NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARDS

Quality standard topic: Chronic heart failure in adults (update)

Output: Equality analysis form – meeting 2

Introduction

As outlined in the Quality Standards process guide (available from www.nice.org.uk), NICE has a duty to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between people from different groups. The purpose of this form is to document the consideration of equality issues in each stage of the development process before reaching the final output that will be approved by the NICE Guidance Executive. This equality analysis 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, 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 is because it is likely to be simpler, and more efficient, to use the evidence underpinning the quality standard to define population groups within the broad protected characteristic categories rather than to start with possibly unsuitable checklists created for other purposes, such as social surveys or HR monitoring tools.

The form should be used to:

- confirm that equality issues have been considered and identify any relevant to the topic
- ensure that the quality standards outputs do not discriminate against any of the equality groups
- highlight planned action relevant to equality
- highlight areas where quality standards may advance equality of opportunity.

This form is completed by the NICE quality standards internal team at each stage within the development process:

- Topic overview (to elicit additional comments as part of active stakeholder engagement)
- Quality Standards Advisory Committee – meeting 1
- Quality Standards Advisory Committee – meeting 2

Table 1

Protected characteristics
Age
Disability
Gender reassignment
Pregnancy and maternity
Race
Religion or belief
Sex
Sexual orientation
Other characteristics
Socio-economic status 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 (e.g. the North/South divide, urban versus rural).
Marital status (including civil partnership)
Other categories 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 are identifiable depends on the guidance topic and the evidence. The following are examples of groups covered in NICE guidance: • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people.

Quality standards equality analysis

Stage: Meeting 2

Topic: Chronic heart failure in adults (update)

1. Have any equality issues impacting upon equality groups been identified during this stage of the development process?

- Please state briefly any relevant equality issues identified and the plans to tackle them during development.

Equality issues were identified prior to QSAC meeting 2 that related to quality statements 3 and 6. A developmental statement (statement 7) has been drafted following QSAC 2 which is closely related to statement 6. The issues raised for statement 6 are also pertinent to statement 7.

Quality statement 3 notes that ACE inhibitors may be less effective in people of African or Caribbean origin. It states that this should be considered by their healthcare professional and closely monitored to ensure that they receive additional treatment promptly if this is needed.

Quality statement 6 seeks to offer a programme of cardiac rehabilitation to everyone with chronic heart failure, including those who may be house bound or nursing home bound. To ensure equality of access to cardiac rehabilitation programmes, measures such as providing transport for people to attend sessions and providing the sessions in different locations, should be considered. Cardiac rehabilitation should be held in centres that have access for disabled people. Statement 6 also states that healthcare professionals should take into account the communication needs of people with chronic heart failure when delivering cardiac rehabilitation, including people with cognitive impairment. All information should be culturally appropriate, and accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People should have access to an interpreter or advocate if needed.

Quality statement 7 seeks to address some of the equality issues raised in relation to statement 6. Specifically it seeks to ensure that programmes of cardiac rehabilitation are provided in a range of locations and at different times to maximize access for those who would find it difficult to attend group / hospital based programmes.

2. Have relevant bodies and stakeholders been consulted, including those with a specific interest in equalities?

- Have comments highlighting potential for discrimination or advancing equality been considered?

This is the final stage of the process to refine the quality standard and statements following comments from stakeholders and discussion at the second QSAC.

The topic overview and request for areas of quality improvement was published and wide stakeholder comment invited, including from those with a specific interest in equalities.

Standing members for Quality Standards Advisory Committees (QSACs) have been recruited by open advert with relevant bodies and stakeholders given the opportunity to apply. In addition to these standing committee members, specialist committee members from a range of professional and lay backgrounds relevant to the topic have been recruited and attended the first quality standards advisory committee to discuss this topic.

The draft quality standard was subsequently published and stakeholder comment invited, including from those with a specific interest in equalities. A wide range of stakeholder comments were received and provided to committee members. The comments, and the need to amend the standard in light of the responses, were considered at QSAC meeting 2.

3. Have any population groups, treatments or settings been excluded from coverage by the quality standard at this stage in the process? Are these exclusions legal and justified?

- Are the reasons for justifying any exclusion legitimate?

The quality standard does not address prevention of heart failure. Prevention is not within the scope of clinical guideline 108 and is covered by the quality standards on cardiovascular risk assessment and lipid modification and secondary prevention after a myocardial infarction, and the quality standard in development on obesity prevention and management in adults.

The quality standard also does not address acute heart failure. Acute heart failure is not within the scope of clinical guideline 108 and is covered by the acute heart failure quality standard, which is in development.

4. If applicable, do any of the quality statements make it impossible or unreasonably difficult in practice for a specific group to access a service or element of a service?

- Does access to a service or element of a service depend on membership of a specific group?
- Does a service or element of the service discriminate unlawfully against a group?
- Do people with disabilities find it impossible or unreasonably difficult to receive a service or element of a service?

No.

5. If applicable, does the quality standard advance equality?

- Please state if the quality standard, including statements, measures and indicators, as described will advance equality of opportunity, for example by making access more likely for certain groups, by tailoring the service to certain groups, or by making reasonable adjustments for people with

disabilities?
Statement 3 highlights the requirement to consider additional treatments for people of African or Caribbean origin as some heart failure medication may be less effective in these groups. Statement 6 highlights the provision of transport and holding sessions in different locations to ensure equality of access to cardiac rehabilitation programmes. It states that cardiac rehabilitation should be held in centres that have access for disabled people. It also states that healthcare professionals should take into account the communication needs of people with chronic heart failure when delivering cardiac rehabilitation, including people with cognitive impairment. All information should be culturally appropriate, and accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People should have access to an interpreter or advocate if needed. Statement 7 has been introduced to specifically address issues of access to cardiac rehabilitation programmes, and seeks to ensure that people with chronic heart failure are offered a choice of programmes at different times and in different locations, including home based sessions. We feel these statements will enhance equality.

6. Is an alternative format of the Information for the Public needed e.g. large font, easy read?
No need identified at this stage.