EQuality Impact Assessment (EQIA) Template

Introduction

The EQIA template has been introduced to bring together equality and quality impact considerations into a single systematic assessment process.

An EQIA should be completed whenever the initial screening process on each scheme in the Financial Recovery Plan indicates that one is required.

The EQIA Panel will oversee the development and quality assurance of EQIAs.

To support understanding and completion of the EQIA process, this document is hyperlinked to a glossary of key terms.

Purpose

The EQIA is designed to:

- Enable details of supporting evidence to be recorded
- Assess the impact of proposed changes in line with the CCGs' duty to reduce health inequalities in access to health services and in health outcomes achieved
- Assess the impact of proposed changes to services in line with the CCGs' duty to maintain and improve the three elements of quality (patient safety, patient experience and clinical effectiveness)
- Assess whether proposed changes could have a positive, negative or neutral impact, depending on people's different protected characteristics defined by the Equality Act 2010
- Identify any unlawful discrimination or negative effect on equality for patients/service users, carers and the general public
- Consider the impacts on people from relevant inclusion health groups (e.g. carers, homeless people, people experiencing economic or social deprivation)
- Identify where any information to inform the assessment is not available, which may indicate that patient engagement is required
- Provide a streamlined process and prevent equality and quality risks from being considered in isolation
- Determine whether a scheme can proceed, proceed with identified action, or not be progressed.

Decisions on whether schemes will be implemented, amended or stopped will be based on a combination of EQIAs, engagement findings and consultation outcomes.

EQIAs are 'live' documents, and as such, are required to be revisited at key stages of scheme development and implementation, particularly following the conclusion of any engagement and consultation activities to inform decision-making.

Scheme title: Restriction of, or stopping Gluten Free Prescribing in Greater Nottingham
Assessor name: Cheryl Gresham
Date of assessment: 9th April 2018

Summary description of QIPP scheme being assessed:

Background

National

Staple gluten free (GF) foods have been available on prescription to patients diagnosed with gluten sensitivity enteropathies since the late 1960s when the availability of GF foods was limited. GF foods are now more widely available in supermarkets, although stock can be variable, with a wider range of naturally GF food types available, meaning that the ability of patients to obtain these foods without a prescription has greatly increased. Adherence to a GF diet is the only way to manage the condition and prevent further ill health related to coeliac disease.

Many Clinical Commissioning Groups (CCGs) now have limited types or units of GF foods available on prescription. A number of CCGs provide only bread and flour; several have stopped prescribing all GF foods. CCGs were set up to ensure that their local populations receive the medicines and treatments they require, with locally managed resources. Differing approaches to the availability of GF foods is creating regional variation across England. Many CCGs have made changes to local prescribing formularies and have restricted or ended GF food (Coeliac UK, 2018b). The prescribing position in CCGs in England (July 2017) is shown below:

CCG Prescribing Status Prescribing Arrangements (July 2017)	Number of CCGs
Following Coeliac UK guidelines	78
Ended all GF foods on prescription (all patients)	25
No restrictions	4
Other restrictions; product type, quantities, or patient status	102

The Department of Health (DH) conducted a national consultation and sought views from the general public as to the availability of gluten free (GF) Foods on prescription in Primary Care (Department of Health, 2017). Changes to the prescribing of GF foods could save NHS resources and reduce the primary care prescription drugs bill by up to £22.7 million in year one following changes (based on Net Ingredient Cost (NIC) and dispensing fees.

This consultation ended on 22nd June 2017, having received 7941 responses. The response to the consultation was published in February 2018 (Department of Health and Social Care, 2018).

Summary of responses from national consultation:

Points of common agreement

- Coeliac Disease (CD) is a disease state and that food is like a medicine for those patients and adherence to a GF diet is the only way of managing the condition and preventing further ill health related to CD.
- The cost to purchase formulated GF food from retail outlets is more expensive than non-formulated GF food. This is especially the case for bread products where the gap between these products is more significant.
- The quality of prescription products when compared to shop bought products can differ. Some prescription products are fortified to provide additional nutrients to patients to avoid malnutrition or vitamin deficiency.
- The availability of GF foods is not always consistent and many smaller/local shops do not always stock a range of GF food. GF food is not routinely available in food banks or budget supermarkets. For patients/parents/carers that rely on food banks, they will need to select foods that are naturally GF such as meat, fish, rice, fruit and vegetables to ensure they adhere to a GF diet.
- Patients in rural areas may depend on pharmacy deliveries for their GF foods, and may have difficulty in obtaining GF supplies from local shops.

- The shelf life of fresh bread products can lead to waste if not collected from the pharmacy in a timely manner. The patient has to rely on freezing surplus fresh bread to avoid waste as pack sizes can often contain 6 - 8 loaves.
- The local changes made by CCGs have led to inconsistencies for patients in England and this is causing inequality in access to GF food on prescription. There are also many different approaches between CCGs which have led to inequality of access to ranges, types or quantities of GF food available on prescription.
- Some CCGs have made changes without consultation, this has excluded patients, their representatives and others from having a say in how their local services are delivered.
- Pharmacies are set up and managed to issue medicines and medical supplies and are not equipped to deal with holding large stocks of foods which often have a short shelf life, or are bulky.
- Out of pocket expenses (OOPE) can be significant on some GF products, especially on fresh bread. Some CCGs have managed these out of the system through alternative GF supply models.
- All GF food products listed in the Drug Tariff are "branded" products, whilst some retail outlets supply generic/own brand GF products.
- The ACBS "recommended" list contains staple GF products, yet prescribing data6 shows that luxury products such as cakes, pastries and sweet biscuits are prescribed. The majority of respondents agreed that only staple products should be available at NHS expense.

Main issues raised:

GF foods are not consistently available in local shops or budget supermarkets. There is often unreliable stock and/or limited range in larger supermarkets, products may also have short expiry or "use by" dates. Certain brands of GF food are not available to buy in supermarkets, limiting patient choice.

The majority of respondents requested bread and mixes to remain on prescription due to inconsistencies in availability, taste differences between prescription only products and those available in supermarkets, the price differences (especially bread), and accessibility, especially those who relied on pharmacy deliveries. Patients stated that GF mixes offered a more flexible option as they could be used at home to make a variety of foods.

Many respondents stated that the money spent on GF food could be better utilised across the NHS, and as GF food is not a medicine it should not be provided by the NHS. It was also stated that patients with other food intolerances or allergies do not get their food on prescription.

Parents or carers of children have requested that GF staples, especially bread, remain on prescription to prevent children feeling "different" to their peers, for example, the ability to take a packed lunch (sandwiches) to school. Some CCGs have retained GF prescribing for those under 18. Additionally this group are less likely to make their own dietary choices; this is especially the case for young children, as they rely on a parent/carer to purchase and prepare their meals. Information provided through the consultation stated that the lack of adherence to a GF diet could impact on the growth rate of children, delay puberty and make them susceptible to other auto immune conditions.

Outcome

The Government has decided to restrict gluten-free prescribing to bread and mixes only (note – there has been no recommendation made about limiting volume of prescribing, which is expressed as number of units). The timescale to implement restriction of all gluten free products, with the exception of some bread and mix products has not yet been announced.

Local

In Nottinghamshire at present the CCGs have different recommendations for restricting prescribing of GF foods.

NHS Rushcliffe, Nottingham West and Nottingham North & East CCGs

A three month consultation was undertaken in 2015 to gather the views of patients, clinicians, partners and the wider public in these CCGs, to understand the potential impact of the following proposals:

1. Stop all prescribing of gluten-free foods
2. Limit to 8 units of bread and/or flour each month (NNE CCG has had this unit reduction in place since January 2015)
3. Limit the products available to flour only (maximum of 4 units per month)
4. Other.

A total of 1016 responses were received.

The formal consultation report was published in March 2016 (NHS Nottingham West, Nottingham North and East and Rushcliffe CCGs, 2016).
Key themes from feedback included**:**

- Fresh bread often goes out of date quickly and leads to increased wastage.
- The buying power of the NHS needed to be addressed – why is the NHS paying such inflated prices?
- Lack of quality in supermarket products.
- More support needed for coeliac patients, including annual reviews.
- Late diagnosis of symptoms caused concern for patients.
- Concerns for vulnerable patients, i.e. children, elderly, low income.
- The introduction of a voucher scheme could benefit patients.

Outcome

In May, 2016, following feedback from the consultation and recommendations from clinical, patient cabinets and governing bodies NHS Rushcliffe, Nottingham West and Nottingham North & East made changes to Gluten Free products available on prescription. As of May 2016 all practices within the three CCGs were requested to ensure no more than four units in total of long life bread and/or flour per month were prescribed for patients with a diagnosed condition of coeliac disease or dermatitis herpetiformis. The medicines management teams work with GP practices to monitor adherence to recommendations.

NHS Nottingham City CCG

In June 2015 the NHS Nottingham City CCG Executive Management Team decided that the City population needs were different from those in the County and the proposed County options were not in line with these needs, so NHS Nottingham City CCG did not enter in to the consultation about changes to prescribing of gluten free foods alongside NHS Rushcliffe, Nottingham West and Nottingham North & East.
Clinicians in NHS Nottingham City CCG prescribe staple gluten free products, in line with the Nottinghamshire Area Prescribing Committee position statement (Nottinghamshire Area Prescribing Committee, 2014) and currently there is no CCG policy about further restricting quantities or items. The medicines management teams work with GP practices to align quantities with those recommended by Coeliac UK (Coeliac UK, 2018a)

NHS Mansfield & Ashfield and Newark & Sherwood CCGs (Mid Notts)
In January 2017 Mid Notts CCGs undertook a month's engagement. 550 responses were received in response to the following questions:

- Stop all prescribing of gluten-free foods
- Limit to 8 units of bread and/or flour each month

- Continue as now and prescribe staple gluten free foods (non-staple foods are no longer prescribed) and continue to follow the Coeliac Society's recommendations for number of units prescribed

53% or responses were in favour of continuing to prescribe gluten free products as now i.e. following Coeliac U.K. guidelines

Key themes for concerns voiced during the consultation were:
- Availability of gluten free products on prescription
- The additional cost of gluten free products in supermarkets
- Need for increased support and advice to follow a gluten free diet
- There should be negotiation between NHS and manufacturers about prices
- A need to recognise the needs of children and vulnerable groups

Outcome

At its meeting on the 16 February 2017, the joint Governing Body for the two CCGs reviewed comments and agreed to stop NHS prescriptions for Gluten Free foods, for all patients, unless there are special circumstances.

Next step for Greater Nottingham (GN) CCGs

The GN Turnaround Director, having taken the views of the CCG Governing Bodies (GB) in Greater Nottingham, has advised to progress with patient engagement and consultation, across City and County, with the following options:

1. City CCG to align their recommendations with the current arrangements in the other Greater Nottingham CCGs (4 units per month of GF long life bread or flour)*
2. All CCGs in Greater Nottingham to adopt the national recommendations (prescribing of GF bread and mixes, no recommended number of units)
3. All Greater Nottingham CCGs to stop all GF prescribing
4. All Greater Nottingham CCGs to stop all GF prescribing, except for defined patient groups e.g. children, where national recommendations will apply

*NOTE – If County status is adopted across GN subsequent national changes will stop prescribing of GF flour, and there may be a need to consider whether prescribing of GF mixes is allowed instead of GF flour.

Context

Coeliac disease is an autoimmune condition associated with chronic inflammation of the small intestine, which can lead to malabsorption of nutrients, triggered by the protein gluten. Symptoms are controlled by excluding foods that contain gluten from the diet. There are no medicines available to treat the condition and it cannot be cured. People with confirmed coeliac disease must give up eating all sources of gluten for life.If someone with coeliac disease is exposed to gluten (found in wheat, barley and rye) they may experience

a range of symptoms and adverse effects. The symptoms from and consequences of not following gluten free (GF) diets may be mild or very severe and can include;

- Abdominal pain, diarrhoea, nausea, bloating, vomiting
- Weight loss in adults or failure to grow at the expected rate in children
- Malnutrition, iron, vitamin B12 and folic acid deficiencies
- Tiredness, headaches
- Skin rash, mouth ulcers, tooth enamel problems
- Osteoporosis, ulcerative jejunitis
- Malignancy (intestinal lymphoma)

Gluten is not necessary for a healthy diet and patients can safely exclude it from their diet and still eat healthily without purchasing special foods. Patients can safely eat meat, fish, vegetables, fruit, rice and most dairy products as these do not contain gluten.

However, the report on the national consultation states that:

- Some prescription products are fortified to provide additional nutrients to patients to avoid malnutrition or vitamin deficiency
- GF formulated prescription food is often fortified with additional nutrients that may be lacking in a coeliac patient's diet, whereas commercially formulated GF foods are less likely to be fortified than their prescription counterparts

Studies have demonstrated that gluten free diet products are poor sources of minerals (such as iron), vitamins (such as folate, thiamine niacin and riboflavin) and fibre (Thompson, 1999; Thompson, 2000). However, Lee et al. (2009) demonstrated that the adding of three servings of gluten-free alternative grains, for example oats, quinoa, buckwheat (pseudo and minor cereals) positively impacts the nutrient profile (fibre, thiamine, riboflavin, niacin, folate and iron) of the grain portion of the gluten-free diet.

Penagini et al., (2013) highlight that the inclusion of pseudo cereals and minor cereals that do not contain gluten in to the diet could offer a less expensive alternative with respect to standard gluten-free choices and could help increase dietary compliance by reducing the economic burden of the diet.

Fry, Madden and Fallaize,(2017) found that more GF foods than regular foods are classified as containing high and medium fat, saturated fat, salt and sugar and have lower fibre and protein content.

Penagini et al., (2013) also highlight other research that there is a need for early education on following a GF diet, as the diet is complicated and can be overwhelming if not presented using a thorough and proactive approach. Studies focusing on compliance to a GF diet indicate that adherence is compromised by a number of factors, including a lack of education and continued support by a physician and dietitian. The National Institute for Health and Care Excellence (2016) recommend that an annual review should be offered to people with coeliac disease so that adherence to a gluten-free diet and symptoms can be reviewed, information and advice about the condition and diet can be refreshed, and any further support needs can be identified.

The disease affects approximately 1 in 100 people in the UK where women are two to three times more likely to develop coeliac disease than men. People with conditions such as type 1 diabetes, autoimmune thyroid disease, Down's syndrome and Turner syndrome are at a higher risk than the general population of having coeliac disease. First-degree relatives of a person with coeliac disease also have an increased likelihood of having the condition. It can be diagnosed at any age.

Supporting evidence and references:

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Saccone, G., Berghella, V., Sarno, L., Maruotti, G., Cetin, I., Greco, L., Khashan, A., McCarthy, F., Martinelli, D., Fortunato, F. and Martinelli, P. (2016). Celiac disease and obstetric complications: a systematic review and metaanalysis. *American Journal of Obstetrics and Gynecology*, 214(2), pp.225-234.

Thompson, T. (1999). Thiamin, Riboflavin, and Niacin Contents of the Gluten-Free Diet. *Journal of the American Dietetic Association*, 99(7), pp.858-862.

Thompson, T. (2000). Folate, Iron, and Dietary Fiber Contents of the Gluten-free Diet. *Journal of the American Dietetic Association*, 100(11), pp.1389-1396.

If you have been unable to find evidence, please describe what you have based this scheme on instead (e.g. activity data, population data, patient experience or public engagement intelligence, clinical opinion etc.):

Health inequalities:

What will be the effect of the scheme in terms of reducing health inequalities in outcomes and in access?

○ Positive impact ◉ Negative impact ○ No impact ○ N/A

Comments/rationale:

Nottingham City:

The level of deprivation is significantly higher in areas of Nottingham City than in most other parts of Greater Nottingham.

Nottingham is ranked 8 th most deprived district in England in the 2015 Index of Multiple Deprivation (IMD), a relative decline on 20th in the 2010 IMD.

About a third of super output areas in the City are in the worst 10% nationally (IMD 2015).

34% of children and 25% of people aged 60 and over live in areas affected by income deprivation (Jsna.nottinghamcity.gov.uk, 2018)

Nottinghamshire County:

Deprivation levels for Nottinghamshire are comparable with England. However, within Nottinghamshire there are communities with both some of the highest levels of deprivation in the country and some of the lowest levels of deprivation. In Nottinghamshire (excluding Nottingham City) there are 25 lower super output areas (LSOAs) in the 10% most deprived LSOAs in England. The most deprived LSOAs are concentrated in the districts of Ashfield, Mansfield, Bassetlaw and Newark & Sherwood (Nottinghamshireinsight.org.uk, 2018).

People living within the more deprived areas of Nottinghamshire have less healthy lifestyle choices and poorer health and wellbeing outcomes. Restriction of all gluten free foods, or partial restriction will impact residents with lower incomes.

- The cost to purchase formulated GF food from retail outlets is more expensive than non-formulated GF food. This is especially the case for bread products where the gap between these products is more significant.
- The quality of prescription products when compared to shop bought products can differ. Some prescription products are fortified to provide additional nutrients to patients to avoid malnutrition or vitamin deficiency.
- The availability of GF foods is not always consistent and many smaller/local shops do not always stock a range of GF food. GF food is not routinely available in food banks or budget supermarkets. For patients/parents/carers that rely on food banks, they will need to select foods that are naturally GF such as meat, fish, rice, fruit and vegetables to ensure they adhere to a GF diet. Patients with lower incomes may not have access to transport and so only have access to local shops.
- Patients in rural areas may depend on pharmacy deliveries for their GF foods, and may have difficulty in obtaining GF supplies from local shops.

Protected characteristics and inclusion health groups:

Impact on the protected characteristic of Age:

○ Positive impact ◉ Negative impact ○ No impact ○ N/A

Comments/rationale:

These changes will affect all patients with a diagnosis of Coeliac disease. Coeliac disease can be diagnosed at any age, although the most frequently diagnosed age range is 40 to 60. A higher proportion of people aged 16-64 in Nottingham City claim some form of benefit than regionally and nationally. To that end a large proportion of the patients in Nottingham City may receive free prescriptions and may not otherwise be able to afford to buy gluten free foods.

The negative impact will be experienced by those who are in receipt of free prescriptions (including children). Nottingham City GB members highlighted that children do not have a choice in making decisions about their diet. In the national consultation parents or carers of children have requested that GF staples, especially bread, remain on prescription to prevent children feeling "different" to their peers, for example, the ability to take a packed lunch (sandwiches) to school. Some CCGs have retained GF prescribing for those under 18. Additionally this group are less likely to make their own dietary choices; this is especially the case for young children, as they rely on a parent/carer to purchase and prepare their meals. Information provided through the consultation stated that the lack of adherence to a GF diet could impact on the growth rate of children, delay puberty and make them susceptible to other auto immune conditions.

Impact on the protected characteristic of Disability:

○ Positive impact ◉ Negative impact ○ No impact ○ N/A

Comments/rationale:

People in this protected characteristic group may be diagnosed with coeliac disease. Patients experiencing one or more mobility, sensory or intellectual impairments may not be able to access and shop at outlets that stock gluten-free products and products that contain gluten may be purchased in error. The availability of GF foods is not always consistent and many smaller/local shops do not always stock a range of GF food Patients in rural areas may depend on pharmacy deliveries for their GF foods, and may have difficulty in obtaining GF supplies from local shops.

The health of people with coeliac disease who also have other long term conditions – eg diabetes – may be adversely affected if they do not carefully adhere to a gluten free diet and ability to achieve nutritional adequacy, as discussed previously, may affect patients in this group.

Impact on the protected characteristic of Gender re-assignment:

○ Positive impact ○ Negative impact ◉ No impact ○ N/A

Comments/rationale:

People in this protected characteristic group may be diagnosed with coeliac disease and these changes should have no impact as a result of that characteristic.

Impact on the protected characteristic of Pregnancy and maternity:

○ Positive impact ◉ Negative impact ○ No impact ○ N/A

Comments/rationale:

People in this protected characteristic group may be diagnosed with coeliac disease.

A metanalysis by Saccone et al., (2016) showed that untreated coeliac disease, or poor adherence to a GF diet has a higher risk of poorer pregnancy outcomes. Prescribing within the Coeliac UK quantity guidance addresses increased nutritional needs of different groups (ie additional allowance for pregnancy, breastfeeding).

Impact on the protected characteristic of Race:

○ Positive impact ○ Negative impact ◉ No impact ○ N/A

Comments/rationale:

People in this protected characteristic group may be diagnosed with coeliac disease and these changes should have no impact as a result of that characteristic. However, some populations shop at culturally specific local stores and not supermarkets where GF foods are located.

Impact on the protected characteristic of Religion or belief:

○ Positive impact ○ Negative impact ◉ No impact ○ N/A

Comments/rationale:

People in this protected characteristic group may be diagnosed with coeliac disease but no evidence has been identified to suggest that their religion or belief would in itself mean that they were adversely or positively affected by prescribing changes.

Impact on the protected characteristic of Sex:

○ Positive impact ◉ Negative impact ○ No impact ○ N/A

Comments/rationale:

Reported cases of coeliac disease are two to three times higher in women than men, so more women than men may be affected by prescribing changes.

People with conditions such as type 1 diabetes, autoimmune thyroid disease, Down's syndrome and Turner syndrome are at a higher risk than the general population of having coeliac disease. Incidence of these conditions vary between males and females, for example, more women than men develop autoimmune hypothyroidism. Turner syndrome is a condition that is only present in females.

Impact on the protected characteristic of Sexual orientation:

○ Positive impact ○ Negative impact ○ No impact ○ N/A

Comments/rationale:

People in this protected characteristic group may be diagnosed with coeliac disease, but no evidence has been identified to suggest that their sexual orientation would in itself mean that they were adversely or positively affected by prescribing changes.

Impact on people in any of the following Inclusion Health Groups:

Carers, Homeless people, People who misuse drugs, New and emerging communities, including refugees and asylum seekers, People experiencing economic or social deprivation, Gypsies, Roma and Travellers

Reduction or discontinuation of the gluten free food prescribing may mean that any of the people in these health groups may not be able to obtain gluten free foods because of limitations in access or cost. It may limit the choices of the types of food they can prepare as they may also not have the skills, facilities or time to be able to use flour/mixes to make any foods.

Due to the reduction or discontinuation of gluten free food prescribing, patients in this group:

- may be unable to afford or be unable to easily obtain gluten free foods
- may not have the facilities, time or skills to make food with the flour/mixes provided
- may put their long term health at risk by choosing cheaper food containing gluten.

○ Positive impact ◉ Negative impact ○ No impact ○ N/A

Impact Assessment Outcome:

Details of any risks identified and overall comments:

Recommendation:

○ Proceed ○ Proceed with action* ○ Stop

*Please provide details of action required:

GLOSSARY *The descriptions for the following terms are worded specifically for this EQIA.*

Term	Description
Access	Access includes the ability of patients to obtain and understand information about their health and health services, as well as being able to access clinical advice and treatment. Patients' access may be limited by a range of factors such as mobility limitations, cognitive function and language barriers.
Age	The protected characteristic of Age refers to being of a specific age or belonging to a particular age range.
Carers	Carers may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population.
Clinical effectiveness	Clinical effectiveness is a component of quality in the NHS. It is the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing and monitoring practice.
Dignity and Respect	This is one of the values incorporated in the NHS Constitution: "We value every person - whether patient, their families or carers, or staff - as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do." Respect, dignity, compassion and care should be at the core of how patients and staff are treated - not only because that is the right thing to do, but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.
Disability	The protected characteristic of Disability includes people with physical or mental impairments or illnesses that have a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. 'Substantial' is more than minor or trivial – e.g. it takes much longer than it usually would to complete a daily task like getting dressed. 'Long-term' means 12 months or more – e.g. a breathing condition that develops as a result of a lung infection. Someone automatically meets the disability definition under the Equality Act 2010 from the day they are diagnosed with HIV infection, cancer or multiple sclerosis, even if they are currently able to carry out normal day to day activities. A disability can arise from a wide range of impairments which can be: • Sensory impairments, such as those affecting sight or hearing • Mental health conditions • Mental illnesses • Learning disabilities • Organ specific – e.g. respiratory conditions, cardiovascular diseases, stroke • Developmental – e.g. autistic spectrum disorders

Term	Description
	• Produced by injury to the body, including to the brain • Impairments with fluctuating or recurring effects – e.g. rheumatoid arthritis • Progressive* – e.g. motor neurone disease, muscular dystrophy, and forms of dementia • Auto-immune conditions, such as systemic lupus erythematosis (SLE). *A progressive condition is one that gets worse over time. The Equality Act 2010 covers people who have had a disability in the past – e.g. if a person had a mental health condition in the past which lasted for over 12 months, but has now recovered, they are still protected from discrimination because of that disability. For further information see Equality_Act_2010-disability_definition.pdf
Engagement	The range of activities designed and deployed by CCGs to: • Gain the views of patients, service users and carers on commissioning and service delivery • Include patients, service users and carers in considering their own health, care and treatment.
Equality Act 2010	A single piece of legislation that replaced previous anti-discrimination Acts. It simplified the law, removing inconsistencies and making it easier for people to understand and comply with. The Act outlaws direct and indirect discrimination, harassment and victimisation of people with relevant protected characteristics in relevant circumstances and requires that reasonable adjustments be made for disabled people. The Equality Act includes a public sector equality duty (PSED), which applies to public bodies and others carrying out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services that are efficient and effective, accessible to all, and which meet different people's needs.
Evidence	Information from research and other sources e.g. activity data, population data, patient experience or public engagement intelligence, clinical opinion, NICE, national strategies, policy documents and reports, evaluation, clinical audit, etc. Evidence-based practice is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal preferences and unique concerns, expectations, and values.
Gender re-assignment	A person has the protected characteristic of gender reassignment if s/he is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning her/his sex by changing physiological, behavioural or other attributes of sex.

Term	Description
Gypsies Roma and Travellers	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. See also Inclusion Health groups.
Health inequalities	Preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.
Homeless people	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. See also Inclusion Health groups.
Inclusion health groups	Groups of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. These include carers, homeless people, people who misuse drugs, asylum seekers and refugees, Gypsies and Travellers, sex workers, people experiencing economic and social deprivation, people who are long-term unemployed, people who have limited family or social networks and people who are geographically isolated.
Negative impact	An effect that could, for example: • Decrease or exclude access to a service or activity • Be detrimental to treatment outcomes • Have an adverse impact on patient experience.
New and emerging communities, including refugees and asylum seekers	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. See also Inclusion Health groups.
Patient choice	Informed decision-making by patients over where/how they receive health care.
Patient experience	Patient experience is one of the three components of quality in the NHS. Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. Patient experience means putting the patient and their experience at the heart of quality improvement.

Term	Description
Patient safety	The NHS is expected to treat patients in a safe environment and protect them from avoidable harm. Patient safety is one of the three components of quality in the NHS and is defined as the prevention of errors and adverse effects to patients associated with health care. While health care has become more effective it has also become more complex, with greater use of new technologies, medicines and treatments. Patient safety issues are the avoidable errors in healthcare that can cause harm (injury, suffering, disability or death) to patients.
People experiencing economic and social deprivation	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. It includes people who are long-term unemployed, or who have limited family or social networks. To comply with the Equality Act 2010, CCGs are required to consider how their strategic decisions might help to reduce the inequalities associated with socio-economic disadvantage, such as inequalities in employment, education, health, housing and crime rates. It is for individual CCGs to consider which socio-economic disadvantages it is able to influence.
People who misuse drugs	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. See also Inclusion Health groups.
Person-centred care	Person-centred care is the principle of 'shared-decision making' – enabling people to make joint decisions about their care with their clinicians. It involves putting patients, and their families and carers, at the heart of deciding what is most valuable for individuals with a range of health conditions, rather than clinicians or other health professionals independently deciding what is best.
Positive impact	An effect that could, for example: • Increase access to a service or activity • Improve treatment outcomes • Enhance patient experience.
Pregnancy and maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
Privacy	Interpreted most broadly, privacy is about the integrity of the individual. It therefore encompasses many aspects of the individual's social needs – privacy of the person, personal information, personal behaviour and personal communications.

Term	Description
Protected characteristics	The Equality Act 2010 outlines nine protected characteristics - Age, Disability, Gender re-assignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief (including no religion or belief), Sex and Sexual orientation. The Equality Act outlaws direct and indirect discrimination, harassment and victimisation of people with relevant* protected characteristics. *Marriage and civil partnership is not a 'relevant' protected characteristic. (This distinction applies only in relation to work, not to any other part of the Equality Act 2010) We all have at least five of the nine protected characteristics - age, race, religion or belief/no religion or belief, a sex and a sexual orientation.
Quality	The definition of quality in health care, enshrined in law, includes three key components: patient safety, clinical effectiveness and patient experience. The NHS aspires to the highest standards of excellence and professionalism in the provision of high quality care – ie care that is safe, clinically effective and focused on providing as positive an experience to service users as possible.
Race	This protected characteristic refers to groups of people defined by their colour, nationality (including citizenship), ethnic or national origins.
Religion or belief	This protected characteristic includes any religion and any religious or philosophical belief. It also includes a lack of any such religion or belief. A religion need not be mainstream or well-known but it must be identifiable and have a clear structure and belief system. Denominations or sects within religions may be considered a religion. Cults and new religious movements may also be considered religions or beliefs. Belief means any religious or philosophical belief and includes a lack of belief. Religious belief goes beyond beliefs about and adherence to a religion or its central articles of faith and may vary from person to person within the same religion. A belief need not include faith or worship of a god or gods, but must affect how a person lives their life or perceives the world.
Safeguarding adults	The Care Act 2014 defines adult safeguarding as protecting an adult's right to live in safety, free from abuse and neglect with people and organisations working together to prevent and stop both the risks and experience of abuse or neglect. Safeguarding balances the adults right to be safe with their right to make informed choices, whilst at the same time making sure that their wellbeing is promoted including, taking into consideration their views, wishes, feelings and beliefs in deciding on any action (s). The Care Act 2014 defines an adult at risk of harm as: 'someone who has needs for care and support, and is experiencing, or at risk of, abuse or neglect and is unable to protect themselves'.

Term	Description
Safeguarding children	Safeguarding children and young people means the actions that are taken to promote their welfare and protect them from harm, abuse and maltreatment. This includes preventing harm to their health or development, ensuring that they experience safe and effective care as they grow up and enabling them to have the best outcomes. Child protection is part of the safeguarding process and focuses on protecting individual children identified as suffering or likely to suffer significant harm. Safeguarding children and child protection guidance and legislation applies to all children up to the age of 18.
Self-care	Also known as self-management. Refers to the key role that individual people have in protecting and managing their own health, choosing appropriate treatments and managing long-term conditions. They may do this independently or in partnership with the healthcare system.
Sex	This protected characteristic refers to whether a person considers that they are a man or a woman.
Sexual orientation	This protected characteristic refers to whether a person's sexual orientation is towards their own sex, the opposite sex or to both sexes.
Shared decision-making	Shared decision-making is a process in which patients, when they reach a decision crossroads in their health care, can review all the treatment options available to them and participate actively with their healthcare professional in making that decision.