Equality Analysis

(Health Inequalities, Human Rights, Social Value)

pan-Birmingham Respiratory Clinical Network Guideline: Diagnosis and management of stable COPD

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

NHS Birmingham CrossCity Clinical Commissioning Group
NHS Birmingham South Central Clinical Commissioning Group
NHS Solihull Clinical Commissioning Group

1. Background

EA Title	pan-Birmingham Respiratory Clinical Network Guideline: Diagnosis and management of COPD		
EA Author	Karen Ennis, Assistant Head of Medicines	**Team**	Medicines Management & Quality
Date Started	06/06/2017	**Date Completed**	4 July 2017
EA Version	V.01	**Reviewed by E&D**	Balvinder Everitt – Senior Manager Equality and Diversity

What are the intended outcomes of this work? Include outline of objectives and function aims

Chronic Obstructive Pulmonary Disease (COPD) is the name used to describe a number of conditions including emphysema and chronic bronchitis where the predominant symptom is breathlessness on exertion.

According to the British Lung Foundation (BLF) around 2% of the whole population and 4.5% of people aged over 40, live with diagnosed COPD with someone being diagnosed with the condition every 5 minutes. However, there is also a belief that there are significant numbers of people living with undiagnosed COPD – the so-called 'Missing Millions'.

The recorded prevalence of COPD varies across the Birmingham & Solihull CCGs with Birmingham South Central and CrossCity slightly lower and Solihull slightly higher than the national average. This translates to around 24,000 people living with diagnosed COPD across the BSol CCGs geography.

The National Institute for Health and Care Excellence (NICE) produce guidelines covering the diagnosis and management of COPD in over 16's which is currently being revised (publication of the updated guidance is expected in November 2018). The national guidance informs the general framework of the local guideline with reference to local patient pathways and formulary options where appropriate.

This guideline has been developed by Dr Alice Turner (HoEFT) in conjunction with the Pan-Birmingham Respiratory Clinical Network which has representation from clinicians from CCGs, acute trusts and community providers along with public health and medicines management support.

The guideline will provide a consistent, evidence-based and cost-effective approach to the management of COPD across Birmingham and Solihull which will reduce variation in practice and improve patient outcomes.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

Staff in all stakeholder organisations will be expected to implement the new guideline. Patients with COPD will be affected by the successful implementation of the guidance.as their care will be in line with the guideline whether their care is delivered in Primary, Community or Secondary Care settings.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
NICE CG101 Published June 2010, currently being revised with anticipated publication date of November 2018	Pan-Birmingham Respiratory Clinical Network	Pan-Birmingham Respiratory Clinical Network
Birmingham & Environs APC Formulary		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

COPD is a condition that affects adults with prevalence increasing with increasing age. There may be a small number of people who develop the condition at an earlier age due to either genetic or environmental variation. We would anticipate a positive impact on both diagnosis and treatment of COPD from implementation of these guidelines.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

COPD prevalence is not affected by disability but more severe COPD may lead to significant physical disability, cognitive impairment and mental health issues such as depression and anxiety and may be considered a disability under the Equality Act 2010. Whilst we would not expect any negative impact resulting from implementation of these guidelines relating to disability, we might anticipate a positive impact for those with severe disease potentially disabled by the condition, resulting from successful implementation of the guidelines leading to better and earlier diagnosis and improved management.

All NHS and Social Care providers are required to uphold the NHS Accessible Information Standard to ensure information and communication support to disabled patients. The guideline will be covered by this standard.

Gender reassignment (including transgender): Describe any impact and evidence

3. Impact and Evidence:
on transgender people. This can include issues such as privacy of data and harassment: COPD prevalence is not affected by gender reassignment (including transgender) therefore we would not expect any negative impact resulting from implementation of these guidelines relating to gender reassignment (including transgender)
Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities: COPD prevalence is not affected by marriage and civil partnership. However, there is a relationship between smoking and COPD prevalence and therefore if the marriage or civil partnership resulted in increased exposure to tobacco smoke, there may be a negative impact on respiratory health. We would not expect any negative impact resulting from implementation of these guidelines relating to marriage and civil partnership
Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities: Pregnant women will experience shortness of breath. Patients who are pregnant and diagnosed with COPD will need to be monitored more closely by their Health care providers for any adverse effects of COPD on their pregnancy. We would not expect any impact from the guidelines, negative or positive.
Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers: There is no evidence which would indicate that COPD prevalence is affected by race. However cultural differences which exist in attitudes towards smoking may impact on rates of COPD across some cultural groups. The application of the guideline will be applied consistently across all ethnicities. All NHS health care providers are required in accordance with the NHS Standard Contract and NHS Constitution to provide services in a manner that is accessible to people with language needs or do not have English as a first language. The guideline would be covered by this requirement.
Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues: COPD prevalence is not affected by religion or belief therefore we would not expect

3. Impact and Evidence:

any negative impact resulting from implementation of these guidelines relating to religion or belief

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

COPD prevalence is greater in males than females. We might reasonably expect a positive impact resulting from implementation of these guidelines relating to gender.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

COPD prevalence is not affected by sexual orientation therefore we would not expect any negative impact resulting from implementation of these guidelines relating to sexual orientation.

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

COPD prevalence is not affected by caring responsibilities unless that role increases the carer to exposure to risk factors such as smoking. We would not generally expect any negative impact resulting from implementation of these guidelines relating to carers. However, we might anticipate positive benefits for carers of people with COPD where improved management of individual with the condition may lead to increased independence through better mobility and ability to perform activities of daily living and reduced potential for disability.

Where appropriate and with consent from patients NHS Health care providers should work to ensure carers are involved in the application of the guideline to support their loved ones and dependents in self-management.

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

The prevalence of COPD is highest amongst people in the lower socio-economic groups where smoking rates are generally higher but other factors may also be relevant. COPD prevalence may be affected by resident status – certain migrant or asylum seeking populations who have been exposed to indoor air pollution from biomass fuels for cooking and heating may carry a risk of developing COPD as a result. Inhaled drug users may also carry a higher risk of developing COPD. Implementation of these guidelines will have a positive impact on these cohorts.

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	The guideline promotes a consistent, evidence-based and cost-effective approach to the management of COPD across Birmingham and Solihull which will reduce variation in practice and improve patient outcomes.
Is there any impact for groups or communities living in particular geographical areas?	No	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	

How will you ensure the proposals reduce health inequalities?

- By actively promoting full implementation of the guideline across the BSol geographical area
- By auditing in the future to assess level of successful implementation

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	The clinical guideline is expected to help protect patient's rights
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	
	How will this affect a person's right to freedom of thought, conscience and religion?	
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	
Autonomy – right to respect for private & family	How will individuals have the opportunity to be involved in discussions and decisions	Encourage shared clinical decision making

life; being able to make informed decisions and choices	about their own healthcare?	
Right to **Life**	Will or could it affect someone's right to life? How?	No
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	N/A no procurement
Create fair employment and good work for all	N/A no procurement
Create and develop health and sustainable places and communities	N/A no procurement
Strengthen the role and impact of ill-health prevention	N/A no procurement

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	**Protected Characteristic/ Group/ Community**	**Date**

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

Engagement has been at a clinical level not at patient level through the Respiratory Clinical Network where there is representation from; UHB, HoEFT and City & Sandwell Acute Trusts, BCHC, SWB, BSC, BCC & Solihull CCGs along with PH.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

The analysis concludes that there are no anticipated adverse impacts of the COPD guideline or its application for protected or vulnerable groups.

This is a clinical guideline based upon national guidance that makes reference to local patient pathways and formulary options - it does not change how a patient accesses their care as we have not undertaken any pathway redesign. Therefore engagement undertaken has been with clinicians rather than patients.
T
he application of the guideline will occur within existing protections and policies for patients including the Accessible Information Standard, Public Sector Equality Duty, and Translation and Interpretation support.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

There are no mitigations or changes required.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

This is a clinical rather than contractual matter but Acute Trust Providers may have relevant KPIs or CQUINs, general practice has QoF and local Primary Care Incentives (such as ACE Excellence in CrossCity and RQUIP in South Central) which may focus on improved delivery of respiratory care

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

N/A

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages.

The assessment will be made available alongside the guideline by all of the stakeholder organisations

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee

	Name	Date
Quality Assured By:	David King – Equality and Human Rights Manager (Arden and Gem CSU)	4 July 2017
Which Committee will be considering the findings and signing off the EA?	BSOL Clinical Policies Sub Committee of the Quality and Safety Committee	10 August 2017
Minute number (to be inserted following presentation to committee)		