Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Community Anticoagulation Service

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

NHS Birmingham CrossCity Clinical Commissioning Group
NHS Birmingham South Central Clinical Commissioning Group
NHS Solihull Clinical Commissioning Group

1. Background

EA Title	Community Anticoagulation Service		
EA Author	Nilima Rahman-Lais	**Team**	Anticoagulation service working group
Date Started	23/01/18	**Date Completed**	05/02/18
EA Version	V0.4	**Reviewed by E&D**	5th Feb 2018

What are the intended outcomes of this work? Include outline of objectives and function aims

Anticoagulants are treatments prescribed to people who are at risk of blood clots which can potentially be fatal. Anticoagulants can be prescribed to people with a range of conditions which might cause harmful clots to form. For some people, short term anticoagulation therapy will be required, for example, after a DVT. For others, however, anticoagulation therapy can be used to manage a long-term condition or the longer-term consequences of a previous cardiac event' (Anticoagulation Europe, UK, 2013).

Oral treatment is either Warfarin or the newer Direct Oral Anticoagulation (DOAC) both of which have different frequencies of administration and associated costs ie traditional Warfarin requires regular patient reviews and blood tests whereas DOAC patients usually require patients to be seen less frequently. Warfarin is cheaper than a DOAC on a cost per dose basis.

The Anticoagulation Self-Monitoring Alliance estimate that around 1.2 million people are on Warfarin therapy annually. NHS England estimate that that there could be as much as 18% of patients who are undiagnosed and need anticoagulation support.

The data shows that there are currently 14,000 patients receiving anticoagulation therapy from across the BSOL which equates to 1.1% of the total BSoL population.

Anticoagulation services have been in place across Birmingham and Solihull for many years

Birmingham Cross City CCG uses the Any Qualified Provider (AQP) model and have 12 providers in total.

Birmingham South Central CCG also use an AQP arrangement and have 9 providers in total.

Solihull CCG opted for a LIS arrangement. The service is provided by the GPs within a practice setting. Each GP takes responsibility for their own listed patients who require anticoagulation therapy.

In July 2017, a 12-month extension was agreed with all the AQP providers to allow the CCG's time to undertake an evaluation on the services. This would provide

suggestions on what form anticoagulation services could take over the next 3 years. As the CCGs are merging from three to one it would also aid in standardising any relevant service areas e.g. governance and data flows. The Solihull Lis will continue to March 2019.

Aim

The proposed model is re-designed to ensure services are provided from a range of locations that are easily accessible to local people, thereby reducing inequalities in access to anticoagulation therapy.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

This service will provide anticoagulation provision to patients across BSOL

Service users/patients – patients requiring anticoagulation services. Service provision in Solihull was via a LIS and therefore, there is a potential for patients in Solihull to have a change in service provision.

All staff involved in anticoagulation services

Partner organisations- GP services, community services, secondary care services other providers of anticoagulation services

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
Commissioning effective anticoagulation services, a resource pack for commissioners September 2016	Birmingham and Solihull CCGs Anticoagulation Working Group	Dr Damian Williams, General Practitioner
Patient Profile Information		Discussions with the Manager for Equality and Diversity
JSNA Birmingham		Nilima Rahman-Lais, Fiona O'Keefe, Romesh Rana – Medicines Management
JSNA Solihull		

Keeling, D.M. et al. (2011). Guidelines on oral anticoagulation with warfarin – fourth edition		
National Institute for Health and Clinical Excellence. (NICE Clinical Guideline CG180). (2014, June). Atrial Fibrillation – the management of atrial fibrillation.		
Cardiovascular Disease Outcomes Strategy Improving outcomes for people with or at risk of cardiovascular disease (2013). Department of Health, London		
NHS England (2013). Everyone counts: Planning for patients 2014/15 to 2018/19.		
Anticoagulation Services Survey Report (2013). Central Midlands CSU.		
NHS Midlands & East (2012). Stroke Services Specification (http://www.angliacn.nhs.uk/nhs-midlands-and-east-stroke-services-review/) .		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

Anticoagulation may be required by all age groups; however, it is more likely to be needed in the elderly. Elderly patients may find it difficult to travel to a clinic/ facility for treatment and may have to rely on family members or **carers** to take them.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

According to Diabetes UK “Heart attacks and strokes are a leading cause of death and ill health among people with diabetes. The formation of clots that reduce blood flow in

3. Impact and Evidence:

vessels supplying the heart and the brain are key to these problems. Blood clots are made of protein fibres that stick together to form a mesh, which traps blood cells and makes blood vessels narrower. Studies show that people with diabetes tend to have clots that are harder to break down and this may be why they are more likely to have a heart attack or stroke" https://www.diabetes.org.uk/research/our-research-projects/northern-and-yorkshire/breaking-down-blood-clots

Anticoagulation is required in a number conditions e.g. AF, DVT etc.

According to NHS Choices (https://www.nhs.uk/conditions/blood-clots/) there is an increased risk of blood clots if you are staying in or recently left hospital – especially if you can't move around much (like after an operation).

Patients with mobility issues, impairments, or learning difficulties may experience barriers to travelling to clinic / facility, accessing facilities, and accessing information / education about their condition in an appropriate format.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

Hormone therapy can carry a risk of blood clotting – this is an issue that will be explored with each individual by their health care provider. Gender reassignment is not undertaken through primary care providers.

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:

No specific impact has been identified in relation to marriage and civil partnerships.

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

DVT occurring during pregnancy are exempt from this service, and are responsibility of secondary care. Service are in place to meet such needs.

Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

According to Diabetes UK - https://www.diabetes.co.uk/diabetes-and-ethnicity.html -

Global studies on ethnic groups and minorities and the rising incidence of diabetes

3. Impact and Evidence:

have revealed one factor in particular; ethnicity can increase or decrease one's risk of developing diabetes.

Whilst in some cases this can be explained by access to healthcare and other socio-economic factors, studies have proved that even with equal access prevalence of diabetes differs between people of different ethnicity.

Ethnicity facts

Type 2 diabetes is up to 6 times more likely in people of South Asian descent

Type 2 diabetes is up to three times more likely in African and Africa-Caribbean people

https://www.diabetes.co.uk/conditions/deep-vein-thrombosis.html - extract from website:

Deep vein thrombosis is the name for blood clots that develop in larger veins such as in the legs.

Thrombosis means blood clot and deep veins are those that lie within the muscle and not visible through the skin. Deep vein thrombosis affects about 1 in 1,000 people each year.

People with diabetes may have an increased risk of DVT, particularly those that have needed surgery or have other inflammatory conditions such as rheumatoid arthritis.

Languages

The 2011 Census recorded English as the main language for 84.7% of usual residents aged three and over in Birmingham. Of the remaining 15.3% (156,553) who classified themselves with a different language, 30% (47,005) were 'non-proficient' (cannot speak English or cannot speak English well); this is twice the regional and national averages. Where English was not the main language the most commonly spoken were Southern Asian languages, with Urdu the highest accounting for 2.9%.

There are 1,150 households (1.3%) in Solihull where no people in the household have English as their main language, proportionally this is much lower than the England (4.4%) or West Midlands (3.7%) averages. A further 2,057 (2.5%) households have at least some people in the household who do not have English as their main language, again much lower than England (5.1%) or the West Midlands (4.8%).

Patients with English language needs may experience barriers to accessing information / education about their condition appropriately.

3. Impact and Evidence:

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

No specific impact has been identified in relation to religion or belief.

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

According to NHS Choices you may be at increased risk of blood clots if you are using combined hormonal contraception such as the combined pill, contraceptive patch or vaginal ring.

No specific negative impact has been identified in relation to sex and the provision of this service.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

According to NHS Choices (https://www.nhs.uk/conditions/deep-vein-thrombosis-dvt/causes/) “Your risk of getting DVT is also increased if you or a close relative have previously had DVT and:

- you're overweight or obese
- you smoke

According to ASH (http://ash.org.uk/home/):

Data from the Integrated Household Survey shows that lesbian and gay people are much more likely to smoke than the general population.
Whilst there is a lack of research on smoking among bisexual and trans people, surveys do show both bisexual and trans people are more likely to smoke (Stonewall, 2012; Rooney, 2012).
Young LGB people are also more likely to smoke, to start smoking at a younger age and smoke more heavily (Corliss et al, 2013).

HIV: Men who have sex with men (MSM) are most at risk of acquiring HIV in the UK (PHE, 2014). As many as 47% of HIV positive men smoke. (Hickson et al, 2005).

However, smoking is not a risk considered in the CHA_2DS_2-VASc score to assess the clinical risk for patients with AF for starting anticoagulation therapy. (NICE clinical guideline CG180)

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

Changes to the location of service provision may result in carer’s needing to travel further to enable the patient to attend clinics.

3. Impact and Evidence:

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

All patients have the right to receive services that are fair and equitable in access and outcome, and to have opportunities to be involved in choices about their care and the services they receive.

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	Possibly	See below
Is there any impact for groups or communities living in particular geographical areas?	Y	The current service in Solihull is provided to patients on GP practice premises. Potentially this may not be possible with the new model.
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	Y	the cost of travelling to a clinic / facility regularly may be prohibitively expensive for some people.

How will you ensure the proposals reduce health inequalities?

The JSNAs for Birmingham and Solihull highlight the importance of Clinical Commissioning Groups (CCGs) and GPs to ensure that patients with long term conditions such are identified and appropriately managed in primary care to reduce the risk of CKD and CVD.

The CCG is therefore seeking to ensure an equitable service for anticoagulation for patients who require this, is provided throughout the CCG area. Service providers will need to demonstrate through the procurement process that they can provide a locally, accessible service.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Proposals for the new care pathway are that they be located close to where patients live and accessible to all aged over 16 years. There are also proposals for domiciliary visits to be made available for those with disabilities, or with highly restrictive mobility rendering them unable to use a taxi for travel. These measures will help to ensure that services are free from barriers to access. Patients within the service will receive education and information about their treatment, and to access this in a range of ways, and this will be accessible to groups with English language needs, and in other accessible formats. This will be more relevant to providers located within a diverse community / area.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	Service will respect private and family life and also improve access to information to support informed decision making.
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	staff delivering the services are equipped with the appropriate skills and competencies to meet the cultural and communication needs for people for whom English is not a first language, including BSL users, or people who have cognitive

		and/or behavioural disabilities. Providers are able to demonstrate an understanding of the diversity of their local area, within which services will be delivered. There is a need to ensure patient satisfaction and involvement activities are inclusive and accessible; e.g. the recommended Patient Survey is accessible in alternative formats and languages, and service reviews involve patients from a range of backgrounds. There is a need to ensure participation in services are monitored by equality groups (Age, gender, disability, ethnicity) to ensure fair access and outcome for patients.
	How will this affect a person's right to freedom of thought, conscience and religion?	Patients within the service will receive education and information about their treatment, and to access this in a range of ways, in order to support concordant clinical decision making
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	Patients within the service to be treated with dignity and respect, are fully informed about their care, and are able to make decisions about their care.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	Patients within the service will receive education and information about their treatment, and to access this in a range of ways, in

		order to support concordant clinical decision making. All care plans will be developed with patient/ carer input and reviewed annually or sooner if required.
Right to **Life**	Will or could it affect someone's right to life? How?	This service reduces the patients risk of stroke and therefore contributes to living a longer healthier life.
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	N/A

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	The model will enable patients to choose their clinic thereby allowing them to control this element of their care. The service will promote improved health and therefore enable the patients to live healthier lives.
Create fair employment and good work for all	The current model in Solihull is restricted to GP provision. The new model will enable outside providers as well as GPs to provide this service
Create and develop health and sustainable places and communities	
Strengthen the role and impact of ill-health prevention	This service supports patients to prevent their risk of stroke and other events for which they are at risk.

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	**Protected Characteristic/ Group/ Community**	**Date**
None	None	N/A

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

There have been no engagement activities with protected groups or communities at this stage.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

This change of service provision is being undertaken without any patient engagement which could result in unintended and unexplored impacts on service users. This poses a risk to the success of its implementation.

It is anticipated that the service redesign will advance access and inclusion for protected / disadvantaged groups, with the following being embedded within the service specification:

•Aims of the service: The service will have equitable access, ensuring that patients are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals. Providers will demonstrate an understanding of their local demographic population ensuring services are responsive to a diversity of need.

•Location of Service: All premises should be easily accessible, with good transport links and fit for purpose, and comply with the Equality Act 2010.

•Accessibility: The provider must accept referrals for all patients within the CCG cohort regardless of socio-economic circumstance, house bound status, or other protected characteristic. The provider must contribute to reducing health inequalities through offering an inclusive and accessible service to vulnerable and easily looked over groups. The provider must ensure all patients are given every opportunity to fully engage with the service. The provider must provide appropriate access at variable times for all patients.

•Patient Satisfaction: Providers will ensure that the patient questionnaire is accessible to all patients. E.g. to include patient's whose first language is not English, patients with disabilities, and patients who require help to complete their questionnaire.

•Patient Satisfaction: Regular patient involvement from a diverse group of patients will be expected in the review and development of the service and the results of the providers response to patient's comments are to be fed back annually to the CCG, unless requested by the CCG more frequently.

•Education and Information: All patients will receive education and information about their treatment and management in accordance with written procedures and clinical protocols, in order to make decisions about their care in partnership with healthcare professionals. Education and information will be accessible through the provision of alternative formats and interpretation provision.

•Informing patients and carers: All staff are sensitive to the cultural, ethnic, and communication needs of people for whom English is not a first language, including BSL users or people with cognitive or behavioural problems or disabilities.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

It is recommended that engagement is undertaken with affected patients to fully understand the impact that this service redesign will have, after which the equality analysis should be updated.

The service specification should include:
Domiciliary visits will be available to patients who meet the definition as laid out by the CCG. This will ensure access for people with disabilities and those with very restricted mobility.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

It is recommended that a number of considerations will need to be built into the service specification to ensure the service meets and addresses the needs of protected and vulnerable groups:

1. Ensure any decisions about locating services consider the needs of the local communities, offer good transport links, and are accessible venues. Ensure any impacts on disabled patients resulting from re-location of services are identified and managed and reasonable adjustments made. This may include longer travel times to services.
2. Ensure carers are involved and engaged in decisions impacting service users.
3. Ensure all service providers can demonstrate they are able to comply with the requirements of the NHS Accessible Information Standard, ensuring accessible information and communication support for patients, service users, carers, and parents with a disability, impairment or sensory loss.
4. Ensure all service providers deliver services in a manner that is sensitive to religious and cultural needs, where language and interpretation needs are met.
5. Ensure all service providers are able to deliver services which meet the language needs of patients.
6. Service providers will be required to monitor and report on the participation in services by protected characteristics (age, race, disability, gender and sex).

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

Equality and Diversity

The Provider must have policies and procedures in place to enable delivery of services which meet the NHS Service Conditions of:

- SC12 – Communication with and involving Service Users, Public and Staff
- SC13 – Equity of access, equality and non-discrimination
- SC14 – Pastoral, Spiritual and Cultural Care

Specifically, the Provider will ensure that they:

- Comply with the Accessible Information Standard
- Involve Service Users (and where appropriate their Carers and Legal Guardians), Staff, GPs and the public when considering and implementing developments to and redesign of Services.
- Provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments).
- Are accessible to people with a disability, including accessing and moving around the facilities and meeting communication and information needs.
- In performing its obligations under this Contract comply with the obligations contained in section 149 of the Equality Act 2010, the Equality Act 2010 (Specific Duties) regulations and section 6 of the Human Rights Act.
- Take account of the spiritual, religious, pastoral and cultural needs of Service Users

Need to conduct local engagement on the service design, with service users and carers to ensure that their needs are being identified and met through the plan. Equality Analysis will require updating following consultation.

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages.

The completed equality analysis will be published on the Bsol web-pages.

13. Sign Off		
The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee		
	Name	**Date**
Quality Assured By:	*Michelle Dunne*	5th Feb 2018
Which Committee will be considering the findings and signing off the EA?	Clinical Policy Group	
Minute number (to be inserted following presentation to committee)		