NHS
Enfield
Clinical Commissioning Group

EQUALITY ANALYSIS

(Equality Impact Assessment)
Adherence to Evidence Based Medicine
24th February 2017

Stage 1

Name of policy/function

Adherence to Evidence Based Medicine

Is this a new or existing policy/function?

[Please check appropriate box]

New ☒ **Existing** ☒

Please give a brief description of policy/function

The Adherence to Evidence based Medicines Programme involves reviewing the evidence base, thresholds and criteria for access to treatments currently in the North Central London CCGs' Procedures of Limited Clinical Effectiveness (PoLCE) Policy and additional procedures where the evidence base has changed since our original thresholds and criteria were introduced.

Scope of the Equality Analysis

The equality analysis covers all the procedures within the scope of the AEBM programme workstreams, these are:

- Bunions
- Hearing Aids
- Knee Replacement Surgery
- Hernia
- Vasectomy
- Uterovaginal Prolapse
- Revision Mammoplasty
- Revision of Hypertrophic Scars
- Cholecystectomy for Gallstones
- Chalazions
- Correction of Ptosis
- Penile Procedures (Penile Implants)
- Homeopathy

It should be noted that procedures are based on the clinical need of a patient and therefore the EIA will consider how different social, cultural and economic factors may play a part in terms of accessibility and how the CCG should ensure equality and equity.

Stage 1: We will be assessing how the change will impact on different protected and vulnerable groups based on the evidence we already know e.g. from our Joint Strategic Needs Assessment, and will carry out evaluation of the impact of the policy on the target population stratified by age, gender, ethnicity and geographical areas to assess if there has been a group disproportionately affected as a result of the policy . More importantly we will assess if the policy change has widened or closed the gap in the inequality from the baseline year following the introduction of the policy change. This will be published with the consultation document for comments and feedback from patients and stakeholders.

Stage 2: We will consider comments and feedback from patients and stakeholders and any further evidence we may come across during consultation and produce a detailed matrix showing how each procedure may impact of protected and vulnerable groups. The outcomes of stage 2 will be shared with stakeholders and all providers. The CCG will monitor the implementation of the EIA action plan.

Consultation, engagement and contribution/outcomes

[Please list who you have consulted with on this EA and what contribution they have made, if any. If the policy/function is customer facing then please mention which protected group from the potential beneficiary groups has been involved]

The CCG has undertaken a pre engagement phase with a public session and discussion with its member practices, at which it tested the principle of the programme and the manner in which the proposals (which include substantial clinical detail) should be shared in order to be accessible to the lay person. The feedback provided is being used to plan further engagement activities. Engagement with partner CCGs, including the NCL Clinical Cabinet has now been undertaken. It is important that secondary care clinicians' views are incorporated into the proposals for new access thresholds, policies and pathways.

In addition, the CCG has engaged with Public Health, Local GPs and Quality and Assurance Leads on the development of the Equality Impact Assessment.

See Appendix A- Engagement log

Impact assessment and actions

Protected Group	Relevance YES/NO	Evidence of impact	Nature of potential impact (positive/negative /unknown)	Recommendations/mitigating actions
Age	Yes	Knee: 72% are 65+ Correction of Ptosis: 62% are 65+ Femoro-acetabular (Hip) Impingement: 81% are 65+	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment on a fair and equal basis, regardless of their age.
Disability (including mental health and learning disability)	YES	The number of adults with moderate and serious physical disabilities varies substantially by age group. The greatest number of adults with moderate physical disability in 2012 was thought to be in the 55-64 year age group, closely followed by the 45-54 year age group. The greatest number of adults with serious physical disability was also thought to be aged 55-64 years.	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment on a fair and equal basis, regardless of their disability. Ensuring accessibility to the provision through the Accessible Information

				Standard by: 1. Asking people if they have any information of communication needs 2. Recording those needs in a set way 3. Highlighting a person's file, so it is clear that they have information or communication needs and clearly explain how those needs should be met 4. Sharing information about a person's needs with other NHS and adult social care providers, when they have consent or permission to do so. 5. Making sure people get information in an accessible way and communication support if they need it
Race/ethnicity	YES	The health experience of different ethnic groups is not uniform, for example the percentage of the population that report their health as 'not good' is highest among the Pakistani and Bangladeshi populations. A higher than average proportion of admissions due to coronary heart disease is	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of

		found in the Pakistani, Bangladeshi, Indian and Mixed White & Asian ethnic groups, reflecting the higher prevalence of coronary heart disease in these groups compared to other Black and Minority Ethnic (BME) groups. A higher than average proportion of admissions due to diabetes is found in the Asian groups, Black Caribbean and Black Other group in most regions. This reflects the higher prevalence of diabetes in these groups, but may also suggest issues around early access to or on-going engagement with primary care which may result in fewer cases being treated before emergency intervention is necessary. Among ethnic minority groups, Black Africans comprise the largest proportion of those seen for HIV care in all regions, and along with the Other ethnic group, also have the highest rates of tuberculosis Some genetic inherited conditions are also more or less common amongst certain ethnicities. For example, sickle cell anaemia and thalassemia's are more prevalent amongst people of Black African and Black Caribbean decent, while Cystic Fibrosis is more strongly associated to those of European decent. However, these sort of diseases can and do occur in people of all ethnicities.		such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment on a fair and equal basis, regardless of their ethnic origin.

Sex/gender	Yes	Bunion Surgery: 86% are Female Hernia Surgery: 78% are Male Knee: 68% are Female Homeopathy: 71% are Male Cholecystectomy for Gallstones: 74% are Female Correction of Ptosis: 65% are Female Ultrasound guided injections for hip pain: 82% are Female	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment of a fair and equal basis, regardless of their sex or gender.
Gender reassignment	YES	There is limited published research into trans health issues outside of gender reassignment pathways of care. LGB&T individuals often experience discrimination and marginalisation that impacts on wider factors such as education, housing stability and perceptions and experiences of crime and violence, meaning that these groups experience specific health inequalities as a result. This may be particularly true for individuals who describe their identity as other than male or female, and therefore may find it difficult to access gender-restricted or targeted services appropriately.	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment of a fair and equal basis, regardless of their gender. LGBT awareness amongst practitioners, practice staff and providers is crucial.

		The protected characteristic of gender reassignment covers only those who are proposing to undergo, are undergoing, or have undergone, the process of changing their gender. It is best practice to consider all trans people as though they are equally protected in the provision of appropriate healthcare services.		
Sexual orientation	YES	There is a substantial body of evidence demonstrating that lesbian, gay, bisexual and trans (LGB&T) people experience significant health inequalities, which impact both on their health outcomes and their experiences of the healthcare system.	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment of a fair and equal basis, regardless of their sexual orientation. Service providers to monitor sexual orientation Local disease registers include gender identity in routine data collection and should aspire to include sexual orientation monitoring. Integrated care must include addressing the specific needs of

				patients related to their sexual orientation.
Religion/belief	YES	Some religious groups experience poorer health outcomes than others e.g. Muslim women/men There is no specific information included in the JSNA about faith but national research does suggest there are factors that play a part in why some faith groups have poorer health outcomes.	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment of a fair and equal basis regardless of their religious affiliation or belief.
Maternity/pregnancy	YES	In some communities women who are pregnant or have babies face multiple disadvantages. How women from particular social backgrounds will access these procedures and how services can play an enabling role so women can qualify for funding under the IFR	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment of a fair and equal basis.

Civil partnership /marriage	No		Unknown	
Human Rights	YES	Groups such as people with disabilities, those who speak little or no English, victims of violence or sex trafficking will often find it difficult to come forward. No patient should be denied a procedure if they meet the threshold as outlined in the proposal. Every patient regardless of their background or personal circumstance must have equal access to the procedure they clinically need.	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment of a fair and equal basis, regardless of their ethnic origin, religious affiliation or where they reside, physical or mental health or weather English is their first of second language.
Socio-economic group	YES	As various national and regional research suggest many groups who are not categorised as protected groups may also experience health inequalities e.g. carers, unemployed people, homeless people, part time workers, sex workers, drug addicts. It is the responsibility of the local commissioners to ensure the services they commission are inclusive and befit these groups.	Unknown	Restricted but equal access policies are applied to the entire population of Enfield and referrals are assessed against criteria derived from best practice evidence. The policy outcomes will not differ between protected groups. The intention of such a policy is to ensure we have the best chance of delivering a benefit to each individual patient who is put forward for treatment of a fair and equal basis.

Social inclusion	No			
Community cohesion	No			

Final outcomes:
[Please check appropriate box]

A. Continue with the policy/proposal as it is ☒
B. Continue with the policy with adjustment or further analysis ☐
C. Stop/remove the policy/proposal ☐
D. Carry out a further analysis of new data ☐

Signature of the SRO/Director:

Date:

01/02/2017

Date of Next Review:
[Statutory requirement at least 3 years unless there is any change in existing policy/function]

Note: There will be another review following the end of the consultation. 01/02/2020

Further information:
Please read the CSU guidance on 'how to complete an equality analysis' when completing an equality analysis.

Please forward a copy of this EA report to the Equality and Diversity Team at the CSU at equality@nelcsu.nhs.uk