Equality Health Impact Assessment

This Equality and Health Inequalities Impact Assessment (EHIA) explains how Wessex Cancer Alliance has considered and addressed the ‘equality duties’ in developing its Communications and Patient, Carer and Public Involvement Strategy. This EHIA has assisted, and will assist, decision-makers to make informed decisions about the Strategy and its legal obligations.

PART A: General Information

1. Title of project, programme or work:

Wessex Cancer Alliance (WCA) Communications and Patient, Carer and Public Involvement Strategy

2. What are the intended outcomes?

The strategy vision is that in three years all Alliance communications and patient, carer and public involvement (PPI) will be:

- Meaningful and impactful to those involved in these activities
- Accessible and inclusive
- More proactive, well planned and coordinated
- Supported and valued by a wider set of stakeholders

The outcomes that this strategy will deliver are:

- There will be a culture of understanding around communications, sharing of information and PPI within the Alliance team
- The team will undertake more meaningful PPI involvement (as reported by those involved). This will shape and influence their workstreams
- The public and patients will receive timely updates and messages about cancer that will be informed by the insight and reports we gather from them
- Alliance stakeholders will be involved and informed of Alliance communications at the right time, in the right way for them (via website, social media and other communication channels)
- Proactive media coverage will be part of business as usual
- People (patients, carers and the public), specifically those communities who experience worse health outcomes, will be more aware of how they can be involved and influence improvements in cancer services across Wessex
- That the way communications and involvement is collectively carried out will be better coordinated, planned and executed, and the way we share intelligence is much more effective.
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3. Who will be affected by this project, programme or work? Please summarise in a few sentences which of the groups below are very likely to be affected by this work.

- The WCA Team
- Partner organisations – statutory and voluntary sector

- The public, patients and carers

The Team will benefit from the clarity of expectations set out in the strategy and support around accessible and inclusive communications and PPI to enable them to build the skills and confidence to do their jobs more effectively.

Partner organisations should benefit from the clarity of expectations set out in the strategy. Trying to create a more coordinated approach to accessible and inclusive communications and PPI should make both easier and more effective for all organisations and ultimately be more impactful for all patients, carers, the public and staff.

The public, patients and carers will benefit from the strategy as we have set out our expectations around accessibility and inclusion for our communications and PPI activities. There is a strong commitment to involving those who are seldom asked for their views.

4. Which groups protected by the Equality Act 2010 and/ or groups that face health inequalities are very likely to be affected by this work?

All groups. WCA's approach to communications and PPI will need to consider all protected characteristics and groups experiencing health inequalities, as well as where people are affected by having more than one of these factors at play, depending on the activity we are undertaking. Details are set out in the rest of the document below.

There are however a number of standards and guidance that the WCA will start from to ensure inclusive, accessible communications and PPI:

- Collect equality monitoring data across the protected characteristics for relevant comms and PPI activities
- Follow the Accessible Information Standard and the NHS Accessible Information and Communications Policy
- NHS Inclusive Language Guidance
- Plain English guidance
- Equality Health Impact Assessments for each new or changing area of work, which will consider impacts on the communications and PPI.

We also recognise the images we use in our communications need to reflect the diverse range of people and communities we serve and will make sure this is the case.

The intention is to build more extensive community networks, for example through our Communities Against Cancer project, and more meaningful involvement activities so that these are informing our communications and that these increasingly reach the right people in right way at the right time.

PART B: Equalities Groups and Health Inequalities Groups

5. Impact of this work for the equality groups listed below.

Focusing on each equality group listed below (sections 5.1. to 5.9), please answer the following questions:

a) Does the equality group face discrimination in this work area?
b) Could the work tackle this discrimination and/or advance equality or good relations?
c) Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?

d) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
e) If you cannot answer these questions what action will be taken and when?

5.1. Age

Each year more than a third (36%) of all cancer cases in the UK are diagnosed in people aged 75 and over (2015-2017). Incidence rates for all cancers combined in the UK are highest in people aged 85 to 89 (2015-2017). The most common cancers vary considerably by age group; different cancer types tend to be diagnosed in young people compared with older people.
Since the early 1990s, incidence rates for all cancers combined have increased for all the broad age groups in the UK. The increase is largest in people aged 0-24 where rates have increased by almost a quarter (23%) (2015-2017).
https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/age

Older people are more likely to get cancer, and screening programmes are focussed on these groups. It is clear therefore that we need to ensure we are communicating with these groups in appropriate ways. Covid19 has taught us that hard copy materials and information through trusted sources of support are effective in reaching isolated older people. We are therefore trying to establish better links with partners including Dorset and HIOW ICS to ensure our reach to all groups is as extensive as it can be. Whilst we do have good digital coverage by older people in our area, we are aware that for some older people this is not an option for communication or engagement.

In terms of involvement, our experience is that older people are often more willing and likely to have time to get involved in patient and public involvement activities. We therefore need to make sure that the way of involving people are fully inclusive of e.g. working aged people and younger people.

We will shortly be engaging with children and young people and their families in the development of new cancer services for these age groups. Ensuring age appropriate information is designed with children and young people shared via a range of sources and in different formats should part of this work. Healthwatch evidence shows us that assumptions are made that children and young people are ‘digital natives’ but we are aware that many young people do not have access to technology and/ or cannot afford data. We will learn a lot from this in terms of our communicating and engaging with this group for other Alliance activities.

The National Cancer Patient Experience Survey (NCPES) results and the Children and Young People’s survey will also give us intelligence about how different age groups experience their cancer care and treatment. Other age disaggregated data around e.g. 2 week wait referrals is also available. We will use all this to inform messaging and PPI activities.

5.2. Disability

The Cancer Alliance recognises the need to ensure its information is accessible in a range of different formats and will work to the NHS’s Accessible Information and Communications Guidance. The Alliance will include an access statement on all public facing leaflets so people know that they can request information in other formats. The Alliance has established a range of suppliers for Easy Read and British Sign Language formats. We can also produce audio formats. We will work with disabled people and other partners to ensure we continue to learn and adapt our communications to meet individual needs.

Likewise our PPI activities will also need to be inclusive of disabled people – whether face to face or online. For each activity we will consider how best we do this, asking advice and guidance from disabled people.

We will need to continue to build relationships with disability and carers organisations directly, as well as via Healthwatch to ensure our reach includes a wide range of disabled people.

For mental health – see below.

5.3. Gender reassignment

There is national intelligence about how Lesbian, Gay, Bisexual, Trans and Questioning (LGBTQ plus) people experience cancer services and also different health behaviours. Regional insight into how people would prefer communications to come through LGBTQ plus specific services. This needs to be considered as we tailor information and build and share this via community and voluntary sector networks.

Locally we have engaged with LGBTQ plus people about their experiences of cervical screening to inform communications with them. We will continue to engage with people about cancer services where they may be affected differently.

The Alliance recognises there will be differences between people who are undergoing gender reassignment and Trans and those who are Lesbian, Gay, Bisexual, and questioning plus.

5.4. Marriage and civil partnership
N/A

5.5. Pregnancy and maternity

N/A - other than to sensitively communicate issues around pregnancy, maternity and fertility in consultation with cancer patients who have been through these experiences.

5.6. Race

Some cancers are more common in certain ethnic groups than others, for example:

- Cancer is more common in white and black males than in Asian males.
- Cancer is more common in white females than in Black or Asian females.

1 in 4 Black Men will be diagnosed with Prostate Cancer in their lifetime, compared to 1 in 8 White men. **Visit link more in-depth cancer incidence statistics by ethnic group**

There is also national insight that people from diverse ethnic and cultural backgrounds around different lifestyles; understanding of the signs and symptoms of cancer; and worse experiences of treatment and care than White British people.

All these factors need to be considered when developing information for local people. The Alliance will have a focus on building networks and involving the diverse Black, Asian and minority ethnic communities in Dorset, Hampshire and Isle of Wight to inform our communications and to extend our reach so that both functions best meets people's needs.

5.7. Religion or belief

There is some overlap, but not an entire overlap, in terms of experiences as set out above. There is therefore a need to understand the perspectives and cancer outcomes of different faith communities to inform our communications and engagement as outlined in our recent conversations with the British Islamic Medical Association.

5.8. Sex or gender

There are around 367,000 new cancer cases in the UK every year, that's around 1,000 every day (2015-2017). In females in the UK, there were more than 179,000 new cancer cases in 2017. In males in the UK, there were around 187,000 new cancer cases in 2017.

Since the early 1990s, incidence rates for all cancers combined have increased by more than a tenth (12%) in the UK. Rates in females have increased by almost a sixth (16%), and rates in males increased by less than a twentieth (2%) (2015-2017).

Over the last decade, incidence rates for all cancers combined have increased by a twentieth (5%) in the UK. Rates in females have increased by around a twentieth (6%), and rates in males have increased by less than a twentieth (1%) (2015-2017).

All cancers combined incidence rates in England in females are 16% higher in the most deprived quintile compared with the least, and in males are 19% higher in the most deprived quintile compared with the least (2013-2017). Around 16,800 cases of all cancers combined each year in England are linked with deprivation (around 7,100 in females and around 9,800 in males). Visit here for:

- Common cancers by age in females
- Common cancers by age in males

In addition to the prevalence data by gender above, NCPES and other intelligence, for example, around bowel screening take up, highlights differences in experiences between men and women. The Alliance will consider where messaging needs to be tailored according to these differences. Men are also more difficult to engage with on health issues so focussed efforts will be made to involve them in the work of the Alliance.

The above highlights that most national cancer data and feedback is still collected in a binary way. The Alliance will use gender neutral language in its communications unless the context calls for it. When the Alliance engages and communicates with local individuals who are non-binary they will ensure their needs are met.

5.9. Sexual orientation

There is some overlap, but not an entire overlap, in terms of experiences as set out above in 5.3. There is therefore a need to understand the perspectives and cancer outcomes of gay men and women and bisexual people and those questioning their sexuality to inform our communications and engagement.

6. Implications of our work for the health inclusion groups listed below.

Focusing on the work described in sections 1 and 2, in relation to each health inclusion group listed below (Sections 6.1. To 6.12), and any others relevant to your work[1], please answer the following questions:

f) Does the health inclusion group experience inequalities in access to healthcare?
g) Does the health inclusion group experience inequalities in health outcomes?
h) Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes?

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[1] Our guidance document explains the meaning of these terms if you are not familiar with the language.

i) Could the work assist or undermine compliance with the duties to reduce health inequalities?
j) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
k) As some of the health inclusion groups overlap with equalities groups you may prefer to also respond to these questions about a health inclusion group when responding to 5.1 to 5.9. That is fine; please just say below if that is what you have done.
l) If you cannot answer these questions what action will be taken and when?

6.1. Alcohol and / or drug misusers

See 6.12 below.

Alcohol is also a known significant risk factor but one people are potentially less likely to know about. This needs to be considered particularly in terms of prevention messaging. Our route to communicating and engaging with people may be best through services supporting them.

6.2. Asylum seekers and /or refugees

There is some overlap in terms of experiences as set under race and religion above. Networks will need to be built with organisations supporting asylum seekers and refugees to ensure effective communications and engagement with them.

6.3. Carers

Insight from carers of cancer patients during Covid19 highlighted a deficit in communications with them, which impacted on their mental health. We already know carers experience poorer health outcomes from the additional pressures caring puts on people. This puts a spotlight on the need to specifically communicate and engage with them to understand their specific needs in terms of supporting others through a cancer journey.

6.4. Ex-service personnel / veterans

The Wessex area has significant serving and ex-service personnel. Networks will need to be built with organisations supporting these groups to ensure effective communications and engagement with them.

6.5. Those who have experienced Female Genital Mutilation (FGM)

There is a specific issue around cervical screening. Research from the UK and elsewhere suggests fear, shame and embarrassment as important barriers for women from these communities attending cervical screening. Fear of being judged or viewed as abnormal alongside negative past experiences of examination are reported by women with FGM as additional barriers to cervical screening.

Communications and involvement around cervical screening specifically will need to address this e.g. by promoting resources such as https://www.jostrust.org.uk/about-us/news-and-blog/blog/smear-tests-fgm.

6.6. Gypsies, Roma and travellers

There is research that found that health beliefs and practices are shaped by historical and contemporary social processes and the marginal position of Gypsies and Travellers. This means people prefer to seek information and support from within the community. Our route to communicating and engaging with people may therefore be through trusted members of the community and services supporting them.

6.7. Homeless people and rough sleepers

Urban and south coast areas of Wessex have significant homeless populations.
Networks will need to be built with organisations supporting these groups to ensure effective communications and engagement with them.

6.8. Those who have experienced human trafficking or modern slavery

The Alliance will need to be built networks with organisations supporting these people to ensure effective communications and engagement with them.

6.9. Those living with mental health issues

People with cancer are at increased risk of developing mental health problems such as depression and anxiety. People with existing serious mental health conditions are also less likely to get cancer diagnosed early.

Both will need to be considered in terms of tailoring messaging, reach those affected by these issues and our involvement activities.

6.10. Sex workers

Networks will need to be built with organisations supporting these people to ensure effective communications and engagement with them.

6.11. Trans people or other members of the non-binary community

See 5.3 above

6.12. The overlapping impact on different groups who face health inequalities

CRUK's 'Cancer Inequalities in the UK 2020: socio-economic deprivation' report highlights significantly poorer cancer outcomes and higher risk factors for people living in areas of deprivation. From cancer incidence, to diagnosis, to treatment and survival, things are stacked against people living in those communities. This research highlights these communities are also less likely to have access to digital technology for a variety of different reasons. This will be no different for areas of deprivation in Dorset, Hampshire and Isle of Wight.

Our communications and involvement activities will have a focus on addressing health inequalities as there is a clear need to level up people's experiences and outcomes. Working with statutory partners and services, the community, voluntary and faith sector, including Healthwatch, Community Voluntary Services organisations, and Communities against Cancer, and others we will seek to extend our networks and insight to inform our work.

7. Other groups that face health inequalities that we have identified.

Have you identified other groups that face inequalities in access to healthcare?
Does the group experience inequalities in access to healthcare and/or inequalities in health outcomes?

Short explanatory notes - other groups that face health exclusion.

As we research and gather more data, we learn more about which groups are facing health inequalities. If your work has identified more groups that face important health inequalities please answer questions 7 and 8. Please circle as appropriate.

If you have not identified additional groups, that face health inequalities, just say not applicable or N/A in the box below.

Yes Complete section 8	[✓ No Go to section 9]	N/A

8. Other groups that face health inequalities that we have identified.

Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes in relation to these other groups that face health inequalities?
Could the work undermine compliance with the duties to reduce health inequalities and, if so, what action should be taken to reduce any adverse impact?
Is the work going to help NHS England to comply with the duties to reduce health inequalities?
If you have identified other groups that face health inequalities please answer the questions below. You will only answer this question if you have identified additional groups facing important health inequalities.

None identified

PART C: Promoting integrated services and working with partners

Short explanatory notes: Integrated services and reducing health inequalities.

Our detailed guidance explains the duties in relation to integrated services and reducing health inequalities. Please answer the questions listed below.

9. Opportunities to reduce health inequalities through integrated services.

Does the work offer opportunities to encourage integrated services that could reduce health inequalities? If yes please also answer 10.

[✓ Yes Go to section 10]	No Go to section 11	Do not know

10. How can this work increase integrated services and reduce health inequalities?

Please explain below, in a few short sentences, how the work will encourage more integrated services that reduce health inequalities and which partners we will be working with.

The health inequalities experienced by cancer patients is replicated in many other health related conditions for which various stakeholders of Wessex Cancer Alliance and health partners, will need to address including CCG's, Public Health, and local Authorities. By developing the processes, networks and intelligence for inclusive accessible communications at the core (strategy level) of Alliance work it should mean that this will permeate through and make it easier for all workstreams and partners, and beyond cancer.

PART D: Engagement and involvement

11. Engagement and involvement activities already undertaken.

How were stakeholders, who could comment on equalities and health inequalities engaged, or involved with this work? For example in gathering evidence, commenting on evidence, commenting on proposals or in other ways? And what were the key outputs.
This initial iteration of the EHIA has been developed looking at existing intelligence, guidance and patient feedback from a wider range of sources covering health inequalities and the protected characteristics. Feedback will be sought from the Alliance Board in early December with a recommendation that we consult on both the WCA Communications and PPI Strategy and this EHIA. The intention will be to seek the widest range of feedback, specifically with patients, carers and others from the groups mentioned above. The EHIA and Strategy will be updated as a result.
12. Which stakeholders and equalities and health inclusion groups were involved?
See above. An updated version will be updated as a result.
13. Key information from the engagement and involvement activities undertaken. Were key issues, concerns or questions expressed by stakeholders and if so what were these and how were they addressed? Were stakeholders broadly supportive of this work?
See above. An updated version will be updated as a result and we can answer this question once further local engagement has taken place.
14. Stakeholders were not broadly supportive but we need to go ahead. If stakeholders were not broadly supportive of the work but you are recommending progressing with the work anyway, why are you making this recommendation?
As above
15. Further engagement and involvement activities planned. Are further engagement and involvement activities planned? If so what is planned, when and why?
For each Alliance workstream there will be a plan for communications and PPI. The intention is that the learning from these activities will feedback into the core Alliance strategy work.
PART E: Monitoring and Evaluation
16. In relation to equalities and reducing health inequalities, please summarise the most important monitoring and evaluation activities undertaken in relation to this work
We will know we have achieved this because we will be able to demonstrate: • Increased reach and engagement with our website and social media • Improved media coverage around cancer services • Increased confidence in the team to undertake patient and public involvement • Improved reach of patients, carers and the public that are involved in activities and people's satisfaction in getting involved • Improved stakeholder satisfaction with Alliance communications

- Improved outcomes from workstream projects where there has been significant communication and PPI involvement, e.g. increase bowel screening uptake in areas of health inequalities.

One of our first tasks, following the adoption of this Strategy, is to assess where we are now and set clear measures and targets to be able to demonstrate the above. We will report these to the Board at least annually.

17. Please identify the main data sets and sources that you have drawn on in relation to this work. Which key reports or data sets have you drawn on?

On implementation of the Strategy, we will draw on the following sources of data:

- Social media and website statistics
- Confidence surveys for training
- Numbers of people who get involved and satisfaction surveys/ action reviews
- Stakeholder survey
- Patient experience case studies
- Project outcome measures – data disaggregated where possible by protected characteristics
- National cancer patient experience survey, National Quality of Life Survey, Children and Young People's Surveys
- Feedback from people through various sources – support groups, national and local charities etc etc
- CADEAS – National Cancer Intelligence Data
- Public Health's Fingertips tool
- Local Joint Strategic Needs Assessments

Specific projects will have their own evaluation measures and we will draw upon the learning of these to inform our communications and involvement across all workstreams.

18. Important equalities or health inequalities data gaps or gaps in relation to evaluation.

In relation to this work have you identified any:

- important equalities or health inequalities data gaps or
- gaps in relation to monitoring and evaluation?

Yes [✓ No]

This will be kept under review.

19. Planned action to address important equalities or health inequalities data gaps or gaps in relation to evaluation.

If you have identified important gaps and you have identified action to be taken, what action are you planning to take, when and why?

N/A

PART F: Summary analysis and recommended action

20. Contributing to the first PSED equality aim.

Can this work contribute to eliminating discrimination, harassment or victimisation?

[✓ Yes]	No	Do not know

If yes please explain how, in a few short sentences

Understanding our communities and then being better able to communicate and engage with people in the right way at the right time should help address discrimination and poorer experiences of cancer services and outcomes.

21. Contributing to the second PSED equality aim.

Can this policy or piece of work contribute to advancing equality of opportunity? Please circle as appropriate.

[✓ Yes]	No	Do not know

If yes please explain how, in a few short sentences

As above

22. Contributing to the third PSED equality aim.

Can this policy or piece of work contribute to fostering good relations between groups? Please circle as appropriate.

[✓ Yes]	No	Do not know

If yes please explain how, in a few short sentences

Ensuring why and how we are addressing health inequalities (of all types) will help address good relations between different groups.

23. Contributing to reducing inequalities in access to health services.

Can this policy or piece of work contribute to reducing inequalities in access to health services?

[✓ Yes]	No	Do not know

If yes which groups should benefit and how and/or might any group lose out?

As above.

24. Contributing to reducing inequalities in health outcomes.

Can this work contribute to reducing inequalities in health outcomes?

Yes	No	Do not know

If yes which groups should benefit and how and/or might any group lose out?

As above.

25. Contributing to the PSED and reducing health inequalities.

How will the policy or piece of work contribute to the achieving the PSED and reducing health inequalities in access and outcomes? Please describe below in a few short sentences.

Understanding our communities and then being better able to communicate with people in the right way at the right time should help address discrimination and poorer experiences of cancer services and outcomes.

26. Agreed or recommended actions.

What actions are proposed to address any key concerns identified in this Equality and Health Inequalities Analysis (EHIA) and / or to ensure that the work contributes to the reducing unlawful discrimination / acts, advancing equality of opportunity, fostering good relations and / or reducing health inequalities? Is there a need to review the EHI analysis at a later stage?

Action	Public Sector Equality Duty	Health Inequality	By when	By whom
Actions are outlined in the Strategy action plan				
This EHIA needs to be reviewed in light of consultation on the Strategy and EHIA post the December WCA Board.	Yes	Yes	March 2021	Jemma Jones and Sue Newell

PART G: Record keeping

27.1. Date draft circulated to E&HIU:	
27.1. Date draft EHIA completed:	
27.2: Date final EHIA produced:	
27.3. Date signed off by Director:	
27.4: Date EHIA published:	
27.5. Review date:	

28. Details of the person completing this EHIA

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Sue Newell	WCA PPI Programme Manager	Sue.newell@helpandcare.org.uk
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29: Name of the responsible Director

Name	Directorate

Sally Rickard	Wessex Cancer Alliance