Equality Impact Assessment Record

New 10-year Cancer Strategy for Scotland

May 2023

Scottish Government
Riaghaltas na h-Alba

Equality Impact Assessment Record

New 10-year Cancer Strategy for Scotland

Policy/Strategy
Cancer Strategy for Scotland 2023-2033

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Is this new policy or revision to an existing policy?
New strategy to follow conclusion of current plan: Recovery and redesign: cancer services - action plan

1. Screening

1.1 Policy Aim

Background
Cancer remains one of Scotland's single biggest health challenges, representing the largest burden of disease. The number of deaths from cancer has increased over the last decade, mainly due to the increasing number of cancer cases.

There have been huge changes in the understanding of the disease and how to prevent, diagnose and treat it better. Increasing cancer survival and the ageing population of Scotland means that the population of survivors is likely to grow substantially in the coming decades, leading to increased demand on the health service.

The current national cancer plan 'Recovery and Redesign: An Action Plan for Cancer Services' was published during the first year of the Covid-19 pandemic and set out a number of priorities to pave the way for remobilisation and recovery of cancer services. This plan comes to an end in March 2023 and a new strategy is required to continue with and improve on the services available to all those affected by cancer, which includes people living with cancer and their families and carers, as well as the workforce.

The new strategy will be in place for 10 years and will be underpinned by three consecutive action plans.

Policy objectives
Our 10-year vision is that: “More cancers are prevented, and our compassionate and consistent cancer service provides excellent treatment and support throughout the cancer journey, and improves outcomes and survival for people with cancer”.

The new strategy will provide a common direction to all affected by cancer, defining a clear strategic intent - **improve cancer survival and provide excellent, equitably accessible, care** - along with a range of priority ambitions to help meet that aim.

The initial three-year period of the strategy will focus on stabilising systems and services, maintaining cancer as a priority while recovery from the Covid-19 pandemic and careful management of finances continues across all health systems. This will be followed by a reform of services and approaches to cancer control, recognising opportunities for change and better meeting strategic ambitions. Towards the end of the strategy, progress will be accelerated to truly transform services, embracing innovation and digital opportunities to best deliver services and support patients.

Throughout the lifetime of the strategy, there will be a focus on those cancer types that are the largest burden and have poorer survival. These include lung, breast and bowel cancer and other less-survivable cancers.

We recognise that a skilled, compassionate and valued workforce is critical in delivering treatment and care to those facing cancer. Recognising the potential of integrated and collaborative working, technological advances, and transformation of service, we will:

- aim to ensure we have the right people in the right place at the right time
- provide career opportunity and appropriate training, and
- support and nurture our staff.

Person-centred care will be key to successful delivery. We will continue to develop and implement support through a single point of contact (SPOC) for each person facing cancer, recognising that treatment and care that reflects what matters personally to people with cancer are as important as clinical outcomes. This includes equal access to services; support for non-clinical needs; and regular and reassuring information and communication. Patient voice and experience will be sought and listened to on a regular basis throughout the lifetime of the strategy, to provide feedback and co-design services where appropriate. Additionally, the Realistic Medicine approach to healthcare should be fundamental to all cancer care. By encouraging healthcare professionals to consider and discuss the impacts that a treatment may have on each individual and their loved ones, cancer patients will continue to receive compassionate care.

There is a broader aim to reduce inequalities which disadvantage people and limit their chance to live longer, healthier lives. Inequalities in cancer survival may be due to specific factors, such as age, whilst others may be more systemic, such as deprivation or geographical difference. By addressing the socio-economic causes of inequalities within society, as outlined in the Programme for Government, we will focus actions in areas and communities most in need to improve outcomes. We will drive to improve screening uptake and thus reduce late stage cancer incidence, by targeted screening and use of new methodologies. We will also focus on enabling more equal access to diagnostic and treatment services as well as clinical trials, wherever any patient lives, as this is crucial to ensuring optimal outcomes and development of and access to new treatments. Whilst travel may be required to access specialist treatment and trial sites, no-one will be disadvantaged due to their financial or geographical position, with support available where appropriate.

To support service delivery and re-design, data collection and intelligence will be used to inform decision-making, policy, and future planning, as well as for audit and improvement purposes and potentially measuring inequalities. We aim to develop a more integrated intelligence system so that all data captured will be a national asset in terms of service provision, planning and costs; clinical use; and measuring outcomes.

By tackling risk factors, such as smoking, obesity, excess alcohol use and physical inactivity, and implementing prevention strategies, we recognise that a significant proportion of cancers can be prevented. Healthy living will be promoted and encouraged through other plans addressing these risks with the aim of both reducing the risk of developing cancer and enhancing outcomes, if a diagnosis of cancer is made. Pre-treatment interventions, including prehabilitation, will support this approach to improve quality of life, maximise treatment rates, and minimise side effects of treatment.

Beyond prevention, earlier and faster diagnosis plays a fundamental role in cancer control and is vital in further improving cancer survival rates in Scotland. For example, innovation and redesign of diagnostics services, such as further roll-out of Rapid Cancer Diagnostic Services, will enable timely access to tests, whilst raising public awareness and encouraging uptake in screening programmes will also help address this ambition.

The provision of safe, effective treatments and cancer medicines is necessary in improving outcomes and quality of life. A range of treatments and medicines will continue to be offered, depending on diagnosis, safety, and effectiveness. New ways of working, including community-based treatment and embracing new technology, will continue to be developed and matched by available resources to support implementation. We will strive to embrace innovation and technological advances. The Centre for Sustainable Delivery (CfSD), established to pioneer and deliver new, better, and more sustainable service delivery, will be particularly important in driving innovation.

To ensure quality of life during and after treatment, rehabilitation, palliative, supportive, and end-of-life care are required. A personalised approach to rehabilitation is key to meeting the needs of each individual, embedded within their pathway of care and aligned with the Once for Scotland Rehabilitation Approach (2022). When needed, high-quality palliative care, care around death, and bereavement support will be available, based on the needs and preferences of the patient and their families and carers.

The Scottish Cancer Network (SCN) will be at the heart of our strategic ambitions. The SCN will continue to be at the forefront of defining clinical management pathways for cancer, from diagnosis, treatment, and care through to the end of life. They will set out clinically agreed best practice in all these areas, assuring patients of common standards of care regardless of where they are in the country.

Rationale for government intervention

Cancer control (decreased incidence and mortality and increased survival) has improved over time, but Scotland still has lower survival rates and improvements have not been as rapid as in other comparable countries.

It is therefore important that the government keeps pace with all the ways to better control and manage cancer within the population. The scope of possible interventions is wide-ranging, for example:

- doing what matters to patients, and building care and treatment around them
- introducing new diagnostic and treatment techniques
- continuing the search for better scientific understanding of the disease.

Cancer control is important in meeting our National Outcome that **we are healthy and active**, through providing treatment and care for those with cancer, but also through population measures that will help prevent cancers in the future. These will be addressed through continuation of screening programmes and public health interventions targeted at specific preventable risk factors.

Governance and direction will be overseen by the Scottish Government, with a national oversight group owning the strategy and associated action plans, and responsibility for reviewing progress against them. Beyond this, responsibility for delivery of actions will vary from national to regional and local levels. The 'Once for Scotland' approach will be a core principle with national decisions and implementation made wherever possible for work that is universally applicable across Scotland. The cancer action plans underpinning the strategy will be owned and driven by relevant governance structures, recognising the breadth of responsibilities involved in delivering the comprehensive set of ambitions.

In addition, delivery of this strategic ambition will be interdependent with a range of other plans in health and beyond, including:

- NHS Recovery Plan (2021)
- National Workforce Strategy for Health and Social Care (2022)
- Digital Health & Care Strategy (2021)

1.2 Who will it affect?

Those people in the adult population who engage with cancer services, including population screening programmes, will be affected. This includes those who receive a cancer diagnosis, for those who are referred on a suspicion of cancer, and for those that are captured in the national screening programmes. In addition, this strategy affects individuals who are indirectly impacted by cancer, namely family, including parents and carers, of individuals who have received a cancer diagnosis. Wider groups affected by the plan include healthcare professionals, NHS boards, national bodies, and the Third Sector.

1.3 What might prevent the desired outcomes being achieved?

Implementation of the new cancer strategy and accompanying action plans will aid continuity, development, improvement of, and innovation within cancer services across Scotland. Equitable access and consistent and efficient delivery of care and treatment will be available to all patients with cancer, regardless of where they live. Failing to implement the strategy would likely lead to inconsistent and inequitable access to cancer care and treatment and, in turn, poorer cancer outcomes. This would likely have a negative impact on those people who may be more vulnerable to certain types of cancer and/or their recovery, for example in terms of their age, sex or race/ethnicity.

Although not protected characteristics, it is well-evidenced that health inequalities are directly linked to social deprivation and geographical location. The new strategy will endeavour to ensure that equitable access to timely treatment, care and support will be provided to all patients facing cancer in Scotland, regardless of their financial position or where they live.

1.4 Initial assessment – is an EQIA required?

As a diagnosis of cancer could affect anyone in the Scottish adult population, it is considered necessary to conduct an EQIA.

2. Framing

2.1 Results of framing exercise

Consultation on draft Strategy

Within Government
We have engaged internally with other policy teams. Included in these discussions were:

- Chief Scientist Office
- Chief Medical Officer
- Clinical Priorities
- Openness and Learning
- Primary Care
- Older people
- Palliative Care
- Pharmacy and Medicines
- National strategies/specialist healthcare
- Earlier Diagnosis
- Diagnostics
- Genomics
- Mental Health
- Health Inequalities
- National Screening programmes
- Population health teams – diet/obesity, alcohol, smoking etc.
- Workforce (recruitment, modelling, care and wellbeing, pay, retirement)
- Chief Nursing Officer/Allied Health Professionals
- Person-centeredness and participation
- Realistic Medicine
- Infrastructure Spend
- Health Technologies

We have also engaged with governance groups aligned to the current national cancer plan and other stakeholder bodies, including:

- National Cancer Recovery Group
- Cancer Data Programme Board
- Detect Cancer Early Programme Board
- Systemic Anti-Cancer Therapy Programme Board
- Radiotherapy Programme Board
- National Cancer Quality Steering Group
- Scottish Primary Care Cancer Group
- Endoscopy and Urology Diagnostic Group
- Scottish Cancer Network
- NHS Education for Scotland
- Healthcare Improvement Scotland
- Diagnostics in Scotland Steering Group

These groups are made up of leading clinicians and service managers from across NHS Scotland, as the main delivery body for the strategy and action plan.

In addition we have engaged directly with the following Health Boards and groups: National Services Division of NHS National Services Scotland, Public Health Scotland, Centre for Sustainable Delivery; and territorial Boards through the Scottish Association of

Medical Directors, Board Chief Executives, Directors of Pharmacy, and Directors of Planning, as well as the Cancer Managers' Forum and the Regional Cancer Networks.

Public Consultation
A public online consultation was open from 12 April to 7 June 2022. Views were sought on areas to prioritise in relation to cancer prevention, management and care: New cancer strategy: consultation - gov.scot (www.gov.scot)

257 responses were received - 156 responses were submitted by individuals and 101 responses submitted by organisations across various sectors.

The responses were independently analysed and the analysis was published on 17 November 2022: Cancer strategy: consultation analysis - gov.scot (www.gov.scot)

The responses, where consent was given, were also published on 17 November 2022: Cancer strategy: draft vision, aims and priority areas - Scottish Government - Citizen Space (consult.gov.scot)

Business/Third Sector
We have consulted with the Scottish Cancer Coalition (SCC) and the Less Survivable Cancers Taskforce (LSCT) on the new Cancer Strategy. The SCC is a partnership of third sector organisations dedicated to improving cancer services and outcomes for patients in Scotland. The LSCT brings together six charities supporting patients who have these specific types of cancer.

We also consulted with a number of other third sector organisations not represented on the SCC, including:

- CanRehab Trust
- Marie Curie
- CLL Support Association

2.2 Extent/Level of EQIA required

The policy may potentially impact on several of the protected characteristics to some extent so a full EQIA is required.

3. Data and evidence gathering, involvement and consultation

Equality evidence finder
Health Inequalities in Scotland (Nov 2022)
Long-term monitoring of health inequalities: March 2022 report
Reducing health inequalities (PHS, 2021)
Cancer Incidence in Scotland (PHS, 2022)

[NOTE: Temporary pause of all adult National Screening Programmes on 30 March 2020; however they were resumed during Summer/Autumn 2020]

Characteristic: Age

Evidence Gathered and Strength/Quality of Evidence

- In mid-2021, the population of Scotland was estimated to be 5,479,900, with 4,568,378 aged 16 and over.[1]
- Age-related risk:
  - Risk of cancer diagnosis increases with age in both sexes.
  - The overall number of cancers increased with age to a peak at 70–74 years, and declined thereafter as the size of the older population decreased.
  - For some cancer sites, risk differs by age group, eg. cervical cancer, where the highest risk is in the younger age groups.[2]
  - There are no data gaps.
- Modifiable risk factors and age:
  - In 2019, the highest proportions of self-reported current smokers were recorded among those aged 25-54 (22%); the lowest smoking prevalence was among those aged 75 and over (7%).
  - In 2019, 66% of adults in Scotland (aged 16 and over) were overweight, including 29% of adults who are classed as obese.
  - 65-74 year-olds have the highest percentage of overweight individuals (79%) and obese individuals (37%).
  - The older a person is, the more likely they are to develop non-melanoma skin cancer – in 2016-2018, 48% of all new non-melanoma skin cancer cases in the UK were diagnosed in people aged 75 and over. In 2018-19, 918 deaths were attributed to non-melanoma skin cancer in the UK.
  - Whilst older age is the main risk for cancer, other risk factors in relation to melanoma include intermittent UV exposure (potential greater impact on young people and children), skin type, family history.[3]
- Comments from consultation analysis (p73):
  - Younger people are disadvantaged throughout the cancer pathway as they are often less aware of symptoms
  - Older cancer patients are less of a priority when it comes to cancer care[4]
- NHS Workforce:
  - At end September 2021:
    - 27.9% of the NHS Scotland workforce (WTE) were aged 34 years and under
    - 49.2% were aged between 35 and 54 years
    - 22.9% were aged 55 years and over[5].

Were any Data Gaps Identified?

No data gaps identified – workforce can be broken down by specialism

[1] National Records of Scotland - Mid-2021 Population Estimates Scotland | National Records of Scotland
[2] Cancer Incidence in Scotland (publichealthscotland.scot)
[3] Equality Evidence Finder, Cancer Incidence in Scotland (publichealthscotland.scot), Non-melanoma skin cancer statistics | Cancer Research UK
Melanoma skin cancer risk | Cancer Research UK
Scottish Health Survey
[4] Cancer strategy: consultation analysis - gov.scot (www.gov.scot)
[5] NHS Education for Scotland 2021 – Official Statistics on the workforce of NHS Scotland, NHS Scotland workforce | Turas Data Intelligence

Characteristic: Disability

Evidence Gathered and Strength/Quality of Evidence
Risk factors in 2019:

- smoking rates were higher (26%) among adults living with a limiting long-term health condition compared to those living with no such condition (13%).
- 38% of adults with a limiting long-term condition in Scotland were obese, compared to 31% of those with a non-limiting condition, and 23% of those without a condition[6]
- Disabled people are more likely than non-disabled people to live with socio-economic deprivation.[7]
- 1.1% of NHSScotland staff in 2021 reported having a disability.[8]

Were any Data Gaps Identified?
No

Characteristic: Sex

Evidence Gathered and Strength/Quality of Evidence

- In mid-2021, of the 4,568,378 people in Scotland aged 16 and over:
  - 2,2054,79 were male
  - 2,362,899 were female[9]
- Risk of incidence between sexes:
  - Risk of majority of cancers is higher in men than women.
  - There are more cases of lung cancer, the most common cancer overall in Scotland, in females than males[10]
- Cancer sites:
  - Most common cancers in females were breast, lung, and colorectal cancers (54% of all female malignancies).
  - Most common cancers in males were prostate, lung, and colorectal cancers (50% of all male malignancies).[11]
- Comments from consultation analysis (p74):
  - Women are treated unequally within the cancer system by being misdiagnosed due to not being taken seriously about symptoms
- In March 2021, 79% of the NHS workforce were female, 213% were male[12].

Were any Data Gaps Identified?
No data gaps identified

Characteristic: Pregnancy and Maternity

Evidence Gathered and Strength/Quality of Evidence

- Cancer during pregnancy is rare and rarely affects the growing foetus.[13]
- While it is possible that being pregnant could delay a cancer diagnosis, due to commonality of pregnancy and cancer symptoms (eg. bloating, headaches, breast

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[6] Scottish Health Survey
[7] Scottish Household Survey: publications
[8] Scottish Household Survey: publications
[9] National Records of Scotland - Mid-2021 Population Estimates Scotland | National Records of Scotland
[10] Cancer Incidence in Scotland (publichealthscotland.scot)
[11] Cancer Incidence in Scotland (publichealthscotland.scot)
[12] Cancer strategy: consultation analysis - gov.scot (www.gov.scot), NHS Education for Scotland 2021 - Official Statistics on the workforce of NHS Scotland
[13] Cancer During Pregnancy | Cancer.Net

changes, rectal bleeding), it is also possible that antenatal care for pregnant women could uncover cancer (eg.an ultrasound could identify ovarian cancer).[14]
- [Cervical screening is paused during pregnancy since it is more difficult to obtain a clear result]
- Breast cancer is the most common cancer found during pregnancy, followed by cervical cancer; gestational trophoblastic disease; Hodgkin/non-Hodgkin lymphoma; melanoma; thyroid cancer.

Were any Data Gaps Identified?
No data gaps identified

Characteristic: Gender Reassignment

Evidence Gathered and Strength/Quality of Evidence
- Participation in cancer screening for female and male cancers may be hard to access for transsexual persons.[15]
- [In terms of s.7 of the Equality Act 2010, a transsexual person is a person who has the protected characteristic of gender reassignment, where the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.]
- In terms of gender identity, participation in cancer screening for (sex-based) female and male cancers may be hard to access for trans men and trans women respectively. This is also applicable to non-binary people.
- Regarding cervical cancer screening, Scotland's National Cervical Screening Programme works closely with the National Gender Identity Clinical Network Scotland to improve access to cervical screening services for transmen and non-binary people who have a cervix. This work has included the development of dedicated information resources for trans and non-binary people on screening, and CPD modules training in sample taking for this group. Additionally, there has already been work to amend cervical screening recall processes to be gender inclusive.
- Comments from consultation analysis (p74):
    - transgender patients… disadvantaged due to a lack of resources and advice about screening …
    - may be reluctant to engage with cancer services[16]

Were any Data Gaps Identified?
- Although research is limited, evidence so far suggests that, in general, being trans or non-binary should not affect diagnosis or treatment of cancer. Therefore no data gaps have been identified.
- Patients presenting with symptoms regardless of gender reassignment status or gender identity will be referred into the appropriate cancer pathway.
- The Scottish Cancer Referral Guidelines were updated in 2019 which supports GPs.

[14] Being pregnant at diagnosis | Cancer in general | Cancer Research UK
[15] Gender Reassignment - NHSGGC, National Gender Identity Clinical Network for Scotland
[16] Cancer strategy: consultation analysis - gov.scot (www.gov.scot)

Characteristic: Sexual Orientation

Evidence Gathered and Strength/Quality of Evidence

- Scottish Surveys Core Questions 2019 showed around 95% of adults identified as straight in 2019, around 3% of adults self-identified as lesbian, gay, bisexual or other.[17]
- In 2018, an estimated 94.6% of the UK population aged 16 years and over (53.0 million people) identified as heterosexual or straight[18]
- Past experience of discrimination or poor treatment can mean that LGBTQ people are less likely to access some key health services, eg. GP services and screening programmes, but are more likely to use A&E and minor injuries clinics.[19]
- 58.7% of NHS staff in 2021 reported being heterosexual; 2.1% reported being lesbian, gay bisexual or other; 39% declined to respond or were not known.[20]

Were Any Data Gaps Identified?

- Although research is limited, the evidence so far suggests that, in general, sexual orientation should not affect diagnosis or treatment of cancer. Therefore no data gaps have been identified.
- Patients presenting with symptoms regardless of sexual orientation will be referred into the appropriate cancer pathway.
- The Scottish Cancer Referral Guidelines were updated in 2019 which supports GPs.

Characteristic: Race

Evidence Gathered and Strength/Quality of Evidence

- There are racial and racialised inequalities with disparities in cancer rates across different ethnicities.[21] For example:
- In all broad ethnic groups, lung, bowel, breast and prostate cancers were the 4 most common cancer types.
- Asian and Black people as well as people with mixed ethnic backgrounds have lower rates of cancer for the majority of cancer types, compared with White people.
- A small number of cancer types are more common in certain ethnic groups compared with White people, such as myeloma and stomach cancer in Black people; gallbladder cancer in Black and Asian people; and prostate cancer in Black men.
- Black and Asian people have far lower rates of melanoma skin cancer than White people.
- People from minority ethnic groups are also more likely to be diagnosed at a later stage, in part due to poorer screening uptake, and have lower survival for some cancer types.[22]
- Additionally, there is less awareness of genetic cancer services among some ethnic groups. A systematic review of what affects ethnic minority (Black African, White

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[17] Scottish Government – Equality Evidence Finder
[18] Office for National Statistics - Sexual orientation, UK: 2018
[19] LGBT populations and mental health inequality – 2018 report, Stonewall's LGBT in Britain Health Report - 2018
[20] NHS Education for Scotland 2021 – Official Statistics on the workforce of NHS Scotland
[21] Delon, C., Brown, K.F., Payne, N.W.S. *et al.* Differences in cancer incidence by broad ethnic group in England, 2013–2017. *Br J Cancer* **126**, 1765–1773 (2022). https://doi.org/10.1038/s41416-022-01718-5
[22] Niksic, M., Rachet, B., Warburton, F. et al. Ethnic differences in cancer symptom awareness and barriers to seeking medical help in England. Br J Cancer 115, 136–144 (2016). https://doi.org/10.1038/bjc.2016.158

Irish, and South Asian) people's access to genetic cancer services found that there was low awareness of these services amongst these groups.[23]

- We know that cancer is more common in more deprived populations in Scotland. In 2017-20, people from non-white minority ethnic groups were more likely to be in poverty compared to those from white ethnic groups, and may be more at risk from cancer.[24]
- Comments from consultation analysis (p73):
  - reluctancy to engage with cancer services and seek screening
  - mistrust of practitioners based on previous negative experiences
  - view cancer as a 'taboo' subject
- 68.3% of NHS staff in 2021 were white; 3.8% were mixed ethnicity, Asian, black or other; 27.9% declined to respond or were not known.[25]

Were Any Data Gaps Identified?
There are no data gaps.

Characteristic: Religion or Belief

Evidence Gathered and Strength/Quality of Evidence
In March 2021, 35.9% of NHS staff reporting having a religion, 28.2% had no religion, 35.9% declined to respond or were not known.[26]

Were any Data Gaps Identified?
Patients presenting with symptoms regardless of religious belief will be referred into the appropriate cancer pathway.

The Scottish Cancer Referral Guidelines were updated in 2019 which supports GPs.

Characteristic: Marriage or Civil Partnership
(the Scottish Government does not require assessment against this protected characteristic unless the policy or practice relates to work, for example HR policies and practices - refer to Definitions of Protected Characteristics document for details)

4. Assessing the impacts and identifying opportunities to promote equality

Do you think that the policy impacts on people because of their age?

Age	Impact	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation	Positive	Through our Detect Cancer Earlier (DCE) campaign, we will develop a public awareness raising campaign based around possible signs, symptoms and risk factors of cancer to facilitate and encourage help-seeking behaviours for anyone concerned about their health. However, we recognise that any public communications should be clear, easy to understand,

[23] Allford A, Qureshi N, Barwell J, Lewis C, Kai J. What hinders minority ethnic access to cancer genetics services and what may help? Eur J Hum Genet. 2014;22(7):866. doi:10.1038/EJHG.2013.25
[24] Poverty in Scotland - Poverty & Inequality Commission (povertyinequality.scot), Deprivation and cancer inequalities in Scotland (CRUK)
[25] Cancer strategy: consultation analysis - gov.scot (www.gov.scot), NHS Education for Scotland 2021 – Official Statistics on the workforce of NHS Scotland
[26] NHS Education for Scotland 2021 – Official Statistics on the workforce of NHS Scotland

		and unambiguous in their meaning, and across a variety of platforms, both digital and non-digital. Work will continue with Health Boards to ensure patients are seen and treated on a clinical basis, with no bias against protected characteristics and patients being treated purely on a clinical basis. The use of Scottish Cancer Referrals Guidelines will be encouraged through the Scottish Primary Care Cancer Group. We will continue to support the Scottish Cancer Network, hosted by NHS National Services Scotland. This is a dedicated national resource to support and facilitate a 'Once for Scotland' approach to cancer services which will assist in enabling equitable access to care and treatment across Scotland. Our vision for a sustainable, skilled workforce where all staff in cancer services are respected and valued will act to eliminate discrimination, regardless of age, disability, sex, pregnancy/maternity, race, religion, gender reassignment status, or sexual orientation.
Advancing equality of opportunity	positive	We will promote healthier lifestyles and so reduce the risk of cancer through strategies and plans such as: •the Tobacco Control Action Plan (2018), •the Diet and Healthy Weight Delivery Plan including support for families to make healthier choices; •the Active Scotland Delivery Plan that supports work to reduce the risk of cancer and contributes to prehabilitation and rehabilitation; and •the Alcohol Framework 2018 that guides actions to reduce alcohol consumption, including increasing awareness of the link between alcohol and cancer. Earlier and faster diagnosis will be vital to further improve cancer survival rates in Scotland: •screening will continue to keep up with technological innovation and emerging clinical evidence to ensure everyone has access to the most effective screening tools possible, including a new national screening programme for those at higher risk of lung cancer •HPV vaccination will be offered to all girls and boys in the first year of secondary school, and continue to reduce cervical cancer incidence •further roll-out of Rapid Cancer Diagnostic Services will ensure early diagnosis or exclusion of cancer for more people in Scotland, which is essential to reduce anxiety for people with cancer symptoms •research and innovation will also be key in improving earlier diagnosis rates. The cross-cutting ambition to eradicate inequalities addresses both specific and systemic aspects of inequality. The strategy

		acknowledges a broad, societal approach as well as targeting specific actions to disadvantaged groups along the cancer pathway. For example: • Protected characteristics such as sex, age, and race/ethnicity can influence cancer risk, access to services, and outcomes. • Scotland's geography leads to challenges in providing equity of access in rural and island communities - improving the accessibility of services through the siting of services, providing transport, ensuring affordability, and increasing digital opportunities are all measures likely to reduce inequalities. • We recognise that certain groups such as older people, disabled people, lower income people, and those living in rural communities are more likely to experience digital exclusion so it will be important to keep abreast of groups most likely to be impacted by digital exclusion in order to mitigate the potential impacts. Person-centred care is key to advancing equality of opportunity as it enables all people with cancer to make informed choices about their own care and treatment, acts to reduce potential unforeseen harms, and ensures individual dignity, compassion and respect. The needs and preferences of each person with cancer is at the forefront of care, rather than the 'patient' or the 'cancer'. Mental health support, across low-level to intensive needs and from diagnosis and treatment through palliative to end-of life care, will be made available and accessible to people with cancer and their support networks. This will ensure that emotional and psychological needs will be met for all people facing cancer diagnosis, treatment and care. Our vision for a sustainable, skilled workforce where all staff in cancer services are respected and valued, and have equal opportunities to continue to work throughout their career.
Promoting good relations among and between different age groups	No impact	

Do you think that the policy impacts disabled people?

Disability	Impact	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation	positive	Our vision for a sustainable, skilled workforce where all staff in cancer services are respected and valued will act to eliminate discrimination, regardless of disability.

		The expansion of certain services, for example the use of digital technologies, should make for better accessibility. However, we recognise that centralisation of specialised services, which is necessary in terms of some cancer treatments and clinical trials, may incur the need for greater travelling distance, expense, and potential separation from family and carers.
Advancing equality of opportunity	positive	See detail under **Age**
Promoting good relations among and between disabled and non-disabled people	No impact	

Do you think that the policy impacts on men and women in different ways?

Sex	**Impact**	**Reasons for your decision**
Eliminating unlawful discrimination	positive	See detail under **Age**
Advancing equality of opportunity	positive	As certain cancers only present in male or female organs, services will end up being specific where appropriate.
Promoting good relations between men and women	none	

Do you think that the policy impacts on women because of pregnancy and maternity?

Pregnancy and Maternity	**Impact**	**Reasons for your decision**
Eliminating unlawful discrimination	positive	See detail under **Age**
advancing equality of opportunity	positive	See detail under **Age**
Promoting good relations	No impact	

Do you think your policy impacts on transsexual people?

Gender reassignment	**Impact**	**Reasons for your decision**
Eliminating unlawful discrimination	positive	All individuals will be screened and tested for cancer based on their anatomy/biology rather than their gender/gender identity. For example, all those with a cervix are offered cervical cancer screening. Patients presenting with symptoms will be referred into the appropriate cancer pathway; the Scottish Cancer Referral Guidelines were updated in 2019 which supports GPs.
Advancing equality of opportunity	positive	The cross-cutting ambition to eradicate inequalities addresses both specific and systemic aspects of inequality. The strategy acknowledges a broad, societal

		approach as well as targeting specific actions to disadvantaged groups along the cancer pathway. Person-centred care is key to advancing equality of opportunity as it enables all people with cancer to make informed choices about their own care and treatment, acts to reduce potential unforeseen harms, and ensures individual dignity, compassion and respect. The needs and preferences of each person with cancer is at the forefront of care, rather than the 'patient' or the 'cancer'.
Promoting good relations	No impact	

Do you think that the policy impacts on people because of their sexual orientation?

Sexual orientation	**impact**	**Reasons for your decision**
Eliminating unlawful discrimination	positive	See detail under **Age**
Advancing equality of opportunity	positive	See detail under **Age**
Promoting good relations	none	

Do you think the policy impacts on people on the grounds of their race?

Race	**impact**	**Reasons for your decision**
Eliminating unlawful discrimination	positive	We will continue to implement the Race Equality Framework and Action Plan (2016) that commits to improving health & wellbeing outcomes and improving access to health and social care services for minority ethnic communities. See further detail under **Age**
Advancing equality of opportunity	positive	See detail under **Age**
Promoting good relations	No impact	

Do you think the policy impacts on people because of their religion or belief?

Religion or belief	**Impact**	**Reasons for your decision**
Eliminating unlawful discrimination	positive	See detail under **Age**
Advancing equality of opportunity	positive	See detail under **Age**
Promoting good relations	No impact	

Do you think the policy impacts on people because of their marriage or civil partnership?

Marriage and Civil Partnership[27]	**Impact**	**Reasons for your decision**

[27] In respect of this protected characteristic, a body subject to the Public Sector Equality Duty (which includes Scottish Government) only needs to comply with the first need of the duty (to eliminate

Eliminating unlawful discrimination	No impact	N/A

5. Decision making and monitoring

Identifying and establishing any required mitigating action

Have positive or negative impacts been identified for any of the equality groups?

Any impacts identified are positive; no negative impacts have been identified

Is the policy directly or indirectly discriminatory under the Equality Act 2010? [28]?
No

If the policy is indirectly discriminatory, how is it justified under the relevant legislation?
N/A

If not justified, what mitigating action will be undertaken?
N/A

Describing how Equality Impact analysis has shaped the policy making process

The new cancer strategy follows on from the current national cancer plan: Recover and redesign: cancer services – action plan. However, considerations of the issues in the Equality Impact analysis has influenced some of the priorities and actions within the policy, particularly in relation to the Eradicating Inequalities ambition.

Monitoring and Review

Governance and direction of the strategy will be overseen by the Scottish Government, with a national oversight group owning the strategy and associated action plans, as well as responsibility for reviewing progress. Ownership of actions will vary from national to regional and local levels. The integration and delivery of the action plans will be the responsibility of the Health Boards.

A monitoring and evaluation plan is being developed to track delivery of the ambitions within the strategy and related outcomes, across the strategy and accompanying action plans' lifetime.

We will also continue to monitor developments taking place in other parts of the UK and elsewhere to ensure that we have a culture of continuous learning and development.

6. Authorisation of EQIA

discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010) and only in relation to work. This is because the parts of the Act covering services and public functions, premises, education etc. do not apply to that protected characteristic. Equality impact assessment within the Scottish Government does not require assessment against the protected characteristic of Marriage and Civil Partnership unless the policy or practice relates to work, for example HR policies and practices.

[28] See EQIA – Setting the Scene for further information on the legislation.

Please confirm that:

- This Equality Impact Assessment has informed the development of this policy:

  Yes ☒ No ☐

- Opportunities to promote equality in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation have been considered, i.e.:

  - Eliminating unlawful discrimination, harassment, victimisation;
  - Removing or minimising any barriers and/or disadvantages;
  - Taking steps which assist with promoting equality and meeting people's different needs;
  - Encouraging participation (e.g. in public life)
  - Fostering good relations, tackling prejudice and promoting understanding.

  Yes ☒ No ☐

- If the Marriage and Civil Partnership protected characteristic applies to this policy, the Equality Impact Assessment has also assessed against the duty to eliminate unlawful discrimination, harassment and victimisation in respect of this protected characteristic:

  Yes ☒ No ☐ Not applicable ☐

Declaration

I am satisfied with the equality impact assessment that has been undertaken for the **Cancer strategy for Scotland 2023-2033** and give my authorisation for the results of this assessment to be published on the Scottish Government website.

Name: Lynne Nicol
Position: Deputy Director, DHQI: Healthcare Planning and Quality Division
Authorisation date: 31/03/2023

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