NHS
North East and North Cumbria

Population Health, Health Inequalities and Cancer Pathways

Ben Anderson, Director of Population Health

North East and North Cumbria Integrated Care Board

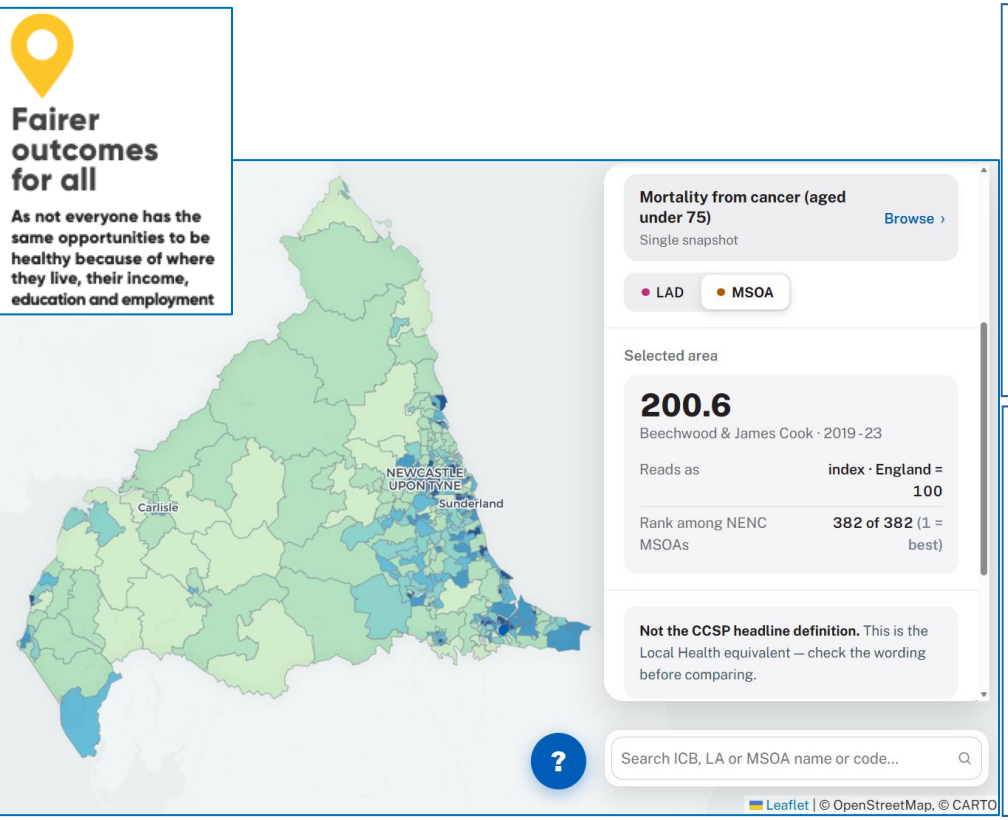
Summary

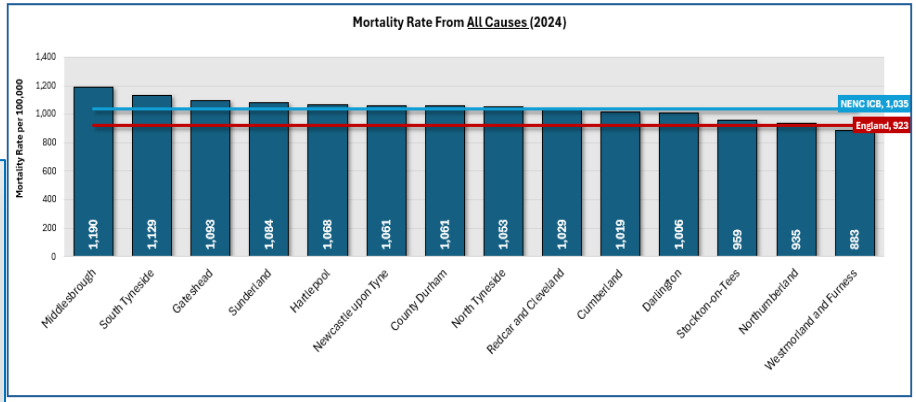
- Cancer and the NENC ICB Strategy
- Burden of disease and cancer
- Deprivation, risks and outcomes
- Intersectionality and barriers to care
- What does proportionate universalism mean in cancer pathways

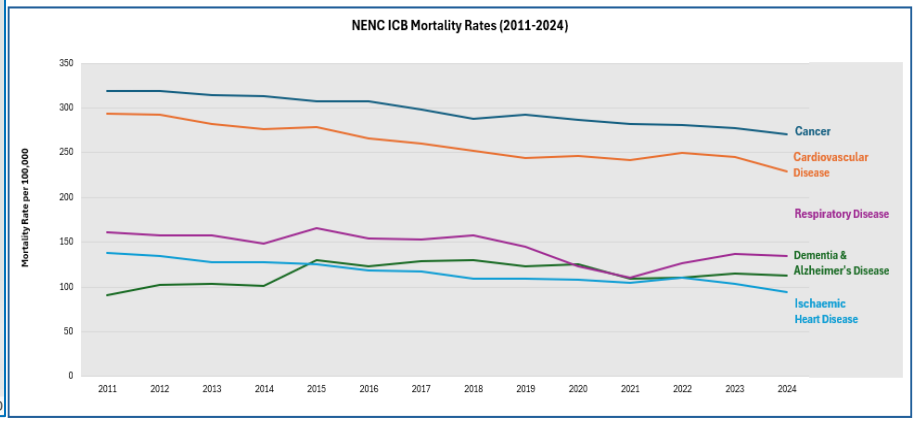
Strategic Fit

- Cancer forms a significant part of NENC's life expectancy gap to England, and the inequalities within NENC
- Lung cancer alone contributes to 1 year of the national LE gap between richer and poorer communities
- There remain significant inequalities in exposure to cancer risk between NENC communities, these create inequalities in incidence, progression and outcomes from cancers
- Tackling risk factors, delivering earlier diagnosis and ensuring faster treatment are key to reducing cancer inequalities

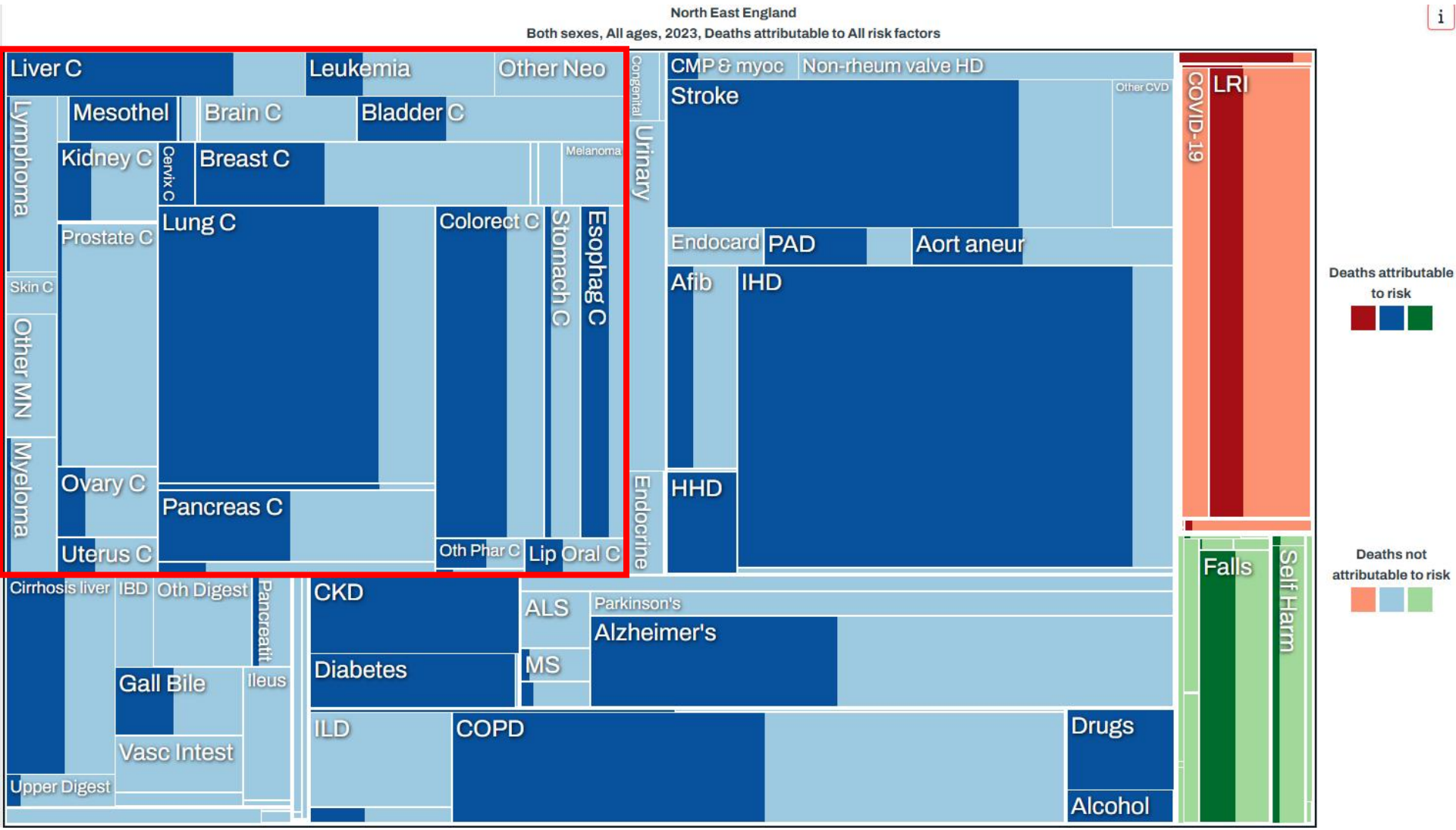
Improving but Unequal Picture







Global Burden of Disease Study



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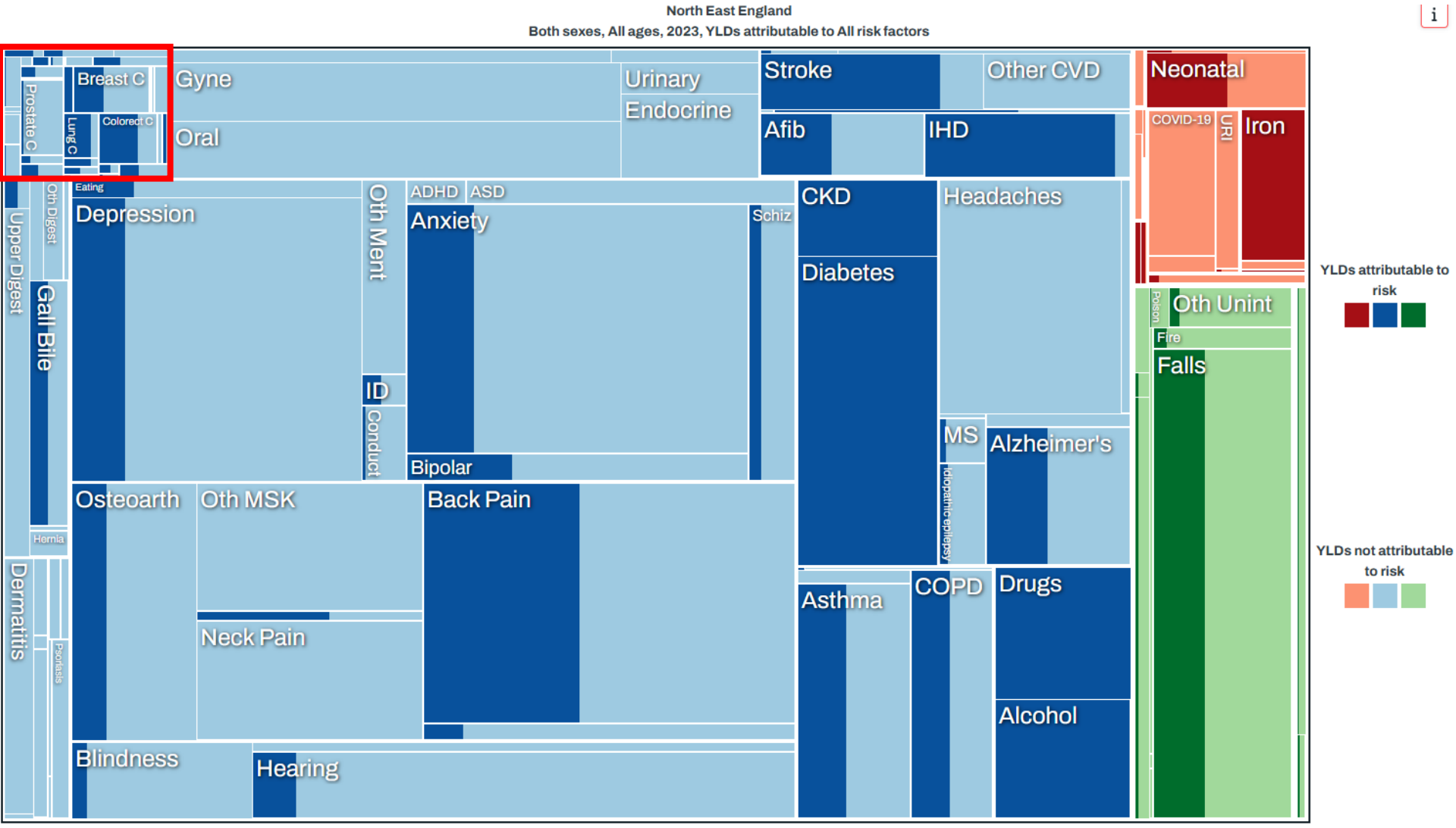

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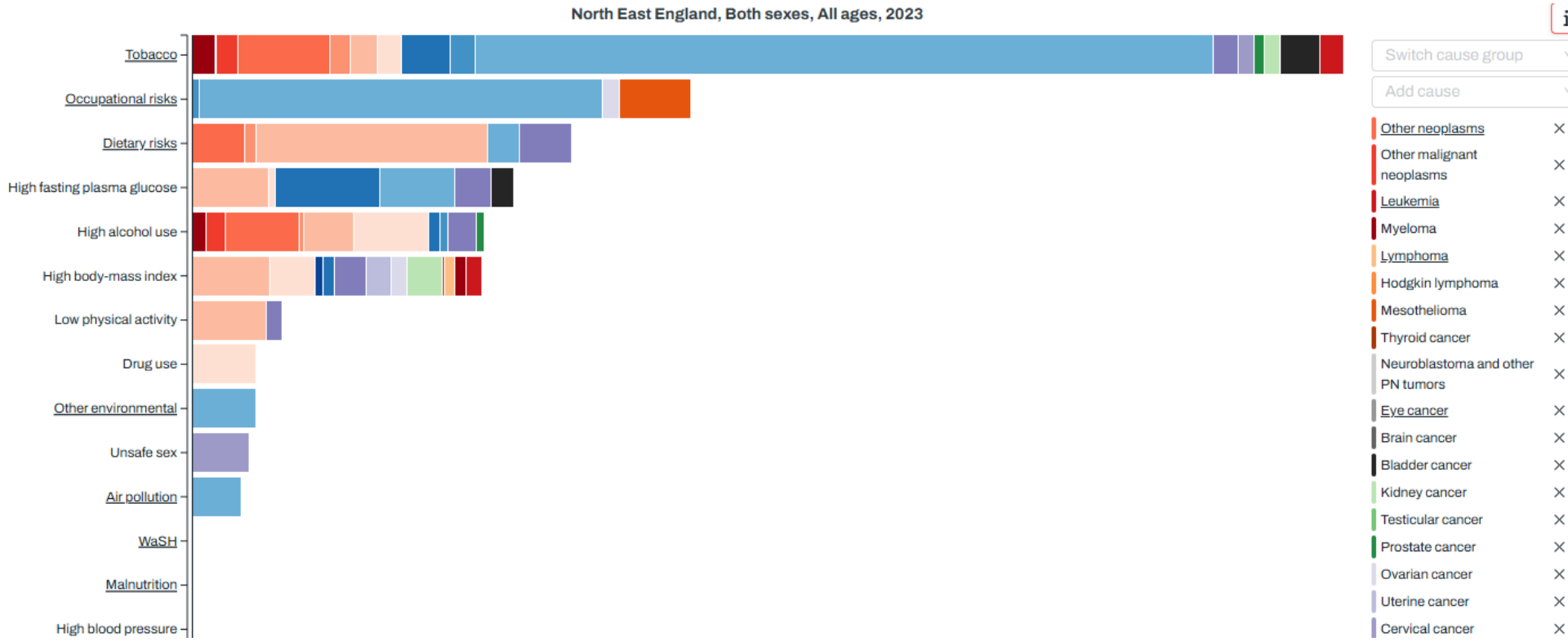


National Cancer Plan

Preventable risk factors for cancer cluster in poorer parts of the country, underpinning inequalities in incidence. In places including Blackpool, Knowsley and Kingston-Upon Hull, age-standardised premature cancer mortality is twice as high as in the best performing area…[NENC ranges from similar to best performing, through to 1.72 times as high]

…There has been little improvement in tackling inequalities in cancer mortality over the last 15 years. This is a clear injustice, and the inverse care law in practice.

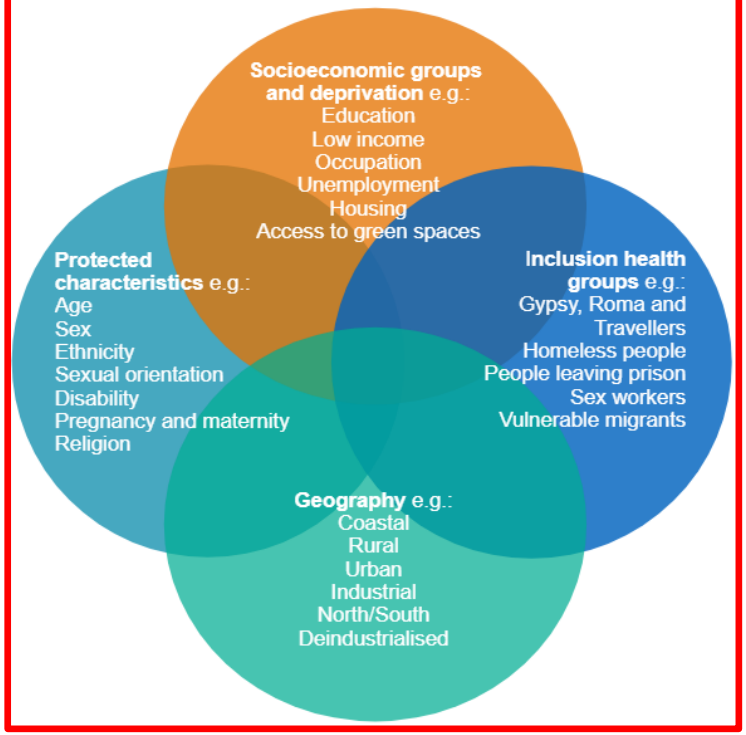
We must do better.

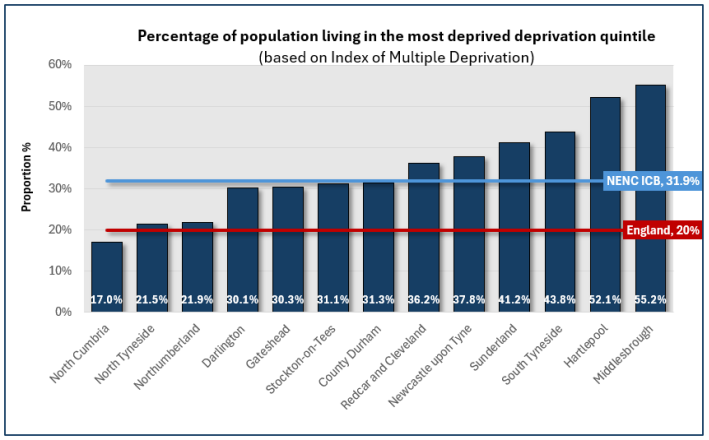
Intersectionality and Multiple Disadvantage

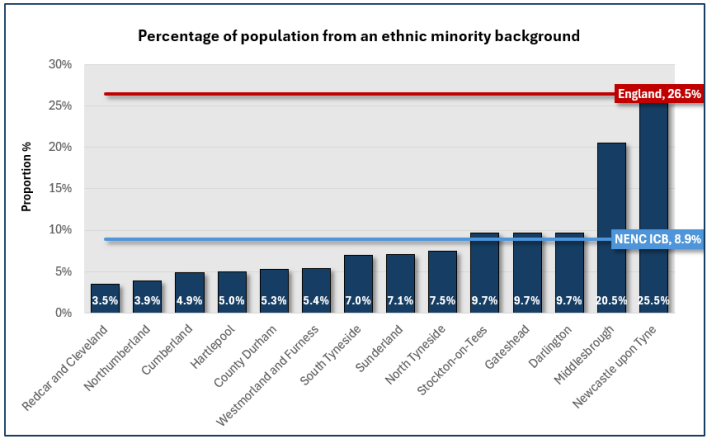
Fairer outcomes for all

As not everyone has the same opportunities to be healthy because of where they live, their income, education and employment

Figure 1. Overlapping dimensions of health inequalities (2)







Earlier diagnosis by deprivation

Northern Cancer Alliance diagnoses, 1 April 2024 to 31 March 2026

Stage 1 or 2, known stage

55.0%

Most deprived quintile

Stage 1 or 2, known stage

62.3%

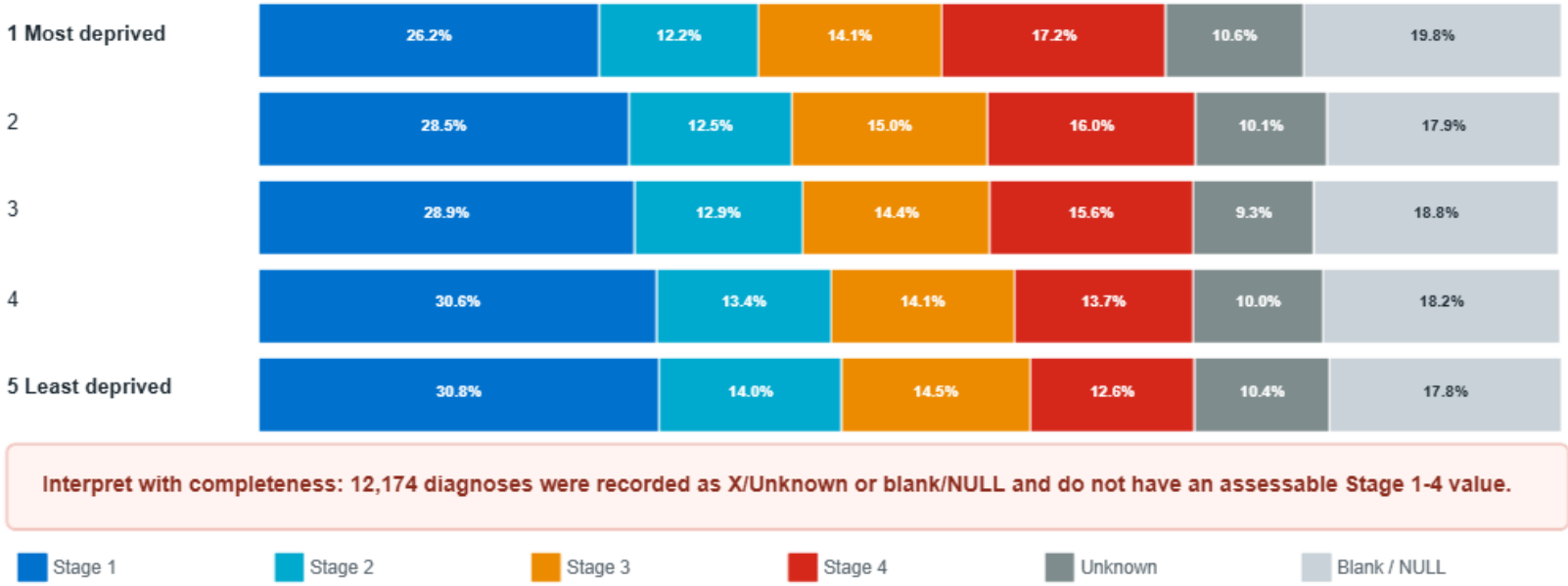
Least deprived quintile

Absolute early-stage gap

7.2 pp

Stage 1 or 2 is lower in the most deprived quintile.

Stage profile across all diagnoses



Interpret with completeness: 12,174 diagnoses were recorded as X/Unknown or blank/NULL and do not have an assessable Stage 1-4 value.

Bowel – route to diagnosis by deprivation

Final Route to Diagnosis and Stage - Bowel April 2025 to March 2026

Emergency Presentation by Stage & IMD Decile 2025 (based on LSOA of current residence)

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	Stage of Cancer								
IMD 2025 Decile	1	2	3	4	Unknown	(blank)	Grand Total	Population 18+	Emergency Presentations per 100,000 Population
1 (most deprived)	7	21	17	21	15	2	83	468,220	17.7
2	7	21	7	14	4	1	54	359,624	15.0
3	3	18	9	17	7	2	56	267,078	21.0
4	4	12	12	14	4	1	47	238,032	19.7
5	7	8	11	17	6	5	54	241,107	22.4
6	3	8	10	8	5	2	36	163,470	22.0
7	4	5	10	5	3	0	27	155,512	17.4
8	2	8	10	11	11	0	42	186,934	22.5
9	4	5	8	9	8	0	34	206,240	16.5
10 (least deprived)	5	10	9	9	2	0	35	199,766	17.5
(blank)		4	8	24	4	2	42		
Grand Total	**46**	**120**	**111**	**149**	**69**	**15**	**510**	**2,485,983**	**20.5**

Emergency Presentations resulting in a Bowel Cancer Diagnosis do not indicate a higher proportion for patients in more deprived areas. If the data is available at a lower level links could be made to screening uptake and patients presenting as a GP Urgent Suspected Cancer Referral or am Emergency.

Source: Rapid Cancer Registration Dataset Extract / Personal Demographics Service / Index of Multiple Deprivation 2025

Bowel – Waiting time breaches by deprivation

Cancer Waiting Times - Lower Gastrointestinal April 2025 to March 2026

Waiting Performance Standards: Percentage Breaches by IMD Decile 2025 (based on LSOA of current residence)

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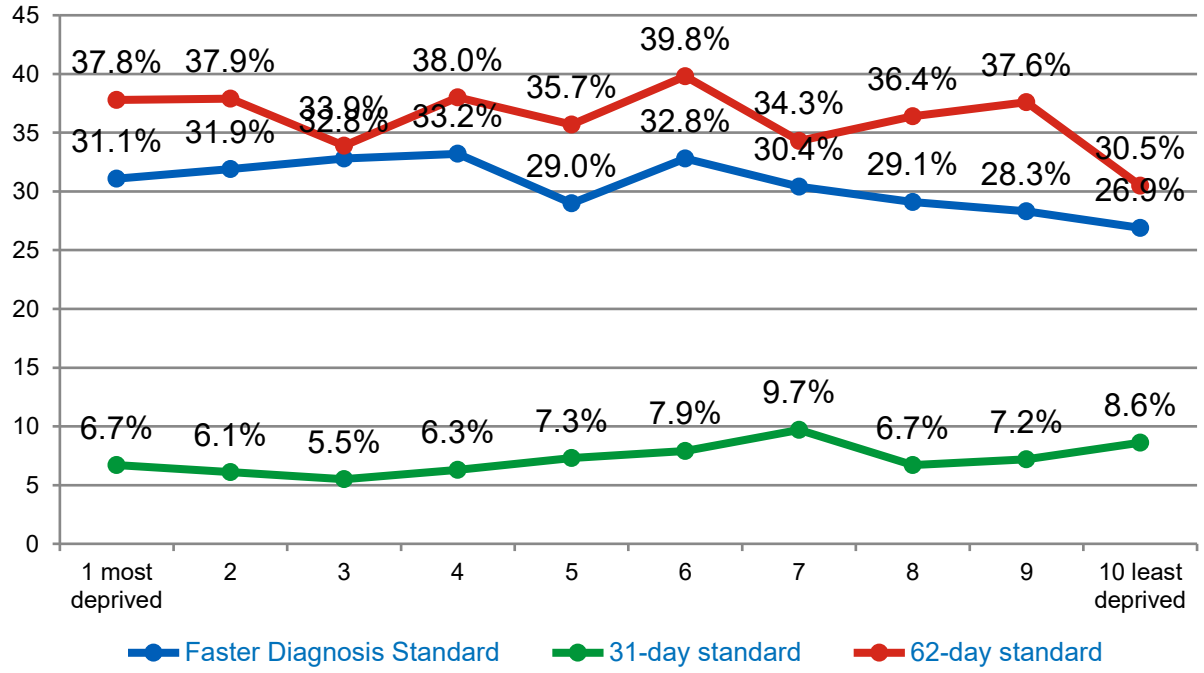


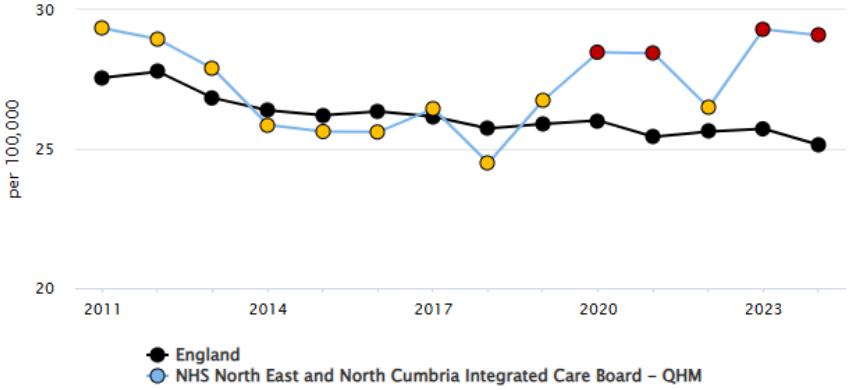
Inequality interpretation

- **FDS shows the clearest deprivation pattern**
  Breaches fall from 31.1% in the most deprived decile to 26.9% in the least deprived. The gap is 4.2 percentage points.
- **The pattern is not fully linear**
  FDS peaks at 33.2% in decile 4. Deciles 1–4 are all above the overall rate of 30.8%, while deciles 8–10 are below it.
- **62-day breaches are also lower in decile 10**
  The least deprived decile records 30.5%, compared with 37.8% in decile 1, a 7.3-point gap. Variation across the middle deciles is uneven.
- **31-day performance shows no deprivation gradient**
  The highest breach rate is decile 7 at 9.7%; the most deprived decile is 6.7%.

FDS and 62-day data indicate poorer performance for patients in more deprived areas, but only FDS shows a broadly ordered gradient; 31-day variation is different and should not be described as deprivation-driven.

Source: Cancer Waiting Times Extracts / Personal Demographics Service / Index of Multiple Deprivation 2025

Mortality rate per 100,000 from colorectal cancer, (Persons, 1 year range)

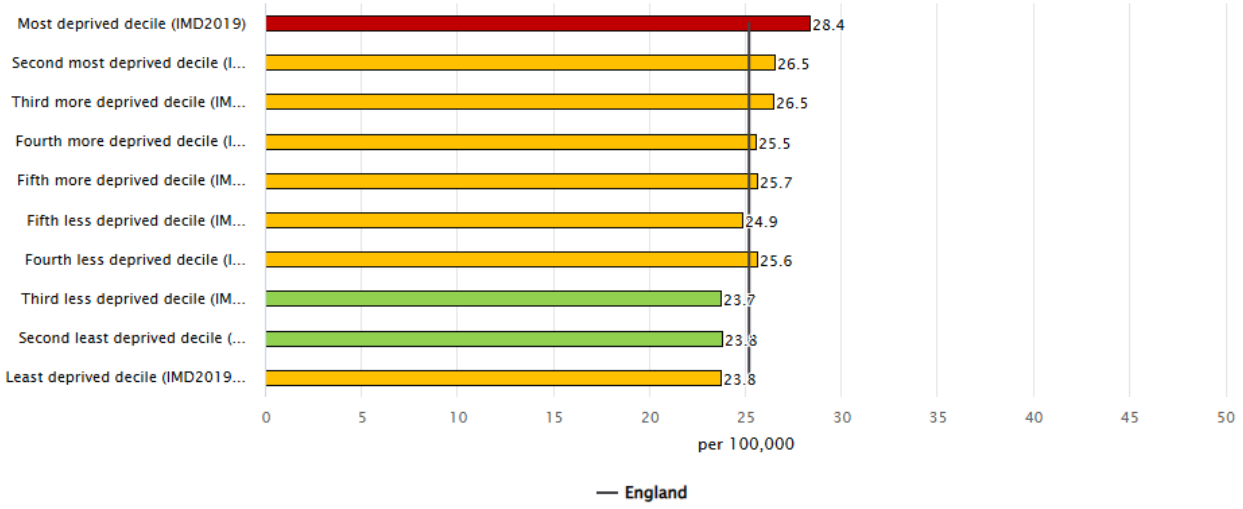


Recent trend: ➡ No significant change

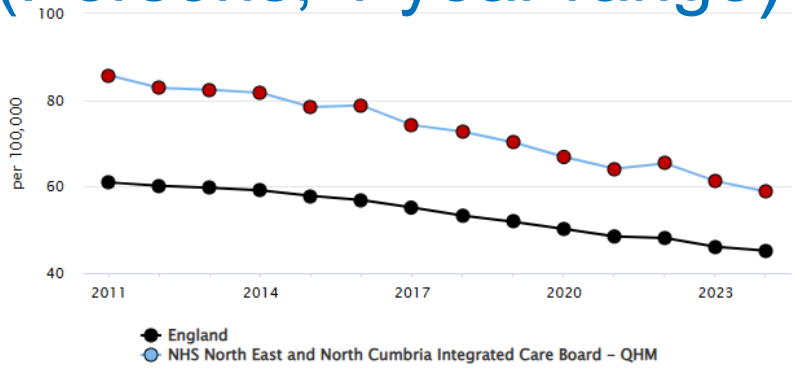
Period		NHS North East and North Cumbria Integrated Care Board - QHM Count	Value	95% Lower CI	95% Upper CI	North East and Yorkshire	England
2011	🟡	794	29.3	27.3	31.5	27.8	27.6
2012	🟡	805	28.9	27.0	31.0	28.3	27.8
2013	🟡	779	27.9	26.0	29.9	27.4	26.8
2014	🟡	738	25.9	24.0	27.8	26.2	26.4
2015	🟡	740	25.6	23.8	27.6	26.8	26.2
2016	🟡	752	25.6	23.8	27.5	25.5	26.3
2017	🟡	787	26.4	24.6	28.4	26.6	26.2
2018	🟡	741	24.5	22.8	26.3	25.6	25.7
2019	🟡	827	26.8	25.0	28.6	25.9	25.9
2020	🔴	890	28.5	26.6	30.4	27.3	26.0
2021	🔴	889	28.4	26.6	30.4	26.5	25.4
2022	🟡	854	26.5	24.7	28.3	25.7	25.6
2023	🔴	953	29.3	27.5	31.2	26.1	25.7
2024	🔴	964	29.1	27.3	31.0	27.2	25.2

Source: OHID, based on Office for National Statistics data

Inequalities – England level only 2024



Mortality rate per 100,000 from lung cancer, all ages (Persons, 1 year range)

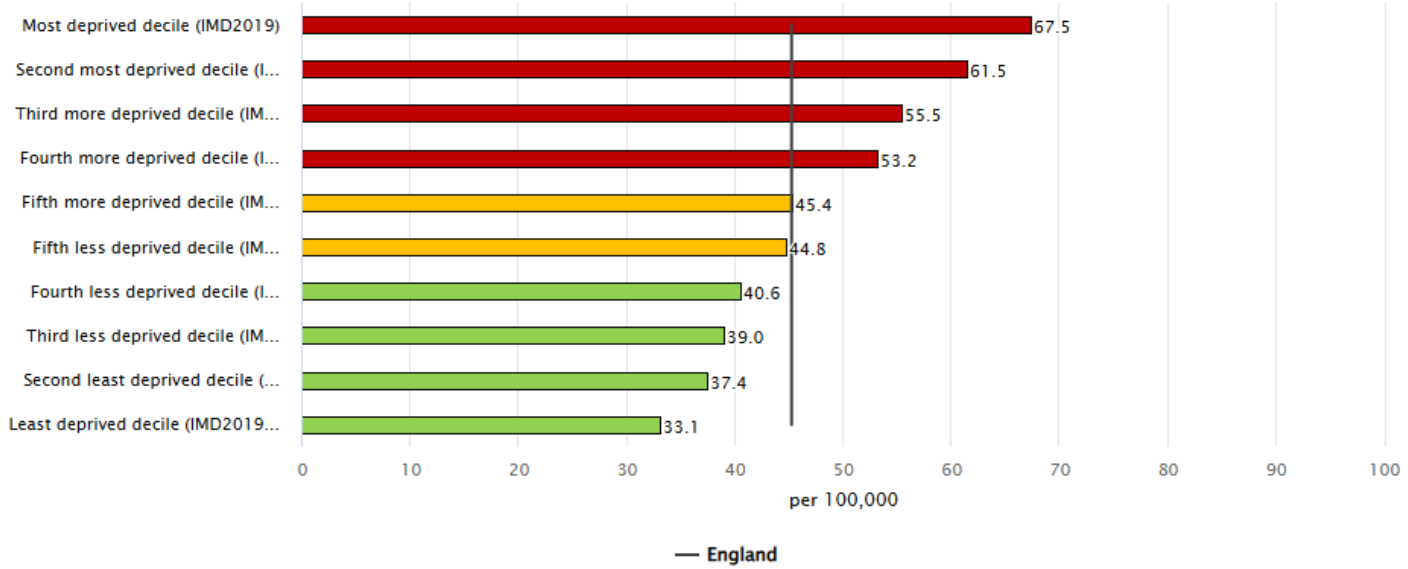


Recent trend: ⬇ Decreasing & getting better

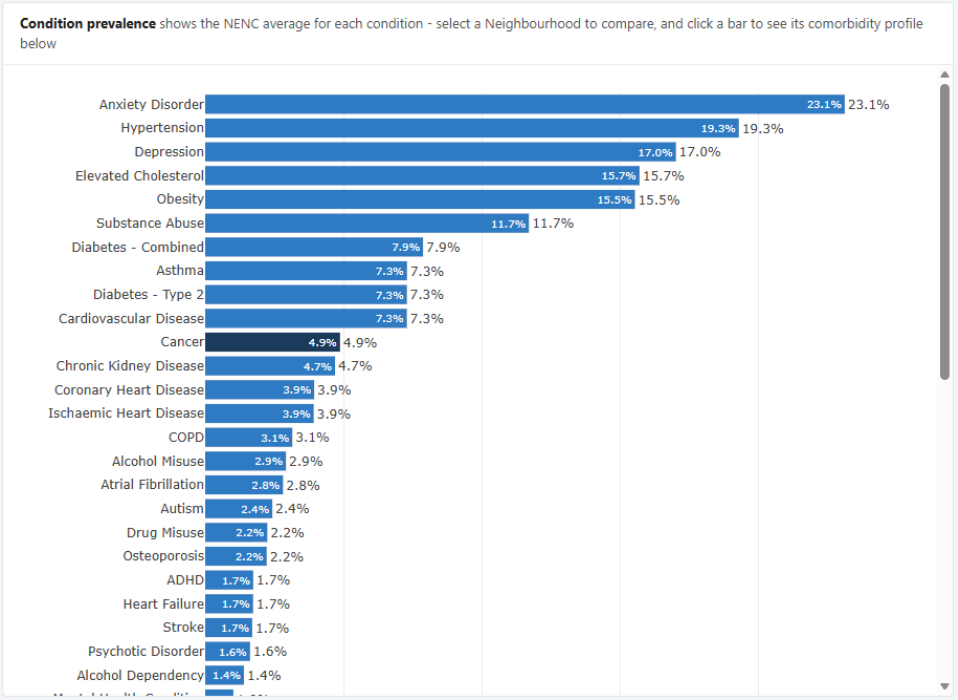
Period	NHS North East and North Cumbria Integrated Care Board - QHM				North East and Yorkshire	England
	Count	Value	95% Lower CI	95% Upper CI		
2011	2,356	85.7	82.3	89.3	77.9	61.0
2012	2,312	82.8	79.5	86.3	74.7	60.1
2013	2,330	82.4	79.1	85.8	75.0	59.7
2014	2,349	81.7	78.4	85.1	74.4	59.1
2015	2,286	78.4	75.2	81.7	70.7	57.8
2016	2,318	78.7	75.6	82.0	71.4	56.9
2017	2,228	74.2	71.2	77.4	68.3	55.1
2018	2,213	72.7	69.7	75.8	66.7	53.3
2019	2,185	70.2	67.3	73.2	64.3	51.9
2020	2,095	66.8	64.0	69.8	62.2	50.2
2021	2,051	64.1	61.4	67.0	59.6	48.5
2022	2,126	65.4	62.6	68.2	60.8	48.1
2023	2,031	61.3	58.6	64.0	56.7	46.1
2024	1,983	58.8	56.3	61.5	54.9	45.2

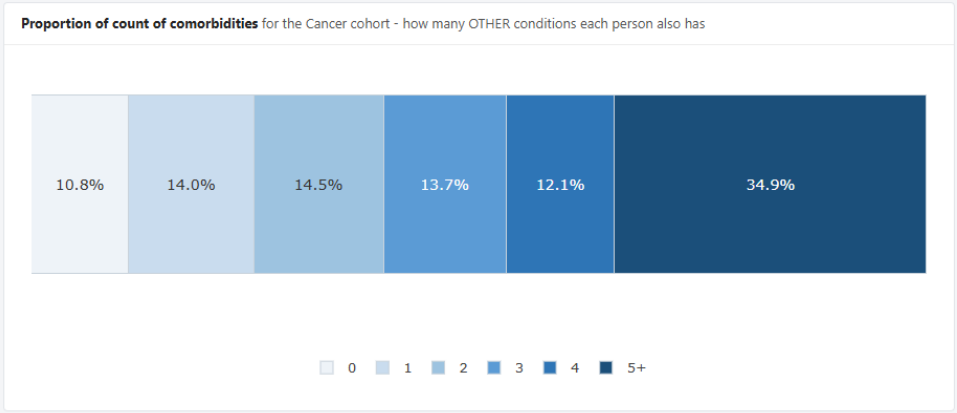
Source: OHID, based on Office for National Statistics data

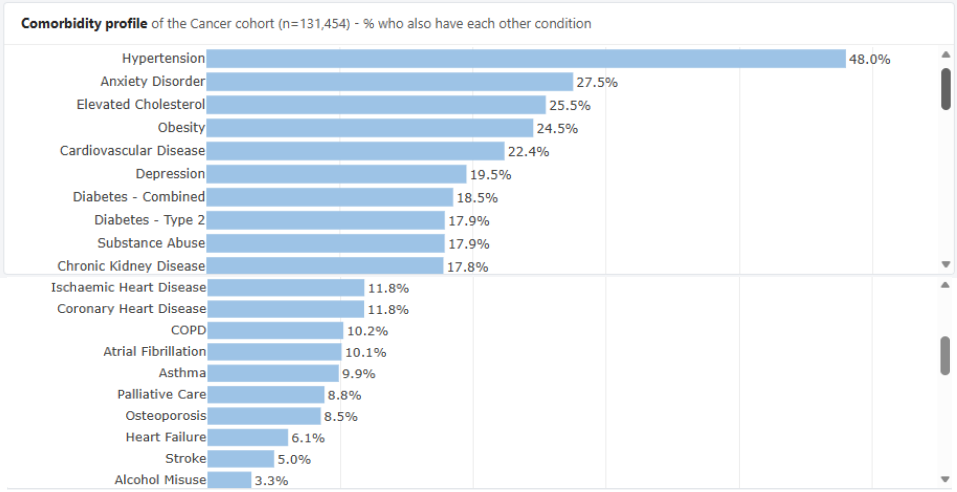
Inequalities – England level only 2024



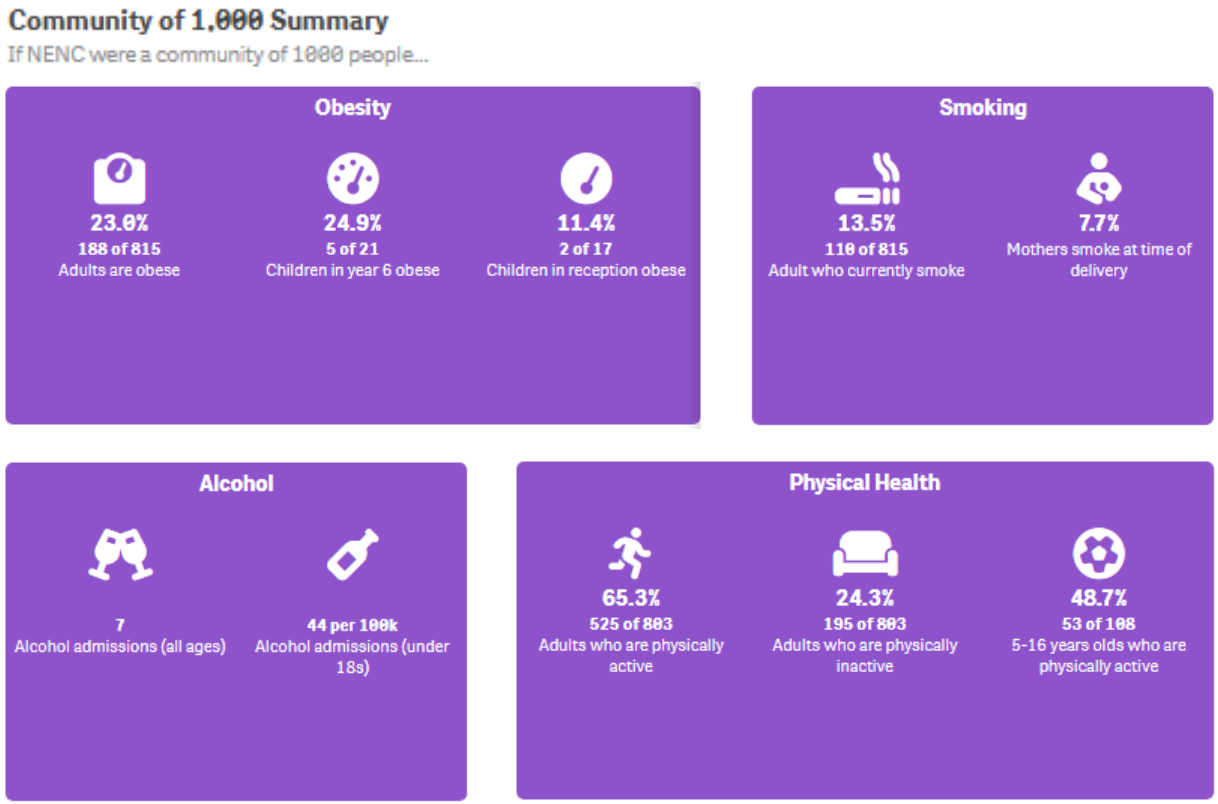
Cancer and Comorbidity







Lifestyle Risk Across NENC



Proportionate Universalism

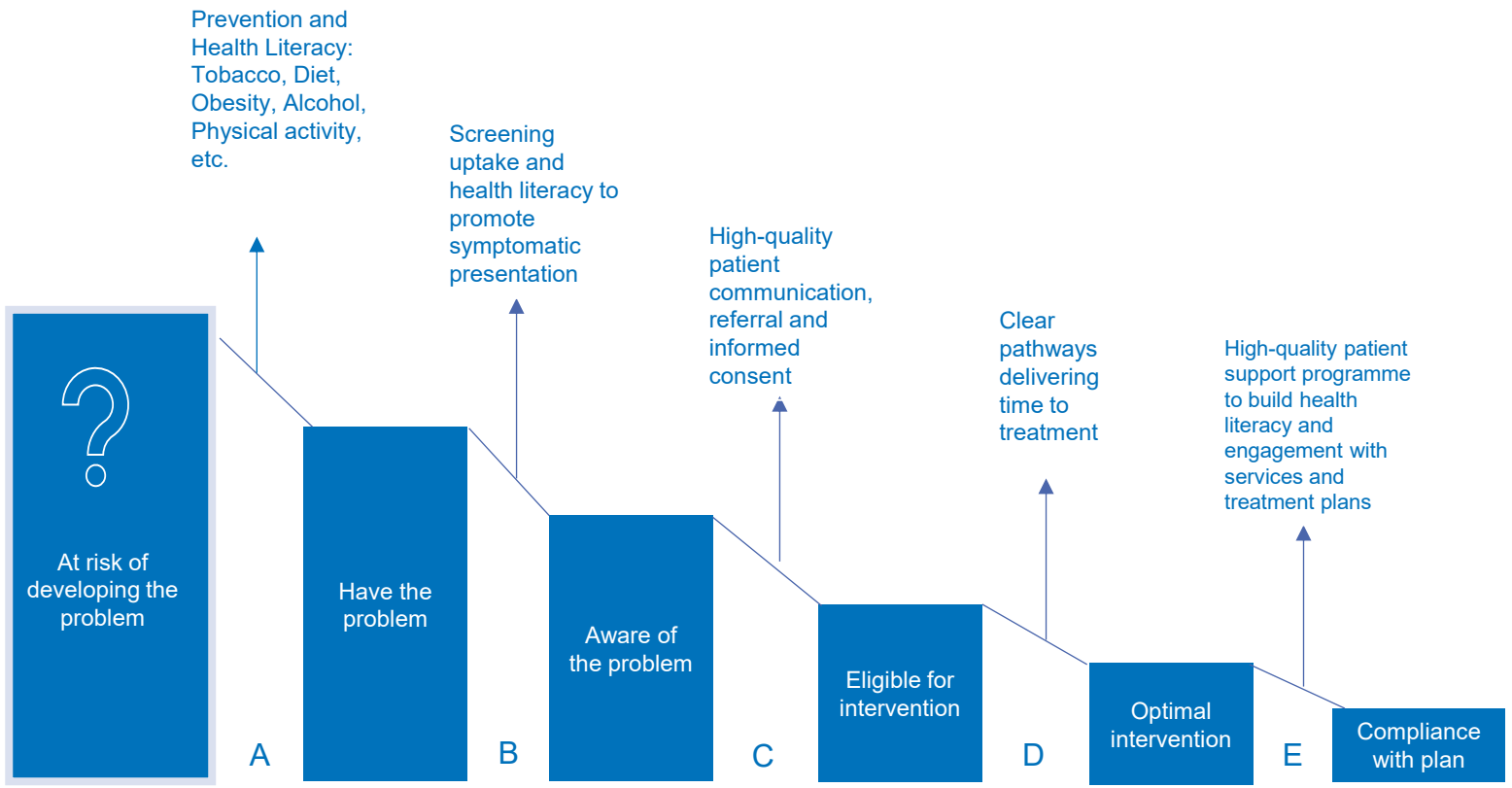
- Introduced in the 2010 Marmot Review proportionate universalism is a concept which aims to reduce health inequalities by ensuring that health actions are universal, but delivered at a scale and intensity proportionate to the level of need.

Proportionate Universalism

In cancer pathways this means:

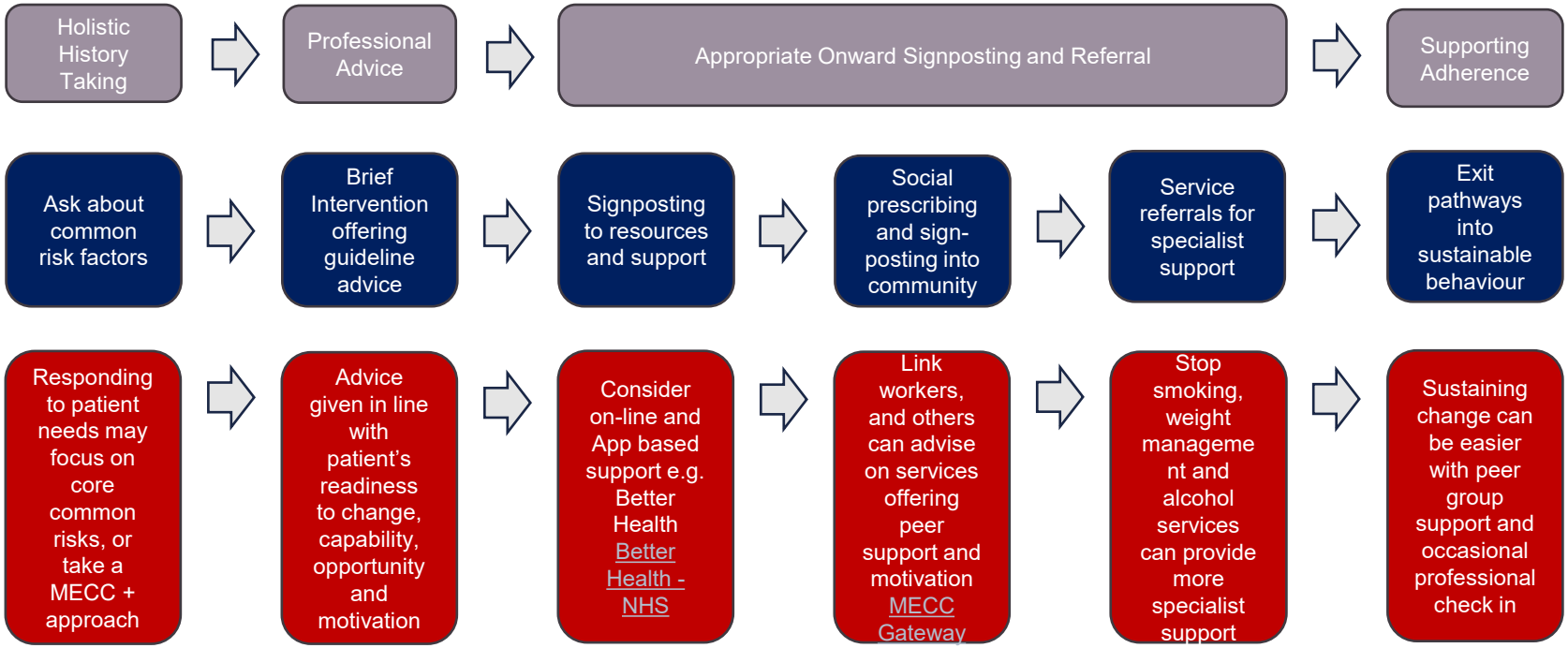
- Target prevention towards communities disproportionately exposed to risk
- Maximise screening uptake in high incidence areas
- Support health literacy amongst communities with late presentations
- Design pathways to overcome barriers to engagement and compliance
- Measure quality by gaps between communities at all points in the pathway

The Intervention Decay Model



Care Pathway for Prevention

Treat the patient, not the disease. We know that cancer patients have high exposure to risk and a high likelihood of co-morbidities



Pathway supported by behaviour change competencies - Competency - BCDF – and the NENC Embedding MECC Framework