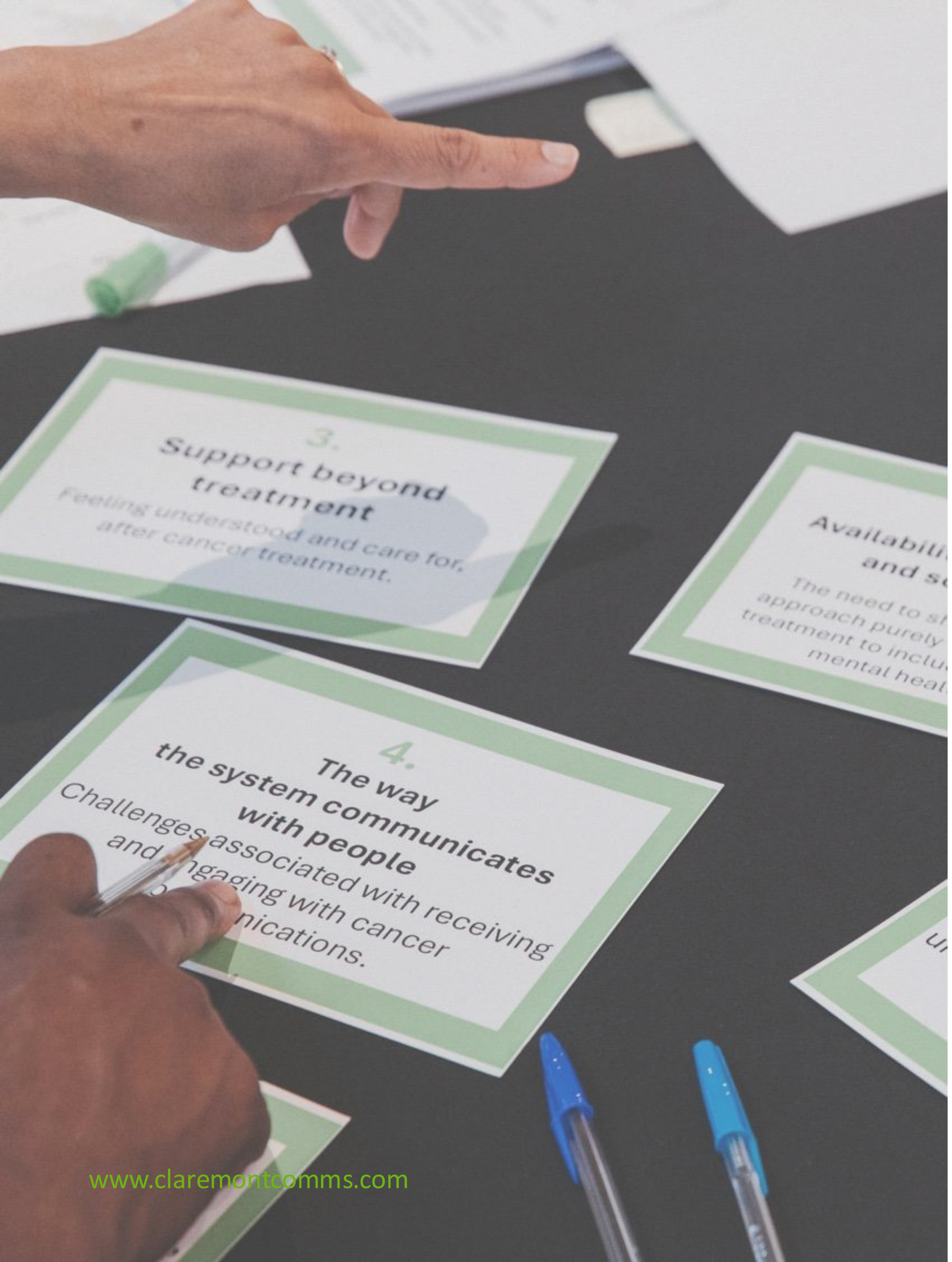
NHS
North East London
Cancer Alliance

North East London
Cancer Alliance

Health Inequalities Strategy



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North-East London Cancer Alliance
Foreword

North East London is a place of rich diversity, where deprivation exists alongside wealth and thriving commerce. Shaped by the history of the East End and centuries of migration from across the world, the area has undergone rapid change since the mid-twentieth century. For those of us who live and work here, this diversity is a source of pride, which we embrace. However, it also contributes to inequalities in health outcomes for many long-term conditions, including cancer.

This strategy was developed out of a clear commitment to address these inequalities and to ensure that everyone living in North East London has equitable access to cancer services across the entire cancer pathway. Everyone diagnosed with cancer should be able to live with a high quality of life for as long as possible, and this right should be available equally to all residents.

We recognise that meaningful change will not happen overnight. Cancer inequalities in North East London are shaped by a complex interplay of social, structural and systemic factors. Addressing them requires a whole-system approach, recognising how these factors influence one another and affect individuals. A strategy alone will not deliver change unless it is grounded in lived experience, actively owned by the system, and translated into everyday practice.

This Health Inequalities Strategy sets out a shared commitment to doing things differently. It has been developed through a citizen-led approach, working alongside residents, communities and partners across North East London, so that lived experience informs priorities and guides action. From the outset, the emphasis has been on developing a shared vision, understanding how the system operates in practice, and identifying where change is most needed and most achievable.

Through desk research, stakeholder engagement, a deliberative Citizens' Panel, and in-depth community engagement, we have focused not only on what needs to change, but on how change can happen in a realistic and sustainable way. This work included mapping the roles, responsibilities and relationships that shape people's experiences of cancer prevention, diagnosis, treatment and care, and identifying where collaboration, clarity and accountability are essential to progress.

The strategy that follows is designed to support collective action. It provides a framework for embedding collaboration across organisations, aligning efforts around shared priorities, and ensuring that responsibility for tackling health inequalities is understood and embraced at every level of the system. Delivering this strategy will require sustained commitment, openness to learning, and a determination to turn insight into action.

This strategy offers a pathway towards fairer cancer outcomes for people and communities across North East London, built on partnership, shared responsibility and lived experience.

Caroline Cook
Early Diagnosis Programme Lead

Executive summary

Why a Health Inequalities Strategy for North East London

Cancer inequalities in North East London are longstanding, persistent and avoidable. They reflect a complex interaction between social disadvantage, structural barriers and how the health and care system is designed and delivered. While improvements have been made in parts of the cancer pathway, these gains have not been experienced equally by all communities.

People living in more deprived areas, some ethnic minority groups, older people, men, people with disabilities and people facing language or digital barriers are more likely to be diagnosed later, experience more complex pathways, and have poorer outcomes. These differences emerge early and accumulate across the cancer journey - from awareness and screening, through diagnosis and treatment, to survivorship and access to ongoing support.

This strategy recognises that addressing cancer inequalities cannot be achieved through isolated interventions or short-term initiatives alone. It requires a coordinated, system-wide approach that looks beyond individual behaviour and focuses on how services are accessed, experienced and navigated in practice.

The Health Inequalities Strategy sets out a shared commitment to reduce these inequalities by focusing on what needs to change, where change is most achievable, and how progress can be delivered and sustained across North East London.

A citizen-led, evidence-informed approach

This strategy was developed through a structured, evidence-led and participatory process, bringing together national and local data, lived experience and professional insight.

From the outset, the emphasis was not only on identifying what needs to change, but on understanding how change can realistically happen within the North East London system.

The development process included:

- **Desk-based review** of national policy, research and local data to understand patterns of inequality and system pressures
- **Interviews with professionals** across public health, cancer services and the voluntary and community sector
- A multi-disciplinary **Steering Group** providing challenge, oversight and system insight
- A deliberative **Citizens' Panel**, supported by additional engagement with groups less well served by traditional engagement methods

Engagement was guided by principles of co-production and accessibility. Lived experience was treated as a core source of insight, shaping priorities throughout the process rather than being used to validate decisions at the end.

This approach ensured the strategy is grounded in real experiences, aligned with existing system realities, and focused on actions that are both ambitious and deliverable.

The Strategic themes

The strategy was **co-developed with residents through the Citizens' Panel**, alongside professional and system-wide insight, to reflect how cancer inequalities are experienced in practice across North East London. It brings together lived experience, local context and evidence to set a clear direction for action.

At its core, the strategy recognises that cancer inequalities are shaped by how systems are designed, communicated and experienced, not by individual behaviour alone. Reducing these inequalities therefore requires coordinated action across the whole cancer pathway, grounded in real experiences and delivered through system-wide collaboration.

The strategy is organised around **six inter-connected themes**, developed directly through the Citizens' Panel and wider engagement. Each theme reflects a key point in the pathway where inequalities persist, together providing a coherent framework for action across North East London.

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1. **Make sure people know what's available to them and why it matters**
Focuses on improving awareness before people enter the system-helping communities understand cancer signs and symptoms, screening and what to expect from services, so people feel confident acting early.

2. **Remove barriers to accessing care**
Addresses the practical and structural barriers that stop people entering or staying on the cancer pathway, including complex processes, digital and language exclusion, and lack of navigation support.

3. **Improve support after treatment**
Aims to improve quality of life after treatment by reducing the "cliff edge" many people experience, strengthening follow-up, survivorship support, peer networks and links between hospital and community care.

4. **Make cancer communications and interactions work for people**
Focuses on improving the clarity, tone and accessibility of letters, conversations and digital tools, recognising that poor communication leads to confusion, anxiety and disengagement from care.

5. **Embed social and psychological support in care pathways**
Recognises cancer affects the whole person and focuses on integrating mental health, psychosocial and practical support into diagnosis and treatment, particularly for people facing additional disadvantage.

6. **Open doors to research**
Aims to improve fair access to research and clinical trials by strengthening how research is explained and offered, addressing trust and stigma, and ensuring opportunities are available to all communities.

From Strategy to Action

This strategy is intended as a practical framework for collective action, not a static document. It provides a clear direction for tackling cancer inequalities while allowing flexibility in how actions are implemented across boroughs, pathways and services.

Delivery will focus on:

- Aligning existing activity across organisations under shared priorities
- Identifying early actions that can make a tangible difference, particularly in Year 1
- Supporting collaboration between health services, local authorities, VCSE partners and communities
- Embedding lived experience into implementation through ongoing involvement, including the Lived Experience Advisory Panel (LEAP)

Progress will be tracked using a combination of quantitative measures and qualitative insight, recognising that numbers alone do not capture changes in access, experience or trust. Learning from delivery will be used to refine actions over time, particularly where inequalities persist or new gaps emerge.

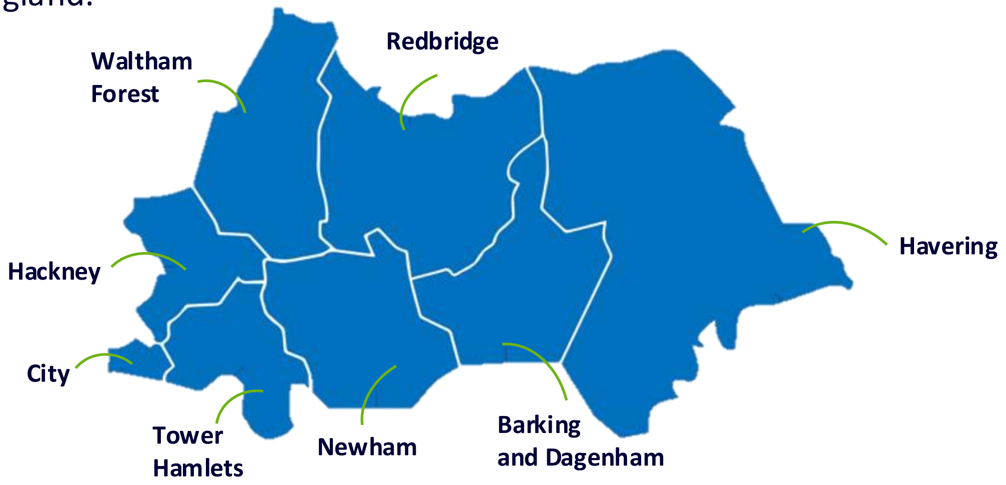
By setting out clear themes, governance arrangements and expectations for delivery, the strategy aims to build sustained momentum and shared ownership across the North East London system - ensuring action on cancer inequalities continues beyond individual projects or funding cycles.

Setting the Scene:

Cancer Inequalities in North East London

A diverse population …

North East London is one of the most diverse and complex areas in England.



Key features of the population include:

- More than half of residents are from a **minority ethnic background.**
- Around **one in four people live in neighbourhoods ranked among the 20%** most deprived nationally.
- Approximately **one in eight people live with a disability** that affects their day-to-day activities.
- Around **200 languages and dialects** are spoken across the area, with many households not using English as their main language at home.

… with unequal outcomes

These population characteristics shape how people experience health and care across the cancer pathway, contributing to differences in outcomes that are both persistent and avoidable.

Differences in language, income, housing, employment, disability and digital access all influence whether people are able to navigate services, understand health information and seek help when symptoms arise.

These factors interact with each other and accumulate over time, contributing to persistent inequalities in cancer outcomes.

National and local data consistently show that people living in more deprived areas, some ethnic minority groups, older people and men are more likely to experience poorer cancer outcomes.

In North East London, inequalities can be seen across the pathway - from prevention and screening, through diagnosis and treatment, to access to ongoing support.

However, the way these inequalities play out is not uniform, and varies across boroughs, neighbourhoods, communities and services.

Inequalities along the cancer pathway

In North East London, inequalities are visible at every stage of the cancer pathway, with people living in more deprived areas and some ethnic minority communities consistently experiencing poorer access and outcomes.

Prevention & Screening

More deprived communities in NEL have the lowest screening uptake. In this area, bowel cancer screening uptake in IMD 1 and 2 is 54% compared with the **national average of 67.7%**

Diagnosis

- **Bowel cancer:** Early diagnosis is low (35–41%) and unequal, with fewer people diagnosed early in deprived areas (IMD1 ~35%) and among Asian populations (34.5% vs 41.5% White).
- **Lung cancer**: Early diagnosis remains low (36–40%) with a higher burden in deprived areas (26% of diagnoses in IMD1 vs 9% in IMD5).

Access to care

- Black males are 2.3x more likely to DNA (‘Did not attend’) a first USC appointment than Black females, and 2x more likely than males of other ethnicities.

Outcomes

People from deprived and minority ethnic communities are less likely to progress smoothly through diagnosis and treatment pathways, contributing to poorer experiences and outcomes across the cancer journey.

These inequalities accumulate across the pathway, meaning people already facing disadvantage are more likely to be diagnosed later, receive more complex care, and experience poorer outcomes.

Our Approach:

How the strategy was developed

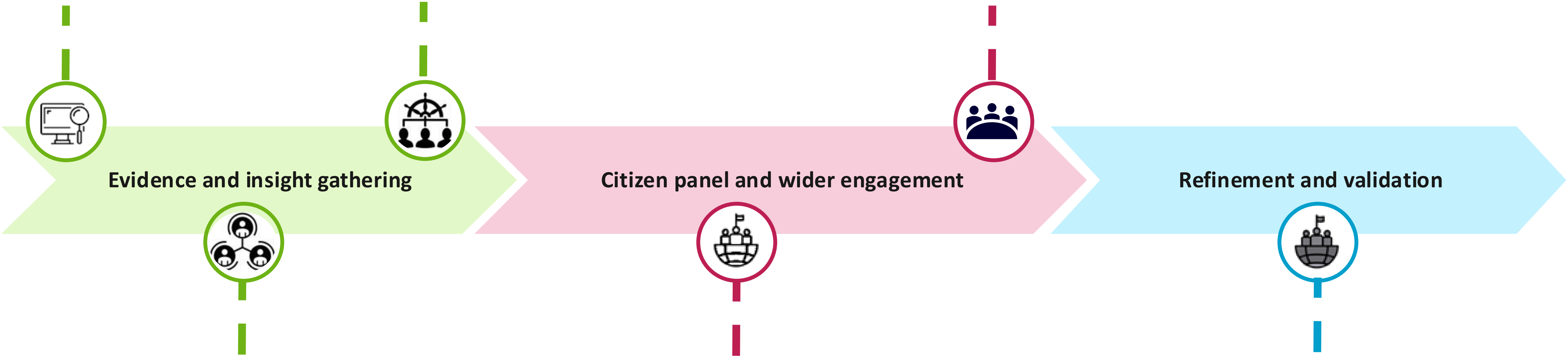
Guiding principles

This strategy was developed through a structured, evidence-led and participatory process. It combines national and local evidence with lived experience and professional insight, ensuring the approach is grounded in both data and the realities of people's lives.

Throughout the process, these key guiding principles informed how decisions were made.

- **Co-production, not consultation:** we prioritised working with people rather than seeking feedback on pre-defined ideas. The Citizens' Panel was central to this approach, providing a structured way to centre lived experience as a guiding input from the start and throughout the process, rather than as a validation step at the end.
- **Consent over consensus:** when working on cancer inequalities, full consensus is rarely achievable given the diversity of experiences, needs and system constraints. Rather than resolving differences, we focused on developing an approach that participants could recognise as inclusive, legitimate, fair and directionally right.
- **Trust, accessibility and trauma-informed:** Engagement methods were designed to be accessible, culturally appropriate and grounded in trauma-informed practice. This meant paying careful attention to how and where people were engaged, creating safer conditions for participation, and recognising past experiences that may shape trust in services.

The programme of work – timeline overview



Desk research: Looked at local reports, data and existing strategies to better understand the landscape of health inequalities.

Stakeholder interviews: Held **10 interviews** with people working in public health, cancer inequalities, and local organisations to hear about what’s working, what’s not, and why.

Steering Group: Organised **3 sessions** with a group of professionals from NEL (public health, cancer alliance, healthcare) to help inform and shape the process.

Evidence and insight gathering

Citizens' Panel: Organised **3 online** sessions and **1 in-person** session with 30 local residents to share experiences and agree priorities to be included in the strategy.

Additional groups: Engaged and spoke to more than 60 people from groups which weren’t included in the Citizens’ Panel (for instance, asylum seekers, sex workers, people with learning disabilities among others) and aligned the priorities with their experiences.

Citizen panel and wider engagement

Refinement and validation

3x workshops with NELCA: organised 1 in-person workshop and 2 online workshops to bring everything together and identify the action plan.

Evidence and insight gathering

We adopted a structured approach to gathering evidence and insight, designed to build a shared understanding of cancer inequalities in North East London and to shape the focus of the strategy from the outset.

Desk research

We reviewed national policy, evidence and local reports from across the seven NEL boroughs to map existing inequalities, current initiatives and areas of focus. This helped identify key demographic groups affected by cancer inequalities, system-level barriers (such as late diagnosis and access challenges), and opportunities to build on existing work. The findings informed early hypotheses and lines of enquiry.

Stakeholder interviews

We conducted 10x interviews with professionals across public health, health inequalities, cancer services, VCSE organisations and community groups. Building on the desk research, these conversations explored cultural, structural and psychological barriers across prevention, diagnosis and care, adding depth, challenge and real-world context to the evidence base.

Steering group

A multi-disciplinary steering group met across several sessions to guide and sense-check the process. The group helped refine scope and priorities, test emerging insights, shape the framing of key questions, and mitigate delivery risks by providing system-level challenge and expert input.

Together, these activities created a robust foundation for the next stages of the work, ensuring that subsequent priorities were evidence-driven, grounded in lived and professional experience, and relevant to the realities of the NEL system.

How stakeholders describe cancer inequalities in NEL

Alongside the population data, 10 stakeholder interviews provided insight into **how cancer inequalities are understood and experienced across the system**. These themes do not represent solutions, but describe the context and constraints within which this strategy needed to be developed.

What the data tells us

Stakeholders recognised the value of national and local data in highlighting where inequalities exist across cancer outcomes, particularly by deprivation, ethnicity, age and gender. At the same time, many noted that data often describes *where* inequalities appear, but is less effective at explaining *why* they occur or how they are experienced by individuals and communities.

Inequalities are shaped by systems

Interviewees consistently highlighted that cancer inequalities are not driven by individual behaviour alone. Instead, they are shaped by how systems are designed and delivered, including referral pathways, service availability, communication methods and eligibility criteria. This can either reduce or reinforce existing disadvantages.

Balancing consistency and local flexibility

Stakeholders described an ongoing tension between the need for a clear, system-wide direction and the importance of allowing flexibility at borough and neighbourhood level. While alignment is necessary to avoid duplication and fragmentation, a purely uniform approach risks overlooking local context, community needs and existing assets.

Measuring progress beyond numbers

There was broad agreement that quantitative outcomes and performance measures are important, but insufficient on their own. Stakeholders emphasised that data does not always capture variation in experience, access or trust, particularly where data quality or availability differs across services and places.

Why lived experience matters

Across interviews, lived experience was consistently identified as essential to understanding cancer inequalities in practice. Stakeholders highlighted how factors such as trust, language, past experiences of care and day-to-day pressures shape engagement with services in ways that are not visible in routine datasets.

The steering group: *plan oversight and input*

Who was involved

The Steering Group brought together system partners with strategic, clinical and population-level insight across North East London, ensuring the strategy was credible, aligned and deliverable. Membership included:

- **NEL Clinical and GP Leads** across key parts of the cancer pathway (early diagnosis, diagnosis and treatment, personalised cancer care)
- **Public Health leads** from the seven NEL boroughs, providing local intelligence on inequalities, population need and place-based priorities
- **North East London Cancer Alliance leads**, ensuring alignment with cancer transformation priorities

What the sessions were for

The Steering Group met three times at critical points in the process, providing oversight, challenge and expert input throughout.

Session 1: Mobilisation and scope
Confirmed the scope and ambition of the strategy, surfaced key risks and constraints, and agreed the recruitment approach for the Citizens' Panel to ensure diversity and representation.

Session 2: Citizen Panel design
Refined the core questions for the Citizens' Panel, reviewed and discussed materials, and sense-checked accessibility, neutrality and inclusion.

Session 3: Playback after the Citizens' Panel
Shared initial strategy themes generated by the Panel and discussed priorities to develop and refine the final strategy

Across all sessions, the Steering Group played a key role in aligning lived experience with system realities, and in strengthening the legitimacy and robustness of the final strategy.

Engaging with the community: the CORE20PLUS

This strategy was shaped through a two-part engagement approach, informed by data, stakeholder insight, steering group advice and the NHS England **CORE20PLUS5 framework**. CORE20PLUS5 is a national approach to reducing health inequalities. It focuses on **the Core20** (people living in the most deprived 20% of communities), and the **PLUS** (population groups who face additional barriers to access and outcomes and who may require more tailored approaches). Using this framework, we designed an engagement process that combined a structured Citizens' Panel with additional, tailored engagement for groups less well served by panel-based formats.

Citizens' Panel (CORE20)

The Citizens' Panel brought together residents from across the seven boroughs of North East London. Participants were recruited with a focus on people living in communities that face greater barriers to accessing timely and high-quality cancer care, reflecting both national evidence and local insight.

Thirty participants took part, representing a wide range of life experiences influenced by factors such as income, language, disability, ethnicity, housing security and confidence in using health services, among others.

The panel provided a structured and supportive space for shared deliberation, enabling participants to explore lived experiences of cancer inequalities, consider trade-offs, and work together to shape priorities for the strategy based on what they felt would make the greatest difference.

Additional engagement (PLUS)

While the Citizens' Panel generated a rich and inclusive set of insights, its format meant that some voices were less able to participate fully.

To ensure the strategy reflects the full breadth of experiences across North East London, we undertook additional**, tailored engagement with PLUS population groups**, as defined within the CORE20PLUS5 framework. These include *Gypsy, Roma and Traveller communities, sex workers, people experiencing homelessness, people with learning disabilities and neurodivergent people, LGBTQ+ individuals, and vulnerable migrants and people seeking asylum*.

Engagement was tailored to different needs and preferences, often delivered in partnership with trusted organisations and practitioners, helping to surface experiences and priorities that may not be captured through standard engagement approaches.

The Citizens' Panel: deep dive

The Citizens' Panel was the primary space where the strategy was created.

It was designed to bring together a diverse group of residents, taking into account the most deprived communities in North East London, enabling them to share lived experience, deliberate on trade-offs and shape priorities for action.

*The panel included 30 people from a mix of:

- → Boroughs and neighbourhoods
- → Ethnic and cultural backgrounds
- → Age groups and genders
- → Health experiences
- → Socio-economic backgrounds
- → Levels of engagement with the health system

**A more detailed overview of the demographic can be found in the Appendix, pp 50.*

How the Citizens' Panel sessions worked

The Citizens' Panel was delivered across multiple facilitated sessions, moving progressively from shared understanding to prioritisation and recommendations. Sessions were designed to be deliberative, paced and accessible, allowing participants to build confidence and understanding over time.

Session 1

Context and the cancer pathway

The first session introduced participants to the purpose of the Citizens' Panel and the role of the Cancer Alliance. Participants heard about and discussed the cancer pathway to build a shared understanding of how prevention, screening, diagnosis and care operate across North East London.

Session 2

Inequalities and early priorities

This session focused on exploring health inequalities in cancer, drawing on participants' own experiences alongside examples from other cancer alliances. Participants began identifying early priority areas grounding emerging themes in lived experience.

Session 3

Expert Q&A and refinement

Participants took part in a Q&A session with a panel of experts (public health and cancer alliances), creating space to ask questions, challenge assumptions and test understanding. Insights from this discussion were used to further refine and stress-test the emerging priority areas for the strategy.

Session 4

In person prioritisation and recommendations

The final session was held in person over a full day. Participants worked together to agree final priority areas and collaboratively brainstorm practical recommendations, balancing ambition with feasibility and impact.

Engaging with additional groups

Alongside the Citizens' Panel, we undertook additional engagement with PLUS population groups who were less able to participate fully and meaningfully in a formal panel setting. PLUS groups were identified locally, drawing on the CORE20PLUS5 framework, data and stakeholder insight. Engagement with these groups was deliberately **tailored to their needs and preferences**, using flexible methods and, where appropriate, working alongside trusted organisations and practitioners who support these communities on a day-to-day basis.

Who we spoke with	How we engaged with them
People experiencing homelessness	We held informal, in-person conversations during foodbank sessions and conducted in-depth interviews with individuals and practitioners who support this group.
People with learning disabilities and neurodivergent people	We ran in-person group sessions in familiar settings alongside support workers to create a supportive environment, so participants were fully able to express themselves.
Gypsy, Roma and Traveler communities	Engagement took place through group discussions and follow-up phone conversations, supported by trusted local organisations.
Sex workers	We conducted anonymous one-to-one phone conversations, alongside in-depth discussions with frontline social workers who work closely with this community.
LGBTQ+	Engagement was done via online interviews and phone calls, allowing participants to choose their preferred and most comfortable format.
Vulnerable migrants (asylum seekers)	We held an in-person group session in a familiar community setting, supported by staff members and interpreters known to participants.

What we heard

As engagement progressed, clear patterns began to emerge in how people described their experiences of cancer prevention, screening and care. The following voices illustrate the experiences and concerns that sit beneath the themes explored in the next section.

The Citizens' Panel

Limited guidance

"There's no one to walk you through the process or tell you what comes next."

Dehumanised care

"Don't treat people like numbers"

Intimidating communication

"Letters are scary, delayed, and confusing"

Hidden health literacy barrier

"Just because someone speaks English, doesn't mean they understand medical letters"

Feeling unheard

"Make us feel listened to!"

… and PLUS population groups

Prejudice and stigma

"Doctors assume health issues are linked to sex work… Often people would not feel listened to."

Low cultural awareness

"We're not allowed a man to touch us in any way, shape or form"

Limited cultural sensitivity

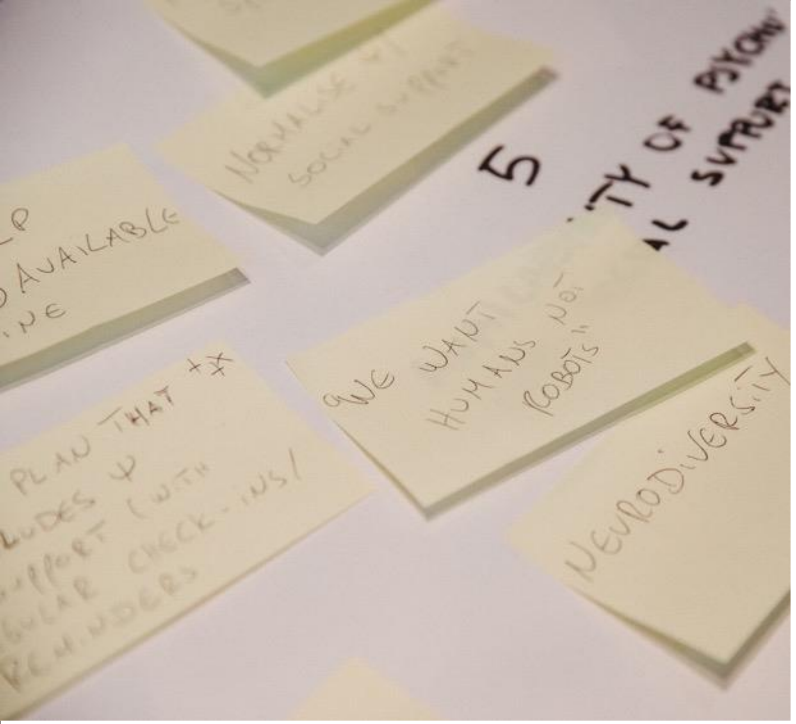
"I'm always being called Mrs. I just want to be called by my name."

Inaccessible communication

"They don't speak like me and you… they say all these big [words] and it makes me feel small because I have to say 'I don't understand'."

External support needs

"Kids play a big role in helping interpret… parents rely on them"



Putting the pieces together

A set of shared themes began to emerge over the course of the Citizens’ Panel sessions, shaped directly by participants through discussion, reflection and collective sense-making. These themes were not pre-defined. Instead, they were developed by the group itself.

During the final in-person session, participants worked in small groups to refine and prioritise these themes using structured activities. This included exercises such as mapping issues by **importance and urgency**, weighing trade-offs, and discussing where action would have the greatest impact. Participants also worked together to brainstorm practical recommendations for how each theme could be addressed in ways that felt realistic and meaningful.

Following the Citizens’ Panel, we engaged with additional PLUS population groups to validate and understand what might be missing from their perspectives. This was to ensure those experiences were also included and directly shaped the strategy.

Together, this iterative process led to the **six themes set out in the following pages**.

Overview: 6 final themes

Make sure people know what's available to them and why it matters	This is about what people know before they enter the system (awareness)	✓ Raise understanding of cancer signs and symptoms, as well as of eligibility criteria and free screening services. ✓ Improve awareness and make sure individuals know what's available and why it matters.
Remove barriers to accessing to care	This is about ensuring no one is excluded because of complex pathways/engagement processes or lack of resources	✓ Simplify processes and strengthen non-digital options (walk-in, phone, face-to-face support) ✓ Use navigators or community-based support models to drive uptake
Improve support after treatment	This is about improving quality of life after treatment	✓ Standardise post-treatment touchpoints, proactive follow-ups, and clear onward support routes ✓ Co-produce culturally relevant survivorship resources

Overview: 6 final themes

Make cancer communications & interactions work for people	This is about how the system communicates and interacts with people once they're in the pathway	✓ Improve the clarity, tone and accessibility of communications from providers and services (letters, verbal explanations, cultural competence of staff) ✓ Ensure that when there are communications/interactions, they are understandable, respectful, and tailored
Embed social and psychological support in care pathways	This is about the integration of mental health and psychosocial support into cancer pathways	✓ Share resources and signposting for tailored counselling and peer support ✓ Strengthen skills of the workforce in identifying and responding to social and psychological need
Open doors to research	This is about expanding fair access to research and clinical trials	✓ Support culturally sensitive research conversations with training for clinicians, and create accessible trial information ✓ Improve data on who is / isn’t being approached for trials, then use it to set targeted inclusion actions

Refinement and validation

Following engagement with the Citizens' Panel and additional PLUS groups, the focus shifted to refining, validating and translating insights into an actionable strategy. This final phase balanced two complementary strands:

1. **Community involvement**, ensuring lived experience continued to shape priorities and expectations for delivery.
2. **NELCA senior team engagement**, ensuring the strategy was realistic, complementary to existing work, and deliverable in practice.

1

Forming an ongoing community partnership

Following the Citizens' Panel, we re-engaged a group of 10 participants to discuss the creation of a **Lived Experience Advisory Panel (LEAP).** This was to move beyond one-off engagements and continue involving diverse community voices and experiences in the implementation of this strategy.

In this session, LEAP reviewed the emerging themes and priorities, discussed how success should be experienced from a community perspective, and helped shape expectations around delivery.

A key part of this phase was discussing what establishing LEAP long-term would look like in practice. In order for it to work, LEAP would need to be enabled and empowered to provide feedback as the strategy is implemented - help to sense-check progress, highlight unintended consequences, and ensure actions align with how the community envisaged change.

Refinement and validation

Following engagement with the Citizens' Panel and additional PLUS groups, the focus shifted to refining, validating and translating insights into an actionable strategy. This final phase balanced two complementary strands:

1. **Community involvement**, ensuring lived experience continued to shape priorities and expectations for delivery.
2. **NELCA senior team engagement**, ensuring the strategy was realistic, complementary to existing work, and deliverable in practice.

2

Refining the strategy with NELCA senior team

We worked closely with NELCA's senior team to translate the six themes into a clear, implementable action plan.

This phase focused on aligning the strategy with existing work programmes, identifying realistic outcomes, and ensuring actions complemented ongoing initiatives across the system.

To support this, NELCA senior staff undertook offline reflection and mapping, reviewing their current and planned activity against the six themes so discussions were informed and concrete.

Building on this preparation, we conducted a series of three structured in-person and online sessions, each designed to progressively refine priorities, actions and implementation approaches. Across these sessions, we also discussed the creation of a LEAP to continue to provide meaningful input during delivery.

Workshop 1 – In-person alignment session

This session brought together the main NELCA team working on health inequalities to reflect on the insights from engagement, share current activity, and discuss the ambition and desired outcomes of the strategy allowing the development of a shared understanding of the strategy direction.

Workshops 2 & 3 – Theme-based action planning (online)

Two online workshops explored each of the six themes in more depth. The NELCA team mapped existing activities, identified gaps, defined desired outcomes, and discussed monitoring and accountability. This ensured each theme was grounded in feasible, system-ready actions.

Engagement in numbers

More than 100
Community members and residents engaged

10
Different VCSEs engaged

7
NEL boroughs represented

The strategy themes:

6 themes

Make sure people know what's available to them and why it matters

This is about what people know before they enter the system (community awareness)

Enablers *(What is going well)*

- Co-produced awareness campaigns with strong engagement.
- Multi-language screening literacy work.
- Clinical animations explaining appointments/treatments.
- Some measurable impact from social media and leaflet drops.

Priority areas *(What we need to focus on)*

- Support efforts to increase registration of people without GPs.
- Improve ability to measure impact beyond simple reach. Accelerate progress on screening uptake and early diagnosis.
- Increase focus on underserved groups (Bangladeshi, ESE Asian, LGBTQIA+, refugees, people with LD).
- Address resource constraints, myths, fear, low literacy and language barriers

Desired outcome *(Where do we want to get to)*

- Empowered population proactively recognising signs and symptoms, engaging with screening and seeking medical advice early.
- Increased understanding of screening pathways (including invitations, letters, timing and next steps) and confidence to act when contacted.
- Measurable rise in awareness of and early diagnosis.
- Reduced inequalities at point of diagnosis.
- Establish a network of community champions across NEL.

Make sure people know what's available to them and why it matters

This is about what people know before they enter the system (community awareness)

Desired outcomes	Activities	Why this matters	How it will be measured	Timeline
• Empowered population proactively recognising signs and symptoms and engaging with screening. • Increased understanding of screening pathways (including invitations, letters, timing and next steps) and confidence to act when contacted. • Measurable rise in awareness of and early diagnosis. • Reduced inequalities at point of diagnosis. • Establish a network of community champions across NEL.	• **Build an outreach-led "champions" model** through trusted VCSE community organisations and local businesses with training + small grants. • **Co-produce and localise campaigns** for underserved communities (explicitly including people with learning disabilities, LGBTQIA+, sex workers, homelessness, refugees/asylum seekers, East & Southeast Asian communities, people not registered with a GP). • **Expand multi-language + low literacy formats** (e.g., clinical animations, easy read, community language content) and ensure these are actively distributed via frontline/community touchpoints rather than just hosted online. • **Create an evaluation approach that goes beyond reach** (link campaign exposure to shifts in intent/knowledge and service actions where feasible).	People are more confident, know what to expect and feel less fearful about engaging with cancer services because information feels relevant, understandable, culturally safe, and actionable, leading to earlier help-seeking and fairer diagnosis outcomes.	• **Knowledge/attitudes**: short pre/post surveys with community partners • **Behavioural proxies**: screening attendance, kit orders, appointments booked after targeted activity • **Equity lens**: monitor uptake/awareness shifts in underserved groups (where data available). • **Process**: number of champions trained; number of co-produced assets; coverage across boroughs/languages.	• **Year 1:** Activities will focus on co-designing and piloting approaches in priority communities, improving links with public health champions, and establishing baseline measures for evaluation. • **Year 2:** The most effective campaign formats will be scaled, with stronger distribution through GP and community touchpoints, alongside embedding a consistent evaluation approach. • **Year 3:** Successful approaches will be sustained as BAU across boroughs, with targeting refined using data and evidence, and progress demonstrated through improved early engagement and diagnosis.

Remove barriers to accessing care

This is about ensuring no one is excluded because of complex pathways/engagement processes or lack of resources .

Enablers *(What is going well)*

- Community outreach (mosques, grassroots grants)
- Simplified diagnostic pathways (colon capsule, Cytosponge, breast pain, HRT bleeding).
- ReciteMe accessibility tools and multi-language support.
- Self-referral pilots improving community diagnostic centre use.

Priority areas *(What we need to focus on)*

- Ability to identify language needs and reasonable adjustments (high “did not attend” (DNA) groups).
- Support national efforts to reduce digital exclusion in GP access and screening invitations.
- Strengthen non-digital access routes and follow-up DNAs.
- Stabilise funding and capacity for outreach.

Desired outcome *(Where do we want to get to)*

- People are aware of initiatives and resources across NEL to support them with wider determinants of health.
- Accessible diagnostics and GP routes for all communities.
- Lower DNA rates and improved pathways for underserved groups.
- People feed advocated/empowered/confident to approach local organisations + embedded neighbourhood/population-based access models (buddy system).

Remove barriers to accessing care

This is about ensuring no one is excluded because of complex pathways/engagement processes or lack of resources .

Desired outcomes	Activities	Why this matters	How it will be measured	Timeline
• People are aware of initiatives and resources across NEL to support them with wider determinants of health. • Accessible diagnostics and GP routes for all communities. • Lower DNA rates and improved pathways for underserved groups. • People feel advocated/empowered/confident to approach local organisations + embedded neighbourhood/population-based access models (buddy system/champions).	• **Fix "reasonable adjustment + language need" identification:** improve capture and sharing of preferred language/format/adjustment needs so screening and appointments can adapt (reducing DNAs). • **Strengthen non-digital access routes**: promote walk-in/phone/face-to-face booking support, plus supported online triage for those digitally excluded. • **Proactive DNA follow-up model**: systematic follow-up to understand "why" and offer tailored rebooking/support (transport, interpretation, advocacy). • **Expand simplified/self-referral diagnostic**s (building on colon capsule/Cytosponge/breast pain/HRT bleeding examples), and ensure comms are in preferred language. • **Support GP registration** for people currently not registered (since it underpins screening invitations).	People can get into the system without friction, leading to fewer missed appointments, less confusion, fewer "drop-offs," and a sense that services are for them, not just for those who can navigate complexity.	• **DNA rates** at key pathway stages (include GP appointments, screening appointments …). • **Access channel mix** (digital vs non-digital booking use) and user feedback on accessibility. • **Uptake of self-referra**l/simplified pathways • **Equity indicators:** breakdown by language need / reasonable adjustments / underserved groups.	• **Year 1:** Pilot improvements to identifying language needs, reasonable adjustments and non-digital access in priority pathways, and establish baseline data on DNAs and access. • **Year 2:** Extend the most effective approaches across additional services and boroughs, improving follow-up for missed appointments and simplifying access routes where feasible. • **Year 3:** Embed successful access and follow-up models into routine practice, using data to maintain focus on groups with persistently higher DNAs and access barriers.

Improve support after treatment

This is about improving quality of life after treatment

Enablers *(What is going well)*

- Strong partnerships (Macmillan, BHRUT, B&D Place, UCLP).
- QoL and personalised care programmes (pan-London).
- CCR QI work in primary care.
- Good engagement with community organisations and support groups.
- High motivation from AHPs and Lead Cancer Nurses

Priority intervention areas *(What we need to focus on)*

- Rebuild trust and cultural sensitivity for underserved groups.
- Smooth the “cliff edge” post hospital treatment.
- Improve information flow between hospital and primary care.
- Secure sustainable funding for support groups and venues.

Desired outcome *(Where do we want to get to)*

- Develop peer support groups and connect/signpost people to relevant orgs.
- Higher QoL survey representation among underserved communities.
- Expanded Patient Partners network.
- Consistent, culturally safe and person-centred post-treatment support.
- Improved and more consistent use of the discharge pack (ensuring it is relevant across communities).

Improve support after treatment

This is about improving quality of life after treatment

Desired outcomes	Activities	Why this matters	How it will be measured	Timeline
• Develop peer support groups and connect/sign-pots people to relevant orgs. • Higher QoL survey representation among underserved communities. • Expanded Patient Partners network • Consistent, culturally safe and person-centred post-treatment support. • Improved and more consistent use of the discharge pack (ensuring it is relevant across communities).	• **Smooth the "cliff edge" transition**: standardise post-treatment touchpoints, proactive follow-ups, and clear onward support routes between hospital and primary care. • **Co-produce culturally relevant survivorship resources** (building on the "Top Tips" type materials and community events). • **Develop a clear, system-wide map of community-based support groups** and strengthen and expand these offers in a sustainable way, so they are accessible, joined-up and used by people after treatment. • **Strengthen patient partner/community** of practice approach to improve reach into underserved groups.	People don't feel abandoned after treatment; instead they experience continuity, confidence, and culturally safe support that helps them manage recovery, long-term impacts, and wellbeing.	• **Quality of Life (QoL) survey** participation and scores, especially among underserved groups. • **National Cancer Experience Survey** (NCES) response rates and subgroup representation. • **Process metrics**: number of support groups sustained; attendance; number of people signposted successfully; uptake of discharge pack. • **Care transitions**: patient-reported "cliff edge" experience (e.g., simple pulse survey at discharge + 3 months after).	• **Year 1**: improve discharge pack + comms; pilot enhanced follow-up in priority communities; complete map of community-based support groups. • **Year 2:** scale support groups + patient partner network growth; improve hospital and primary care information flows. • **Year 3**: embed survivorship support as standard; demonstrate improved equity in QoL/experience survey participation.

Make cancer communications & interactions work for people

This is about how the system talks to people once they're in the pathway

Enablers *(What is going well)*

- New animations (Personalised Cancer Care pathways, treatment, trials).
- Multilingual chatbot and Top Tips materials.
- ReciteMe-enabled website in 100+ languages.
- Improved CPE scores on clarity of diagnosis/discharge.

Priority intervention areas *(What we need to focus on)*

- Cultural-competency training for reception/admin staff.
- Improve information flows between primary and secondary care.
- Tailored support for people with multiple long-term conditions.

Desired outcome *(Where do we want to get to)*

- Routine use of preferred language for screening and appointment communications.
- Fully culturally-competent frontline staff.
- Consistent 24/7 wrap-around support via chatbot.
- Smooth, person-centred, joined-up communication across all care transitions.

Make cancer communications & interactions work for people

This is about how the system talks to people once they're in the pathway

Desired outcomes	Activities	Why this matters	How it will be measured	Timeline
• Routine use of preferred language for screening and appointment communications. • Fully culturally-competent frontline staff. • Consistent 24/7 wrap-around support via chatbot. • Smooth, person-centred, joined-up communication across all care transitions.	• Put in place local processes and resources to support people to understand and act on screening and pathway communications (e.g., locally delivered, accessible communication and follow-up alongside national letters) • Deliver frontline training and practical resources for reception/admin “gatekeepers” (cultural competence + communication skills). • Scale accessible tools already underway (ReciteMe website accessibility; animations; chatbot) and ensure active promotion at key touchpoints. • Improve information flows between primary and secondary care so patients aren’t repeating stories or missing informations at transitions.	People feel respected and understood, know what’s happening next, and can act on information, reducing anxiety, confusion, and avoidable disengagement.	• **CPE / patient experience measures** on clarity of diagnosis/discharge. • **Comms accessibility KPIs**: % letters available in preferred language/easy read; chatbot usage; ReciteMe usage. • **Training completion + confidence shift** for reception/admin staff (pre/post). • **Pathway friction**: complaints/themes analysis; “I didn’t understand what to do next” survey item.	• **Year 1:** Pilot local processes and resources to support understanding of screening and pathway communications, alongside frontline training and accessible follow-up; soft launch chatbot/animations distribution plan. • **Year 2:** scale training; formalise cross-setting information flow improvements; broaden chatbot content and promotion. • **Year 3:** embed across all services; show sustained improvements in experience/clarity measures and reduced communication-related drop-offs

Embed social and psychological support in care pathways

This is about the integration of mental health and psychosocial support into cancer pathways.

Enablers *(What is going well)*

- Peer support roles improving attendance and engagement.
- Psychological support development programme.
- Multi-language psychological support materials.
- Anti-racism reflective sessions for psychosocial workforce.
- High workforce receptiveness (psychologists, CNSs, AHPs)

Priority intervention areas *(What we need to focus on)*

- Strengthen psycho-oncology capacity and resourcing.
- Secure sustainable funding for support worker roles.
- Integrate psychological assessment into diagnostic pathways.
- Develop specialist interventions for severe mental illness and multi-morbidity

Desired outcome *(Where do we want to get to)*

- Peer support roles embedded as BAU.
- Psychological screening in all diagnostic pathways.
- Consistent, equity-focused psychosocial support.

Embed social and psychological support in care pathways

This is about the integration of mental health and psychosocial support into cancer pathways.

Desired outcomes	Activities	Why this matters	How it will be measured	Timeline
• Peer support roles embedded as BAU. • Psychological screening in all diagnostic pathways. • Consistent, equity-focused psychosocial support.	• Formalise peer support/navigation roles beyond a single service area. • Develop/implement psychosocial assessment in diagnostics (including pathways for severe mental illness and multi-morbidity). • Workforce development: strengthen skills in identifying and responding to social and psychological need, including practical psychosocial support, trauma-aware practice and effective referral to support services. • Build the dataset and referral monitoring by age/gender/ethnicity etc. and use it to target inequities.	People are supported as whole humans - with mental health and social needs addressed alongside medical care - which improves engagement, reduces distress, and helps those most at risk of exclusion stay on the pathway.	• **Referral and uptake data** for psychological support services, stratified by demographics • **Attendance/engagement** among groups supported by peer roles • **Patient-reported outcomes**: distress screening completion, wellbeing feedback measures. • **Workforce metrics:** training completion; confidence and competence self-assessment.	• **Year 1:** embed peer role BAU in at least one pathway; agree psychosocial screening protocol; start baseline referral monitoring. • **Year 2**: scale peer roles + screening to additional pathways; strengthen workforce training offer • **Year 3:** standardise across system; demonstrate reduced inequities in access to psychosocial support and improved engagement

Open doors to research

This is about expanding fair access to research and clinical trials

Enablers *(What is going well)*

- Clinical trial animations for low-literacy and multilingual audiences.
- Improved proactive research conversations (CPE survey).
- Stated ambition to remove “guinea pig” stigma.

Priority intervention areas *(What we need to focus on)*

- Address inequalities in clinical trial participation (Black, African, Caribbean groups).
- Provide culturally sensitive communication training for clinicians.
- Clarify missing local initiatives to improve inclusion.
- Improve data on who is/ isn’t being approached for trials.

Desired outcome *(Where do we want to get to)*

- Equitable trial recruitment across all demographics.
- Clinicians confident holding culturally sensitive research discussions.
- Ensure deep-seated barriers to research engagement, such as stigma, are taken into account in trial invitation materials and comms.

Open doors to research

This is about expanding fair access to research and clinical trials

Desired outcomes	Activities	Why this matters	How it will be measured	Timeline
• Equitable trial recruitment across all demographics. • Clinicians confident holding culturally sensitive research discussions. • Ensure deep-seated barriers to research engagement, such as stigma, are taken into account in trial invitation materials and comms.	• Develop accessible versions of generic clinical trials' information (e.g., purpose, what it means to take part in a trial, differences between different phases, animations for low literacy / multilingual audiences, etc.) and distribute via trusted/community + clinical channels. • Train clinicians in culturally sensitive research conversations, including how to communicate "out of scope" eligibility in a respectful way. • Improve data on who is / isn't being approached for trials, then use it to set targeted inclusion actions. • Proactive outreach to groups experiencing trial access inequalities (particularly Black African and Black Caribbean communities), ensuring complementary assets materials explicitly address stigma, concerns about exploitation, and long-standing barriers to research participation.	People can make informed choices about research without fear or stigma, and communities that have historically been excluded get fair access to innovation, research trial options, and better outcomes over time.	• Trial approach + consent rates by demographic group (to directly assess equity). • Patient experience: short measure on whether research was explained clearly/respectfully; stigma perceptions ("guinea pig" narrative). • Clinician confidence/competence pre/post training. • CPE survey items related to proactive research discussions (referenced as an enabler).	• Year 1: establish baseline data; co-design accessible versions of generic clinical trials' information ; pilot clinician training in a few sites. • Year 2: scale distribution + training; introduce consistent approach to approaching patients about trials. • Year 3: embed equitable recruitment practice as BAU; demonstrate narrowing participation gaps and reduced stigma

Governance, Accountability and Ongoing Involvement

Governance, Accountability and Ongoing Involvement

Moving into the delivery of the strategy, the initial focus will be on clarifying accountability and formalising ongoing citizen involvement.

Define role of:

- Theme leads ("champions"), responsible for driving and ensuring accountability for the development and implementation of actions within each theme
- Voluntary, community and social enterprise (VCSE) organisations, communities and residents
- North East London Cancer Alliance staff
- North East London Integrated Care Board
- Primary and secondary care providers
- External partners, including Claremont

Formalise Citizens' involvement:

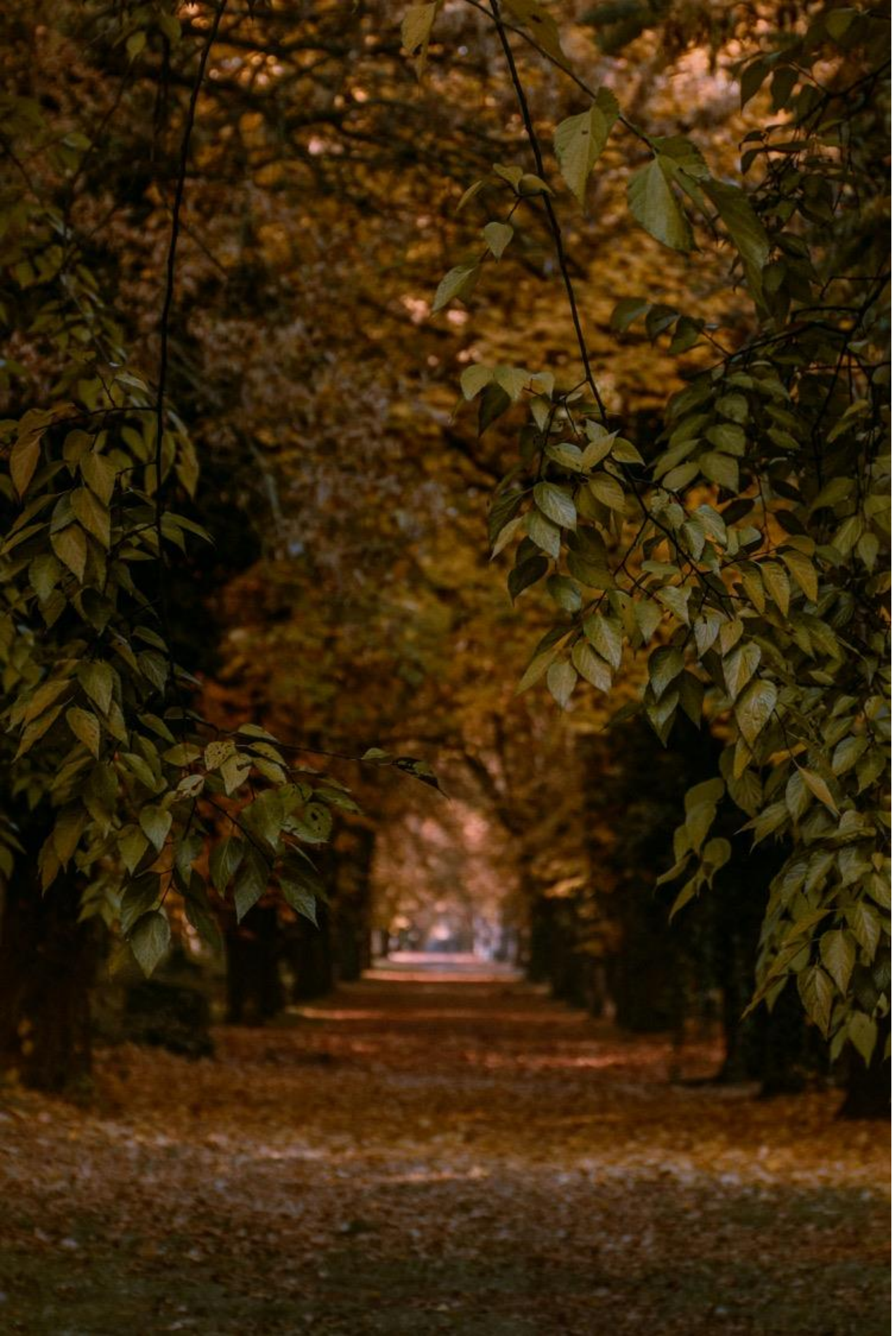
- LEAP (Lived Experience Advisory Panel) involvement and supporting logistics
- Define what meaningful involvement will look like throughout implementation
- Establish clear feedback loops, informed by how LEAP members wish to contribute

Impact and risk

Risk Register

Risk	Likelihood x Impact	Mitigations	Risk score after mitigations
Loss of momentum leading to the strategy becoming "on the shelf".	3x5 = 15	• Regular (e.g., monthly) progress checkpoints linked to governance and reporting cycles. • Name system champions with clear accountability; integrate actions into existing NELCA work programmes.	1x5 = 5
Community disengagement or disappointment if progress feels slow, intangible, or misaligned with expectations.	3x5 = 15	• Establish LEAP with clear purpose and feedback loops. • Communicate progress transparently (including limitations). • Involve LEAP in sense-checking delivery and unintended consequences.	1x5 = 5
Delays in implementation timelines due to system changes, capacity constraints or competing priorities.	4x4 = 16	• Developed a phased delivery approach. • Conduct realistic scoping session(s) with senior NELCA ownership and review of dependencies.	2x4 = 8
Limited monitoring and evaluation capacity leading to weak evidence of impact.	3x4 = 12	• Define a small set of feasible indicators per theme; align evaluation with existing data sources where possible. • Supplement quantitative data with lived-experience feedback via LEAP.	1x4 = 4
Implementation of activities across boroughs is varied, leading to inconsistent progress.	3x4 = 12	• Support local adaptation while monitoring equity of reach and outcomes across boroughs.	2x4 = 8
Over-reliance on short-term funding and pilot activity may limit the strategy's long-term impact and lead to fragmented delivery.	4x4 = 16	• Clear mapping of pilot activity to long-term strategic goals; defined timelines and funding needs; early planning for scaling or BAU adoption; regular review to ensure pilots remain aligned with strategy.	2x4 = 8

Looking ahead



A note on what comes next

What the strategy puts in place

This strategy provides a shared foundation for coordinated action across North East London, bringing together evidence, lived experience and system insight into a clear set of priorities focused on reducing inequalities at every stage of the cancer pathway.

It enables partners to move with more alignment, clarity and confidence - shifting from isolated initiatives to more joined-up, equity-focused approaches across the cancer pathway. Crucially, it creates a common direction that supports collaboration, accountability and sustained progress rather than one-off activity.

How the strategy can evolve

The strategy is intended to be a living framework rather than a fixed endpoint. As activities begin to be implemented, learning from delivery, evaluation data and lived-experience feedback will be used to refine priorities, adapt approaches and strengthen impact over time – particularly where inequalities persist or new gaps emerge along the pathway.

Ongoing involvement from LEAP, alongside regular review through governance structures, will help ensure the strategy remains responsive to emerging needs, system changes and new evidence. This iterative approach supports continuous improvement and helps embed equity-focused ways of working as business-as-usual, ensuring that progress is maintained across the whole pathway rather than concentrated in individual interventions or time-limited initiatives.

The plan for the next few months

Involving external stakeholders

Over the next phase, focus will shift from strategy development to communication and early implementation and mobilisation across the system.

This will involve engaging key external stakeholders including borough ***public health teams, NHS providers, VCSE partners and community organisations*** to align activity with the six strategic themes.

Engagement will prioritise organisations already delivering related work, to avoid duplication and build on existing strengths.

Early conversations will focus on clarifying roles, identifying opportunities for collaboration, and ensuring that emerging actions are feasible within current system constraints.

Claremont support

Claremont will continue to work with NELCA, providing regular strategic and delivery support over the next year.

This will include support with implementation planning, sense-checking emerging activity against the strategy, advising on evaluation and learning approaches, and helping to maintain momentum through structured check-ins.

Claremont will also support facilitation where needed, particularly around alignment and ongoing involvement of LEAP.

Lived Experience Advisory Panel

LEAP will play a key role in supporting the transition from strategy to delivery.

While the exact role and responsibilities for this group are still being confirmed, we envision LEAP to act as an ongoing sounding board, helping to sense-check whether implementation reflects the priorities, expectations and experiences expressed during the Citizens’ Panel and wider engagement.

LEAP members may be involved in reviewing progress, highlighting unintended consequences, and advising on how activity is being experienced by communities.

Appendix

The Citizens' Panel:

Demographic characteristics

Ethnic Group	
White	13
Asian or Asian British	9
Black, Black British, Caribbean or African	6
Mixed or Multiple ethnic groups	2

Age	
25–34	6
35–44	6
45–54	9
55–64	5
65-74	4

Physical disability	
Yes	9
No	21

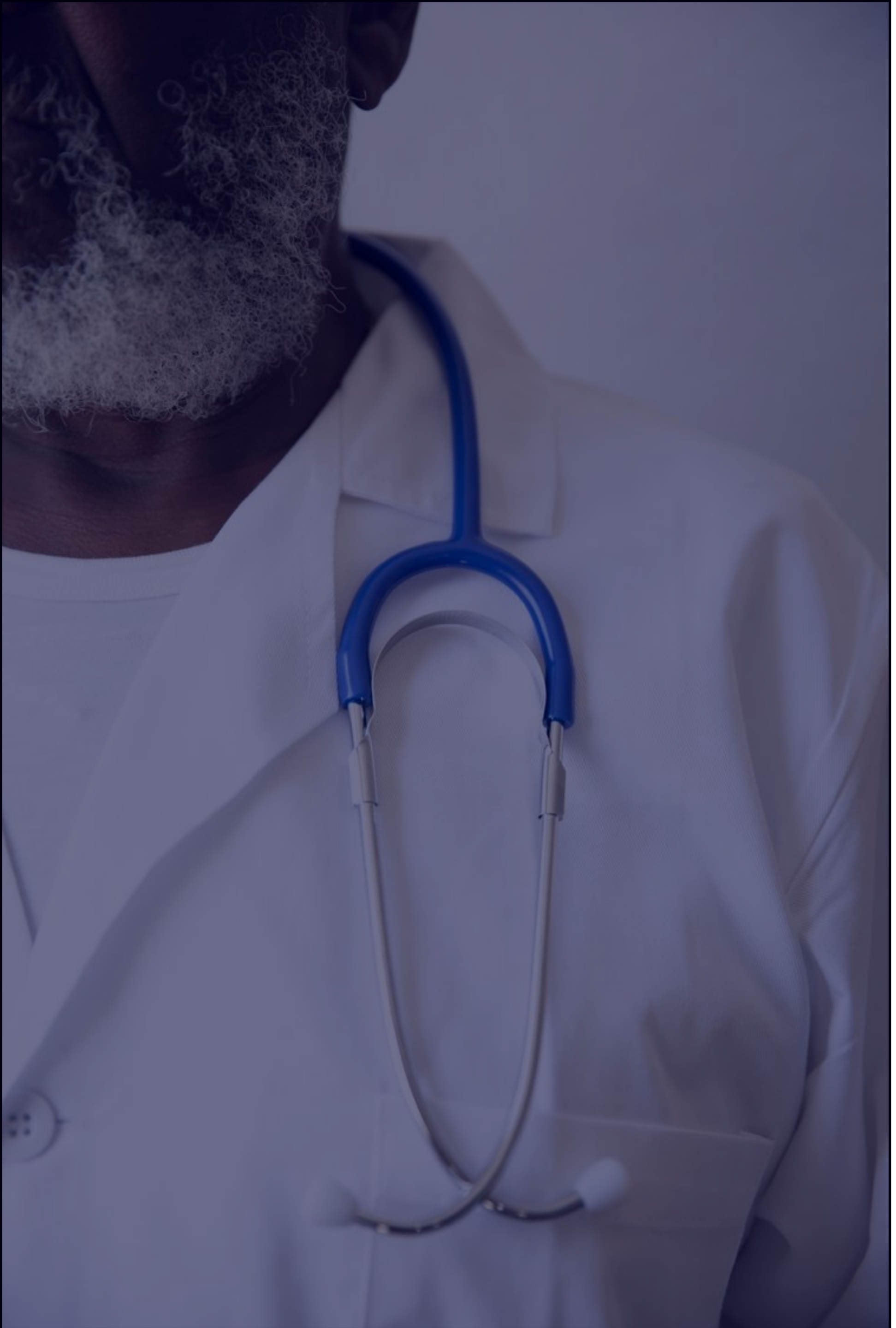
The Citizens' Panel:
Socioeconomic characteristics

Employment status	
Employed (full-time or part-time)	15
Unemployed	5
Retired	4
Unable to work due to illness/disability	3
Carer	2
Career break due to having a child	1

Housing situation	
Owner-occupied (owned outright/mortgage)	11
Private rented	6
Social housing (council/ housing association)	7
Living with family/parents	3
Temporary/insecure housing	3

Financial situation	
I get by, but it's often tight	20
I am financially comfortable	6
I struggle to afford necessities	3
OK at the moment	1

Receiving benefits	
Not receiving benefits	14
Means-tested benefits	11
Disability-related benefits	5



The Citizens' Panel:

Cancer-related experience and healthcare use

NHS use	
NHS use in the past 5 years	30

Cancer-related experience	
Have/had a cancer diagnosis	6
Carer / family member of someone with cancer	12

Screening attitudes

	Yes	**No**	**I don't remember**
Attended screening	20	10	/
Declined screening	7	19	4

NHS
North East London
Cancer Alliance

Web: www.nelcanceralliance.nhs.uk

Facebook: @NelCancerAlliance

Instagram: @CancerNEL

LinkedIn: https://www.linkedin.com/company/north-east-london-cancer-alliance/

Reddit: https://www.reddit.com/user/CancerNEL/

TikTok: @nelcanceralliance

WhatsApp: https://bit.ly/4oSF8Ku

X: @CancerNel

YouTube: https://www.youtube.com/@nelcanceralliance