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Invisible geographies - The Rural and Coastal Blind Spot in UK Cancer Policy: A Content Analysis

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Abstract:	Background: The United Kingdom's (UK) diverse geography means many people live in rural and coastal areas, where cancer outcomes are often poorer than in urban settings. Devolution means that the four nations of the UK have distinct approaches to cancer care. Scotland, Wales, and Northern Ireland have recently published national cancer strategies, while England's new plan is expected later in 2025. This study examined UK cancer policy documents, to identify, how, and to what extent, rural or coastal issues were considered. Methods: UK cancer policy documents from 2000-2024 were sourced via The International Cancer Control Partnership (ICCP) website (https://iccp-portal.org/), UK government sites and Google. Documents were searched for rural and coastal related terms. Results: Fifty-five documents were included (England n=17; Northern Ireland n=10; Scotland n=21; Wales n=7). No recent policies included a specific section or explicit recommendations for rural or coastal cancer care. Across the policies, contextual analysis highlighted that terms to promote rural or coastal equity rarely appeared within recommendations. Northern Ireland gave more attention to rural issues than other nations, as evidenced by a rural needs impact assessment and supporting documents

	to inform Northern Ireland's Cancer Strategy 2022-2032. Conclusion: Despite sizeable rural and coastal populations facing specific health challenges across the UK, national cancer policies excepting Northern Ireland gave minimal guidance for delivering cancer care tailored to these communities. Other UK nations should consider adopting more rural-centric approaches like Northern Ireland. Policy Summary: Coastal and rural health issues have received policy attention via the Chief Medical Officer for England's annual reports (2021; 2023) and more recently in the UK Government's 10 Year Health Plan for England (July 2025). However, when it comes to high-level cancer policy across the UK, the needs of rural and coastal people with cancer are not being adequately or specifically recognised.

Lincoln Institute for Rural and Coastal Health

17th August 2025

Dear Professor Aggarwal,

We are enclosing our article entitled **'Invisible geographies - The Rural and Coastal Blind Spot in UK Cancer Policy: A Content Analysis'** for consideration in the *Journal of Cancer Policy* where we believe it is an excellent fit with your journal.

Rural and coastal dwellers affected by cancer are at risk of poorer outcomes compared to urban counterparts. Our study analysed the content of 55 UK cancer policy documents, to identify, how, and to what extent, rural or coastal issues were considered.

Coastal and rural health issues have received policy attention via the Chief Medical Officer for England's annual reports in 2021 and 2023 and more recently in the UK Government's 10 Year Health Plan for England published in July 2025. However, when it comes to cancer policy across the UK, our analysis shows that the needs of rural and coastal people with cancer are not being recognised in high-level cancer policy.

All authors have contributed to and approved the submitted manuscript. The study was a desk-based content analysis of publicly available health policy documents; therefore, ethical approvals were not necessary. The study has not been published elsewhere and is not currently being considered for publication elsewhere.

On behalf of the co-authors, we thank you for considering our article in the Journal of Cancer Policy.

Best wishes,

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Title: Invisible geographies - The Rural and Coastal Blind Spot in UK Cancer Policy: A Content Analysis

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Highlights

- Rural and coastal cancer patients face poorer outcomes compared to urban
- The four nations of the UK have different approaches to delivering cancer care
- 55 UK cancer policy documents were reviewed for rural and coastal content
- UK cancer policy lacks specific focus on the needs of rural and coastal communities
- Unified UK-wide approaches to rural and coastal cancer care could improve outcomes

Title: Invisible geographies - The Rural and Coastal Blind Spot in UK Cancer Policy: A Content Analysis

Abstract

Background: The United Kingdom's (UK) diverse geography means many people live in rural and coastal areas, where cancer outcomes are often poorer than in urban settings. Devolution means that the four nations of the UK have distinct approaches to cancer care. Scotland, Wales, and Northern Ireland have recently published national cancer strategies, while England's new plan is expected later in 2025. This study examined UK cancer policy documents, to identify, how, and to what extent, rural or coastal issues were considered.

Methods: UK cancer policy documents from 2000-2024 were sourced via The International Cancer Control Partnership (ICCP) website (https://iccp-portal.org/), UK government sites and Google. Documents were searched for rural and coastal related terms.

Results: Fifty-five documents were included (England n=17; Northern Ireland n=10; Scotland n=21; Wales n=7). No recent policies included a specific section or explicit recommendations for rural or coastal cancer care. Across the policies, contextual analysis highlighted that terms to promote rural or coastal equity rarely appeared within recommendations. Northern Ireland gave more attention to rural issues than other nations, as evidenced by a rural needs impact assessment and supporting documents to inform Northern Ireland's Cancer Strategy 2022-2032.

Conclusion: Despite sizeable rural and coastal populations facing specific health challenges across the UK, national cancer policies excepting Northern Ireland gave minimal guidance for delivering cancer care tailored to these communities. Other UK nations should consider adopting more rural-centric approaches like Northern Ireland.

Policy Summary: Coastal and rural health issues have received policy attention via the Chief Medical Officer for England's annual reports (2021; 2023) and more recently in the UK Government's 10 Year Health Plan for England (July 2025). However, when it comes to high-level cancer policy across the UK, the needs of rural and coastal people with cancer are not being adequately or specifically recognised.

Keywords: cancer policy; health policy; inequalities; content analysis; rural health; coastal health; United Kingdom; England; Scotland; Wales; Northern Ireland

1. Introduction

In the United Kingdom (UK), one in two people will be diagnosed with cancer in their lifetime [1]. An estimated three million people in the UK currently live with cancer, predicted to rise to 5.3 million by 2040 [2]. This increase, coupled with NHS workforce shortages and longer-term impacts of COVID-19 [3], will likely result in a considerable loss of life-years [4, 5]. UK cancer outcomes already lag behind other high-income countries with comparable healthcare systems [6-8].

Health has been a devolved matter (decision-making moving from London to devolved nations) for over twenty years, establishing four separate UK health services [9], NHS England, NHS Scotland, NHS Wales and NHS Northern Ireland [10]. Currently, plans are underway to abolish NHS England aiming to cut bureaucracy, save £175 million annually and increase ministerial control [11].

Devolution has led to distinct approaches to cancer care, with each UK nation prioritising its own policy initiatives and funding mechanisms. Scotland, Wales and Northern Ireland have recently published national cancer strategies and plans [12-15]. The UK Government has announced their intention to publish a National Cancer Plan for England later in 2025 [16].

Previous key cancer policies in the UK include the Calman-Hine report, The NHS Cancer Plan 2000, The Cancer Reform Strategy, and the NHS Long-Term Plan [17-20]. These have led to more centralised care, with a distinction between cancer units (treating common cancers close to the patient's home) and cancer centres (providing specialised care for all cancers often outside a patient's local area). While this has improved outcomes for many [21], it often requires patients, particularly those from rural or coastal areas, to travel long distances [22].

The UK is geographically diverse, with significant rural populations (Table 1) facing unique healthcare challenges, including workforce shortages [23] and unequal access to diagnostics, treatment and clinical trials, typically located in larger cities or academic centres. Global evidence associates rural living with poorer cancer experiences and outcomes [22, 24-30], along with unmet psychosocial needs concerning finances, travel, and access [31]. In England, people with cancer who live in deprived rural areas face the longest travel times to treatment centres [22], and poorer geographical access to care has been associated with poorer outcomes [30]. It is essential to explicitly consider where geographical issues intersect with health, social and economic deprivation [32].

Coastal areas also face persistent health inequalities acknowledged in the annual reports of the UK Chief Medical Officer in 2021 [33] and 2023 [34] and recently in the UK Government's 10 Year Health Plan for England published in July 2025 [35]. Similar to rural areas, the UK has significant coastal populations (Table 1). Some of these formerly desirable and prosperous coastal seaside towns are now characterised by deprivation, lower educational attainment, alcohol and substance misuse, greater disability and poor physical and mental health, compared to non-coastal areas [36, 37]. For cancer, there is accumulating [38-42], research specifically acknowledging needs and challenges for UK coastal cancer patients. Whilst differences between rural and coastal communities are recognised, both settings face reduced access to health services, including cancer care. Therefore, national, and devolved cancer policymakers, should not neglect these challenges faced by rural and coastal communities [43]. This paper presents a comprehensive content analysis of UK cancer policy to identify the extent to which rural or coastal issues were considered.

Table 1: Estimates of the Rural and Coastal Populations Across the UK

Nation	Rural Population	Coastal Population
England	~10 million people live in rural areas (17% of population) [44].	12.3 million* (22% of population) [39].
Northern Ireland	~670,000 (36% of population) [45].	~760,000** (40% of population) [46]
Wales	~1,022,000 (32% of population) [47].	~1.88 million*** (60% of population) [48]
Scotland	~930,000 (17% of population) [49].	~2.3 million**** (41% of population) [50].

*Notes: Figures are approximate and taken from a range of data sources. Definitions of 'rural' and 'coastal' differ across the four nations. Coastal populations can be classed as both coastal-urban and coastal-rural. *Figure is from Lower Super Output Area analysis (LSOA designated as 'coastal' if 25% or more of postcodes within 5km of the coastline) **Figure is derived from an Ireland-wide study (40% reside within 5km from the coastline) which includes Northern Ireland and the Republic of Ireland, this is a reasoned approximation and not an official statistic, The Northern Ireland Statistics and Research Agency (NISRA) do not have an official definition of "coastal community". ***60% figure comes from a 2015 Welsh Government Report which states that over 60% of the population lives and works in coastal areas which is a publicly available proxy in the absence of detailed GIS analysis. ****Scottish figure relates to populations who live within 5km of the coastline.*

2. Methods

Design

We performed a quantitative content analysis, which counts specific occurrences of words, concepts, or terminologies in text. It assumes that the degree of explicit recognition in the text reflects the level of policy attention and activity related to these issues outside the documents themselves [51]. We systematically searched documents for terms relating to "rural" and "coastal". Cancer policy was defined as decisions by UK governments in relation to cancer control, planning and care, as articulated through publicly available documents. This included both cancer policy (broad scope in relation to cancer at a wider system level: prevention, screening, treatment, research, workforce, long-term strategies) as well as cancer care policy (more focused on delivery of care to patients). This approach allowed evaluation of content and insight into gaps and priorities of UK-wide cancer policy. The following research question guided this content analysis:

To what extent do the four nations of the United Kingdom consider rural or coastal settings in cancer policy?

Inclusion of Policy Documents

We focused only on country-level cancer strategies, or plans, published since 2000, setting out ambitions for future cancer care and service delivery for the four nations of the UK. This was deemed the most relevant time frame in terms of recency and to account for policies under different national and devolved governments. The International Cancer Control Partnership (ICCP) website (https://iccp-portal.org/) was searched for UK cancer policy documents up to September 2024 [52]. We performed supplementary searching on Google and UK government websites. The final documents included the most recent national cancer strategies for the devolved nations [12-15], acknowledging that the most recent country-level cancer strategy available for England was 'Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020' [53]. An overview of included cancer policy documents can be found in the Appendices (A.1).

Analysis

We searched for words, phrases, or concepts relating to rural or coastal settings (see Appendices A.2). Terms searched reflected barriers to care, identified via the extant literature, e.g.

deprivation, travel, access, inequality, workforce, digital. We also searched for terms in relation to 'urban' 'city' 'town'. All policy documents were saved as PDF files. To find occurrences of words in relation to rural and coastal, the Text Search Query function was used. Additionally, full-texts of each document was reviewed to ensure that no text relevant or conceptually aligned to rural and coastal communities were missed. Data were tabulated in a frequency table (CSV format) for each UK nation. The CSV files were loaded into R (Version 4.5.1) to visualise data using a heat map. In the Appendices (A.3) we also report on contextual details of where words "geog(graphy & graphical)", "rural" and "travel" and "transport" appear within the policy documents.

3. Results

A total of 55 UK cancer policy documents (A.1) were included (England n=17, Scotland n=21, Northern Ireland n=10 and Wales n=7). Across all recent cancer policy documents, there were no specific sections or explicit recommendations for rural or coastal cancer care. Across the policies, contextual analysis (A.3) highlighted that terms to promote rural or coastal equity rarely appeared within recommendations. Table 2 provides a summary of findings and Table 3 highlights the narrative where terms were reported in the most recent national policies. Figure 1 shows the frequency of keywords in cancer policies across all four nations of the UK.

English Cancer Policy Documents

In England, across all the 17 documents, "rural" appears 13 times and "coast/coastal" 10 times (nine uses in relation to place names). Terms relating to rurality appeared sporadically with normally fewer than five instances per document; in many policy documents they were entirely absent. Despite few rural and coastal references, the documents do show consistently high use of broader place-based terms, including "local" (n=731), "community" (n=296) and "regional" (n=220). The terms "travel" (n=33), "deprivation" (n=225), "inequality" (n=297) "workforce" (n=240) are also frequent with "access" (n=705) alone reaching >50 mentions in multiple documents.

The term "rural" is only once referenced (Table 2 & Table 3) in the most recent cancer strategy for England [53] (Table 3). There were eight uses of geography/geographic in the same document. There were three uses of "travel" in this document. An equality impact assessment (E16_2015) was performed for this most recent strategy and "rural" and "coastal" do not feature as an item in this.

Scottish Cancer Policy Documents

In Scotland, 21 documents provide the most extensive temporal coverage of all four UK nations. Despite this, rural appears only 18 times across all documents and coastal terms are entirely absent. Multiple documents particularly between 2004-2012 show small but consistent use of rural terminology, however, this is less frequent in the more recent policy documents. Terminology unique to the Scottish context such as "highland" (n=97), "island" (n=17) and "isles" (n=3) appear across some of the policies, but are absent in most of the documents. Scotland mirrors England in its consistent emphasis on terms such as "local" (n=542) "community" (n=229) and "regional" (n=649). Similarly, words in relation to barriers like "access" (n=971), "deprivation" (n=173), "inequality" (n=178) and "workforce" (n=353) occurred frequently and consistently across the documents, indicating policy attention on structural challenges to the delivery of cancer care.

The most recent Scottish cancer plan and strategy (2023) [14, 15] , mentions "rural" once and "remote" three times, with a further two mentions in the updated plan published in 2024

(S21_2024). There were five uses of geography/geographical in the 2023 cancer strategy [15], which specifically acknowledges the challenges of equity and accessing cancer care for rural and island communities (Table 3).

Northern Irish Cancer Policy Documents

In Northern Ireland, the word "rural" appears 113 times across 10 documents but "coast(al)" was not found in any of these documents. Compared to the other nations, "rural" appears much more frequently; largely due to supporting documents for the most recent Cancer Strategy for Northern Ireland 2022-2032 [12] which gives considerable attention to the rural context. Looking specifically at those supporting documents, not surprisingly, the highest number of occurrences are in a Rural Needs Impact Assessment document (n=70), followed by Public Consultation on the Cancer Strategy Report (n=11) as well as featuring in the Equality Impact Assessment (n=5). In the final cancer strategy itself, the word rural features eight times, although cited only once in the main text, the other seven occurrences being in footnotes and references (Table 3).

Notably "rural" features 19 times in the Regional Cancer Framework: A Cancer Control Programme for Northern Ireland published in 2008. Similar to other UK nations, "access" (n=340), "workforce" (n=130), "deprivation" (n=79) featured frequently and consistently across most policy documents. "Travel" (n=74) and "transport" (n=22) appeared across some of the policies, although not in all of the Northern Irish documents.

Welsh Cancer Policy Documents

In Wales, "rural" and "coast(al)" were entirely absent in all seven cancer policy documents. Similarly to other UK nations, there were frequent and consistent mentions of "access" (n=194) and "workforce" (n=126). Whilst there is no explicit "rural" mention in the recent Cancer Improvement Plan for NHS Wales 2023-2026 [13] there were multiple occurrences of "Region/al/ally" referring to different regions in Wales and expressing intent to set up regional hubs for specific services (Table 3). In the most recent Welsh plan, there were also statements about improving equity of access to cancer research across different geographies (Table 3).

Table 2: Summary of Rural and Coastal Occurrences in UK Cancer Policy Documents

Nation	Coverage	No. of Docs	Overall mentions of "Rural"	Overall Mentions of "Coastal"	Mentions in most recent policy	Key Related Terms (Highest counts across all documents)	Observations on findings
England	2000-2015	17	13	10	***2015 Achieving World Class Cancer Outcomes*** [53] Rural (n=1) Coastal (n=0)	Research (n=899) Local (n=731) Access (n=705) GP (n=671) Community (n=296)	Only one rural mention in the most recent strategy; frequent general place-based terms.
Northern Ireland	2008-2022	10	113	0	***A Cancer Strategy for Northern Ireland 2022-2032*** [12] Rural (n=8*) Coastal (n=0)	Access (n=340) Regio(n&al&ally) (n=287) Research (n=235) Workforce (n=130) Community (n=123)	Rural count largely inflated due to a Rural Needs Impact Assessment document. Only one mention in the narrative of the most recent strategy itself.
Scotland	2001-2024	21	18	0	***Scotland's Cancer Strategy 2023-2033*** [15] ***& Cancer Action Plan for Scotland 2023-2026*** [14] Rural (n=2) Coastal (n=0)	Access (n=971) Regio(n&al&ally) (n=649) Research (n=595) Local (n=542) Workforce (n=353)	2023 policy briefly notes rural and island challenges but relies more on broader health equity terms.
Wales	2012-2023	7	0	0	***Cancer Improvement Plan for NHS Wales 2023-2026*** [13] Rural (n=0) Coastal (n=0)	Research (n=315) Access (n=194) Local (n=169) Workforce (n=126) GP (n=70)	No direct references to "rural" or "coastal"; More emphasis on regional coordination.

*Note: *7/8 of these occurrences are in footnotes and references*

Table 3: Example narrative where rural and coastal related terms appear in most recent UK cancer policies.

Nation	Document name	Example text
England	Achieving World-Class Cancer Outcomes A Strategy For England 2015-2020	*"Devolved decision-making, within national standards and ambitions: Cancer services (and the NHS more broadly) are too extensive for all decisions to be made nationally.* ***Local*** *or* ***regional*** *decision-making unlocks creativity and innovation, provides a vehicle for clinicians and patients to drive service development, and enables appropriate consideration of* ***local*** *circumstances (e.g.* ***rural geographies****). However,* ***local*** *decision-making must be within a national framework of agreed service quality standards and appropriate population sizes". (Page 17)* *"So it may be less burdensome for patients to* ***travel*** *for their surgery to centres where volumes are higher and outcomes better. Nevertheless, the option of increasing centralisation further needs evaluation. We need to balance the opportunities for improved outcomes through greater specialisation, with the implications for patients having to* ***travel*** *further." (In relation to how to improve survival, service configurations for surgery Page 37)*
Northern Ireland	A Cancer Strategy for Northern Ireland 2022-2032	*"In addition, there are challenges in ensuring* ***equitable access*** *for all sections of the population, particularly seldom-heard and underrepresented sectors, e.g. LGBTQ+ people, those from ethnically diverse backgrounds, people with cognitive impairment such as those with dementia, those experiencing homelessness, people in long-term institutional care including prison care, the ageing and frail population, and those* ***living in rural and remote areas****." (Page 100).*
Scotland	Cancer Strategy for Scotland 2023-2033 & Cancer Action Plan for Scotland 2023-2026	*"Scotland's* ***geography*** *means there are particular challenges in providing* ***equity*** *of* ***access*** *to some* ***rural*** *and* ***island*** *communities. Improving the accessibility of services through the location of services and use of digital technology, providing transport, maintaining support structures, ensuring affordability and increased focus on cultural competence of services are all measures likely to reduce inequalities. Speciality outreach services can improve access and self reported health." (Page 48).* *"****Access*** *should be equitable regardless of* ***geographical*** *or socio-economic factors, ethnicity, gender, disability or other equality characteristic." (Page 51).*
Wales	A Cancer Improvement Plan for NHS Wales 2023-2026	*"Welsh Government to hold Health Boards to account for delivery of cancer waiting time targets and recovery trajectories against backlogs and to incorporate a greater focus on* ***regional*** *working e.g. across cancer sites, with the establishment of* ***regional*** *waiting lists for some diagnostics and treatments." (Page 36).* *"Managing and monitoring* ***local*** *research portfolios is important to ensuring cancer clinical trials can be offered to patients in a timely and* ***equitable*** *way right across Wales. Improving the efficiency of trial setup and delivery processes and ensuring all relevant patients are approached about research is key to improving* ***equity*** *of* ***access*** *to research across populations,* ***geographies*** *and tumour sites." (Page 74).*

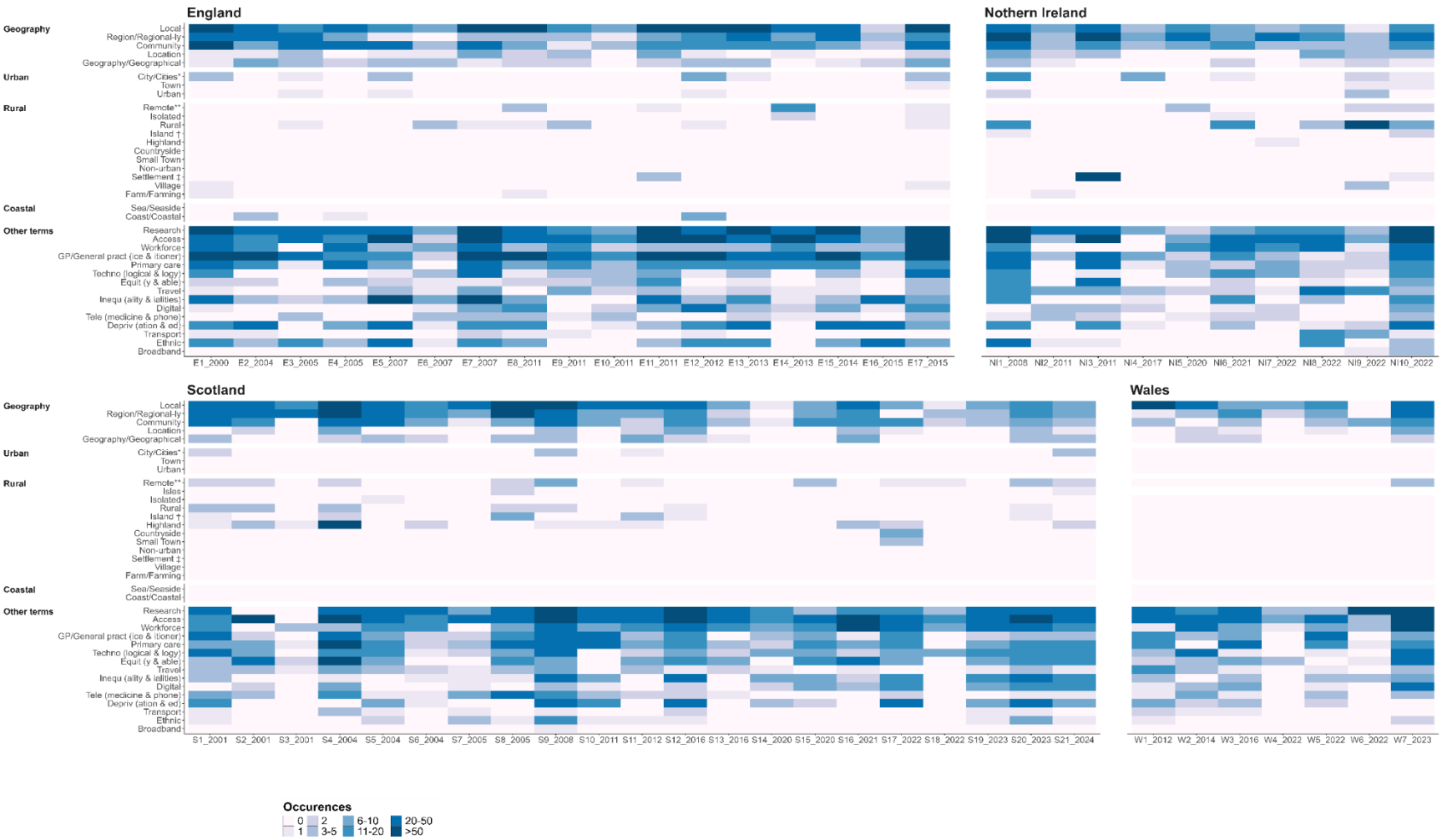

Figure 1: Heat Map Showing Occurrence of Terms in UK Cancer Policy *Notes: Labels on the x axis refer to document number and year of publication. Corresponding list of all policy documents and their titles can be found in the Appendices (A1). X axis moves from left (earlier time point) to right (most recent time point). X axis ranges in length for each nation due to a different number of policy documents being analysed per nation. Darker colours denote higher frequency counts of terms.*

4. Discussion

Analysis of 55 UK cancer policy documents indicates that rural and coastal contexts are largely overlooked. Despite sizeable populations in these areas, recent policies rarely acknowledge their unique challenges. This gap may reflect a lack of research to guide policy, with the UK and Europe lagging behind countries such as Australia, Canada, and the USA in academic output on rural and coastal cancer issues [24]. Across documents, key terms such as "rural" and "coastal" appeared infrequently, in passing, or in footnotes, and almost never within substantive policy recommendations. This contrasts to frequent use of broader spatial or structural terms such as "local", "regional", "community" and "access". These terms suggest some recognition of geographical disparities in service provision, but fall short of explicitly articulating targeted strategies or interventions to address rural or coastal challenges such as increased travel burden [22, 31], workforce shortages [23] or limited access [30, 31].

Our findings suggest limited engagement with rural and coastal issues in cancer policy, with refences often lacking specific recommendations. This may stem from insufficient evidence on the scale, causes and solutions for inequalities in healthcare access, transport, and digital health infrastructure. High quality, targeted research is urgently required to inform future policy. Future cancer strategy should directly acknowledge rural and coastal challenges, supported by meaningful consultation with these communities to guide future planning and the tailored and effective interventions [24, 43].

It is unclear whether the upcoming cancer plan for England will recognise the needs of rural and coastal communities [16, 43]. Of already published national plans Northern Ireland's Rural Needs Impact Assessment is commendable but substantive integration of rural considerations into the recent Northern Irish cancer strategy is still limited. We encourage all nations of the UK to follow Northern Ireland's lead in conducting a Rural Needs Impact Assessment to inform e development and implementation of cancer planning going forward.

The concept of "coastal" health inequalities is relatively new and largely absent from UK cancer policy, though it has gained attention through the Chief Medical Officer's 2021 and 2023 reports [33, 34] and the UK Government's 10-Year Health Plan (July 2025) [35]. This growing recognition offers an opportunity to embed coastal cancer care challenges directly into policy, rather than subsuming them under broader health inequality agendas. There is an important opportunity to capitalise on this and to specifically recognise the challenges of coastal cancer care in upcoming policy. Research evidence on cancer and coastal communities is still preliminary, abut growing [38-42]. Existing data show higher rates of emergency cancer diagnosis compared to national trends [54]. This aligns with suggestions that inequalities in coastal communities could partly stem from poor engagement with cancer screening [33]. F

A UK-wide approach to rural and coastal cancer care research, priority setting, and policy making is needed, one that recognises shared challenges and nation-specific issues. Stakeholders, including patients and carers, should build consensus on research priorities to align with the information needs of policy makers, with the ultimate goal of improving geographically equitable care. The process could run alongside extensive patient and public involvement and engagement (PPIE) and co-production with rural and coastal communities, focusing on granular, place-based data to avoid homogenisation and enabling targeted, effective policy and interventions.

An important limitation of our analysis is basing it on publicly available (some had broken weblinks but were accessible via members of the research team) cancer policy documents without evaluating implementation or seeking information about local-level initiatives that

could already be implemented to meet specific needs in rural or coastal communities of the UK. It is vital that cancer policy documents remain freely available to ensure equity of access, transparency and informed decision-making. Without open-access, accountability and progress in cancer care are threatened. Future research could also usefully examine local, national and international policies from high output countries in rural cancer research (e.g. USA, Canada, Australia) to assess how rural or coastal issues are addressed there. Research should also investigate whether the policy gaps identified here lead to service disparities or poorer outcomes in rural and coastal areas at a local, regional and national level.

5. Conclusion

Despite significant rural and coastal populations across the four countries of the UK, national cancer policies, with the exception of Northern Ireland, currently give limited consideration to the challenges of living with, or caring for someone with, cancer in rural and coastal settings. The other UK nations should consider adopting more rural-centric approaches (e.g. Rural Impact Assessments) like Northern Ireland when it comes to support future cancer policies. If the UK and its respective nations are to achieve equitable cancer care, future national and devolved strategies need to move beyond generic references to “access” and “local” and directly engage with the structural, geographic and social determinants that are impacting on rural and coastal communities.

6. Policy Summary

Coastal and rural health issues in England have received considerable policy attention via the Chief Medical Officer for England’s 2021 and 2023 annual reports [33, 34] and more recently in the UK Government’s 10 Year Health Plan for England published in July 2025 [35]. However, in current national cancer policy across the four nations of the UK, the needs and challenges of rural and coastal people affected by cancer are not being sufficiently recognised. It is unclear whether the upcoming National Cancer Plan for England [43] will change this, while the soon-to-be published Northern Ireland Cancer Research Strategy, represents a further opportunity to stand out from the other UK nations as a driver of cancer research and its implementation in rural and coastal settings

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Appendix 1 (A1) Overview of included Cancer Policy Documents

Scotland Cancer Policy Documents

Document name and year	Ref	Available at	Last accessed
Scottish Government (2024). Cancer Action Plan 2023 – 2026 Progress Report 1: June 2023 – March 2024	S21	https://www.gov.scot/publications/cancer-action-plan-progress-report-1-june-2023-march-2024/	06/07/2025
Scottish Government (2023). Cancer Strategy for Scotland 2023-2033	S20	https://www.gov.scot/publications/cancer-strategy-scotland-2023-2033/	06/07/2025
Scottish Government (2023). Cancer Action Plan for Scotland 2023-2026	S19	https://www.gov.scot/publications/cancer-action-plan-scotland-2023-2026/	06/07/2025
Scottish Government (2022). National Radiotherapy Plan for Scotland. Improving Radiotherapy Services and Patient Outcomes Across Scotland	S18	https://www.gov.scot/publications/national-radiotherapy-plan-scotland/	06/07/2025
Scottish Government (2022). Scotland's National Cancer Plan: A Report of Progress on Actions as at 31 August 2022	S17	https://www.gov.scot/publications/scotlands-national-cancer-plan-report-progress-actions-31-august-2022/	06/07/2025
Scottish Government (2021). Collaborative and Compassionate Cancer Care The Cancer Strategy for Children and Young People in Scotland 2021–2026	S16	https://www.gov.scot/publications/collaborative-compassionate-cancer-care-cancer-strategy-children-young-people-scotland-20212026/	06/07/2025
Scottish Government (2020). Recovery and Redesign. An Action Plan for Cancer Services	S15	https://www.gov.scot/publications/recovery-redesign-action-plan-cancer-services /	06/07/2025
Scottish Government (2020). Beating Cancer: Ambition and Action (2016). An update: achievements - new action, and testing change	S14	https://www.gov.scot/publications/beating-cancer-ambition-action-2016-update-achievements-new-action-testing-change/pages/action-and-achievements-to-date/	06/07/2025
Scottish Government (2016). Right diagnosis, right treatment, right team, right place; The cancer plan for Children and Young People in Scotland, 2016-19	S13	https://www.iccp-portal.org/sites/default/files/plans/Scotland_children_young_people_cancer_plan.pdf	06/07/2025
Scottish Government (2016). Beating Cancer: Ambition and Action	S12	https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2016/03/beating-cancer-ambition-	06/07/2025

		action/documents/00496709-pdf/00496709-pdf/govscot%3Adocument/00496709.pdf	
Scottish Government (2012). Cancer Plan for Children and Young People in Scotland 2012-15. Managed Service Network for Children and Young People with Cancer in Scotland	S11	https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2012/03/cancer-plan-children-young-people-scotland-2012-15/documents/cancer-plan-children-young-people-scotland-2012-15-managed-service-network-children-young-people-cancer-scotland/cancer-plan-children-young-people-scotland-2012-15-managed-service-network-children-young-people-cancer-scotland/govscot%3Adocument/00390510.pdf	06/07/2025
Scottish Government (2011). Detect Cancer Early Implementation Plan	S10	Hyperlink to plan on the below page but appears to no longer be online - https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/pages/detect-cancer-early /	Not available (team member has a copy).
Scottish Government (2008). Better Cancer Care, an Action Plan	S9	https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2008/10/better-cancer-care-action-plan/documents/0067458-pdf/0067458-pdf/govscot:document/0067458.pdf	06/07/2025
Scottish Executive (2005). Cancer in Scotland Action for Change Monitoring Report 2005	S8	No longer available online.	Not available (team member has a copy).
Scottish Executive (2005). Cancer in Scotland: Action for Change. A guide to securing access to information	S7	No longer available online.	Not available (team member has a copy).
NHS Scotland (2004). Cancer in Scotland. Action for Change. Bowel Cancer Framework for Scotland	S6	https://www.gov.scot/publications/bowel-cancer-framework-scotland/	06/07/2025
Scottish Executive (2004). Cancer in Scotland: Sustaining Change	S5	https://webarchive.nrscotland.gov.uk/20190121224549/http://www2.gov.scot/Publications/2004/05/19344/36955	06/07/2025
Scottish Executive (2004). Cancer in Scotland: Action for Change. Fourth Monitoring Reports	S4	https://www.publications.scot.nhs.uk/files_legacy/sehd/publications/cis404/cis404.pdf	06/07/2025
Scottish Executive (2001). Cancer In Scotland: Action for Change. The Structure, functions and working relationships of Regional Cancer Advisory Groups	S3	https://www.scot.nhs.uk/sehd/mels/HDL2001_71guidance.PDF	06/07/2025
NHS Scotland (2001). Cancer in Scotland. Action for Change. Implementation/Investment Plan 2001-02.	S2	https://www.publications.scot.nhs.uk/files_legacy/sehd/publications/csii/csii.pdf#:~:text=At%20the%20launch%20of%20Cancer%20in%20Scotland:%20Action	06/07/2025

Scottish Government (2001). Cancer in Scotland Action for Change.	S1	No longer available online.	Not available (team member has a copy).

Wales Cancer Policy Documents

Document name and year	Ref	Available at	Last accessed
Wales Cancer Network (2023). A Cancer Improvement Plan for NHS Wales 2023-2026	W7	https://performanceandimprovement.nhs.wales/functions/networks-and-planning/cancer/cancer-improvement-plan-docs/full-plan/	06/07/2025
Wales Cancer Network (2022). Moving Forward: A cancer Research Strategy for Wales	W6	https://walescancerresearchcentre.org/crest/	06/07/2025
Wales Cancer Network (2022). Rapid Diagnosis Clinics: A National Programme for Wales Implementation specification for health boards across Wales	W5	https://performanceandimprovement.nhs.wales/functions/networks-and-planning/cancer/workstreams/rapid-diagnosis-clinics-programme/rdc-documents/rapid-diagnosis-clinics-a-national-programme-for-wales/	06/07/2025
Welsh Government (2022). The quality statement for cancer The quality statement describes what good quality cancer services should look like	W4	https://www.gov.wales/quality-statement-cancer-html	06/07/2025
Wales Cancer Network (2016). Cancer Delivery Plan for Wales 2016-2020 The highest standard of care for everyone with cancer.	W3	https://www.tenovuscancercare.org.uk/media/5z1psivk/cancer-delivery-plan-for-wales-2016-2020.pdf	06/07/2025
NHS Wales (2014). Radiotherapy Equipment Needs and Workforce Implications 2006-2016 (update report to 2020)	W2	https://www.gov.wales/sites/default/files/publications/2019-10/radiotherapy-equipment-needs-and-workforce-implications-2006-2016-update-report-to-2020.pdf	06/07/2025
Welsh Government (2012). Together For Health – Cancer Delivery Plan. A Delivery Plan up to 2016 for NHS Wales and its Partners. The highest standard of care for everyone with cancer	W1	https://www.tenovuscancercare.org.uk/media/fdafmgm1/together-for-health-cancer-delivery-plan-for-nhs-wales-2012.pdf	06/07/2025

Northern Ireland Cancer Policy Documents

Document name and year	Ref	Available at	Last accessed

Department of Health (2022). A Cancer Strategy for Northern Ireland 2022-2032	NI10	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-cancer-strategy-march-2022.pdf	06/07/2025
Department of Health (2022) A Rural Needs Impact Assessment for the Cancer Strategy 2022-2032	NI9	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-cancer-strategy-rural-need-impact-assessment.pdf	06/07/2025
Department of Health (2022) Equality Impact Assessment for the Cancer Strategy 2022-2032	NI8	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-cancer-strategy-eqia.pdf	06/07/2025
Department of Health (2022) Funding Plan and Additional Documents in Relation to the Cancer Strategy 2022-2032	NI7	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-cancer-strategy-revised-funding-plan.pdf	06/07/2025
Public Consultation on the Cancer Strategy Report and Associated Documents (2021)	NI6	https://www.health-ni.gov.uk/consultations/consultation-cancer-strategy-northern-ireland-2021-2031	06/07/2025
Department of Health (2020). Rebuilding Health And Social Care Cancer And Haematology Treatment Services In Northern Ireland Policy Statement	NI5	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-rebuilding-hsc-plans.pdf	06/07/2025
Department of Health, Social Services and Public Safety (2017). Mid-Term Review Of The Skin Cancer Prevention Strategy And Action Plan	NI4	https://www.health-ni.gov.uk/sites/default/files/publications/health/Mid-term%20review%20of%20skin%20cancer%20prevention%20strategy%20and%20action.pdf	06/07/2025
Department of Health, Social Services and Public Safety (2011). Service Framework For Cancer Prevention, Treatment And Care (unknown date).	NI3	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/service-framework-for-cancer-prevention-treament-and-care-full-document.pdf	06/07/2025
Department of Health, Social Services and Public Safety (2011). Skin Cancer Prevention Strategy And Action Plan 2011-2021.	NI2	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/skin-cancer-prevention-strategy-action-plan-2011-21.pdf	06/07/2025

Department of Health, Social Services and Public Safety (2008). Regional Cancer Framework A Cancer Control Programme for Northern Ireland	NI1	https://www.iccp-portal.org/sites/default/files/plans/cancer_control_programme.pdf	06/07/2025

England Cancer Policy Documents

Document name and year	Ref	Available at	Last accessed
Independent Cancer Taskforce (2015). Achieving World-Class Cancer Outcomes A Strategy For England 2015-2020	E17	https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf	06/07/2025
The Equality Impact Assessment for the above strategy (2015)	E16	https://www.cancerresearchuk.org/sites/default/files/taskforce_equality_impact_assessment.pdf	06/07/2025
Department of Health, Public Health England, NHS Improvement (2014). Improving Outcomes: A strategy for Cancer. Fourth Annual Report	E15	https://assets.publishing.service.gov.uk/media/5a7d6f80ed915d269ba8aa71/fourth_annual_report.pdf	06/07/2025
NHS Improvement, Macmillan Cancer Support, Department of Health (2013). Living With And Beyond Cancer: Taking Action To Improve Outcomes	E14	https://assets.publishing.service.gov.uk/media/5a74c301e5274a3f93b489b6/9333-TSO-2900664-NCSI_Report_FINAL.pdf	06/07/2025
Department of Health, Public Health England, NHS Improvement (2013). Improving Outcomes: A strategy for Cancer. Third Annual Report	E13	https://assets.publishing.service.gov.uk/media/5a7d6f80ed915d269ba8aa71/fourth_annual_report.pdf	06/07/2025
Department of Health (2012). Improving Outcomes: A strategy for Cancer. Second Annual Report	E12	https://assets.publishing.service.gov.uk/media/5a7cb45de5274a2f304ef94a/IOSC-Second-Annual-Report-Final.pdf	06/07/2025
Department of Health (2011). Improving outcomes: A strategy for cancer	E11	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf#:~:text=This%20Outcomes%20Strategy%20sets%20out%20how%20%E2%80%93%20in	06/07/2025
Department of Health (2011). Improving Outcomes: A Strategy for Cancer Stakeholder engagement report	E10	https://assets.publishing.service.gov.uk/media/5a7cbdc1ed915d63cc65c92f/dh_123431.pdf	06/07/2025

Department of Health (2011). The impact assessment for Improving Outcomes: A Strategy for Cancer	E9	https://assets.publishing.service.gov.uk/media/5a7b895bed915d131105fe42/dh_123505.pdf	06/07/2025
Department of Health (2011). Improving Outcomes: A strategy for Cancer. First Annual Report	E8	https://assets.publishing.service.gov.uk/media/5a7ca62040f0b65b3de0a457/dh_131787.pdf	06/07/2025
NHS (2007). Cancer Reform strategy	E7	https://webarchive.nationalarchives.gov.uk/ukgwa/20130104165259/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006	06/07/2025
Department of Health (2007). Impact Assessment of the Cancer Reform Strategy	E6	https://webarchive.nationalarchives.gov.uk/ukgwa/20130104214029/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_081004	06/07/2025
Department of Health (2007). Cancer Reform Strategy Equality Impact Assessment	E5	https://webarchive.nationalarchives.gov.uk/ukgwa/20130104214031/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_081005	06/07/2025
National Audit Office (2005). The NHS Cancer Plan: A Progress Report	E4	https://webarchive.nationalarchives.gov.uk/ukgwa/20170207052351/https:/www.nao.org.uk/wp-content/uploads/2005/03/0405343.pdf	06/07/2025
National Audit Office (2005). Tackling Cancer: Improving the Patient Journey	E3	https://webarchive.nationalarchives.gov.uk/ukgwa/20170207052351/https:/www.nao.org.uk/wp-content/uploads/2005/02/0405288.pdf	06/07/2025
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Click here to view linked References

Appendix 2 (A2) Overview of search terms

Concept	Terms
Geography	**Geog (raphy & raphical) etc** Topography Location Landscape Local Regio (n & al & ally)
Urban	Urban City Cities Town
Rural	**Rural** Remote Isolated Small Town Country Countryside Farm Farming Highland Island Isles Village Settlement Non-urban
Coastal	Coast Coastal Sea Seaside
Other	**Travel** **Transport** Depriv (ation & ed) Access Inequ (ality & ialities) Equit (y & able) Ethnic Workforce Techno (logical & logy) Tele (medicine & phone) Digital Broadband Primary care General pract (ice & itioner) GP

	Community Research

Appendix 3 (A3) Contextual Details

Contents

SCOTLAND

Scottish Policy Documents

1. Scottish Government (2023). Cancer Strategy for Scotland 2023-2033. Available here.
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		SCOTLAND																				
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Geography	**Geog (raphy & raphical) etc**	5	0	0	0	10	0	0	1	2	6	0	4	5	0	2	5	2	0	0	3	3
	Topography	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Location	4	0	0	1	5	0	0	0	6	2	0	5	0	0	0	0	6	0	2	0	1
	Landscape	0	2*	2*	6*	4*	3*	0	1*	1*	1	0	1*	0	0	0	0	0	0	0	0	0
Rural	**Rural**	1	0	0	0	0	0	0	0	1	0	0	2	2	0	0	0	4	0	4	4	0
	Remote	3	0	1	1	0	4	0	0	0	1	0	6	2	0	0	0	2	0	2	2	2
	Isolated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	Small Town	0	0	0	04	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Country	0	0	2	0	3	3	1	2	7	2	2	6	0	1	7	6	2	0	0	8	0
	Countryside	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Regio (n & al & ally)	18	4	3	0	16	6	0	2	14	9	7	42	205	10	19	48	142	22	47	29	6
	Farm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Farming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Highland	0	0	0	2	3	0	0	0	0	1	1	1	0	0	2	0	79	1	4	1	2
	Island	1	0	0	0	0	0	0	0	1	3	0	0	9	0	0	0	2	0	0	1	0
	Isles	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	1
	Village	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Settlement	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Non-urban																					
Barriers	**Travel**	5	1	0	0	1	0	1	2	1	5	0	8	3	1	2	3	10	1	4	4	1
	Transport	1	1	0	0	0	0	0	0	2	0	0	1	0	1	0	1	5	0	0	1	0
	Depriv (ation & ed)	24	6	0	32	0	2	4	0	27	0	18	33	0	0	1	6	0	0	0	13	7
	Access	70	35	17	44	68	39	13	28	64	46	25	52	48	48	13	24	174	0	108	20	35
	Inequ (ality & ialities)	49	14	0	18	2	6	7	0	28	0	7	26	1	1	1	0	1	0	0	3	14
	Equit (y & able)	13	8	0	10	40	14	0	6	12	9	0	8	14	0	0	6	53	2	44	5	14
	Ethnic	6	1	0	0	0	0	0	0	1	1	1	12	1	3	0	2	0	0	0	1	1
	Workforce	39	31	10	26	54	14	7	13	30	20	10	26	9	0	11	18	5	3	0	15	12
	Techno (logical & logy)	19	14	6	8	2	8	6	2	6	2	0	26	9	2	1	16	16	0	8	23	12
	Tele (medicine & phone)	1	0	0	2	0	0	0	1	2	2	3	12	24	6	1	1	13	0	4	6	1
	Digital	17	8	0	12	3	10	2	0	2	0	1	4	0	1	0	0	9	0	2	0	14
	Broadband	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Coastal	Coast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Coastal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sea	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Seaside	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urban	Urban	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	City	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2	3
	Cities	0	0	0	0	0	0	0	0	0	1	0	2	0	0	0	0	0	0	0	0	0
	Town	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary care	Primary care	19	7	0	12	7	11	2	4	17	7	26	30	26	3	2	16	52	1	8	8	11
	General pract (ice & itioner)	1	0	0	0	1	0	0	0	1	4	5	1	0	2	0	3	1	0	0	2	2
	GP	4	2	0	11	0	6	3	0	11	1	20	23	19	0	2	5	42	0	2	20	1
	Community	7	4	2	19	13	15	1	5	18	2	9	25	8	1	10	22	28	0	16	21	3
	Local	15	9	1	9	23	9	1	7	25	22	22	66	79	27	15	30	96	17	29	30	10
Other	Research	40	23	4	12	12	5	17	32	68	30	33	89	32	10	38	39	35	0	0	50	26

Remote usually referring to “remote monitoring” or “remote consulting.”
Country usually referring to the whole country (e.g. Scotland, England etc)
*Landscape not usually literal – e.g. medicine’s landscape, simplifying the cancer landscape

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Contextual Details of the word "Geog (raphy & raphical)" etc in the Scottish Policy Documents

REF 1 (Cancer Strategy for Scotland 2023-33) **– 5 uses of geog(raphy & raphical)**

Page 14/68 - Chapter 1 The Strategy and its Context
-Section 1.5 Realistic Medicine, Person-Centred Care and 'What Matters'
Diagram on Person Centred Care and why it matters. Individual patient factors – '**geographical** location'

Page 17/68 - Chapter 1 The Strategy and its Context
- Section 1.6 Governance and Delivery.
"However, many other aspects of delivery will be carried out at a local or regional level, reflecting local services, **geographies**, populations and the needs of the individual with cancer."

Page 32/68 - Chapter 3 Strategy Ambitions
- Section 3.3 Our Strategic Ambitions – Ambition 3 Best Preparation for Treatment ("Pre-Treatment")

"Harness Data: Continuous improvement in the provision of timely, high-quality, transparent, and integrated data will enable an improved understanding of barriers to earlier diagnosis and variation (**geographical**, socio-economic, ethnicity and other equalities data). This includes having more timely staging data available for all stageable cancer types."

Page 48/68 - Chapter 3 Strategy Ambitions
- Section 3.3 Our Strategic Ambitions – Ambition 8 Tackling Inequalities

"Scotland's **geography** means there are particular challenges in providing equity of access to some rural and island communities. Improving the accessibility of services through the location of services and use of digital technology, providing transport, maintaining support structures, ensuring affordability and increased focus on cultural competence of services are all measures likely to reduce inequalities. Speciality outreach services can improve access and self reported health."

Page 51/68 - Chapter 3 Strategy Ambitions
- Section 3.3 Our Strategic Ambitions – Ambition 9 Mental Health As Part of Basic Care

"Access should be equitable regardless of **geographical** or socio-economic factors, ethnicity, gender, disability or other equality characteristic."

REF 5 (Collaborative and Compassionate Cancer Care The Cancer Strategy for Children and Young People in Scotland 2021–2026) **– 10 uses of geog(raphy & raphical)**

Page 12/82 – Section 1: Our Story So Far
- National Multi-Disciplinary Teams

Table 1 – NHS Scotland Paediatric, Teenager and Young Adults Cancer MDTs. Geography of each meeting is listed in the table i.e. local, regional or national MDT meetings.

Page 30/82 – Section 3: The Way Forward and Our Ten Ambitions
- Ambition 3 – Incorporated Supportive Care Services

> "Action 11: Health Boards will ensure equitable and timely access to specialist AHP assessment and interventions at all stages of the cancer journey, regardless of age, stage of treatment or **geographical** location"

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Page 37/82 – Section 3: The Way Forward and Our Ten Ambitions

- Ambition 6 – Integrated Palliative and End of Life Care Services
  "The MSN CYPC advocates strongly that end of life care should be delivered in the appropriate and preferred location of the patient and family with the vast majority of children and young people choosing the community setting. This often requires coordination of highly complex care between interdisciplinary and interagency services to ensure safe delivery of a bespoke management plan. True choice cannot not always be offered throughout Scotland currently as there is significant **geographical** variability in local service provision and access to 24/7 specialist support. The MSN CYPC is committed to addressing this inequality of access to end of life care by collaboration with key stakeholders to develop a specialist national nursing and medical model which can complement the local services available and includes Paediatric Oncology Outreach Nurse Specialists, Adult Community Hospices, Community Children's Nurses, District Nurses, Primary Care and Children's Hospices Across Scotland (CHAS)."

Page 41/82 – Section 3: The Way Forward and Our Ten Ambitions

- Ambition 8 – Education, Training and Staff Support
  "A historical challenge within the MSN CYPC has been the **geographical** separation of patients and clinical teams. New technology provides the opportunity for more regular collaboration between regions, enabling specialist team members to offer input into the care of patient wherever they are treated."

Page 47/82 – Section 3: The Way Forward and Our Ten Ambitions

- Ambition 9 – Specialist and Sustainable Workforce
  "The provision of specialist age-appropriate cancer services for TYAs in adult cancer services is delivered through the development of a national TYA cancer network model of care (Appendix 4). This encompasses TYA cancer hubs established across the five adult regional cancer centres and nominated **geographical** regions"

Page 51/82 – Section 3: The Way Forward and Our Ten Ambitions

- Ambition 10 – Age Appropriate Services and Effective Transitions
  "TYAs with cancer have to navigate complex and varied patient pathways. Their sometimes transient lifestyle, influenced by educational, family, and social factors, can mean that TYAs move between a number of different care settings and across **geographical** locations. The purpose of the TYA element of the MSN CYPC is to navigate these challenges; ensuring optimal, effective and efficient TYA cancer services which deliver excellent patient experience. This will be achieved through the effective coordination of patient pathways between providers and within the network's **geographical** area, and sometimes beyond."

Page 53/82 – Section 3: The Way Forward and Our Ten Ambitions

- Ambition 10 – Age Appropriate Services and Effective Transitions
  "Returning to education and employment was also identified as a top ten research priority for TYAs contributing to the James Lind Alliance work (Aldiss et al, 2019). However resource to enable TYAs to achieve employment and educational goals are not consistently or comprehensively supported across TYA cancer services in Scotland, and access can be dependent on **geographical** location. The MSN CYPC recognises the importance of this area to young people and aims to identify what resource is available and where there are gaps. The MSN CYPC will also work with young people to undertake a needs analysis."

Page 56/82 – Section 5: Development of the Strategy

- "The MSN CYPC National Clinical Director developed an initial draft strategy and following this a Cancer Strategy Oversight Group was initiated to review and finalise; incorporating the wide feedback received. The group consisted of representatives from each of the associated professions aligned to children and young people's cancer services, including appropriate **geographical** representation (Appendix 6)."

Page 58/82 – Section 6: Summary of Actions

- Table of Actions – Action 11 "Health Boards will ensure equitable and timely access to specialist AHP assessment and interventions at all stages of the cancer journey, regardless of age, stage of treatment or **geographical** location"

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***REF 8 (Right diagnosis, right treatment, right team, right place; The cancer plan for Children and Young People in Scotland, 2016-19)* – 1 use of geog(raphy & raphical)**

Page 19/36 – Priority Areas: Working as a Multi-Disciplinary Team
"Over the last decade there has been an increased investment in psychosocial support for young cancer patients and their families; this is largely through the services and support provided by CLIC Sargent social workers, nurse specialists, play specialists, play therapists, clinical psychologists, Teenage Cancer Trust youth support coordinators, spiritual care services and allied health professionals.

Work is ongoing to identify families that require psychological support or advice on other relevant services available. From initial work carried out within the psychological health workstream there is recognition that many of the previous disciplines offer emotional support but this is variable across age and **geographical** boundaries."

***REF 9 (Beating Cancer: Ambition and Action)* – 2 uses of geog(raphy & raphical)**

Page 31/64 – Chapter 6: Improving Treatment
"Our National Clinical Strategy makes clear our ambition that, where clinically appropriate, services should be planned and delivered at a local level. Where there is, though, evidence that better outcomes could only be reliably and sustainably produced by planning services on a regional or national level, we must look to the future and plan our services on a population basis regardless of **geographical** boundary."

Page 41/64 – Chapter 7: Workforce
"Our Ambitions:
- To have a diverse, sustainable, workforce caring for people with cancer.
- To support equity of access to specialist care regardless of **geography**.
- To see all people with cancer, who need it, have access to a specialist nurse during and after their treatment."

***REF 10 (Cancer Plan for Children and Young People in Scotland 2012-15. Managed Service Network for Children and Young People with Cancer in Scotland)* – 6 uses of geog(raphy & raphical)**

Page 27/40 – How will we demonstrate success?
- Improved Outcomes
  "Access to trials
  The MSN will deliver equity of access to clinical trials irrespective of **geography** and age. Recruitment by trial availability across the age range will be monitored and audited."

Pages 32-34/40 – Appendix 1: International Comparators
- "The main differences which distinguish Scotland from other international models surround:
  • The low volume of cases per year.
  • The distribution of the Scottish population in relation to the landmass (>50% of the population is contained within 3 health board areas).
  • The uneven distribution of resources (2 large University children's hospitals 50 miles apart).
  • Challenges of climate and **geography** and hence, travel.
  • Quality of national clinical databases.
  • The link between general practice and paediatric specialties

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Based on these elements, several countries stand out as important exemplars and sources of experience. Norway With a population of 4.7 million people containing 975,000 children under the age of 16, Norway is divided into 4 **geographical** and administrative health regions (Southeast, West, Middle, and North) with one serving University Hospital in each region. 55% of the population live in the south-eastern health region but all 4 regions treat their own children with little in the way of cross regional flow (with the exception of the densely populated Stavanger region (Rogaland) which is traditionally referred patients to the National Hospital in Oslo instead of Bergen to which the patients **geographically** belong. This has historic, logistical as well as political reasons)

…

Canada With scale and a widely distributed population being a major challenge, children's Cancer services in Canada are delivered from 17 different centres to accommodate their 1300 new cases of cancer per year in children under age 18. The directors of these 17 treatment centres constitute "C 17" the Council of Directors and it is this body that ensures that research, education, communication and engagement is consistent across Canada. Whilst each clinical unit functions in an individual fashion, policies and programs are consistent as is commitment to trial entry, (C 17 has 185 clinical trials open as members of COG (Children's Oncology Group). Trials are approved by Health Canada and C 17 enjoys strong educational grant support with regular substantial charitable donations to the C 17 council which is able to effect a pan-Canada oncology service in spite of the **geographic** challenges posed by its landscape and climate. A frequently unrecognised feature of the Canadian population is its ethnic mix with 19.8% of the Canadian population being immigrant adding the additional feature of diversity into the challenges posed to the clinical service

…

Several messages emerge from these countries which are relevant if not important items for our service. Pointers can be taken from each as follows:

• Provider volume is not itself the sole proxy of quality of care in paediatric oncology.
• The link between primary and secondary care is key to early referral and collaborative working.
• GP training in paediatrics and making the" first point of contact" as expert as possible is a key educational objective.
• Achieving consistent policy and practice in the face of differing **geographies** problems and experiences requires collaboration best served by integration into a single service network.
• Investment in today's trials produces tomorrow's optimal outcome treatments.
• Most centres in the world have too few patients to conduct large studies; international collaboration between sites is a prerequisite.
• Commitment to a national database is essential in order to facilitate outcome analysis on the mid to long term and provide the requisite assurance of quality of care"

REF 12 (Better Cancer Care, An Action Plan) **– 4 uses of geog(raphy & raphical)**

Page 74/114 – Chapter 7: Living With Cancer

"Tackling The Costs:

The Scottish Government's commitment to abolishing prescription charges for all by 2011 has been welcomed by patients across Scotland but it recognises that this is only part of the picture. The Cancer Costs study by Macmillan Cancer Support showed that Scottish cancer patients face the highest costs in the UK for travelling to hospital for treatment, spending an average of £636 on travel and parking throughout the course of their cancer treatment. Whilst some of this disparity is an inevitable consequence of **geography**, the Scottish Government is committed to reducing the financial burden on cancer patients and has announced that hospital car parking charges at all NHS hospitals (except the three sites developed under Private Finance Initiative (PFI) arrangements) will end from 31 December 2008."

Page 84/114 – Chapter 8: Improving Quality of Cancer Care for Patients

- "MCNs are required to assess how services within their **geographical** areas perform against these standards."

Page 85/114 – Chapter 8: Improving Quality of Cancer Care for Patients

- A Broad Approach to Quality

  "Better Health, Better Care sets out the basis for NHSScotland's approach to quality improvement. This is based on the Institute of Medicine's definition for quality and has six specific goals:

  ■ Patient-centred – considers the patient's preferences and requests in every health care decision regarding diagnosis, treatment and care
  ■ Safe – helps cure the patient instead of causing more injury or discomfort
  ■ Effective – provides the right services to the right people, only when they really need them

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■ Efficient – targets the application of resources (staff, supplies, equipment) to maximise resource use and avoid passing on costs to the patient
■ Equitable – ensures that every patient receives the same standard of care regardless of gender, ethnicity, **geographical** location and socioeconomic status
■ Timely – provides treatment quickly, reducing waits and (sometimes harmful) delays. The future work programme for quality improvement in cancer services needs to reflect all six dimensions of this model, which are both interlinked and essential, thereby providing a clear focus on quality at national, regional and local level"

Page 90/114 – Chapter 8: Improving Quality of Cancer Care for Patients

- Equitable Care
  "Multi-disciplinary teams that work within regional MCNs were introduced in the early 2000s to minimise **geographic** inequalities in the quality of care and to ensure the highest standards of care were provided throughout Scotland"

REF 13 (Cancer in Scotland: Action for Change Monitoring Report 2005) **– 5 uses of geog(raphy & raphical)**

Pages 25-26/92 – South East Scotland Cancer Network (SCAN) Monitoring Report

- 4. Waiting Times Summary
  "The 2005 Commitment (Our National Health): No cancer patient to wait longer than two months (62 days) from urgent GP referral to first treatment…We have however identified issues which are common to all **geographical** areas and all patient pathways and which may need a national approach.
  [3rd issue identified as common to all areas] - Clinical investigation and diagnosis
  "Decisions about appropriate treatment are made after discussion by a multidisciplinary team (MDT). MDT meetings are periodic and their time and **geographical** dispersion put additional strain on shortage specialities. The need to access all relevant information may further delay this important part of the process."

Page 30/92 – South East Scotland Cancer Network (SCAN) Monitoring Report

- 10. Patient Focus Public Involvement
  "*1.7 Is there a library or list of patient information available across all Cancer Networks?*
  The CIN provides a comprehensive library of over 1000 documents catalogued by audience, tumour type, subject, and **geographical** relevance. Resources include: patient information leaflets about different types of cancer and how they are diagnosed and treated, virtual tours, patient experiences, and practical non-medical information."

Page 74/92 – West of Scotland Cancer Network (WOSCAN) Monitoring Report

- Multi-disciplinary team meeting
  Regional
  "The regional lymphoma MDT (via teleconferencing) for pathology review of lymphoma and clinical discussion continues to develop. More **geographical** sites across the West of Scotland are now linking-in to this meeting. The registration and clinical discussion forms for this meeting have been further developed to facilitate collection of audit data on the patients presented at these meetings. A formal report on cases discussed at the MDT is now forwarded to the referring clinician."

Page 88/92 – West of Scotland Cancer Network (WOSCAN) Monitoring Report

- 8.5 Lanarkshire
  Managed Clinical Network
  "NHS Lanarkshire are currently reviewing the Lanarkshire **geographical** network as a subunit of the West of Scotland Cancer Network in the light of the move to single-system working."

REF 15 (Cancer in Scotland. Action for Change. Bowel Cancer Framework for Scotland) **– 2 uses of geog(raphy & raphical)**

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Page 18/29 – 4. Improving Cancer Treatment and Care

- "The three regional cancer groups have made much progress over the last three years. Multi-disciplinary team working and tumour specific cancer networks are in place for most cancers and in most **geographical** areas. This is true for bowel cancer, with all regions having recognised groups of clinicians working together across institutional and **geographical** boundaries, in line with the accepted definition of a managed clinical network (NHS HDL (2002) 69)"

REF 16 (Cancer in Scotland. Sustaining Change) – 5 uses of geog(raphy & raphical)

Page 9/63 – Introduction

"So what is the role of the national (Scottish Executive) team? Think of us as the coordination hub – acting as links between the **geographical** areas, disease specific and generic networks and between the cancer programme and other NHSS initiatives"

Page 14/63 – Chapter 1: Cancer in Scotland: Where we are now.

- "**Geographical** and socio-economic variations within Scotland
  The risk of getting cancer is unevenly distributed in the population. High incidence rates are seen in the central belt, particularly in Greater Glasgow and Lothian NHS Board areas. For men, this is due to historical patterns of exposure to the main risk factors for cancer, predominantly smoking. For women, the distribution of incidence is more even, due to the combination of breast and some other female gender-specific cancers, and tobacco-related cancers. While the latter are more common in lower socio-economic groups, breast cancer is commonest in higher socio-economic groups. Thus, the **geographical** distribution of cancer in women masks important differences in risks for particular types of cancer across the country."

Page 43/63 – Chapter 4: Investing in Staff and Technology

- Nursing Care
  "A Framework for Nursing People With Cancer in Scotland has been developed, overseen by an Executive group chaired by the Chief Nursing Officer. Consultation with nurses about the content was conducted through a series of four national conferences held between November 2002 and August 2003. The Framework sets out the strategic vision that will shape nursing services for people with cancer across NHS Scotland, in all care settings and in all **geographic** areas. It is expected to improve patient care through focused and coordinated nursing services."

Page 55/63 – Chapter 6: Making It Happen

- Next Steps table
  "look at barriers preventing the involvement of patients, such as **geographical**, ethnic and socioeconomic factors"

REF 17 (Cancer in Scotland: Action for Change. Fourth Monitoring Reports) – 2 uses of geog(raphy & raphical)

Page 4/78 – North of Scotland Cancer Network (NOSCAN) Monitoring Report

- **2. Regional Cancer Advisory Group**
  "Leo McClymont, an ENT Surgeon at Raigmore took up the Chair of NOSCAN in May 2003. The rotational aspect of this position allows each **geographical** area a significant potential to increase their ownership, understanding and support of overall NOSCAN processes and aims"

Page 56/78 – Cancer in Scotland: Progress on projects funded from slippage in 2003/04

Code	Location	Action	Capital £	Revenue £	Milestones/ Target Dates	Respnsible Lead	Budget Holder	Measurable benefit to patient	Note
SES3-24		Skin – purchase of neoprobe portable		15,000				To enable SNLB to be performed with greatest	

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		gamma probe for sentinel lymph node biopsy						reliability. To allow SNLB to be performed in ALL appropriate cases. To offer service in more than 1 **geographical** location. To produce a centre of excellence for this technique.	

REF 20 (Cancer in Scotland: Action for Change. 2001) **– 3 uses of geog(raphy & raphical)**

Page 21/72 – Chapter 2: Preventing Cancer

- "Although many initiatives are already improving the Scottish diet, the factors which affect it are more than simply a matter of personal choice and, as with smoking, socio-economic and **geographical** factors are very important."

Page 42/72 – Chapter 5: Improving Cancer Treatment and Care

- *Managed clinical networks for cancer*

  "Managed clinical networks bring together all of the professions and disciplines involved in the care of patients with a particular cancer type. They ensure that the best possible quality of care is provided equitably across a **geographical** area. Regional networks have already been established in some areas and for some cancer types, e.g. the Glasgow & West of Scotland Gynaecological Cancer Network. To ensure that there is comprehensive coverage across Scotland other tumour specific networks will follow.

  > *Our National Health confirmed that by 2002, fully functional cancer MCNs will be in place for all cancer services.*

  To be effective, cancer MCNs require appropriate support. If they are to audit their work – and as noted variously throughout this document, clinical audit is essential – they need to be supported by the provision of clinical support, information systems and audit staff. Because network members – clinical and managerial – are employed by many different Trusts and belong to many different disciplines, they will also need help in working across **geographical**, institutional and professional boundaries."

REF 21 (Cancer Action Plan 2023 – 2026 Progress Report 1: June 2023 – March 2024) **– 3 uses of geog(raphy & raphical)**

Page 36/39 – Appendix A: Headline Indicators

"PHS Cancer Intelligence Platform: Work is ongoing to establish the indicator during the lifetime of the first Action Plan. The CIP is currently live internally within the PHS Cancer & Adult Screening Team. By July 2024, this will contain five datasets relevant to cancer (the cancer registry data, cancer waits, death data, pathology data and all acute hospital discharges (SMR01). In addition, CIP holds the necessary reference files (such as populations, **geographical** lookups, deprivation data). The intention is that three datasets will be added annually thereafter as these datasets become available to PHS.
Headline Indicator I
Vision: Equitably accessible care
Cross-cutting aim: Reduced health inequalities in all areas above
Indicators: In line with this cross-cutting aim, wherever possible, we will monitor data broken down by equalities, socioeconomic and **geographic** characteristics. This will include analysis of sex and age group, SIMD quintile, and **geography** if possible, subject to statistical disclosure control."

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Contextual Details of the word "Rural" in the Scottish Policy Documents

REF 1 (Cancer Strategy for Scotland 2023-33) – 1 use of "Rural" and 1 use of "Island"

Single use of "Rural" & "Island" in Chapter 3 "Strategy Ambitions." Ambition 8: Tackling Inequalities – Our 10 year vision (page 48)

"Scotland's geography mean there are particular challenges in providing equity of access to some **rural** and **island** communities. Improving the accessibility of services through the location of services and use of digital technology providing transport, maintaining support structures, ensuring affordability and increased focus on cultural competence of services are all measures likely to reduce inequalities. Speciality outreach services can improve access and self-reported health.[27]"

References : 27 NHS Scotland (2013) Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities, page 48

REF 9 (Scottish Government (2016). Beating Cancer: Ambition and Action) - 1 use of "Rural" and 1 use of "Island"

"Rural" and Island" used in Chapter 6 "Improving Treatment." (Page 32)

There are excellent examples of **rural** chemotherapy services delivering treatment supported by cancer centres, including services in Lochgilphead, Lorne and **Islands** Hospital, Western Isles Hospital, and Elgin Memorial Hospital. These services are developed in cooperation with larger centres to facilitate local access to cancer treatment."

REF 12 (Scottish Government (2008). Better Cancer Care, an Action Plan – 2 uses of "Rural"

"Rural" used in Chapter 7 Living with Cancer – Cancer Poverty (page 70)

*"The work of Macmillan Cancer Support and its partners in this field has made a valuable contribution to the lives of many people with cancer and the Scottish Government will invest £500,000 to help ensure the continuing expansion and success of this work. This will, amongst other things, allow for the development of new approaches to the delivery of financial advice and support to cancer patients and their families, including those living in **remote** and **rural** communities*

"Rural" used in summary table at end of Chapter 7 Living with Cancer (page 82)

Bullet point reiterating above – *"Work with MacMillan Cancer Support to develop the work of benefits advisors throughout Scotland, including new funding to extend services in new ways to **remote** and **rural** communities."*

REF 13 (Scottish Executive (2005). Cancer in Scotland Action for Change Monitoring Report 2005.) – 2 uses of "Rural"

"Rural" used in Section 7 reporting on NOSCAN (North of Scotland Cancer Network's Bowel Cancer Framework) (Page 4)

*"In collaboration with the **Remote** and **Rural** Areas Initiative (RARARI), NESCCAG funded a programme to promote symptom awareness, based on models developed in the West of Scotland."*

"Rural" used in WOSCAN (West of Scotland Cancer Network) report on palliative care. (Page 84)

*"Two **rural** group practices have adopted the Gold Standards Framework (GSF) for palliative care."*

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REF 17 (Scottish Executive (2004). Cancer in Scotland: Action for Change. Fourth Monitoring Reports) – 3 uses of "Rural" and 1 of "Rurality"

In NOSCAN report section on Palliative Care (page 12)

"Rural" used in table reporting measurable benefit of plan for "Provision of Videoconferencing Equipment" benefit is:

*"Improve communication and increase the knowledge and skills of those delivering palliative care, especially in **remote rural** areas. Improve access to specialist advice and support."*

In WOSCAN report section on Improving Treatment and Care (Page 71)

"Rural" used in table reporting measurable benefit of plan to introduce Multi-disciplinary Paediatric Oncology Support/Palliative Care Team benefit is:

*"To enhance the management and support of children in **rural** areas. Multidisciplinary working, improving access to care, equity of access improved."*

In WOSCAN report section on Palliative Care (Page 72)

"Rural" used in table reporting measurable benefit of plan to introduce Consultant in Palliative Medicine (noting is delayed) benefit is:

*"Promote equity across **rural** areas. Enhance patient care through reduction in travel requirements."*

In NOSCAN report section on Palliative Care (Page 20)

"Rurality" used in table reporting on evidence of measurable benefit of introducing a Consultant in Palliative Care in NHS Highland who appears to have delivered training to PCPs

"Lochaber - there were 5 education meetings in Lochaber between April 03 and Sept 03 with a total attendance from 5 to 40 depending on rurality."

REF 19 NHS Scotland (2001). Cancer in Scotland. Action for Change. Implementation/Investment Plan 2001-02 – 4 uses of "Rural"

"Rural" used twice in tables for "Building Capacity: Palliative Care" and in North of Scotland Subsection Table on Building Capacity describing "measurable benefit for patients" of plan to introduce videoconferencing facilities in Tayside as:

"Improve communications and information sharing with remote and rural areas. Improved patient access to specialist advice and support. Enhance knowledge and skills. amongst palliative care staff." (Page 14)

"Rural" used twice in tables for "Building Capacity: Palliative Care" and in "measurable benefit for patients" of plan to introduce a consultant in palliative medicine in Argyll and Clyde benefit as:

"Promote equity of access across rural areas. Enhance patient care through reduction in travel requirements"
(Pages 16 + 32)

REF 20 (Scottish Government (2001). Cancer in Scotland: Action for Change) – 4 uses of "Rural"

Return to top

“Rural” used in Chapter 2 (Preventing Cancer) (Page 21)

“Local availability of fresh fruit and vegetables as well as efficient public transport are major considerations in deprived and rural communities.”

“Rural” used In box in same chapter (It’s Happening already describing the Scottish Community Diet Project) (Page 21)

“The scheme also supports healthy home food delivery services, and training and supporting local people to participate in food initiatives in rural communities.”

“Rural” used in Chapter 7 (Investing in Our Staff and In Technology) in section on “Telemedicine” (Page 58)

“Telemedicine is a rapidly developing field with great potential to improve access to high quality care irrespective of distance. Examples include the use of videoconferencing and electronic transmission of x-ray images. Used to support MCNs, telemedicine can improve rapid access to up-to-date information and provide better access to specialist advice leading to faster diagnosis and more efficient use of resources. For patients, particularly those in remote and rural areas, there will be greater scope to receive the care they need closer to home.”

“Rural” appears in Glossary (Page 71)

“RARARI – Remote and Rural Areas Resource Initiative” – **This is the only mention of RARARI in the whole document!**

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Contextual Details of the words “Travel” and “Transport” etc in the Scottish Policy Documents

REF 1 (Cancer Strategy for Scotland 2023-33) **– 5 uses of “travel” and 1 of “transport”**

Page 8/68 – “We will continue the direction of **travel** laid out in the National Clinical Strategy for Scotland (2016)”

Page 38/68 – Chapter 3: Strategy Ambitions
Ambition 4 – Safe, realistic and effective treatment
“People with cancer requiring complex operations are usually very receptive to being treated by highly specialist teams, even where it involves increased **travel**, but it is crucial that they are appropriately supported in doing so (practically, financially and emotionally as required).”

Page 45/68 – Chapter 3: Strategy Ambitions
Ambition 7 – Person-centred care for all
“People with cancer are at the heart of all decisions and actions involving them. They are given the opportunity to co-design their own care plan, and information including a treatment summary is readily available. A single point of contact (SPOC) is at the centre of this. Where possible, diagnostic tests and treatment are situated close to home and **travel** to specialist care is fully supported, making use of the continued advancement in new technologies”

Page 49/68 – Chapter 3: Strategy Ambitions
Ambition 8 – Tackling inequalities
“Scotland’s geography means there are particular challenges in providing equity of access to some rural and island communities. Improving the accessibility of services through the location of services and use of digital technology, providing **transport**, maintaining support structures, ensuring affordability and increased focus on cultural competence of services are all measures likely to reduce inequalities. Speciality outreach services can improve access and self reported health.”

“Disparities in access to diagnostic and treatment services will be improved using new technology that facilitates alternative siting of services and remote consultations (see Flourishing Research and Innovation). We will make sure that efforts to add more digital elements into the health system are proportionate to ensure that nobody is left behind, while meeting the expectations of those who want to interact in this way. People with cancer will not be disadvantaged by the cost of **travel** or loss of paid working days.”

Page 54/68 – Chapter 3: Strategy Ambitions
Ambition 10 Flourishing research and innovation
“We live in a time of extraordinary innovation in technology that provides opportunities to diagnose and treat people with cancer. These range from the genomics revolution in diagnostics and treatment, to advances in the use of AI, 5G, Internet of Things in healthcare through to the apps, tools and products that we now use in our everyday lives. Recent health service examples include the use of video appointments such as Near Me and the use of drones in supply chains.29 In March 2022, we reached 1.5 million Near Me appointments across Scotland, saving an estimated 49 million **travel** miles for patient, families and staff”

REF 2 (Cancer Action Plan for Scotland 2023-26) **– 1 use of “travel” and 1 of “transport”**

Page 8/30 – Chapter 2: The Actions
2.1 Preventing More Cancers

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"Being physically active is one of the most important steps people of all ages and abilities can take for cancer prevention, treatment, and control. We support the WHO ambition to reduce physical inactivity by 15% by 2030. We will implement the Active Scotland Outcomes Framework that provides a common structure for the wide range of actions we are taking across **transport**, education, environment, health and sport sectors."

Page 11/30 – mention of Gypsy **Travel**ler communities.

***REF 5 (Collaborative and Compassionate Cancer Care: The Cancer Strategy for Children and Young People in Scotland 2021-2026)* – 1 use of "travel"**

Page 22/82 – Section 3: The Way Forward and our Ten Ambitions
Ambition 1 – Enhancing and improving outcomes

"The Scottish Government recommends that all children, teenagers and young adults with cancer participate in clinical trials.
However data collected by the MSN CYPC has demonstrated that many children and young people, particularly those in the TYA group, are not treated on clinical trials. A lack of available front-line clinical trials for common cancer within this age group is the main factor. There are situations where inequitable access to a clinical trial is seen within Scotland. MDTs serve to highlight such discrepancies. In addition it is clear that there has been an affect of the COVID-19 pandemic on clinical trial entry, with many trials closing to recruitment for periods of time. Reluctance to **travel** or being away from home has also impacted."

***REF 7 (Beating Cancer: Ambition and Action (2016). An update: achievements - new action, and testing change)* – 1 use of "travel"**

Page 13/16 – Actions on best care and support for all people with and beyond cancer
"45. We will assess how the Scottish Government can support the wider provision of patient information and support, including through maximising the reach and impact of local directories, and how people with cancer **travel**ling for treatment and care can be best supported."

***REF 8 (Right diagnosis, right treatment, right team, right place; The cancer plan for Children and Young People in Scotland 2016-19)* – 2 uses of "travel"**

Page 14/36 – How will this look for the patient?
"With Scotland representing one third of the UK land mass and less than ten percent of the UK population, equitable access to the pathway of care for young people with cancer is an MSN priority. These pathways recognise that for some treatments and procedures, patients will need to **travel** within and out with Scotland. Currently around 20-30% of young patients requiring radiotherapy are **travel**ling to the USA for Proton radiotherapy supported by the National Services Division (NSD)."

***REF 9 (Beating Cancer: Ambition and Action)* – 1 use of "travel" and 2 of "transport"**

Page 27/64 – "Diagnostic services have an important influence on the diagnosis of cancer and the subsequent delivery of cancer treatment. Statistics from EUROCARE studies suggest that poorer survival in Scotland primarily relates to late presentation.54 Imaging plays a vital role in ensuring accurate and timely diagnosis and staging of cancer as do laboratory-based investigations. Diagnostic specialities require specific clinical expertise and specialist equipment, supported by efficient and timely mechanisms for sample collection, **transport**, processing, imaging, interpretation and reporting."

Page 47/64 – reference to patients from **travel**ling community
Page 59/64 – One of the references listed is on www.transport.scot.gov

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REF 10 (Cancer Plan for Children and Young People in Scotland 2012-15. Managed Service Network for Children and Young People with Cancer in Scotland) **– 5 uses of "travel"**

Page 6/40 – Executive summary

"It is a plan for a system that spans across Scotland, and ensures equity of care irrespective of residence, that plans care for those who need to **travel** beyond our national boundaries for rare cancers and very specific treatments; that plans to care for those where the nature of the illness dominates over the ability of the treatment and where supportive palliative care is needed."

Page 15/40 – How will we achieve success?

Education and training

"The development of e-health as an educational tool will help provide a web based learning facility eliminating the need for **travel**. E-health will host educational material appropriate to all disciplines. MDT meetings are currently held by video-conference to minimise **travel** and all educational meetings will have a video-conferencing facility, wherever appropriate, to allow access to all."

Page 21/40 – Processes and structures

Palliative Care

"The stages of the treatment journey each child and family **travels** is outlined in Figure 2."

Page 32/40 – Appendix 1: International Comparators

"The main differences which distinguish Scotland from other international models surround:
• The low volume of cases per year.
• The distribution of the Scottish population in relation to the landmass (>50% of the population is contained within 3 health board areas).
• The uneven distribution of resources (2 large University children's hospitals 50 miles apart).
• Challenges of climate and geography and hence, **travel**.
• Quality of national clinical databases.
• The link between general practice and paediatric specialties."

REF 12 (Better Cancer Care, an Action Plan) **– 8 uses of "travel" and 1 use of "transport"**

Page 60/114 – Section 6: Treatment

Example of Good Practice in Scotland

"The benefits for patients receiving some of their chemotherapy in Orkney are:
■ It greatly reduces the **travel** burden and time away from home for patients
■ Patients are more satisfied
■ It is safer (when given in a structured system) as local staff are more aware of potential problems and have the appropriate training to respond as necessary
■ It reduces **travel** costs and inpatient admissions, helping to address capacity issues in the cancer centre"

Page 74/114 – Section 7: Living with cancer

Tackling the costs

"The Cancer Costs study by Macmillan Cancer Support showed that Scottish cancer patients face the highest costs in the UK for **travel**ling to hospital for treatment, spending an average of £636 on **travel** and parking throughout the course of their cancer treatment. Whilst some of this disparity is an inevitable consequence of geography, the Scottish Government is committed to reducing the financial burden on cancer patients and has announced that hospital car parking charges at all NHS hospitals (except the three sites developed under Private Finance Initiative (PFI) arrangements) will end from 31 December 2008. This applies to all car parking provision made available by NHS Boards, including hospitals, healthcare facilities and premises where NHS Boards use a contractor to manage their car park facilities on their behalf. Those NHS Boards with PFI contracts in place have been asked to enter into discussions with their PFI provider to explore what opportunities exist for limiting or reducing charges for parking.
Further work will also be commissioned in conjunction with other statutory and voluntary sector stakeholders in order to:
■ Improve public **transport** links to healthcare facilities
■ Raise awareness of the schemes that are available to reimburse travel costs
■ Make greater use of new technologies and ways of working to cut back on unnecessary **travel**."

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Page 101/114 – Section 9: Delivery
"Telehealth, where deployed effectively, can improve the patient's experience of care by reducing the need for **travel** to major cities and hospitals to receive their care and treatment. It offers a range of options remotely via phones, (including mobile phones) and broadband, often involving video-conferencing. The Scottish Centre for Telehealth is supporting NHS Boards to pilot the use of telehealth to help redesign and improve patients' access to healthcare, no matter where they live."
"Example of Good Practice:
In May 2006, the Scottish Government supported the project team at the Scottish Centre for Telehealth by funding a pilot to test the 'proof of concept' in the use of tele-endoscopy. This used remote diagnostic technology to facilitate the examination of an airway for patients with symptoms of head and neck cancer. The pilot delivered a remote diagnostic service from Aberdeen to Shetland, following which, the clinics are now part of routine service delivery, with high levels of patient satisfaction being reported. In May 2008, this pilot was extended to deliver a remote diagnostic service from Raigmore to Stornoway and a local Speech and Language Therapist has been trained to perform endoscopy and facilitate the clinics. The final phase will see the delivery of a Head and Neck review appointment service to a local Community Hospital in Aberdeenshire.

The economic evaluation of the above project by Health Economic Research Unit (HERU) at the University of Aberdeen will be assessed by the Scottish Cancer Taskforce to ascertain wider roll out of the model of care. It is likely roll out of the model will be recommended if it is shown to be safe and effective, demonstrates better use of equipment and improved clinical outcomes for patients and reduces the number of patients who have to **travel** to major cities for specialist investigations."

REF 13 (Cancer in Scotland Action for Change Monitoring Report 2005) **– 3 uses of "travel"**

Page 7/92 NOSCAN 11. Patient Focus and Public Involvement
NOSCAN-wide PPI work
"NOSCAN expenses policy and claim form for reimbursing patient representatives involved in the work of NOSCAN for **travel** and out of pocket expenses. £5,000 grant from Macmillan Cancer Relief for 2003/04 secured to help us do this."

Page 24/92 SCAN – Telemedicine
Usage
"There has been a steady increase in the use of the equipment at most sites, both for SCAN-related meetings and others… SCAN group meetings have also been held between WGH, Fife, Dumfries and Borders. Use of videoconferencing for most future meetings has been scheduled, with emphasis on linking the most remote sites (Borders and Dumfries), and this will save a great deal of **travelling**, and increase attendance."

Page 31/92 SCAN – 10. Patient Focus and Public Involvement
"*1.16 Is there a process to share and benefit from others' experiences using leaflets or websites adapted as required?*
Examples of good practice with regard to patient information are shared across the SCAN region via the CIN. Resources developed specifically for the Network have been adapted for use offline, e.g. a virtual tour of radiotherapy at the Edinburgh Cancer Centre has been modified for inclusion in the Dumfries & Galloway patient **travel** pack. The architecture of the Network itself has been adapted for use by NOSCAN, the SE Scotland Epilepsy MCN, and the Edinburgh Child Protection Committee."

REF 14 (Cancer in Scotland: Action for Change. A guide to securing access to information) **– 1 use of "travel" and 1 use of "transport"**
Page 15/27 Chapter 3: Information needs across the patient pathway
Patient Pathway Model 2 diagram – Financial/Social factors including **transport**

Page 16/27 Chapter 3: Information needs across the patient pathway
Diagram on information needed by patients:
"Hospital information – general e.g. **travel**/parking"

REF 15 (Cancer in Scotland. Action for Change. Bowel Cancer Framework for Scotland.) **– 2 uses of "travel"**
Page 5/29 Executive Summary

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"The purpose of this framework is not to draw conclusions, but rather to set a direction of **travel**."

Page 7/29 Chapter 1: Preventing Cancer
Table on basic elements of preventing cancer includes section on physical activity – "Helping to build capacity among community planning partners for developing active **travel** as an integral part of their physical activity plans"

REF 16 (Cancer in Scotland: Sustaining Change) **– 3 uses of "travel" and 1 use of "transport"**

Page 5/63 Executive Summary
Page 7/63 Introduction
Page 22/63 Bowel Cancer Screening Pilot Next Steps
All metaphorical uses of travel – i.e. direction of travel for policy/services

Page 38/63 Improving Access To Treatment and Care
Older People
"Cancer cannot be isolated from other issues that impact on older people's health and well-being, including tackling pensioner poverty, improving housing and access to **transport**. A strategy is being developed to facilitate a more co-ordinated approach to older people's issues within the Executive, including identifying gaps and opportunities for addressing them. The cancer programme aims to play full and active part in these initiatives."

REF 17 (Cancer in Scotland: Action for Change. Fourth Monitoring Reports) **– 10 uses of "travel" and 5 uses of "transport"**

Page 6/78 NOSCAN – Scottish Cancer Research Network –
"Managing Budgets - there is a consensus that the budgets are very tight. There is also a consensus that the staff listed are the minimum needed to fulfil the objectives. This year there will be savings because of the timing of appointments, and these will fund costs related to staff training, as **travel** and associated costs for this will be high, particularly in Year 1."

Page 8/78 NOSCAN – Patient information and patient/public involvement
"Tayside University Hospital Trust has developed Patient Information Guides for staff in relation to writing/reviewing information, protocol for production of information leaflets, and patient information evaluation tool. This has resulted in the Radiotherapy Department developing patient information leaflets covering a variety of cancer sites, as well as one detailing **travel** arrangements to the Centre. Oncology Ward feedback received through patient stories have also been undertaken by Ward 32 Charge Nurse, also a patient/carer feedback session in October led by patient representative. For the second quarter of 2003/04, Tayside Health Council have advised 4 cancer users on complaints procedures in relation to problems with waiting times."

Other references to travel and transport are all in tables of progress with 2001-02 and 2003-04 investments in North, West and South Scotland e.g.
Increased sessions from visiting oncologist
Provision of Videoconferencing equipment - Improved access to specialist advice without need to travel (patients and clinicians); improved communications
Outpatient clinic for haematology
Expansion of chemo day unit facility at St Johns Hospital, Livingston
Recruitment of a Macmillan nurse specialist

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REF 18 (Cancer In Scotland: Action for Change. The Structure, functions and working relationships of Regional Cancer Advisory Groups) – 1 use of "travel"

Page 1/5

"3. Cancer in Scotland: Action for Change was published on 3 July 2001. It sets a clear direction of **travel** for developing and improving cancer services in Scotland over the coming years and it is itself set within the wider framework for change and implementation."

REF 19 (Cancer in Scotland. Action for Change. Implementation/Investment Plan 2001-02) – 2 uses of "travel"

Page 16 + 19/48 Building Capacity: Palliative Care table

Plan	Tumour Type	Capital £000	Revenue £000	Measurable benefit For patients	Milestones/Target dates	Responsible Lead
Argyll & Clyde- Consultant in Palliative Medicine				Promote equity of access across rural areas Enhance patient care through reduction in **travel** requirements	By March 2002	Dr D Morton
Videoconferencing links between Aberdeen and Inverness	Gynaecological			Improved access to specialist advice without need to **travel** (patients and clinicians); improved communications	Installation by February 2002	Mrs M Vobes

REF 20 (Cancer in Scotland: Action for Change) – 4 uses of "travel" and 1 use of "transport"

Page 1/72 Summary

"1. The Scottish Executive's cancer strategy, *Cancer in Scotland: Action for Change*, is being published today. It sets out a clear direction of **travel** for developing and improving cancer services over the coming years."

Page 17/72 Chapter 2: Preventing Cancer

"Local availability of fresh fruit and vegetables as well as efficient public **transport** are major considerations in deprived and rural communities."

Page 37/72 Chapter 5: Improving Cancer Treatment and Care

"In Scotland, specialist treatments such as radiotherapy and chemotherapy are provided from five Cancer Centres – in Aberdeen, Dundee, Edinburgh, Glasgow and Inverness – and consultant oncologists based in these centres **travel** extensively to provide support and
care to patients across the country"

Page 38/72 Chapter 5: Improving Cancer Treatment and Care

"Through their planning processes Regional Cancer Advisory Groups will require to match the need for effective and safe treatment with patient expectations of receiving that treatment as close to home as possible with minimal delay and disruption to their everyday lives. However, we recognise, as do patients, that it may sometimes be inevitable to have to **travel** to local or more distant hospitals or centres for treatment.

WHAT PEOPLE SAY
If you have to **travel** to a specialist centre, that's OK, but you need appointment times to allow you time to get there and get home again"

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***REF 21 (Cancer Action Plan 2023 – 2026 Progress Report 1: June 2023 – March 2024)* – 1 use of "travel"**

Page 21/39 Ambition 7: Person-centred care for all
"Our 10-year vision is that people with cancer are at the heart of all decisions and actions involving them. They are given the opportunity to co-design their own care plan, and information including a treatment summary is readily available. A single point of contact (SPOC) is at the centre of this. Where possible, diagnostic tests and treatment are situated close to home and **travel** to specialist care is fully supported, making use of the continued advancement in new technologies."

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WALES

Welsh Policy Documents

1. Wales Cancer Network (2023). A Cancer Improvement Plan for NHS Wales 2023-2026. Available here.
2. Wales Cancer Network (2022). Moving Forward: A cancer Research Strategy for Wales. Available here.
3. Wales Cancer Network (2022). Rapid Diagnosis Clinics: A National Programme for Wales Implementation specification for health boards across Wales. Available here.
4. Welsh Government (2022). POLICY AND STRATEGY The quality statement for cancer The quality statement describes what good quality cancer services should look like. Available here.
5. Wales Cancer Network (2016). Cancer Delivery Plan for Wales 2016-2020 The highest standard of care for everyone with cancer. Available here.
6. NHS Wales (2014). RADIOTHERAPY EQUIPMENT NEEDS AND WORKFORCE IMPLICATIONS 2006-2016 (UPDATE REPORT TO 2020). Available here.
7. Welsh Government (2012). Together For Health – Cancer Delivery Plan. A Delivery Plan up to 2016 for NHS Wales and its Partners. The highest standard of care for everyone with cancer. Available here.

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		WALES						
		1	2	3	4	5	6	7
Geography	**Geog (raphy & raphical) etc**	2	0	0	0	2	2	0
	Topography	0	0	0	0	0	0	0
	Location	7	0	1	0	1	2	0
	Landscape	1	2	0	0	0	0	0
Rural	**Rural**	0	0	0	0	0	0	0
	Remote	4	0	0	0	0	0	0
	Isolated	0	0	0	0	0	0	0
	Small Town	0	0	0	0	0	0	0
	Country	1	0	2	0	2	0	0
	Countryside	0	0	0	0	0	0	0
	Regio (n & al & ally)	33	0	6	2	12	4	1
	Farm	0	0	0	0	0	0	0
	Farming	0	0	0	0	0	0	0
	Highland	0	0	0	0	0	0	0
	Island	0	0	0	0	0	0	0
	Village	0	0	0	0	0	0	0
	Settlement	0	0	0	0	0	0	0
	Non-urban					0		0
Barriers	**Travel**	3	0	1	0	1	4	14
	Transport	0	0	0	0	1	1	2
	Depriv (ation & ed)	0	0	2	0	4	2	8
	Access	64	3	23	6	35	29	34
	Inequ (ality & ialities)	7	4	3	0	4	0	4
	Equit (y & able)	27	1	0	3	9	3	2
	Ethnic	2	0	0	0	0	0	1
	Workforce	67	4	6	1	6	41	1
	Techno (logical & logy)	23	0	1	0	1	27	4
	Tele (medicine & phone)	5	0	4	0	1	10	1
	Digital	37	0	1	0	6	3	1
	Broadband	0	0	0	0	0	0	0
Coastal	Coast	0	0	0	0	0	0	0
	Coastal	0	0	0	0	0	0	0
	Sea	0	0	0	0	0	0	0
	Seaside	0	0	0	0	0	0	0
Urban	Urban	0	0	0	0	0	0	0
	City	0	0	0	0	0	0	0
	Cities	0	0	0	0	0	0	0
	Town	0	0	0	0	0	0	0
Primary care	Primary care	11	1	15	0	26	0	11
	General prac (tice & titioner)	1	0	4	0	1	0	0
	GP	8	0	37	0	7	4	14
	Community	18	6	5	0	4	0	4
	Local	26	0	14	6	9	22	92
Other	Research	76	120	4	3	50	20	42

*referring to financial settlement ** titling cities mainly *** island of Ireland

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Contextual Details of the word "Geog (raphy & raphical)" etc in the Welsh Policy Documents

REF 1 (A Cancer Improvement Plan for NHS Wales 2023-2026) – 2 uses of "geog(raphy/raphical)"

Page 27/45 Chapter 12: Effective treatments
Health Board and Trust Specific Action Plans
Cwm Taf Morgannwg UHB
"Identify funding for the additional posts set out in the South East Wales Business Case. Once funding is agreed, recruit the required **geographical** spread of the service required".

Page 39/45 Chapter 15: Key system wide enablers
c). Cancer research
"Managing and monitoring local research portfolios is important to ensuring cancer clinical trials can be offered to patients in a timely and equitable way right across Wales. Improving the efficiency of trial setup and delivery processes and ensuring all relevant patients are approached about research is key to improving equity of access to research across populations, **geographies** and tumour sites."

REF 5 (Cancer Delivery Plan for Wales 2016-2020 The highest standard of care for everyone with cancer) – 2 uses of "geog(raphy/raphical)"

Page 4/24 Foreword
"At the heart of service quality improvement is tackling variation. Incidence of cancer varies by 23% between the most and least deprived areas in Wales. As a small country with a small number of providers we can do substantially better to tackle differences in services and reduce inequalities. Targeted prevention including diet, tobacco and lifestyle advice, uptake of population screening programmes and equitable access to care, will help to drive down socio-economic and **geographical** variation in outcomes."

Page 20/24 Improving cancer information
"Systems also need to provide information for public health purposes, such as population-based cancer registration and for research to improve targeting of prevention and treatments. Population-based cancer registration (PBCR) is a well-established endeavour internationally. In Wales, a high quality PBCR is operated by the Public Health Wales Welsh Cancer Intelligence and Surveillance Unit (WCISU). It systematically collects quality-assured information on all defined new cases of cancer in a **geographically**-defined population from multiple data sources. This allows population cancer incidence, mortality and survival rates to be calculated and compared over time and with other populations."

REF 6 (RADIOTHERAPY EQUIPMENT NEEDS AND WORKFORCE IMPLICATIONS 2006-2016 (UPDATE REPORT TO 2020) – 2 uses of "geog(raphy/raphical)"

Page 21/65 Section A: Capacity and Demand
Estimating Demand

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“33. There are several possible reasons for the shortfall and variation in the actual access rates achieved compared to the modelled predictions, with the main issues considered to be as follows:
a. Equipment procurement - lack of timely planning and commissioning of new and replacement linear accelerators, associated equipment and works to meet population requirements.
b. **Geography** - It is recognised that the uptake of radiotherapy diminishes with the distance that patients have to travel to a radiotherapy centre. The 2006 Report highlighted that the **geography** of Wales and social and economic factors means that some patients face a considerable journey to their nearest radiotherapy centre which may impact on uptake and outcomes. There are a number of initiatives that could help to ease the travel burden, including satellite units, the use of patient hotels, dedicated door-to-door transport and more suitable appointment times.”

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Contextual Details of the word "Rural" etc in the Welsh Policy Documents

REF 1 (A Cancer Improvement Plan for NHS Wales 2023-2026) – 4 uses of "remote" and 33 uses of "region/regionally" etc

Multiple mentions of different regions in Wales throughout the document, as well as working more regionally /setting up regional hubs for certain services

Page 19/45 Chapter 10: Elective Care Recovery

"The All-Wales Teledermoscopy Programme will address the dermatology waiting list back log. Patients with low-risk lesions are invited to attend clinical photography appointments with images reviewed **remotely** by dermatologists, allowing the clinician to signpost the patient appropriately, ensuring appointments are reserved for those patients with a clinical need and reducing unnecessary travel for patients…

…Cancer Services have developed new ways of working during the COVID-19 pandemic and it is important lessons are learned from these and what worked well is maintained, such as **remote** consultations and ensuring timely access to expert opinions from primary and non-specialist secondary care. Further work is needed to explore how to optimise **remote** consultations for the patients this works well for, whilst recognising that this does not work well for everyone."

Page 36/45 Chapter 15: Key system wide enablers

a.) Workforce:

"Retention: For example, working with Health Boards to develop retention approaches; support for more flexible/**remote** working models; establishing career pathways for all professionals"

REF 3 (Rapid Diagnosis Clinics: A National Programme for Wales Implementation specification for health boards across Wales.) – 1 use of "country" and 6 uses of "region/regionally" etc

Page 9/31 Section 1.3: RDC Aims and Objectives [RDC: *Rapid Diagnosis Clinic*]

"Reduce unwarranted variation in referral for, access to, and in the reliability of relevant diagnostic tests by setting standards for RDCs nationally, mandating consistent data collection to enable benchmarking and providing **regional** support to roll out RDCs. Data return from all health boards will allow ongoing evaluation and further research into the clinical model"

Page 12/31 Section 2.0: The Road to Implementation

"Swansea Bay UHB remain committed to taking on a leadership role within the national programme, expanding their **regional** diagnostic service, and providing an enhanced level of support, training and education to other sites."

Page 13/31 Section 2.1 RDC Access Criteria

"For RDCs to remain efficient and effective a once weekly clinic model has been endorsed as the minimum set standard for all RDC clinics in Wales. Services operating more **regionally** may need to increase this frequency to accommodate demand. Further learning to help put this into practice will be shared by Swansea Bay who have successfully run twice weekly clinics."

Page 15/31 Section 3.0: The Vague Symptoms Pathway

"Most importantly, the pathway is designed to be a benchmark of what each RDC in Wales will ultimately strive to achieve. This should guarantee a uniform high standard of patient experience regardless of which RDC they attend in the **country** and regardless of the healthcare setting."

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Contextual Details of the word “Travel” and “Transport” in the Welsh Policy Documents

REF 1 (A Cancer Improvement Plan for NHS Wales 2023-2026) – 3 uses of “travel”

Page 13/45 – reference to ‘direction of **travel’** for cancer screening services policy.

Page 19/45 Section 10: Elective Care Recovery
“The All-Wales Teledermoscopy Programme will address the dermatology waiting list back log. Patients with low-risk lesions are invited to attend clinical photography appointments with images reviewed remotely by dermatologists, allowing the clinician to signpost the patient appropriately, ensuring appointments are reserved for those patients with a clinical need and reducing unnecessary **travel** for patients.”

Page 35/45 Section 14: Improving patient experience
b.) Signposting to emotional support, benefits advice and other holistic services
“People affected by cancer will also be more acutely impacted by the cost-of-living crisis and will have specific needs as a result of their diagnosis. A cancer diagnosis will often lead to increased **travel** costs, energy bills and pressure on household budgets.”

REF 3 (Rapid Diagnosis Clinics: A National Programme for Wales Implementation specification for health boards across Wales.) – 1 use of “travel”

Page 14/31 Section 3.1: Covid-19 Considerations
“It may also be necessary to incorporate virtual elements into the pathway. The multi-disciplinary team (MDT) meetings may need to be held virtually to minimise contact and **travelling** between sites. However, the face-to-face collaborative approach is a proven vital component of the cultural change RDCs enable. Evidence shows the model improves both staff and patient experience and virtual working may temporarily delay the development of shared working, team building, and a holistic consensus approach to the MDTs. Virtual working should therefore be reviewed regularly in line with official national guidance.”

REF 5 (Cancer Delivery Plan for Wales 2016-2020 The highest standard of care for everyone with cancer) – 1 use of “travel” and 1 use of “transport”

Page 17/24 – Meeting the needs of people affected by cancer
“Access to services has been noted as a challenge and services should be provided as locally as is feasible, with health boards providing support for **transport** and accommodation as appropriate”

Page 18/24 – Meeting the needs of people affected by cancer
“40. Where possible health boards should provide care locally and support patients who need assistance to **travel** or stay away from home.”

REF 6 (RADIOTHERAPY EQUIPMENT NEEDS AND WORKFORCE IMPLICATIONS 2006-2016) – 4 uses of “travel” and 1 use of “transport”

Page 16/65 - Section A: Capacity and Demand

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Current capacity and radiotherapy activity
"23. The largest increase in activity was recorded in the North Wales Cancer Treatment Centre (51%), followed by South West Wales Cancer Centre (15%). It is important to note that in 2004/5, the radiotherapy service in North Wales was still being developed, and patients were still **travelling** into England for treatment which explains the high percentage increase; this cross border flow has now dropped significantly."

Page 21/65 – Section A: Capacity and Demand
Estimating Demand
"33. There are several possible reasons for the shortfall and variation in the actual access rates achieved compared to the modelled predictions, with the main issues considered to be as follows:

a. Equipment procurement - lack of timely planning and commissioning of new and replacement linear accelerators, associated equipment and works to meet population requirements.

b. Geography - It is recognised that the uptake of radiotherapy diminishes with the distance that patients have to **travel** to a radiotherapy centre. The 2006 Report highlighted that the geography of Wales and social and economic factors means that some patients face a considerable journey to their nearest radiotherapy centre which may impact on uptake and outcomes. There are a number of initiatives that could help to ease the **travel** burden, including satellite units, the use of patient hotels, dedicated door-to-door **transport** and more suitable appointment times."

Page 40/65 – Section C: Radiotherapy Developments
Context
"74. … The increased accuracy of treatment may also in some cases allow the entire curative treatment dose to be delivered in a much smaller number of (highly targeted) treatment fractions. This is more convenient both for the department and for patients, especially those that have to **travel** a long way to the radiotherapy centre."

REF 7 (Together For Health – Cancer Delivery Plan. A Delivery Plan up to 2016 for NHS Wales and its Partners. The highest standard of care for everyone with cancer) – 14 uses of "travel" and 2 uses of "transport"

Page 13/42- Section 6.3 Delivering fast, effective treatment and care
"Every cancer patient undergoing complex surgery in Wales should receive excellent peri-operative care, as delivered through the enhanced recovery after surgery (ERAS) and the Transforming Theatres initiatives. Cancer surgery services should be configured in a way that enables the highest standard of multidisciplinary care and outcome. This will require Local Health Boards, working through the Cancer Networks or WHSSC, to centralise services for which good outcomes depend upon volume. When this happens, patients and families need to be supported in **travel** and accommodation arrangements by their Local Health Boards."

Page 14/42- Section 6.4 Meeting people's needs
"People receiving NHS care have a right to be cared for with dignity and respect. Services need to be planned and delivered around the patient and their individual needs rather than the needs of the NHS. Where people have to **travel** for more specialist cancer care, NHS organisations are expected to put appropriate **transport** arrangements in place with care being provided as close to home as possible"

Page 23/42- Annex 1: Summary of outcomes
"Outcome 2 – Cancer is detected quickly where it does occur or recur

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• easier access to primary care services;
• more accessible information and support services provided through local pharmacies;
• more clinical support available 24 hours a day, 365 days a year;
• more direct access to diagnostics for GP;
• a greater range of local services meaning less need to **travel**, particularly for diagnosis and care after treatment;"

Multiple references to 'general direction of travel' in terms of policy/outcomes

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NORTHERN IRELAND

Northern Irish Policy Documents

1. Department of Health (2022). A Cancer Strategy for Northern Ireland 2022-2032. Available here.
2. A Rural Needs Impact Assessment was published alongside it and can be found here.
3. There is also an equality impact assessment document, here.
4. Finally, a funding plan and additional documents are here
5. Public consultation report and associated documents are still available here.
6. Department of Health (2020). Rebuilding Health And Social Care Cancer And Haematology Treatment Services In Northern Ireland Policy Statement. Available here.
7. Department of Health, Social Services and Public Safety (2017). Mid-Term Review Of The Skin Cancer Prevention Strategy And Action Plan. Available here.
8. Service Framework For Cancer Prevention, Treatment And Care (unknown date). Available here.
9. Department of Health, Social Services and Public Safety (2011). Skin Cancer Prevention Strategy And Action Plan 2011-2021. Available here.
10. Regional Cancer Framework A Cancer Control Programme for Northern Ireland (2008). Available here.

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		NORTHERN IRELAND									
		1	2	3	4	5	6	7	8	9	10
Geography	**Geog (raphy & raphical) etc**	1	2	1	0	2	0	0	0	1	3
	Topography	0	0	0	0	0	0	0	0	0	0
	Location	5	4	8	0	0	0	0	4	2	7
	Landscape	0	0	0	0	0	0	0	0	0	0
Rural	**Rural**	8	70	5	0	11	0	0	0	0	19
	Remote	2	2	0	0	0	5	0	0	0	0
	Isolated	0	0	0	0	1	0	0	0	0	0
	Small Town	0	0	0	0	0	0	0	0	0	0
	Country	0	0	0	0	0	0	1	1	5	0
	Countryside	0	0	0	0	0	0	0	0	0	0
	Regio (n & al & ally)	33	4	17	21	8	22	7	85	3	87
	Farm	0	0	0	0	0	0	0	0	0	0
	Farming	0	0	0	0	0	0	0	0	1	0
	Highland	0	0	0	1	0	0	0	0	0	0
	Island	2***	0	0	0	0	0	0	0	0	1***
	Village	0	3	0	0	0	0	0	0	0	0
	Settlement	1*	0	0	0	0	0	0	73+	0	0
	Non-urban	0	0	0	0	0	0	0	0	0	0
Barriers	**Travel**	5	13	22	1	2	2	4	6	7	12
	Transport	1	10	11	0	0	0	0	0	0	0
	Depriv (ation & ed)	34	2	1	0	3	0	1	18	0	19/20
	Access	75	8	27	28	21	10	0	83	3	85
	Inequ (ality & ialities)	18	0	3	0	11	0	1	0	0	1/15
	Equit (y & able)	10	0	1	0	2	0	0	29	0	4/7
	Ethnic	4	0	19	0	0	0	0	1	1	31
	Workforce	33	1	25	19	22	14	0	0	0	16
	Techno (logical & logy)	20	1	2	7	13	4	0	1	0	13
	Tele (medicine & phone)	5	0	0	2	2	1	0	2	3	1
	Digital	9	0	0	2	1	0	2	4	3	0
	Broadband	5	1	0	0	0	0	0	0	0	0
Coastal	Coast	0	0	0	0	0	0	0	0	0	0
	Coastal	0	0	0	0	0	0	0	0	0	0
	Sea	0	0	0	0	0	0	0	0	0	0
	Seaside	0	0	0	0	0	0	0	0	0	0
Urban	Urban	0	5	0	0	0	0	0	0	0	2
	City	1**	1	0	0	1	0	6	0	0	16**
	Cities	0	1	0	0	0	0	0	0	0	0
	Town	1	1	0	0	0	0	0	0	0	0
Primary care	Primary care	14	2	2	6	2	5	1	39	0	28
	General practice	6	0	1	0	5	0	1	0	0	3
	GP	24	2	0	3	8	2	5	32	3	28
	Community	19	3	5	5	12	10	3	18	4	44
	Local	12	1	7	4	8	14	3	26	6	37
Other	Research	82	4	13	12	9	2	8	29	21	55
+ as in budget settlement											

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Contextual Details of the word "Geog (raphy & raphical)" etc in the Northern Irish Policy Documents

REF 1 (A Cancer Strategy for Northern Ireland 2022-2032) – 1 use of "geography/geographical"

Page 69/140- Teenagers and Young Adults
"Due to the specific age-appropriate needs of teenagers and young adults, TYA cancer care is a distinct speciality. Cancer is a rare disease in this age group and therefore the young people become a rarity amongst their peers. Their specific needs are both psychosocial and physical. TYA with cancer interact with many services including haematology, oncology, medical and surgical specialities, psychology, psychiatry, palliative care, social work, youth work and education. Their care also transcends professional, organisational and **geographical** boundaries."

REF 2 (A Cancer Strategy for Northern Ireland 2022-2032 - Rural Needs Impact Assessment) – 2 uses of "geography/geographical"

Page 6/10 – Section 3: Identifying the social and economic needs of persons in rural areas
"Through ongoing engagement with people with lived experience of cancer in Northern Ireland, including workshops with people from a wide **geographical** and cancer diagnosis we have taken steps to identify issues that are important to people living in rural areas in relation to the cancer services and the Cancer Strategy. As part of the public consultation we will seek additional information."

Page 7/10 – Section 3: Identifying the social and economic needs of persons in rural areas
"In terms of wider engagement, stakeholders were consulted with widely across **geographical** areas at a variety of cross sectoral and engagement sessions."

REF 3 (A Cancer Strategy for Northern Ireland 2022-2032 – Equality Impact Assessment) – 1 use of "geography/geographical"

Page 38/40 – Section 7: Co-production and involvement process
Cancer Strategy Service User and Carer Reference Group
"A reference group was established with 27 people with lived experience representing different **geography**, demographics and cancer specialities. This group was openly recruited via advertisement regionally through the PCC Make Change Together platform. The group have participated across a range of activities, including an induction and regional workshop as well as providing specific feedback on the action by speciality."

REF 9 (Skin Cancer Prevention Strategy And Action Plan 2011-2021) – 1 use of "geography/geographical"

List of references: Ovensen, L., Andersen, R., and Jakobsen, J (2003). **Geographical** differences in vitamin D status, with particular reference to European countries. Proc.Nutr.Soc. 62, 813-821.

REF 10 (Regional Cancer Framework: A Cancer Control Programme for Northern Ireland) – 3 uses of "geography/geographical"

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Page 33/81 – Section 6: Improving Access to Diagnosis and Treatment
"6.4 Modern Information Communication Technologies promise greater ease of access to expert opinion and benefits in education and training. ICT can also help to reduce the constraints of **geography** in providing a service and improve communication between distant sites. This is particularly relevant in the effective treatment of cancer, which is seen to depend critically on, often difficult, early diagnosis. Developments such as telemedicine have the potential to facilitate multidisciplinary cancer meetings locally, regionally, nationally and internationally. As well as promoting effective communication between health professionals, effective ICT solutions must provide a common and secure platform for handling images and other patient specific data."

Page 34/81 – Section 6: Improving Access to Diagnosis and Treatment
"6.6 The planning for, and delivery of, cancer services will be progressed across the Cancer Network by supporting clinical networks of healthcare professionals, patients and voluntary sector representatives to work together in a co-ordinated way across **geographical**, organisational and professional boundaries."

Page 35/81 – Section 6: Improving Access to Diagnosis and Treatment
"6.16 There have been difficulties in meeting workforce needs in different parts of Northern Ireland. Cancer workforce planning should be developed to meet the needs of the local population and circumstances, including the **geography** and epidemiology of a 'locality'. An overall regional workforce plan should be built up through the Cancer Network to reflect these local needs. Cancer Units and the Cancer Centre based MDTs have an important role in this through the identification of the priority workforce gaps and training needs. The aggregated plans will support the DHSSPS and professional bodies in the development of strategies to ensure the correct numbers of professionals are trained, in place and working effectively to offer the maximum benefit to patients."

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Contextual Details of the word Rural in the Northern Irish Policy Documents

REF 1 Department of Health (2022). A Cancer Strategy for Northern Ireland 2022-2032

Word rural appears 3 times on P 22 (Theme 1 Preventing Cancer)

"There is currently no strong evidence to link radon exposure to cancers other than lung cancer or to other diseases. The Department of Agriculture, Environment and Rural Affairs and other agencies are contributing to a UK National Radon Action Plan. "

Then appears in 3 citations from Department of Agriculture, Environment and Rural Affairs.

"Word rural appears once on P100 (Theme 3 Supporting People to Live and Die Well)

Out-of-hours (OOH) advice and support from specialist palliative care professionals and a palliative care pharmacy is not routinely available to all health and social care teams in all locations across Northern Ireland. Where advice is available, this is usually done on an ad hoc, historical or good will basis. Specialist palliative care provision is currently only available on a Monday–Friday 9–5pm basis with no formalised out-of-hours provision. In addition, there are challenges in ensuring equitable access for all sections of the population, particularly seldom-heard and underrepresented sectors, e.g. LGBTQ+ people, those from ethnically diverse backgrounds, people with cognitive impairment such as those with dementia, those experiencing homelessness, people in long-term institutional care including prison care, the ageing and frail population, and those living in ***rural*** *and remote areas."*

Then appears in 3 citations in bibliography as references from UK Department for Environment, Food and Rural Affairs

REF 2 – Rural Needs Impact Assessment of A Cancer Strategy for Northern Ireland 2022-2032

This document is a rural needs impact assessment apparently conducted as a statutory requirement in respect of the Rural Needs Act (NI) 2016. The document reports on a wide consultation with multiple stakeholders around the implications for rural-dwellers of the latest NI cancer strategy. It uses the word "rural" on seventy occasions. It recognised the challenges of rural residence with respect to cancer, particularly challenges of centralization of services and the need to travel, but make few clear and definite recommendations. The clearest statement of intent perhaps appears in Section 4 – Considering the Social and Economic Needs of Persons in Rural Areas where it states:

"The Cancer Strategy has recommended delivery of treatment, care and support closer to home when possible utilising technology to avoid unnecessary travel based on the learning from the pandemic. This will enable those living with cancer in both rural and urban areas across Northern Ireland to travel less."

However, the mechanisms to realise these ambitions are not clearly stated.

REF 3 -Equality Needs Impact Assessment of A Cancer Strategy for Northern Ireland 2022-2032 – "rural" used 5 times

In section 3.1 Key Findings in Gender Section, Mitigation Subsection the word "rural" appears twice

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"Throughout the development of the Strategy we have worked with people with lived experience of cancer services in Northern Ireland and their representative groups. The impact of the Strategy on people with dependents and those living in rural areas has been considered, including access to services, access to travel either by public transport or private vehicle and scheduling of appointments at appropriate times."

"During COVID-19 many appointments moved from face to face to virtual and this has been welcomed by some, particularly in rural areas. Through the Strategy there will be increased opportunity for a more flexible approach to the delivery of services. This will be beneficial to patients and staff."

In section 8.0 Outcome of Consultation the word rural appears three times.

"Not all stakeholders who responded to the consultation provided a response to the EQIA, however using the information provided by direct answers to the EQIA and Rural needs screening together with relevant answers to other questions a number of significant issues have been identified."

"These responses were supportive of the approach outlined in the documents; they also provided additional suggestions to strengthen the existing commitment to equality particularly in the area of health inequalities and specific requirements to access services that exist across the equality groups, including gender, age, disability and indeed in relation to the rural dwellers."

"It was also clear from consultees that the Strategy and its implementation should address the issues surrounding health literacy and communications. As with all consultation responses the issues raised in response to the EQIA and Rural Needs have been taken into account in the redrafting of the Strategy, these are included in the changes highlighted above."

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Contextual Details of the words “Travel” and “Transport” etc in the Northern Irish Policy Documents

REF 1 (A Cancer Strategy for Northern Ireland 2022-2032) – 5 uses of “travel” and 1 use of “transport”

Page 24/140 – mention of road transport contributing to air pollution, a cause of lung cancer

Page 52/140- Systemic Anti Cancer Treatment
On home delivery of oral SACT: “However, as a proportion of the total number of SACT delivered, its use is proportionately likely to fall over the next 10 years. This will afford the opportunity to explore the development of other models of delivery of this treatment in the future, for example delivery of treatments in health and wellbeing centres, or in non-cancer unit hospitals with day care facilities. Failure to provide SACT at home or near to home for those suitable is adding to the footfall in hospitals and is costly in both time and **travel** for people living with cancer.”

Page 58/140- Haematological Cancers
“Currently, the BCH site provides autologous haematopoietic stem cell transplantation (auto-HSCT) and sibling allogeneic transplantation (allo-HSCT). Patients undergoing Matched Unrelated Donor (MUD) transplant receive pre-transplant work-up and post- transplant follow-up in BCH [Belfast City Hospital] but they must **travel** to another centre such as St James’s Hospital in Dublin or a London-based transplant unit to undergo the procedure. The number of people undergoing auto-HSCT is rising year on year. In 2019, the transplant service was unable to meet the demands and as a result, patients were transferred to King’s College Hospital, London for transplantation. In order to meet the ever-increasing demand for haematopoietic stem cell transplantation and avoid **travel** outside of Northern Ireland, expansion of transplant capabilities at BCH is required.”

Page 59/140- Haematological Cancers
“**Travel** for people can be challenging given their underlying diagnosis and usually involves at least two to three visits to a GB site before CAR-T takes place. Following the procedure, people spend three to four weeks in hospital before returning home.”

Page 66/140- Children and Young People
“However, it does mean that families from outside Belfast must **travel** to RBHSC for all treatment and care – possibly passing other hospitals with children’s wards and services on the way. There is a need to explore options for the development of shared-care services for procedures such as blood tests and oral chemotherapy outside of Belfast.”

REF 2 (A Cancer Strategy for Northern Ireland 2022-2032 - Rural Needs Impact Assessment) – 13uses of “travel” and 10 uses of “transport”

Page 3/10 – Section 1: Defining the activity subject to Section 1(1) of the Rural Needs Act (NI) 2016
“The default definition cited above (Population Settlements of less than 5,000) is not useful in differentiating impacts in respect of this policy. People living in both large and small settlements would be similarly impacted by changes in the location of hospital stroke services. The following alternative definition, as suggested by DAERA, is proposed: “Populations outside of a 30 minute drive time of Derry/Londonderry or Belfast”. This definition is better able to distinguish between those who will be most impacted by additional **travel** times caused by proposed changes to services. It should be noted that the service under consideration is not provided within rural communities but provided inside a hospital environment. The benefits of enhancing these services would be experienced by both urban and rural dwellers.”

Page 4/10 – Section 2: Understanding the impact of the Policy, Strategy, Plan or Public Service
“Throughout the development of the Strategy we have worked with people with lived experience of cancer services in Northern Ireland and their representative groups. The impact of the strategy on people living in rural areas has been considered throughout this process. Issues identified that impact on people living in

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rural areas centre around access to services, access to **travel** either by public transport or private vehicle and scheduling of appointments at appropriate times. Cancer services are currently provided in the 5 major hospital sites plus specialist surgery in Belfast Trust. All children in NI diagnosed with cancer before their 16th birthday, are treated in the Royal Belfast Hospital for Sick Children and already **travel** for treatment. In the Strategy we are proposing that some procedures and treatments should be delivered closer to home for example phlebotomy while other highly specialised treatments such as radiotherapy will always only be provided in the North West Cancer Centre in Altnagelvin and the NI Cancer Centre at Belfast City Hospital. In addition, some very specialist treatments are not available in NI and people have to **travel** to centres in GB and Dublin. This is also the case for very rare cancers."

Page 5/10 – Section 3: Identifying the Social and Economic Needs of Persons in Rural Areas
"Existing data from hospital admissions is patchy and varied. Many people are treated in several hospitals and trusts across their pathway so data per hospital site may not be an accurate reflection of areas that service users **travel** from. The availability of public **transport** in rural areas is also much inferior to that in towns and cities, and crucial rural bus services are under increasing threat due to decreasing profitability and reductions in subsidies.

The most recent published data from the **Travel** Survey NI (2016-18) revealed that less than a quarter (20%) of rural dwellers live within a 3 minute walk of the nearest bus stop, compared with 39% of those living in urban areas – with 9% of rural dwellers living a 44 minute or longer walk to their nearest stop. This may have implications in relation to access to services. Access to key services can be a marker of disadvantage for people in rural communities, particularly for those living in more remote areas and for those without private **transport**. In rural areas more than an hour from Belfast, NISRA's Multiple Deprivation Measure (MDM) indicates that access to key services by public **transport** is particularly poor, while for others, journeys made by public **transport** may simply be impractical due to a combination of journey length and remote location."

Page 8/10 – Section 3: Identifying the Social and Economic Needs of Persons in Rural Areas
"Throughout the development of the Strategy we have worked with people with lived experience of cancer services in Northern Ireland and their representative groups. The impact of the strategy on people living in rural areas has been considered throughout this process. Issues identified that impact on people living in rural areas centre around access to services, access to **travel** either by public **transport** or private vehicle and scheduling of appointments at appropriate times. During COVID-19 many appointments moved from face to face to virtual and this has been welcomed by some, particularly in rural areas. These issues are intertwined and have both a social and economic impact. **Travel** to appointments from rural locations can often take a full day of **travel** for the patient and family member/carer. This results in considerable social, emotional, physical and financial impacts for example, taking time off work, paying for fuel, making suitable arrangements for childcare or social responsibilities."

Page 9/10 – Section 4: Considering the Social and Economic Needs of Persons in Rural Areas

"The Cancer Strategy has recommended delivery of treatment, care and support closer to home when possible utilising technology to avoid unnecessary **travel** based on the learning from the pandemic. This will enable those living with cancer in both rural and urban areas across Northern Ireland to **travel** less. Currently there are a number of community and voluntary organisations which support people with cancer with **travel** for cancer treatment.

Consultation took place with the trade unions representing staff from all Trust areas; **transport** was discussed and difficulties arriving at appointment times will be considered as part of the upcoming consultation process."

REF 3 (A Cancer Strategy for Northern Ireland 2022-2032 – Equality Impact Assessment) – 22 uses of "travel" and 11 uses of "transport"

Page 10-11/40 – Section 3.1 Gender
Service User Profile/Potential Impact
"Some evidence suggests that women are more likely to have dependants/be a carer than men and therefore this may have an impact, particularly if there is increased **travel** to attend appointments."

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"Women with dependants or caring responsibilities may be impacted, particularly if there are increased **travel** times associated with the implementation of the actions."

Page 12/40 – Section 3.1 Gender
Mitigation
"In the 2017/18 Health Survey for Northern Ireland, 79% of respondents indicated that, if they needed a routine procedure or operation they would be prepared to **travel** within Northern Ireland if it meant that waiting times would be reduced. 39% of respondents indicated that they would be prepared to **travel** up to 1hr to a hospital and 27% said up to 2hrs. Throughout the development of the Strategy we have worked with people with lived experience of cancer services in Northern Ireland and their representative groups. The impact of the Strategy on people with dependents and those living in rural areas has been considered, including access to services, access to **travel** either by public **transport** or private vehicle and scheduling of appointments at appropriate times. During COVID-19 many appointments moved from face to face to virtual and this has been welcomed by some, particularly in rural areas. Through the Strategy there will be increased opportunity for a more flexible approach to the delivery of services. This will be beneficial to patients and staff."

Page 16/40 – Section 3.2 Age
Staff
"If staff need to relocate or alter working patterns they may experience an increase in **travel** time and associated costs. This could lead to difficulties for staff with childcare, or other caring responsibilities, and to some older staff volunteering for early retirement. Younger staff who may be in a lower income bracket may experience difficulty meeting an increase in **travelling** costs or may have less access to public **transport**. Any increase in additional posts may create opportunities for staff."

Page 21-22/40 – Section 3.6 Dependant Status
"In developing this Strategy we have engaged with people who have lived experience of cancer and carers from across Northern Ireland. They also highlighted the importance of flexible appointment times, especially for those **travelling** a greater distance and/or by public **transport** and for those with caring responsibilities."

"Potential Impact - Carers

Some groups of carers will have particular needs and issues in relation to reconfigured services:

- Age – Younger and older carers tend to have less access to a car and rely more heavily on public **transport** than other age groups. The location of cancer services thus has particular implications for their ability to visit the person they care for. As so-called 'sandwich carers', those in middle age groups at times carry caring responsibilities for both children and elderly relatives. Longer **travel** times will negatively impact on their ability to juggle both sets of responsibilities…
- Disability – Some carers who themselves have a disability may face additional challenges in relation to care at home and an earlier discharge. Likewise, they are likely to have particular needs in relation to **transport** and location, similar to those outlined above under 'age'. Those with sensory impairments or a learning disability will have needs for information to be provided in an appropriate format and for communication to draw on appropriate support.

…Those with a caring responsibility may have to attend appointments in relation to their own health, and/or accompany a dependant for an appointment. They may be impacted by additional **travel** times."

Page 29/40 – Section 3.7 Disability
"Staff with a disability may experience issues relating to reasonable adjustments and attitudes of new colleagues.

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Staff relocating to a new building may experience changes to their home to work journeys. If **travelling** by public **transport** there may be an adverse impact if the public **transport** services available to the new location are not adequate.
Staff **travelling** to work by car may be adversely affected if their current location provides disabled parking facilities and these are not available at the new location…
… Staff with disabilities may be affected by workplace related considerations and **travel**. Reasonable adjustments will be made concerning existing and newly appointed staff in the workplace. Some staff with disabilities may be asked to consider relocating from their current workplace."

Page 32/40 – Section 3.8 Ethnicity

7 references to 'travellers'/'travelling community'

"Ethnic Minority populations are less likely to have a car and rely more on public **transport**. Irregular public **transport**, combined with prolonged **travelling** times, can therefore represent a further barrier to accessing health care for ethnic minority patients. Getting to hospitals is particularly difficult for people without a car or who are living in places with inadequate public **transport** options."

REF 4 (A Cancer Strategy for Northern Ireland 2022-2032 – Funding Plan) – 1 use of "travel"

Page 14/36 - Action 24. Review our model of delivery for Systemic Anti-Cancer Treatment Services including the delivery of near/close to home SACT

"Outcomes of investment:
- Timely, efficient and compassionate transfer of patients out of Northern Ireland and back home again for specialist treatments supported by good communication and follow-up care.
- Less stress to patients, families and carers.
- People will not have to **travel** to receive specialist treatment which could be provided safely closer to home. • People will receive safe, effective and evidence-based treatment and care in a timely way.
- Treatment will be cost effective and efficient with fewer hospital attendances.
- There will be safe prescribing of SACT for all oncology and haematology patients."

REF 5 (A Cancer Strategy for Northern Ireland 2022-2032 – Funding Plan) – 2 uses of "travel"

One mention of 'direction of travel' in terms of setting policy

Page 53/70
"The lack of access to clinical trials in Northern Ireland was also highlighted, given that there were no recommendations on how these will be improved. Furthermore, a participant expressed their frustration at how patients currently have to **travel** to England for these trials."

REF 6 (Rebuilding Health And Social Care Cancer And Haematology Treatment Services In Northern Ireland Policy Statement) – 2 uses of "travel"

Page 10/24 – Section 1: Rebuilding Plan for Cancer Services over the Short-term
Cancer diagnostics

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"14. PET-CT is a significant constraint on a number of pathways, in particular upper GI and lung. A second PET scanner has been commissioned within Belfast Trust. The second scanner was due to be operational in April 2020. Unfortunately, the pandemic meant that trainers could not **travel** from England to provide training to the local teams so "go live" was delayed. Staff training was completed in June 2020 and scanning has now commenced. Activity will be built up incrementally over the coming weeks increasing to 4 sessions per week by August 2020. This should address the immediate capacity gap. Interim arrangements which provided additional capacity through Blackrock Clinic will be stood down once the current cohort of patients with planned dates has been completed (approximately 85 patients). All new patients will be scanned in Belfast going forward. Action 6: Belfast Trust to ensure incremental increase in activity on second scanner as per agreed plan with HSCB."

Page 15/24 – Section 2: Oncology Services Medium-Term Stabilisation Plan
"4. With the advent of COVID-19, virtual clinics and the use of remote assessment has become a necessity and will continue to be so for the foreseeable future. Cancer Units consider that there will always be a requirement for some level of on-site consultant presence. However, there is agreement that targeted use of remote assessment from the centre may enable more effective use of consultant resource (as consultants will not be required to **travel** for every clinic) and will enable more patients to be "seen", mitigating the impact of COVID-19 on waiting times. However, while units have supported remote assessment to date, they report that it has placed a significant strain on Cancer Unit nursing staff in terms of ensuring appropriate local follow up of actions arising for the remote consultation (e.g. arranging bloods, ECHOs, PICs, pharmacy verification, etc.) and this has given rise to governance concerns."

REF 7 (Mid-Term Review Of The Skin Cancer Prevention Strategy And Action Plan) – 4 uses of "travel"

Page 15/24 – Section 5.4 Objective 3 – to increase individual and organisation-wide practice of sun safety behaviours
"Action 5: Encourage relevant organisations i.e. the leisure, tourism and **travel** industries, the met office etc. to promote safe sun messages and explore possibilities for cross-border co-operation
• Contacts were developed and best practice shared with the Irish Cancer Society in ROI.
• Agreement was secured from the NI Tourist Board to include a link to the care in the sun website on its FAQ page.
• A care in the sun leaflet was designed specifically for people travelling abroad, either on sun or ski holidays, and agreement secured from a number of leisure/travel organisations to distribute including Belfast City Airport, passport offices and **travel** agencies."

REF 8 (Service Framework For Cancer Prevention, Treatment And Care) – 6 uses of "travel"

Page 43/240 - SECTION 1:AN INTRODUCTION TO SERVICE FRAMEWORKS
"The standards seek to ensure that health and social care services are…
Accessible – health and social care that is timely, within a reasonable **travel** distance / **travel** time, and provided in a setting that is appropriate to the needs of the person in terms of skills and resources;"

Page 118/240 - SECTION 6: Effective Treatment and Care
"Overarching standard 24: All patients with cancer who require radiotherapy should have equitable and timely access to complex radiotherapy techniques in line with tumour group specific recommended best practice.
Rationale: It is estimated that by 2016, Northern Ireland will need to increase the availability of radiotherapy treatments by up to 70%.
Modern radiotherapy uses accurately targeted, high dose radiation. This improves cancer cure outcomes and reduces normal tissue complications. At present Northern Ireland does not have the full range of modern radiotherapy techniques including: a brachytherapy service for patients with lung and localized prostate cancer, high dose rate gynaecological brachytherapy, stereotactic radiotherapy, image guided radiotherapy (IGRT) and intensity modulated radiotherapy (IMRT). This means that some patients have to **travel** to England to get treated. Some patients who do not wish to or who are too unwell to **travel** cannot access treatment."

Other uses of "travel" are in reference to substances travelling through bloodstream

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REF 9 (Skin Cancer Prevention Strategy And Action Plan 2011-2021) – 7 uses of "travel"

All references to travel/travelling are in relation to overseas travel increasing risk of skin cancer.

REF 10 (Regional Cancer Framework A Cancer Control Programme for Northern Ireland) – 12 uses of "travel"

Page 39/81 - Radiotherapy
"In planning for the decade from 2015-2025, consideration needs to be given as to how future capacity should be planned for including the need to address the issue of equitable access for the population in the western parts of Northern Ireland and concerns about **travelling** times (see Appendix 4 Equality Impact Assessment). Any review should also take account of further specialisation and advances in technology."

Page 64/81 - Radiotherapy
"**Deprived areas**
The document advises that the DHSSPS has calculated access times to GP practices (including branch surgeries) for each 2001 Census Output Area. Accessibility is defined as how far people are from services and not how easily they can access the service they require within the health and social care system. Accessibility times reflect **travel** for vehicles, not pedestrians. A very small proportion of the population (0.1% or 1,830 people) live more than 15 minutes away from a GP practice and none live more than 30 minutes away. 22% of people and one third of GP practices are located in deprived areas. The average **travel** time to the nearest GP practice in deprived areas is 3.2 minutes and is slightly less than the Northern Ireland average of 4.1 minutes. When weighted for need, there is virtually no difference in **travel** times.

Rural/non-rural areas
13% of GP practices are located in the most rural areas. This is similar to the proportion of the Northern Ireland population who live in these areas (15%). The average time it takes to **travel** to the nearest GP practice from rural areas is 7 minutes. This is double the average in non-rural areas. The difference is slightly less when the **travel** time is weighted for need."

Remaining uses of 'travelling/traveller' are in reference to travelling community.

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ENGLAND

English Policy Documents

1. Independent Cancer Taskforce (no date). Achieving World-Class Cancer Outcomes A Strategy For England 2015-2020. Available here.
2. The Equality Impact Assessment is also available here.
3. Department of Health (2013). Living With And Beyond Cancer: Taking Action To Improve Outcomes. Available here.
4. Department of Health (2011). Improving outcomes: A strategy for cancer. Available here.
5. Department of Health (2011). Improving Outcomes: A Strategy for Cancer Stakeholder engagement report. Available here.
6. The impact assessment document is available here.
7. Department of Health (2014). Improving Outcomes: A strategy for Cancer. Fourth Annual Report. Available here.
8. Department of Health (2013). Improving Outcomes: A strategy for Cancer. Third Annual Report. Available here.
9. Department of Health (2012). Improving Outcomes: A strategy for Cancer. Second Annual Report. Available here.
10. Department of Health (2011). Improving Outcomes: A strategy for Cancer. First Annual Report. Available here.
11. NHS (2007). Cancer Reform strategy. Available here.
12. NHS (2007). Impact Assessment of the Cancer Reform Strategy. Available here.
13. NHS (2007). Cancer Reform Strategy Equality Impact Assessment. Available here.
14. NHS (2000). The NHS Cancer Plan. A Plan for Investment. A Plan for reform. Available here.
15. National Audit Office (2005). The NHS Cancer Plan: A Progress Report. Available here.
16. National Audit Office (2005). Tackling Cancer: Improving the Patient Journey. Available here.
17. National Audit Office (2004). Tackling Cancer in England: saving more lives. Available here.

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		ENGLAND																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Geography	**Geography/Geographic**	8	2	0	2	0	2	1	3	3	2	1	4	3	1	2	5	10
	Topography	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Location	2	0	1	7	0	3	0	0	1	2	7	1	1	1	0	3	1
	Landscape	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rural	**Rural**	1	0	0	0	0	4	0	0	1	1	1	4	0	0	0	1	0
	Remote	1	0	17	1	0	0	0	0	0	5	0	0	0	0	0	0	0
	Isolated	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Small Town	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Country	26	3	0	14	0	2	8	14	16	9	35	1	9	56	6	3	24
	Countryside	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Region(al)	14	3	6	9	1	4	45	25	15	4	3	0	1	32	8	29	21
	Farm	0	0	0	0	0	0	0	0	0	1%	0	0	0	1*	0	0	0
	Farming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Highland	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Island	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Village	1	0	0	0	0	0	0	0	0	0	0	0	0	1*	0	0	0
	Settlement	0	0	0	3*	0	0	0	0	0	0	0	0	0	0	0	0	0
	Non-urban	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Barriers	**Travel**	3	0	1	3	2	7	1	2	1	0	6	1	5	1	0	0	0
	Transport	0	0	0	0	0	1	0	0	1	1	2	0	0	1	0	0	1
	Deprivation/deprived	9	21	0	3	1	0	25	33	13	12	15	1	34	15	7	0	36
	Access	89	7	55	72	11	36	45	38	67	45	86	2	51	46	15	26	14
	Inequality/inequalities	10	21	1	29	0	0	4	13	3	7	63	6	100	29	4	2	5
	Equity/equitable	3	0	0	14	3	2	1	1	0	2	1	1	2	2	3	0	2
	Ethnic	7	22	0	5	0	0	8	11	16	8	12	1	30	15	5	15	5
	Workforce	60	4	12	5	2	14	5	4	5	3	32	6	4	47	21	0	16
	Techno (logical & logy)	21	1	0	8	3	3	4	4	1	1	43	3	1	15	0	0	0
	Tele (medicine & phone)	5	0	1	0	5	1	1	2	0	3	5	3	0	0	0	5	0
	Digital	14	1	2	8	2	0	6	3	25	16	10	1	0	1	0	0	0
	Broadband	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Coastal	Coast	0	0	0	0	0	0	0	0	5$	0	0	0	0	0	1$	0	3
	Coastal	0	0	0	0	0	0	0	0	1$	0	0	0	0	0	0	0	0
	Sea	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Seaside	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urban	Urban	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0
	City	1	0	0	0	0	0	0	1	8$	0	0	0	3	2	0	1	0
	Cities	3	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0
	Town	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary care	Primary care	18	1	18	11	3	13	11	18	13	8	41	0	8	38	22	1	15
	General practice	3	0	0	0	1	1	3	1	5	5	3	0	4	1	0	0	6
	GP	91	16	23	64	12	32	54	40	57	48	55	2	8	50	11	46	62
	Community	36	2	14	14	4	1	7	11	11	8	48	4	32	53	23	21	7
	Local	66	2	28	78	6	15	43	57	56	56	152	8	20	70	36	12	26
Other	Research/ers/ing	127	8	27	63	9	11	96	58	46	23	172	10	41	106	39	24	39

$as place names
% a care farm in Ipswich
*5-a-day pilot site

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Contextual Details of the word "Geog (raphy & raphical)" etc in the English Policy Documents

REF 1 (Achieving World-Class Cancer Outcomes A Strategy For England 2015-2020) – 8 uses of "geography/geographic"

Page 17/92 – 3. Principles

"Devolved decision-making, within national standards and ambitions: Cancer services (and the NHS more broadly) are too extensive for all decisions to be made nationally. Local or regional decision-making unlocks creativity and innovation, provides a vehicle for clinicians and patients to drive service development, and enables appropriate consideration of local circumstances (e.g. rural **geographies**). However, local decision-making must be within a national framework of agreed service quality standards and appropriate population sizes".

Page 19/92 – 4. How should we reduce the growth in the number of cancer cases?

"Local organisations are best-placed to determine which combination of initiatives across education, housing, planning and healthcare would deliver the most impact, and which should be led through workplace health and wellbeing initiatives. A local approach also enables occupational risk factors in specific **geographies** to be taken into account."

Page 25/92 – 5. How should we improve survival?

"In 2014/15, overall uptake for gFOBt bowel screening was around 58%, with wide variation across the country (33 – 67 per cent). The **geographical** variation, and the range of uptake across different groups, demonstrates a significant opportunity to improve."

Page 28/92 – 5. How should we improve survival?

"Variation in the stage at which cancers are diagnosed exists between **geographic** locations, ethnicities, genders and across socio-demographic factors. It is estimated that thousands of advanced stage diagnoses could be avoided each year if socio-demographic inequalities at stage of diagnosis were eliminated."

Page 37/92 – 5. How should we improve survival?
Section 5.3.2.1 Radiotherapy

"Recommendation 29: From autumn 2015, NHS England should commence a rolling programme of replacements for LINACs [standard linear accelerator] as they reach 10-year life, as well as technology upgrades to all LINACs in their 5th year. All LINACs that are already ten years old should be replaced by the end of 2016 at the latest. This should be driven through a national capital fund, overseen in the first 2-3 years by a small implementation team, who will also need to ensure that equipment is **geographically** distributed to serve local populations optimally."

Page 67/92 – 8. How should we improve the efficiency and effectiveness of delivery and drive implementation?

"Recommendation 78: NHS England should set expectations for and establish a new model for integrated Cancer Alliances at sub-regional level as owners of local metrics and the main vehicles for local service improvement and accountability in cancer. We advise that Cancer Alliances should be co-terminus with the boundaries of Academic Health Science Networks (AHSNs), although in some large AHSN **geographies** there may be a need for two Alliances."

Page 72/92 – 8. How should we improve the efficiency and effectiveness of delivery and drive implementation?
Section 8.5.3. Deficits in treatment and care workforce

"CNS posts have increased for some areas of practice in England between 2007 and 2014. However, the specialist adult cancer nursing workforce in general is not expanding sufficiently to keep pace with the growing number of people with cancer. There is an urgent need for investment in cancer specialist nursing roles, particularly in rarer cancers and certain **geographies**."

Section 8.5.4 Optimising workforce deployment

"There is more we could do to optimise how the workforce is deployed, in addition to increasing staff numbers in those areas where we are facing shortfalls. A number of barriers exist which inhibit the best deployment of workforce across provider boundaries. This ultimately impacts on patient care. We know that in some parts of the country patients are not being offered the treatment that would be best for them because visiting medical oncologists do not have capacity.

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Similarly, in radiotherapy, it is unrealistic to expect every provider to have the workforce and equipment to support access to every innovative technique. But currently we are not networking effectively to facilitate regional access for patients within a **geographic** area."

REF 2 (Achieving World-Class Cancer Outcomes: A Strategy For England 2015-2020 – Equality Assessment) – 2 uses of "geography/geographic"

Page 11/12 - 3. Assessment of the NHS Cancer Strategy: 2015-2020 impact on equality
"Transform our approach to support people living with and beyond cancer:
We recommend accelerating the roll-out of stratified follow up pathways and the "Recovery Package". The aim should be that by 2020 every person with cancer will have access to elements of the Recovery Package, and stratified pathways of follow-up care will be in place for the common cancers. A national quality of life measure should be developed by 2017 to ensure that we monitor and learn lessons to support people better in living well after treatment has ended. We also recommend that CCGs should commission appropriate End of Life care, in accordance with the NICE quality standard, and taking into account the independent Choice Review and forthcoming Ambitions

EqIA:

- As NICE says, local authorities are uniquely placed to tackle health inequalities, as many of the social and economic determinants of health, and the services or activities which can make a difference, fall within their remit. The challenge is to reduce the difference in mortality and morbidity rates between rich and poor and to increase the quality of life and sense of wellbeing of the whole local community

- This should benefit all groups in society and reduce **geographical** variation. As part of the consultation and engagement surrounding the development of the Choice Review, specific engagement work was undertaken with BME groups – NHS England commissioned interviews with 20 black or minority ethnic families and with organisations not directly related to End of Life Care, asking for comments on the care principles and what the impact might be on different groups. The Deputy Director for Equalities at NHS England was involved with this work. The responses were summarised, setting out how this work had regard to people from population groups sharing the protected characteristics defined in the Equalities Act and others affected by health equalities"

Page 12/12 - 3. Assessment of the NHS Cancer Strategy: 2015-2020 impact on equality
"Overhaul processes for commissioning, accountability and provision.
We recommend setting clearer expectations, by the end of 2015, for how cancer services should be commissioned. For example, most treatment would be commissioned at population sizes above CCG level. By 2016, we should establish Cancer Alliances across the country, bringing together key partners at a sub-regional level, including commissioners, providers and patients. These Alliances should drive and support improvement and integrate care pathways, using a dashboard of key metrics to understand variation and support service redesign. We should also pilot new models of care and commissioning. For example, the entire cancer pathway in at least one area should have a full devolved budget over multiple years, based on achieving a pre-specified set of outcomes.

EqIA:

- This is largely managerial, but is likely to reduce **geographical** variation and hopefully benefit all groups in society.

- Increases in appropriate workforce groups will benefit all groups in society. Deployment of the newly trained staff will need to be monitored so hospitals in all parts of the country benefit."

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REF 4 (Improving outcomes: A strategy for cancer) – 2 uses of "geography/geographic"

Page 24/101 – Section 2. Putting patients and the public first: information and choice
Using information to reduce inequalities
"2.18 Further analyses to inform the equality agenda are planned on rarer cancers, access to cancer treatment and outcomes for people with mental health problems, as well as examining survival, mortality and incidence by **geographical** area. We will continue to publish one-year survival data to identify which groups are more likely to present late."

Page 58/101 – Section 6. Improving outcomes for cancer patients: better treatment
Reducing regional variations
"6.6 There are considerable **geographical** variations in access to surgery. For example, while England as a whole lags behind comparable countries in terms of potentially curative surgery for lung cancer, the 2009 National Lung Cancer Audit showed that the resection rate varies from less than 5% in some networks to more than 25% in others. It is not acceptable to have such variations across the country."

REF 6 (Improving Outcomes: A Strategy for Cancer Stakeholder engagement report – Impact Assessment) – 2 uses of "geography/geographic"

Page 3/42

Enforcement, Implementation and Wider Impacts	
What is the **geographic** coverage of the policy/option?	England"

Page 13/42 – Radiotherapy
"Option 3: Increasing efficiency of linacs, and increasing number of linacs by 12 50. Option 3 expands capacity and envisages that clinical practice changes go further to move more services to satellite sites. This would help to improve the **geographical** spread of services, and would improve patient choice"

REF 7 (Improving Outcomes: A strategy for Cancer. Fourth Annual Report) – 1 use of "geography/geographic"

Page 85/90 - Annex E – NCIN national analyses published October 2013 to October 2014
Reference to a poster titled "Managing disclosure in health statistics using statistical **geographies**"

REF 8 (Improving Outcomes: A strategy for Cancer. Third Annual Report) – 3 uses of "geography/geographic"
Page 16/80 - Impact of new structures and arrangements on services and outcomes
New structures and partnerships
"2.31. There are four SCN [Strategic Clinical Networks] groupings, which operate throughout the country and which cover: cancer; cardiovascular; maternity and children; and mental Health, dementia and neurological conditions. The four are **geographically** based on the 12 NHS England Clinical Senate areas "

Page 19/80 – Using intelligence to support improvement

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“Chemotherapy – Systemic Anti-Cancer Therapy (SACT) dataset
3.6. The two year implementation period for the SACT programme finishes at the end of March 2014. The dataset covers the collection of treatment data on all adult solid tumours, haematology and paediatric chemotherapy. The majority of the 149 trusts providing chemotherapy are fully engaged with the programme and submitting data on a monthly basis. The aim is to achieve full **geographical** coverage with all of the data fields completed by the end on the implementation period.”

Page 22/80 – Using intelligence to support improvement
Survivorship Data
“3.25. Evidence on the economic burden of cancer is limited due to the lack of reliable data on cost of care. In partnership with Imperial College London, City University London and Macmillan Cancer Support NCIN is developing a new dataset for England which links patient data in the National Cancer Data Repository with data on hospital activity and NHS costs. This will enable research on the magnitude and variation of cancer costs across different stages of the disease, **geographical** areas and pathways of care.”

REF 9 (Improving Outcomes: A strategy for Cancer. Second Annual Report) – 3 uses of “geography/geographic”
Page 21/113 – Making intelligence more accessible and user friendly
“1.58. During 2012, NCIN has worked with the bone cancer charity, Sarcoma UK, to provide commentary for a public audience. As mentioned previously, the NCIN also worked with Macmillan Cancer Support to pilot a new public-friendly website for colorectal cancer in June 2012; Macmillan are considering the next steps for this project. Many other cancer charities are also providing data about services and outcomes broken down by **geographical** area, helping patients to make informed decisions about their care.”

Page 59/113 – Patient Reported Outcome Measures (PROMs)
“4.17. Key messages from the pilot were:
• the response rate of 66% (3,300 out of 4,992) showed that people who survive cancer are willing to participate in such surveys, which provide very valuable data about cancer survivors’ health and wellbeing
• the presence of one or more long-term condition in addition to cancer was associated with a significantly lower quality of life
• people from the most disadvantaged **geographical** areas reported lower quality of life scores and lower scores on other measures”
Page 86/113 – Clinical Networks
“8.15. It is proposed that this element of the total should be divided equally between 12 support teams as core funding, with the remaining £32 million to be allocated according to population size, taking into account rurality and inequalities. These support teams will cover defined **geographical** areas that could contain one or more Cancer Networks.”

REF 10 (Improving Outcomes: A strategy for Cancer. First Annual Report) – 2 uses of “geography/geographic”
Page 76/92 – End of Life Care
Survey of bereaved people
“6.29 The national survey will allow us, for the first time, to compare the quality of the experience of care at the end of life across different conditions, different care settings and different **geographies**. It will give feedback for the first time on the family and carer experience as well as the patient’s. It will be the data source for the new national indicator for end of life care in Domain 4 of the NHS Outcomes Framework. The indicator is currently going through the DH’s development process.”

Page 86/92 – Clinical networks and senates

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"8.12 Clinical senates are intended to bring together a range of experts, professionals and others from across different areas of health and social care to provide cross-cutting advice on strategic commissioning decisions for broad **geographical** areas of the country."

REF 11 (Cancer Reform strategy) – 1 use of "geography/geographic"

Page 82/144 – The role of the clinical nurse specialist

"5.44 Data indicate that substantial variation in the number of clinical nurse specialists available to support cancer patients at key points in the cancer pathway still exists across cancer networks. There can be a significant variation in the provision of CNSs between cancer networks. This cannot simply be explained by **geographical** differences in cancer incidence or patient flows."

REF 12 (Impact Assessment of the Cancer Reform strategy) – 4 uses of "geography/geographic"

"What is the geographic coverage of the policy/option?" – question asked but not answered for 4 different options discussed in the impact assessment.

REF 13 (Cancer Reform Strategy Equality Impact Assessment) – 3 uses of "geography/geographic"

2 x footnotes on breast and cervical screening data tables advising that figures are indicative only as geographical areas may vary slightly in some cases, plus one paper referenced with geographical in the title.

REF 14 (The NHS Cancer Plan. A Plan for Investment. A Plan for reform) – 1 use of "geography/geographic"

Page 20/98 – A postcode lottery for cancer care

"There are widespread **geographical** inequalities in the quality and type of treatment patients receive, because of shortages of specialist staff, fragmentation of care, inadequate access to surgical facilities, a postcode lottery on prescribing and insufficient radiotherapy facilities"

REF 15 (The NHS Cancer Plan: A Progress Report.) – 2 uses of "geography/geographic"

Page 16/41 – Cancer networks

"1.8 By early 2001 there were 34 established cancer networks covering the whole of England, each serving a population of between 700,000 and 3 million based around **geographical** health communities. Headed by a network board, and with a core management team, networks comprise acute trusts, primary care trusts (responsible for commissioning and, in some cases providing, cancer services), voluntary sector organisations, local authorities and a wide range of working groups responsible for developing guidelines and implementing good practice, and they include patient and carer involvement. Networks are accountable to strategic health authorities and are responsible for coordinating expert clinical advice, management and local strategy; working together to improve quality of care and address any inequalities in provision and access."

Page 29/41 – Cooperation

"2.16 Cancer networks are a partnership of constituent organisations, at the centre of which is the network management team. They were set up to ensure integrated care across **geographical** localities. They were new to the NHS, but since their creation there have been various structural changes to the NHS, including new organisations and new roles for strategic health authorities and primary care trusts. These changes require strong and committed partnership working among the networks' constituent organisations, and appropriate resourcing of, and effective planning and monitoring by, network management teams."

REF 16 (Tackling Cancer: Improving the Patient Journey) – 5 uses of "geography/geographic"

Page 11/73 – Geographical Variations

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23 Our **geographical** analysis was based on the boundaries of the four Regional Directorates of Health and Social Care: London, the South, the Midlands and East, and the North. At this high level, differences are statistically significant. Taking the 80 questions referred to in paragraph 21, patients from the London region gave less positive responses than patients from other regions for 62 of these questions, and gave the most positive response to only eight of the questions. Differences were particularly noticeable in a range of survey questions in relation to Community and Hospital services, and the interface between them, detailed in Appendix 3. Further analysis strongly indicates that the less positive experience of London cancer patients in these questions persists even after allowing for cancer type, gender and age differences (see Appendix 3)."

Page 20/73
"1.20 There were variations in the provision of written material between cancer types and **geographical** areas,"

Page 34/73
"2.31 The NHS should be capable of responding sensitively to the diverse nature of communities it serves. Among our respondents, roughly 100 people from black and minority ethnic background answered the questions about religious beliefs and more than three quarters had strong religious beliefs. They were more likely to say that their religious beliefs had not been taken into account than patients as a whole, and four in ten of those (excluding "don't knows") reported that a religious counsellor had not been available. However, this remains an area where little research has been done. In our focus groups there was a general feeling among all groups that attempts were made to provide religious support, although there were difficulties for minority group members in **geographical** areas where there were few minorities. Afro-Caribbean women felt strongly that their existing local spiritual support network was always their first port of call."

Page 45/73
"3.25 During our visits to hospitals and hospices we were told by staff involved in palliative care that the new Departmental funding and the National Institute for Clinical Excellence guidance were welcomed as they indicated that palliative care was now a priority for the NHS, but that challenges remained – some arising from the sector's success. Hospice staff reported:

- continued shortages of specialist staff. There was a general shortage of specialist palliative care nurses and many unfilled consultant posts, some unfilled for many years. Shortages of such posts are not universal – there are considerable inequalities between **geographical** areas. The additional funding for specialist palliative care provided by the Department is helping to recruit 63 additional palliative care consultants and 168 cancer nurse specialists;"

REF 17 (Tackling Cancer in England: saving more lives) – 10 uses of "geography/geographic"

Page 8/67
"15. In the past, England's survival rates were lower than for most other European countries and the United States. However, the most recent data available on an internationally comparable basis covers patients diagnosed in the early 1990s and whose 5-year survival pre-dates the changes introduced to English cancer services in recent years. There are limitations on the ability to make comparisons at a national level because cancer registries in many countries do not provide enough **geographical** coverage for direct comparison."

Page 11/67 - Recommendations
(b) Since there are lead times of several years to introduce screening programmes, the Department of Health should, following completion of its option appraisal of the best test available, move swiftly to finalise an implementation timetable including recruitment of staff and workforce expansion for the national roll-out of bowel cancer screening. Consideration needs to be given to prioritisation of **geographical** areas with the highest bowel cancer mortality.

Page 21/67
"Incidence, mortality and survival rates are not uniform **geographically**."

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Page 29/67
"1.22 Survival rates from these periods for all the major cancers are higher in the USA than Europe, although, prior to expansion of **geographical** coverage in 2001, survival data from the United States (known as the Survival, Epidemiology and End Results (SEER) programme) was drawn from registries covering approximately 14 per cent of the United States population. Five-year relative survival rates for all cancers in the United States were 56 per cent for persons diagnosed in 1987 and 63 per cent for persons diagnosed in 1992. Recent research on breast cancer has shown that the higher survival rates for the disease in the registries in the SEER programme compared with Europe (around 85 per cent for women diagnosed in the early 1990s) are linked to diagnosis of the disease at a less advanced stage in the United States."

Page 32/67
"2.1 The Calman-Hine report, produced under the leadership of the Chief Medical Officers for England and Wales and published in 1995 recognised the need for a major step forward in the provision of cancer care in England. Most importantly, the report outlined a framework for the management of patients already diagnosed with cancer, with the emphasis on high quality, patient-centred care. A series of interlinked cancer centres and local units covering the entire country were to be developed, within a series of **geographically** defined cancer networks to modernise and integrate services. There are now 34 Cancer Networks, each covering a population of around 1-2 million people. Implementation was the responsibility of the former NHS Regions although no specific additional resources were made available when the report was published."

Page 48/67
"2.86 Concerns remain however that wide variations in usage persist between different parts of the country. An illustration of such **geographical** variations is provided by data supplied by Roche relating to the use of Herceptin. The drug was approved for use by NICE in March 2002 as a treatment for women suffering from metastatic breast cancer who have a tumour expressing an excess of a particular protein."

Page 49/67
"2.90 Research on co-morbidity has established that higher co-morbidity is associated with increased deprivation. Co-morbidity also increases with age, and particularly affects males and those with tobacco-related tumours. However, co-morbidity may not explain all treatment variations for the deprived. For example, research identified that women from deprived areas undergo much higher proportions of mastectomies (breast removal) rather than breast conservation surgery. Whether **geographical** and socio-economic inequalities in treatment are due to discrimination, patient preference, patient delay in presentation or comorbidity remains unclear"

Page 56/67 Methodology
"Analysis of other cancer data produced by the NHS and others
3 On our behalf Professor David Forman and Dr Diane Stockton from the UK Association of Cancer Registries analysed data on 72,000 breast, bowel and lung cancers registered in 2000 to examine variations in treatment and patient demographics in different **geographical** areas. Registries use different methodologies for data collection, so this sort of comparative analysis had not previously been done. As a result, we have been conservative in our use of the data and avoided unreliable comparisons. It should be noted that registries are dependent on the availability of treatment information in clinical notes and on treatment centres making these available."

+ 1 use of "geographical" in the title of a paper referenced.

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Contextual Details of the word Rural in the English Policy Documents

REF 1 (Achieving World-Class Cancer Outcomes A Strategy For England 2015-2020) – 1 use of "rural"

Page 17/92 – 3. Principles

"Devolved decision-making, within national standards and ambitions: Cancer services (and the NHS more broadly) are too extensive for all decisions to be made nationally. Local or regional decision-making unlocks creativity and innovation, provides a vehicle for clinicians and patients to drive service development, and enables appropriate consideration of local circumstances (e.g. **rural** geographies). However, local decision-making must be within a national framework of agreed service quality standards and appropriate population sizes".

REF 6 (Improving Outcomes: A Strategy for Cancer Stakeholder engagement report – Impact Assessment) – 4 uses of "rural"

Page 3/42 – Specific Impact Tests: Checklist

Does your policy option/proposal have an impact on…?	Impact	Page ref within IA
Statutory equality duties[1] Statutory Equality Duties Impact Test guidance	Yes	23
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	23
Small firms Small Firms Impact Test guidance	No	23
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	24
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	24
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	24
Human rights Human Rights Impact Test guidance	No	24
Justice system Justice Impact Test guidance	No	24
Rural proofing Rural Proofing Impact Test guidance	No	24
Sustainable development Sustainable Development Impact Test guidance	No	24

Page 12/42 – Radiotherapy

"44. Clinical evidence suggests that some patients, who could benefit from radiotherapy, are currently being deterred from taking the treatment because of long travel times in **rural** areas. This is a particular barrier when the patient has already undergone a surgical or chemotherapy treatment, and may have to travel long distances over a number of weeks. The advances in communication technology now mean that smaller radiotherapy centres are now feasible, serviced by a clinical and planning hub many miles away, which would not have been possible a decade ago. Manchester has already opened one such satellite site in Oldham and is currently planning a second."

Page 24/42 – Wider Impacts

Social Impacts

"133. No significant adverse impact has been found in relation to **rural** issues or the justice system. Human rights issues are covered within the separate Equality Impact Assessment"

REF 9 (Improving Outcomes: A strategy for Cancer. Second Annual Report) – 1 uses of "rural"

Page 86/113 Clinical Networks

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"8.15. It is proposed that this element of the total should be divided equally between 12 support teams as core funding, with the remaining £32 million to be allocated according to population size, taking into account **rurality** and inequalities. These support teams will cover defined geographical areas that could contain one or more Cancer Networks"

REF 10 (Improving Outcomes: A strategy for Cancer. First Annual Report) – 1 use of "rural"

Page 16/92 – List of NCIN publications

2011: "The effect of **rurality** on cancer incidence and mortality"

REF 11 (Cancer Reform strategy) – 1 use of "rural"

Page 45/144 – Genetic predisposition and cancer

"2.51 The range of service models explored included services targeted for specific ethnic minority populations, lower-socioeconomic groups and **rural** communities. They also involved a range of health professionals including primary care nurses, outreach genetics counselling from the genetics specialist service, GPs with special interests and cancer specialist nurses."

REF 12 (Impact Assessment of the Cancer Reform strategy) – 4 uses of "rural"

Pages 17-18/19 Impact Tests

"**RURAL** PROOFING IMPACT TEST

Rural issues have been considered as part of the development of the policy, but no significant adverse impact was found. Indeed the move towards more local services is likely to positively impact on **rural** communities."

REF 16 (Tackling Cancer: Improving the Patient Journey) – 1 use of "rural"

Page 44/73

"3.22 The Department has established an annual £50 million central budget to develop specialist palliative care services for three years from 2003-04. The extra £50 million is specifically to meet the commitments in the NHS Cancer Plan. It is to help tackle inequalities in access to specialist palliative care, and to enable the NHS to make a realistic contribution to the costs hospices incur in providing agreed levels of service. The Big Lottery Fund (formerly the New Opportunities Fund) is also making grants of £45 million to the development of adult palliative care services, concentrating on **rural** and inner city areas."

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Contextual Details of the words “Travel” and “Transport” etc in the English Policy Documents

REF 1 (Achieving World-Class Cancer Outcomes A Strategy For England 2015-2020) – 3 uses of “travel”

Page 37/92 – 5. How should we improve survival?
Section 5.3.1.1. Service configuration for surgery
“Surgery tends to involve a small number of hospital visits, whereas most radiotherapy and chemotherapy is delivered in multiple doses over many weeks. So it may be less burdensome for patients to **travel** for their surgery to centres where volumes are higher and outcomes better. Nevertheless, the option of increasing centralisation further needs evaluation. We need to balance the opportunities for improved outcomes through greater specialisation, with the implications for patients having to **travel** further. We must also take into account the need for general surgical cover in smaller hospitals, and ensuring the availability of a broader team infrastructure to support patients.”

Page 45/92 – 5. How should we improve survival?
Section 5.6.2 Children, teenagers and young adults
“Recommendation 43: NHS England, working through the CTYA Clinical Reference Group should:
• Consider whether paediatric treatment centres should be reconfigured to provide a better integrated network of care for patients and families.
• Establish clear criteria for designation and de-designation of treatment centres for TYA patients.
• Ensure that any transition gap between children’s’ and adult services is addressed.
• Assess impact of proposals on **travel** times for families”

REF 3 (Living With And Beyond Cancer: Taking Action To Improve Outcomes) – 1 use of “travel”

Page 79/135 – 7. Taking Action: Sustaining Recovery
New approaches to follow-up
“7.11 NHS Improvement prototypes in breast, colorectal and prostate cancer in adults were targeted to achieve 50% reductions in routine follow-up. Results show that stratifying patients for follow-up according to risk can realise significant financial savings, which can be re-invested in enhanced community support and services at other points in the pathway.
> Reduced outpatient activity, with 3,400 prospective outpatient slots over 6 months saved across 7 prostate and colorectal tumour project sites as a result of using remote monitoring systems. It should be noted that there was a wide variation in follow-up practices in different project sites and for different tumour types.
> Reduced unplanned admissions for lung cancer patients, with a 6–8% reduction.
> Reduced costs for patients, with fewer visits to hospital and less **travel**, parking and loss of work.”

REF 4 (Improving outcomes: A strategy for cancer) – 3 uses of “travel”

Page 21/101 – Section 2. Putting patients and the public first: information and choice
The Information Revolution in Cancer
2.5 While we cannot pre-empt the outcome of the consultation on An Information Revolution, we are confident of the general direction of **travel**.

Page 24/101 – Section 2. Putting patients and the public first: information and choice
Expanding patient choice
“2.22 Applying choice across the pathway will be important for cancer as patients may wish to choose different providers for different forms of treatment and care. For example, a patient may be prepared to **travel** further for surgery from a specialist provider with better outcomes, but may wish to receive treatments such as chemotherapy and radiotherapy closer to their home. Others may prefer to **travel** but might face barriers which prevent them from doing so and some patients may prefer the benefits of the close working relationships developed between service providers within an area. Effective choice should not involve a series of one-off decisions but rather a process of continuous patient engagement with entitlements to revisit decisions provided it is clinically appropriate.”

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REF 5 (Improving Outcomes: A Strategy for Cancer Stakeholder engagement report) – 2 uses of "travel"

Page 8/22 – 14. Service Users
Box 2: Key messages from Service User Workshops
"Information about access to the care and treatment environment needs to be embedded and offered within a clinical setting e.g. questions about **travelling** for chemotherapy and radiotherapy. The clinical team needs to pay more attention to issues related to **travelling** for treatment and the scheduling of appointment times to match times when the patient has access to resources such as a friend being able to take them to hospital."

REF 6 (Improving Outcomes: A Strategy for Cancer Stakeholder engagement report – Impact Assessment) – 7 uses of "travel" and 1 use of "transport"

Page 12/42 – Radiotherapy
"44. Clinical evidence suggests that some patients, who could benefit from radiotherapy, are currently being deterred from taking the treatment because of long **travel** times in rural areas. This is a particular barrier when the patient has already undergone a surgical or chemotherapy treatment, and may have to **travel** long distances over a number of weeks. The advances in communication technology now mean that smaller radiotherapy centres are now feasible, serviced by a clinical and planning hub many miles away, which would not have been possible a decade ago. Manchester has already opened one such satellite site in Oldham and is currently planning a second."

Page 13/42 – Radiotherapy
"Option 3: Increasing efficiency of linacs, and increasing number of linacs by 12
50. Option 3 expands capacity and envisages that clinical practice changes go further to move more services to satellite sites. This would help to improve the geographical spread of services, and would improve patient choice. Option 3 is effectively option 2 plus an increase of 12 in the number of linear accelerators over the SR period, in areas which currently have long **travel** distances to the nearest radiotherapy centre."

"57. While facilities are developed in England to treat 1500 patients per annum, patients are referred overseas for treatment. A "high priority" list of cancers has been identified but it is recognised that there is limited capacity to treat patients overseas and that **travelling** for treatment will not always be appropriate. A clinical reference panel advises on individual cases."

Page 28/42 – Annex 2 Detailed Evidence Base - Radiotherapy
"Option 3 – Option 2 plus increase the number of linear accelerators by 12 over the SR period in areas which currently have long **travel** distances to the nearest radiotherapy centre.
17. This option assumes that, in addition to the overall capacity constraint to radiotherapy, **travel** distance also acts as an additional disincentive to some patients. This means that a higher proportion of additional patients will have a stronger indication that radiotherapy will be beneficial than in option 2."

Page 30/42 – Annex 2 Detailed Evidence Base - Radiotherapy
"In option 3, the base case again assumes a 3% extra chance of living 10 years and gaining 5 QALYs for the expansion of existing capacity. However the new capacity is assumed to reduce the barriers to patients, who would normally expect to have an increased probability of benefits of treatment, but who are not willing or are unable to **travel** to current treatment centres. For the additional patients who are treated in the new capacity, the benefits have been assumed to be 7.5%, ie will gain an extra 10 years of life on average. In this case, the sensitivity analysis looks at the chances of extra life years for both old and new capacity together. All the cases tested are below the £25,000 QALY threshold"

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REF 7 (Improving Outcomes: A strategy for Cancer. Fourth Annual Report) – 1 use of "travel"

Page 53/90 - Proton Beam Therapy

"4.23. Patients suitable for PBT abroad currently **travel** for treatment at specialist centres in the USA (Jacksonville and Oklahoma) and Switzerland (Villigen). Of the 675 patients referred for consideration for treatment since the programme started in 2008, 524 have been approved for treatment, of which 379 (72%) are children"

REF 8 (Improving Outcomes: A strategy for Cancer. Third Annual Report) – 2 uses of "travel"

Page 53/80- Proton Beam Therapy

"5.20. Highly selected patients suitable for PBT abroad currently **travel** to the USA for treatment at specialist centres in Jacksonville and Oklahoma. Support is provided for **travel** and accommodation and access is through a 'virtual' national expert clinical reference panel. Of the 502 patients referred for consideration for treatment since the programme started in 2008, 370 have been approved for treatment, of which 258 are children. An essential part of the overseas programme is the collection of clinical outcome data."

REF 9 (Improving Outcomes: A strategy for Cancer. Second Annual Report) – 1 use of "travel" and 1 use of "transport"

Page 52/113 Other issues relevant to improving survival rates

"Making sure older people have access to appropriate interventions

3.51. We have been concerned for some time that a number of older people may be receiving sub-optimal treatment for their cancer. This may be due to assumptions being made about an older person's ability to tolerate treatment, in the absence of a full assessment of their health. Lack of practical support, such as **transport** or support with caring responsibilities, also presents a barrier to some older patients receiving treatment"

Page 57/113 Proton Beam Therapy

"Until the national service becomes fully operational, high priority cases will continue to **travel** overseas for this treatment. In 2011-12, 79 patients went overseas for treatment and we expect to send 100 in 2012-13 increasing to 400 by the end of 2013-14."

REF 10 (Improving Outcomes: A strategy for Cancer. First Annual Report) – 1 use of "transport"

Page 43/92 Other issues relevant to improving survival rates

Making sure older people have access to appropriate interventions

"3.39 Undertreatment of older people may happen because assumptions are made about an older person's ability to tolerate treatment without undertaking a full assessment of their health. Furthermore, lack of practical support, such as **transport**, presents a barrier to some older patients receiving treatment."

REF 11 (Cancer Reform strategy) – 6 uses of "travel"

Page 78/144 Decision making and choice

"Choice of Treatment

A man with bowel cancer needs surgery to remove the tumour. His surgeon can perform a standard operation to remove it requiring a major incision and hospital stay of around 10-14 days. A team in a neighbouring hospital have recently been trained to remove such tumours using a new keyhole surgical technique offering a faster recovery time. He may wish to choose the new treatment, even if it means **travelling** further"

Page 82/144 Helping patients meet the costs of cancer

"5.50 Cancer can also significantly affect a person's finances. A Macmillan Cancer Support survey in 2006 found that 70% of cancer patients incurred **travel** costs. Based on the average number of trips, the cost per patient was estimated to be £325. Other costs to patients include the cost of adjusting to disabilities caused by cancer or cancer treatment, prescription charges and the cost of home care. Estimates suggest that the cost of these to cancer patients could be around £200 a year"

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“5.53 There are a number of ways in which the Department of Health is working to support people in financial hardship with the costs associated with their healthcare. The NHS Low Income Scheme provides support for people in financial difficulties with prescription charges, dental treatment, sight tests and glasses and **travel** to receive NHS treatment through the Hospital **Travel** Costs Scheme”

Page 98/144 Delivering care in the most appropriate setting
“7.15 A theme of many of these service models is to provide care outside of hospital settings where possible, with efficient access to hospital services when necessary. Most cancer patients want to receive as much of their care as possible close to home. However, they also recognise that they may have to **travel** to see a specialist team to receive the highest possible quality of care, especially for complex investigations or treatments”

Page 99/144 Delivering care in the most appropriate setting
“7.16 The Leeds haematological service has also pioneered a patient-centred monitoring service in response to the increased number of patients diagnosed with haematological malignancy not requiring immediate treatment. The service is community-based using primary care phlebotomy and central haematological review of laboratory parameters, with symptoms identified by a patient self-assessment questionnaire. This approach is effective at identifying patients in need of treatment and results in improved access and convenience with less **travel** for patients and significantly reduced waiting times. Patients are supplied with copies of all relevant information and have access to telephone advice empowering them to manage their condition.”

REF 12 (Impact Assessment of the Cancer Reform strategy) – 1 use of “travel”

Page 16/19 - 1 reference to travel in relation to greenhouse gas emissions.

REF 13 (Cancer Reform Strategy Equality Impact Assessment) – 5 uses of “travel”

Page 8/43 - Cancer inequalities baseline assessment
“25. Treatment and care is affected in the following ways:
Little evidence of differences in treatment and care according to socioeconomic status; and Macmillan Cancer Support found that cancer patients spent on average £380 on **travel** during their treatment.

29. Financial help is available from the Government to help cancer patients and survivors. This includes Attendance Allowance (AA), Bereavement Benefit, Carer's Allowance, Council Tax Benefit, Disability Living Allowance (DLA), Housing Benefit, Incapacity Benefit, Income Support, Industrial Injuries Disablement Pension, Jobseekers Allowance, Pneumoconiosis, Byssinosis and Miscellaneous Diseases Scheme and Statutory Sick Pay. In addition the NHS Low Income Scheme provides support for people in financial difficulties with prescriptions charges, dental treatment, sight tests and glasses and **travel** to receive NHS treatment through the Hospital **Travel** Costs Scheme. To increase uptake of this financial support the Department is piloting information prescriptions that help people find the help that is available and will roll these out across the country in due course.”

Page 22/43 - 4. Assessment of Cancer Reform Strategy impact on inequality
“Delivering care in the most appropriate setting
108. Much of the focus in the past decade has been on reducing hospital waits and ensuring that patients have access to specialists who can deliver high quality cancer treatment. Most cancer patients want to receive as much of their care as possible close to home. However, they also recognise that they may have to **travel** to a specialist centre to receive the highest possible quality of care, especially for complex investigations or treatments. Close cooperation between community services and those in hospitals and specialist centres is vital if patients are to receive optimal care.”

Page 40/43 Annex 2: References
1 mention to travel in the title of a paper referenced.

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REF 14 (The NHS Cancer Plan. A Plan for Investment. A Plan for reform) – 1 use of "travel" and 1 use of "transport"

Page 29-30/98 - Other cancer risk factors

"Exposure to high concentrations of radon, a naturally occurring radioactive gas, increases the risk of lung cancer. Radon levels vary considerably between different parts of the country. The Department of Health has worked with the Department for the Environment, **Transport** and the Regions (DETR) on pilot studies with local authorities, to provide information and encourage remedial action in homes affected by radon. DETR will be running a new radon programme in partnership with 31 local authorities from the areas most affected by radon."

Page 50/98 – A new goal for cancer waiting times

"5.9 Past decades of under investment mean this goal is not yet within reach. It will need more equipment and additional staff, working in new ways. It will take time and effort to achieve. But it is important to have a shared direction of **travel**. Provided that we can recruit the extra staff, and the NHS makes the necessary reforms, we hope to achieve this goal by 2008."

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