Appendix B: equality and health inequalities assessment (EHIA)

2023 surveillance of early and locally advanced breast cancer (NICE guideline NG101) and advanced breast cancer: diagnosis and treatment (NICE guideline CG81)

STAGE 1. Surveillance review

Date of surveillance review: January 2023

Focus of surveillance review: early, locally advanced and advanced breast cancer

Standard review

1.1 On reviewing the existing EIA or EHIA and issues log for the guideline(s), describe below any equality and health inequalities issues relevant to the current surveillance review
When NG101 was updated in January 2018, the committee identified that some of the recommendations made would be applicable to men as well as women, as men can be diagnosed with breast cancer. Where this is the case, the committee used the terms 'person' or 'people' so as not to discriminate against men. However, some of the recommendations, such as those relating to breast-conserving surgery are only applicable to women (breast-conserving surgery is only carried out in women) and so in these recommendations the terms 'woman' or 'women' were used. The guideline recommends the use of a prognostic tool called 'PREDICT' when planning adjuvant therapy and this tool has not been validated in men. This recommendation is therefore applicable for women only, and the caution is included in the recommendation that 'it has not been validated in men'. However, in practice, some clinicians may choose to use this tool in men, as they have no alternative tools available. Similarly, the validation of this tool may have under-represented some ethnic groups, and this is added as a caution too. However, there is no data in the validation studies specifying exactly what populations or ethnic groups were included. The committee were aware that written information may need to be available in alternative languages, as well as English, or in other formats that are suitable to people's individual needs. To address this the committee cross-referenced the recommendations to the NICE guideline on patient experience.

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The committee were aware that there are elevated rates of triple-negative breast cancer among some ethnic groups, for example Afro-Caribbean people, and they are therefore more likely to be affected by delays to optimal treatment if progesterone receptor status is not known. The recommendations made by the committee will reduce this inequality as progesterone receptor testing will be performed upfront in all people allowing for earlier determination of triple-negative status.

The committee were also aware that for some topics there was a lack of evidence for older people as many clinical trials had not included older people, and for one review where this was agreed by the committee to be particularly important (use of taxanes) the committee used formal consensus methods to try and ascertain if specific recommendations could be made for older people.

The recognition that information and support would need to address individual needs in terms of language, readability and applicability to different ethnic origins, religions or dietary requirements relates to recommendations in the previous guideline which were refreshed to meet current editorial standards, but no evidence had been reviewed. The cross-reference to the NICE guideline on patient experience was therefore included in the guideline, but not in the evidence reports.

The discussion of the equality considerations due to elevated rates of triple-negative breast cancer among Afro-Caribbean people was discussed in the committee's discussion of the evidence for review question 3.1, in evidence review C.

No equality issues relating to NICE guideline CG81 have previously been identified.

1.2	Did you identify any equality and health inequalities issues through initial intelligence gathering (for example, national policy documents, topic expert/patient group feedback, evidence searches, implementation data)?

The National Audit of Breast Cancer in Older Patients (NABCOP) 2018 Annual Report reported that rates of surgery in older women vary considerably across breast units in the UK. Breast surgery rates are also lower in the UK than compared with other European countries such as Ireland and Poland.
Feedback from topic experts and patient groups also highlighted that there is geographical variation in whether immediate breast reconstruction is offered and in the type of reconstruction provided.
A search for NIHR alerts identified the following:
A study of over 3,000 women in the UK suggests that breast cancer surgery is a safe option for women over 70 (see breast cancer surgery is safer for older women than has been assumed).
A study of over 10,000 women in the UK showed that genetic risk scores which predict the risk of breast cancer in White Europeans need to be modified for women from the

following ethnic groups otherwise the risk of breast cancer would be exaggerated: Black British (predominantly Afro-Caribbean), Asian (further details not provided), 'mixed-race' and Ashkenazi Jews (see genetic risk scores for breast cancer are not accurate in some ethnic groups).

System intelligence highlighted that current recommendations need reviewing for applicability to males, trans and non-binary people and amended where appropriate.

1.3	If you have consulted stakeholders or topic experts, what questions did you ask about equality and health inequalities issues?

The breast cancer standing committee were asked whether they were aware of any issues related to health inequalities for specific subgroups of the population that had not been addressed within the draft surveillance review (for example, in relation to protected characteristics or other dimensions of health inequalities such as deprivation, geographical factors, and being from a vulnerable group).

Several committee members said that the applicability of recommendations to male breast cancer patients needs to be considered and recommendations amended accordingly. An example given was male hormonal symptoms in response to endocrine treatment for hormone positive breast cancer.

The lower accuracy of mammograms for identifying breast cancer in breasts with dense breast tissue was highlighted as an issue for follow-up surveillance; and it was noted that younger females are more likely to have dense breasts.

For older patients, concerns about 'ageism' and active treatment options being discouraged were raised. It was suggested that age should be addressed, separately for specific areas (for example, geriatric assessment), embedded in relevant sections, or in combination because the majority of breast cancer cases occur in older patients and the UK has an ageing population, which is increasing.

Comments on inequalities in accessing screening were provided, highlighting that women from ethnic backgrounds experience differences in breast screening attendance, the stage and age of diagnosis, survival outcomes, and experiences of care and treatment. Lower breast screening uptake may be due to cultural and language barriers and a lack of tailored interventions. Some cultures are also very against showing their body to those who aren't family.

Geographical inequalities in access to and availability of breast reconstruction and access to a named nurse specialist were highlighted. Feedback was received that there are

inequalities in support for people with severe lymphoedema and access to appropriate support, including language and cultural barriers, and geographical constraints. Comments were received on the importance of ensuring the provision of appropriate information and consideration of appropriate decision aids to address needs of people with learning and/or cognitive disabilities and those with neuro-diverse conditions to enable informed decisions.

1.4 What equality and health inequalities issues have been identified during this surveillance review and what was the impact on the current review and outcome decision?
All areas for update should ensure an assessment of the applicability of evidence to male breast cancer patients is made; and that it is clearly written within new recommendations, who recommendations apply to, in line with NICE's style guide. This should also include consideration of trans and non-binary people; ethnicity; and of the age of patients where possible, in particular in relation to updates in the areas of surgery and systemic treatments, where feedback indicates there may be differences in interventions offered to patients based solely on their age. Issues of geographical inequalities are beyond the remit of NICE as this is about commissioning and funding of services. Concerns about language and format of information provided to patients is already addressed within NICE guideline NG101 which recommends that 'all members of the breast cancer clinical team should follow the recommendations on communication in NICE's guideline on patient experience in adult NHS services' and it has been recommended that this is also reflected in recommendations for people with advanced breast cancer.

Updated by surveillance reviewer _Toby Mercer & Charlotte Haynes_____

Date_02/12/2022_____

Approved by NICE surveillance associate director __Kay Nolan_____

Date___22/12/2022_____