

**EQIA on Policy on the Management of Oral Anticancer therapy**  
**Section A: Assessment**

**Name of Policy – Policy on the Management of Oral Anticancer therapy**

**Person/persons conducting this assessment with Contact Details**  
**Nia Evans, Lead Haematology Pharmacist, UHW 02920 743710**

**20/1/16**

**1. The Policy**

Is this a new or existing policy?

New

What is the purpose of the policy?

The aim of this policy is to ensure that oral anticancer therapy is prescribed, dispensed and taken safely and in compliance with national guidelines.

How do the aims of the policy fit in with corporate priorities? i.e. Corporate Plan

The policy aims fit with corporate priorities such as quality and safety, and medication related policies such as “Safe Administration of Medication”

Who will benefit from the policy?

All staff involved in the prescribing, administration or supply of oral anticancer therapy

Patients

What outcomes are wanted from this policy?

Safe systems of work

Staff trained

Multi-disciplinary teamwork and effective communication

Adequate staffing levels

Are there any factors that might prevent outcomes being achieved? (e.g. Training/practice/culture/human or financial resources)

Paper systems (lack of electronic prescribing) makes outcomes more difficult to achieve

Staff availability outside of core working hours

Staff time in the working day

Any contributory factors not being successfully met.

## 2. Data Collection

What qualitative data do you have about the policy relating to equalities groups (e.g. monitoring data on proportions of service users compared to proportions in the population)?

We can identify compliance issues through discussion with patients on an individual basis, this occurs regularly with the Clinical Nurse Specialist and before each treatment cycle. Patients with additional needs are also identified as such and their treatment plan modified accordingly (e.g colour coding of medications, use of multi-compartment compliance aids etc).

What quantitative data do you have on the different groups (e.g. findings from discussion groups, information from comparator authorities)?

Please indicate the source of the data gathered? Internet

AGE - Cancer is primarily a disease of older people, with incidence rates increasing with age for most cancers. More than a third (36% in the UK in 2010-2012) of cancers are diagnosed in people aged 75 and over. <http://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/age#heading-Zero> We are able to gather data on age of patients using databases such as CANISC or PAS/Pharmacy system. Patients also tend to use more medications with age due to co-morbidities.

ETHNIC GROUP - It is apparent that people from the Black and Minority Ethnic ethnic groups investigated are at a lower risk of developing cancer than the White ethnic group and, in general, there is not an across the board inequality of cancer incidence for the BME ethnic groups. However, some inequality in relation to both the incidence of and survival from cancer does exist for specific types of the disease (including myeloma which has a higher incidence in black males than other ethnic groups) <http://www.ncin.org.uk/view?rid=75>

GENDER - The gender difference in cancer susceptibility is one of the most consistent findings in cancer epidemiology. Hematologic malignancies are generally more common in males and this can be generalized to most other cancers.

*Front Genet. 2012; 3: 268. Gender Differences in Cancer Susceptibility: An Inadequately Addressed Issue*  
*M. Tevfik Dorak\* and Ebru Karpuzoglu*

**SOCIOECONOMIC FACTORS** – Info from Cancer research UK report states ‘between 1986-90 and 1996-99 the gap in survival rates between the most and least deprived groups increased for 19 out of 33 cancer types and stayed the same or decreased for the remaining 14 cancer types.

Higher smoking prevalence among lower socioeconomic groups is the single most important contributing factor to inequalities in cancer and health. There are also differential levels of exposure or engagement in other risky health behaviours, by socioeconomic group, that contribute to inequalities in cancer rates.

Women from lower socioeconomic groups are less likely to attend both cervical and breast screening and initial evidence from the bowel screening programme supports the existence of such inequalities in uptake. There is evidence that those from lower socioeconomic groups use health services less in relation to need, often referred to as the ‘inverse care law’. At the same time this group is more likely to have cancer diagnosed at an advanced stage, a factor which negatively impacts upon the range of treatment options available and the chances of a positive outcome. The increased presence of co-morbidities and risky health and lifestyle factors may also mean that those from lower socioeconomic groups are less likely to be able to physically cope with some cancer treatments. Finally, there is some evidence that those from deprived areas are less likely to use palliative care services and if they do, they are less likely to use them in their own homes. This may be because there is less availability of such services in areas with increased rates of deprivation, or there may be low levels of awareness of available services among communities’.

[http://www.cancerresearchuk.org/prod\\_consump/groups/cr\\_common/@nre/@pol/documents/generalcontent/crukmig\\_1000ast-3347.pdf](http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@pol/documents/generalcontent/crukmig_1000ast-3347.pdf)

**DISABILITY** - Patients automatically meet the disability definition under the Equality Act 2010 from the day they are diagnosed with..... cancer.

<https://www.gov.uk/definition-of-disability-under-equality-act-2010>

What gaps in data have you identified? (Please put actions to address this in your action plan?)

CANISC holds basic patient demographic such as age and sex, and ethnic group may be inputted but other info regarding equality is not recorded unless clinically relevant.

An internet search was conducted on 26.1.2016 included using the following search terms “equality impact assessment oral anticancer therapy” “equality impact assessment oral chemotherapy”, “studies oral anticancer therapy” as well as inserting the particular protected characteristic and ‘cancer’ where appropriate

The searches revealed several equality impact assessments but they were generally lacking in detail and sometimes just statements of equality. Examples can be found by following the links below though it should be noted that this is not an exhaustive list but a representative list of the data collected:

<http://www.nuh.nhs.uk/handlers/downloads.ashx?id=13682>

<http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Pharmacy/CytotoxicProducts.pdf>

These impact assessments concluded that there was no impact or neutral impact on any of the protected characteristic groups.

#### Age

One study states that age has not been shown to be a consistent predictor of adherence except that adolescents are significantly less adherent than other pediatric patients. Reasons for nonadherence are complex in most situations. Factors that have been frequently associated with nonadherence to recommended medical therapies include individual patient characteristics, features of the disease and the treatment regimen, and aspects of the medical care system. One study included in this review stated ‘Adherence rates were lower in the young (age younger than 45 years), the very old (aged older than 85 years), and nonwhite women’.

*CA Cancer J Clin.* 2009 Jan-Feb;59(1):56-66..Patient adherence and persistence with oral anticancer treatment.  
Ruddy K<sup>1</sup>, Mayer E, Partridge A.

Another study concluded that ‘most older women with early-stage breast cancer were adherent to short-term oral chemotherapy in a randomized clinical trial. Age was not associated with adherence’.

*J Clin Oncol.* 2010 May 10;28(14):2418-22. Adherence and persistence with oral adjuvant chemotherapy in older women with early-stage breast cancer in CALGB 49907: adherence companion study 60104.Partridge AH et al

## Race

One study included in this review stated 'Adherence rates were lower in.....nonwhite women'.

*CA Cancer J Clin. 2009 Jan-Feb;59(1):56-66..Patient adherence and persistence with oral anticancer treatment.*

*Ruddy K<sup>1</sup>, Mayer E, Partridge A.*

<http://www.healthscotland.com/equalities/race/gypsytravellers/accessing-services.aspx>

The report [Insights into the use of the Hand-Held Record and other methods of NHS engagement with Gypsy/Travellers in Scotland \(March 2013\)](#) was produced by NHS Health Scotland as a result of the [Equal Opportunities Committee third report from the Gypsy/Traveller and Care Inquiry The Hidden Carers, Unheard Voices research](#) (PDF:2.51 MB) (external link) by the Minority Ethnic Carers of Older People Project (MECOPP) into Carers within the Gypsy/Traveller community. It highlights qualitative research into the often informal caring structures within the Gypsy/Traveller community: Findings included Gypsies/Travellers not feeling listened to and a reluctance to engage with services unless there is a trusted contact.

There is a body of evidence from small scale research in various locations in England which provides insight into access to services:

- [Peer led research in England with Save the Children in 2005](#) (PDF: 3.4 MB) (external link), interviewing 135 young Gypsies/Travellers has shown that 84 per cent feel that access to a doctor or dentist has not improved or has got worse since 2001.
- [Research with Gypsy/Travellers and GPs in Sheffield](#) (PDF: 683KB) (external link) found a common experience of Gypsies/Travellers' was difficulty in gaining access to GPs. There were several contributory causes, including reluctance of GPs to register Travellers or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal barriers.
- According to [research from the University of Brighton and NHS Brighton and Hove](#) (PDF: 692KB) (external link), there are a number of complex and diverse social, cultural and environmental barriers that prevent many Gypsies/Travellers accessing essential health care services across Sussex and throughout England, such as racism, lack of knowledge of Gypsy/Traveller culture from NHS staff and inadequate healthcare provision for Gypsies/Travellers.

- The [Mapping the Gypsy Traveller community in England: what we know about their health service provision and childhood immunization uptake](#) (external link) explored what is known about local Gypsy Traveller populations, the estimate of immunizations rates and described current services to increase immunization as well as to address wider health issues. It was found that there is an ongoing need to improve knowledge of population numbers and the provision of and access to services that are culturally sensitive and responsive to the needs of Gypsy Traveller communities. Immunization services are only one component of a wider strategy for improving the health of Gypsy Travellers through effective health and social care interventions.

### Sexual Orientation

Macmillan have produced a guide for health professionals about supporting Lesbian, Gay and Bisexual and Trans people with cancer, while Lesbian, Gay, Bisexual and Trans (LGBT) people report many good experiences of care, there are some areas that still need attention. The Department of Health, Cancer Patient Experience Survey (2010) of 67,000 LGBT and heterosexual patients suggested that there are some differences relating to human rights, specifically, the respect and dignity with which LGBT cancer service users were treated. They reported less positive experiences than their heterosexual counterparts in regard to:

- Doctors never talked in front of patient as if they
- were not there
- Never felt treated as a set of cancer symptoms rather
- than as a whole person
- Always treated with respect and dignity by hospital
- staff
- Hospital staff always did everything they could to
- control their pain
- Patient was given information about support/self
- help groups for people with cancer
- Doctors/nurses never deliberately did not tell patient
- things they wanted to know

[http://www.macmillan.org.uk/Documents/AboutUs/Health\\_professionals/SupportingLGBTPeoplewithCancer.pdf](http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/SupportingLGBTPeoplewithCancer.pdf)

Currently the evidence base relating to LGBT communities and their experiences of cancer and cancer information, support and services is limited. Cancer Research UK therefore believes that in order to effectively provide such services, which meet the needs of the LGBT communities, the Government and related stakeholders should commission and undertake research to better understand the:

- Unmet need for information and support relating to cancer
- Availability of charity and private sector cancer information, support and services
- Rates of lifestyle behaviours, which impact upon cancer rates
- Cancer and HPV rates
- Experiences of individuals when accessing health and cancer services
- Awareness of the needs of LGBT communities among health professionals

[http://www.cancerresearchuk.org/prod\\_consump/groups/cr\\_common/@nre/@pol/documents/generalcontent/crukmg\\_1000ast-3350.pdf](http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@pol/documents/generalcontent/crukmg_1000ast-3350.pdf)

Stonewall, the gay charity, have conducted research into the health and care needs of:

[Lesbian and bisexual women - Prescription for Change](#)

[Gay and bisexual men - Gay and Bisexual Men's Health Survey](#)

[Older lesbian, gay and bisexual people - Lesbian, Gay and Bisexual People in Later Life](#)

Two key factors of note are:

50 per cent of [lesbians and bisexual women](#) have had negative experiences in the NHS in the past year. Though it should be noted that this UHB has not been made aware if this is applicable here. Though, it should be noted that a questionnaire about health services that was distributed at the 2014 Cardiff Pride event indicated that there was an overall positive experience in service usage.

41 per cent of [lesbian, gay and bisexual people](#) over the age of 55 currently live alone and thus the issue of carers becomes noteworthy.

<http://www.healthylives.stonewall.org.uk/what-we-do/health-policy/default.aspx>

### Religion/Belief

A meta-analysis published in 2015 suggest that greater Religion/spirituality is associated with better patient-reported physical health. These results underscore the importance of attending to patients' religious and spiritual needs as part of comprehensive cancer care.

*Cancer*. 2015 Nov 1;121(21):3760-8. Religion, spirituality, and physical health in cancer patients: A meta-analysis. Jim HS<sup>1</sup>, Pustejovsky JE<sup>2</sup>, Park CL<sup>3</sup>, Danhauer SC<sup>4</sup>, Sherman AC<sup>5</sup>, Fitchett G<sup>6</sup>, Merluzzi TV<sup>7</sup>, Munoz AR<sup>8</sup>, George L<sup>3</sup>, Snyder MA<sup>8,9</sup>, Salsman JM<sup>8,9</sup>.



### Carer

Although being a carer is not a protected characteristic it is covered by the Equality Act and this noted by this NHS organisation

<http://www.cardiffandvaleuhb.wales.nhs.uk/opensoc/207688>

Medication needs of patients may be tended to by carers as demonstrated in the Cardiff and Vale carers measure document.

They note that patients may have relatives, friends or carers who help them with their medicines. This is common with elderly patients or with patients where English is not their first language. Also they note that Carers can be very helpful in establishing an accurate drug history and can also give an insight into how medicines are managed at home. They recognise however, for the need to be mindful of maintaining confidentiality

### Marital status

A study published in 2013 states that even after adjusting for known confounders, unmarried patients are at significantly higher risk of presentation with metastatic cancer, undertreatment, and death resulting from their cancer. This study highlights the potentially significant impact that social support can have on cancer detection, treatment, and survival.

*Marital Status and Survival in Patients With Cancer Ayal A. Aizer et al; JCO September 23, 2013 JCO.2013.49.6489*

## **3. Impact**

Please answer the following

Consider the information gathered in section 2 above of this assessment form, comparing monitoring information with census data as appropriate (see [www.ons.gov.uk](http://www.ons.gov.uk) Office National Statistics website) and considering any other earlier research or consultation. You should also look at the guidance in Appendix 1 with regard to the protected characteristics **stating the impact and giving the key reasons for your decision.**

**Do you think that the policy impacts on people because of their age?** (This includes children and young people up to 18 and older people)

The incidence of cancer increases with age so there may be higher proportion of patients on oral anticancer therapy who are older than 65. There is some evidence that adherence with treatment is less in adolescents and young and very old patients. Patients will be dealt with as an individual and adolescents have access to specialist facilities/personnel and others in their peer group who have cancer on the Teenage Cancer Trust Unit. There may be a potential negative impact for younger or very old patients with in terms of adherence with medication, however this can be mitigated against in this health board through working closely with patients, carers, family members and advocates and through patient-centred care (joint decision making) and training.

**Do you think that the policy impacts on people because of their caring responsibilities?**

No

**Do you think that the policy impacts on people because of their disability?** (This includes Visual impairment, hearing impairment, physically disabled, Learning disability, some mental health issues, HIV positive, multiple sclerosis, cancer, diabetes and epilepsy.)

There may be a potential negative impact for patients with disability in terms of communication and/or sensory loss issues. However this can be mitigated against in this health board through working closely with patients, carers, family members and advocates and through patient-centred care and training. Healthcare professionals work with patients on an individual basis and consider the use of colour coding of medications, large print, use of diagrams, compliance aids etc.

**Do you think that the policy impacts on people because of Gender reassignment?** (This includes Trans transgender and transvestites)

No

**Do you think that the policy impacts on people because of their being married or in a civil partnership?**

No, however some research suggests that unmarried patients with cancer have worse outcomes

**Do you think that the policy impacts on people because of their being pregnant or just having had a baby?**

No, however it is advised not to treat patients who are pregnant or breastfeeding with anticancer therapy due to potential risk to the foetus or baby, therefore it is possible that fewer than expected pregnant patients will be affected by this policy. However after thorough risk-benefit discussion with the patient and discussion at Multidisciplinary team meeting pregnant patients are sometimes treated with such medications.

**Do you think that the policy impacts on people because of their race?** (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities.)

Potential negative impact of knowing how to take their medications for patients where English is not their first language, or they are not able to read and write English. However this can be mitigated against if this health board through the use of appropriate interpretation and translation services working closely with carers, family members and advocates and through patient-centred care and training.

**Do you think that the policy impacts on people because of their religion, belief or non-belief?** (Religious groups cover a wide range of groupings the most of which are Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs. Consider these categories individually and collectively when considering impacts)

Potential negative impact where a drug contains ingredients which are not appropriate to a person's faith e.g. porcine products, products derived from blood. However this can be mitigated against if this health board through working closely with patients to establish their beliefs and acceptable medications and through patient-centred care and dealing with such matters sensitively.

**Do you think that the policy impacts on men and woman in different ways**

No. Although haematological cancers are more prevalent in men, all the impact assessments found stated that there was no impact on people who share this characteristic. There was no internal evidence found to say otherwise

**Do you think that the policy impacts on people because of their sexual orientation?** (This includes Gay men, heterosexuals, lesbians and bi-sexuals)

No research evidence was found with regard to the impact of sexual orientation. All the impact assessments found stated that there was no impact. However, it has been well documented by organisations such as Stonewall that some lesbians and bisexual women have had negative experiences in the NHS. However this can be mitigated against in this health board through working closely with patients, carers, partner or family members and advocates and through patient-centred care and training. A UHB survey found that overall experiences within this health board was positive.

#### **4. Summary.**

Which equality groups have positive or negative impacts been identified for (i.e. differential impact). There is a possibility of an adverse impact on certain protected characteristics in terms of age, disability/sensory loss, race and faith. These risks can be mitigated against in this healthboard by working with patients, carers and through the adoption of a patient centred-approach and appropriate training for staff, use of translation and interpretation services, use of compliance aids etc.

Is the policy directly or indirectly discriminatory under the equalities legislation? No

If the policy is indirectly discriminatory can it be justified under the relevant legislation? N/A

## Appendix 3

### Cardiff and Vale University Health Board Action Plan

#### Section B: Action

##### 5. Please complete your action plan below. Issues you are likely to need to address include

- What **consultation** needs to take place with equality groups (bearing in mind any relevant consultation already done and any planned corporate consultation activities)  
Representatives from pharmacy, medical and nursing staff were also consulted. Input from the pharmacy quality and safety group was key to development.
- What **monitoring**/evaluation will be required to further assess the impact of any changes on equality target groups? Please see action plan below re establishing a monitoring mechanism

#### Equalities Impact Assessment Implementation Action Plan

Issue to be addressed	Responsible Officer	Action Required	Timescale for completion	Action Taken	Comments
Ensuring consistency –	Director of Pharmacy and	Robust implementation	End 2015		

monitor uptake of documentation	Medicines Management	programme			
The assessment has identified possible negative impact which can be mitigated against through working with patients, carers/training and patient centred approaches	Director of Pharmacy and Medicines management	Develop robust monitoring mechanism.	Patient by patient approach		
Amend current audits to reflect monitoring of equality target groups.	Director of Pharmacy and Medicines management	Liaison with pharmacy quality and safety team.			

## 6. Report, publication and Review

**Please record details of the report or file note which records the outcome of the EQIA together with any actions / recommendations being pursued (date, type of report etc)**

QSE to review and approve policy and EQIA.

**Please record details of where and when EQIA results will be published**

Once the policy has been approved the documentation will be placed on the intranet and internet.

**Please record when the EQIA will be subject to review.**

Three years after the approval date - in 2018.

**Name of person completing** \_ Nia Evans \_

**Signed** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Name of Senior Manager Authorising Assessment and Action Plan for publication**

\_\_\_\_\_ Darrell Baker

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## **Appendix 4**

### **Format for publication of EQIA results**

#### **Executive Summary**

This should provide a summary of the results of the EQIA, in particular focusing on any decisions that have been made.

Cardiff and Vale University Health Board (UHB) recognises the importance of managing oral anticancer drugs safely. There are potential negative impacts in regard to age, disability, faith and race protected characteristics. Welsh language issues will be addressed by the policy being made available in the language upon request. There is no equality based reason as to why the policy could not or should not go ahead.

#### **Background**

The aim of this policy is to ensure that oral anticancer therapy is prescribed, dispensed and administered safely.

The policy aims fit with corporate priorities such as quality and safety, and medication related policies such as “Safe Administration of Medication”. All staff involved in the prescribing, dispensing and administration of oral anticancer therapy, and patients will benefit from the policy.

#### **The scope of the EQIA**

Information was sourced from legislation, Google searches on equality impact assessments and related research.

When no evidence was found, the Cardiff and Vale Intranet was searched.

The Equality Manager and was consulted. Representatives from pharmacy, medical and nursing staff were also consulted.

#### **Key findings**

The assessment found from considering previous equality impact assessments that the overall view was that there could be a negative impact on age, disability, faith and race protected characteristics. These risks can be mitigated against in this healthboard by working closely with patients, carers and through the adoption of a patient centred-approach and appropriate training for staff, use of translation and interpretation services, use of compliance aids etc.

#### **Recommendations**

In conclusion, outside of the possible protected characteristics areas noted – age, disability, faith and race-which can seemingly be mitigated against there is nothing from an equalities perspective that should prevent this policy going ahead.