settings been excluded from coverage by the quality standard at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

No population, treatments or settings have been excluded from coverage by the quality standard at this time.

Completed by lead technical analyst: Rachel Gick

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Approved by NICE quality assurance lead: Mark Minchin

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### 2. PRE-CONSULTATION STAGE

### 2.1 Have any potential equality issues been identified during the development of the quality standard (including those identified during the topic engagement process)? How have they been addressed?

The QSAC prioritised a statement on providing tailored information and support through the diagnostic process, to update statement 1 in QS124. The QSAC noted stakeholder comments around poorer experiences of the diagnostic process for cancer among people with learning disabilities and autistic people. Current practice findings from the [2021 Cancer Patient Experience Survey](https://www.ncpes.co.uk/2021-national-results/) highlight the need to provide reasonable adjustments; in particular, support for additional sensory and communication needs when explaining the reason for a cancer referral in primary care and information about diagnostic tests in advance.

The QSAC also noted that the information needs to be given in a way that is mindful of different language (comprehension) needs. The committee also felt that it is important to provide materials in formats that will be meaningful for younger people; the committee noted that the briefing paper highlighted that people in the 16 to 24 age groups were significantly less likely to agree that their referral had been explained in a way they could understand. The committee suggested that providing information in digital formats is particularly important for children and young people. They however also noted that there are potential issues around lack of access through digital exclusion and accessibility of the information, which would need to be addressed.

When referring people for suspected cancer, there is a need to respect cultural concerns, for example, sex of clinician if religious objections. Quality statement 1 attempts to address the need to provide information that takes into account people’s preferences and their cultural beliefs.

Members of QSAC suggested inequalities issues at post-committee review in relation to statement 2. They highlighted that healthcare professionals need to be alert to cues indicating additional literacy needs when giving instructions for pre-referral tests (such as FIT) to people whose first language is English. The following groups have been identified as having a poorer experience of cancer care around communication needs:

* People with learning disabilities and autistic people (aged 16 and over): the 2021 Cancer Patient Experience Survey’s [national deep-dive (qualitative) report](https://www.ncpes.co.uk/2021-national-results/) highlighted the need to improve support for additional sensory and communication needs, including the need to provide information in an ‘Easy Read’ format and making reasonable adjustment.

It was highlighted that socio-economic factors may affect access to non-specific symptoms clinics in rural locations due to financial barriers. The [Local Government Association and Public Health England’s 2017 Health and wellbeing in rural areas case study report](https://www.local.gov.uk/publications/health-and-wellbeing-rural-areas) identifies access to transport, including its impact on daily living costs, as a risk factor for health within rural populations.

The equality and diversity section for the statement highlights the need to ensure access to services for non-specific symptoms pathways among underserved groups with known inequalities.

The QSAC discussed quality improvement areas suggested by stakeholders for a range of specific cancer sites. A statement on colorectal cancer (number 5) was progressed. During review of the standard after the meeting, the committee highlighted groups who may need additional support to carry out FIT. Examples of adjustment are highlighted in the equality and diversity considerations section of this statement.

The QSAC prioritised a statement on GP access to non-urgent access to diagnostic imaging through NHS England’s national scheme. During internal review we were advised that this scheme is only available to adults.

It was suggested that 2 statements in [QS18](https://www.nice.org.uk/Guidance/QS18) which refer to CA125 testing (1 and 2) were included as cross-references in QS124, as statements 6 and 7. In relation to these statements, in the list of statements section, a sentence has been added highlighting that statements 6 and 7 also apply to transgender men and non-binary people.

### 2.2 Have any changes to the scope of the quality standard been made as a result of topic engagement to highlight potential equality issues?

No changes have been made to the scope of the quality standard at this stage.

### 2.3 Do the draft quality statements make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

Direct access services for concerning symptoms which do not meet the threshold for an urgent referral to a specialist (as defined in NG12) are currently available to adults only. No barriers to access have been identified for subgroups among this population.

### 2.4 Is there potential for the draft quality statements to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No.

### 2.5 Are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 2.1, 2.2 or 2.3, or otherwise fulfil NICE’s obligation to advance equality?

No.

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