NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Flu vaccination: increasing uptake in clinical risk groups and health and social care workers

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

1.0 Scope: before consultation (To be completed by the developer and submitted with the draft scope for consultation)

1.1 Have any potential equality issues been identified during the development of the draft scope, before consultation, and, if so, what are they? (Please specify if the issue has been highlighted by a stakeholder)
Age: People aged 65 years and over are not covered by this guideline as there is a relatively high uptake in this population group. There was greater identified need in the groups this guideline will cover by virtue of their much lower uptake rates. Disability: There is some evidence to suggest eligible people with lower mobility have lower uptake, outreach interventions will be considered in the evidence. In addition, people with learning disabilities are an eligible group in the chronic conditions group, which has identified need and low uptake. Gender reassignment: No potential equality issues were identified during scope development for this target group. Pregnancy and maternity: This is a target group for the guideline Race: BME groups have higher prevalence of conditions classified as eligible under the clinical risk group category therefore as this group has chronically low uptake, uptake may be disproportionately low in these groups. Religion or belief: There may be a lower uptake among groups who have religious or spiritual beliefs against receiving vaccinations. Sex: There is evidence to suggest there is generally greater uptake among women than men although there may be higher compliance among men in the over 75 age group (people aged 65 years and over are not covered by this guideline).

Sexual orientation: There is evidence that the lesbian, gay, bisexual, and transgender community are less able to access more traditional healthcare services, so uptake may be disproportionately low in these groups.

Socio-economic disadvantage: These groups tend to have a higher prevalence of chronic conditions, as those in clinical risk groups have lower overall uptake than those who are socioeconomically disadvantaged may have a disproportionately low uptake. There is some evidence that lower vaccination uptake is associated with poorer health choices, for example smoking. Long term smokers are disproportionately drawn from lower socio-economic groups, so uptake may be disproportionately low in this group. In addition, there is evidence that low health literacy is linked to lower use of preventative health services.

Travellers and asylum seekers: By focusing on primary and secondary care, there may be a potential issue about their routes through which interventions are delivered as these groups may not routinely use primary care.

- Do inequalities in prevalence, access, outcomes or quality of care for any groups (particularly those sharing protected characteristics) need to be addressed by the scope? -

As noted above access issues may be encountered by those with mobility issues or travellers and asylum seekers. In addition those from BME or lower socioeconomic groups tend to have a high prevalence of chronic conditions and thus may have a disproportionately low uptake of flu vaccination as the statistics show chronically low uptake in those in clinical risk groups.

2.0 Scope: after consultation (To be completed by the developer and submitted with the final scope)

2.1 Have any potential equality issues been identified during consultation, and, if so, what are they?

Age: Stakeholders queried why people age 65 years and over are not covered by this guideline. It was noted that although uptake is best in this population group, there are still many non-responders and work to engage these patients may be of benefit. Stakeholders queried why children are not covered by the guideline. It was noted that there is scope to improve uptake in practice for the GP delivered cohorts of the programme. It was also noted there are wide variations in uptake by GP providers.

Pregnancy and maternity: Stakeholders noted that separate consideration needs to be given to women who do not attend antenatal care, e.g. travellers, refugees, asylum seekers. Stakeholders also raised the need for a specific NICE pathway for pregnant women supporting women's choice in receiving flu vaccination in settings other than GP practice.

Race: Stakeholders noted there is some evidence of an association with ethnicity, with some studies reporting lower uptake in ethnic minority groups, although in some cases this was mediated by lower health literacy levels. A difference between uptake in people with certain conditions was also noted, with uptake higher for those with diabetes than heart disease or respiratory disease. BME groups have higher prevalence of conditions classified as eligible under the clinical risk group category therefore as this group has chronically low uptake, uptake may be disproportionately low in these groups.

Socio-economic disadvantage: Stakeholders noted that individuals who are diagnosed with a learning disability should be specified within the scope.

Marriage and civil partnership: Stakeholders noted there is some evidence that higher vaccination rates are reported among those who are either married or have some form of social support network.

Carers: Stakeholders queried why carers are not covered by this guideline. Stakeholders noted that like frontline health and care staff, carers are also in regular and close contact with older people, people with a disability and people in a clinical risk group and are at increased risk of passing the flu virus on to the person with care needs. Stakeholder also noted that relatives sharing a home or in close contact with high risk groups should be considered for inclusion within the guideline.

Guideline development: before consultation (to be completed by the developer before draft guideline consultation)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
The committee has considered the applicability of the identified evidence across groups and settings. The committee reached a consensus that interventions demonstrating an effect in one eligible group would likely have an effect in other eligible groups raising awareness, and increasing accessibility. They also agreed that those with responsibility for providing flu vaccination could see an increase in flu vaccine uptake across all groups if their own knowledge regarding eligibility and opportunities to vaccinate were increased, if providers invite and remind individuals in eligible groups regarding flu vaccination and encourage vaccine acceptance. Age: clarification in the scope context and in the draft guideline regarding age cut off has been made. Due to the consistency of different approaches demonstrated in the evidence across age groups the committee did not make any particular adjustments for age, especially as it was recognised that when targeting children for vaccination the intervention would generally target the parent. However, there was some recognition that older children (teenagers) may be in a position to be involved in decision making but other than one study no specific evidence for this older age group of children was available. This evidence had parity with approaches across all eligible groups. Pregnancy and maternity: Evidence has been identified regarding pregnant women specifically regarding educational interventions, message framing, SMS text messaging, provider prompts and multicomponent interventions – but nothing was identified regarding 'pregnant women who do not attend antenatal clinics'. The committee did not feel the evidence was strong enough to make specific recommendations for this group but has recognised in the recommendations and committee discussion that particular opportunities to offer and provide may exist for this group due to contact with antenatal services regularly, but that overall taking a similar multicomponent approach to other groups would work best. Where evidence regarding tailoring of advice or other interventions has been identified the committee has considered the application of this evidence across groups and settings including pregnant women. Specific evidence regarding pregnant women who do not attend antenatal clinics has not been identified but the committee feel that having the primary and secondary care approaches has the potential to overcome some of these issues in how they have outlined recommendations regarding opportunistic identification and offer of flu vaccination. Race: Evidence did not outline findings by race or ethnicity, where this type of demographic information was available post-hoc sub-group analysis was not

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possible. As the vast majority of evidence was from North America, there was some potential lack of applicability to the UK context if sub-group analysis had been possible, as the cultural and ethnic mix is very different from the UK context. The committee were of the opinion that based on the evidence considered and the recommendations made they would be applicable to all eligible groups but personal circumstances and preferences including language need to be considered when tailoring interventions, although there was no evidence on how this should be done best for different groups in the UK – as a result the committee have made research recommendations about tailoring. There is also a link provided to relevant PHE documents that consider language and other cultural factors included in the implementation section to support delivery of the recommendations. Disability: Learning disabilities have been outlined specifically in the scope. Evidence regarding people with learning disabilities and increasing flu vaccination uptake was not identified. Despite the lack of evidence regarding disability and the uptake of flu vaccinations the committee did reach a consensus and were of the opinion that the recommendations made would apply to eligible groups with disabilities. The committee agreed that any recommendations would need to be tailored to the individual needs of people with learning disabilities. The committee acknowledged that there was a lack of evidence regarding some of the specific details of the tailoring of interventions and have made a research recommendation to address this. Carers: Carers have been specifically outlined in the scope. There was a lack of identified evidence regarding carers. In response the committee requested expert testimony to inform the committee and to help them input into the economic modelling. The committee made recommendations that focused on carers based on the limited evidence, their expertise and consensus supplemented by the expert testimony. Based on the economic modelling the committee were of the opinion that the recommendations developed would apply to all carers but to account for the modelling outcomes would require consideration of the consequences on the person they care for should a carer fall ill, and the delivery of the vaccine should based on clinical opinion of the risk to the person being cared for. They recognised that any carer who is at risk themselves due to age or a condition they live with would and should receive the vaccination due to that eligibility status anyway and not due to being a carer. The committee have also developed a research recommendations focused on carers to address the identified lack of evidence and to further understand the effectiveness and cost effectiveness of increasing vaccination in carers.

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?
Socioeconomic: The committee highlighted a lack of evidence on increasing flu vaccination uptake in underserved groups including children (that is those who are vulnerable in addition to their risk of complications to flu), how their needs are being met and the level of unmet need in these groups (for example those who are not in regular contact with healthcare services) and what is the best way to engage them to increase flu vaccine uptake. The committee considered expert testimony on delivery of flu vaccination to homeless people and despite the lack of evidence regarding 'underserved groups' specifically, have reached a consensus on the evidence they do have about approaches that could be considered for this group to overcome some of the barriers presented in engaging them in the flu vaccination programme if they are eligible for a free vaccination. The committee have made specific recommendations regarding the identification of eligible groups, raising and sustaining awareness in providers and eligible groups and opportunistically identifying and offering flu vaccination with consideration of working with voluntary and statutory groups who may enable access, there was however, no means to deal with unmet need due to undiagnosed conditions. Due to the lack of evidence and potentially important issue of unmet need in this group he committee have developed a research recommendation.

3.3 Were the Committee's considerations of equality issues described in the consultation document, and, if so, where?
The committee noted in the committee discussion section that there was a lack of evidence with which to provide specific recommendations for specific groups but through consensus were satisfied that the evidence they had considered could apply across groups and settings. Recommendations make reference to the need to tailor information and other interventions to the needs of individuals eligible for flu vaccination which could include any groups covered by the protected characteristics but not exclusively. The committee have made research recommendations regarding carers and vulnerable groups, to address the identified lack of evidence. They have made research recommendations regarding messages and intervention tailoring to address the lack of detail in the evidence considered regarding the specific nature of the tailoring required when developing interventions for certain eligible groups

3.4 Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
No

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 or 3.3, or otherwise fulfil NICE's obligation to advance equality?
The committee have considered the evidence and developed recommendations that on consensus they feel apply across eligible groups. The committee caveat the recommendations with the need to consider the needs of eligible individuals when developing and implementing the outlined recommendations. The committee recognised that for many groups there is a lack of evidence and have developed research recommendations in the hope that more research is undertaken to clarify specific issues related to interventions to increases uptake of flu vaccination. The committee also acknowledge the lack of evidence regarding the tailoring of messages and interventions to individuals in some at risk groups. Although the committee agreed by consensus that the evidence they have considered and the subsequent recommendations they have made would likely apply to all eligible groups there is some uncertainty which is reflected in recommendation wording. In response the committee has developed research recommendations that seek to address the lack of detail in the evidence regarding the specific nature of the tailoring required when developing and delivering interventions.

Completed by Developer Sarah Willett, Guideline Lead (Public Health)

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Approved by NICE quality assurance lead Christine Carson, NICE Quality Assurance Guideline Lead

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