NHS
Birmingham CrossCity
Clinical Commissioning Group

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Harmonised Treatment Policies

NHS Birmingham CrossCity Clinical Commissioning Group
NHS Birmingham South Central Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Solihull Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Wolverhampton Clinical Commissioning Group

Equality Analysis Pro-forma

1. Background

Title	Further amendments required in light of NHSE EBI Policy 2018 publication **Harmonised Treatment Policies**		
EA Author	Balvinder Everitt – Senior Manager Equality & Diversity / Michelle Dunne – Senior Manager Quality and Assurance	**Directorate**	Quality
Date Started	28th November 2018	**Date Completed**	1st April 2019.
EA Version	V.02	**Reviewed by E&D**	Michelle Dunne – Senior Manager Quality and Assurance

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

Following the publication of NHSE's Evidence-Based Interventions Policy 28th November 2018, Birmingham and Solihull CCG have taken the time to review the proposed policies in line with the relevant Birmingham and Solihull CCG Harmonised Clinical Treatment Policies.

The following Birmingham and Solihull current policies have identified as requiring amendment which will come into effect from 1st April 2019:

1. **18. Removal of Benign (non-cancerous) or Congenital Skin Lesions**

   Amendments made:

   - The word 'cyst' has been removed from the BSol CCG policy
   - The definition of persistently infected has been brought in line with NHSE's definition which is as follows: requiring at least 2 courses of antibiotics (oral or intravenous) per year.

2. **Policy for Eyelid Surgery (Upper and Lower)**

   Amendments made:

   - Criteria for surgical treatment of chalazion has been widened in line with NHSE to include: If the chalazion Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy

3. **Policy for Hysterectomy for Heavy Menstrual Bleeding**

   Amendments made:

   - NG 44 has been replaced by NG 88 and the policy has been updated to reflect this.

4. **Policy for Ganglion**

   Amendments made:

   - NHSE EBI 17 criteria only relates to ganglia of the wrist.
   - BSol CCG policy has been revised to include the provision that if clinically safe to undertake, aspiration of the wrist ganglion should have been tried and failed prior to surgical intervention.

Following this NHSE EBI 17 review it has been determined by Birmingham & Solihull CCG that the minor changes listed above will have no material impact on equality with regard to the policy amendments.

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The policy describes the access and exclusion criteria which the listed CCG's have agreed to apply to the Harmonised Treatment Policies.

The main objective for having treatment policies is to ensure that:

- Patients receive appropriate health treatments in the right place and at the right time;
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted

Commissioning decisions are made in accordance with a set of commissioning principles, and the Birmingham, Black Country and Solihull CCG's Individual Funding Request Policy.

The Equality Analysis has been completed on the policy document on behalf of the listed and participating CCGs.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.
Patients will be impacted by the policy, and staff will be responsible for implementing the policy.

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
Harmonised Treatment Policies	Policy Harmonisation Working Group (with representation across the CCGs)	A range of appropriate clinical experts have advised on the relevant policies.
Individual EA's completed on each policy in 2014		
Individual Funding Request Policy		
Census 2011		
NICE guidelines		

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.

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3. Impact and Evidence:

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

Birmingham's population in 2011 was 1,073,045 million. It is a young population with 66% being under 44 years old. The 20-29 age group represents around 19% of the total population. People aged over 65 represents about 13% of the population. Conversely, Solihull has a more ageing population with 21% of the population above 65 years. Wolverhampton has a larger working age population, with projected growth in populations over 65 years, and between 0-15 years. Sandwell has a youthful population with 21% of its residents age 0 to 15 years and 62% under the age of 45 years. Walsall's population structure has become increasingly 'dependent' since 2001, with an above average proportion of the resident population made up of children and older people, and a correspondingly lower proportion of working age people. Walsall has an over-representation again of people in the older age groups, aged 65 and above. At around age 85 national levels are higher once again, possibly as a result of life expectancy in Walsall being lower than it is nationally.

The policy applies to adults and children alike. Some treatments maybe more applicable to either children on adults and therefore exceptions have been built into certain treatment policies which are justifiable on the grounds of clinical appropriateness. E.g. Policy for Grommets. There is no evidence for adverse impacts on the grounds of age.

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:

Disability in the United Kingdom 2013 Facts and Figures – Papworth Trust report**:** Almost 1 in 5 people (19%) in the UK have a disability. Only 17% of disabled people were born with their disabilities. The majority of disabled people acquire their disability later in life.

In Birmingham CrossCity CCG there are 2,738 patients diagnosed as having a Learning Disability on GP registers.

The Cataracts policy sufficiently ensures access to appropriate surgery for people who are experiencing disabling visual symptoms. NICE is currently reviewing its Clinical Guidance for 'Cataracts in adults: management'. NICE is currently planning to issue this guidance in **April 2018**.

Feedback on the Aesthetic policy strongly supports the need to take account of the psychological impact on individuals of living with a physical problem. An example cited by Heart of England Foundation Trust (HEFT) is Pinnaplasty ('Ear Pinning'), which can help schoolchildren avoid serious emotional distress. Another example cited was delaying treatment for varicose veins, which may then result in surgery being needed in the future. The policy makes consideration for the need to make reasonable adjustments for disabled people appropriately, for instance in the Policy

3. Impact and Evidence:

for Cosmetic Surgery. In addition, the IFR process can be applied to consider any such extenuating factors.

There is no evidence for adverse impacts on the grounds of disability.

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

The Policy for Cosmetic Surgery indicates that hair depilation will not be funded. This would not have any known adverse impacts for transgender people, as an alternative care pathway is in place for people undergoing gender re-assignment treatments (which include hair depilation). A national gender identity services review is currently underway which the CCGs will respond appropriately to. There is no evidence of adverse impacts on the grounds of gender reassignment.

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:

There are no known impacts for marriage and civil partnership.

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

There are some policies that will more likely affect women who have been pregnant. The Policy for Cosmetic Surgery Abdominoplasty will only be funded where there is deemed to be exceptional clinical need through the IFR process.

There are no known adverse impacts for pregnancy and maternity.

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

Birmingham has a BME profile of around 42%. Solihull has a BME profile of around 11%. Wolverhampton has a BME profile of 35%. Sandwell has a BME profile of around 30%. Walsall has a BME profile of 23%.

The policy will be applied fairly and consistently. There are no known impacts for race / ethnicity.

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

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3. Impact and Evidence:

The 2011 Census: religion and belief:

- Just over 46% of the people of Birmingham are Christian
- Birmingham's second largest religion is Islam (21.8%)
- 65% of Solihull residents categorise themselves as Christian, with the second largest group of 21% having no religion.
- Wolverhampton now has the 2nd highest percentage of Sikh residents in England. Sikh residents account for 9% of the city's population (England = 0.8%). Christian residents continue to account for the majority of the population at 56%, however, this group has seen an 11% decrease since 2001. Those residents who stated that they had no religious affiliation increased by almost 9% to 20%. This trend mirrors the national picture.
- 59% of Walsall's residents identify as Christian, followed by 20% with no religion, and 8% Muslim.

Male Circumcision Policy - the treatment will only be funded for medical reasons, not religious reasons.

The Policy for Male Circumcision will impact people practicing male circumcision for religious purposes. For religious circumcision each individual CCG will apply its own policy. There is a potential that this could lead to variation in access to this service (make circumcision for religious purposes) across the geographical footprint.

It is recommended that each CCG develop and agree a common approach to male circumcision for religious purposes, (this may include good quality referral information for people wanting to access such a service, raising awareness of quality issues, raising awareness of NICE guidelines).

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

Some aspects of the policy may impact on men and women in different ways. Decisions about access to treatment are based on clinical needs, which can sometimes be differentiated by the biological sex of the individual. There is no evidence of sex discrimination.

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:

'Out and About' Mapping LGBT Lives in Birmingham – September 2011 by Birmingham LGBT (Community Trust) highlights that LGB people have worse health outcomes. Accurate statistics on LBG people are limited.

There are no known impacts of this policy for sexual orientation.

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

3. Impact and Evidence:

There are no known impacts for carers.

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)

- Over 50% of Birmingham residents live in poverty.
- Solihull is one of the least deprived areas within the region, ranking 65th most deprived nationally, though is polarised with some areas ranking within the 10% most deprived.
- Wolverhampton has the second equal highest level of child poverty in the West Midlands, behind Birmingham, and was the only place in the region where child poverty increased between 2007 and 2008.
- Sandwell was ranked the 12th most deprived local authority in 2010.
- Walsall ranks 39 in the Index of Deprivation with 20% of its neighbourhoods in the 10% most deprived areas.

The policy will be applied fairly and consistently. There are no known impacts for any specific disadvantaged groups.

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	The creation of a harmonised set of policies across the Birmingham and Solihull footprint will help to reduce health inequalities an ensure that everyone receives the same level of fair access to treatments irrespective of where they live.
Is there any impact for groups or communities living in particular geographical areas?	Yes	People practicing their faith or religious belief may congregate in specific places or geographical communities, where there is access to religious facilities and communities. The absence of a common policy approach towards

		male circumcision for religious purposes across the Birmingham and Solihull footprint could lead to inequalities in accessing this medical procedure and also the quality of the procedure depending on which CCG a patient is located to.
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaced?	No	
How will you ensure the proposals reduce health inequalities? It is recommended that the CCGs agree a common approach to developing a Male Circumcision Policy for Religious Purposes to inform relevant faith communities of how to access information about the procedure, referral information to approved providers, and quality assurance including information on NICE guidelines.		

5. Human Rights	**Yes/No**	**Evidence**
Could this result in a person being treated in an inhuman or degrading way?	No	
Will the person's right to respect for private and family life be interfered with?	No	
Will someone be deprived of their liberty?	No	
Does this respect a person's right to a fair trial?	Yes	
Will it affect a person's right to life?	No	
Will this affect a person's right not to be discriminated against?	No	
Will this affect a person's right to freedom of thought, conscience and religion?	No	
How will you ensure the proposals enhance human rights? The CCG's will work towards the NHS human rights principles of Fairness, Respect, Equality, Dignity, and Autonomy. These principles apply across the work of the CCG's and NHS organisations.		

6. Social Value

What additional benefit could be elicited from the specification or procurement to the benefit of the community, including any economic, social, and environmental benefits?

	Yes/No	Evidence
Does this promote training and employment opportunities for under-represented groups, for example for youth employment, women's employment, long-term unemployed, people with physical or learning disabilities	No	
Does this promote fair and ethical trading	No	
Will this stimulate social integration	No	
Will this contribute to climate change mitigation targets and to energy efficiency	No	

How will you ensure the proposals benefit the community, including any economic, social, and environmental benefits?

The policy is not part of procurement so social value considerations will not apply.

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
Birmingham and Solihull Health and Social Care Overview and Scrutiny Committees (HSCOSC)	Disabled people (Blind) Mixed groups Age	The formal engagement period ran from **1 February** until **14 March 2016**.
Joint Health and Social Care Overview and Scrutiny Committee		

Each CCG used its existing stakeholder database to ensure information, including briefing documents and leaflets, were pro-actively disseminated. This included:

- 79 local third sector voluntary and community organisations, including Birmingham and Solihull Healthwatch, Birmingham Voluntary Service Council (BVSC) and Birmingham LGBT;
- 136 local councillors and 12 Members of Parliament (MPs);
- Letters, meetings and briefing for both Birmingham and Solihull Health and Social Care Overview and Scrutiny Committees (HOSCs); and
- A range of patients, support groups, CCG public and patient panels and networks.

The CCGs also took the opportunity to ensure that bespoke, targeted, engagement took place to ensure that key groups of stakeholders had the opportunity to be involved in

aspects of the PLCV consultation which were specific to them. For example the Royal National Institute for Blind People (RNIB) were contacted directly regarding proposed changes to cataract procedures. BID Services (a charity which provides services to deaf and hard of hearing people in the West Midlands) were also contacted by email and telephone to highlight the consultation to their community. Birmingham CrossCity CCG also offered to help support patients with a hearing impairment to attend the PLCV public events.

Furthermore, emails were sent to the West Midlands Academic Health Science Network (WMAHSN), Age UK, RNIB, the Birmingham Voluntary Services Council (BVSC) and Healthwatch Birmingham to publicise the consultation via their own newsletters, e-bulletins, social media and respective websites.

Demographics

- Of those responding, **67** were between the ages of 35 and 74. The majority of respondents were found in the in the 55 – 64 age group (**22**) and 45-54 age group (**21**);

- **50** identified themselves as female with **23** identifying themselves as male. There were no Trans or Intersex respondents;

- **59** stated they were 'heterosexual', **4** as 'gay or lesbian', **2** as 'bisexual' and a **single** respondent stated 'other';

- **58** describe themselves as 'English, Welsh, Scottish, Northern irish or British'. **5** describe themselves as 'Caribbean' and **3** as 'Indian'. Of the remaining respondents, there was a **single** respondent from a 'Gypsy & Irish Traveller', 'Irish', 'Mixed/Multiple ethnic' and 'Any other ethnic' backgrounds;

- **45** respondents identified themselves as Christian. Others stated they were Atheist (**6**) Hindu or Agnostic (**2** each) or Muslim (**1**). **7**identified themselves as following a religion not offered as an option in the survey, with **10** respondentspreferring not to say if they followed a religion or faith;

- **49** respondents came from Birmingham and **12** from Solihull;

- When asked if their day to day activities were limited by a health problem or disability, the majority of respondents (**52**) responded 'No', with **3** preferring not to say. Of those who were affected, **4** felt their activities were limited 'a lot' with a further **14** feeling they were limited 'a little'.

Providers and Clinical Engagement

Each CCG providing a briefing to its GP members through their established channels, for example membership newsletters, network meetings, GP training events and intranet 'members' areas'. The details of individual policies were shared with Primary Care Clinicians and examples of the policies were shared with local branches of Birmingham LMC.

Those providers involved in the provision of the treatments impacted by the proposed changes to policies were directly contacted by their co-ordinating commissioner CCG during spring 2015, and asked for feedback on the proposed changes. Clinical Responses were received from:

- University Hospitals Birmingham NHS FT
- Heart of England NHS FT
- Birmingham Children's Hospital NHS FT

- Royal Orthopaedic Hospital NHS FT
- Birmingham Women's Hospital NHS FT
- Birmingham Community Healthcare NHS FT
- Royal National Institute for the Blind
- NHS England West Midlands Local Eye Network

In April 2016, after the end of the public engagement timetable, we also received feedback from:

- Royal College of Surgeons
- Chartered Society of Physiotherapists

Online Survey

The core channel for feedback was an online survey. This was chosen as the preferred method, as it enabled feedback to be received in a consistent manner against a standard set of questions for each policy. In total there were **75** responses to the survey.

Events

There were **two** public meetings events and a further **127** contacts between the engagement team, the general public and stakeholder organisations. There was also significant media marketing including social media.

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 …..):

Key feedback from pre-engagement events:

- The need for a more simplified patient questionnaire;
- Production of a glossary of terms, to help people understand clinical terminology used in the policies;
- Ensure terms and definitions are used consistently, i.e. Botox or Botulism toxin;
- Production and availability of a document detailing the changes to the criteria for each policy for each CCG; and
- The need for information to be clear and easy to read, using plain English, with minimal jargon. It was suggested a user-friendly patient leaflet for each Policy should be produced which could be printed off for patients.

Conclusion and key findings

Respondents indicated there was significant support for the six objectives underpinning the review of the 21 PLCV policies:

1. To ensure that procedures and treatments are offered consistently and fairly to patients;
2. To end the 'postcode lottery; which currently exists, by having the same eligibility criteria for treatments;
3. To ensure that policies meet the latest national clinical guidance and are supported by robust clinical evidence;
4. To stop using treatments that do not have any benefits for patients, or have a very limited evidence base;
5. To prioritise treatments which provide the greatest benefits to patients; and
6. To stop offering cosmetic treatments e.g. Botox injections, liposuction, face lift, repairs of ear lobes and thigh lift.

However, there was mixed support from the public survey for the individual policies under review. Of the 21 policies produced for consideration, **eleven** produced neutral results from the survey, with no significant levels of support or disagreement. For **seven** policies

the largest proportion of survey respondents disagreed or strongly disagreed with the proposed policies; only **three** policies saw significant support from survey respondents. It is important to note that the assessment of policies felt to be procedures of limited clinical value is an ongoing, iterative, process. For this reason all policies will be continuously reviewed to ensure they are both up to date and fit for purpose.

8. Summary of Analysis

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

CCG's operate within finite budgetary constraints thereby necessitating CCG's to prioritise resources and provide interventions with the greatest proven health gain. The intention of the policy is to ensure equity and fairness in respect of access to NHS funding for interventions and to ensure that interventions are provided within the context of the needs of the overall population and the evidence of clinical and cost effectiveness.

The policy refers to the Individual Funding Request Policy where by exceptional factors can be considered in an individual request for funding for treatment. This helps to ensure that where individuals are unable to comply with a criteria for inclusion for treatment because of a protected characteristic or are impacted negatively in other ways by the lack of a treatment, the IFR process can be applied to address this, thereby preventing the potential for blanket ban and restrictions which can lead to unintended discrimination.

In sum, the analysis reveals there are variations in potential impact for individuals due to a protected characteristic including age, sex, pregnancy and maternity, disability, and religion and belief or no belief. However there are clinical justifications for the criteria, and processes in place to make the appropriate adjustments and prevent any unfair discrimination or disadvantage from occurring. Health inequalities could be created in the absence of a common approach to addressing requests for male circumcision for religious purposes – as currently each CCG adopts its own approach. Overall, health inequalities are likely to reduce or be minimised due to the shared and common approach and application of the Harmonised Treatment Policies.

The results of the consultation and engagement indicates support for the principles and objectives of the 21 PLCV. Equality concerns highlighted during the consultation can be addressed through the IFR procedure.

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.

1. It is recommended that the CCGs agree a common approach to developing a Male Circumcision Policy for Religious Purposes to inform relevant faith communities of how to access information about the procedure, referral information to approved providers, and quality assurance including information on NICE guidelines.

2. It is recommended that the IFR Policy is assessed for its impact on equalities at its next review.

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:

It is expected that the participation in the treatments stipulated within the Policy will be fairly low, and introducing an equality monitoring process will be too resource intensive for the small numbers involved.

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):

N/A

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 Policy will be published on the respective CCG's web sites.

The Equality Analysis will be shared with the Harmonisation Policy Working Group.

13. Sign Off

The Equality Analysis will need to go through a process of quality assurance and sign-off from the Manager for Equality and Diversity or Manager for Assurance and Compliance:

	Manager for Equality and Diversity/ Manager for Assurance and Compliance	Date
Quality Assured By		

Equality Analysis Pro-forma

Signed Off By	Bal K Everitt	11 August 2016
Will the EA be considered by Committee / Governing Body / SMT	Revised Changes Approved at Clinical Policies Sub-Group Committee	03.05.2019

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