NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE quality standards

Equality impact assessment

Acute respiratory infections and virtual wards

The impact on equality has been assessed during quality standard development according to the principles of the NICE equality policy.

### 1. TOPIC ENGAGEMENT STAGE

### 1.1 Have any potential equality issues been identified during this stage of the development process?

### The guideline scope identifies that acute respiratory infections are more common in some groups and some also have a higher risk of worse outcomes, including:

* older people
* some people with learning disabilities
* pregnant women
* men
* lower socioeconomic groups
* newly arrived migrants
* people experiencing homelessness

Some pulse oximetry devices have been reported to overestimate oxygen saturation levels in people with darker skin, which may lead to them not being treated when treatment is needed unless an adjustment is made in interpreting the test results.

Some population groups such as older people, people who do not speak English, people living in rural areas, people experiencing homelessness and people with low levels of literacy/health literacy may find it more difficult to access healthcare for acute respiratory infections, and this may include access to remote consultations and care due to digital poverty.

### 1.2 Have any population groups, treatments or settings been excluded from coverage by the quality standard at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

In line with the guideline this quality standard will not cover acute respiratory infection in:

* under 16s
* People aged 16 and over with
  + known COVID-19
  + respiratory infections acquired while inpatients in hospital
  + a respiratory infection during end-of-life care
  + aspiration pneumonia, bronchiectasis or cystic fibrosis.

Assessment and management of acute respiratory infection in these groups is covered by other NICE guidance and quality standards.

Completed by lead technical analyst: Melanie Carr

Date: 27/6/2023

Approved by NICE quality assurance lead: Craig Grime

Date: 27/6/2023

### 2. PRE-CONSULTATION STAGE

### 2.1 Have any potential equality issues been identified during the development of the quality standard (including those identified during the topic engagement process)? How have they been addressed?

The topic experts agreed that issues should be highlighted in relation to pulse oximetry devices as these may be used in initial assessment of acute respiratory infection. A consideration has therefore been added to statements 1 and 2 to highlight that healthcare professionals should recognise that some pulse oximetry devices have been reported to overestimate oxygen saturation levels in people with darker skin. Adjustments should be made when interpreting the test results to ensure that treatment is provided when appropriate.

A topic expert highlighted that there are higher antibiotic prescribing rates in more deprived areas. We have therefore added a consideration to statement 3 to highlight that commissioners should work with providers to tackle higher antibiotic prescribing rates in more deprived areas. Prescribing targets should reflect the needs of the local population.

Stakeholders and topic experts highlighted the importance of ensuring that people are not excluded from benefiting from virtual wards due to digital exclusion. A consideration has therefore been added to statement 4 to highlight that some people may be digitally excluded because they don’t have their own device such as a smartphone. This could be linked to their age, socio-economic factors or disability. It is important that suitable devices and training are provided so that these people can benefit from the virtual ward, if they wish to do so. Providers should consider loaning a smart device and providing internet access for those who do not have it. They should also consider different accessibility features including devices with large screens and buttons, screen-reading software, translation services and apps in multiple languages.

Topic experts also highlighted the importance of considering the needs of people with mental health needs who may be admitted to a virtual ward. A consideration has therefore been added to statements 4, 6 and 7 to highlight that health and social care professionals should help people to access support, if needed, to people admitted to a virtual ward with mental health needs.

Stakeholders and topic experts highlighted the importance of ensuring that accessible information and advice is given so that people are not excluded from using virtual wards. A consideration has therefore been added to statements 2, 4, 5, 6, 7 and 8 to highlight that people should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare services. Information should be in a format that suits their needs and preferences, including those who are digitally excluded. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed. For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

### 2.2 Have any changes to the scope of the quality standard been made as a result of topic engagement to highlight potential equality issues?

The scope of the quality standard has been extended to include Covid-19, bronchiectasis, and cystic fibrosis as they may all be treated on an acute respiratory infection virtual ward.

### 2.3 Do the draft quality statements make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

The draft quality statements do not make it more difficult for specific groups to access services.

### 2.4 Is there potential for the draft quality statements to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

The draft quality statements do not have an adverse impact on people with disabilities.

### 2.5 Are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 2.1, 2.2 or 2.3, or otherwise fulfil NICE’s obligation to advance equality?

No further explanations to alleviate barriers could be added.

Completed by lead technical analyst: Melanie Carr

Date: 11/8/23

Approved by NICE quality assurance lead: Mark Minchin

Date: 6/9/23

### 3. POST CONSULTATION STAGE

### 3.1 Have any additional potential equality issues been raised during the consultation stage, and, if so, how has the committee addressed them?

Stakeholders highlighted the importance of recognising that some people who are experiencing health inequalities due to disability, mental health needs, ethnicity and socio-economic deprivation will find it more difficult to access remote consultations and virtual wards and may need more support and information. An equality consideration has therefore been added to statements 1 and 2 to ensure that adults are supported to ensure they can communicate effectively with healthcare services during remote and face-to-face assessments. For remote assessments this should include making sure the person is able to use any digital technology and offering alternatives if necessary. It also includes ensuring services are accessible to those who do not speak or read English. Adults should have access to an interpreter or advocate. if needed. Any support provided should be culturally and age appropriate. The considerations in statements 4 and 6 also emphasise that healthcare professionals should be aware that some people may need more support and information to enable them to use virtual ward services for example due to disability, mental health needs and socio-economic deprivation.

Stakeholders highlighted that people with neurodiverse conditions may need additional support with communication. This group has been added to the considerations in statements 4,6 and 7.

A stakeholder suggested that statement 1 should include asking about race within the initial assessment so that oxygen saturation results from a smartphone can be interpreted within a remote consultation. The experts in the working group agreed this should not be included as pulse oximetry is affected by skin colour rather than race.

### 3.2 If the quality statements have changed after the consultation stage, are there any that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

Statement 2 on face-to-face assessment has been revised to acknowledge that there are some circumstances when remote prescribing of antimicrobials may be necessary. Stakeholders emphasised that some people would find it very difficult to access a face-to-face assessment due to disability or where they live.

Draft statement 7 on having a personalised self-escalation plan has been merged with statement 4 on information about the virtual ward service and statement 6 on support to self-manage while admitted to a virtual ward. As the content is still included in the quality standard this will not have any impacts on access for specific groups.

### 3.3 If the quality statements have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

See details for statement 2 above.

### 3.4 If the quality statements have changed after consultation, are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 and 3.3, or otherwise fulfil NICE’s obligations to advance equality?

No other explanations can be made.

Completed by lead technical analyst: Melanie Carr

Date:12/10/23

Approved by NICE quality assurance lead: Mark Minchin

Date: 17/10/23

### After NICE Guidance Executive amendments – if applicable

### 4.1 Outline amendments agreed by Guidance Executive below, if applicable:

No amendments were requested by Guidance Executive.

Completed by lead technical analyst: Melanie Carr

Date: 25/10/23

Approved by NICE quality assurance lead: Mark Minchin

Date: 25/10/23

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