

**NATIONAL INSTITUTE FOR HEALTH AND CARE
EXCELLENCE**

NICE guidelines

Equality and health inequalities assessment (EHIA)

Suspected cancer: recognition and referral: Partial update

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: Suspected cancer: recognition and referral (update)

Equality and health inequalities assessment (EHIA)

STAGE 1. Informing the scope

Guideline: Suspected cancer: recognition and referral: Partial update [NG12]

Date of completion: July 2025

Focus of guideline or update:

- Ovarian cancer and the signs and symptoms and a suspected cancer pathway referral.
- Unexplained weight loss in adults and a suspected cancer pathway referral.
- Endometrial cancer, HRT, unscheduled post-menopausal vaginal bleeding and a suspected cancer pathway referral.

1.1 What 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?

Here are the approaches that have been used to identify potential equality and health inequalities issues for this suspected cancer: recognition and referral update.:

- Review of one existing [Equality and health inequalities assessment \(EHIA\) and four existing Equality Impact Assessments \(EIAs\)](#) from previous versions of the suspected cancer guideline (2023; 2021).
- Surveillance review: [Surveillance review in May 2024](#), which involved checking for any new equality or health inequalities issues.
- Surveillance review: [Surveillance review of suspected cancer and menopause in 2024](#), which involved checking for any new equality or health inequalities issues.
- Surveillance review: [Surveillance review of weight loss in suspected cancer in 2025](#), which involved checking for any new equality or health inequalities issues.
- NICE Clinical Knowledge Summaries (CKS) - [Ovarian cancer](#).
- NICE CKS - [Endometriosis](#).
- Key word searches in web search engines e.g. gender reassignment, disability, race.

- Information scientist carried out the search in Medline (Ovid), HMIC (Ovid), SPP (Ovid), Central (Wiley) databases for Disabilities, Gender reassignment and Religion/beliefs sections.

1.2 What potential equality and health inequalities issues have been identified during the check for an update or during development of the draft scope?

Based on the information provided in the previous EHIA, EIA documents, surveillance reviews, NICE CKSs and results from key word searches in web search engines, here are the potential equality and health inequalities issues identified for the suspected cancer: recognition and referral update:

1. Protected characteristics

- Age:

Older women (aged 70 years and over) are more likely to be diagnosed via emergency diagnosis, i.e. delays in cancer diagnosis are more common among older women. [Target Ovarian Cancer \(2022\)](#). Additionally older women are more likely to be diagnosed with late-stage cancer. [Williams et al \(2019\)](#), [RCOG and BGCS \(2024\)](#).

Women of working age may delay presentation to primary care ([Jeffrey 2025](#)). Additionally, women aged 55 years or less are more likely to have three primary care consultations before referral to diagnostic tests ([Williams et al 2029](#)). Bleeding is less likely to be considered in primary care as a symptom of endometrial cancer in premenopausal women. [Williams et al \(2019\)](#).

The need for digital literacy and the ability to navigate digital services may also be a barrier to older people seeking healthcare. [Age UK \(2024\)](#).

- Gender reassignment:

There is a lack of evidence regarding the equality and health inequalities issues experienced by this population specific to this update. Transgender men may face barriers to screening that could include female-only clinics and non-inclusive materials ([Berner et al 2021](#)). Factors, such as limited knowledge about cervical health, trauma history or exam-related distress may prevent transgender men from attending cancer related investigations. [Weyers et al \(2020\)](#). Discrimination in healthcare settings discourages many trans people from seeking necessary care. Trans patients may face transphobia, denial of services, and may be more likely to experience unfair treatment by GPs. LGBTQ+ individuals frequently report microaggressions, such as incorrect assumptions about partners, fertility needs, sexual orientation, gender identity, or pronouns. [Royal College of Nursing \(2025\)](#).

- Being married or in a civil partnership:

Marital status was not found to delay diagnosis and no other issues regarding equality or health inequalities have been identified. [Williams et al \(2019\)](#).

- Disability:

There is a lack of evidence regarding the equality and health inequalities issues experienced specific to disability and this update. The barriers applicable to general cancer diagnosis are likely applicable to suspected ovarian cancer and endometrial cancer diagnosis. People with physical disabilities may face delays in cancer diagnosis relating to barriers to the process of diagnosis such as inaccessible medical equipment, for example examination not suited to wheelchair users (Agaronnik et al 2021, [Tosetti et al 2023](#)). There is also the risk that symptoms may be attributed to the disability that the person has and not recognised as a cancer symptom ([Iezzoni et al 2022](#); [Shah et al 2024](#)).

People with a learning disability are more likely to have multiple long-term conditions than the general population ([NHS England, 2023](#)). This means that they may have their new symptoms attributed to their underlying disability, or an already diagnosed long-term condition rather than the possibility of a new condition being explored. Individuals with learning disabilities may present cancer symptoms in non-standard ways, such as through behavioural changes rather than verbal complaints ([Pelleboer-Gunnink et al, 2017](#)). Changes in behaviour, mood, eating patterns, or daily routines may be the only indicators of underlying pain or illness. Healthcare professionals often lack the training to recognise these "soft signs" as potential indicators of serious medical conditions and [Bristol, North Somerset and South Gloucestershire Integrated Care Board \(2024\)](#).

For people with learning disability inadequate transportation and lack of available carers have resulted in delayed cancer diagnoses [Nuffield Trust \(2024\)](#).

- Race:

There are geographical variations in diagnosis and treatment of cancer in females from different ethnicities ([NDRS and NHS England 2025](#)). Variation by ethnicity in diagnostic pathway and diagnosis rate is observed in ovarian cancer. Women from minority ethnic groups are more likely to be diagnosis via emergency presentation, and less likely to be diagnosed via two-week wait referral than White women ([Target Ovarian Cancer 2022](#)). Additionally, there are variation in time to treatment, where women from minority ethnic groups (Black and Asian) are likely to wait five to six days longer for treatment than White women ([RCOG and BGCS 2024](#)). The variation in diagnostics pathway and time to treatment could have implication on health outcomes, such as stage of cancer on diagnosis, and cancer survival rates.

The unscheduled bleeding related to uptake of HRT is associated with increase in referral to endometrial cancer investigation in secondary care ([RCOG and BGCS 2024](#)). A lower uptake of HRT is observed among female patients from ethnic minority groups (5.2% in Black and 6.2% in Asian) compared with 23.3% in White female patients aged 45 to 55 years old ([NHS and ECLIPSE,2024](#)). The issue is further complicated as non-investigation of symptoms, including postmenopausal bleeding, is associated with increased delay in diagnosis ([Williams et al,2019](#)).

- Religion or belief:

Organisational, cultural, and social factors are shown to influence whether ‘bodily sensations’, such as abdominal distension or pain, are interpreted as symptoms that lead to health-seeking behaviour. These ‘sensations’ may be interpreted as due to menopause or a non-gynaecological cause. Additionally, women may feel embarrassed to present to doctor with symptoms or feel worried about what the doctor might find([Williams et al 2019](#)).

2. Socioeconomic deprivation

Living in more deprived areas of the UK is associated with higher prevalence of all cancers risk factors (e.g. smoking and obesity), lower awareness of symptoms that could indicate cancer, and experience barriers to seeking help. It is recognised that there is potential for intersectionality between these factors and the other factors (protected or otherwise), and all these factors contribute to higher cancer incidence, delayed diagnosis, longer waiting for urgent referrals, increased diagnosis via emergency presentation, later stage diagnosis, missing out on certain treatments, and lower cancer survival([Cancer Research UK 2025](#)). Comorbidities, more common among people living in deprived areas [Cancer Research UK \(2025\)](#), are associated with misdiagnosis or relating symptoms to other conditions leading to delay in diagnosis. [Williams et al \(2019\)](#).

A systematic review outlined an association between lower education attainment, belonging to lower socioeconomic groups and delayed diagnosis in ovarian and endometrial cancers ([Williams et al 2019](#)), and disparities have been observed in diagnosis by area of deprivation ([RCOG and BGCS 2024](#)).

3. Geographical area variation

There are geographical variations in demographic factors (age, socioeconomic deprivation, and ethnicity) among women lead to variation in cancer diagnosis ([NDRS and NHS England 2025](#); [RCOG and BGCS 2024](#)). The geographic variation in diagnosis may lead to variation in cancer related health outcomes within and between demographic groups based on where they live. For example, ethnic minority groups have a different experience in suspected cancer referral, later stage diagnosis, and treatment based on

where they lived in the UK. Rurality and distance from health care providers may increase delays in diagnosis ([Williams et al 2019](#)).

4. Inclusion health and vulnerable groups

There is a lack of evidence regarding the equality and health inequalities issues experienced by inclusion health and vulnerable groups specific to this update. However, we have identified some more general barriers faced by inclusion health and vulnerable groups relating to accessing cancer services.

Refugees, asylum seekers, seasonal workers, and undocumented migrants often encounter difficulties in accessing healthcare services, ([Asif et al 2022](#)). Proof of identification requirements, challenges navigating the healthcare system, cultural and language differences are likely to also impact on presentation at primary care with symptoms that may be cancer related ([Kugel et al 2021](#)).

People experiencing homelessness (PEH) have higher cancer incidence and mortality rates than the housed population ([Gateway C, 2025](#)). PEH are more frequently exposed to cancer risks such as smoking, alcohol and substance use, high-risk sexual behaviour, poor diet, and environmental hazards ([Gateway C, 2025](#)). Mental and physical health issues, along with trauma, can affect health-seeking behaviour ([Gateway C, 2025](#)). Environmental conditions may also hinder awareness of cancer symptoms. Lack of a fixed address limits access to screening invitations and follow-up care ([Gateway C, 2025](#)). Transport issues, rigid appointment times, and fear of discrimination may further reduce access, widening health inequalities ([Gateway C, 2025](#)).

Cultural values around privacy and modesty, also may pose barriers. Both Roma and Gypsy/Traveller communities consider cancer as a taboo topic, often kept within the family and hidden from others ([Condon et al 2021](#)).

1.3 How can the identified equality and health inequalities issues be further explored and considered at this stage of the development process?

1. Review questions: When undertaking the review where data is available, the review will aim to identify and analyse information on different diagnostic pathway in specific population groups including but not limited to adults with mental health conditions, LGBTQ+ individuals, people from lower socioeconomic backgrounds, and individuals from ethnic minority groups.

1.4 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?

Not Applicable – the scope will not be consulted on.

1.5 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?

The views and experiences of those affected by equality and health inequalities issues will be included in the guideline development process through the following mechanisms:

1. Committee expertise: Members with experience of working with diverse populations will be included.
2. Evidence review: The evidence review process will include extracting data related to equality and health inequalities where available.
3. Committee discussions: The Committee will consider equality and health inequalities implications throughout their discussions and when developing recommendations.
4. Consultation feedback: Consideration will be given in the feedback received during the consultation phase that addresses equality and health inequalities issues.

These approaches should ensure that the guideline development process meaningfully includes the views and experiences of those affected by equality and health inequalities issues. During development, if needed additional steps (such as targeted consultations or additional expert input) will be considered.

1.6 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?

Not applicable

1.7 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?

Not applicable

Completed by developer: Armina Paule

Date: July 2025

Approved by committee chair: Britta Stordal

Date 30/09/2025

Approved by NICE quality assurance lead _____

Date _____

STAGE 2. Development of guideline or topic area for update
(to be completed by the developer before consultation on the draft guideline or update)

Suspected cancer: recognition and referral: Partial update [NG12]

Date of completion: October 2025

Focus of guideline or update:

- Ovarian cancer and the signs and symptoms and a suspected cancer pathway referral.
- Unexplained weight loss in adults and a suspected cancer pathway referral.
- Endometrial cancer, HRT, unscheduled post-menopausal vaginal bleeding and a suspected cancer pathway referral.

2.1 From the evidence syntheses and the committee's considerations thereof, what were the main equality and health inequalities issues identified? Were any **further** potential issues identified (in addition to those identified during the scoping process) or any gaps in the evidence for any particular group?

- Age

The scope of this update includes only people ≥ 18 years old. The committee recognised that serum CA125 testing is less reliable in younger adults, particularly those under 40. The committee raised concerns about the delayed ovarian cancer diagnosis in people under 50 where symptoms may be misattributed to other causes due to the rarity of the disease in this demographic. The findings of the evidence review, combined with the committee expertise and discussion contributed to the development of recommendations for setting age-band thresholds based on clinical and cost-effectiveness.

- Socio-economic factors

The committee discussed that people from deprived backgrounds present to primary care later and at more advanced stages of ovarian cancer. They acknowledged that primary care clinicians working in the most deprived population may consider using lower threshold to refer people for ultrasound scan.

- Geographical area variation

The committee noted that there is regional variation in ultrasound availability and waiting times for ultrasound scan.

The committee did not note any additional equalities or health inequalities issues in the evidence. The committee did not note any equalities or health inequalities issues for unexplained weight loss in adults or for endometrial cancer, HRT and unscheduled post-menopausal vaginal bleeding.

2.2 How have the committee's considerations of equality and health inequalities issues identified in 1.2 and 2.1 been reflected in the guideline or update and any draft recommendations?

- Age

Ovarian cancer

There was an acknowledgement that ovarian cancer is more likely in older women but that whilst less prevalent, ovarian cancer can be missed in younger women. To address the potential equalities and health inequalities while basing the recommendation on the presented evidence, the committee opted to recommend that clinicians should not rely on serum CA125 to make ultrasound decisions and should use clinical judgement and assessment of symptoms for patient presenting with symptoms that may suggest ovarian cancer in those aged 39 and under

The committee recommended 10-year age banding serum CA125 thresholds in patients aged ≥ 40 to provide primary care practitioners with more bespoke thresholds for arranging ultrasound scans. The new bespoke thresholds lower the serum CA125 thresholds for those aged ≥ 50 , with the aim of increasing the appropriate access to the referral pathway.

Unexplained weight loss

The committee have recommended that unexplained weight loss should be investigated in people over the age of 60. Introducing an age-based threshold could minimise the number of people without cancer who get inappropriately referred whilst maximising the number of people with cancer who get appropriately referred. The committee discussed that for under 60 years presenting with unexplained weight loss alone is rare. The committee acknowledged that whilst adults 18 to 59 years of age are not covered by the updated recommendation on unexplained weight loss as a non-site-specific symptom, the guideline has 'safety netting' recommendations to consider a review for people with any symptom associated with increased cancer risk who do not meet the criteria for referral or investigative action.

- Gender reassignment

No specific considerations, but the language in the guideline has been updated to be more gender inclusive now referring to 'women, and trans men and non-binary people with female reproductive organs'.

- Geographical variation

The committee discussed the issue of geographical variations in access to ultrasound and the impact this had in terms of the arrangement of ultrasound scans. The committee discussed that clinicians working in deprived areas may consider lowering thresholds to refer for possible ovarian cancer because patients may present later with more advanced

disease. The evidence review for dual compared with sequential serum CA125 and ultrasound did not identify any studies and recommendations could not be developed. To address this the committee developed a research recommendation to stimulate research in this area.

Section 1.2 highlights potential equalities and health inequalities issues related to, disability, race, religion or belief, socioeconomic deprivation and inclusive health groups. These were general issues and not specific to ovarian cancer or non-site-specific-weight-loss or endometrial cancer. There was nothing highlighted in the evidence reviews that alluded to issues outlined and as such the committee have not sought to address them in the recommendations developed.

2.3 Could any draft recommendations potentially increase inequalities?

It is unlikely that any draft recommendations would increase inequalities.

2.4 How has the committee's considerations of equality and health inequalities issues identified in 1.2 and 2.1 been reflected in the development of any research recommendations?

No. The committee did not make any specific research recommendations based on any of the equality and health inequalities themes identified. However, based on some of the general issues regarding groups with protected and other characteristics surfaced in this EHIA, sub-group analysis has been included in the PICO for research recommendations.

2.5 Based on the equality and health inequalities issues identified in 1.2 and 2.1, do you have representation from relevant stakeholder groups for the guideline or update consultation process, including groups who are known to be affected by these issues? If not, what plans are in place to ensure relevant stakeholders are represented and included?

Yes. Out of a total of 276 stakeholders registered or identified as relevant for this guideline 45 represent patient groups (for example British Asian Cancer Charity, Cancer Research UK and Young Lives vs Cancer) of which 9 consider more specifically, issues relating to ovarian and endometrial cancer (for example Ovacom, Womb Cancer Alliance and The Eve Appeal).

2.6 What questions will you ask at the stakeholder consultation about the impact of the guideline or update on equality and health inequalities?

Based on the recommendation and the research recommendation developed it was not felt that specific questions regarding equality and health inequalities was required. However, due to the change in current practice that the recommendations are suggesting the following questions will be asked at consultation:

Would it be challenging to implement any of the draft recommendations?

- a. Please say why and for whom?
- b. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives).

Completed by developer: James Jagroo/Armina Paule

Date: 29th October 2025

Approved by committee chair: Britta Stordal

Date: 31st October 2025

Approved by NICE quality assurance lead: Kate Kelley

Date: 11/12/2025

STAGE 3. Revisions and final guideline or update

(to be completed by the developer before guidance executive considers the final guideline or update)

Suspected cancer: recognition and referral: Partial update [NG12]

Date of completion: March 2026

Focus of guideline or update:

- Ovarian cancer and the signs and symptoms and a suspected cancer pathway referral.
- Unexplained weight loss in adults and a suspected cancer pathway referral.
- Endometrial cancer, HRT, unscheduled post-menopausal vaginal bleeding and a suspected cancer pathway referral.

3.1 How inclusive was the consultation process on the draft guideline in terms of response from groups (identified in box 2.2) who may experience inequalities related to the topic?

There were 16 stakeholder organisations from across the sector that responded to the consultation. The stakeholders were a mix of charities, academic institutions, professional bodies, royal colleges, clinical networks and NICE clinical reference panel:

- Six charities responded to the consultation: AMMF – The Cholangiocarcinoma Charity, BAME Health Collaborative, Breast Cancer Now, Cancer Research UK, OUTpatients charity, and Target Ovarian Cancer.
- Three professional bodies: British Gynaecological Cancer Society, British Society of Gastrointestinal and Abdominal Radiology, Society of Radiographers.
- Two academic institutions: University of Birmingham and University of Oxford.
- Two clinical networks: Greater Manchester Cancer Alliance and The International Ovarian Tumor Analysis group.
- Two royal colleges: The Royal College of General Practitioners and Royal College of Nursing.
- NICE GP Reference Panel.

3.2 Have any **further** equality and health inequalities issues beyond those identified at scoping and during development been raised during the consultation on the draft guideline or update, and, if so, how has the committee considered and addressed them?

1) Protected characteristics outlined in the Equality Act 2010

Age: no comments related to age.

Disability: comments related to the guideline development processes consideration of people with learning disabilities

Barriers that people with a learning disability may face, in relation to equality and health inequalities, are addressed in the EHIA document. No data were available in the identified studies to support subgroup analyses as outlined in the protocol, so no recommendations were made specifically for people with learning disabilities. It was also noted that the recommendations on patient information and support which were not part of this update refer to [NICE's guideline on patient experience in adult NHS services](#) which includes the consideration of learning disabilities.

Gender reassignment: comments related to the potential intersection of testosterone, post-menopausal bleeding and cancer risks for trans and non-binary people who choose to retain their gynaecological organs.

Gender reassignment has been considered in the EHIA which notes the lack of evidence and the committee discussed the EHIA implications in their decision making and recommendation development. The potential impact of gender affirming therapy and cancer risks is not within the scope of this guideline update. Clarification of the types of HRT included in the update was added to the terms used.

Pregnancy and maternity: no comments related to pregnancy and maternity.

Race: comments related to not identifying any evidence regarding BAME groups and possible systemic bias and poor health outcomes in recommendations.

The guideline development team response: The EHIA's function in NICE guideline development is to systematically identify, assess and consider equality and health inequalities issues across the guideline development process and identify areas for action to promote equality and reduce health inequalities. Though evidence may not be identified, the committee consider the EHIA in their discussion and development of recommendations and research recommendations.

Comments were received regarding the revised CA125 thresholds and the use of the non-site specific weight loss measure of $\geq 5\%$ mean weight loss within 6-months, the evidence outlined and the potential to create inequalities as the sample from which the data has been collected won't necessarily be representative of all UK populations - reference was made to ethnic diversity.

The NICE response outlines that the evidence underpinning the CA125 recommendation is drawn from two UK-based studies that included a total of 393058 participants of which 14.4% (n=49138) identified as Asian/Asian British, Mixed, Black/Black British or Other

ethnicity and the committee explicitly considered equality and health inequalities in their deliberation when developing recommendations as evidenced by this EHIA and the committee discussions section of the guideline and corresponding evidence reviews. The NICE response also outlines that the evidence underpinning the non-site-specific weight loss measure of $\geq 5\%$ mean weight loss within 6-months is derived from a UK-based study of 326240 participants which whilst not broken down by ethnicity was UK-based. The committee explicitly considered equality and health inequalities in their discussions and the wording of the corresponding recommendations regarding 'Symptoms of concern in adults (Recommendation 1.13: Non-site-specific symptoms)' is inclusive of ethnic minorities as it applies to all people aged 60 or over with unexplained weight loss. The committee recognised the importance of ensuring that the recommendations are applicable to all population groups; and further highlighted that an Equality and Health Inequalities Assessment (EHIA) was developed as part of this update to identify any potential equality or health inequality issues and that the committee explicitly considered these matters throughout its discussions.

Religion or belief: no comments related to religion or belief.

Sex: no comments related to sex.

Sexual orientation: no comments related to sexual orientation.

- 2) **Socioeconomic deprivation:** no comments related to socioeconomic deprivation.
- 3) **Geographical area variation:** no comments related to geographical area variation.
- 4) **Inclusion health and vulnerable groups:** no specific comments related to inclusion health and vulnerable groups.

3.3 If any recommendations have changed after consultation, how could these changes impact on equality and health inequalities issues?

There was no change to the recommendations based on the comments listed in section 3.2. However, to provide further clarification regarding testosterone and its consideration in this guideline in the context hormone replacement therapy (HRT), a definition of HRT has been provided

3.4 Following the consultation on the draft guideline and response to questions 2.1 and 3.2, have there been any further committee considerations of equality and health inequalities issues across the four dimensions that have been reflected in the final guideline?

No further issues have been identified, and further considerations from the committee.

3.5 Please provide a summary of the key equality and health inequalities issues that should be highlighted in the guidance executive report before sign-off of the final guideline or update

None

Completed by developer: Armina Paule

Date: 03/03/2026

Approved by committee chair: Britta Stordal

Date: 14/04/2026

Approved by NICE quality assurance lead: Sara Buckner

Date: 19/03/2026

STAGE 4. After guidance executive amendments – only if applicable

(to be completed by appropriate NICE staff member after guidance executive. This stage should be skipped if GE does not apply)

Suspected cancer: recognition and referral: Partial update [NG12]

Date of completion: March 2026

Focus of guideline or update:

- Ovarian cancer and the signs and symptoms and a suspected cancer pathway referral.
- Unexplained weight loss in adults and a suspected cancer pathway referral.
- Endometrial cancer, HRT, unscheduled post-menopausal vaginal bleeding and a suspected cancer pathway referral.

4.1 Outline any amendments related to equality and health inequalities issues suggested by guidance executive and what the outcome was.

No amendments were proposed, as no issues relating to equality or health inequalities were identified. Consequently, no changes were required.
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Completed by developer: Armina Paule

Date: 03/03/2026

Approved by committee chair: Britta Stordal

Date: 14/04/2026

Approved by NICE quality assurance lead: Sara Buckner

Date: 19/03/2026