



*National Institute for  
Health and Clinical Excellence*

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# **Positively equal**

**A guide to addressing equality issues in  
developing NICE clinical guidelines**

**Second edition**

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## Foreword

The Centre for Clinical Practice at NICE is committed to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations.

The first edition of 'Positively equal' was launched in September 2009, together with an ambitious training programme to support our own staff and the people who work with us – particularly staff in the National Collaborating Centres and chairs and members of guideline development groups. Since then, consideration of equality issues has become an integral part of both the procedures and the culture of the Centre for Clinical Practice.

The key changes in this edition of 'Positively equal' are to take account of the simplifying effect of the Equality Act 2010, which replaced the existing anti-discrimination laws with a single Act and created a clear public sector equality duty. The changes also recognise that the Act has extended NICE's legal obligations in a number of ways.

'Positively equal' remains a thorough, accessible and practical guide, and I expect it to continue to be a key resource for everyone involved in the work of the Centre for Clinical Practice.

Professor Mark Baker  
Director, Centre for Clinical Practice  
NICE

# 1 Introduction

## 1.1 *Purpose and intended audience of 'Positively equal'*

### Box 1 Principle 1 of the NHS constitution

The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

Eliminating unlawful discrimination and advancing equality of opportunity is both a legal duty and an important ethical and moral priority for NICE. 'Positively equal' is designed as an essential tool to help inform consideration of equality issues as a systematic and integrated part of the clinical guideline development process.

'Positively equal' is for everyone involved in developing NICE clinical guidelines, including the National Collaborating Centres, chairs and members of guideline development groups (GDGs) and staff in the Centre for Clinical Practice.

Since publication of the first edition of 'Positively equal', the Equality Act 2010 has replaced the various anti-discrimination laws that formed its legal context with a single act. The Act simplifies the law in order to make it easier for people to understand and comply with, while also strengthening it in important ways.

This second edition of 'Positively equal' is intended to help all those involved in developing NICE's clinical guidelines to understand the Act's **public sector equality duty**, which came into force on 5 April 2011. The equality duty requires that all public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all.

This guide also explains how NICE goes beyond its legal obligations through its commitment to reducing health inequalities related to socioeconomic status.

## 1.2 *How this guide is structured*

This edition of 'Positively equal' is divided into three main parts:

- Section 2 outlines the legal and organisational context for considering equality issues in clinical guideline development. In particular, it explains the public sector equality duty and the protected characteristics defined in the Equality Act 2010.

- Section 3 shows how the obligations and commitments in section 2 are taken into account within the guideline development process, and provides advice to guideline developers on how to identify and deal with equality issues through the use of structured checklists.
- Section 4 presents examples of how to meet the public sector equality duty in the context of clinical guideline development, drawn from NICE's experience in addressing equality issues.

'Positively equal' should be read in conjunction with these other NICE documents:

- The guidelines manual (2012), which explains how NICE develops clinical guidelines.
- Social value judgements: principles for the development of NICE guidance (2008), which describes the principles that NICE follows in designing the processes it uses to develop its guidance.
- NICE's equality scheme and action plan (2010–2013), which sets out how NICE is meeting its obligations on equality and discrimination.
- NICE's annual equality reports, which show the progress made in implementing the equality scheme.

Links to these documents and other key sources of information about equality can be found in section 5.

### **1.3      *Feedback, updates and questions***

This guide will be updated in line with new legislation and developments at NICE. Please ensure that you always refer to the latest version by checking the NICE website.

We encourage you to help us improve the guide by providing your feedback and ideas for future editions. Please e-mail [equalities@nice.org.uk](mailto:equalities@nice.org.uk) with your suggestions.

If you have any questions about the content of the guide, or about any aspect of equality, diversity or human rights issues at NICE (including any questions about addressing these issues during guideline development), e-mail [equalities@nice.org.uk](mailto:equalities@nice.org.uk).

## **2 Legal and organisational context**

### **2.1 Introduction**

This section explains NICE's commitment to equality, by setting out both its legal obligations and how it is committed to going beyond compliance. Further explanation of key concepts is available in the glossary (section 6).

### **2.2 Legal obligations under the Equality Act 2010**

Until 2010, several pieces of legislation formed the legal basis for NICE's duties in relation to equality. This situation was greatly simplified by the introduction of the Equality Act 2010 ('the Act'), which replaced the previous anti-discrimination laws with a single Act.

#### **2.2.1 The public sector equality duty**

For performance of its public functions (such as producing clinical guidelines), NICE's duties are now expressed in a single public sector equality duty ('the equality duty'). The equality duty supports good decision-making by encouraging public bodies to understand how different people will be affected by their activities. For NICE, much of whose work involves developing advice for others on what to do, this includes thinking about how people will be affected by its recommendations when these are implemented (for example, by healthcare and other professionals).

The equality duty has three aims (see box 2).

#### **Box 2 The public sector equality duty**

The equality duty requires public bodies to have **due regard** to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and people who do not share it
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics covered by the equality duty are listed in box 3.

### Box 3 The protected characteristics

The protected characteristics are:

- **age**
- **disability**
- **gender reassignment**
- **pregnancy and maternity**
- **race** – this includes ethnic or national origins, colour or nationality
- **religion or belief** – this includes lack of belief
- **sex**
- **sexual orientation**

The equality duty also applies to **marriage and civil partnership**, but only with respect to the requirement to have due regard to the need to eliminate discrimination.

Having **due regard** means consciously thinking about the three aims of the equality duty as part of the decision-making process. In the context of clinical guideline development, having due regard requires considering equality issues at every stage of the development process, from decisions about what to include or exclude from the scope, through decisions made in planning of evidence reviews and other development work, to the judgements upon which recommendations are based.

Having due regard to the need to **advance equality of opportunity** involves considering the need to:

- remove or minimise disadvantages suffered by people as a result of their protected characteristics
- meet the needs of people with protected characteristics
- encourage people with protected characteristics to participate in public life or in other activities where their participation is low.

**Fostering good relations** involves tackling prejudice and promoting understanding between people who share a protected characteristic and others.

Complying with the equality duty may involve treating some people more favourably than others, as far as this is allowed by discrimination law. The equality duty also explicitly recognises that disabled people's needs may be different from those of non-disabled people. Public bodies should therefore take account of disabled people's impairments when making decisions about policies or services. This might mean making reasonable adjustments or treating disabled people more favourably than non-disabled people in order to meet their needs.

It is also important to note that the new Act has created a ban, effective from 1 October 2012, on age discrimination (that is, discriminating against people belonging to a particular age group), except where different treatment is justified as a proportionate means of meeting a legitimate aim. NICE does not refer to age in guidance recommendations unless there is evidence that age is a good indicator of either risk or benefit from treatment. If age is referred to, the reasons for the reference must be explained.

Finally, meeting its obligations under the Equality Act 2010 helps NICE to meet its obligations under the Human Rights Act 1998.

## 2.2.2 Implementing the public sector equality duty

The information in this section is based on the booklet 'Equality Act 2010: Public Sector Equality Duty: What do I need to know? A quick start guide for public sector organisations', published by the Government Equalities Office.

Public bodies need to consider the three aims of the equality duty as part of the decision-making process. The weight given to the equality duty, compared with other factors that need to be considered, will depend on how much a particular function of the public body affects discrimination, equality of opportunity and good relations, and the extent of any disadvantage that needs to be addressed.

Principles to guide implementation of the equality duty are set out in box 4.

### Box 4 Principles for implementing the equality duty

Public bodies should ensure:

**Knowledge** – those who exercise the public body's functions need to be aware of the requirements of the equality duty. Compliance with the equality duty involves a conscious approach and state of mind.

**Timeliness** – the equality duty must be complied with before and at the time that a particular policy is under consideration or decision is taken – that is, in the development of policy options, and in making a final decision. A public body cannot satisfy the equality duty by justifying a decision after it has been taken.

**Real consideration** – consideration of the three aims of the equality duty must form an integral part of the decision-making process. The equality duty is not a matter of box-ticking; it must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.

**Sufficient information** – the decision maker must consider what information he or she has and what further information may be needed in order to give proper consideration to the equality duty.

**No delegation** – public bodies are responsible for ensuring that any third parties

which exercise functions on their behalf are capable of complying with the equality duty, are required to comply with it, and that they do so in practice. It is a duty that cannot be delegated.

**Review** – public bodies must have regard to the aims of the equality duty not only when a policy is developed and decided upon, but also when it is implemented and reviewed. The equality duty is a continuing duty.

Public bodies must also record the process of considering equality issues so that they are able to demonstrate compliance with the equality duty. There is no explicit requirement to refer to the equality duty in recording the process of consideration but it is good practice to do so.

## **2.3      *Enforcement***

The Equality and Human Rights Commission has powers to enforce the public sector equality duty and to promote good practice.

## **2.4      *Beyond compliance***

### **2.4.1 Socioeconomic status and tackling health inequalities**

In addition to meeting its legal obligations, NICE is committed to going beyond compliance, particularly in terms of tackling health inequalities. Specifically, NICE considers that, alongside the protected characteristics listed in box 3, it should also take account of socioeconomic status in its equality considerations. There are two main reasons for this.

First, in the last 50 years there have been impressive improvements in the health of the UK population. On average, we are living healthier and longer lives than ever before. But health inequalities – for example, between deprived areas and the rest of the country; between men and women; between people from different ethnic groups – persist, and in some cases are becoming wider. The causes of health inequality, including socioeconomic, environmental and behavioural factors, are complex and interconnected. Many of them must be addressed through measures that improve people’s economic, housing, employment and educational opportunities. But the structure and operation of the health system itself, and the extent to which it is geared to address the needs of disadvantaged groups and overcome the barriers they face, will make a vital contribution to healthier, more productive lives for more people – and to a more equal society.

Second, as shown in box 1, the NHS Constitution makes it clear that the whole NHS has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with those in the rest of the population.

## 2.4.2 Other groups

For similar reasons, NICE considers that it should take account of other groups who experience poor health because of circumstances that are often affected by, but go beyond, sharing a protected characteristic or socioeconomic status. Whether such groups can be identified depends on the guidance topic and the evidence. Examples of groups covered in NICE guidance include:

- refugees and asylum seekers
- migrant workers
- looked-after children
- homeless people.

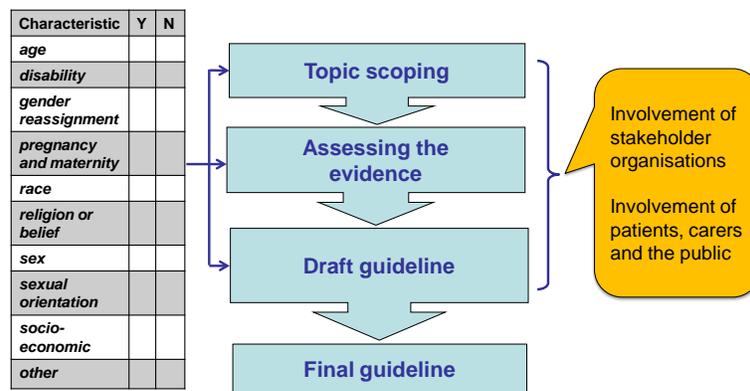
Together, the protected characteristics, socioeconomic status and other groups form NICE's equality groups.

### 3 Equality in guideline development: procedures and checklists

#### 3.1 Introduction

This section explains how the obligations and commitments described in section 2 should be put into practice within the clinical guideline development process, during both scoping and the stages where recommendations are drafted, consulted on and finalised (the development stage and the consultation and redraft stage). In particular, it describes how considering equality issues is an integral part of guideline development (see Figure 1) and how NICE demonstrates its compliance with the equality duty when producing guidelines.

**Figure 1 Equality in guideline development**



For a comprehensive guide to the process and methods for developing NICE clinical guidelines, see ‘The guidelines manual (2012)’.

#### 3.2 The scoping stage

##### 3.2.1 Overview

The scoping stage comprises developing the draft scope, engaging stakeholders through the stakeholder scoping workshop, consulting on the draft scope and finalising the scope.

The scope provides a framework within which to conduct the guideline development work. It briefly describes the epidemiology relevant to the disease or condition, and defines the aspects of care that the guideline will cover in terms of: populations to be included or excluded; healthcare setting; types of

intervention and treatment to be included and excluded; the main outcomes that will be considered; and defining links with other relevant NICE guidance.

### **3.2.2 Equality requirements**

In the scope, the key requirements for addressing equality issues are to establish:

- whether and to what extent the guideline is likely to be relevant to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations
- whether and to what extent it is proportionate to include particular equality issues in the scope.

Considering and assessing both of these factors is needed to ensure ‘due regard’ for equalities. The checklist in box 5 provides a framework to enable robust discussion and decision-making, and should be applied across all of NICE’s equality groups.

Equality considerations should be part of each step in the scoping stage – from scoping group meeting 1 through to sign-off of the final scope.

### **3.2.3 Checklist**

Box 5 lists questions to be considered during scoping.

#### **Box 5 Checklist for scoping**

#### **1. What are the potential equality or discrimination issues linked to the guideline topic?**

- Are there inequalities in prevalence, risk factors or impact – or in use or benefit – related to the topic or intervention?
- Is the condition more common, or is its severity greater, in people from a specific group or with a particular disability?
- Is there a risk of discrimination?
- Do comments from stakeholders highlight the potential for direct or indirect discrimination, or for promoting equality?

#### **2. Should any changes be made to the scope?**

- Consider the degree of relevance to equality, and the proportionate response in relation to this. The greater the relevance of a function to equality, the greater the regard that should be paid to equality issues.
- Consider the views of stakeholders.
- Summarise any changes made at this stage.
- Identify any information gaps that have been identified.

**3. As it currently stands, is the scope discriminatory?**

- Have groups who need special consideration been identified?
- Are there any exclusions?
- If there are exclusions, are the reasons legitimate, and is the exclusion proportionate?

**4. Should any further information be identified and assessed?**

- Have important stakeholders been omitted from or not responded to the consultation process?
- Consider specific questions for stakeholders (for example, at the scoping workshop).
- Summarise the action to be taken.

**5. Is there anything specific that should be done to ensure that the GDG will have relevant information to consider equalities issues when developing guidance?**

- Action to address this needs only to be proportionate.
- Consider specific questions for stakeholders.
- Consider relevant bodies to consult.

Clear, contemporary records of consideration and decisions on these issues, and any others that arise during scoping, should be made.

### **3.2.4 Good practice reminders**

These reminders aim to highlight good practice during scoping. Examples and case studies are provided to demonstrate good practice in action.

#### **Identify population subgroups accurately**

It is important to list all relevant population subgroups and to indicate which are included in and excluded from the scope. Terminology and categories used should be specific and precise, and generic terms should be avoided.

For example, the classification ‘women of South Asian, African, Caribbean or Middle Eastern family origin’ was flagged as being potentially misleading when the scope for an update of the antenatal care clinical guideline was being prepared, because it was too broad. Lists of ethnic (or other) groups that are referred to in the scope must be accurate and definitive, not illustrative, so as not to exclude – and thereby potentially discriminate against – other at-risk subgroups. So under ‘South Asian’, for example, terminology should state ‘all South Asian populations’, or should list specific relevant subgroups, such as ‘Indian, Pakistani, Bangladeshi’ and so on. Similarly, using the word ‘including’ before a list of ethnic groups should be avoided, because this could imply that other at-risk groups are affected, but are not listed.

## **Encourage discussion**

In order to be sure that all pertinent issues are picked up, encourage discussion at the stakeholder scoping workshop about:

- any further issues associated with subgroups, treatments or settings that have been omitted and/or need to be flagged up for consideration
- any inequalities in prevalence, risk factors or severity that need to be taken into account when preparing the scope.

### **3.2.5 Checks and sign-off**

After the workshop, a check should be made to identify whether anything that has been raised suggests that any of the questions in the checklist need to be revisited.

After consultation on the draft scope, the guideline developers should consider whether comments from stakeholders have highlighted any equalities issues that may have been overlooked previously, or had been considered but may now need to be revisited.

Before the final scope is signed off, a final check should be carried out to assess whether the questions raised have been addressed. An equality impact assessment form (see appendix 1) is completed so that it is clear what equality issues were identified and what protected characteristic or other attribute each issue is relevant to. The form is signed off by NICE alongside the final scope.

## **3.3 *The development stage and the consultation and redraft stage***

### **3.3.1 Overview**

At the start of guideline development, the key clinical issues listed in the scope are translated into review questions. This may also be done as part of the scoping process. Review questions must be clear, focused and closely define the boundaries of the topic. They should relate to a specific patient problem because this helps to identify the relevant evidence (see 'The guidelines manual (2012)' for examples of question structure). Review questions are important both as the starting point for the systematic review and as a guide for development of the recommendations by the GDG. The objective is to ensure that the GDG is provided with the best possible evidence on the effectiveness and cost-effectiveness of interventions identified in the scope.

Robust recommendations are then developed, based on the review of the evidence.

During consultation on the draft guideline, stakeholders are asked to comment on whether and how the recommendations could be changed to better eliminate discrimination, advance equality of opportunity and foster good relations. As with

all stakeholder consultation comments, the GDG reviews the comments and makes appropriate changes to the guideline.

### **3.3.2 Equality requirements**

Consideration of equality issues should be integral to assessing the evidence of the effectiveness and cost effectiveness of interventions. When developing recommendations, it is important to ensure that the recommended treatment, care and information will meet the needs of, and be accessible to, people from all sections of the community, including those from disadvantaged groups.

In both assessing evidence and developing recommendations, a key requirement is to ensure that recommendations are formulated so as to avoid unlawful and other harmful discrimination, advance equality and foster good relations.

Considering and assessing all of these factors is needed to meet NICE's legal obligations and our wider commitment to promoting health equality. The checklists below provide a framework to enable robust discussion and decision-making.

### **3.3.3 Checklists**

Box 6 provides a checklist of questions to be considered early in development (for example, when setting review questions and protocols).

#### **Box 6 Checklist for early guideline development**

- 1. How relevant is the evidence to eliminating discrimination, advancing equality and fostering good relations?**
- 2. Do the review questions reflect the scope?**
  - Do they identify issues affecting specific groups?
- 3. Was the search strategy comprehensive?**
  - Consider a range of study types for addressing the review questions (such as qualitative studies).
- 4. Were particular issues identified during consultation on the scope?**
  - Consider amending the search strategy in the light of comments.
- 5. Were the evidence review criteria inclusive?**
  - Check that criteria do not inappropriately exclude studies on specific groups.
- 6. What is the state of the evidence base?**
  - Where are the evidence gaps?

Box 7 provides a checklist of questions to be considered when formulating recommendations.

### **Box 7 Checklist for formulating recommendations**

#### **General questions**

1. How relevant are the recommendations to discrimination and equality? Which recommendations are likely to be most relevant?
2. Where evidence is unavailable to assess a potential issue, could this be reflected in recommendations for future research?

#### **Questions to consider to avoid discrimination include:**

1. Does access to the intervention depend on membership of a specific group?
2. Do any criteria make it easier or more difficult in practice for people in a specific group to gain access to the intervention?
3. Does the way in which people would be assessed for whether or not they receive the intervention make it easier or more difficult for people in a specific group to gain access to it?
4. Does any part of the recommendation make it plausible that a person's age, disability, gender reassignment, pregnancy and maternity, marriage or civil partnership, race (including ethnic or national origins, colour or nationality), religion or belief (including lack of belief), sex, sexual orientation or socioeconomic status could affect their access to an intervention? If so, what steps could be taken to address this?
5. Does any recommendation refer to age? If so, is age a good indicator of either risk or benefit from treatment and is the reason for the reference explained?
6. Do comments from stakeholders highlight areas of possible discrimination or ways of avoiding it?

#### **Questions to consider to advance equality of opportunity include:**

1. Could the recommendations advance equality for people in a specific group, either through access to the intervention or by means of the intervention? Have stakeholders identified particular opportunities?
2. Could the recommendations be reformulated to make implementation more acceptable to, or appropriate for, people in a specific group?
3. Would more favourable treatment of any kind help disabled people to gain access to the intervention on the same basis as people without that disability?

What additional measures would achieve this?

4. Do comments from stakeholders highlight opportunities for advancing equality?

**Questions to consider to foster good relations include:**

1. Is there an opportunity to tackle prejudice?
2. Is there an opportunity to promote understanding?
3. Do comments from stakeholders highlight the need for tackling prejudice or promoting understanding?

Clear, contemporary records of consideration and decisions on these issues, and any others that arise, should be made.

### **3.3.4 Good practice reminders**

The reminders in this section aim to highlight good practice when developing recommendations and consulting on the draft guideline. Examples and case studies are provided to demonstrate good practice in action.

#### **Identify gaps in the evidence**

From the start of scoping, it is important to identify limits and gaps in the research evidence, and to recognise that, even after searching all relevant literature and conferring with relevant healthcare and other professionals, it is still possible to overlook key equality issues and implications. Where evidence is unavailable, this should be documented and acknowledged.

For example, during development of the Osteoarthritis guideline (NICE clinical guideline 59), it emerged that very little data existed on the use of osteoarthritis therapies (non-pharmacological and pharmacological) in very old patients. This is of increasing concern in the context of the demographic shift towards longer life expectancy. Issues that came to the fore for further consideration and research included the need to tailor exercise therapies more precisely to ability and more careful titration of opioids.

#### **Identify population subgroups accurately**

The evidence should be examined to specifically document any information relating to:

- the effectiveness of different interventions for different population subgroups
- any adverse effects of interventions on different population subgroups.

### **Be alert to emerging issues**

Be aware that new equality considerations and implications may emerge at any time in relation to clinical, service delivery or economic issues. Documenting evidence, considerations and decisions is a priority throughout guideline development and consultation.

### **Consider additional measures**

Bear in mind the possibility of treating certain groups of people more favourably than others in order to achieve overall equality of opportunity.

For example, the Medicines adherence guideline (NICE clinical guideline 76) recommended that 'healthcare professionals should adapt their consultation style to the needs of individual patients so that all patients have the opportunity to be involved in decisions about their medicines at the level they wish'. The guideline also made a separate recommendation to 'consider any factors such as physical or learning disabilities, sight or hearing problems and difficulties with reading or speaking English, which may affect the patient's involvement in the consultation'.

### **Use appropriate language**

Ensure that language and terminology used in review questions and in the final guideline is specific, unpatronising and non-discriminatory. The NICE style guide (available from the NICE webboard for National Collaborating Centres) provides guidance for guideline developers on appropriate language.

### **3.3.5 Checks and sign-off**

See appendix 2 for the Guidelines Equality Impact Assessment Form – Recommendations. This should be submitted to NICE with the draft clinical guideline for consultation. It is signed off by NICE during guideline validation.

This form should be completed so that is clear, for each equality issue identified (whether at scoping or afterwards), what the impact on the recommendations has been or, if there is no impact, why this is.

## 4 Equality in guidance development: examples

### 4.1 Introduction

This section includes examples of equality issues identified during NICE guideline development, with explanations of how they were addressed in the final published guidelines. It aims to improve understanding of the process of identifying and handling equality issues by showing what how this can work in practice. The examples may be useful for explaining to people unfamiliar with the public sector equality duty what bearing it has on developing clinical guidelines. However, the examples shown are not intended as a guide to what to do in similar situations. For every guideline, the procedures explained in the previous sections need to be followed to ensure that due regard is given to the need to eliminate discrimination, promote equality of opportunity and foster good relations with respect to NICE's equality groups.

A wide range of equality groups is covered. Examples are included both of issues having an impact on recommendations and of issues not having an impact, with explanations.

### 4.2 Age

#### 4.2.1 Chronic kidney disease (NICE clinical guideline 73)

Issue	Impact
This guideline recommended testing for chronic kidney disease (CKD) in people who had risk factors such as diabetes, hypertension, cardiovascular disease, structural renal tract disease, renal calculi or prostatic hypertrophy, multisystem diseases with potential kidney involvement, a family history of stage 5 CKD or hereditary kidney disease. The GDG considered it important that age was not used as a marker to test people for CKD in the absence of these risk factors.	A recommendation was made that 'in the absence of [the risk factors mentioned], do not use age, gender or ethnicity as risk markers to test people for CKD...'

#### 4.2.2 Metastatic spinal cord compression (NICE clinical guideline 75)

Issue	Impact
In this guideline, the GDG considered it important that age should not be a factor in decision-making about surgery or radiotherapy.	A recommendation was made that 'patients with metastatic spinal cord compression should not be denied either surgery (if fit enough) or radiotherapy on the basis of age alone'.

#### 4.2.3 Alcohol use disorders: physical complications (NICE clinical guideline 100)

Issue	Impact
The GDG identified certain vulnerable groups (for example, people who are frail, have cognitive impairment or are 16 or 17 years old) who might have difficulties accessing medically assisted alcohol withdrawal services.	The GDG recommended that a lower threshold for hospital admission be used for these people:  'For certain vulnerable people who are in acute alcohol withdrawal (for example, those who are frail, have cognitive impairment or multiple comorbidities, lack social support, have learning difficulties or are 16 or 17 years), consider a lower threshold for admission to hospital for medically assisted alcohol withdrawal.'

This example also illustrates that the same issue can relate to more than one of NICE's equality groups. Here the issue was relevant not only to age but also to disability.

#### 4.2.4 Chronic obstructive pulmonary disease (COPD) (update) (NICE clinical guideline 101)

Issue	Impact
The GDG noted that the ageing process affects lung volumes, which are often measured in the diagnosis of COPD. This can lead to overdiagnosis of COPD in older people and	A recommendation was made specifically about older and younger people:  'Consider alternative diagnoses or

underdiagnosis in younger people.	investigations in: <ul style="list-style-type: none"> <li>• older people without typical symptoms of COPD where the FEV<sub>1</sub>/FVC ratio is &lt; 0.7</li> <li>• younger people with symptoms of COPD where the FEV<sub>1</sub>/FVC ratio is ≥ 0.7.’</li> </ul>
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### 4.3 Disability

#### 4.3.1 Acutely ill patients in hospital (NICE clinical guideline 50)

Issue	Impact
<p>The need to address the care of people with communication difficulties was highlighted during development of the guideline.</p>	<p>The guideline included a recommendation that covers the care of patients with communication difficulties:</p> <p>‘The critical care area transferring team and the receiving ward team should take shared responsibility for the care of the patient being transferred. They should jointly ensure:</p> <ul style="list-style-type: none"> <li>• there is continuity of care through a formal structured handover of care from critical care area staff to ward staff (including both medical and nursing staff), supported by a written plan</li> <li>• that the receiving ward, with support from critical care if required, can deliver the agreed plan.</li> </ul> <p>The formal structured handover of care should include:</p> <ul style="list-style-type: none"> <li>• a summary of critical care stay, including diagnosis and treatment</li> <li>• a monitoring and investigation plan</li> <li>• a plan for ongoing treatment, including drugs and therapies, nutrition plan, infection status and</li> </ul>

	<p>any agreed limitations of treatment</p> <ul style="list-style-type: none"> <li>• physical and rehabilitation needs</li> <li>• psychological and emotional needs</li> <li>• specific communication or language needs.'</li> </ul>
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#### 4.3.2 Motor neurone disease: non-invasive ventilation (NICE clinical guideline 105)

Issue	Impact
<p>During scoping, the need to search specifically for evidence on respiratory impairment in people with motor neurone disease who have severe cognitive impairment or dementia was highlighted.</p>	<p>This search was carried out and the guideline included a recommendation explicitly focussed on this sub-population, outlining what should be assessed before making a decision to offer non-invasive ventilation to patients with dementia:</p> <p>'Before a decision is made on the use of non-invasive ventilation for a patient with a diagnosis of dementia, the neurologist from the multidisciplinary team should carry out an assessment that includes:</p> <ul style="list-style-type: none"> <li>• the patient's capacity to make decisions and to give consent</li> <li>• the severity of dementia and cognitive problems</li> <li>• whether the patient is likely to accept treatment</li> <li>• whether the patient is likely to achieve improvements in sleep-related symptoms and/or behavioural improvements</li> <li>• a discussion with the patient's family and/or carers (with the patient's consent if they have the capacity to give it).'</li> </ul>

### 4.3.3 Nocturnal enuresis: the management of bedwetting in children and young people (NICE clinical guideline 111)

Issue	Impact
In the context of a discussion about alarm systems, the need to take account of the needs of children with hearing impairment was identified.	The guideline recommends the following:  'Consider an alternative type of alarm (for example, a vibrating alarm) for the treatment of bedwetting in children and young people who have a hearing impairment.'

## 4.4 *Pregnancy and maternity*

### 4.4.1 Caesarean section (update) (NICE clinical guideline 132)

Issue	Impact
A number of stakeholders highlighted the need for the guideline to specifically consider women with tocophobia (fear of childbirth).	In a group of recommendations (1.2.9.1 to 1.2.9.5), guidance is given on appropriate care for women requesting a caesarean section, including women with anxieties about vaginal birth, which ensures that women's requests are dealt with in a supportive and empathic manner. The guideline includes 2 recommendations specifically about the care of women with anxieties about vaginal birth. These state that such women should be offered perinatal health support and that the person providing this support should be allowed access to the delivery suite antenatally so that this supportive care can be given in the context of the birthplace when this is appropriate.
It was highlighted that women with pelvic girdle pain are not considered as a specific subgroup, particularly in relation to maternal choice.	Although it was not thought appropriate to add this subgroup of women to the guideline scope, the update does address the issue of maternal choice for all women in a way that promotes choice within a supportive framework.

	Thus a woman's preferences for mode of birth are given priority, whatever her underlying reasons for that preference.
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#### 4.4.2 Epilepsy update (NICE clinical guideline 137)

Issue	Impact
The scope identified pregnant women and women of childbearing age as requiring inclusion as a subgroup.	<p>The GDG searched for evidence on pregnant women and women of childbearing age and considered the evidence when developing recommendations. The final guideline included a recommendation on the risks of anti-epileptic drug therapy:</p> <p>'Discuss with women and girls of childbearing potential (including young girls who are likely to need treatment into their childbearing years), and their parents and/or carers if appropriate, the risk of AEDs causing malformations and possible neurodevelopmental impairments in an unborn child. Assess the risks and benefits of treatment with individual drugs. There are limited data on risks to the unborn child associated with newer drugs. Specifically discuss the risk of continued use of sodium valproate to the unborn child, being aware that higher doses of sodium valproate (more than 800 mg/day) and polytherapy, particularly with sodium valproate, are associated with greater risk.'</p>

#### 4.5 Race

##### 4.5.1 Schizophrenia (update) (NICE clinical guideline 82)

Issue	Impact
Evidence reviewed for this update on whether services such as assertive community treatment, crisis resolution	Consensus recommendations and research recommendations were made to address inequalities in access and

and home treatment teams, case management or culturally specific or culturally skilled mental health services increased the number of people from black and minority ethnic (BME) groups who remained in contact with services. The consensus of the GDG was that people with schizophrenia from BME groups are more likely than people with schizophrenia from other groups to be disadvantaged or to have impaired access to and/or engagement with mental health services.	engagement. These included, for example, a recommendation that:  'Mental health services should work with local voluntary BME groups to jointly ensure that culturally appropriate psychological and psychosocial treatment, consistent with this guideline and delivered by competent practitioners, is provided to people from diverse ethnic and cultural backgrounds.'
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#### 4.5.2 Neonatal jaundice (NICE clinical guideline 98)

Issue	Impact
It was recognised that there could be difficulty of recognising jaundice in babies with darker skin tones.	The guideline recommends involving parents and carers in recognising jaundice, as well as careful visual inspection of the baby in bright light and examination of the sclerae, gums and blanched skin (for all skin tones).

Interestingly, a similar issue arose in the guideline 'Bacterial meningitis and meningococcal septicaemia' (NICE clinical guideline 102). Again, the GDG recommended checking the soles of feet, palms of hands and conjunctivae in people with darker skin tones, to ensure equality of opportunity between these people and others.

#### 4.5.3 Chronic obstructive pulmonary disease (COPD) (update) (NICE clinical guideline 101)

Issue	Impact
The issue of ethnic groups in whom recognising and diagnosing COPD may differ from the general population was identified.	The original guideline recommended the use of ERS 1993 reference values, but noted that these were not applicable in black and Asian populations. In an attempt to improve on this, the GDG for the update searched for new reference values. However, this search confirmed that no new reference values were available for these populations. Therefore it was

	not possible to go beyond the original recommendation.
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This is a useful example, as it illustrates that considering equality issues does not always lead to a different recommendation. In this case, the new GDG could not go beyond the work of the original GDG because reference values that would have allowed it to do so were simply lacking. What must always happen, however, is that due regard is given to the issue, as was the case here.

## **4.6 Religion or belief**

### **4.6.1 Type 2 diabetes (NICE clinical guideline 66)**

<b>Issue</b>	<b>Impact</b>
In reviewing evidence that assessed the effectiveness of different forms of dietary advice targeting weight loss, the GDG was conscious of the need to take into account the link that can exist between religious belief and diet.	The GDG felt that it was important to make a recommendation to address this:  'Provide dietary advice in a form sensitive to the individual's needs, culture and beliefs, being sensitive to their willingness to change and the effects on their quality of life.'

### **4.6.2 Venous thromboembolism: reducing the risk (NICE clinical guideline 92)**

<b>Issue</b>	<b>Impact</b>
Heparin is one of the main interventions recommended within the guideline and is of animal origin. Some patients with religious or personal beliefs about the use of animal-derived products may be concerned by this.	The guideline tries to ensure that these patients are given the opportunity to express their concerns and to receive information about alternative prophylaxis options by including a recommendation which states:  'Be aware that heparins are of animal origin and this may be of concern to some patients. For patients who have concerns about using animal products, consider offering synthetic alternatives based on clinical judgement after discussing their suitability, advantages and disadvantages with the patient.'

#### 4.6.3 Infection control (update) (NICE clinical guideline 139)

Issue	Impact
It was identified that there might be concerns among people of certain faiths (for example, Islam) about using handrubs that contain alcohol.	If religious belief is a source of concern, patients should be made aware of the official stand of religious bodies about products. When information is available, it is helpful to direct patients to these information sources to clarify the position. For example, the official position of Muslim Councils of Britain is that 'External application of synthetic alcohol gel... is considered permissible within the remit of infection control because (a) it is not an intoxicant and (b) the alcohol used in the gels is synthetic, i.e., not derived from fermented fruit. Alcohol gel is widely used throughout Islamic countries in health care setting.'
It was identified that exposing the forearms is not acceptable to some NHS staff because of their Islamic faith.	The GDG did not feel that a separate recommendation was necessary to address the issues, as they are covered by the Muslim Spiritual Care Provision in NHS guidance on staff clothing.

#### 4.6.4 Acute upper gastrointestinal bleeding (NICE clinical guideline 141)

Issue	Impact
The management of upper gastrointestinal bleeding in people of the Jehovah's witness denomination was discussed in view of their refusal of blood transfusions.	While this issue was not considered specific to people with upper gastrointestinal bleeding, and there are other guidelines dealing with this particular issue, the 'patient-centred care' text in the guideline was customised to address people's religious beliefs.

## 4.7 Sex

### 4.7.1 Lipid modification (NICE clinical guideline 67)

Issue	Impact
The GDG looked at evidence of the risk of cardiovascular disease (CVD) in South Asian men and women. It was found that the risk of CVD was higher among South Asian men than among white men. For women there was no robust evidence for a difference in the risk of CVD between South Asian ethnic groups and the general population.	The GDG considered the evidence and made a recommendation that 'The estimated CVD risk for men with a South Asian background should be increased by a factor of 1.4.'

### 4.7.2 Autism in adults (NICE clinical guideline 142)

Issue	Impact
Because autism spectrum conditions are more prevalent in men than in women, it was highlighted that women with autism may be overlooked.	The guideline addresses this issue through several specific recommendations (especially 1.8.3, 1.8.1, 1.8.4 and 1.4.9) that discuss promoting engagement, access and information and minimising victimisation.

## 4.8 Socioeconomic status

### 4.8.1 Common mental health disorders (NICE clinical guideline 123)

Issue	Impact
The scoping process identified inequalities of access to services for people with common mental health disorders based on socioeconomic status.	It was recommended that all healthcare professionals involved in the design of care pathways for common mental health disorders promote the active engagement of all populations served by the pathway, and offer assessments and interventions that are appropriately adapted to their needs.

## **5 Links to other resources**

### **5.1 Introduction**

This section provides links to other resources that may be of use both for understanding NICE and the public sector equality duty, and for considering particular equality issues.

### **5.2 Resources**

#### **5.2.1 NICE resources**

[The guidelines manual \(2012\)](#). This explains how NICE develops clinical guidelines.

[Social value judgements: principles for the development of NICE guidance \(2008\)](#). This describes the principles that NICE follows in designing the processes it uses to develop its guidance.

NICE's [equality scheme and action plan \(2010–2013\)](#). This sets out how NICE is meeting its obligations on equality and discrimination.

[NICE's annual equality reports](#). These show the progress made in implementing the Equality Scheme.

#### **5.2.2 Government Equalities Office resources**

[Equality Act 2010: Public Sector Equality Duty: What do I need to know? A quick start guide for public sector organisations \(2011\)](#).

#### **5.2.3 Equality and Human Rights Commission resources**

[The essential guide to the public sector equality duty \(2012\)](#)

[Meeting the equality duty in policy and decision-making \(2012\)](#)

[Engagement and the equality duty: A guide for public authorities \(2012\)](#)

[Objectives and the equality duty: a guide for public authorities \(2012\)](#)

[Equality information and the equality duty: a guide for public authorities \(2012\)](#)

#### **5.2.4 Department of Health resources**

[The NHS Constitution for England \(2012\)](#)

## 6 Glossary of key terms

### Diversity

Diversity is about recognising and valuing difference in its broadest sense. It is about creating a working culture and practices that recognise, respect, value and harness difference for the benefit of an organisation and the people whose lives it influences, and for society as a whole. Critically, diversity acknowledges that people should not be disadvantaged as a result of having different values, abilities, lifestyles or needs, but that everyone should be appreciated as valued members of the community, with a right to equal treatment.

***Note:** Diversity is wider than equal opportunity. It is about giving value to the differences between people and working creatively with these differences to stimulate fresh ideas, broaden perceptions and empower each person to contribute so that we achieve the best results.*

### Direct discrimination

Fortunately increasingly rare, this is when a person or particular group of people is openly treated less favourably than others in the same or similar circumstances.

***Example – drug treatment:** If a drug was recommended for men but not women without any evidence or legitimate need, this would amount to direct discrimination.*

### Due regard

‘Due regard’ comprises 2 linked elements: relevance and proportionality. The greater the relevance of a function to equality, the greater the regard that should be paid to equality issues. In practice, this means that action to address the most significant inequalities should be prioritised.

### Equality

Equality is about creating a more equal society where everyone can participate fully and have the opportunity to fulfil their potential. Equality does not necessarily mean treating everyone the same; it acknowledges that some needs – particularly those of disadvantaged groups – may have to be met in different ways according to different life situations.

***Note:** Equality and diversity are not interchangeable – they need to be addressed together. There is no equality of opportunity if difference is not recognised and valued.*

### Equal opportunity/opportunities

Equal opportunity is about preventing or removing bias, prejudice and stereotyping, so that discrimination on the grounds of difference does

not occur. It means treating people equitably, according to need and acknowledging their diversity. Measures to ensure equal opportunity can be voluntary or statutory, and are based on the recognition that not all groups or people have the same ease in accessing opportunities – and that discrimination can be direct or indirect.

### **Health inequity**

A health inequity is an unnecessary, avoidable, unfair and unjust difference in someone's health or healthcare.

**Note:** *'Health inequity' should not be used interchangeably with 'health inequality', because the differences in health or healthcare that people experience are not necessarily unfair or unjust. Health inequity is concerned with social justice, values or politics, while inequalities in health are a matter of fact.*

### **Indirect discrimination**

This is when apparently neutral conditions, criteria or provisions are applied that disadvantage people from one group compared with others, and which cannot be shown to be proportionate (that is appropriate and necessary) to achieve a legitimate aim.

**Example – swimming therapy:** If swimming therapy is recommended for treating arthritis, joint injuries or cerebral palsy conditions, consideration should be given to recommending an alternative physical activity for Muslim women, whose faith does not allow them to be uncovered in front of, or to exercise in the presence of, men.

### **Lawful discrimination**

In certain limited circumstances, the law allows for discrimination that is proportionate, can be backed by evidence and meets a legitimate need. Positive action to put people from under-represented groups on an equal footing with those from other groups is also sometimes permitted (although positive discrimination, which puts people from a particular group at an advantage compared with others, is never allowed).

**Example – sickle-cell anaemia and thalassaemia:** Services and treatments for sickle-cell anaemia and thalassaemia can be legitimately targeted at people of African, Caribbean, Asian and Mediterranean origin, who are significantly more likely to develop these disorders.

### **Reasonable adjustments**

Reasonable adjustments can include altering physical features, and providing reasonable alternatives or auxiliary aids or services. In some cases, it may mean waiving a policy or amending it to allow exceptions. Where a policy or practice is discriminatory or detrimental to people with disabilities, there may be a requirement to discontinue it completely.

## Appendix 1

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

### CLINICAL GUIDELINE EQUALITY IMPACT ASSESSMENT – SCOPING

**Clinical guideline:** insert full title of guideline

As outlined in [The guidelines manual \(2012\)](#), NICE has a duty to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. The purpose of this form is to document the consideration of equality issues at the scoping stage of the guideline development process. This equality impact assessment is designed to support compliance with NICE's obligations under the Equality Act 2010 and Human Rights Act 1998.

Table 1 lists the equality characteristics and other equality factors NICE needs to consider – not just population subgroups sharing the 'protected characteristics' defined in the Equality Act, but also groups affected by health inequalities associated with socioeconomic factors or other forms of disadvantage. Table 1 does not attempt to provide further interpretation of the protected characteristics.

This form should be completed by the guideline developer before scope sign-off, and approved by the NICE lead for the guideline at the same time as the scope. The form will be published on the NICE website with the final scope. The form is used to:

- record any equality issues raised in connection with the guideline during scoping by anybody involved, including NICE, the National Collaborating Centre, the GDG Chair and stakeholders
- demonstrate that each of these issues has been considered and explain how it will be taken into account during guideline development if appropriate
- highlight areas where the guideline may advance equality of opportunity or foster good relations
- ensure that the guideline will not discriminate against any of the equality groups.

**Table 1 NICE equality groups**

<b>Protected characteristics</b>
<ul style="list-style-type: none"> <li>• Age</li> <li>• Disability</li> <li>• Gender reassignment</li> <li>• Pregnancy and maternity</li> <li>• Race</li> <li>• Religion or belief</li> <li>• Sex</li> <li>• Sexual orientation</li> <li>• Marriage and civil partnership (protected only in respect of the need to eliminate unlawful discrimination)</li> </ul>
<b>Additional characteristics to be considered</b>
<ul style="list-style-type: none"> <li>• Socio-economic status</li> </ul> <p>Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas, or inequalities or variations associated with other geographical distinctions (for example, the North–South divide; urban versus rural).</p>
<ul style="list-style-type: none"> <li>• Other</li> </ul> <p>Other groups in the population experience poor health because of circumstances often affected by, but going beyond, sharing a protected characteristic or socioeconomic status. Whether such groups can be identified depends on the guidance topic and the evidence. The following are examples of groups that may be covered in NICE guidance:</p> <ul style="list-style-type: none"> <li>• refugees and asylum seekers</li> <li>• migrant workers</li> <li>• looked-after children</li> <li>• homeless people.</li> </ul>

### **1. Have equality issues been identified during scoping?**

- Record any issues that have been identified and plans to tackle them during guideline 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?

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

- Are the reasons legitimate? (that is, they do not discriminate against a particular group)
- Is the exclusion proportionate?

### **3. Have relevant stakeholders been consulted?**

- Have all relevant stakeholders, including those with an interest in equality issues been consulted?
- Have comments highlighting potential for discrimination or advancing equality been considered?

**Signed:**

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***NCC Director***

***Date:***

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***GDG Chair***

***Date:***

**Approved and signed off:**

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***CCP Lead***

***Date:***

## Appendix 2

### NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE CLINICAL GUIDELINE EQUALITY IMPACT ASSESSMENT - RECOMMENDATIONS

**Clinical guideline:** insert full title of guideline

As outlined in [The guidelines manual \(2012\)](#), NICE has a duty to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. The purpose of this form is to document the consideration of equality issues in each stage of the guideline production process. This equality impact assessment is designed to support compliance with NICE's obligations under the Equality Act 2010 and Human Rights Act 1998.

Table 1 below lists the protected characteristics and other equality factors NICE needs to consider, i.e. not just population groups sharing the 'protected characteristics' defined in the Equality Act but also those affected by health inequalities associated with socioeconomic factors or other forms of disadvantage. The table does not attempt to provide further interpretation of the protected characteristics.

This form should be drafted before first submission of the guideline, revised before the second submission (after consultation) and finalised before the third submission (after the quality assurance teleconference) by the guideline developer. It will be signed off by NICE at the same time as the guideline, and published on the NICE website with the final guideline. The form is used to:

- record any equality issues raised in connection with the guideline by anybody involved **since scoping**, including NICE, the National Collaborating Centre, GDG members, any peer reviewers and stakeholders
- demonstrate that all equality issues, both old and new, have been given due consideration, by explaining what impact they have had on recommendations, or if there is no impact, why this is.
- highlight areas where the guideline should advance equality of opportunity or foster good relations
- ensure that the guideline will not discriminate against any of the equality groups

**Table 1 NICE equality groups**

<b>Protected characteristics</b>
<ul style="list-style-type: none"><li>• Age</li><li>• Disability</li><li>• Gender reassignment</li><li>• Pregnancy and maternity</li><li>• Race</li><li>• Religion or belief</li><li>• Sex</li><li>• Sexual orientation</li><li>• Marriage and civil partnership (protected only in respect of need to eliminate unlawful discrimination)</li></ul>
<b>Additional characteristics to be considered</b>
<ul style="list-style-type: none"><li>• Socio-economic status</li></ul> <p>Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas, or inequalities or variations associated with other geographical distinctions (for example, the North–South divide; urban versus rural).</p>
<ul style="list-style-type: none"><li>• Other</li></ul> <p>Other groups in the population experience poor health because of circumstances often affected by, but going beyond, sharing a protected characteristic or socioeconomic status. Whether such groups can be identified depends on the guidance topic and the evidence. The following are examples of groups that may be covered in NICE guidance:</p> <ul style="list-style-type: none"><li>• refugees and asylum seekers</li><li>• migrant workers</li><li>• looked-after children</li><li>• homeless people.</li></ul>

**1. Have the equality areas identified during scoping as needing attention been addressed in the guideline?**

Please confirm whether:

- the evidence reviews addressed the areas that had been identified in the scope as needing specific attention with regard to equality issues (this also applies to consensus work within or outside the GDG)
- the GDG has considered these areas in their discussions.

*Note: some issues of language may correlate with ethnicity; and some communication issues may correlate with disability*

What issue was identified and what was done to address it?	Was there an impact on the recommendations? If so, what?
<b>Other comments</b>	

Insert more rows as necessary.

**2. Have any equality areas been identified after scoping? If so, have they have been addressed in the guideline?**

Please confirm whether:

- the evidence reviews addressed the areas that had been identified after scoping as needing specific attention with regard to equality issues (this also applies to consensus work within or outside the GDG)
- the GDG has considered these areas in their discussions.

*Note: some issues of language may correlate with ethnicity; and some communication issues may correlate with disability*

<b>What issue was identified and what was done to address it?</b>	<b>Was there an impact on the recommendations? If so, what?</b>
<b>Other comments</b>	

Insert more rows as necessary.

**3. Do any recommendations make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention?**

For example:

- does access to the intervention depend on membership of a specific group?
- does using a particular test discriminate unlawfully against a group?
- would people with disabilities find it impossible or unreasonably difficult to receive an intervention?

**4. Do the recommendations promote equality?**

State if the recommendations are formulated so as to advance equality, for example by making access more likely for certain groups, or by tailoring the intervention to specific groups.

**5. Do the recommendations foster good relations?**

State if the recommendations are formulated so as to foster good relations, for example by improving understanding or tackling prejudice.

**Signed:**

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***NCC Director***

***Date:***

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***GDG Chair***

***Date:***

**Approved and signed off:**

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***CCP Lead***

***Date:***

## Appendix 3

### **Standard equalities text for consultations on draft guidance**

Do you think this guidance could be changed to advance better equality of opportunity relating to age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race (this includes ethnic or national origins, colour or nationality), religion or belief (this includes lack of belief), sex, sexual orientation, socioeconomic status or any other characteristic?

In answering this question, please include details of:

- which particular parts of the guidance you have in mind **and**
- why and how you think equality of opportunity, discrimination or the fostering of good relations is affected.

### **Standard equalities text for final publication**

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.