**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE**

**NICE Centre for Guidelines**

**Equality and health inequalities assessment (EHIA)**

**Pneumonia**

The considerations and potential impact on equality and health inequalities have been considered throughout the quality standard development, process according to the principles of the NICE equality policy and those outlined in [Quality Standards process guide](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards).

# STAGE 1. Topic engagement

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| * 1. What approaches have been used to identify potential equality and health inequalities issues during development of the topic engagement comments form?
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| *Equality and health inequality issues have been identified using the equality impact assessment (EIA) for the NICE guideline update on pneumonia. This guideline is currently being updated. All of the issues in section 1.2 have been identified from* [*the guideline EIA*](https://www.nice.org.uk/guidance/indevelopment/gid-ng10357/documents)*.*  |

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| * 1. What potential equality and health inequalities issues have been identified during development of the topic engagement comments form?
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| 1. *Protected characteristics outlined in the Equality Act 2010*

*Age: Pneumonia is more common in older people (people who are 65 and over) and they have a higher risk of serious illness and worse outcomes. The rate of hospitalisation increases with age in older adults. This may be linked to increasing frailty.**Older adults may face difficulties accessing healthcare due to their reduced ability to travel to appointments, or in the case of remote consultations, reduced access or ability to use technology, including using appointment booking systems.* *Frailty is associated with an increased susceptibility to and severity of pneumonia in older adults. Pneumonia is also more common in children younger than 5 years and it is more difficult to determine the cause in this age group. Babies, in particular, are at higher risk of serious illness if they develop pneumonia.* *Pneumococcal vaccination is offered to babies, children and older people by the NHS. It is effective at preventing pneumococcal pneumonia and reduces deaths due to pneumococcal pneumonia. Older people may not be aware of this vaccine or think it is not important and therefore are less likely to be vaccinated. Unvaccinated people are more vulnerable to catching pneumococcal pneumonia than vaccinated people.**Disability: People with pre-existing health conditions (such as chronic obstructive pulmonary disease and heart disease), may be more likely to be hospitalised or develop severe pneumonia. In some cases, these pre-existing conditions may also be considered a disability depending on the severity and effects upon the individual.* *People with learning disabilities are more susceptible to respiratory illnesses like pneumonia. They also have poorer outcomes if admitted to hospital with pneumonia. This may be due to discrimination at point of care, not being listened to, or they may have trouble with accessing healthcare.**Gender reassignment: No issues identified at this stage.* *Pregnancy and maternity: No issues identified at this stage.* *Race: There are racial disparities in pneumonia care and management in hospitals that are associated with worse outcomes. This may be linked to a lack of awareness of the need to adjust test results to take into account differences between racial groups, leading to poorer care for these groups. For example, some pulse oximetry devices have been reported to overestimate oxygen saturation levels in people with darker skin, which may lead to them not being treated when treatment is needed unless an adjustment is made in interpreting the test results.* *People who do not speak English may have barriers to accessing care, understanding information provided verbally or in writing and being involved in shared decision making regarding their care.**Religion or belief:* *Some people who are eligible for vaccination may not be vaccinated against pneumococcal pneumonia due to their, or their family’s religion or beliefs. Unvaccinated people are more vulnerable to catching pneumococcal pneumonia than vaccinated people.**Sex:* *There is a higher incidence of community acquired pneumonia in males and it can be more severe than in females. This may be associated with biological differences, such as hormonal cycles and variation in cultural and health practices between males and females. There are also differences in help seeking behaviour between males and females, which may increase the males’ risk for pneumonia hospitalisation.**Sexual orientation: No issues identified at this stage.* 1. *Socioeconomic status and deprivation (for example, variation by area deprivation such as Index of Multiple Deprivation, National Statistics Socio-economic Classification, employment status, income)*

*Pneumonia rates vary with deprivation level and those social circumstances impact on the care of people with pneumonia following hospital discharge.* *People from lower socio-economic groups have increased pneumonia incidence and mortality. This is associated with factors like disproportionate exposure to air pollutants, poor housing, fuel poverty, poor diet and prevalence of chronic conditions (like chronic obstructive pulmonary disease) compared to the general population.* *Smoking is more common in lower socioeconomic groups, deprived and underserved populations like prisoners. Smoking is a risk factor for pneumonia and mortality. Specific consideration may also need to be given to children whose parents are smokers as they are more likely to develop chest infections like pneumonia.*1. *Geographical area variation (for example, geographical differences in epidemiology or service provision- urban/rural, coastal, north/south): No issues identified at this stage.*
2. *Inclusion health and vulnerable groups (for example, vulnerable migrants, people experiencing homelessness, people in contact with the criminal justice system, sex workers, Gypsy, Roma and Traveller communities, young people leaving care and victims of trafficking)*

*There is disproportionate incidence of pneumonia among refugees and immigrants in Europe. This is likely to vary between countries due to differences in immigration patterns, and differences in pneumococcal vaccine uptake, variations in rates of antimicrobial resistance, as well as the impact of previous childhood disease. In cases where migrants are not vaccinated against pneumococcal pneumonia, they could be more vulnerable to catching it. This risk may be further increased if they live in deprived areas or have poor living conditions or have poor access to healthcare services.**People experiencing homelessness are more likely to develop pneumonia. This is associated with deprivation, poor living conditions, higher rates of smoking, reduced access to healthcare services as well as the higher prevalence of chronic conditions and the overrepresentation of certain pathogens that increase their risk of developing pneumonia. People experiencing homelessness also face challenges similar to those highlighted for people from lower socioeconomic groups.**People with low levels of health literacy are more likely to be under-vaccinated and therefore more vulnerable to catching pneumococcal pneumonia than people who are vaccinated. They may also be from deprived or lower socioeconomic areas. People with low literacy levels may be unable to understand information leaflets relating to their care if they develop pneumonia.* |

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| * 1. How can the identified equality and health inequalities issues be further explored and considered at this stage of the development process?
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| *The guideline EHIA notes that specific guideline recommendations may need to be made for the following groups: older people, younger children, people with pre-existing conditions including pregnant women, people with learning disabilities, people from ethnic minorities, males, people in lower socioeconomic or deprived groups, smokers, newly arrived migrants, people experiencing homelessness and people with low levels of literacy/health literacy.* *If specific guideline recommendations are included in the updated guideline, these can be considered by the quality standards advisory committee during discussions.* *In addition, any further areas raised by stakeholders and specialist committee members will be considered by the QSAC.* *Any equality and health inequality issues will be included in the relevant sections of the quality standard and reviewed throughout development.*  |

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| * 1. Do you have representation from stakeholder groups that can help to explore equality and health inequalities issues during the topic engagement process including groups who are known to be affected by these issues? If not, what plans are in place to address gaps in the stakeholder list?
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| *Organisations representing patients will be contacted as part of the topic engagement and consultation processes. These include:* * *Asthma + Lung UK*
* *Age UK*

*There will also be lay representation on the QSAC. These will be standing lay members and topic specialist lay members.*  |

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| * 1. How will the views and experiences of those affected by equality and health inequalities issues be meaningfully included in the quality standard development process going forward?
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| *Stakeholders will be consulted throughout development of the quality standard.* *The Quality Standards and Indicators Hub will also continue to discuss the topic with the NICE Public Involvement team throughout development.*  |

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| * 1. Has it been proposed to exclude any population groups from coverage by the quality standard? If yes, could these exclusions further impact on people affected by any equality and health inequalities issues identified?
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| *No population groups have been excluded.*  |

Completed by lead analyst: Eileen Taylor

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Approved by NICE quality assurance lead: Craig Grime

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