Indicator development programme

Equality Impact Assessments

These equality impact assessments accompany proposed indicators in the March 2024 consultation.

[IND2023-164 cardiovascular disease prevention: Risk assessment (general population) 2](#_Toc159849811)

[IND2023-165 cardiovascular disease prevention: Risk assessment (modifiable risk factors or comorbidities) 2](#_Toc159849812)

[IND2023-166 cardiovascular disease prevention: Risk assessment (modifiable risk factors) 2](#_Toc159849813)

[IND2023-167 COPD: annual review (high risk) 4](#_Toc159849814)

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# IND2023-164 cardiovascular disease prevention: Risk assessment (general population)

# IND2023-165 cardiovascular disease prevention: Risk assessment (modifiable risk factors or comorbidities)

# IND2023-166 cardiovascular disease prevention: Risk assessment (modifiable risk factors)

1. Have any potential equality issues been identified during the development process?

No potential issues have been identified during the development process of these indicators.

1. Have any population groups, treatments or settings been excluded from coverage by the indicator? Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

The indicators exclude people diagnosed with the following:

* Type 1 diabetes
* CVD
* Familial hypercholesterolemia
* CKD 3a to 5
* Current lipid lowering therapies
* 20% risk ever recorded.

These exclusions are justified. NICE guideline NG238 does not recommend CVD risk assessment in people who are already at established high risk of CVD because of type 1 diabetes, CKD 3a to 5 or familial hypercholesterolemia. These individuals are most likely on treatment or surveillance, therefore do not need to be reassessed.

CVD risk assessment is also not validated in people who are diagnosed with CVD.

People on current lipid lowering therapies are excluded as the purpose of risk assessment is to help consider risk modification and this is already underway.

People with a previous risk score of 20% are excluded to avoid repeat assessment in people for whom risk modification should already be undertaken.

1. Does the indicator 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?

No, the indicator does not make it difficult in practice for a specific group to access services compared with other groups.

1. Is there potential for the indicator to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No, the indicator does not require for a person to attend in person, the risk assessment can be carried out based on information already recorded in primary care electronic records.

Completed by lead technical analyst: Jean Masanyero-Bennie

Date: 13.02.2024

Approved by NICE quality assurance lead: Craig Grime

Date: 14.02.24

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# IND2023-167 COPD: annual review (high risk)

1. Have any potential equality issues been identified during the development process?

The [2021 GIRFT national speciality report for respiratory medicine](https://gettingitrightfirsttime.co.uk/medical_specialties/respiratory/) indicated that COPD mainly affects people over the age of 50 and is closely associated with levels of deprivation. COPD is the second most common reason for hospital admission and the fifth biggest killer in the UK, accounting for a quarter of all deaths from lung disease. A [2022 Health Foundation report](https://www.health.org.uk/news-and-comment/charts-and-infographics/quantifying-health-inequalities) indicated that COPD is over three times more common in the most deprived areas of England than the least. [Asthma and Lung UK](https://www.asthmaandlung.org.uk/breathing-unequal) reports that those living in the most deprived communities are at much higher risk of being admitted to hospital and dying from a lung condition than those in the least deprived communities. A [recent Asthma and Lung UK survey](https://pubmed.ncbi.nlm.nih.gov/35853736/) indicated that respondents with COPD reporting frequent exacerbations were more likely to have lower household income and to live in a cold and damp home.

[QOF data for 2022-23](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2022-23) indicated that 74% of people with COPD on the register had a review in the preceding 12 months (indicator NM170). Annual reviews can help support people with COPD to self-manage their condition. A recent [report from Asthma and Lung UK](https://www.asthmaandlung.org.uk/breathing-unequal) suggests that people from lower socioeconomic status backgrounds are less likely to be able to self-manage their lung condition, and this has been further exacerbated by the cost of living crisis in the UK. A 2022 [survey by Asthma and Lung UK](https://www.asthmaandlung.org.uk/sites/default/files/2023-03/delayed-diagnosis-unequal-care.pdf) concluded that a decline in care quality following the COVID-19 pandemic has particularly impacted self-management for people with COPD who are poorer.

This indicator is complementary to the universal indicator for COPD reviews (NM170) and supports targeted quality improvement for people with COPD who are at higher risk of hospital admission.

1. Have any population groups, treatments or settings been excluded from coverage by the indicator? Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

The indicator does not include people with COPD who are not at high risk of hospital admission. These people are, however, included in the universal indicator for COPD reviews (NM170).

Given that the focus of this additional indicator is on reducing health inequalities, this exclusion is justified.

1. Does the indicator 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?

This indicator does not make it more difficult for specific groups to access services providing it is used in addition to the universal indicator for COPD reviews (NM170).

1. Is there potential for the indicator to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No.

Completed by lead technical analyst: Melanie Carr

Date: 06.02.24

Approved by NICE quality assurance lead: Craig Grime

Date: 23.02.24

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# IND2023-156 Pregnancy and neonates: 6-week postnatal check

# IND2023-160 Pregnancy and neonates: 6-week postnatal check (complex social factors)

1. Have any potential equality issues been identified during the development process?

Complex social factors or social situations may impact adversely on the outcomes of pregnancy for woman and their babies.

1. Have any population groups, treatments or settings been excluded from coverage by the indicator? Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

Indicator 2033-160 focuses on women with complex social factors who gave birth in the preceding 12 months. This is defined, as per the Maternity Services data set and NICE’s guideline on [pregnancy and complex social factors](https://www.nice.org.uk/Guidance/CG110), NICE guideline CG110, as:

• women who misuse substances

• recent migrants, asylum seekers or refugees, or women who have difficulty reading or speaking English

• young women aged under 20

• women who experience domestic abuse.

All women who gave birth in the preceding 12 months are covered under IND2023-156.

1. Does the indicator 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?

No.

1. Is there potential for the indicator to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No.

Completed by lead technical analyst: Eileen Taylor

Date: 02.02.24

Approved by NICE quality assurance lead: Craig Grime

Date: 23.02.24

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# IND2023-161 Smoking: cessation success in people with bipolar, schizophrenia and other psychoses

1. Have any potential equality issues been identified during the development process?

People with a long-term mental health condition are more likely to smoke than the rest of the population and smoking prevalence increases with severity of condition. [Local Tobacco Control Profiles](https://fingertips.phe.org.uk/profile/tobacco-control) from the Office for Health Improvement and Disparities show that 13% of the adults in the general population or current smokers, but prevalence is 25% in adults with long term mental health condition (2021/22 data).

1. Have any population groups, treatments or settings been excluded from coverage by the indicator? Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

No.

1. Does the indicator 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?

No.

1. Is there potential for the indicator to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No.

Completed by lead technical analyst: Eileen Taylor
Date: 02.02.24

Approved by NICE quality assurance lead: Craig Grime
Date: 23.02.24

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