NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Acute Respiratory Infection (ARI) in over 16s: Initial assessment and management

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

1.0 Checking for updates and scope: before scope consultation

1.1 Is the proposed primary focus of the guideline a population with a specific communication or engagement need, related to disability, age, or other equality consideration? If so, what is it and what action might be taken by NICE or the developer to meet this need? (For example, adjustments to committee processes, additional forms of consultation.)
No. The guideline focuses on adults aged over 16 years with a suspected acute respiratory infection and does not focus on a population with a specific communication or engagement need, related to disability, age, or other equality consideration.

1.2 Have any potential equality issues been identified during the check for an update or during development of the draft scope, and, if so, what are they?
This document has been compiled using evidence identified by scoping searches and the views of topic experts and committee members while drafting the scope of the guideline. This guideline is focused on suspected acute respiratory infections and NICE has published guidelines on specific respiratory infections. For comprehensiveness equality issues identified during the scoping and development of these guidelines have also been reviewed and considered in this section. These

guidelines included: Cough (acute): antimicrobial prescribing (2019) NG120; NG115; Chronic obstructive pulmonary disease (acute exacerbation): antimicrobial prescribing (2018) NG114; Bronchiectasis (non-cystic fibrosis), acute exacerbation: antimicrobial prescribing (2018) NG117; pneumonia in adults (2022) (CG191).

- Age
    - Acute respiratory infections are more common in 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.
    - Older people may face difficulties with 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.
- Disability
    - Evidence indicates that many of those supported by learning disability services will have compromised or vulnerable respiratory status (Chapman et al, 2018); with those with learning disabilities having higher rates of asthma, COPD and upper respiratory tract infections and poorer measured lung function. People with learning disabilities may 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.
    - There is evidence to suggest that in people with learning disabilities respiratory disease is a more common immediate cause of death than for people without learning disabilities. Data from 343 GP practices in England (Hosking et al, 2016) found that deaths caused by respiratory diseases were nearly 7 times more common in adults with learning disabilities than in the general population.
    - The committee raised the importance of the consideration mental capacity when considering shared decision making.

- Gender reassignment
    - The committee highlighted that consideration may need to be given to any intervention an individual has undergone for the purposes of gender reassignment when considering treatment for any suspected acute respiratory infection. One study (Peitzmeier et al, 2016) suggests that chest binding among transgender adults can cause chest pain and shortness of breath; and linked to chest binding and transgender individuals more generally, evidence indicates that they experience barriers to accessing care and had relatively low care seeking-behaviour (Brooke et al 2018).
- Pregnancy and maternity
    - Pregnant women are at greater risk of developing complications due to acute respiratory tract infections which is typically pneumonia. There is evidence to suggest that pre-existing health conditions, like asthma and anaemia, increase the risk of pregnant women developing pneumonia. The management of infections in pregnancy or lactation may need separate consideration (for example choice of medicine, doses, and course lengths) to take account of risks to the unborn child or baby.
- Race
    - There is evidence to suggest that 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 consider 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, following information provided verbally or in writing and being involved in shared decision making regarding their care.

- The committee highlighted that it is important that ethnicity is not conflated with race during the development of this guideline.

- Religion or belief
    - There was no evidence identified that highlighted any equalities issues specific to acute respiratory infections and an individual's religion or belief; but more generally religion or belief has been highlighted as potentially impacting treatment compliance and access to health services (Szczepura 2005); and one study did highlight religious events and mass gatherings as potential areas for increased transmission of bacterial and viral respiratory tract infections (Al-Tawfiq et al 2022).
- Sex
    - There is evidence to suggest that there is a higher incidence of mortality from respiratory disease in England (2020) for men (130 per 100,000) than women (89 per 100,000). This may be associated with biological differences, such as hormonal cycles and variation in cultural and health practices between males and females. Furthermore, there are differences in help seeking behaviour between males and females, which may increase a male's risk for pneumonia hospitalisation.
- Sexual orientation
    - There were no potential issues identified specific to acute respiratory infections and an individual's sexual orientation; but more generally there is evidence that LGBT+ people have disproportionately worse health outcomes and experiences of healthcare (Government Equalities Office, 2018).
- Socio-economic factors
    - Mortality from respiratory disease is a major contributor to the overall life expectancy gap between lower and higher socioeconomic groups. Mortality considered preventable from respiratory disease in the under 75s (2017 to 2019) was 2.9 times higher in the most socioeconomically deprived areas in England compared to the least deprived. This inequality

is related to a multitude of factors, such as greater exposure to risk factors such as smoking, air pollution, poor housing, and occupational hazards, as well as variation in healthcare quality and access.

- People living in lower socioeconomic areas have a lower life expectancy than the general population, and evidence highlights that chronic obstructive pulmonary disease (COPD) is responsible for 8% of this difference in men and for 12% of this difference in women. These differences in prevalence are associated with factors like disproportionate exposure to air pollutants, poor housing, fuel poverty, alcohol consumption, poor diet, and chronic conditions such as obesity compared to the general population.
- Smoking is more common in lower socioeconomic groups, deprived and underserved populations. Smoking is a risk factor for respiratory disease and may increase the risk of respiratory infections.
- The committee discussed the issue of access and how it potentially impacted all the characteristics outlined in this EIA. They highlighted that the issue of rurality and digital poverty will need consideration in the development of this guideline given the focus of two draft scope questions on virtual and face-to-face consultations with adults with suspected acute respiratory infection.

- Other definable characteristics:
  - Newly arrived migrants (including refugees, asylum seekers and unaccompanied asylum-seeking children, irregular migrants)
    - There is agreement that refugees and asylum seekers are not a notable source of respiratory disease transmission. However, there is some evidence about the disproportionate incidence of respiratory infection among refugees and immigrants in Europe. One study outlined that this might be due to the arduous nature of their flight and precarious living and housing circumstances which may impact nutrition and their immune system. This risk may be further increased if they have poor access to healthcare services.

This trend is likely to vary between countries due to differences in immigration patterns, vaccine status, variations in rates of antimicrobial resistance, as well as the impact of previous childhood disease.

- People experiencing homelessness
  - People experiencing homelessness are at significantly higher risk of respiratory illness. 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 with low levels of literacy/health literacy.
  - Literacy and health literacy entail people's knowledge, motivation, and competence to access, understand, appraise, and apply health information to make judgments and take decisions in everyday life concerning healthcare, disease prevention, and health promotion to maintain or improve quality of life during their life course. People with low levels of health literacy are more likely to be under-vaccinated and thus more vulnerable to catching influenza or pneumococcal pneumonia than vaccinated ones. Low health literacy was associated with a decreased likelihood of using preventative health measures, and in one review this was associated with those aged 65 years and over which could impact the risk of acute respiratory infection. People with low literacy levels may not be unable to understand information leaflets relating to their care if they develop a respiratory infection.

1.3 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee?
The committee agreed that the scope as it is currently written would not exclude any of the groups outlined or exacerbate any of the issues highlighted. The specific

1.3 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee?
issues identified do not need to be added to the scope or review protocols as currently written as they are not specifically excluded. Any evidence that meets the criteria outlined in the review protocols related to the specific items raised would be extracted and considered in the guideline development process. The committee agreed that all the issues outlined would be considered in light of the evidence of effectiveness and cost-effectiveness in the guideline development process.

Completed by Developer: James Jagroo

Date: 15/02/23

Approved by NICE quality assurance lead: Kay Nolan

Date 07/03/2023

2.0 Checking for updates and scope: after targeted engagement

2.1 Have any potential equality issues been identified during targeted engagement, and, if so, what are they?
No additional equality issues were identified during targeted engagement.

2.2 Have any changes to the scope been made as a result of targeted engagement to highlight potential equality issues?
No additional equality issues were identified during the targeted engagement.

2.3 Have any of the changes made led to a change in the primary focus of the guideline which would require consideration of a specific communication or engagement need, related to disability, age, or other equality consideration? If so, what is it and what action might be taken by NICE or the developer to meet this need? (For example, adjustments to committee processes, additional forms of consultation)
No additional equality issues were identified during the targeted engagement.

Updated by Developer Chris Carmona

Date 08/03/2023

Approved by NICE quality assurance lead: Kay Nolan

Date: 08/03/2023

3.0 Guideline development: before consultation (to be completed by the Developer before consultation on the draft guideline)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
The committee were presented with the EIA items identified from section 1.0 and section 2.0 for consideration alongside the systematic reviews of effectiveness and cost-effectiveness. It was noted that for section 2.0 (after targeted engagement) no additional EIA items were raised. The scope is inclusive of all adults and young people over 16 as noted in section 1.1 of the EIA document therefore the specific issues of increased ARI prevalence regarding older people, people with learning disabilities, sex, sexual orientation, socio-economic factors and other definable characteristics (newly arrived migrants, people experiencing homelessness and people with low levels of literacy/health literacy) have been considered by the committee and where the evidence has allowed in the development of the guideline. The Committee highlighted that any recommendations would be cognisant of any ongoing treatments and potential impact on pregnancy and those undergoing gender reassignment. Most of the EIA issues raised in sections 1.0 and 2.0 are part of broader issues that are not necessarily ARI specific, and whilst the draft recommendations themselves may not address these items specifically they have been considered in the drafting of recommendations. The issue of access was a common theme across section 1.0 of the EIA within the categories of age, disabilities, gender reassignment, race, religion and belief, sex, sexual orientation, socio-economic factors (but not pregnancy and maternity); and the identified other definable characteristics (newly arrived migrants, people experiencing homelessness and people with low levels of literacy/health literacy). The rationale and impact section for the draft recommendations acknowledges "*that people contacting NHS services remotely might not have equal access to digital technology and the skills needed to use it."* The committee acknowledged the lack of evidence regarding the views and experiences of remote consultations and have developed a draft research recommendation to encourage further research in this area. During Committee discussion the issue of 'settings' was discussed with specific reference to remote consultations with health services. The Committee referred to the need to adopt a patient centred as well as a holistic approach. The Committee highlighted the importance of not 'missing people' and the ability of the patient to operate in a virtual environment, which speaks to issues identified regarding rurality and digital poverty more broadly. The committee considered the issues raised in the EIA when drafting the draft recommendations. The Committee have recommended

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
that for 'Remote contact with NHS services at first presentation' "*Approach all remote consultations in a holistic, person-centred way including making sure the person is able to use any digital technology being used or suggested*" A discussion was had as to whether a similar item should feature in recommendations regarding 'In-person first contact' but the Committee felt that this is already part of the clinician's job and is already mandated by law and there would be no additional benefit or purpose to adding this to recommendations. This guideline links to NICE's information on making decisions about your care which refers to NICE clinical guideline 138 (Patient experience in adult NHS services: improving the experience of care for people using adult NHS services). This guideline has recommendations focused on 'Knowing the patient as an individual,' 'Essential requirements of care,' 'Tailoring healthcare services for each patient,' 'Continuity of care and relationships' and 'Enabling patients to actively participate in their care' which speak to all issues raised as part of section 1.0 of the EIA.

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?
• **Age** No additional issues have been identified relating to age at this stage of guideline development. • **Disability** No additional issues have been identified relating to Disability at this stage of guideline development. • **Gender reassignment** It was raised that the conflation of sex and gender identity, and loss of fidelity may be happening in NHS records which could impact clinical care. The issue of conflating sex and gender are not specifically outlined in the draft recommendations and are a broader issue beyond this guideline. This guideline does refer to adopting a person-centred and holistic approach to remote consultations by cross reference NICE's information on making decisions about your care which cross refers to NICE clinical guideline 138 which seeks to make sure that all adults using NHS services have the best possible experience of care. Whilst not addressing the issue directly raised the potential issue of access and appropriateness of a remote approach are outlined in recommendation 1.1.3 and the corresponding rationale and impact section.

- **Pregnancy and maternity**

  No additional issues have been identified relating to pregnancy and maternity at this stage of guideline development.

- **Race**

  During committee discussions the issue of ethnicity was raised and the importance of not conflating this with race. Ethnicity whilst not mentioned specifically has been considered in the EIA as separate from race in line with the definition of race as a protected characteristic. This issue was also raised in section 1.0 of the EIA. The Committee agreed that whilst issues of race and ethnicity are not explicitly outlined in the draft recommendations, their consideration is implied more broadly in recommendation 1.1.3 by checking the appropriateness of a remote approach with patients prior to adopting it; through references to adopting a person-centred and holistic approach to remote consultations and through the reference to NICE's information on making decisions about your care which cross refers to NICE clinical guideline 138 which seeks to make sure that all adults using NHS services have the best possible experience of care. The rationale for draft recommendations 1.1.3 to 1.1.6 also refers to the issues raised under race (and ethnicity) as well as the other EIA items, regarding access to ensure they are considered when the guideline is implemented in totality.

- **Religion or belief**

  No additional issues have been identified relating to religion or belief at this stage of guideline development.

- **Sex**

  No additional issues have been identified relating to sex at this stage of guideline development.

- **Sexual orientation**

  No additional issues have been identified relating to sexual orientation at this stage of guideline development.

- **Socio-economic factors**

  No additional issues have been identified relating to socio-economic factors at this stage of guideline development.

- **Other definable characteristics**:

  No additional issues have been identified relating to other definable characteristics at this stage of guideline development.

3.3 Have the Committee's considerations of equality issues been described in the guideline for consultation, and, if so, where?
The guideline document considers the equality issues raised indirectly and directly. The draft recommendations reflect the issues raised in the EIA. Draft recommendations 1.1.3 to 1.1.6 focused on 'Remote contact with NHS services at first presentation.' Draft recommendation 1.1.3 outlines the need to "*Approach all remote consultations in a holistic, person-centred way including making sure the person is able to use any digital technology being used or suggested*." This recommendation seeks to address the central theme running through the EIA regarding access and the barriers these present. The recommendations do not specifically refer to each of the issues raised under each of the protected characteristics or other definable characteristics but address the central point regarding access more broadly. As outlined, a discussion was had by the Committee, as to whether a similar item should feature in recommendations 1.1.7 to 1.1.12 regarding 'In-person first contact' but as this is already part of the clinicians' job and is already mandated by law there would be no additional benefit or purpose to adding this to recommendations. The rationale and impact section for draft recommendations 1.1.3 to 1.1.6 makes reference to the issues raised, regarding access to ensure they are considered when the guideline is implemented in totality. As outlined, this guideline outlines a link to NICE's information on making decisions about your care which cross refers to NICE clinical guideline 138 (Patient experience in adult NHS services: improving the experience of care for people using adult NHS services). This guideline has recommendations focused on 'Knowing the patient as an individual,' 'Essential requirements of care,' 'Tailoring healthcare services for each patient,' 'Continuity of care and relationships' and 'Enabling patients to actively participate in their care' which speaks to all issues raised as part of section 1.0 of the EIA.

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 issues were identified that indicate that the preliminary recommendations make it more difficult for a specific group to access services compared with other groups

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 issues were identified that indicate that the preliminary recommendations would have an adverse impact on people with disabilities that is a consequence of their disability. It has been noted that some people with disabilities who present to services may need additional support and that clinicians will need to be cognisant of this and the difficulties in determining ARI in those that may not fit their usual health profile.

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 box 3.4, or otherwise fulfil NICE's obligation to advance equality?

No issues were identified that indicate that the preliminary recommendations make it more difficult for a specific group to access services compared with other groups.

Completed by Developer: James Jagroo

Date: 21st July 2023

Approved by NICE quality assurance lead: Kay Nolan

Date: 17 August 2023

4.0 Final guideline (to be completed by the Developer before GE consideration of final guideline)

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
Stakeholders (n=3) raised concerns that recommendations could mean an increase in attendance at face-to-face consultation in order to access antibiotic treatment, which could potentially exacerbate existing inequalities in access for those people who lack the means and ability to attend such consultations, such as vulnerable adults and those with children. Stakeholders added that this would be occurring within the context of an already overwhelmed service, especially during influenza and covid season and respiratory illness peaks. This issue was raised under 'age' and 'socioeconomic factors' primarily but has not been placed under a specific characteristic as it applies across all protected and other definable characteristics. The committee acknowledged the on-going system pressures but agreed that people with signs and symptoms of a serious acute respiratory infection need to be seen face-to-face so a more thorough assessment can be conducted. However, they agreed that access to treatment is a key issue and have amended the recommendation that whilst antimicrobials should not be 'routinely' prescribed for ARI's based on a remote consultation alone if there is a 'sound clinical reason' to prescribe remotely; for example, if the person is unable to attend a face-to-face appointment and the prescriber is confident of the clear need for antibiotics they can be prescribed. Stakeholders (n=2) raised concerns regarding 'Box 1' (which outlined signs and symptoms with high probability of indicating pneumonia in people with suspected ARI) and its applicability to everyone 16 years and over. The concerns were that the characteristics outlined were too broad and could not account for everyone 16 years and over. Stakeholders also raised that access to clinically validated equipment is variable. Stakeholders highlighted the examples of 'young adults' and 'pregnancy and maternity' when raising these items, but they have not been placed under those categories as they apply across all protected and other definable characteristics. The committee considered these comments, deleted 'Box 1' and added some examples of 'symptoms of concern' to the recommendations to emphasise that it is for the individual undertaking the remote consultation to determine whether the person they are assessing may have a serious illness and require a face-to-face assessment or whether they can be safely managed remotely. The committee have also added a recommendation to offer self-care advice to those who do not need a face-to-face assessment because their infection is self-limiting. This recommendation means that while a person may not be prescribed antibiotics, they will understand why that's the case and will also be provided with information about when to seek medical advice, for example if symptoms worsen, if symptoms do not improve over an agreed time,

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
or if the person becomes systemically unwell. Stakeholders (n=4) raised concerns about the ability of CRB65 to estimate the risk of pneumonia in all people aged 16 years or older, with a specific issue raised relating to how CRB65 would be used with people with a learning disability or autism. Stakeholders highlighted the examples of young people and people with a 'learning disability and/or autism', but this issue has not been placed under a specific category as it applies across protected and other definable characteristics. The committee highlighted that CRB65 would be used as an adjunct to a clinical diagnosis of pneumonia and is not intended to be used in isolation. They have added to the recommendation about CRB65 to highlight that "CRB65 scores can be affected by pregnancy or the presence of a co-morbidity" – which adds to the recommendation that reinforces the use of clinical judgement along with CRB65 scores to inform decisions regarding the need for hospital assessment, the need for home-based care or a shared decision about the best pathway of care for the individual. The committee have also added to the recommendation to consider a patient's social circumstances with specific reference made to frailty, learning disability and autism. The committee have added to the rationale and impact section for this recommendation specifying that the results of CRB65 "need to be considered in the context of red flags such as rapid deterioration of complications or broader factors", with specific examples provided including people with multi-morbidities, learning disabilities and autism; emphasising that these 'red flags' indicate increased risk of deterioration. One stakeholder raised concerns that when referring to 'remote' consultations we are referring to a variety of modes and that this should be acknowledged specifically so as to not unintentionally exclude individuals. This comment was made without reference to a specific protected or other definable characteristic. The committee considered the comment and felt that the recommendations are quite explicit in outlining that remote consultations should be approached in a 'holistic and person-centred way' with explicit reference made to 'making sure the person is able to use any digital technology being used or suggested.' The committee did not think it useful to provide a list of modes for remote consultation as this could be interpreted as an exclusive list. One stakeholder raised concerns regarding the ranges of CRP outlined in the recommendations, and that the actions as a consequence of this may not account for individual context. The stakeholder highlighted that CRP levels at baseline are influenced by pregnancy and at post-partum and may differ by age. This comment was made with reference to 'pregnancy and maternity', and 'age' but this issue has not been placed under those categories specifically as it could apply across all

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
protected and other definable characteristics. The recommendation about CRP has been clarified to emphasise that CRP is an adjunct to clinical assessment specifying that 'If it is unclear whether to prescribe antibiotics on clinical assessment alone consider a point of care C-reactive protein (CRP) test to support clinical decision making.' The rationale and impact section acknowledges the limitations of CRP testing, highlighting the committee's discussion regarding the time lag for the onset of symptoms with infections, that they correspond to the presence of CRPs and the issue with samples being taken early in the course of an infection. The rationale and impact section highlights that CRP tests are to guide antibiotic prescribing only in cases where a clinical decision cannot be made, and outline a discussion of the evidence underpinning the thresholds stated, highlighting that at a CRP test result of 100mg/l or more most people who test positive will have an infection. The rationale and impact section outlines the antimicrobial stewardship rationale supporting the thresholds and that whilst highlighting that some infections may be missed, the recommendation states that CRP is not done in isolation but as a further check to support clinical decision making regarding the need for immediate antibiotics or a back-up prescription. • Age Specific comments were raised regarding 'age' related to access and face-to-face appointments, applicability of 'Box 1', the applicability of CRB65, clarification of what constitutes remote testing and the applicability of CRP testing. All these items have been addressed in the preceding narrative as whilst the issue mentioned has been raised under 'age' they apply to all protected and other definable characteristics. • Disability Specific comments were raised regarding 'disability' related to access and face-to-face appointments, the applicability of CRB65 and clarification of what constitutes remote testing. These were made related to learning disability and autism specifically. All these items have been addressed in the preceding narrative as whilst the issues mentioned has been raised under 'disability' they apply to all protected and other definable characteristics. Stakeholders (n=2) highlighted the need to refer to reasonable adjustments, emphasise the importance of communication and to consider making reference to NHS initiatives such as the 'health passport'. Stakeholders also suggested that it would be useful to specifically mention the role of 'family and supporters' in providing input when an individual with learning disabilities is being considered remotely or face-to-face. The committee agreed that the consideration of learning disabilities and autism was important but felt that this was accounted for sufficiently in the text box

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
that precedes the recommendations that highlights that ‘People have the right to be involved in discussions and make informed decisions about their care’ and signposts the reader to NICE's information on making decisions about your care which provides NICE’s resources on shared decision making which considers how to support those using guidelines including people with learning disabilities and/or autism. The committee highlighted that the recommendations specify that remote consultations should be approached in a ‘holistic and person-centred way’ with explicit reference made to ‘making sure the person is able to use any digital technology being used or suggested.’ The committee recognised the need to be explicit and provide some examples for context throughout the recommendations, for example where reference is made to ‘taking into account the patient’s social circumstances’ when deciding on treatment for pneumonia people with a learning disability or autism is specified. In the rationale and impact section the committee have specified the need for the consideration of red flags including broader factors when interpreting the results of CRB65 (as an adjunct to clinical assessment) which now specifies the example of ‘those with learning disabilities and autism’. • Gender reassignment No specific comments were raised regarding ‘gender reassignment’ but points raised regarding access and face-to-face appointments, applicability of ‘Box 1’, the applicability of CRB65, clarification of what constitutes remote testing, and the applicability of CRP testing may have equality implications. All these items have been addressed in the preceding narrative. • Pregnancy and maternity Specific comments were raised regarding ‘pregnancy and maternity’ related to the applicability of ‘Box 1’, the applicability of CRB65 and the applicability of CRP testing. All these items have been addressed in the preceding narrative as whilst the issue mentioned has been raised under ‘pregnancy and maternity’ they apply to all protected and other definable characteristics. • Race No specific comments were raised regarding ‘race,’ but points raised regarding access and face-to-face appointments, applicability of ‘Box 1’, the applicability of CRB65, clarification of what constitutes remote testing, and the applicability of CRP testing may have equality implications. All these items have been addressed in the preceding narrative.

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
• Religion or belief No specific comments were raised regarding ‘religion or belief,’ but points raised regarding access and face-to-face appointments and clarification of what constitutes remote testing may have equality implications. All these items have been addressed in the preceding narrative. • Sex No specific comments were raised regarding ‘sex,’ but points raised regarding access and face-to-face appointments, applicability of ‘Box 1’, the applicability of CRB65, clarification of what constitutes remote testing, and the applicability of CRP testing may have equality implications. All these items have been addressed in the preceding narrative. • Sexual orientation No specific comments were raised regarding ‘sexual orientation,’ but points raised regarding access and face-to-face appointments, applicability of ‘Box 1’, the applicability of CRB65, clarification of what constitutes remote testing, and the applicability of CRP testing may have equality implications. All these items have been addressed in the preceding narrative. • Socio-economic factors Specific comments were raised regarding ‘socio-economic factors’ related to access and face-to-face appointments. This has been addressed in the preceding narrative as whilst the issue mentioned has been raised under ‘socio-economic factors’ they apply to all protected and other definable characteristics. • Other definable characteristics: No specific comments were raised regarding ‘other definable characteristics’ but points raised regarding access and face-to-face appointments, applicability of ‘Box 1’, the applicability of CRB65, clarification of what constitutes remote testing, and the applicability of CRP testing may have equality implications. All these items have been addressed in the preceding narrative.

4.2 If the recommendations have changed after consultation, are there any recommendations that 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 issues were identified

4.3 If the recommendations have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No issues were identified. The recommendations have changed but these changes have sought to make more specific reference to people with learning disabilities and autism in line with stakeholder comments and committee deliberation as an included population within the scope of this guideline.

4.4 If the recommendations have changed after consultation, 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 question 4.2, or otherwise fulfil NICE's obligations to advance equality?
No issues were identified. The recommendations have changed but these changes have sought to make more specific reference to the need for the consideration of people's individual context when applying the recommendations.

4.5 Have the Committee's considerations of equality issues been described in the final guideline, and, if so, where?
Access and remote consultations were a theme raised in the EIA. Recommendations outline that remote consultations should be approached in a 'holistic and person-centred way' with explicit reference made to 'making sure the person is able to use any digital technology being used or suggested' and have added the need to offer 'alternatives if necessary. The rationale and impact section of the guideline highlights the range of healthcare practitioners with various levels of clinical acumen and judgment involved in remote consultations and outlines the committee's agreement that it was important to "check that remote assessment is appropriate to assess for signs and symptoms of serious illness including pneumonia.' Access, face-to-face consultations, and treatment was a theme raised in the EIA. In the rationale and impact section of the guideline the committee agreed that face-to-

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face assessment is necessary if signs and symptoms of a serious acute respiratory infection (including pneumonia) are suspected but recognised the potential equalities implications of this and accessing subsequent treatment. As a result, they have amended the recommendation which acknowledges that whilst antimicrobials should not be 'routinely' prescribed for ARI's based on a remote consultation alone if there is a 'sound clinical reason' to prescribe remotely for example if the person is unable to attend a face-to-face appointment and the prescriber is confident of the clear need for antibiotics they can be prescribed. Concerns regarding Box 1 and its applicability to people aged 16 years and over were a theme raised in the EIA. Box 1 has now been deleted and the committee have added some examples of 'symptoms of concern' to recommendation 1.2.2 to emphasise that it is for the individual undertaking the remote consultation to determine whether the person they are assessing may have a serious illness and require a face-to-face assessment or whether they can be safely managed remotely based on their assessment of the individual and their specific context. Concerns regarding the ability of CRB65 to estimate the risk of pneumonia in all people aged 16 years or older and the usability of CRB65 with people with a learning disability and/or autism was a theme raised in the EIA. The recommendation about CRB65 has been amended to highlight that "CRB65 scores can be affected by pregnancy or the presence of a co-morbidity" with the recommendation reinforcing the use CRB65 as an adjunct to clinical judgement to inform decisions regarding the need for hospital assessment, the need for home-based care or a shared decision about the best pathway of care for the individual. The recommendations now make it more explicit that when deciding on treatment for pneumonia that a patient's social circumstances are to be considered with specific reference made to frailty, learning disability and autism. The rationale and impact section for this recommendation has been amended specifying that the results of CRB65 "need to be considered in the context of red flags such as rapid deterioration of complications or broader factors", with specific examples provided including people with multi-morbidities, learning disabilities and autism; emphasising that these 'red flags' indicate increased risk of deterioration. Concerns regarding CRP and the interpretation of test results against stated thresholds for all people aged 16 years or over was a theme raised in the EIA. The recommendation about CRP testing has been clarified to emphasise that CRP is an adjunct to clinical assessment and the rationale and impact section acknowledges the limitations of CRP testing, highlighting the committee's discussion regarding the time lag for the onset of symptoms with infections, that they correspond to the presence of CRPs and the issue with samples being taken early in the course of an

4.5 Have the Committee's considerations of equality issues been described in the final guideline, and, if so, where?
infection. The rationale and impact section outlines the antimicrobial stewardship rationale supporting the thresholds and that whilst highlighting that some infections may be missed, the recommendation states that CRP is not done in isolation but as a further check to support clinical decision making regarding the need for immediate antibiotics or a back-up prescription.

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