NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

GUIDELINES EQUALITY IMPACT ASSESSMENT FORM
SCOPING

As outlined in the guidelines manual NICE has a duty to take reasonable action to avoid unlawful discrimination and promote equality of opportunities. The purpose of this form is to document that equalities issues have been considered in reaching the final scope for a clinical guideline.

Taking into account **each** of the equality characteristics below the form needs:

- To confirm that equality issues have been considered at **every stage** of the scoping (from drafting the key clinical issues, stakeholder involvement and wider consultation to the final scope)
- Where groups are excluded from the scope, to comment on any likely implications for NICE's duties under equality legislation
- To highlight planned action relevant to equalities.

This form is completed by the National Collaborating Centre (NCC) Director and the Guideline Development Group (GDG) Chair **for each guideline** and submitted with the final scope for sign off by the Chair of the Guidelines Review Panel (GRP) and the lead from the Centre for Clinical Practice.

EQUALITY CHARACTERISTICS
Sex/gender • Women • Men
Ethnicity • Asian or Asian British • Black or black British • People of mixed race • Irish • White British • Chinese • Other minority ethnic groups not listed
Disability • Sensory • Learning disability • Mental health • Cognitive • Mobility • Other impairment
Age[1] • Older people • Children and young people • Young adults [1.] Definitions of age groups may vary according to policy or other context.
Sexual orientation & gender identity • Lesbians • Gay men • Bisexual people • Transgender people
Religion and belief
Socio-economic status Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas (e.g. the Spearhead Group of local authorities and PCTs, neighbourhood renewal fund areas etc) or inequalities or variations associated with other geographical distinctions (e.g. the North/South divide, urban versus rural).
Other categories[2] • Gypsy travellers • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people [2.] This list is illustrative rather than comprehensive.

GUIDELINES EQUALITY IMPACT ASSESSMENT FORM: SCOPING

Guideline title: Pneumonia (including community-acquired pneumonia)

1. Have relevant equality issues been identified during scoping?

- Please state briefly any relevant issues identified and the plans to tackle them during development
- For example
    - if the effect of an intervention may vary by ethnic group, what plans are there to investigate this?
    - If a test is likely to be used to define eligibility for an intervention, how will the GDG consider whether all groups can complete the test?

Some differences in outcomes have been observed i.e. hospitalisation rates are greater in the older people as is mortality; and male mortality rate is higher than the female mortality rate in every age group. Pneumonia rates also vary with deprivation level. The Developers will consider whether these differences are related to variation in management during development of the Guideline. However, the current consensus is that the prevalence of co-morbidity is chiefly responsible for the observed differences.

2. If there are exclusions listed in the scope (for example, populations, treatments or settings) are these justified?

- Are the reasons legitimate? (they do not discriminate against a particular group)
- Is the exclusion proportionate or is there another approach?

a) Patients acquiring pneumonia while intubated: Ventilator-associated pneumonia is a different entity, with different causative organisms and a different patient population requiring management of several (often complex) problems in addition to the pneumonia that arises as a complication of their management. Moreover the investigations required are different since other potential causes of respiratory distress must be excluded in the ventilated population. The healthcare professionals looking after these patients are usually intensive care specialists. Mortality in ventilated patients is much higher than in patients contracting pneumonia in the community or in hospital, but who are not intubated for a reason other than pneumonia.

b) Patients who are immunosuppressed or immunocompromised, and those with bronchiectasis: Again, the causative organisms are likely to be different from those in CAP or HAP. Moreover the incidence of infection with different organism varies between different causes of immune-suppression, complicating the management and potentially extending considerably the complexity of any guidance.

c) People up to the age of 18: Children are a large population, requiring substantially different preventative, diagnostic, management and treatment strategies. This group should also rationally be subdivided by age based on the common causative pathogens (which are different in neonates, infants to under 5's and older children). The incidence of complications, particularly empyema, is also different from that in adults and impacts on the management strategies. These factors indicate that a separate guideline for children would be prudent.

These groups require specific management and would require separate guidance.

3. Have relevant bodies and stakeholders been consulted?

- Have relevant bodies been consulted?
- Have comments from stakeholders that highlight potential for discrimination or promoting equality been considered in the final draft?

Registered stakeholders have been consulted on the contents of the scope both at a scoping workshop and a during the scope consultation.