NHS
Bedfordshire
Clinical Commissioning Group

Bedfordshire CCG equality impact assessment and health inequality impact assessment (EqIA) template

This template is an adapted version of the NHS England Equality and Health Inequalities template which was published in September 2014 and is the current standard.

If you require training, or a refresher session, on assessing impact and/or how to compete this template this is available from Paul Curry who is our equality and diversity manager. You can contact him on ext. 5944 or paul.curry@bedfordshireccg.nhs.uk

Equality Analysis

Title of policy, service, proposal etc being assessed:
Value Based Elective Commissioning: Gluten-Free prescriptions proposal is to **stop providing gluten-free foods unless there are specific circumstances whereby a dependant patient could be at risk of dietary neglect**.

What are the intended outcomes of this work?

Coeliac disease is a chronic inflammatory autoimmune disease of the digestive system. Symptoms can include bloating, diarrhea, nausea and tiredness. The main treatment for coeliac disease is a lifelong gluten-free diet, which can reduce long term complications such as nutritional deficiencies and osteoporosis.

Under BCCG current policy, people with coeliac disease can obtain a wide range of gluten-free foods provided by the NHS including

- bread/rolls
- bread mixes
- crackers
- pasta
- pizza bases
- breakfast cereals
- oats

This is normally supplied via NHS prescription and products available are included within the Drug Tariff. Bedfordshire CCG commissions the supply of gluten-free foods directly from community pharmacy from a local formulary.

A decision was taken over 30 years ago to include gluten-free foods on prescription when there was limited availability of gluten-free foods to buy. Today the availability of gluten-free foods has increase dramatically and they are found in almost all majort supermarkets.

All CCGs across the East of England have either ceased funding gluten-free foods or put restrictions on the groups to that receive gluten-free foods prescriptions.

The gluten-free food service in Bedfordshire costs £315,000 per annum, including administration fees. Bedfordshire CCG currently provides gluten-free food for approximately 500 patients with coeliac disease.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc. If you believe that there is no likely impact on people explain how you've reached that decision and send the form to the equality and diversity manager for agreement and sign off

This will affect any individuals who would currently receive gluten free prescriptions, as well as the organisations that provide these services.

Evidence

What evidence have you considered? Against each of the protected characteristics categories below list the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic).

This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section on page 9 of this template.

If you are submitting no evidence against a protected characteristic, please explain why.

The evidence base for this EqIA is evidence from the literature and a formal consultation with residents of the BCCG area and key stakeholders.

Age Consider and detail age related evidence. This can include safeguarding, consent and welfare issues.

BCCG does not collect data on the age breakdown for those with coeliac disease in Bedfordshire. In the consultation, nearly all age groups showed more agreeing the proposal than not. The age groups where more disagreed with the proposal were (<18 (n=3) and 75-84 (n=73). The prevalence of coeliac disease has been shown to increase with increasing age (West 2014), which may mean that those receiving prescriptions are more likely to be in the older age groups and who will now have to pay for these foods. This could impact an individual's or income and/or their adherence to a gluten-free diet, with associated health complications.

Disability Detail and consider disability related evidence. This can include attitudinal, physical and social barriers as well as mental health/ learning disabilities.

BCCG does not collect data and has not found data on the disability of those with coeliac disease in Bedfordshire and therefore has not identified adverse impacts or inequalities as a result of this policy. In the consultations, all disability groups had more individuals agreeing with the proposal except those with LTC (43.3% vs 44.3%, n=97) and those with a sight disability who all disagreed with the proposal (n=4)

Gender reassignment (including transgender) Detail and consider evidence on transgender people. This can include issues such as privacy of data and harassment.

BCCG does not collect data and has not found data on the gender assignment of those with coeliac disease in Bedfordshire and therefore has not identified adverse impacts or inequalities as a result of this policy.

Marriage and civil partnership Detail and consider evidence on marriage and civil partnership. This can include working arrangements, part-time working, caring responsibilities.

BCCG does not collect data and has not found data on marriage/civil partnership in those with coeliac disease in Bedfordshire and therefore has not identified adverse impacts or inequalities as a result of this policy.

In the consultation all groups had more individuals agreeing with this policy except those in civil partnerships (n=2, 50%).

Pregnancy and maternity Detail and consider evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities.

BCCG does not collect data and has not found data on maternity/pregnancy in those with coeliac disease in Bedfordshire and therefore has not identified adverse impacts or inequalities as a result of this policy.

In the consultation, all groups had more individuals agreeing with this policy

Race Detail and consider race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers.

BCCG does not collect data on the racial breakdown for those with coeliac disease in Bedfordshire. BCCG has not been able to find national data. No differences were seen responses between most ethnic groups. Only 1/3 of those with Indian origin (8/22) agreed with the proposal. Culture impacts diet and therefore those individuals where the cultural diet includes gluten containing staples such as bread may be more likely to receive prescriptions for gluten-free foods and now have to pay for these foods. This could impact an individual's income and/or their adherence to a gluten-free diet, with associated health complications.

Religion or belief Detail and consider evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.

BCCG does not collect data and has not found data on the religion/beliefs of those with coeliac disease in Bedfordshire and therefore has not identified adverse impacts or inequalities as a result of this policy. In the consultation, all religions/belief groups had more individuals agreeing with the proposal except Judaism (n=2)

Sex Detail and consider evidence on men and women. This could include access to services and employment.

BCCG does not collect data on the gender breakdown for those with coeliac disease in Bedfordshire. There was no difference in responses to the consultation between men and women. Women are twice as likely than men to be diagnosed with celiac disease, which may relate to healthcare utilisation and ascertainment (West 2014). Therefore it may be that more women are receiving gluten-free prescriptions than men and who will now have to pay for these foods. This could impact an individual's and/or income or their adherence to a gluten-free diet, with associated health complications.

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

BCCG does not collect data and has not found data on the sexual orientation of those with coeliac disease in Bedfordshire and therefore has not identified adverse impacts or inequalities as a result of this policy. In the consultation, all groups had more individuals agreeing with the policy except bisexuals (n=16) and gay women (n=3)

Carers Detail and consider evidence on part-time working, shift-patterns, general caring responsibilities.

Carers may find their caring role more stressful as a result of having to find gluten free products for their cared for which would have been provided for them under the exisitng policy.

Other identified groups Detail and consider evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality, income, resident status (migrants, asylum seekers).

BCCG does not collect data on the socioeconomic level of those with coeliac disease in Bedfordshire. Those in the least socially deprived groups are more likely to have a diagnosis of coeliac disease (West 2014, Zingone 2015), and therefore receive a prescription for gluten free food. This is most likely due to health seeking behaviours rather than underlying differences in incidence (West 2014, Zingone 2015) Higher education level is associated with adherence to a gluten-free diet (Villafuerte-Galvez). Therefore there are currently health inequalities as those living in the least deprived areas and best educated are most likely to be diagnosed and treated, as well as being most likely to adhere to a gluten-free diet. Some gluten-free foods (e.g. bread, pasta) are currently more expensive than the budget gluten-containing alternatives, and therefore spending on a gluten-free diet could be increased for individuals. This would have a greater impact on those with low incomes, either decreasing their available income or and/or their adherence to a gluten-free diet, with associated health complications.

Engagement and involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

Yes - An extensive formal consultation was undertaken over a 3 month period. This received 1054 individual responses and formal responses from four organisations.

See Value Based Elective Commissioning (VBEC) – Formal Consultation Report

How have you engaged stakeholders in testing the policy or programme proposals?

Yes, Value Based Elective Commissioning (VBEC) – Formal Consultation Report

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

See Value Based Elective Commissioning (VBEC) – Formal Consultation Report

Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will mitigate any negative impacts? How you will include certain protected groups in services or expand their participation in public life?

Organisations that provided formal responses on this proposal were the British Dietetic Association, the British Specialist Nutrition Association LTD, the Nutrition and Dietetic Department, Bedford Hospital NHS Trust and Bedfordshire Local Pharmaceutical Committee (see Value Based Elective Commissioning (VBEC) – Formal Consultation Report: Appendix). Issues that were highlighted by these organisations included the availability and increased cost of a gluten-free diet, the clinical complications associated with non-adherence to a gluten free diet and the potential impact on low income families and elderly/immobile patients. Many felt that additional support for coeliac patients would be beneficial.

Additional evidence and impact assessment

Bedfordshire CCG do not collect data on the demography and epidemiology of those with coeliac disease. Population screening studies suggest that in the UK 1 in 100 people are affected by coeliac disease (NICE 2015), however most of these will not have a diagnosis. A recent study using the Clinical Practices Research Datalink estimated a 2011 a diagnosed point prevalence of coeliac disease of 0.24% or 1 in every 420 people (West 2014). Applied to the Bedfordshire CCG weighted population that would provide an expected prevalence of 1078 individuals with a diagnosis of coeliac disease. BCCG provides gluten-free foods for approximately 500 individuals.

West (2014) noted that although screening studies report very little variation with age and sex, diagnosed prevalence was higher in females and males and increased with age. It was also noteable that coeliac disease was also more commonly diagnosed in the areas with the least socioeconomic deprivation. The rate of coeliac disease diagnosis has been shown to be 80% higher in children living in the least deprived areas when compared the children in the most deprived areas (Zingone 2015). This may be due to those in deprived areas being less likely to seek medical care (West 2014, Zingone 2015).

No published studies were identified by BCCG on the economic or health impact of removing prescriptions for gluten-free foods for coeliac disease.

Assessing the impact of the proposal identified that women and those in older age groups may be more likely to be diagnosed with coeliac disease (and therefore may be more likely to receive prescriptions for gluten-free food). Specific cultural diets may have a higher reliance on gluten-containing foods such as bread or pasta, and therefore may be more likely to receive prescriptions for gluten-free foods. Groups that receive free prescriptions (e.g. children and the elderly) may be more likely to receive gluten-free foods on prescription.

A recent review (Kurien 2016) highlights the variability of follow-up for those with coeliac disease in the UK and the difficulties of reliably measuring the poor adherence to a gluten-free diet that subsequently leads to poor outcomes. Kurien (2016) identified that work was required to establish the most cost effective way of delivering coeliac disease follow-up care with options including hospital, primary, community pharmacy, dietician or other support.

To mitigate any impact on vulnerable groups as much as possible it is recommended that BCCG:

- Provide prescriptions of gluten-free foods where a dependant patient is at risk of dietary neglect
- Increasing the awareness, dietary support and education for those with coeliac disease through GPs, dieticians, community pharmacies and other mechanisms including suppliers especially in key groups.

For all proposals, it should be noted that individual funding request process is still available for patients who believe that they have exceptional circumstances

Now consider and detail below how the proposals could support the elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation

The equality analysis of these proposals has not identified any current or potential direct or indirect discrimination based on a persons protected characteristic(s) status. Where a non-discriminatory impact has been identified mitigating actions are proposed

Advance equality of opportunity

N/A

Promote good relations between groups

N/A

Next Steps

How will you share the findings of the Equality analysis?

The analysis will be shared as part of the QIPP process and will be discussed with the Executive Management Team, Governing Body and the local authority Overview and Scrutiny Committees. Stakeholders in the formal consultation will also be informed.

Health Inequalities Analysis

Evidence

1. What evidence have you considered to determine what health inequalities exist in relation to your work? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section on the last page of this template.

See Full consultation report and Summary report.

References

Impact

2. What is the potential impact of your work on health inequalities? Can you demonstrate through evidenced based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?

Organisations that provided formal responses on this proposal were the British Dietetic Association, the British Specialist Nutrition Association LTD, the Nutrition and Dietetic Department, Bedford Hospital NHS Trust and Bedfordshire Local Pharmaceutical Committee (see Value Based Elective Commissioning (VBEC) – Formal Consultation Report: Appendix). Issues that were highlighted by these organisations included the availability and increased cost of a gluten-free diet, the clinical complications associated with non-adherence to a gluten free diet and the potential impact on low income families and elderly/immobile patients. Many felt that additional support for coeliac patients would be beneficial.

Additional evidence and impact assessments

Bedfordshire CCG do not collect data on the demography and epidemiology of those with coeliac disease. Population screening studies suggest that in the UK 1 in 100 people are affected by coeliac disease (NICE 2015), however most of these will not have a diagnosis. A recent study using the Clinical Practices Research Datalink estimated a 2011 a diagnosed point prevalence of coeliac disease of 0.24% or 1 in every 420 people (West 2014). Applied to the Bedfordshire CCG weighted population that would provide an expected prevalence of 1078 individuals with a diagnosis of coeliac disease. BCCG provides gluten-free foods for approximately 500 individuals.

West (2014) noted that although screening studies report very little variation with age and sex, diagnosed prevalence was higher in females and males and increased with age. It was also noteable that coeliac disease was also more commonly diagnosed in the areas with the least socioeconomic deprivation. The rate of coeliac disease diagnosis has been shown to be 80% higher in children living in the least deprived areas when compared the children in the most deprived areas (Zingone 2015). This may be due to those in deprived areas being less likely to seek medical care (West 2014, Zingone 2015).

A systematic review of 38 studies (Hall 2009) found adherence is most strongly associated with cognitive, emotional and socio-cultural influences, membership of an advocacy group and regular dietetic follow-up, though evidence was of variable quality. The authors stated that the weight of the available evidence is against a correlation between adherence and either education or socioeconomic status

More recently, US studies using self-reported measures of adherence have identified a mixture of factors correlating with adherences. Shah (2014) found that severity of symptoms and lower perceived importance of treatment and income were associated with poor adherence. Villafuerte-Galvez (2015) found that that education levels, knowledge of the gluten free diet, perceptions of the effectiveness of the diet, perceptions of cost and self-effectiveness correlated with adherence scores. When assessing cost and income, Villafuete-Galvez (2015) report that their patient population was evenly divided on whether cost was considered to be an obstacle to adherence, and those that did consider cost to be a limiting factor had lower rates of adequate adherence. However, there was no difference in median annual household income when comparing those with adequate adherence to those with inadequate adherence, indicating that other factors such as knowledge and perceptions may be playing a key part in adherence.

A recent review (Kurien 2016) highlights the variability of follow-up for those with coeliac disease in the UK and the difficulties of reliably measuring the poor adherence to a gluten-free diet that subsequently leads to poor outcomes. Kurien (2016) identified that work was required to establish the most cost effective way of delivering coeliac disease follow-up care with options including hospital, primary, community pharmacy, dietician or other support.

For those currently receiving prescriptions for gluten-free foods, there will be a cost impact as they will need to purchase these items. The cost impact may be higher if the individual wishes to replace like with like, rather than with naturally gluten-free foods (e.g. rice, potatoes). Gluten-free bread can be more expensive than the same budget gluten-containing items. This would have a greater impact on those with low incomes; either requiring a change in dietary approach or potentially decreasing their available income and/or their adherence to a gluten-free diet. Stakeholders have highlighted concerns that accessing alternative gluten-free food may be more difficult for people on low incomes as smaller shops and budget supermarkets have fewer choices.

However, those in more deprived areas are also less likely to be diagnosed with coeliac and therefore less likely to receive treatment, and therefore are more likely to be experiencing health complications associated with coeliac disease.

3. How can you make sure that your work has the best chance of reducing health inequalities?

To mitigate any impact on vulnerable groups as much as possible by:

- Providing prescriptions of gluten-free foods where a dependant patient is at risk of dietary neglect
- Increasing the awareness, dietary support and education for those with coeliac disease through GPs, dieticians, community pharmacies and other mechanisms including suppliers especially for key groups
- For all proposals, it should be noted that individual funding request process is still available for patients who believe that they have exceptional circumstances

Monitor and Evaluation

1. **How will you monitor and evaluate the effect of your work on health inequalities?**

To monitor the short-term impact of the change in policy by auditing the use of gluten-free prescriptions for patients at risk of dietary neglect

For your records

Name of person(s) who carried out these analyses: Emmeline Watkins/Lianne Bowskill

Date analyses were completed: 09/09/2016

Date passed to equality and diversity manager for sign off: 09/09/2016

Equality and diversity manager's statement:

The purpose of an Equality Impact Assessment (EqIA) is to give decision makers information on the potential impact on each of the relevant protected characteristic groups (as defined by the Equality Act 2010) and those where there may be health inequalities considerations (as required by the Health and Social Care Act 2012).

It is a requirement of the Equality Act that impact is considered as part of the decision making process, alongside other considerations, such as budget, staffing implications etc. This is paying due regard (as required by the Equality Act) to the general equality duty to eliminate discrimination, advance equality of opportunity and foster good relations.

Where there is a potential negative impact there is a requirement to, if possible, remove or reduce that impact.

This report covers three distinct proposals, gluten-free foods, over the counter (OTC) medicines and specialist fertility services, and, quite correctly, the report author has undertaken three separate EqIAs.

For all three EqIAs it is clearly identified that there is limited local and national data on the provision of each service to identified protected characteristic groups. This does make assessing impact more difficult, but it is not useful to speculate on why this may be and it is not practical to retrospectively gather that information for each of the three EqIAs. The report author has used the findings from the comprehensive consultation, which does break its findings down by protected characteristic, to fill some of the information gaps.

In each of the three EqIAs the report author has identified where there may be potential adverse impacts on particular protected characteristics and/or health groups and has proposed actions that to mitigate that impact.

Any assessment of the quality of the EqIA and how it can support decision makers to pay due regard should look at whether the data is sufficiently comprehensive and conclusions reached are logical based on the data available. Given the limited data but using the consultation data available the report author has looked in detail at potential impact and the conclusions reached are logical.

It is, therefore, reasonable to say that the EqIAs provided give decision makers the information needed to consider and meet their due regard Duty.

Consideration of the EqIAs should be an active part of the decision making process and recorded in any minutes of the meeting.

Paul Curry
Equality and Diversity Manager
12 September 2016

References

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Zingone F, West J, Crooks CJ, Fleming KM, Card TR, Ciacci C, Tata LJ. 2015. Socioeconomic variation in the incidence of childhood coeliac disease in the UK. Arch Dis Child. 2015 May; 100(5):466-73. doi: 10.1136/archdischild-2014-307105. Epub 2015 Jan 22.