Surrey Cancer Inequalities Plan:

Evidence-based recommendations to address cancer inequalities in Surrey

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What are cancer inequalities?

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people:

- Healthcare inequalities are part of wider inequalities, and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare.
- These inequalities can occur by socio-economic factor, geography, possession of specific characteristics, or membership of socially excluded (or 'inclusion') groups[1].
- Inequalities can occur across the cancer care continuum, from prevention, diagnosis and treatment, through to living beyond cancer, and end of life care.
- Reducing health inequalities is an NHS priority at the national and system level, as laid out by the 2019 NHS Long Term Plan. The Health and Care Act 2022 promotes integration and partnership working to tackle health inequalities through integrated care systems (ICSs), integrated care partnerships, place-based partnerships and working with people and communities.

Why do we need a Surrey Cancer Inequalities Plan?

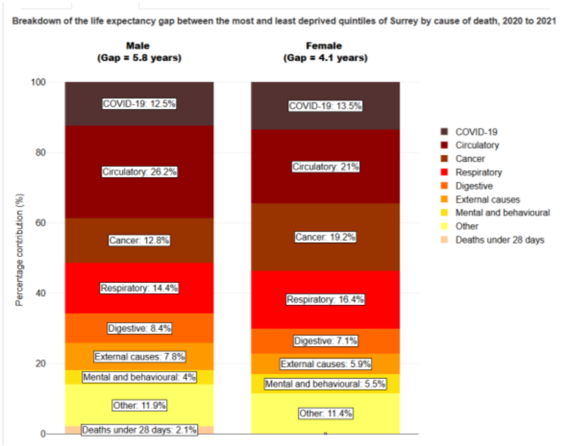
In 2023, cancer was the leading cause of death in Surrey, responsible for 23.9% of deaths across the county[2].

Cancer is also the second largest contributor to the gap in life expectancy between the most and least deprived quintiles in Surrey in females, after circulatory disease, and third largest in males after circulatory and respiratory disease[3]. In Surrey, the cancers with the highest incidence, prevalence and mortality rates are **prostate**, **breast**, **colorectal** and **lung** – the same pattern as seen nationally[4]. But we know from local data there is variation in cancer incidence and mortality rates between different areas in Surrey[5]. For example:

- Between 2015-2019, 122 people per 100,000 living in Shepperton Town were diagnosed with cancer, compared to 70 per 100,000 in Woldingham.
- Between 2016-2020, the under 75 mortality ratio in Godalming Farncombe and Catteshall was 137, compared to 25 in Ewhurst (compared to England value of 100)

We also know from national data that there is variation in outcomes by gender, age, deprivation and other factors[5]. For example:

- Between 2021-2023, 148.2 people in the most deprived decile (IMD2019) died from cancer per 100,000, compared to 105.2 per 100,000 in the least deprived decile. Of the four most common cancers, this deprivation gap is particularly large for lung cancer.


Breakdown of the life expectancy gap between the most and least deprived quintiles of Surrey by cause of death, 2020 to 2021

Any of this variation that arises from avoidable, unfair and systematic factors are cancer inequalities. This plan aims to identify key inequalities that can be seen across the cancer pathway from existing data, and make recommendations to further understand and address them in Surrey.

Purpose of the Surrey Cancer Inequalities Plan

Objectives of the Surrey Cancer Inequalities Plan

The objectives of the plan are to:

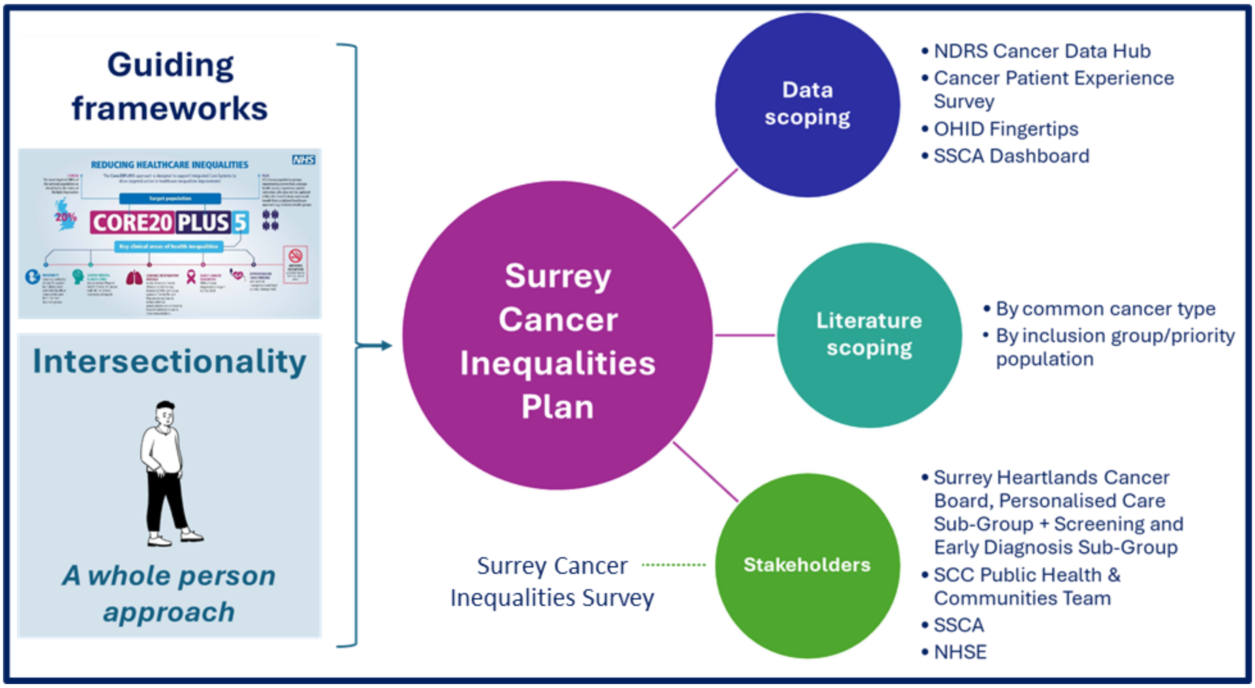
a. Improve our knowledge and understanding of groups experiencing inequalities in relation to cancer outcomes and experiences of cancer care across Surrey

b. Provide recommendations to address inequalities in prevention, screening, diagnostics referrals, treatment, personalised care, access, experience and outcomes

How was the plan was developed?

The plan was developed as part of a two-year Cancer Inequalities post funded by Macmillan Cancer Support based in Surrey County Council Public Health & Communities team, working closely with Surrey Heartlands Integrated Care System.

The recommendations are based on a comprehensive data and literature scoping and stakeholder consultation process, including a survey of stakeholders working across the system to map planned, ongoing or recently completed cancer inequalities work in Surrey. In the next phase of work, Surrey County Council will work with NHS Surrey Heartlands and other partners to develop an action and implementation plan based on the recommendations made in the over-arching plan.



Abbreviations: *NDRS, National Disease Registration Service; NHSE, National Health Service England; OHID, Office of Health Improvement and Disparities; Surrey County Council; SSCA, Surrey and Sussex Cancer Alliance.*

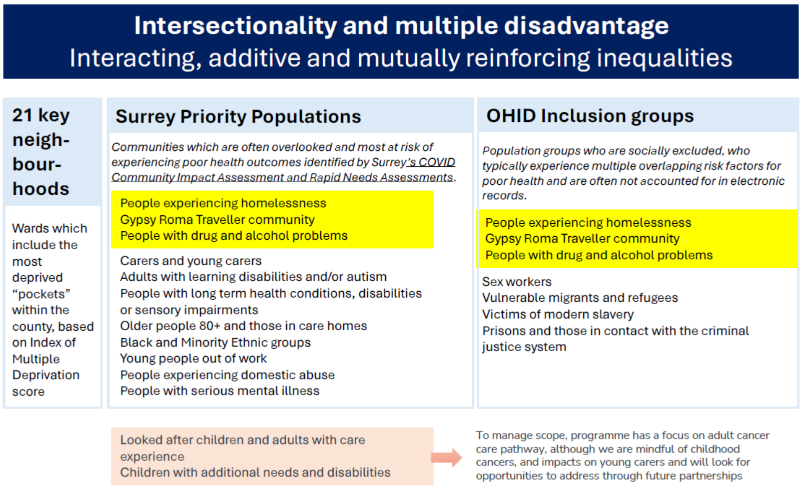
Overarching principals of the plan

NHS England CORE20Plus5

CORE20Plus5 is the NHS England approach to inform targeted action to reduce healthcare inequalities at a national and system level[6].

The approach defines two target populations and 5 key clinical areas of focus:

- **Core20:** the most deprived 20% of the national population, defined by the Index of Multiple Deprivation. In Surrey, these are defined as the Key Neighbourhoods in the Health and Wellbeing Strategy.
- **PLUS:** population groups identified at a local level. In Surrey, this includes both the Priority Populations defined in the Health and Wellbeing Strategy, and inclusion health groups
- **5:** Early diagnosis of cancer (at Stage 1 or 2) is defined as one of five core clinical areas of focus



Intersectionality and multiple disadvantage
Interacting, additive and mutually reinforcing inequalities

21 key neigh-bour-hoods	Surrey Priority Populations	OHID Inclusion groups
Wards which include the most deprived "pockets" within the county, based on Index of Multiple Deprivation score	*Communities which are often overlooked and most at risk of experiencing poor health outcomes identified by Surrey's COVID Community Impact Assessment and Rapid Needs Assessments.*	*Population groups who are socially excluded, who typically experience multiple overlapping risk factors for poor health and are often not accounted for in electronic records.*
	People experiencing homelessness Gypsy Roma Traveller community People with drug and alcohol problems	People experiencing homelessness Gypsy Roma Traveller community People with drug and alcohol problems
	Carers and young carers Adults with learning disabilities and/or autism People with long term health conditions, disabilities or sensory impairments Older people 80+ and those in care homes Black and Minority Ethnic groups Young people out of work People experiencing domestic abuse People with serious mental illness	Sex workers Vulnerable migrants and refugees Victims of modern slavery Prisons and those in contact with the criminal justice system

Looked after children and adults with care experience
Children with additional needs and disabilities

→ To manage scope, programme has a focus on adult cancer care pathway, although we are mindful of childhood cancers, and impacts on young carers and will look for opportunities to address through future partnerships

Evidence-based and informed by behavioural science

Behavioural science provides a framework for using evidence to identify and modify behaviours that contribute to inequalities. The COM-B model is one model of behaviour change that states that in order for an individual to perform a behaviour, they require the Capability, Opportunity and Motivation (COM) to do so[7]. Identifying these drivers of behaviour enables the matching of evidence-based behaviour change techniques and interventions to tackle cancer inequalities. In this plan, we present a summary of key data on inequalities related to each key touchpoint along the cancer pathway, from exposure to risk factors (primary prevention), to screening and diagnosis processes, and treatment access, engagement and experience.
This plan is accompanied by a set of data packs mapping variations between groups that can be seen across the cancer pathway.

Collaboration and knowledge exchange

Addressing health inequalities is a statutory duty of Surrey County Council's Public Health function, and of the two Integrated Care Board's serving Surrey's residents (NHS Surrey Heartlands and NHS Frimley). Much work has already been completed or is planned to address cancer inequalities in Surrey as identified by the Surrey Cancer Inequalities Survey. It is essential insights and actions are shared between partners to maximise the impact of this work in reducing inequalities for our residents..

1. Primary prevention

Around 40% of cancers can be prevented by reducing exposure to risk factors. Smoking is the largest cause of cancer in the UK, followed by overweight and obesity.

Inequalities in exposure to cancer risk factors arise due to a complex interaction of systemic, cultural, social, psychological and behavioural drivers. To tackle the inequalities in cancer incidence seen nationally and locally, it is vital to identify and address the modifiable factors driving these differences in exposure to the largest cancer risk factors, including:

Tobacco[1]

In 2022/23, 9% adults (18+) in Surrey said they currently smoke, and a quarter used to smoke. Whilst the Surrey smoking prevalence in adults aged 18+ estimated by Annual Population Survey (APS) data is lower than England (12.4%) there is variation between districts and boroughs, ranging from 4.0% in Woking to 12.% in Tandridge (2021-2023). Key inequalities are explored in the Smoking and Tobacco Control JSNA. For example, in Surrey routine and manual workers; people with a long-term mental health condition and people in treatment for substance misuse have higher than average smoking prevalence.

Alcohol[3]

In 2017-2019, 38 people per 100,000 residents in Surrey were diagnosed with alcohol-related cancer, a similar incidence rate to England. Estimates ranged between districts and boroughs from 34 per 100,000 in Woking, to 42 per 100,000 in Surrey Heath. In Surrey, the incidence rate of alcohol-related cancers is higher among females (41) than males (36). National data shows incidence rate of alcohol-related cancers is significantly higher in the 30% most deprived areas compared to average rate. Alcohol use inequalities in Surrey are explored in the Substance Misuse JSNA.

Overweight and obesity[2]

In 2022/23, 58.2% adults were classified as overweight or obese. Whilst prevalence in Surrey is lower than across England (64%), there is substantial variation between districts and boroughs from 51% in Elmbridge to 66.1% in Tandridge. Key overweight/obesity inequalities are explored in the Food and Health JSNA. For example, obesity is more common among people living in poverty, older people, some black and minority ethnic groups and people with disability. The latest National Child Measurement Programme (NCMP) data for Surrey shows children from black ethnic backgrounds have the highest obesity prevalence by ethnic group.

Sun and UV

4% of cancer cases, and 87% of melanoma cases are caused UV radiation. The 5-year crude prevalence rate of melanoma is 153.9 per 100,000 people in NHS Surrey Heartlands – the sixth highest of all ICS regions in England[4]. Conversely to most other cancer types, melanoma rates are higher in areas of low compared to high deprivation. In Surrey Heartlands, age-standardised 5-year rolling age-standardised melanoma incidence rate (2016-2020) is similar between males and females (35.4 and 32.1 per 100,000 respectively) and is highest in older adults (80+) compared to other age-groups.[5]

HPV vaccination[6]

Human papillomavirus (HPV) causes 99.8% of cervical cancers. This sexually transmitted virus affects around 80% people. Vaccination is recommended in England for children aged 12-13 and people at higher risk from HPV. 2022/2023 data show coverage for one dose for this age group in Surrey is far below the 90% goal (77% for females; 71% for males). National data show coverage is lower in more deprived areas, and among people of black and Asian ethnicity compared to people of white ethnicity. Research suggests females with learning disabilities, autism and/or serious mental illness are less likely receive the vaccine than those without.[7]

Next steps and recommendations

1.1 Run awareness campaign on key cancer risk factors targeted to high-risk populations, including areas of highest deprivation

1.2 Implement recommendations from local lung cancer screening evidence review to drive equitable uptake of co-located smoking cessation services amongst population at highest risk of lung cancer (eg, high deprivation, people who currently smoke)

1.3 Conduct a review of inequalities in cancer specific dietary risk factors to inform evidence-based, tailored communication and education recommendations

1.4 SCC Public Health improvement team to continue to drive targeted action to educate residents to minimise high-risk behaviours and exposures (tobacco and alcohol use, diet and exercise, sun)

1.5 Implement recommendations from HPV vaccination uptake primary research interviews and evidence review to facilitate uptake for young people with learning disabilities

2. Cancer screening

Equitable cancer screening is a key mechanism through which Surrey can meet NHS England's CORE20Plus5 framework target for 75% of cancers to be diagnosed at early stage (Stage 1 or 2), when survival outcomes are better.

National cancer screening programmes are offered across Surrey for breast, bowel and cervical cancers. Lung cancer screening is currently being rolled out across the county as part of the national expansion of the Lung Cancer Screening Programme. There are shared and pathway specific inequalities in uptake detailed in the Surrey Screening JSNA. Shared inequalities include those seen by deprivation: uptake across all programmes is lowest in areas with the highest deprivation. Across all programmes, GP registration is required to receive a postal invitation to cancer screening. Many members of inclusion health groups, such as Gypsy Roma Traveller communities and people experiencing homelessness, are not GP-registered, or do not have a stable address and therefore may not receive an invitation. Other key intersectional barriers that lead to inequalities in screening include **capability barriers**, such as literacy, health literacy and digital literacy, and competing priorities; **environmental/opportunity barriers**, such as inadequate transport options, or social/carer support options; and **motivational barriers** such as fatalism. Members of Surrey priority populations and inclusion health groups are more likely to face many of these barriers than the general population.[1]

Bowel[2]

Bowel cancer screening is offered to everyone registered with a GP aged 50 to 74 every two years in England. Since 2021, the age has been lowered gradually from 60 in a phased rollout. Screening is in the form of a faecal immunochemical test (FIT) that can be collected at home and sent by post for testing. Coverage in 2023/24 (ages 60 to 74) was 74.0% in NHS Surrey Heartlands, and 73.0% in NHS Frimley, slightly higher than the England average (71.8%). But there is significant variation by PCN, ranging from 68.5% in Sasse Network 3 to 78.7% in Guildford.

Breast[2]

Breast screening is offered to women registered with a GP aged 50 to 70 every two years in England. Eligible women are invited for a mammogram, which uses X-rays to image the breasts, at a clinic or mobile unit. Coverage in 2023/24 was 71.3% in NHS Surrey Heartlands, and 73.0% in NHS Frimley, slightly higher than the England average (69.9%). But there is very wide and significant variation by PCN, ranging from 64.9% in Woking Wise 2 to 79.4% in Leatherhead.

Cervical[2]

Cervical screening is available to women and people with a cervix registered with a GP aged 25 to 64 in England. All eligible people registered as female with their GP automatically receive an invitation; trans men do not receive postal invitations if registered as male with their GP, but are entitled to screening if they have a cervix. People aged 25-49 are invited every 3 years; people aged 50 to 64 are invited every 5 years. There is a trend for decreasing coverage in the 25-49 age group nationally and in Surrey, with wide variation from 58.6% in Central and North Guildford PCN to 76.9% in South Tandridge PCN. Coverage is stable and higher for the 50-64 age group, but still varies significantly from 70.3% in Cobham and Oxshott to 80.4% in Guildford East.

Lung[3]

Lung cancer screening is being rolled out in phases across Surrey starting in summer 2025 as part of the national expansion of the programme, previously known as Targeted Lung Health Checks.

People aged 55-74 who have ever-smoked will be invited to have a telephone risk-assessment; those identified as being at higher risk of lung cancer will be invited to attend a low dose CT scan, and offered free stop-smoking support. Collated evidence from UK studies and pilots shows lung screening uptake is lowest for people living in the most deprived areas and people who currently smoke (compared to those who used to smoke). Mixed evidence shows potential differences in uptake by age, sex and ethnicity.

Next steps and recommendations

2.1	To run a series of connector sessions between GP practices and populations at high risk of not being registered with a GP and/or experiencing housing instability (eg, GRT, homelessness, prison populations) to facilitate invitation to cancer screening programmes
2.2	To work with PCNs with the lowest uptake of breast, bowel and cervical cancer screening to identify key drivers to low uptake and make evidence-based recommendations to improve equitable uptake
2.3	To implement recommendations from lung cancer inequalities screening review during roll out of lung cancer screening in Surrey
2.4	To implement recommendations from evaluation of breast screening in prisons project to facilitate wider engagement with cancer screening and early diagnosis with Surrey's prison populations
2.5	To develop implementation toolkit to facilitate evaluation and uptake of recommendations from initial research into cervical screening uptake for people with LD and SMI; following this, to work with screening providers to adapt insights from cervical screening focused work into uptake of screening for people with learning disabilities, to adapt and inform recommendations for other screening programmes (breast, bowel, lung)

3A. Early diagnosis: % Stage 1 or 2

For cancers with no current screening programmes, different mechanisms must be engaged to drive equitable early diagnosis, in line with the CORE20Plus5 approach

In Surrey Heartlands, in the 12 months to October 2024, 69% cancers were diagnosed at Stage 1 or 2. This proportion varied by cancer site: cancers with the lowest proportions of early diagnosis for **pancreatic** (27%), **oesophago-gastric** (28%), **non-Hodgkin lymphoma** (36%), **ovarian** (38%) and **lung** cancers (40%). Inequalities can relate to presentation to a GP, referral by the GP, and processing referrals (including conducting, interpreting and communicating diagnostic tests). Nationally, differences in the proportion of cancers diagnosed at an early stage are seen by deprivation, gender, ethnicity and age. The following boxes describe patterns seen in Rapid Cancer Registration Data national data for the 12 months preceding Oct 2024[1]:

Deprivation[1]

Across all sites combined, the proportion of cancers diagnosed at an early stage decreases as deprivation increases. Looking by IMD quintile, 55% of the most deprived 20% (IMD1) are diagnosed at S1/2 compared to 62% in the least deprived quintile (IMD5). This gap is largest for **Hodgkin Lymphoma** (8 percentage points difference between IMD4 (second least deprived) and IMD1 (most deprived), **bladder** (85% in IMD5 VS 78% IMD1), **colorectal cancers** (51% IMD5 VS 46% IMD1) and **uterine cancers** (81% IMD5 vs 76% IMD1). The inverse pattern is seen for some cancer sites, with the gap seen for ovarian cancer (39% in IMD5 vs 46% in IMD1) and kidney (56% S1/2 vs 42% in least deprived).

Ethnicity[1]

Across all sites combined, similar proportions were diagnosed at an early stage across ethnic groups: 58% for people of white ethnicity; 60% for people of Black or Asian ethnicity; 61% for people of Unknown and Mixed or Other ethnicity. But patterns differ substantially by site. The largest differences between ethnic groups are seen for **ovarian cancer** (57% S1/2 Black VS 42% S1/2 White ethnicity); **melanoma** (94% S1/2 White VS 82% Black and Asian ethnicity); **prostate cancer** (66% S1/2 Mixed/Other VS 65% Black VS 54%White ethnicity); **uterine cancer** (78% S1/2 White vs 66% Black ethnicity); **lung** (43% Black VS 40% White VS 30% Unknown ethnicity); and **colorectal** cancer (49% White VS 38% Black ethnicity).

Gender[1]

Across all sites combined, a lower proportion of cancers are diagnosed at an early stage in males (52%) compared to females (66%). This pattern is observed across most cancer sites, with the largest differences in proportion of S1/2 diagnoses seen for **breast cancer** (9 percentage point difference), **lung cancer** (7 percentage point difference), **Hodgkin Lymphoma** (7 percentage point difference). However, the inverse pattern is true for **bladder cancers** (8 percentage point difference).

Age[1]

Across all cancer sites combined, a higher proportion are diagnosed at S1/2 in younger compared to older adults (69% S1/2 age 0-49 VS 52% age 80+), although this pattern does vary between cancer types. Of cancer types more likely to be diagnosed at an early stage in younger adults, the difference is largest for **ovarian** (71% age 0-49 vs 25% age 80+) and **prostate** cancers (79% age 0-49 vs 30% age 80+). Among cancer types more likely to be diagnosed at an early stage in older adults, the difference is largest for **bladder** (83% 80+ vs 69% age 0-49) and **oesophageal cancers** (33% age 80+ vs 22% age 0-49).

Inclusion health and priority populations[2]

Data on inclusion groups and priority populations is limited, even at a national level. Literature suggests inclusion groups face many barriers to early diagnosis at patient, staff and service level. **Patient barriers** can relate to low awareness of signs, symptoms and screening programmes, as well as mistrust (rooted in systemic barriers to education, information dissemination and high-quality service delivery) and social norms; and practical barriers such as cost, transport and language; **staff barriers** can relate to (un)conscious bias, ineffective communication and workload; and **service level or systemic barriers** can relate to challenges registering at GP practices without ID or proof of address, inadequate training on inclusion group engagement and limited resource for outreach.

Next steps and recommendations

3.1	Adapt the CRUK Cancer Awareness Measure+ to identify local inequalities in cancer awareness to inform targeted campaigns
3.2	Co-develop and run outreach events to raise awareness of symptoms of non-screen detected cancers at high-risk of late-diagnosis focusing on areas of high deprivation, males and inclusion health groups, including health communications confidence/self-advocacy training
3.3	Develop communications guidance (based on MECC/VBA approach) for patient-facing staff involved in delivering cancer screening to capitalise on screening as a teachable moment for non-screen detected cancer symptoms

3B. Routes to diagnosis

The proportion of cancers diagnosed at an early stage, and net survival, are higher for those diagnosed through managed routes compared to emergency presentations.

National data from 2020 show 78% cancers diagnosed at Stage 1 and 79% of cancers diagnosed at Stage 2 were done so via managed routes[1]*. Managed routes include cancer screening, urgent suspected referral and routine referral. Even after adjusting for stage of diagnosis, people diagnosed with cancer via emergency presentation have lower survival rates than those diagnosed via managed routes[2]. National data also shows variation exists in the proportions of patients diagnosed by emergency routes by deprivation, gender, ethnicity and age; patterns from the most recent National Disease Registration Service data from 2020 are described below[1*]:

Ethnicity[1]

Across combined sites, the proportion diagnosed by emergency presentation was similar across ethnic groups, ranging from 21% in people of unknown ethnicity to 26% in people of Chinese ethnicity. Data by cancer site available for breast, colorectal, lung and prostate showed proportions were broadly similar for all except small cell lung cancer, for which the numbers were so small that it was not possible to make meaningful comparisons. Research analysing longer-term national data (2006 – 2016) across 10 cancer sites found greater proportions of patients of Other ethnic group [28.1% (n = 1112)], followed by the White group [19.2% (n = 28,963)] were diagnosed as emergencies compared with Mixed [16.4% (n = 13,070)], Asian [13.6% (n = 606)], or Black [14.8% (n = 680)] patients. These differences held across all patient characteristics (age groups, sex, quintiles of deprivation, morbidity scores, and regions) but differed by cancer types. The paper concluded that where inequalities exist, the adverse cancer outcomes among Asian and Black patients are unlikely to be arising solely from a poorer diagnostic process[3].

Deprivation[1]

Across combined sites, the proportion diagnosed by emergency presentation increases as deprivation increases. 27% cancers in the most deprived quintile (IMD1) are emergency presentations VS 19% in the least deprived (IMD5). This pattern is seen across most common cancer types, with some of the largest gaps seen for **soft tissue** (30% IMD1 vs 17% IMD5), **pancreatic** (51% IMD1 VS 40% IMD5), **colorectal** (29% IMD1 VS 22% IMD5) and **oesophageal cancers** (26% IMD1 VS 20% IMD5).

Age[1]

Across combined sites, the proportion diagnosed by emergency presentation increases as age increases from 50. 42% cancers in 85+ year olds are emergency presentations, compared to 15% in the 50-59 age group. This pattern is seen across most common cancer types, with the largest gaps for **brain** (43% 80+ VS 33% 50-59), **ovarian** (56% 80+ VS 22% <50 years) and **kidney cancers** (51% 80+ vs 19% 50-59).

Gender[1]

Across combined sites, the proportion diagnosed by emergency presentation was slightly higher in males (24%) compared to females (21%). This pattern varies across cancer site; the largest site-specific differences have higher proportions of emergency diagnoses for females compared to males (i.e. **liver**: 39% M VS 45%F; **colorectal:** 22% M VS 27% F), **bladder** (14%M VS 19%F)). Wider gaps are seen for other cancer types (eg,haematological cancers), but low overall numbers mean confidence intervals are too wide to make meaningful comparisons.

Cancer site[1]

Haematological, (66% ALL; 59% AML), **unknown primary** (65%), **biliary tract** (52%), **pancreatic** (45%) and **brain** cancers (45%) had the highest proportions diagnosed via emergency presentation; this pattern has remained the same every year since 2013. In Surrey Heartlands, between 2013-2020,data are reported showing differences in the proportions diagnosed via non-emergency routes between these four cancer sites: 95-97% breast cancers; 88-94% prostate cancers; 77-79% of colorectal cancers; and 62-75% of **lung cancers**.

Inclusion health and priority populations

As with other points on the pathway, data on routes to diagnosis is limited for these groups. Analysis of national mental health service use datasets (2002-2018) linked to national cancer registry and hospitalisation data (2006-2018) found rates of emergency presentation for lung, prostate, breast and colorectal cancers were significantly higher in people with history or mental health/addiction service use than people without [4].Data from the LeDeR programme showed that between 2017-2019, 35% of people with a learning disability who died with cancer were diagnosed via emergency presentation[5]. A national study led by University of Surrey researchers found that receiving a diagnosis of cancer is more difficult for people in prisons, due to additional barriers such as health literacy, GP appointment booking systems and communication between oncology and prison staff [6]

Next steps and recommendations (see previous page)

3.4 To develop and deliver a webinar on key inequalities in early-stage and routes to diagnosis delivered to primary care professionals to raise awareness and drive equitable referrals by managed routes

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*The COVID-19 pandemic impacts generalisability of data between 2020-2022. However, trend data shows this is an enduring well-established pattern: a higher proportion of cancers diagnosed at S1/2 are done so via managed routes, compared to emergency presentation.

4A. Time to treatment

Inequalities can arise within the crucial time window between referral, diagnosis and treatment. Longer time periods leave more time for a cancer to progress, therefore ensuring equity of progression to treatment is critical for tackling inequalities in outcomes.

From October 2023, the NHS moved to three waiting time standards for cancer diagnosis and treatment: the Faster Diagnosis Standard (at least 75% patients have cancer diagnosed or ruled out within 28 days of referral); 31-day treatment standard (at least 96% start treatment within 31 days of a decision to treat); 62-day treatment standard (at least 85% start treatment within 62 days of being referred or consultant upgrade). Public data to identify local variations by demographics are limited, however comparisons between Trusts in Surrey show variation by place and cancer site. National data and research reveal wider inequalities related to deprivation, gender, ethnicity and age:

Differences by patient characteristic[1]

Cancer Research UK analysed data on patients waiting over 104 days from urgent suspected referral to first cancer treatment in England between 2017-2023. They found the % waiting over 104 days increased by year from 4.1% in 2017/2018 to 11.6 in Q1 and Q2 of 2022/23. **Strong deprivation gradients** were seen for several sites, including breast cancer, colon cancer and melanoma. They found the **deprivation gradient** (those in the most deprived quintile are most likely to be the longest waiters) was present, even when other demographic characteristics and trust were controlled for. They also found **patients aged 60-69** were most likely to be longest waiters compared to other age-groups; **patients with a co-morbidity score over 0** were more likely to wait over 104 days; **patients diagnosed at stage 4** were least likely to wait over 104 days. The authors noted that population-wide analysis of associations between patient survival and meeting waiting times can be complicated since shorter times from referral to treatment do not necessarily equate to a better outcome. For instance, people at later stages and who are sicker may be more likely to be seen quickly, decline treatment or die before starting treatment. However, on an individual level, long waits can negatively impact patients' mental health, lead to disease progression and risk poorer outcomes. They highlighted the importance of focusing on sites individually to improve specific pathways and understand reasons for delays.

Differences between NHS Trusts in Surrey[2]

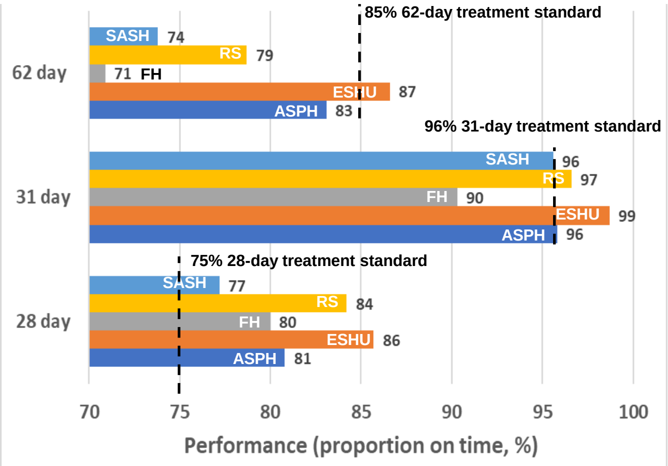


Figure 1. There is variation between Trusts serving Surrey residents in waiting time standards performance (%) from provider monthly reports (Jan-Dec 2024) collated by NHS England. Over the 12-month period, all Trusts met the 28-day standard, all but Frimley met the 31-day standard, but only Epsom and St Helier met the **62-day standard.**

*Abbreviations: **RS**=Royal Surrey NHS Foundation Trust; **SASH**=Surrey and Sussex Healthcare NHS Trust; **FH**=Frimley Health NHS Foundation Trust; **ASPH**=Ashford & St Peter's Hospitals NHS Foundation Trust; **ESHU**= Epsom & St Helier University Hospitals NHS Foundation Trust.*

Where are the biggest shortfalls in the 62-day wait in Surrey Heartlands?
Based on provider data from January-December 2024, across combined Trusts in Surrey Heartlands (SASH, RS and ASPH), 78% reach the 62-day treatment standard. Looking at proportions, the largest short falls by cancer site are in **lung** (62% meet standard), **gynaecological** (66% meet standard), **urological** (64% meet standard) and **breast** (71% meet standard). Looking at absolute numbers of standard breaches, the highest numbers are for breast (n=232) and lung (n=192)

Next steps and recommendations

4.1	To conduct service and journey maps for people with lung cancer focusing on people experiencing deprivation and groups with highest smoking prevalence
4.2	To run Surrey Cancer Summit and affiliated co-design workshops to raise awareness of issues identified through service and journey mapping and co-develop solutions

4B. Treatment access, engagement and experience

Understanding variations in access to, engagement with and experience of their cancer pathway between groups, from initial diagnostic tests through to treatment, helps identify and address factors that contribute to inequalities in both survival and holistic wellbeing

The NHS National Cancer Patient Experience Survey (NCPES) captures local patient perspectives that help understand which factors may be driving differences in access, engagement and experience between tumour groups, ages, genders, ethnicity, deprivation and long-term condition status. The latest scores show that in 2023 in Surrey Heartlands, 63% patients were offered information about how to get financial help or benefits. This falls below the national score (70%), and was lower for people of Asian or Black ethnicity (50%), people with long-term conditions (LTC) (58%), people over 75 (58% aged 75-84, 55% 80+) and people with upper gastro (46%) or urological cancers (48%). Other large variations between groups in Surrey Heartlands are seen across multiple questions; the largest variations by percentage point difference (ppd) are described below[1]:

Hospital staff support

- People of **Black ethnicity, younger people (35-44), and upper GI or urological patients** were less likely to be offered information about financial help and benefits
- People of **mixed ethnicity, younger people (35-44) and sarcoma patients** were less likely to get the right overall level of support for their health and wellbeing from hospital staff

Hospital care

- **Younger people (35-44, and 45-54), gynaecological cancer patients, more deprived groups (IMD2) and people of Black ethnicity** were less likely to always feel involved in decisions about their care and treatment in hospital
- **Younger people (35-44) and more deprived groups (IMD2**) were less likely to always feel able to get support from ward staff when needed
- **Younger people (35-44, and 45-54), and gynaecological patients** were less likely to have confidence and trust in the team looking after them

Treatment and side-effects

- **Younger people (35-44)** were less likely to feel staff did everything they could to help a patient control their pain, and to have enough understandable information about hormone therapy and response to radiotherapy/hormone therapy.
- **Upper GI patients** reported lower levels of being offered practical advice on dealing with immediate treatment side effects, having possible long-term side effects explained in a way they could understand in advance of treatment and being able to discuss options for managing long-term side effects.

Support and care from the GP practice

- **Upper GI and lung cancer patients**, more **deprived** groups (IMD2) and **those with LTCs** were less likely to feel their referral for diagnosis was explained in a way they could understand
- **Lung cancer** patients were less likely to report only speaking to a primary care professional once or twice before diagnosis
- **Lung cancer** patients and **those aged over 85** were less likely to report receiving the right amount of support from their GP practice during treatment

Diagnostic tests and deciding on treatments

- **Younger patients (35-44)** and **females** were less likely to report feeling the length of time waiting for diagnostic tests was about right
- Fewer **lung cancer patients** reported being told they could go back for more information about their diagnosis compared to other cancer types
- **People aged 45-54, females and more deprived groups** (IMD2) were less likely to know they could get further advice from a different healthcare professional before making decisions about their treatment options
- **People of Mixed or Black ethnicity** were less likely to report feeling treatment options were explained in a way they could completely understand

Support at home and living with and beyond cancer

- **People of Black ethnicity** were less likely to report the care team gave their family or someone else close all the information needed to help care for them at home
- **Older people (85+), more deprived groups (IMD2) and people with LTCs** were less likely to report that during treatment they could definitely get enough care and support at home from community or voluntary services
- **Prostate** patients, and **adults aged 55-64** were less likely to report getting enough emotional support at home from community or voluntary services after treatment
- **Younger adults (35-44) and those with gynaecological cancer** were less likely to report being given enough information about the possibility signs of cancer coming back or spreading
- **More deprived groups (IMD2) and younger adults** were less likely to receive the right amount of information + support between final treatment and follow-up

Participation in the NCPES

The 2023 Surrey Heartlands CPES response rate (55%) exceeded the national rate (52%). But some sub-groups were under-represented, which prevented sub-group analyses. Participation from the following under-represented groups should be improved to improve insight into potential inequalities between groups: **(1) Ethnicity:** Gypsy, Irish Traveller or Roma; mixed ethnicity (white and black Caribbean, white and black African, white and Asian); Pakistani and Bangladeshi ethnicity; black Caribbean and other Black/African/Caribbean background; Arab or 'any other' ethnic group **(2) Survey type:** 0 respondents completed the survey by phone or translation service, potentially missing capturing perspectives of those who may experience inequalities related to literacy and/or language **(3) Tumour group:** Very low numbers of Brain/CNS (n=6) and sarcoma (n=10) patients responded to the 2023 survey. There are also no specific insights captured from inclusion health groups or for most of Surrey's priority populations (with the exception of older adults, and those with long-term conditions).

Next steps and recommendations

4.3	Work with staff recruiting NCPES respondents to drive uptake from under-represented groups (including GRT communities, minoritised ethnic groups; people requiring translation services and telephone completion)
4.4	Develop action plan with accountabilities and timelines targeting biggest variations in reported experience between groups in hospital care and support outside the hospital identified by the CPES

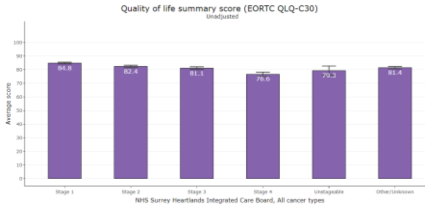
5. Living with cancer, palliative and end-of-life care

As treatments advance, people are increasingly living for longer with cancer, often for many years. During this time, it is important holistic wellbeing is supported, including physical, social, spiritual and emotional domains of health. But inequalities in access to support lead to unfair and avoidable differences in quality of life.

The drive to increase early diagnosis rates aims to improve cancer survival. But for people diagnosed at an advanced stage, cancer remains an incurable condition. Indeed, between 2021 and 2023, 8,056 people in Surrey died from cancer[1]. Palliative care and hospice services support people to live well with cancer right through to the final weeks, days and hours of life. Part of this care is also provided in general practice. We know that people experiencing cancer inequalities, such as those experiencing the highest levels of deprivation, are more likely to be diagnosed at a late stage, and more likely to die from cancer. However, evidence also suggests they are more likely to have a lower quality of life whilst living with the disease, and towards end of life:

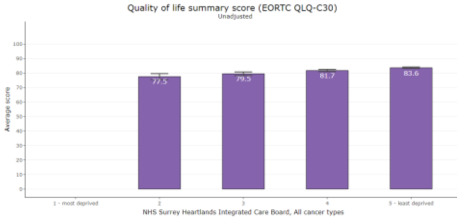
Quality of Life (QOL) for people with cancer in Surrey Heartlands[2]

People with Stage 4 cancer have a lower quality of life than those with Stage 1, 2 or 3:


Quality of life summary score (EORTC QLQ-C30)
Unadjusted

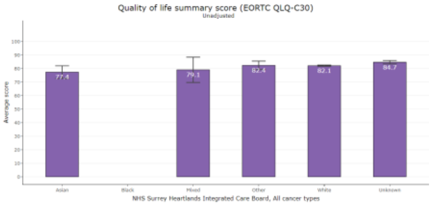
The chart above shows a summary score from the questionnaire measuring quality of life (EORTC QLQ-C30). It is based on how the person answers the symptom (for example, pain) and function (for example, physical) questions that make up the questionnaire.

People in more deprived areas have a lower quality of life than those in more affluent areas:


Quality of life summary score (EORTC QLQ-C30)
Unadjusted

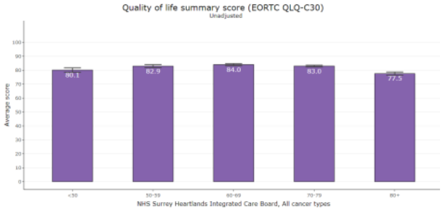
The chart above shows a summary score from the questionnaire measuring quality of life (EORTC QLQ-C30). It is based on how the person answers the symptom (for example, pain) and function (for example, physical) questions that make up the questionnaire.

People of Asian and Mixed ethnicity have a lower quality of life than those of White ethnicity:


Quality of life summary score (EORTC QLQ-C30)
Unadjusted

The chart above shows a summary score from the questionnaire measuring quality of life (EORTC QLQ-C30). It is based on how the person answers the symptom (for example, pain) and function (for example, physical) questions that make up the questionnaire.

People over 80 years have a lower quality of life than younger people with cancer


Quality of life summary score (EORTC QLQ-C30)
Unadjusted

The chart above shows a summary score from the questionnaire measuring quality of life (EORTC QLQ-C30). It is based on how the person answers the symptom (for example, pain) and function (for example, physical) questions that make up the questionnaire.

The Cancer Quality of Life Survey is a national survey run by NHS England. People who have had a cancer diagnosis are asked to complete the survey around 18 months after diagnosis. The EORTC QLQ-C30 is a cancer specific questionnaire used as part of this survey to measure quality of life across 5 domains: physical, work and leisure, emotional, concentration and memory and social. Looking at the data collected between September 2020 to December 2024, as well as the variations in EORTC QLQ-C30 quality of life scores in Surrey Heartlands, the results also show variation in quality of life by cancer type. Adjusted scores are lowest for people with: **Upper GI** (80.1), **haematological** (81.7), **gynaecological** (82.5), **breast** (83.4) and **lung cancers** (83.8). The highest score was 89.3, reported for people with prostate cancer. For all cancer types, the scores in Surrey Heartlands are higher than the average score for England, except melanoma (88.6 Surrey Heartlands, 90.3 England). The figures to the left show the variation in QOL summary score by patient factor in Surrey Heartlands.

Looking at the domains of the EORTC QLQ-C30 scores with the largest between groups variation reveals further patterns in Surrey Heartlands, based on the most recent full year of data (cancers diagnosed in 2022):
(NB. These scores are not adjusted, and there are wide confidence intervals):

- **By stage of diagnosis: Stage 1 scores higher than Stage 4 across all domains.** The domains with the largest points difference between Stage 1 and 4 are **Work and leisure** (16.5 points difference) and **social** (15 points difference), followed by physical (13.5 points difference)
- **By deprivation: People from areas of highest deprivation (IMD2) score lower than most affluent areas (IMD5).** The domains with the largest points difference between IMD2 (most deprived in Surrey) and IMD5 are '**Work and leisure**' (9.9 point difference: IMD2 vs IMD5), and **social** (9.5 point difference: IMD2 vs IMD5). The smallest difference is for concentration and memory (IMD2 vs IMD5.
- **By ethnicity:** People of **Asian ethnicity** score lower than other ethnic groups across all domains except physical, where they scored second lowest after 'Other'. The largest gaps are seen for **concentration and memory** (11.7 point difference: Asian; 86.3 Other; 83.8 Unknown; 82.3 White), **social** (10.5 point difference: Asian 70.3 v Unknown 80.9), and **emotional** (9.6 point difference: Asian 70.7, White 80.3)
- **By age: There is more variation in pattern by age.** The largest difference in scores is seen in the **physical domain** – older adults 80+ score of 64.9 is 19.9 points lower than people aged 50-59 (86.8 score). This older age-group also score 16.8 points lower than 60-69 year olds in the work and leisure domain (65.2 vs 82.4). However, people aged under 50 score the lowest compared to other age groups in emotional (18.3 point difference, <50 (62.8) vs 70-79 (83.3)) and social (9.4 point difference, <50 (71.4) vs 60-69 (80.8)

Identifying drivers of inequalities in QOL

Understanding the drivers of the variation in quality-of-life scores by cancer stage and other demographic factors is key to addressing inequalities. For example:

- **Inequalities in advanced care planning (ACP)[3]:** ACP is a voluntary process of person-centred discussion about patient preferences and priorities for their future care. It is widely recommended by palliative care experts and could reduce inequalities. However, evidence suggests engagement with ACP is more likely among white patients, those with higher levels of education, and with a support network.
- **Inequalities in access to hospice care[4]:** A systematic review of inequalities in access to hospice care found that oldest old, ethnic minorities and those living in rural or deprived areas are under-represented in hospice populations. The authors suggest this is driven by prognostic uncertainty, institutional cultures, unique needs of particular groups and public awareness of services.

Next steps and recommendations

5.1	Carry out focus group with groups with lowest reported quality of life to identify drivers and ways to tackle variation, including engagement with ACP and perception of, access to and engagement with palliative and end of life care services.

6. Cross-system collaboration

Dedicated input from and collaboration between system partners, centring residents' voices, is needed to drive meaningful and sustained impact on cancer inequalities

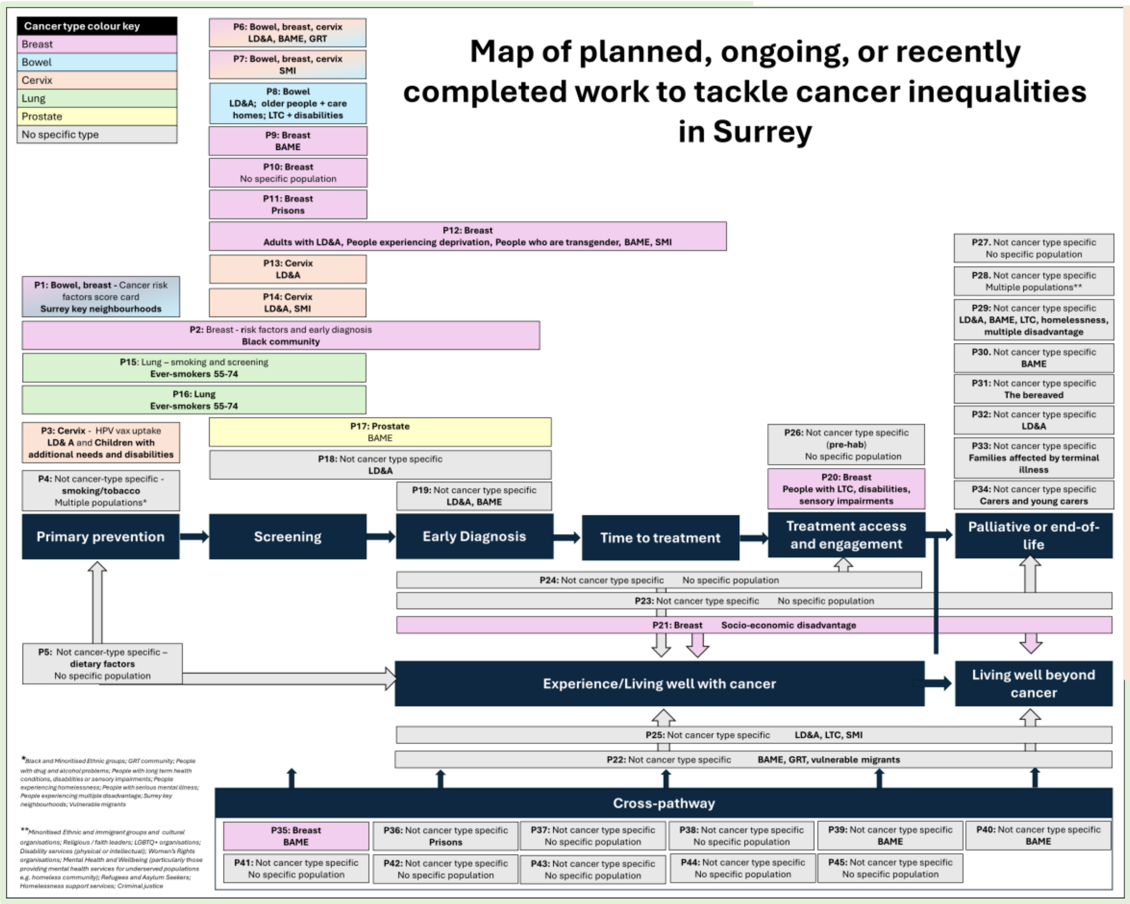
Stakeholder consultation with cross-system partners via meetings and a comprehensive survey highlighted system-level strengths and challenges in tackling cancer inequalities in Surrey. To make progress, it is important to find ways to overcome these challenges whilst capitalising on the strengths. The map below shows the distribution of planned, ongoing, and recently completed projects mapped to key cancer pathway touchpoints. Each project is described in more detail in the Index of Surrey Cancer Inequalities Projects available on the Surrey Cancer Inequalities Resource Hub. This resource can be used to identify and share knowledge between system partners.

Current strengths in tackling inequalities in Surrey

- Wide range of projects targeting inequalities in primary prevention, screening and early diagnosis. This approach is aligned with the CORE20Plus5 framework early diagnosis focus
- Targeted work with a range of Surrey priority populations and inclusion health groups, in particular minoritised ethnic groups and people with learning disabilities and/or autism
- Strong collaboration taking place between partners, including VCSE partners, acute trusts, primary care, community healthcare providers, hospices, universities and the local authority.

Opportunities for future focus

- Build on existing community and system partnerships developed in pathway-way point specific projects with groups at risk of inequalities (eg, people with severe mental illness, people experiencing homelessness, vulnerable migrants) to address other cross-pathway inequalities experienced by these populations (see Map of work below)
- To conduct work to identify, understand and address inequalities experienced by groups at-risk of poor outcomes with no current activity (see below)



Map of planned, ongoing, or recently completed work to tackle cancer inequalities in Surrey

Cancer type colour key
Breast
Bowel
Cervix
Lung
Prostate
No specific type

Primary prevention → **Screening** → **Early Diagnosis** → **Time to treatment** → **Treatment access and engagement** → **Palliative or end-of-life**

Experience/Living well with cancer → **Living well beyond cancer**

Cross-pathway

P1: Bowel, breast - Cancer risk factors score card
Surrey key neighbourhoods

P2: Breast - risk factors and early diagnosis
Black community

P3: Cervix - HPV vax uptake
LD& A and **Children with additional needs and disabilities**

P4: Not cancer-type specific - **smoking/tobacco**
Multiple populations*

P5: Not cancer-type specific – **dietary factors**
No specific population

P6: Bowel, breast, cervix
LD&A, BAME, GRT

P7: Bowel, breast, cervix
SMI

P8: Bowel
LD&A; older people + care homes; LTC + disabilities

P9: Breast
BAME

P10: Breast
No specific population

P11: Breast
Prisons

P12: Breast
Adults with LD&A, People experiencing deprivation, People who are transgender, BAME, SMI

P13: Cervix
LD&A

P14: Cervix
LD&A, SMI

P15: Lung – smoking and screening
Ever-smokers 55-74

P16: Lung
Ever-smokers 55-74

P17: Prostate
BAME

P18: Not cancer type specific
LD&A

P19: Not cancer type specific
LD&A, BAME

P20: Breast
People with LTC, disabilities, sensory impairments

P21: Breast **Socio-economic disadvantage**

P22: Not cancer type specific **BAME, GRT, vulnerable migrants**

P23: Not cancer type specific No specific population

P24: Not cancer type specific No specific population

P25: Not cancer type specific **LD&A, LTC, SMI**

P26: Not cancer type specific
(**pre-hab**)
No specific population

P27. Not cancer type specific
No specific population

P28. Not cancer type specific
Multiple populations**

P29: Not cancer type specific
LD&A, BAME, LTC, homelessness, multiple disadvantage

P30. Not cancer type specific
BAME

P31: Not cancer type specific
The bereaved

P32: Not cancer type specific
LD&A

P33: Not cancer type specific
Families affected by terminal illness

P34: Not cancer type specific
Carers and young carers

P35: Breast
BAME

P36: Not cancer type specific
Prisons

P37: Not cancer type specific
No specific population

P38: Not cancer type specific
No specific population

P39: Not cancer type specific
BAME

P40: Not cancer type specific
BAME

P41: Not cancer type specific
No specific population

P42: Not cancer type specific
No specific population

P43: Not cancer type specific
No specific population

P44: Not cancer type specific
No specific population

P45: Not cancer type specific
No specific population

**Black and Minoritised Ethnic groups; GRT community; People with drug and alcohol problems; People with long term health conditions, disabilities or sensory impairments; People experiencing homelessness; People with serious mental illness; People experiencing multiple disadvantage; Surrey key neighbourhoods; Vulnerable migrants*

***Minoritised Ethnic and immigrant groups and cultural organisations; Religious / faith leaders; LGBTQ+ organisations; Disability services (physical or intellectual); Women's Rights organisations; Mental Health and Wellbeing (particularly those providing mental health services for underserved populations e.g. homeless community); Refugees and Asylum Seekers; Homelessness support services; Criminal justice*

Surrey priority populations and inclusion health groups with no targeted activity identified in survey of cancer inequalities work in Surrey:

- Looked after children and adults with care experience
- Young people out of work
- People experiencing domestic abuse
- Victims of modern slavery
- Sex workers.

Next steps and recommendations

6.1 To maintain a Surrey Cancer Inequalities Resource Hub collating key insights, outputs, and a live activity map to facilitate ongoing knowledge exchange, collaboration and strategic planning

6.2 To develop and implement a training offer on how to use data, evidence and behavioural science to inform targeted cancer inequalities action for cross-system partners

6.3 To drive opportunities to share cancer inequalities project-specific plans and findings at existing cancer and inequalities boards and sub-groups, proactively inviting VCSE and academic partners to share their insights

Recommendations overview

A summary of recommendations to tackle cancer inequalities in Surrey

Primary prevention

1.1	Run awareness campaign on key cancer risk factors targeted to high-risk populations (eg, areas of highest deprivation)
1.2	Implement recommendations from local lung cancer screening inequalities evidence review, working in partnership with Surrey stop smoking service, to drive equitable uptake of co-located smoking cessation services amongst populations at highest risk of lung cancer (eg, high deprivation, people who currently smoke)
1.3	Conduct a review of inequalities in cancer specific dietary risk factors to inform evidence-based, tailored communication and education recommendations
1.4	SCC Public Health improvement team to continue to drive targeted action to educate residents to minimise high-risk behaviours and exposures (tobacco and alcohol use, diet and exercise, sun)
1.5	Implement recommendations from local HPV vaccination uptake primary research interviews and evidence review to facilitate uptake for young people with learning disabilities

Screening

2.1	To run a series of connector sessions between GP practices and populations at high risk of not being registered with a GP and/or experiencing housing instability (eg, GRT, homelessness, prison populations) to facilitate invitation to cancer screening programmes
2.2	To work with PCNs with the lowest uptake of breast, bowel and cervical cancer screening to identify place-specific drivers of low uptake and make evidence-based recommendations to improve equitable uptake
2.3	To implement recommendations from local lung cancer inequalities screening review during roll out of lung cancer screening in Surrey
2.4	To implement recommendations from evaluation of breast screening in prisons project to facilitate wider engagement with cancer screening and earlier diagnosis within Surrey's prison populations
2.5	To develop implementation toolkit to facilitate evaluation and uptake of recommendations from initial research into cervical cancer screening uptake for people with LD and SMI; following this, to work with screening providers to adapt insights from cervical cancer screening focused work into uptake of screening for people with learning disabilities to adapt and inform recommendations for other screening programmes (breast, bowel, lung)

Early diagnosis and routes to diagnosis

3.1	Adapt the CRUK Cancer Awareness Measure+ to identify local inequalities in cancer awareness to inform targeted campaigns
3.2	Co-develop and run outreach events to raise awareness of symptoms of non-screen detected cancers at high-risk of late-diagnosis focusing on areas of high deprivation, males and inclusion health groups, including health communications confidence/self-advocacy training
3.3	Develop and share communications guidance (based on MECC/VBA approach) for patient-facing staff involved in delivering cancer screening to capitalise on screening as a teachable moment for non-screen detected cancer symptoms
3.4	To develop and deliver a webinar on key inequalities in early-stage and routes to diagnosis delivered to primary care professionals to raise awareness and drive equitable referrals by managed routes

Time to treatment, and treatment access, engagement and experience

4.1	To conduct service and journey maps for lung cancer pathway focusing on high deprivation and groups with highest smoking prevalence
4.2	To run co-design workshops to raise awareness of issues identified through service and journey mapping and co-develop solutions
4.3	Work with staff recruiting NCPES respondents to drive uptake from under-represented groups through targeted outreach (including GRT communities, minoritised ethnic groups; people requiring translation services and telephone completion)
4.4	Develop experience action plan with accountabilities and timelines targeting biggest variations in experience between groups in hospital care and support outside the hospital identified by the NCPES

Living with cancer, palliative and end-of-life care

5.1	Carry out focus group with groups with lowest reported quality of life to identify drivers and ways to tackle variation, including engagement with ACP and perception of, access to and engagement with palliative and end of life care services.

Cross-system collaboration

6.1	To maintain a Surrey Cancer Inequalities Resource Hub collating key insights, outputs, and a live activity map to facilitate ongoing knowledge exchange and collaboration
6.2	To develop and implement a training offer on how to use data, evidence and behavioural science to inform targeted cancer inequalities action for cross-system partners
6.3	To drive opportunities to share cancer inequalities project-specific plans and findings at existing cancer and inequalities boards and sub-groups, proactively inviting VCSE and academic partners to share their insights

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Living with cancer, palliative and end of life care:

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Cancer Inequalities Resources produced by SCC

- Surrey Cancer Inequalities Resource Hub: Cancer Inequalities in Surrey: Resource Hub | Surrey-i
- Using behavioural science to identify and address local cancer inequalities toolkit (developed by Surrey County Council Public Health and Communities team) – available for download on the Resource Hub
- Surrey Cancer Inequalities Map and Index – available for download on the Resource Hub