

## Equality Impact Assessment of Heart Disease Improvement Programme

### Section 1: Ownership and background

- 1.1 **Title:** Heart Disease Improvement Programme
- 1.2 **Start date:** 2008
- 1.3 **Publication date:** 31 May 2011
- 1.4 **Owner:** Mel Miller
- 1.5 **Directorate/unit/committee/group:** Guidance and Standards Directorate
- 1.6 **Related Programme of work:** Heart Disease Clinical Standards, April 2010
- 1.7 **Type of work being assessed:** Output

### Section 2: Involvement and impact

- 2.1 **Aims of the output :** The Heart Disease Improvement Programme is a nationally coordinated quality improvement programme for heart disease in Scotland. It aims to bring about improvements in the quality of care and outcomes for patients with coronary heart disease and their families. The programme was established to support sustainable measurement and review of the heart disease standards over the longer term. This approach allows service providers to evidence the quality of local heart disease services, to inform their own improvement activities and to provide a measure of wider assurance. The programme links evidence based practice, patient safety and patient-centred care. It provides a unique opportunity to improve quality of care and demonstrate to patients and the public that NHSScotland is delivering this consistently.
- 2.2 **Stakeholders:** NHS Boards, NHS staff, patients, the general public, voluntary sector.

### **2.3 Evidence of potential impact (from existing Healthcare Improvement Scotland documentation, research, consultation or literature search):**

The primary literature search carried out as part of the Heart Disease Clinical Standards, April 2010, reveals potential impact to key equality groups of people living with heart disease: race, gender and age.

Cardiac arrhythmia and atrial fibrillation is more prevalent in white men, compared to all other ethnic groups except Pacific Islanders (Borzecki et al, 2008). This study was adjusted for age, body mass index and predisposing comorbidities. White men have significantly higher odds of atrial fibrillation: 1.8 times more likely than black or Hispanic men. These findings concur with other studies of atrial fibrillation and race (Freestone et al 2003). A large scale US study of cardiac device implantation reported a statistically significant difference in the overall rate of implantation in white patients compared to other race groups. Two studies provide evidence of the link between atrial fibrillation and gender, with males more significantly affected than females (Friberg et al 2003, Murphy et al 2007). An association between prevalence of atrial fibrillation and age is widely acknowledged, with a positive correlation between prevalence of heart disease and increasing age. Murphy et al (2007) report rates of 0.03% in those under 45, 3.05% in patients between 65 and 74 and 7.07% in patients 75 or over.

A key prospective study concludes that heart failure is more prevalent in people of African-American origin, with a corresponding 34% higher 5 year mortality rate than white patients (East et al 2004). A Swedish systematic review of the epidemiology, natural history and management of male and female heart failure patients identifies that the incidence of heart failure is higher in men than women, although the prevalence rate is similar, women survive longer than men (Stromberg et al 2003).

Studies of chest pain describe the prevalence and treatment of angina in the UK and Europe. The Scottish study reports that although angina is more common in men than women, women are significantly less likely to be prescribed any of the common drug therapies, with the exception of nitrates. Older patients (75+) of both sexes were also less likely to be prescribed the optimal therapeutic drugs for the condition (Murphy et al 2006).

### **2.4 Areas where evidence is unavailable or unclear:**

There is very little published literature on the impact on the main equality groups in relation to: treatments for heart failure, patient experience of cardiology care. Small scale studies and narrative reviews demonstrate racial differences in understanding of the heart condition, patient information and drug regime compliance (Lip et al 2004), Shroff et al 2007, Vivian EM, 2006). More evidence is required on the impact of alcohol, tobacco and socio-economic factors on the prevalence and treatment of heart disease. Stromberg (2003) report that the impact of heart failure on men and women differs, with women more likely to report lower overall quality of life.

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## Section 3: Checklist

### 3.1

We have checked the following protected characteristics, as a legal obligation:	Positive Impact identified	Negative impact identified	Additional information
Age	yes	no	
Disability	no	no	
Gender	yes	no	
Gender Reassignment	no	no	
Marriage or Civil Partnership	no	no	
Pregnancy or Maternity	no	no	
Race	yes	no	
Religion or Belief	no	no	
Sexual Orientation	no	no	
<b>In accordance with Healthcare Improvement Scotland policy we have also checked the following characteristics:</b>			
Criminal Justice	no	no	
Homelessness	no	no	
Language or social origin	no	no	
Mental Health	no	no	
Poverty	no	no	

### **3.2 This output promotes or improves equality by**

This output seeks to improve equality by implementing a comprehensive programme of work to improve the delivery of heart disease care and the patient experience associated with that care for all individuals receiving it. This programme of work includes the development and publication of the heart disease standards, assessment of each heart disease managed clinical network against the standards, a national programme of heart disease audit and the development of a sustainable process of improvement methodology linked to the Scottish Patient Safety Programme. This coordinated approach to service improvement reflects the commitment to achieving the three Quality Ambitions for people and their families living with heart disease:

- 1) Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.
- 2) There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.
- 3) The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

The heart disease improvement programme recognises and values diversity and is committed to eliminating discrimination and reducing inequality for people who use heart disease clinical services in Scotland. The programme seeks to monitor local services to ensure that all patients have consistent access to high quality clinical care in diagnosis and treatment, regardless of their membership to a specific equality group. The programme will work closely with the territorial health boards and the voluntary sector (British Heart Foundation Scotland) at all times to bring about local improvements. The programme is committed to sharing the learning it obtains, adding to the knowledge base of equality information for people who live with heart disease in Scotland and ensuring that heart disease services are of high quality and fair for all.

### **3.3 A full Equality Impact Assessment is not required.**

**This has been agreed because** no negative impacts have been identified.

### **3.4 Recommendations:** The programme will complete on 31<sup>st</sup> May 2011. Work will continue until then in its current form. Key learning will be shared within established networks and with identified stakeholders.

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**3.5 Review date for this Checklist:** May 2012

**3.6 Assessors:** Mel Miller and Fiona Campbell  
**Date of assessment:** 4 May 2011

**3.7 Quality Assurance (E&D Officer):** Jeniffer Kibagendi

**Date of Quality Assurance:** 18 July 2011

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