Equality Health Impact Assessment (EHIA) record

Senior Programme Manager	Claire Marsh
Programme Manager	Teresa Corbett
Project Leads	Amanda Cummings, June Davis, Abi Desouza, Sandra Dyer, Mary Edwards, Andrew Merwood
EHIA Lead	Emma Leatherbarrow
Summary	Personalised Care in Cancer Work Programme
Proposal	Wessex Cancer Alliance (WCA)'s vision is that all people affected by cancer across Wessex will experience culturally appropriate, integrated personalised care from the point of screening, and throughout diagnosis, treatment, and after treatment has been completed or throughout palliative, best supportive and end of life care. This will include support with healthy lifestyle choices and preventing or best managing consequences of treatment, in line with a biopsychosocial approach to care. All people affected by cancer across Wessex will have choice and control of their care with initiatives promoting supported self-management and shared decision making. We will seek to provide the best intervention for the person at the best time, in the best place and with the best people involved.

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Instruction Guide

The purpose of undertaking an Equality Health Impact Assessment (EHIA) is to demonstrate due regard has been considered to eliminate unlawful discrimination and enhance equality of opportunity for the service. This document is designed to support you in planning your own EHIA.

How to Use This Document for EHIA Planning

☑ Consider your project and write down the people who will be affected by/use it

☑ Review info in the main EHIA and write down positive and negative impacts for your target audience of your project

- Identify similar or related issues in your own project.

☑ Consider and record what you will do to avoid negative impacts for people

☑ Continue to revisit and adjust your plan as you gain new insights or as conditions change. Your EHIA should evolve as your project develops.

Things to remember..

1. **This document is a starting point…**
    - The document is not a checklist or a definitive framework. The examples provided are meant to inspire your thinking and guide your initial planning steps. Ideas listed are not exhaustive but represent common scenarios that may or may not apply to your specific context.
    - The issues and activities proposed in this document may not necessarily fall within the remit of WCA or the responsibility of the project/programme lead. However, they are provided as illustrative examples that may be useful for discussion with project collaborators. Within your EHIA, it is advisable to clearly identify who is responsible for implementing mitigation measures and ongoing monitoring.
    - Contact the named EHIA lead if you have any questions about developing your EHIA.

2. **This document is a living document.**
    - Question whether there are other risks or consequences that need to be considered.
    - Please suggest risks, mitigations, or monitoring actions that are not included. The programme lead will update this document regularly, and also add any relevant resources to support your EHIA.
3. **There are different ways you can use this document to develop your own EHIA.**
    - **EHIA as part of your PID:** Some projects will need a brief description of relevant risks and mitigations, with reference to this document to provide detail. This should reduce duplication of effort and admin burden for the project lead. However, it is important to provide details on any project specific risks or actions, as well as ownership of these. Always specify who is responsible for any mitigating or monitoring actions (e.g. Trust, WCA, project lead etc.)
    - Other projects will benefit from a more detailed EHIA or an EHIA focused on the **pathway template**, as different aspects may need to be considered at distinct points in the pathway.

Overarching principles for personalised care programme projects

- Conduct individual assessments to understand support needs regardless of individual’s status.
- Include holistic, comprehensive assessment and care planning.
- Advocate for shared decision making and enable informed care and choice.
- Use person-centred, strength-based language. Emphasise support rather than risk.
- Provide training, protected time, and reflective practice for workforce.
- Engage community leaders for trust-building.
- Provide specialist navigators or advocates where appropriate.

- Adopt trauma-informed care approaches.
- Co-produce services with affected communities.
- Use disaggregated data to monitor outcomes.

Consider intersectionality:
Overlapping social determinants and protected characteristics (e.g., ethnicity, disability, sexual orientation) affect care experiences. For example:

- A Black or South Asian person in a deprived area may face multiple barriers to screening.
- An elderly person with cognitive impairment may struggle with post-treatment navigation.
- A trans person experiencing homelessness may lack continuity in palliative care.
- Older persons living in a rural area are more likely to experience digital exclusion.

Supportive resources

Health Inequalities - Welcome to Wessex Cancer Alliance

A focus on inequalities - Wessex Cancer Alliance Team - Futures (internal)

Contents

EHIA for different characteristics

Age

(For the purpose of this document, we focus on teenagers and young people, people of working age and older people specifically)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Initiatives such as prehab/rehab may support older and working age populations maintain independence and/or quality of life during and after treatment. - Shared decision-making and supported self-management empower individuals of all ages to take an active role in their care, with appropriate adjustments. - A personalised care and biopsychosocial approach considers age-related physical, psychological, and social needs, improving the relevance and effectiveness of care for both younger and older people.	- Assumptions or stereotypes based on age could lead to unequal care and support. - There can be a lack of community and/ or specific issue support for working age people to signpost to	- Ensure communications are age-inclusive, with non-digital alternatives available and accessible formats for those with sensory or cognitive impairments. - Train staff to avoid age-related bias and ensure they understand the differing needs across life stages. - Embed age-specific care pathways that address unique needs—e.g. fertility counselling for younger patients, frailty assessments for older patients. - Develop peer support and age-appropriate resources, including for teenagers, young adults, and older adults. - Work with organisations and clinical teams to improve signposting to community-based support both locally and nationally.	- Review and take action on experiences of treatment and care for different age groups and other demographics based on NCPES, QOL and other national and local surveys. - Monitor referral rates, treatment decisions, and uptake of personalised care elements (e.g. care plans, supported self-management tools) by age group. - Monitor risk of age-specific disparities or unintended impacts. - Involve people from a range of age groups in co-design and feedback processes to ensure services are inclusive and responsive.

Teenagers and young adults

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Emphasising personalised care, supported self-management, and shared decision-making allows TYA to feel empowered and respected in decisions about their care, important for this age group's autonomy and identity development. - Potential integration of education, employment advice, and mental health support with medical care will support holistic recovery and long-term wellbeing. TYA-focused health promotion could encourage healthy behaviours early, improving outcomes and preventing late effects of treatment.	- Younger people may have their psychosocial needs (e.g. fertility preservation, employment, parenting) overlooked if care is not fully personalised to their age-specific circumstances. - TYAs often experience social isolation due to their age. The social networks they may rely on—peers and family—can be disrupted, making it more difficult to adjust.	- Develop services that are specifically targeted to the needs of TYAs, such as age-appropriate psychological support, peer networks, and targeted social services that recognise the impact of cancer on young adulthood. Establish peer support programs or groups to reduce isolation. - Link to TYA specific charities e.g. TCT - Link to TYA Therapy workers - Acknowledge that TYA services are regional, so isolation may be due to family being far away. - Utilise facilities of the regional TYA Units	- Regularly collect feedback from teenagers and young adults about their experience of care

Looked After Children and Young People (LAC / CYP)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- - The biopsychosocial approach recognises the significant psychological and social factors affecting looked after children, such as trauma, neglect, or instability. - - The emphasis on choice and control can help empower young people in care to participate meaningfully in their care planning, potentially improving trust and engagement. - - A system aiming to offer “the best intervention at the best time” can prioritise proactive support and earlier interventions to prevent disengagement or poor outcomes.	- LAC/CYP may face barriers to consent and advocacy, particularly if their legal status, care placements or social work support are not clearly aligned with healthcare needs. - They are at higher risk of health inequality, poorer mental health, and disrupted healthcare continuity due to placement moves or instability in relationships with professionals. - Confidentiality and safeguarding concerns can complicate communication and may lead to assumptions or inappropriate involvement of carers without due consideration of the young person’s voice and rights. - Cancer care environments and communications may not be trauma-informed or developmentally appropriate, leading to fear, mistrust, or disengagement.	- Develop and embed trauma-informed care pathways specifically adapted for LAC/CYP within cancer services, with input from paediatric specialists, CAMHS, and local authority representatives. - Clarify legal frameworks around consent and parental responsibility for looked after children in all cancer settings, including who can make decisions or attend appointments. - Ensure named clinical leads or keyworkers are assigned to all LAC/CYP affected by cancer to provide consistent care coordination and a trusted point of contact. - Provide developmentally appropriate information and communication, involving young people in decisions wherever possible. - Train staff on the specific vulnerabilities, rights, and experiences of looked after children, including how to sensitively address complex histories and support emotional wellbeing.	- Work with local authority children's services and designated professionals to identify LAC/CYP within cancer services and monitor their care pathways and outcomes. - Collect feedback from looked after children and young people directly (where appropriate), as well as from their carers and professionals, on their experiences of cancer care. - Regularly audit access, treatment delays, and follow-up rates for LAC/CYP against those of non-looked after peers. - Include representation from care-experienced young people and local children-in-care councils in service review and planning groups. - Monitor staff completion of training on trauma-informed care and LAC awareness.

People of working age

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised care can be tailored to fit around work schedules, reducing the burden of multiple or inflexible appointments. - Initiatives that promote autonomy and self-management empower individuals to take control of their care while maintaining employment where possible. - A biopsychosocial approach recognises the socio-economic pressures on working-age individuals, allowing services to be more responsive and inclusive.	- People of working age may face significant financial difficulties if they need to take extended time off work for treatment. Some individuals may face challenges in accessing appropriate care during working hours. - Individuals may struggle to balance work and medical needs. - Discrimination or negative attitudes at the workplace, potentially affecting job security, career progression, or access to flexible working arrangements. - People with school age children can find it difficult to access support for them.	- Work with employers and cancer care services to create flexible working arrangements. This may include adjusted hours, the possibility to work from home, or part-time work options. Develop and promote access to financial support mechanisms for people of working age. - Integrate access to mental health and employment support services to help individuals transition back into the workforce and address issues related to work-life balance. Cancer care navigators can help working-age individuals coordinate their medical treatments, reduce wait times, and schedule appointments in ways that are most convenient for their employment situation. - Improve signposting advice on Cancer Matters Wessex for parents with cancer looking for support for their children. - Utilise digital solutions e.g. Video OPA’s. - Explore of options of treatment delivery closer to home or at home.	- Regularly track the impact of cancer on individuals of working age by collecting data on income loss, employment status, and economic hardship, as well as balancing work and care effectively. - Develop partnerships with local employers and trade unions to monitor how workplace support is being integrated, ensuring that policies are being applied fairly and effectively to support people of working age affected by cancer.

Older adults

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
Older adults, especially those with advanced cancers, can benefit from a clear focus on palliative care that is sensitive to their needs, including pain management, comfort, and psychosocial support, which are vital as they approach end-of-life care.	- Older adults often have complex medical histories, multiple comorbidities, and may face challenges in navigating healthcare systems. - They may face challenges related to frailty, cognitive decline, or other age-related conditions, making it difficult for them to engage. - Physical, cognitive, or financial barriers may hinder their access and engagement. - The healthcare system may not always be equipped to address the specific needs of older adults, especially in terms of home care or community-based resources. - Older adults may experience greater levels of loneliness and depression, which can impact their willingness or ability to engage in care decisions or adhere to treatment regimens.	- Consider the unique needs of older adults, including frailty, polypharmacy, and the need for age-appropriate psychosocial support. - Ensure that services are accessible in terms of both physical access (e.g., transportation to appointments) and communication (e.g., clear information, assistance with navigating the healthcare system). - Provide access to support services such as home care, social work, and mental health support tailored to older adults. - Work with community-based services and integrate them with cancer care pathways to better support older adults who may face challenges outside of the clinical setting. - Ensure that older adults are actively engaged in their care decisions. Provide clear, understandable information about their options and involve them, along with their families, in decision-making regarding the best treatment plans and support systems. - Use tools such as advanced care planning to discuss preferences regarding end-of-life care early in the treatment process. - Consider chronical age vs. physical age. Use validated frailty tools to identify needs rather than making decisions based on age alone.	- Gather feedback directly about their experiences with cancer care. - Monitor the clinical outcomes for older adults, such as recovery rates, survival rates, and quality of life assessments. - Ensure that access is equitable and that there are no barriers preventing particular age groups from receiving appropriate care. - Assess whether older adults are receiving the appropriate level of care, especially in areas like mental health support, physical therapy, and palliative care. Evaluate if there are gaps in services or unmet needs. - Track the availability and effectiveness of caregiver support programs.

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Disability

(including learning disability, neurodiversity, physical disability, cognitive and sensory impairment)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Emphasis on choice, control, and shared decision-making empowers individuals with disabilities, helping to reduce historic disparities in care planning and delivery. - Supported self-management can enhance independence and confidence for people with long-term physical, sensory, learning, or mental health impairments, promoting autonomy. -	- Labels may cause distress or stigma. Locations or services may not be physically accessible, which could lead to unequal access. - Failure to make reasonable adjustments Individuals with hearing, visual, cognitive, or learning disabilities may face challenges in accessing information or participating in shared decision-making without accessible formats or support. - Digital tools and communication may unintentionally exclude people with cognitive impairments, poor digital literacy, or lack of access to assistive technology.	- Provide information in multiple formats as required (e.g., Easy Read, Braille, BSL interpretation, large print, audio, appropriate language etc.) in line with the Accessible Information Standard - Offer communication support such as advocates or communication aids, or specialist navigators. Facilitate engagement with the support of a carer/family member/friend. - Co-develop digital tools with disabled people to ensure usability and offer non-digital alternatives where needed. Consider use of voice activation, sign language in videos, screen-reader voice-to-text options, conversational artificial intelligence, conversational cloud and chatbots. - Ensure physical accessibility. Embed disability-specific needs into personalised care plans, ensuring reasonable adjustments are clearly documented and acted upon.	- Monitor referral rates, treatment decisions, and uptake of personalised care elements (e.g. care plans, supported self-management tools). - Monitor risk of disparities or unintended impacts. Consider equity of access and outcomes, focusing on the experience of disabled patients. - Establish mechanisms for ongoing feedback from people with disabilities, carers, and representative organisations. Use this feedback to co-design services and improvements.

People with multiple long-term health conditions

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Supports the coordination of cancer treatment with management of other chronic conditions, reducing fragmented services. - Ensuring the best intervention at the right time and place increases the likelihood of proactive management of both cancer and coexisting conditions.	- People with MLTCs may face more complex pathways, with increased risk of treatment burden, fragmented care, conflicting medical advice, or duplication of care. - Existing services may not be sufficiently tailored or flexible to meet the combined demands of cancer and other chronic conditions, especially for those with mobility or cognitive limitations. - If care pathways are cancer-focused without integrated MDT (multi-disciplinary team) input for other conditions, holistic needs may be unmet	- Consider care coordination roles (e.g. cancer care coordinators, link workers) to align cancer care with existing condition management plans. - Ensure involvement of MDTs including professionals experienced in managing MLTCs (e.g. geriatricians, specialist nurses, mental health workers) - Design service models with flexibility for longer appointments, home visits, or virtual options to accommodate fluctuating health states.	- Monitor differences in access, outcomes, and patient experience. Incorporate feedback mechanisms specific to people with MLTCs, including their experience of coordination and personalisation. - Assess use of shared care plans and communication across primary, secondary, and tertiary services to track improvements in care integration.

People with Serious Mental Illness (SMI)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Shared decision making enables individuals with SMI to be active participants, supporting autonomy and building trust in services. - Support for healthy lifestyle choices may contribute to reducing the health risk factors (e.g. smoking, poor diet, inactivity) prevalent among people with SMI.	- People with SMI often experience difficulty accessing and navigating healthcare systems. Risk of missed appointments. - Stigma and discrimination: Risk of being overlooked or not fully listened to, especially if symptoms of SMI are misinterpreted. - Physical and mental health services are often poorly integrated, potentially leading to gaps in care continuity for people with SMI. - Cognitive or emotional challenges may affect ability to understand complex medical information.	- Provide specialist navigators or advocates and mental health liaison staff to support understanding and engagement. - Use of clear, accessible communication methods, visual aids, - Ensure workforce are trained in mental health awareness and trauma-informed approaches to care. - Collaborate across primary care, oncology, and mental health teams. - Offer outreach, home visits or virtual consultations for those who may struggle to attend appointments.	- Monitor uptake, engagement, and outcomes for people with SMI. - Establish mechanisms for feedback on satisfaction, barriers, and perceived involvement in care decisions. Involve people living with SMI in service design and quality improvement processes. - Review how often reasonable adjustments (e.g., longer appointments, advocacy support) are used. - Evaluate effectiveness of joint working protocols and care coordination.

Sex (issues that are more likely to be specific to men and women, e.g. caring responsibilities, FGM, domestic abuse, health behaviours)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Emphasis on personalised care allows for services to be responsive to sex-specific needs and experiences across the cancer pathway. - Gender-sensitive communication and support can promote uptake of programmes. - Holistic care can address sex-related experiences of cancer (e.g. menopausal symptoms from treatment in women, or erectile dysfunction in men).	- Women are statistically more likely to have unpaid caring responsibilities, which can limit their ability to attend or engage. - Men may be less likely to engage with services or disclose emotional distress due to societal norms around masculinity, potentially affecting mental health outcomes and engagement. - Risk of gendered assumptions in care (e.g. assuming women are primary caregivers or that men are less emotional) may reduce the quality of personalised care. -	- Train staff in gender-sensitive communication and unconscious bias awareness to avoid stereotypes. - Ensure flexible appointment options (e.g. evenings/weekends, virtual consultations) to accommodate caring responsibilities. - Develop targeted outreach and engagement strategies to increase participation. - Offer psychological support services tailored to different coping styles, including male-specific or female-specific groups if preferred.	- Disaggregate service use, satisfaction, and health outcomes data by sex (and where possible, gender identity) to track disparities. - Monitor attendance rates at various times of day and compare to assess the impact of flexible appointments. - Evaluate the uptake and outcomes of initiatives by sex to ensure equitable benefit.

Sexual orientation

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised care can foster a more inclusive environment where LGBTQ+ individuals feel seen and respected throughout their cancer journey. This can be especially beneficial for LGBTQ+ individuals who may face minority stress, stigma, or isolation.	- Risk of heteronormative assumptions about a patient's partner, support network, or identity, leading to miscommunication or exclusion. - Lack of disclosure due to fear of discrimination can limit the effectiveness of personalised or psychosocial care plans. - A lack of trust, or previous negative experiences may impact engagement. engagement with health services. - LGBTQ+ individuals may feel that support groups or health education initiatives are not tailored to or inclusive of their experience	- Training for healthcare professionals, including guidance on inclusive language, family structures, and addressing unconscious bias. - Allow for self-identification of sexual orientation. Demonstrate the service is a safe space for LGBTQ+ individuals. - Review patient-facing materials and websites to reflect diverse sexual orientations and relationships (e.g., using non-gendered language). - Co-produce services with LGBTQ+ groups to ensure relevance and inclusion.	- Assess uptake of sexual orientation disclosure and any correlation with experience or outcomes data. Track progress, identify disparities, and inform continuous improvement. - Feedback loops with LGBTQ+ service users to provide ongoing input and co-design of services. - Evaluate the impact of LGBTQ+ training on staff knowledge, confidence, and behaviour change through pre/post assessments and observation.

Gender reassignment (People who identify as Transgender, non-binary or gender fluid)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
Holistic approaches to care incorporate gender identity and associated psychological and social dimensions, offering gender-affirming support. Personalised care supports people to actively participate in their care, ensuring preferences around gender identity and related care sensitivities are respected.	- Risk of misgendering or incorrect documentation. Labels may cause distress or stigma. Use of incorrect names/pronouns can cause distress or disengagement. - Lack of inclusive care and binary gender assumptions can lead to inappropriate or alienating care experiences. - Lack of accurate data on gender-diverse populations can result in service gaps or unmet needs. - Lack of knowledge of the impact of cancer and/or treatment on current or future gender affirmative treatment may affect treatment adherence/choices. - There may be misalignment between administrative gender markers and affirmed gender. Use of single-sex spaces (e.g., wards or support groups) can unintentionally exclude or distress trans or non-binary individuals. Risk of discrimination or discomfort from other patients in shared spaces, especially if policies are unclear or inconsistently applied. - Transgender and non-binary people may avoid care due to prior negative experiences, contributing to late diagnoses or poor outcomes.	- Provide specialist navigators or advocates. - Develop inclusive care protocols/ forms/ questionnaires and environments. Review and adapt clinical and administrative processes. Incorporate inclusive language and processes that respect diverse gender identities (e.g. use of preferred names/pronouns, inclusive forms). - Co-designed training on gender identity to improve interactions and reduce stigma. - Co-design services with transgender and non-binary individuals and advocacy groups to ensure relevance and cultural safety. - Raise awareness of support available from local and national charities and the UK Cancer and Transition Service - Visibility and communication that services are inclusive and gender-affirming, helping build trust and engagement. - Implement clear policies across Wessex cancer services about single-sex spaces. Provide gender-neutral facilities where possible (e.g. individual changing rooms, toilets) alongside single-sex spaces to offer inclusive options.	- Monitor inclusivity and care quality. - Assess disparities in access, experience, and outcomes. - Evaluate staff confidence and capability in delivering gender-inclusive care. - Include representation from the gender-diverse community to review progress and update action plans. - Track complaints and patient feedback related to gender identity and use of spaces, aiming for prompt investigation and resolution.

Civil partnership & marriage

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised, integrated care, which supports recognition of all family and support structures, including civil partners and spouses. Shared decision-making and patient choice may include the involvement of a spouse or civil partner. - Culturally appropriate care will lead to better acknowledgment of diverse family dynamics and relationships, fostering inclusivity. Recognition and involvement of spouses in care planning can enhance psychosocial support for the patient and their partner.	- Potential for overlooking non-traditional relationships in clinical settings. - Staff may inconsistently involve civil partners if there is lack of clarity or training on relationship recognition in healthcare settings.	- Provide staff training on inclusive communication, relationship recognition, and the legal standing of civil partnerships and marriages. - Ensure processes recognise civil partners equally to spouses, including documentation, patient information, assessments, and care planning discussions, and family involvement in care. - Develop protocols that explicitly allow patients to identify their civil partner or spouse as a key support person or decision-making participant.	- Review and audit care plans and decision-making documentation to ensure consistent inclusion of partners. - Monitor complaints or concerns related to relationship recognition or exclusion in care processes.

Pregnancy & maternity (includes breastfeeding)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised care has the potential to address the unique needs of pregnant or postnatal individuals affected by cancer, ensuring that care pathways reflect both oncology and maternity priorities. Holistic care that includes mental and emotional health, which is particularly important for individuals navigating both cancer and the perinatal period. - Enables individuals to participate fully in their care planning, including consideration of fertility preservation, treatment timing, and breastfeeding choices.	- May overlook the specific needs of those who are pregnant or recently given birth, especially if maternity care providers and health visitors are not integrated into the cancer care team. - There may be limited access to adapted resources or support services, such as counselling or peer support, which are sensitive to the dual burden of cancer and pregnancy/maternity. - There is a risk of implicit bias or assumptions impacting the degree to which patients are informed or supported in choices related to their reproductive role. - Some cancer treatments may require temporary or permanent cessation of breastfeeding, which can be distressing and affect bonding and mental health. - Services may lack facilities for breastfeeding or expressing milk (e.g. private rooms, refrigeration), making care access more difficult.	- Develop and implement clear pathways that incorporate cancer care and maternity services, ensuring multidisciplinary input from obstetrics, oncology, and primary care. - Ensure training for healthcare professionals on the unique needs and rights of patients who are pregnant or have recently given birth. - Provide accessible information and counselling about fertility, treatment impacts on pregnancy, breastfeeding, and parenting with cancer. - Engage patient representatives and maternity voices in service design and feedback. - Ensure support services (e.g., transport, childcare) are available or signposted for individuals managing appointments with pregnancy or childcare responsibilities. - Ensure care plans include infant feeding considerations as part of personalised care planning, especially for younger patients and those in the postpartum period. Ensure access to breastfeeding-friendly facilities such as private spaces, fridges for milk storage, and flexible appointment times.	- Collect and analyse patient experience data and outcomes. - Review clinical outcomes for pregnant patients or new parents to identify disparities or service gaps. - Track staff training uptake on pregnancy-related cancer care and assess improvements in confidence and competence. - Regularly consult with service users with lived experience to inform service improvements. - Work with maternity and breastfeeding support groups to gather feedback on care experience and identify gaps.

Religion & belief (and none)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised care supports spiritual care and psychological well-being alongside physical health, which aligns with religious or belief-based values. - Shared decision-making can empower individuals to choose treatments compatible with their beliefs (e.g. blood transfusion refusals, dietary requirements, end-of-life rituals). - Personalised care supports the inclusion of chaplaincy, spiritual care services, and access to appropriate information and environments.	- Risk of conflicts with appointment times or misunderstanding of care preferences. - Lack of staff awareness or training may result in inadvertent disrespect of religious beliefs (e.g. scheduling treatment on holy days, ignoring fasting practices). - Assumptions about belief systems may lead to stereotyping or overlooking individual preferences. - Certain treatment environments or dietary provisions may not accommodate religious practices (e.g. lack of prayer space, no halal/kosher/vegetarian food). - Risk of exclusion of people with no religious belief if spiritual care is offered in a way that assumes faith-based frameworks.	- Respect religious observances and include holistic care planning. - Training and awareness for workforce on religious literacy and belief sensitivity. - Include questions on spiritual, religious, and belief needs as part of care planning. - Ensure flexible appointment scheduling to accommodate religious observance and fasting periods (e.g. Ramadan, Yom Kippur). - Provide inclusive catering options at events that respect a variety of dietary laws and preferences. - Create and maintain quiet/prayer/reflection spaces that are multi-faith and also welcoming to those with no belief. - Engage with chaplaincy services.	- Collect feedback via patient surveys and experience measures. - Monitor complaints or concerns raised relating to religion or belief to identify trends and gaps. - Review care outcomes and service usage by religion and belief where data is available, to detect inequities. - Establish or engage with a Religion & Belief Advisory Group to regularly review practice and policy. - Annual audit of staff training completion and satisfaction with spiritual care provision.

Race and ethnicity (include Gypsy, Roma, and Travellers)

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Truly personalised care will address the specific beliefs, values, and communication styles of different ethnic groups, including those traditionally underserved such as Gypsy, Roma, and Traveller (GRT) communities. - Personalised, integrated care offers an opportunity to reduce disparities in outcomes among ethnically diverse populations. - Empowerment through shared decision-making respects cultural views and preferences around illness, treatment, and end-of-life care.	- Risk of disengagement due to cultural views, or systemic mistrust.(e.g. stigma / taboos around cancer diagnosis) - Historical mistrust of healthcare systems within some communities may result in underuse of services or refusal of care. - Structural racism and unconscious bias may still influence decision-making or the way services are accessed or delivered. - Lack of familiarity with healthcare systems in the UK - Digital exclusion may disproportionately affect ethnic minority groups who may not have access to digital tools used in supported self-management strategies. - For those who are mobile or “on the road” there is a risk of a lack of continuity in care as potentially moving between healthcare trusts	- Co-produce services with members of ethnic minority communities to ensure services are responsive and trusted. - Culturally adapted communication. - Provide specialist navigators or advocates. - Train healthcare staff in cultural competence and anti-racism. - Partner with trusted community organisations to improve outreach, education and uptake of screening and support services.	- Monitor data to identify and address disparities in access, treatment, outcomes, and patient experience. - Track uptake of services by ethnic group to identify and address any underrepresentation. - Regularly review complaints and feedback by ethnicity to identify patterns related to discrimination or cultural inappropriateness. - Establish a community advisory group to review progress and shape future service developments with representation from ethnic minority communities.

People with language barriers

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
Person-centred care promotes flexibility and adaptability in communication styles, potentially increasing accessibility. Supported self-management initiatives could empower individuals once resources are provided in accessible formats.	- Language barriers and health literacy challenges may impede access to and understanding of services, particularly for those whose first language is not English or have low literacy. Risk of disengagement. - If not proactively addressed, language barriers can hinder participation in shared decision-making and supported self-management. - Language barriers can impact communication during emotional, palliative, or high-stress healthcare moments. - Language barriers may compound existing health inequalities, particularly in underrepresented migrant or refugee communities.	- Provision of professional interpreting services (in-person, telephone, or video). - Translated patient materials in the most commonly spoken community languages across Wessex. - Cultural competence training for all staff, with a specific module on language accessibility and communication techniques. - Community engagement with multilingual advocates, community health workers, and charities supporting non-English speaking populations to co-develop accessible messaging. - Use of visual aids, infographics, video, voice notes and simple language to support comprehension, regardless of literacy level. - Ensure language support is clearly signposted and easily accessible throughout the care journey, including via digital platforms.	- Track usage of interpreting services (volume, languages used, settings) to identify gaps and demand trends. - Monitor uptake by language group to assess equity. - Regularly review translated materials for accuracy and cultural appropriateness in collaboration with native speakers and patients. - Establish a working group or steering committee including people with lived experience of language barriers to evaluate ongoing effectiveness and shape future initiatives.

People experiencing digital exclusion

(people who lack access to devices, internet connectivity, digital literacy, or confidence to use digital platforms) This group includes older adults, individuals on low income, people with certain disabilities, those in rural areas, and non-English speakers.

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Inclusive service design would include development of hybrid care models. - Potential to address social isolation if digital inclusion initiatives (e.g. device loans or training) are incorporated as part of holistic care planning. -	- Exclusion from self-management tools, digital health platforms (e.g. patient portals, online support groups), or remote consultations could lead to unequal access to care. - Barriers to accessing information could increase health inequalities. - Risk of reduced involvement if information is only available online or in complex digital formats.	- Offer choice in communication and care delivery methods, ensuring all services have an offline equivalent. Sharing of communication preference along the pathway - Design non-digital pathways ensuring inclusion for digitally excluded populations. Potential for tailored non-digital options in communications and service delivery (e.g. face-to-face, telephone, paper-based formats). - Conduct digital literacy assessments to identify support needs where appropriate and available. - Provide access to digital skills training or referral to community-based digital inclusion services. - Partnership with local libraries, community centres and charities to create access points for digital services with in-person support. - Ensure all digital platforms follow accessible design standards (e.g. WCAG 2.1, multi-language options, large print, text-to-speech compatibility). - Utilise community digital support hubs e.g. local council services, libraires freely available	- Conduct audits of communication preferences and access modes across demographics. - Gather feedback from service users on accessibility and usability of digital vs. non-digital care. - Monitor uptake and outcomes of digital vs. non-digital services. - Record the volume of users who require a) digital and b) telephone/written/face to face support to ensure the service has sufficient provision to meet the demand for non-digital elements.

Deprivation

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised care can help reduce health inequalities linked to socio-economic deprivation. - Personalised care may help overcome traditional barriers to access and engagement often experienced by people from deprived backgrounds. - Supported self-management and shared decision-making empowers individuals, including those from deprived communities who often feel disempowered by traditional models of care. - Healthy lifestyle support potential to address wider determinants of health, such as smoking, obesity, and mental health issues, which are often more prevalent in deprived populations.	- Competing life priorities (e.g. housing insecurity, low income), which can make sustained engagement with care more challenging when facing further costs due to cancer diagnosis. - Reduced access to services due to transport difficulties, digital exclusion, or lower health literacy, which may limit their ability to engage. - A ‘universal offer’ model may inadvertently reinforce inequalities by failing to account for the specific needs and barriers. Also may be stigma around sharing circumstances and seeking help. - People living in deprivation may experience a higher incidence of adverse childhood experiences and trauma, which can be associated with long-standing socioeconomic disadvantage.	- Co-produce services with people from deprived communities to ensure they are relevant, accessible, and equitable. - Design services proportionate to need, ensuring more resources and support are directed to deprived communities. - Ensure availability of community-based services, outreach, and navigators or link workers to support individuals in navigating the health system. - Flexible appointment times, transport support, and non-digital communication options to overcome access barriers. - Train staff to recognise and adopt a trauma-informed approach to respond to the impact of deprivation on engagement, trust, and care outcomes. - Outreach and mobile units in deprived areas. Community outreach, transport support, non-digital alternatives	- Collect and analyse service access, engagement, and outcomes data disaggregated by Index of Multiple Deprivation (IMD) scores or postcode-level deprivation data. - Monitor uptake and engagement by deprivation quintile to identify gaps and adapt strategies. - Establish feedback loops from community partners and voluntary sector organisations working with deprived populations to inform service improvement. - Regularly review workforce training data to ensure all staff are trained in health inequalities and equity-informed practice.

Armed forces/ veterans

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
Emphasis on personalised care and biopsychosocial approach aligns well with recognising the complex needs of veterans, including physical, psychological, and social factors. - Commitment to choice and control supports self-directed care, which may resonate with veterans' sense of autonomy and responsibility. - Initiatives such as supported self-management, and integrated care could benefit veterans who may prefer structured, goal-oriented pathways.	- Veterans may face barriers to engagement, including mistrust of civilian services, reluctance to seek help, or unrecognised service-related trauma. Potential delays in help-seeking due to military culture - Frequent relocations or fragmented medical records (especially during transitions from military to civilian NHS care) can delay cancer diagnosis, treatment, or follow-up. Potential disparities in continuity of care when transitioning from military to civilian healthcare systems. - Frequent relocations may also mean that people are isolated from family and long-time friends. - Some veterans may experience mental health challenges (e.g. PTSD, depression) that affect their ability to access or engage with cancer services, especially during emotionally intense periods like diagnosis or palliative care. Complex trauma and PTSD can be re-triggered by invasive procedures, clinical settings (e.g. MRI machines, loss of autonomy during treatment), or palliative environments. - Lack of identification or recording of veteran status in health systems may mean veterans' specific needs go unnoticed or unaddressed.	- Train staff in military cultural awareness, including understanding the impact of service-related trauma, and how to ask sensitively about veteran status. - Include veteran status in electronic patient records, and ensure patients are routinely asked if they have served in the armed forces. - Establish clear referral pathways to veteran-specific mental health and social support services (e.g. Op COURAGE, Royal British Legion, SSAFA). - Promote peer support or buddy systems that include veterans who have navigated cancer care. -Build in continuity of care mechanisms, including assigned care coordinators or key workers who can liaise with both civilian and armed forces-linked services.	- Monitor identification and recording of veteran status across cancer services. - Collect feedback from veterans and armed forces families on their experience of care. - Track outcomes for veterans (where identifiable), including treatment adherence, psychological wellbeing, and use of support services. - Work with local community groups to review service delivery and identify areas for improvement.

People living in rural, island and coastal communities.

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised care can address local needs in rural, island and coastal areas, where populations may have distinct health beliefs, lifestyle patterns, and access preferences. - Could empower individuals in remote areas to take more control over their care, which is vital where health services are geographically dispersed. - Digital health tools, telemedicine, and remote monitoring can reduce travel burdens for rural patients. Virtual appointments could be a valuable tool to complement in-person care. - Island or rural populations often have close-knit communities. By leveraging community ties and networks, initiatives can benefit from strong local support systems, which may help with emotional wellbeing, practical assistance, and peer support for individuals undergoing cancer treatment.	- People in rural, island and coastal communities often face barriers such as long travel distances to support services. This may limit access to financial, social, and healthcare support. - Frequent, complex, and extended travel can be disruptive to individuals' daily lives, including work and family responsibilities. - Telehealth solutions may inadvertently exclude those without reliable broadband, digital literacy, or appropriate devices. - There may be limited availability of a comprehensive healthcare infrastructure and cancer workforce in rural and island areas, affecting continuity and quality of care. - Poor public transport links may limit attendance at appointments and engagement with support services. - Fiscal impact of expensive travel options. - Economic vulnerability: People in farming, fishing, or tourism industries, especially those in self-employment or seasonal work, often lack sick pay or job security. A cancer diagnosis may result in significant income loss due to the inability to work, exacerbating the risk of cancer poverty. - Island populations tend to experience greater isolation in terms of access to healthcare services, transportation, and support networks, which can have significant implications for cancer diagnosis, treatment, and recovery.	- Outreach and mobile units in rural and coastal areas to reduce travel requirements. - Invest in training and supporting local primary and community care providers to deliver support closer to home. Establish, expand, or work with local cancer support groups and networks. - Digital inclusion initiatives including digital training, loan devices, and support for broadband access in rural and coastal communities to enable remote consultations and self-management tools. Increase access to telemedicine services, supporting virtual consultations with healthcare providers. - Establish transport schemes (e.g., volunteer driver services or subsidised travel) to support attendance. - Offer appointments and services outside traditional hours/ at preferred times to accommodate travel time and personal circumstances. - Develop financial assistance schemes specifically designed to cover the cost of travel, including transport subsidies or coverage of accommodation costs for patients and carers. - Provide tailored advice and services for farming and tourism employers to create supportive work environments. Develop resources to help self-employed workers in these sectors navigate the complexities of benefits, insurance, and social care services. Include partnerships with local agricultural or tourism organisations to offer advocacy and financial advice. - Offer services to address the mental health burden and financial stress in vulnerable sectors and isolated regions.	- Geographic analysis of access and outcomes: assess uptake and patient experience across rural vs. urban areas. - Gather and review feedback from people in rural and coastal communities to understand barriers and successes. - Monitor engagement with digital tools by postcode to identify gaps in access and tailor support accordingly. - Track recruitment, retention, and distribution of cancer care professionals in rural and island areas. - Measure the use of mobile units, transport schemes, and community-based interventions to inform ongoing service planning. - Monitor frequency of travel, travel times, and costs associated with these journeys, as well as delays or outcomes impacted by travel barriers. - Regularly track the monetary impact of cancer on individuals within the farming and tourism sectors by collecting data on income loss, employment status, and economic hardship during and after treatment. - Survey patients about their experiences with accessing care and the challenges they face in travelling to treatment centres. This feedback will help refine mobile healthcare services, telehealth provisions, and travel support. - Collaborate with local community leaders and healthcare providers to assess ongoing needs and improve care.

People experiencing homelessness or Housing insecurity.

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised care can be particularly beneficial for individuals experiencing homelessness, who often fall through the cracks of fragmented healthcare systems. Coordinated services improve continuity and access. - Biopsychosocial approach naturally encompasses the social determinants of health, including housing instability. - Personalised support empowers individuals, potentially restoring autonomy often lost during housing crises. - Mobile, community-based, or outreach care models could align with the vision of delivering care in the “best place” for the person, such as shelters, hostels, or drop-in centres.	- Difficulty accessing services due to lack of fixed address, communication tools, or transportation may impact engagement. - Stigma or discrimination may occur affecting engagement and trust, and affect standards of care, inclusion in treatment decisions etc.. - Challenges in continuity of care—frequent changes in living circumstances can disrupt care, management of side effects and post-treatment monitoring. - Barriers to engaging in lifestyle interventions due to limited means and competing priorities such as finding food or shelter.	- Use trauma-informed care approaches. - Outreach services and mobile health units to deliver care directly to places accessible. - Appointment flexibility and walk-in services rather than reliance on scheduled appointments that may be hard to keep. - Work with specialist navigators, advocates, care coordinators or link workers with experience supporting people experiencing housing insecurity. - Close collaboration with housing, social care, and voluntary sector services, especially those already supporting the homeless population. - Provision of transport vouchers, phone access, and safe storage of medicines to improve engagement and treatment adherence. - Training for healthcare professionals on the impact of housing insecurity and how to provide non-discriminatory, trauma-informed care.	- Data collection to identify disparities in access or outcomes. - Monitoring of engagement among those without fixed addresses. - Review of missed appointments and care interruptions to identify patterns and adjust services accordingly. - Regular collaboration with homelessness charities and housing services to review service delivery and address barriers proactively.

People in contact with the justice system

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised, and integrated care provides a strong foundation to address the specific needs of individuals in or exiting the justice system. - Principles align well with promoting autonomy and reablement, which are critical in supporting people transitioning from custody into the community. - Holistic model is particularly relevant, as people in contact with the justice system often face a complex mix of physical, mental health, and social challenges, including substance misuse, housing instability, and stigma.	- Individuals in secured facilities or under probation supervision may face logistical and systemic barriers to accessing services. - Custodial sentences or transfers between facilities can interrupt continuity of care and reduce access to specialists. - Digital Exclusion: individuals may be unable to access digital support tools due to restrictions or lack of digital literacy. - Stigma and Discrimination can lead to reduced engagement and lower quality care. - Unable to access third sector support services. - Lack of family support networks and family communications with HCPs. - Lack of privacy and time to have personalised care conversations	- Develop pathways that include liaison roles (e.g. prison healthcare navigators or probation health link workers) to coordinate care across custody and community. - Train workforce on the needs of justice-involved individuals, including trauma-informed approaches and anti-stigma education. - Establish formal agreements between NHS cancer services and prison healthcare providers to ensure integration and care continuity. - Offer alternative access routes such as mobile units or in-reach specialist visits to custodial settings. Consider flexibility in appointment scheduling for those on probation or recently released. - Involve people with lived experience of the justice system in service co-design to ensure relevance and accessibility of initiatives.	- Monitor access, outcomes, and patient experience, including in-reach and post-release settings. - Regular reviews of joint working arrangements with justice services to ensure care pathways are functional and inclusive. - Establish feedback loops, e.g., patient panels or interviews with individuals in contact with the justice system, to ensure their needs are being met and service adjustments are timely.

People experiencing drug and alcohol dependence.

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Personalised care recognises the interconnection between mental, physical, and social health, which aligns well with the complex needs of individuals experiencing substance dependence. - Tailored services accommodating dual diagnoses (e.g., cancer and substance use disorder) can assist with engagement, adherence, and outcomes. - Support for healthy lifestyle choices could empower individuals in recovery by addressing behaviours that may have contributed to or worsened their health, promoting long-term wellbeing. - Recognising the autonomy of individuals with lived experience of dependence can reduce stigma and promote dignity and trust in the healthcare relationship.	- Stigma and discrimination , which may impact how they are treated by healthcare providers or their willingness to seek care. - Chaotic lifestyles, mistrust of healthcare institutions, or fear of judgment may reduce uptake, engagement, follow-up, and adherence. - Cancer care may not be well-integrated with substance use services, leading to fragmented or poorly coordinated care. - Risk of delays in accessing services due to irregular health service contact or assumptions about patient reliability. - Symptoms or experiences may be overlooked or misattributed.	- Educate clinical and support staff on the impact of substance dependence, trauma-informed care, and anti-stigma practice. - Strengthen links and coordinate care between oncology services and drug and alcohol services, including use of shared care plans and joint case management. - Offer low-threshold, flexible appointments, and outreach to accommodate unpredictable attendance and needs. - Provide specialist navigators or advocates. Involve peer workers or recovery navigators to build trust and promote sustained engagement with services.	Track engagement, outcomes, and patient satisfaction to identify disparities. Service feedback loops to inform continuous service improvement. Audit and review for inclusion and effectiveness for those with substance use needs. -Establish feedback loops from community partners and voluntary sector organisations working with people experiencing drug and alcohol dependence to inform service improvement.

Vulnerable adults (e.g. sex workers, victims of modern slavery, refugees/asylum seekers, victims of domestic abuse and other socially excluded groups)- link to points on race/ethnicity, literacy, language barriers etc. as needed.

Positive impact	**Negative impact**	**Possible mitigating actions**	**Potential ways to monitor actions**
- Personalised care acknowledges the need to consider the whole person, including social and psychological contexts, which is highly beneficial for these groups who often experience complex needs. - Personalised care and shared decision-making can empower individuals who may have previously experienced a lack of autonomy or control. - Support for healthy lifestyles and managing consequences of treatment offers an opportunity to improve long-term outcomes for individuals who may have historically had limited access to preventive or follow-up care. - Integrated care across services can help reduce fragmentation and better address safeguarding, housing, mental health, substance misuse, and immigration concerns.	- May be reluctant or unable to access support due to fear of stigma, previous negative experiences with healthcare providers, immigration status, language barriers, or lack of trust in institutions. - Health services may fail to identify individuals in these groups, especially if they are hidden populations or avoid public services. Insecure housing, poverty, and mobility issues may make continuity of care and attendance at appointments difficult. - Without proper training in trauma-informed care, healthcare staff may unintentionally retraumatise individuals through invasive procedures or lack of sensitivity to past trauma. - Initiatives promoting supported self-management may rely on digital tools, which socially excluded groups may not have access to or confidence in using. - Certain groups, such as refugees and asylum seekers, may face unique challenges in accessing services due to evolving immigration policies and increased political scrutiny.	- Train staff in trauma-informed care and safeguarding protocols to ensure sensitive and appropriate interactions with vulnerable individuals. - Co-produce care pathways and outreach models with people who have lived experience in these groups to ensure relevance and acceptability. - Partner with trusted community organisations, NGOs, and outreach workers who have established relationships with these communities to facilitate access to care. - Offer non-digital options for self-management and communication, including face-to-face contact, printed materials, and interpreters. - Implement safe access points (e.g., through drop-in centres, mobile units, or anonymous clinics) where individuals can seek support without fear of exposure or reprisal. - Offer home visits, transport solutions, or local delivery via community hubs where possible. Provide specialist navigators or advocates. Use trauma-informed care approaches. - Ensure anonymity and confidentiality is preserved at all levels of care.	- Collect disaggregated data (where safe and appropriate) on access, engagement, and outcomes for these groups. - Conduct regular service user feedback sessions with representatives or advocates. - Audit service accessibility and outcomes with a focus on inclusion and equity. - Track referral patterns from trusted partners and third-sector organisations to assess uptake and identify gaps. - Report on staff training completion in trauma-informed and inclusive care practices and evaluate its impact on service delivery.

Caregivers

Positive impact	Negative impact	Possible mitigating actions	Potential ways to monitor actions
- Caregivers often provide emotional and practical support to their loved ones, supporting the provision of personalised care. - Providing them with the tools and resources to engage in shared decision-making can lead to better, more informed choices. - Emphasis on shared decision making and self-management may be adapted to include caregivers as key participants, especially when patients cannot advocate for themselves. - Supported self-management programs that include caregivers can ensure that both the patient and caregiver are adequately prepared to manage the day-to-day complexities of cancer care. - Consideration of the psychological and social toll on caregivers could potentially open access to emotional and practical support.	- Partners and caregivers may be dealing with their own health issues while simultaneously caring for a loved one with cancer. This can lead to caregiver burnout, depression, and anxiety. - Caregivers may reduce or eliminate their own social activities in favour of focusing on their caregiving role, increasing risk for social isolation. - Caregivers may struggle to navigate complex cancer pathways without structured support, leading to poor outcomes or disengagement. - If staff lack training on the Mental Capacity Act, there is risk of failing to accurately assess capacity, undermining a person's legal rights or excluding caregivers inappropriately. - Without clear processes, patients with fluctuating or impaired capacity may not be meaningfully involved in decisions when they are able to be. Caregivers may be asked to make decisions without legal authority or appropriate support, creating ethical and legal risks. - Assumptions about relationships. People may not have positive relationships with the person assumed to be their caregiver (e.g. victims of elder abuse or domestic abuse)	- Avoid assumptions about relationships. Review guidance on vulnerable adults for working with people who may be victims of abuse by their assumed caregiver/ family member. - Ensure caregivers are routinely recognised as partners in care, with their consent, and receive appropriate signposting to support services. - Provide access to respite care for caregivers, engaging with short-term care services or support groups. - Create flexibility in appointments and care settings (e.g. home visits, virtual check-ins) to better accommodate the needs of both the patient and caregiver. - Provide resources for caregivers, including local support networks, online forums, and information on navigating the healthcare system, to ensure they feel supported in their role. - Develop programs that offer psychological support for caregivers Encourage caregivers to engage in self-care, providing resources on how to manage stress and maintain their own mental health while caregiving. - Provide information on available benefits, tax reliefs, and other financial support programs that cater to caregivers. - Recognise the caregiver's health and well-being in the care planning process. - Ensure that community-based resources (such as transportation, home healthcare, and support networks) are accessible to caregivers. - Include caregivers in shared decision-making with the cancer patient to ensure they are adequately informed and equipped to support treatment decisions. - Empower caregivers to advocate for the individual's values and preferences where capacity is limited, ensuring that care remains person-centred. - Develop and provide dementia- and cognitive-impairment-friendly communication materials and care pathways. - Train all relevant staff on how to assess capacity, involve caregivers, and apply best interests decisions lawfully. Identify patients who may lack capacity early and ensure appropriate legal documentation is in place (e.g., Lasting Power of Attorney, Court of Protection Orders). Implement systems to support advance care planning when individuals do have capacity, to record their values and preferences for future care (e.g. Primary Care - consent to care recorded within primary care services.)	- Collect regular feedback from caregivers to assess their satisfaction with the support they receive. - Track the physical and emotional health of caregivers through regular assessments, monitoring for signs of burnout, depression, and stress. - Evaluate whether services are meeting the needs of caregivers and making a positive impact on their ability to care for the cancer patient while maintaining their own well-being. - Regularly review how caregivers are involved in care planning and shared decision-making. Assess whether caregivers feel that their needs and voices are being heard in the process. - Audit the use and documentation of capacity assessments and best interest decisions across services. - Track uptake of staff training on MCA and consent processes. - Engage with local dementia alliances, learning disability partnerships, and carer support organisations to co-review practices. - Ensure reviews of complex or disputed cases involving consent and capacity are completed regularly.