NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Equality and health inequalities assessment (EHIA)

Contents

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality and health inequalities assessment (EHIA) template

Bladder cancer: diagnosis and management

The considerations and potential impact on equality and health inequalities have been considered throughout the guidance development, maintenance and update process according to the principles of the NICE equality policy and those outlined in Developing NICE guidelines: the manual.

This EHIA relates to:

Bladder cancer: diagnosis and management

2024 surveillance of Bladder cancer: diagnosis and management (NICE guideline NG2)

STAGE 1. Surveillance review

Date of surveillance review: June 2024

Focus of surveillance review: All aspects of 'Bladder cancer: diagnosis and management' including urothelial cancer

Issues identified from 2023 topic expert feedback

Protected characteristics:

- Sex: The experts noted that bladder cancer may be diagnosed at a later stage in women compared to men. One expert mentioned that there seems to be biological reasons as to why women with muscle-invasive bladder cancer (MIBC) do worse than men with MIBC. This suggests potential inequalities in diagnosis and outcomes based on sex.

Socioeconomic deprivation:

- One expert stated that bladder cancer has always been associated with lower socioeconomic groups. Access to healthcare is also noted as a confounder as to why some people present later and have poorer outcomes.

Geographical area variation:

- No specific issues related to geographical variation were identified in the expert feedback.

Inclusion health and vulnerable groups:

- The experts did not identify any specific issues related to inclusion health or vulnerable groups.

Additional points:

- One expert mentioned that the impact of ethnicity on bladder cancer prognosis is unclear, although a number of groups are looking at the effect of sex and ethnicity on bladder cancer.
- Another expert noted that bladder cancer is related to environmental exposure from smoking and occupation, which are more common in lower socio-economic groups.

In summary, the main equality and health inequalities issues identified by the experts relate to potential disparities in diagnosis and outcomes based on sex and socioeconomic status. The impact of ethnicity is unclear and requires further research. No specific issues were highlighted regarding geographical variation or inclusion health and vulnerable groups.

Issues identified during this surveillance review

Gender differences in immunotherapy response:

- A systematic review and meta-analysis by Schneidewind 2023 found a trend towards better outcomes in women compared to men receiving immunotherapy for advanced or metastatic urothelial cancer. In a pooled analysis of two studies using atezolizumab, women had a significantly better objective response rate.
- While this suggests potential gender-specific differences in immunotherapy response, none of the included studies provided UK-specific data. Therefore, the relevance of these findings to the UK population and healthcare system is unclear.
- The current NICE recommendations do not address potential gender differences in treatment response. While this evidence is not strong enough to add a new recommendation, it could prompt a review of the evidence base to monitor for emerging UK-specific data on gender differences in outcomes.

Undertreatment in advanced urothelial cancer:

- A systematic review by Kearney 2023 found that a substantial proportion of patients with locally advanced or metastatic urothelial cancer do not receive guideline-recommended systemic treatment. Factors associated with higher rates of non-guideline-concordant care included older age, female sex, poor performance status, and metastatic disease.
- Notably, this review included data from two UK studies (Davies 2020 and Kearney 2020) which reported some of the highest rates of non-standard treatment among European countries, ranging from 69.6% to 74.0%. This suggests that undertreatment may be a particularly significant issue in the UK setting.
- Patients receiving non-standard treatment had significantly shorter overall survival compared to those who received systemic therapy, indicating potential health inequalities in access to and outcomes of care for advanced bladder cancer in the UK.
- The current recommendations emphasise the importance of specialist multidisciplinary team review (1.5.1) and discussion of treatment options with patients (1.5.3, 1.7.1, 1.7.5). However, they do not explicitly address the issue of undertreatment or specify risk factors for non-guideline-concordant care.
- While the evidence is not definitive, it could warrant a review of the recommendations to consider adding more specific guidance around addressing undertreatment and ensuring equitable access to guideline-concordant care, particularly for high-risk groups.

Geographic variation in treatment patterns:

- The systematic review by Kearney 2023 found that rates of non-standard treatment varied by geography, with ranges of 40-74% in European studies, 14-60% in US studies, and 9-63% in other locations.

- The high rates of non-standard treatment reported in the UK studies compared to other European countries suggest that there may be geographic inequalities in bladder cancer management within the UK, although the reasons for this variation are not clear from the evidence presented.
- The current recommendations do not address geographic variation in care. This evidence could prompt a review to consider adding a recommendation around monitoring and addressing geographic disparities in treatment patterns and outcomes.

Impact on the current review and outcome decision

- While the Schneidewind 2023 review suggests potential gender differences in immunotherapy response, the lack of UK-specific data limits its immediate relevance to the NICE guideline update at this time.
- However, the Kearney 2023 review provides more compelling evidence of undertreatment and geographic variation in advanced bladder cancer care in the UK specifically. These findings highlight important equality and health inequalities issues that could be considered in future updates to the NICE guideline.
- Although the current evidence may not be strong enough to warrant immediate changes to the guideline recommendations, it does support the need for further UK-specific research to better understand and address these potential disparities in bladder cancer management and outcomes.
- As the UK evidence base evolves, there may be opportunities to incorporate more specific recommendations or discussion of equality and health inequalities considerations in subsequent updates to ensure the NICE guideline is optimised for the UK population.

In summary, the surveillance review has identified undertreatment and geographic variation as key equality and health inequalities issues in bladder cancer diagnosis and management that may be particularly relevant to the UK based on the limited data available. While gender differences in immunotherapy response are also a potential concern, more UK-specific research is needed to determine the significance of this issue in the UK population. These findings underscore the importance of ongoing monitoring and research to inform future updates to the NICE guideline that address potential disparities in care and promote equitable access to high-quality bladder cancer services for all patients in the UK.

Completed by: Toby Mercer, Technical Analyst

Date: 06/06/2024

Approved by NICE CFG topic hub senior topic adviser or associate director: Kay Nolan, associate director

Date: 06/06/2024

STAGE 2. Informing the scope

Bladder cancer: diagnosis and management (NICE guideline NG2)

Date of completion: 26/05/2026

Focus of guideline update: treating non-muscle-invasive bladder cancer and radical cystectomy.

2.1 Check existing EIAs or EHIAs at the very beginning of scoping (during early preparation stages). Note any equality and health inequality issues identified.
Existing EIAs and EHIAs include the NG2 2015 EIA and the 2024 surveillance review EHIA, summarised in stage 1 of the current EHIA report. Any equality and health inequalities issues identified in these sources have also been included in section 2.3 of the current EHIA report.

2.2 What additional approaches have been used to identify potential equality and health inequalities issues during the check for an update or during development of the draft scope?
Searches were conducted to identify equality issues specific to bladder cancer and discussions were held with early committee members during scoping. Equality issues that were identified during the scoping and development of the 2015 guideline and the health inequalities briefing that accompanies this guideline have also been considered.

2.3 What potential equality and health inequalities issues have been identified during the check for an update or during development of the draft scope?
1) Protected characteristics: a. *Age* Older adults often face age-related obstacles—such as physical weakness, cognitive impairments, and limited mobility—that hinder timely access to healthcare. These challenges may be intensified by ageist attitudes within the healthcare system, which can result in delayed diagnoses, fewer treatment options, and a lack of proactive care. Additionally, practical difficulties, including transportation issues and navigating complex healthcare processes, may further compound these barriers (Scott et al., 2024). These can apply to older people who need help from family members or carers, while other older people may face difficulties in accessing appointments because they are carers for other family members (young and old).

As age increases so does the relative risk of bladder cancer incidence and mortality, in particular after the ages of 50 and 65 years (Su et al., 2025). Age is considered to be the most important risk factor in bladder cancer. The highest proportion of advanced bladder cancer diagnosis was in people aged 65-74 years old (Zhou et al., 2024). There is a potential increase of bladder cancer for females with earlier age at menopause (Hyldgaard et al., 2021). The EIA report from the NG2 2015 guidance also identified that elderly patients may not be offered cystectomies or radical treatment because older people and those with frailty are more likely to experience postoperative complications and mortality after radical treatment for bladder cancer (Tempo et al., 2025; Fang et al., 2026).

b. *Disability*

The EIA report from the NG2 2015 guidance identified that cystectomy may not be an option for people with poor manual dexterity, visual impairment or mental impairment. Cystectomy often results in the use of an ostomy appliance which is less likely to be manageable for these people. No other potential issues specific to bladder cancer were identified.

A person with a learning disability may have additional information needs and require information to be provided in a manner that addresses these needs to be fully accessible for example easy to read information leaflets or verbal communication. In contrast, people with sensory disabilities (for example, people with visual impairment) may require information presented in Braille and verbally. Some disabled people (for example, people with learning disabilities, dementia or who have more severe forms of autism) may require the support of a carer or advocate to help them to understand what is happening to them and to ensure that the consent that they give is informed. Best interest meetings where a multidisciplinary meeting is arranged for specific decisions around the person's care may be needed if they lack the mental capacity to make decisions themselves.

Some disabled people may need support to physically access appointments (with travel or accessing buildings) and a lack of availability of carers/ family members may compound this problem. Additional preparation and support may also be needed to help some disabled people, such as those with learning disabilities or neurodivergent people, get used to the environment before they have imaging or treatment.

c. *Gender reassignment*

Research often overlooks the significant inequalities the transgender community faces. People may delay seeking treatment due to fear of stigma,

past negative experiences, or concerns about confidentiality (Scott et al., 2024). Transgender people are also often underrepresented in clinical trials.

d. *Marriage and civil partnership*
No potential issues specific to bladder cancer were identified.

e. *Pregnancy and maternity*
MRI during pregnancy is not recommended due to the high level of background parenchymal enhancement during pregnancy and lactation (NHS England). Radiotherapy is also avoided. Fertility can be a concern for people deciding whether to have radical cystectomy and can also be affected by systemic anticancer therapies. However, it is rare for women of childbearing age to develop bladder cancer.

Some drugs may be contraindicated during pregnancy**.** For example, the BNF also states that females of childbearing potential should have a pregnancy test within 7 days before starting treatment with enfortumab vedotin and use effective contraception during and for at least 12 months after last treatment (BNF).

f. *Race*
Incidence rates for some smoking-related cancers including bladder cancer have been reported to be lower in non-white minority ethnic groups compared with the corresponding white group, with the exception of Chinese people who have the lowest smoking prevalence compared with the highest bladder cancer incidence rate (Delon et al., 2022, Maruthappu et al. 2015). This is potentially explained by culturally-specific risk factors for example dietary soy which has been associated with increased bladder cancer risk and is frequently used in Chinese cuisine (Sun et al. 2002).

In the UK people from ethnic minorities reported less positive experiences across varying care dimensions including access to GPs and bladder cancer awareness (Scott et al., 2024; Underwood et al., 2025). About 18-23% of all cancer diagnoses occur through emergency presentations. Asian, black, and mixed ethnicities had lower odds of emergency diagnosis compared to white people. In addition, Black people were more likely to be diagnosed via GP referral than white people (Scott et al., 2024). Bias in doctor-patient interactions commonly stemming from subconscious stereotypes may also delay cancer diagnosis (Scott et al., 2024). Delays in diagnosis are often made worse by fear, cultural beliefs, and stigma. Additionally, systemic data gaps caused by historically poor data collection regarding race and ethnicity, and underrepresentation of ethnic minorities in clinical trials have resulted in

limitations to the evidence base regarding differences in treatment efficacy and side-effect data.

People from ethnic minority family backgrounds may have additional barriers to receiving healthcare, including different language needs and cultural expectations. People who do not speak English as a first language may have difficulty describing their medical history or lifestyle factors in English, potentially leading to misclassification of risk. These language barriers, as well as other additional challenges—like a preference for traditional medicine—can limit access to information and care. In addition, they may find it harder to access support services if they are not culturally appropriate or accessible to people with poor English language skills.

g. *Religion or belief*

No potential issues specific to bladder cancer were identified.

h. *Sex*

Men have 3-4 times higher risk of developing bladder cancer and are more commonly diagnosed with bladder cancer compared to women; however, women have higher mortality rates by stage cases as they are more often diagnosed with more advanced bladder cancers (Mancini et al., 2019; Shweiki et al., 2025). Women also have shown higher risk of recurrence or progression of non-muscle invasive bladder cancer, significantly longer hospital stays, operative times, higher blood loss and higher 90-day mortality and perioperative complication rate (Mancini et al., 2019). The sex-disparity for survival rates is highest in bladder cancer compared to other cancers (Zhou et al., 2024). There is a strong difference between men and women presenting with symptoms for bladder cancer, potentially explaining some, but not all, of the sex-disparity regarding advanced bladder cancer diagnosis (Zhou et al., 2024). For example, women presenting with symptoms of bladder cancer may be mis-diagnosed or not investigated further as these symptoms could be explained by other benign conditions that are common in woman (such as cystitis or blood in the urine being attributed to spotting between periods or having a period). Research also shows that cancer-related stigma can vary depending on a woman's country of origin and how long she has lived in the UK (Scott et al., 2024).

i. *Sexual orientation*

There are persistent disparities in access, experience, and outcomes for people who identify as lesbian, gay, or bisexual. These groups of people are often underrepresented in research evidence. Variations in knowledge and attitudes within health and care systems can influence assessment, diagnosis, and treatment. In addition, individuals may delay seeking care

because of previous negative experiences, perceived stigma, or concerns about confidentiality (Scott et al., 2024).

2) **Socioeconomic deprivation**

Incidence of bladder cancer and mortality rates from it have been reported to be highest in countries with a high level of socioeconomic development (Huang et al., 2024). It is believed that this is due to bladder cancer specific risk factors in these areas such as occupational exposure to aromatic amines and polycyclic aromatic hydrocarbons. In England, bladder cancer incidence has been reported as higher in workers with industrial occupations that are more commonly associated with lower socio-economic status, again due to levels of exposure to potential carcinogens including cigarette smoking (Cumberbatch et al., 2024). Cancer Research UK (2026) reported that the proportion of patients diagnosed with bladder cancer as an emergency increased in more deprived areas.

Patients with muscle invasive and non-muscle invasive bladder cancer who live in higher socio-economic areas may be more likely to receive optimal treatment (Russell et al., 2020). Patients across different socio-economic areas receive different levels of care with this inconsistency likely to impact survival rates. For example, people with higher socio-economic status were more likely to receive additional treatments, meanwhile people with lower socio-economic status were less likely to accept chemotherapy for metastatic bladder cancer.

3) **Geographical area variation**

Access to healthcare can be significantly limited by geographical location. Treatment facilities are often concentrated in urban and affluent areas, making it harder for people in deprived regions to access care. These individuals may face additional travel time and costs, which can result in missed appointments, delays in treatment, or even an inability to receive care. This challenge is especially pronounced for radiotherapy and drug therapies where courses can last many months, as it typically requires multiple visits over several days or weeks (Scott et al., 2024).

4) **Inclusion health and vulnerable groups**

Migrants may be deterred from seeking care because of NHS charges and fear of medical information and their contact details being shared with immigration enforcement.

For Gypsy, Roma and Traveller communities, barriers accessing healthcare services could include language difficulties, low literacy levels, poor knowledge of the health system, and distrust in authority.

People experiencing homelessness and people in prison may have difficulties in accessing care and being diagnosed in a timely manner. Groups of people who move around a lot, such as people experiencing homelessness; migrants, refugees and asylum seekers; and people in Gypsy, Roma and Traveller communities may experience difficulties in moving cancer care between centres and are more likely to lost between systems. This movement may make it harder for healthcare professionals to access previous test results, including for comparisons between scans or biopsy results and people may experience delays in diagnosis and treatment as a result.

2.4 How can the identified equality and health inequalities issues be further explored and considered at this stage of the development process?
Early committee members will be asked to review the draft EHIA and helps us identify any additional issues that we can include in the document. We will also be consulting on the draft scope and EHIA and will include any issues raised by stakeholders in the next stage of the EHIA.

2.5 Do you have representation from stakeholder groups that can help to explore equality and health inequalities issues during the consultation process including groups who are known to be affected by these issues? If not, what plans are in place to address gaps in the stakeholder list?
Patient groups and charities such as Action Bladder Cancer UK, Camden Carers Centre, The Urology Foundation, and Urostomy Association and Friends, families and Travellers are registered as stakeholders currently. Other groups including Fight Bladder Cancer have been invited to register as stakeholders. We will also ask early committee members to suggest any additional groups who should be invited to register stakeholders.

2.6 How will the views and experiences of those affected by equality and health inequalities issues be meaningfully included in the guideline development process going forward?
We will try to make sure that different viewpoints and backgrounds are covered by appointing lay members with different perspectives, expertise and lived experiences of bladder cancer, where possible. In order to facilitate lay members' participation in the committee meetings, we will consider offering additional support before, during and after meetings, depending on their situational needs.

2.7 If applicable, what questions will you ask at the draft scope stakeholder consultation about the guideline/update and potential impact on equality and health inequalities?
We do not plan to ask any specific questions about health inequalities during the scope consultation.

2.8 Has it been proposed to exclude any population groups from the scope? If yes, how do these exclusions relate to any equality and health inequalities issues identified?
Children (younger than 18 years) were excluded from the original scope of this guideline because their management is provided by paediatric oncology services. Adults with bladder sarcoma or upper tract urothelial carcinoma were additionally excluded from the original scope of this guideline because the management of these populations are distinct from bladder cancer or because they are usually managed by different professional groups. These exclusions are unlikely to relate to any identified equality and health inequalities issues.

Completed by topic team:
Anja Fricke, Technical Analyst; Rachel Connolly, Senior Technical Analyst

Date: 26/05/2026

Approved by committee chair: Louis Savage

Date: 09/07/26

Approved by NICE CFG topic hub senior topic adviser:
Sara Buckner

Date: 1st July 2026