NHS England and NHS Improvement: Equality and Health Inequalities Impact Assessment (EHIA) : Evidence Based Interventions Programme

A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal.

1. Name of the proposal (policy, proposition, programme, proposal or initiative) : Evidence Based Interventions: List Two.

2. Brief summary of the proposal in a few sentences

In 2019 the Expert Advisory Committee (EAC) drew up a list of tests, treatments and procedures. The intention is to provide guidance for an additional set of interventions to supplement the programme's initial list of 17 interventions published in November 2018, which should not be routinely commissioned, except in certain circumstances where specific clinical criteria are met. The proposed tests, treatments and procedures were selected because:

- The evidence suggests they are potentially ineffective, inappropriate or can do more harm than good; and/or
- They been superseded by other, more effective treatments.

In July 2020, the Expert Advisory Committee ran a public engagement exercise hosted by the Academy of Medical Royal Colleges (AoMRC). This proposal relates to the publication of the new guidance, covering 31 additional interventions, and its incorporation into the NHSE/I programme for implementation.

3. Main potential positive or adverse impact of the proposal for protected characteristic groups summarised

Please briefly summarise the main potential impact (positive or negative) on people with the nine protected characteristics (as listed below). Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below. Please note that these groups may also experience health inequalities.**

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
Age: older people; middle years; early years; children and young people.	• A respondent to the engagement exercise asked for the programme to clarify which procedures applied to children versus adults, and this point was repeated again during a webinar (the latter specifically referencing the age ranges detailed in EBI's proposed clinical codes). • It was noted that risk profiles vary with age. For example, older people may be at increased risk for hematoma when undergoing SWL (shock wave lithotripsy). • Age profiles by intervention are available in Appendix A.	**Reducing Adverse Impacts:** • To ensure the guidance is widely accessible, the programme will be creating patient information leaflets, which will be co-developed with patients in the most affected age ranges. We will design these in order to maximize uptake and comprehension amongst those age groups who will benefit most. We will work with our Demonstrator Community, and where a system demonstrates effective implementation of the guidance for a specific age group, we will take the learning from their approach and make it available to others. • The guidance and codes have been reviewed and amended to consider requests for clarification, including the age ranges referred to. • On balance, for those patients who would otherwise require surgery, SWL is safer

		and contains less risk than surgical removal. Decisions are made on a case-by-case basis following clinician-patient discussion.
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.		
Gender Reassignment and/or people who identify as Transgender	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated with gender reassignment and/or people who identify as transgender from the implementation of this guidance. • The guidance has no specific reference to or known impact on gender reassignment or transgender individuals or issues. Throughout the engagement, we did not receive any submissions which referenced gender reassignment or transgender people, nor questions raised in the engagement events which we ran.	**Increasing Positive Impacts:** • We will work with our Demonstrator Community, and where a system demonstrates effective implementation of the guidance, we will take the learning from their approach and make it available to others to use and support. • In developing our patient information leaflets (see above), we will provide oversight opportunities to the Health and Wellbeing Alliance (including the LGBT Consortium).
Marriage & Civil Partnership: people married or in a civil partnership.	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated with	

	marital status from the implementation of this guidance.	
Pregnancy and Maternity: women before and after childbirth and who are breastfeeding.	• While data is unavailable with respect to this characteristic, we expect that there are no adverse impacts associated with pregnancy or maternity status arising from the implementation of this guidance.	
Race and ethnicity[2]	• For several reasons, some conditions are more common or serious within certain ethnic groups. For example, Black men are at higher risk of prostate cancer. PSA (prostate-specific antigen) testing has been raised by multiple engagement respondents and several times during the clinical webinars and patient focus groups. The specific suggestion is that Black men may be disadvantaged by lack of access to PSA testing, a commonly used method to identify prostate cancer.	**Reducing Adverse Impacts:** • The variation has been clinically reviewed, and it has been agreed that the data does not indicate any adverse clinical outcomes from implementing the clinically developed guidance for any specific group. • The EAC has added further emphasis to the guidance to ensure high-risk groups, including Black men have PSA testing appropriately.

Religion and belief: people with different religions/faiths or beliefs, or none.	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated with religion and belief from the implementation of this guidance.	
Sex: men; women	• Clinical conditions have different effects according to patient sex. For example, hernias present differently in different sexes, and osteoporosis is more common in women. In our data analysis, differences in the numbers of procedures received differed by sex. For example, in the vertebroplasty intervention, it is higher for women[3]. This is due to osteoporosis being more common in women.	**Reducing Adverse Impacts:** • The clinical guidance has been drafted to capture the different presentation of hernia in women.
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated on people by sexual orientation from the implementation of this guidance.	

4. Main potential positive or adverse impact for people who experience health inequalities summarised

[3] This applies to those interventions which do not explicitly exclude a given sex

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). Please state **N/A if your proposal will not impact on patients who experience health inequalities.**

Groups who face health inequalities[4]	**Summary explanation of the main potential positive or adverse impact of your proposal**	**Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact**
Looked after children and young people	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated on looked after children and young people from the implementation of this guidance.	
Carers of patients: unpaid, family members.	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated on carers of patients from the implementation of this guidance.	
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on homeless people from the implementation of this guidance. • An issue was raised on the difficulty of accessing and completing certain alternative	**Reducing Adverse Impacts:** • Access to access to healthcare, for vulnerable groups, is a wider, recognised problem which various initiatives are attempting to address. This is a complex issue where individual circumstances may play a significant role, and the appropriate treatment may depend on information

Groups who face health inequalities[4]	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	courses of healthcare with no fixed abode.	obtainable only in the clinician-patient interaction.
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on people involved in the criminal justice system from the implementation of this guidance.	
People with addictions and/or substance misuse issues	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on people with addictions and/or substance abuse issues from the implementation of this guidance.	
People or families on a low income		
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).	• There is no routinely collected data by intervention on people with poor literacy or health literacy issues, so we cannot definitively assess, at a national level, if there will be any direct	

Groups who face health inequalities[4]	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
	adverse or positive impacts on this population.	
People living in deprived areas	• We received no engagement submissions related specifically to people in deprived areas; those which related to deprivation by income have been addressed in the 'people on a low income' section above.	
People living in remote, rural and island locations		
Refugees, asylum seekers or those experiencing modern slavery	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on refugees, asylum seekers or those experiencing modern slavery from the implementation of this guidance.	
Other groups experiencing health inequalities (please describe)	• While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on other groups experiencing health inequalities from the implementation of this guidance.	

5. Engagement and consultation

a. Have any key engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes X	No	Do Not Know

b. If yes, please briefly list up the top 3 most important engagement or consultation activities undertaken, the main findings and when the engagement and consultative activities were undertaken.

Name of engagement and consultative activities undertaken		**Summary note of the engagement or consultative activity undertaken**	**Month/Year**
1	Six-week national engagement exercise.	The EAC engagement exercise ran for six weeks and specifically requested views on any impacts associated with the protected characteristics and health inclusion groups via its online form and virtual webinars. This was requested both in general and with respect to any specific interventions. The language used to request these views was drafted in conjunction with an EAC member who is an NHSE/I recognized advocate for people experiencing health inequalities. The language was also legally validated. As part of our engagement and consultation, we sourced feedback from the NHSE/I Health and Wellbeing Alliance.	**August 2020**
2	Four clinical engagement webinars.	During the engagement exercise, we engaged widely on equalities issues. One mechanism for this was the three clinical webinars held, which allowed participants to raise any issues, including technical issues, with the guidance in relation to specific groupings of interventions. During these webinars, all participants were explicitly asked whether any deleterious	**August 2020**

		effects on any protected characteristics or those in health inclusion groups would result from the proposed changes. Similarly, a data and measurement webinar was also held, which asked the same question.	
3	Three virtual, patient-centred focus groups.	Three focus groups were held in August to work through the changes in detail with a small, informed group of patients. Twenty-nine patients participated across the three sessions, which explored a diverse range of possible impacts from the changes which the EAC considered. This allowed us to explicitly ensure that in-depth patient perspectives were considered. An external organisation, the Patients Association, was commissioned to design and lead these sessions. They also drew the audience from their own network of patients, which ensured objectivity, committed participation, and knowledge of the EBI programme.	**August 2020**
4	Data Analysis	The EBI team conducted a preliminary analysis to link NHS data with demographic data. This was performed by triangulating activity data for each List Two intervention with available demographic data (age, gender, ethnicity, disability (physical and learning) and deprivation scores).	**August 2020**

6. What key sources of evidence have informed your impact assessment and are there key gaps in the evidence?

Evidence Type	Key sources of available evidence	Key gaps in evidence
Published evidence	• NICE Clinical Guidance • NICE-accredited Clinical Guidance • NICE Equality Impact Assessments (for NICE Guidance and NICE-accredited guidance) • Peer-reviewed published clinical literature	• N/A.

Evidence Type	Key sources of available evidence	Key gaps in evidence
Consultation and involvement findings	• Responses to the EAC engagement exercise.	• N/A.
Research	• Bespoke data analysis (see Appendix A), derived from: (A) SUSPlus hosted on National Commissioning Data Repository (NCDR) (Admitted Patient Care Spells, Outpatient Spells, Emergency Care Data Sets) (B) GP Registration Data (2011 Census); (D) Indices of Multiple Deprivation 2019; (E) Outcomes Based Healthcare Segmentation Model.	• N/A.
Participant or expert knowledge For example, expertise within the team or expertise drawn on external to your team	• EAC members. • EBI Programme Team. • Expert patient advocate for health inclusion groups, April Wareham.	• N/A.

7. Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please add an x to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?	X	X	X
The proposal may support?			
Uncertain whether the proposal will support?			

8. Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?	X	X
The proposal may support?		
Uncertain if the proposal will support?		

9. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1	N/A	
2	N/A	
3	N/A	

10. Summary assessment of this EHIA findings

This assessment should summarise whether the findings are that this proposal will or will not make a contribution to advancing equality of opportunity and/or reducing health inequalities, if no impact is identified please summarise why below.

The EAC's approach – considering a wide range of information sources (published evidence and data) and stakeholder views – has allowed us to identify and provide mitigations for the equality suggestions identified. Nevertheless, where this type of impact was considered, the EAC has stressed the corrective action or preventative measures we are taking, or which are already embedded in the EBI programme. None of the interventions are subject to a blanket ban and will still be available for patients when it is clinically appropriate.

In summary, in addition to the wide-ranging evidence and analysis we have deployed to mitigate against potential questions, the programme also positively enhances relations between protected groups and contributes to health inequality reductions by:

- Providing clear and transparent decision-making guidelines, with the aim of reducing the unwarranted variation. This is intended to create consistency in policies across England, reducing the variation caused by individual clinician and system discretion;
- Where a specific group requires one of the interventions, access may be easier due to inappropriate patients being directed towards alternatives, generating capacity for appropriate patients;
- Recommending lifestyle changes which can have generally beneficial effects.

While the result of this proposal will be to create national policy, health systems will be responsible for local implementation. Commissioners will need to assess the impact on their local population from an equalities perspective, using this EHIA to support their efforts.

Promoting equality and addressing health inequalities are at the heart of NHS England's and NHS Improvement's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

11. Contact details re this EHIA

Team/Unit name:	Evidence Based Interventions/Commissioning Policy Unit
Division name:	Commissioning Policy Group
Directorate name:	Primary Care, Community Services, and Strategy Directorate
Date EHIA agreed:	13/11/2020
Date EHIA published if appropriate:	

Internal decision-making not for external circulation

12. Do you or your team need any key assistance to finalise this EHIA? Please delete the incorrect responses. If you require assistance please submit this EHIA and the associated proposal to EHIU (england.eandhi@nhs.net).

Yes:	**No:**	**Uncertain: X**

13. Assistance sought re the completion of this EHIA:

If you do need assistance to complete this EHIA, please summarise the assistance required below.

14. Responsibility for EHIA and decision-making

Contact officer name and post title:	Henri Rapson
Contact officer e: mail address:	henri.rapson@nhs.net
Contact officer mobile number:	07730 371088

Team/Unit name: Commissioning Policy Unit/Evidence Based Interventions Programme	Division name: Commissioning Policy Group	Directorate name: Primary Care, Community Services and Strategy
Name of senior manager/ responsible Director: Dr. Johannes Wolff	Post title: Deputy Director, Commissioning Policy Group	E-mail address:johannes.wolff@nhs.net

15. Considered by NHS England or NHS Improvement Panel, Board or Committee[5]

Yes:	No: X	Name of the Panel, Board or Committee: N/A

Name of the proposal (policy, proposition, programme, proposal or initiative):			
Decision of the Panel, Board or Committee	Rejected proposal	Approved proposal unamended	Approved proposal with amendments in relation to equality and/or health inequalities

Proposal gave due regard to the requirements of the PSED?	Yes:Y	No:	N/A:
Summary comments:			
Proposal gave regard to reducing health inequalities?	Yes:Y	No:	N/A:
Summary comments:			

16. Key dates

Date draft EHIA completed:	18/09/2020

[5] Only complete if the proposal is to be considered by a Panel, Board or Committee. If it will not be considered by a Panel, Board or Committee please respond N/A.

Date draft EHIA circulated to EHIU:[6]	26/10/2020
Date draft EHIA cleared by EHIU: [7]	13/11/2020
Date final EHIA produced:	01/12/2020
Date signed off by Senior Manager/Director:[8]	
Date considered by Panel, Board or Committee:	N/A
Date EHIA published, if applicable:	
EHIA review date if applicable [9]:	

[6] If the team producing the proposal has important unresolved issues or questions in relation to equality or health inequalities issues, the advice of the EHIU should be sought. A draft EHIA must also be completed, and attached to the proposal, if the proposal is to be considered through NHS England and NHS Improvement's Gateway process.
[7] If the EHIU raises concerns about the proposal, the EHIA should state how these concerns have been addressed in the final proposal.
[8] The Senior Manager or Director responsible for signing off the proposal is also responsible for signing off the EHIA.
[9] This will normally be the review date for the proposal unless a decision has been made to have an earlier review date.

Appendices

Appendix A: Data and Analysis

EHIA Analysis: EBI List Two

Methodology

Methodology and Sources:

- List 2 Data:
  - Spells from Baseline Year 2018-04-01 to 2019-03-31
  - Index of Multiple Deprivation (IMD) Decile Data Joined onto Patient Lower Super-Output Area (LSOA)
- Age and Sex Data:
  - National: Aggregated Age-Sex GP banded Registration Data where the Effective Snapshot Date is 2018-09
- Ethnicity Data:
  - National: Ethnicity Data from National Census 2011 with Effective Snapshot Date of 2011-03-27

Limitations:

- Ethnicity:
  - Ethnicity Data tends to be less complete for Outpatient Activity.
- Interpretation:
  - Statistical tests have not been performed in the following analysis.

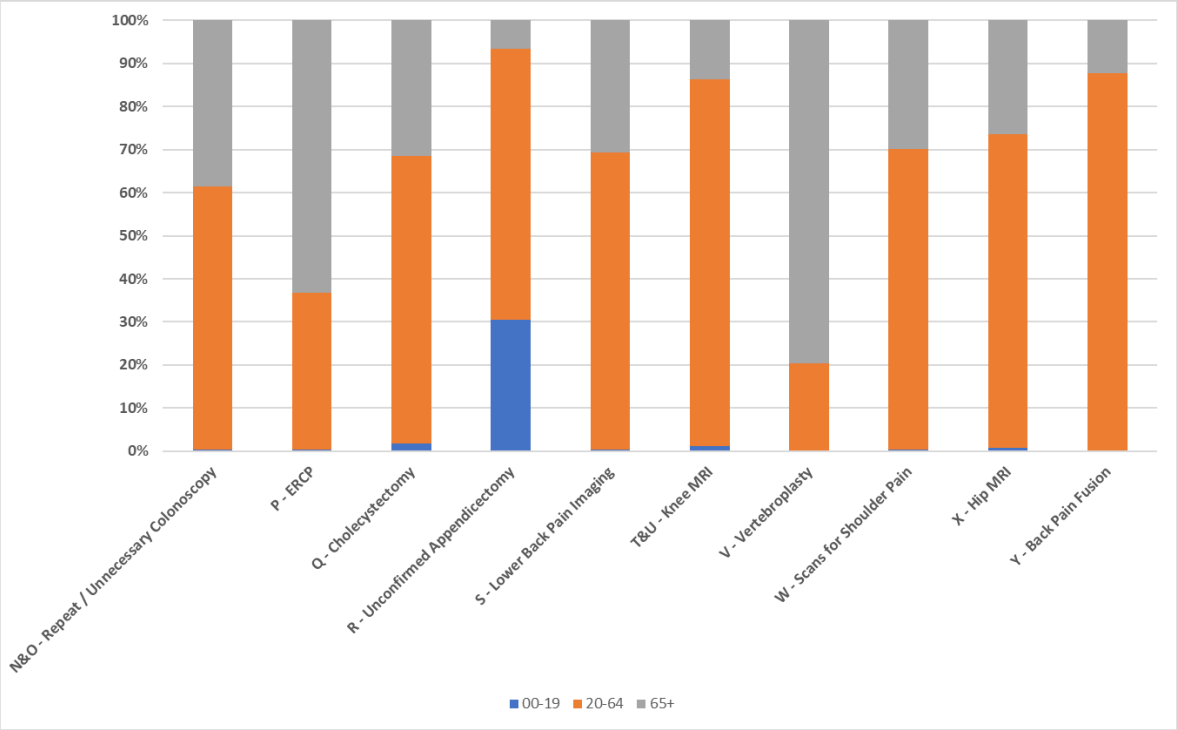
Age:

For interventions where data is available (20 out of 25 interventions), the 20-64 year old age group was mostly represented in terms of activity for those interventions.

- For the 0-19 year old age group, the interventions that are most represented include: adenoidectomy (100%) and unconfirmed appendicectomy (30.4%).
- For the 20-64 year old age group, the interventions that are most represented include: knee arthroscopy (84.4%); discectomy (88.6%); knee MRI (85.1%) and back pain fusion (87.8%).
- For the 64 plus age group, the interventions that are most represented include: cystoscopy (62.1%); benign prostatic hyperplasia (79.6%); ERCP (63.2%) and vertebroplasty (79.6%).

Figure A1. Age profiles by each EBI list 2 intervention as a proportion of total spells for 2018/19 data

Figure A2. Age profiles by each EBI list 2 intervention as a proportion of total spells for 2018/19 data (continued).



Sex:

Our data demonstrates that the distribution of the interventions varies by sex:

- 15 out of 25 interventions are broadly balanced between males and females, with no sex category exceeding 60% of the total.
- 6 out of25 interventions are between 60-90% distributed to either females or males(4 towards females, 2 males).
- 3 out of25 interventions are distributed to either females or males at a proportion of over 90% of the total, with 2 out of3 exclusively applying to men.

Figure A3. EBI list 2 interventions by sex as a proportion of total spells for 2018/19 data.

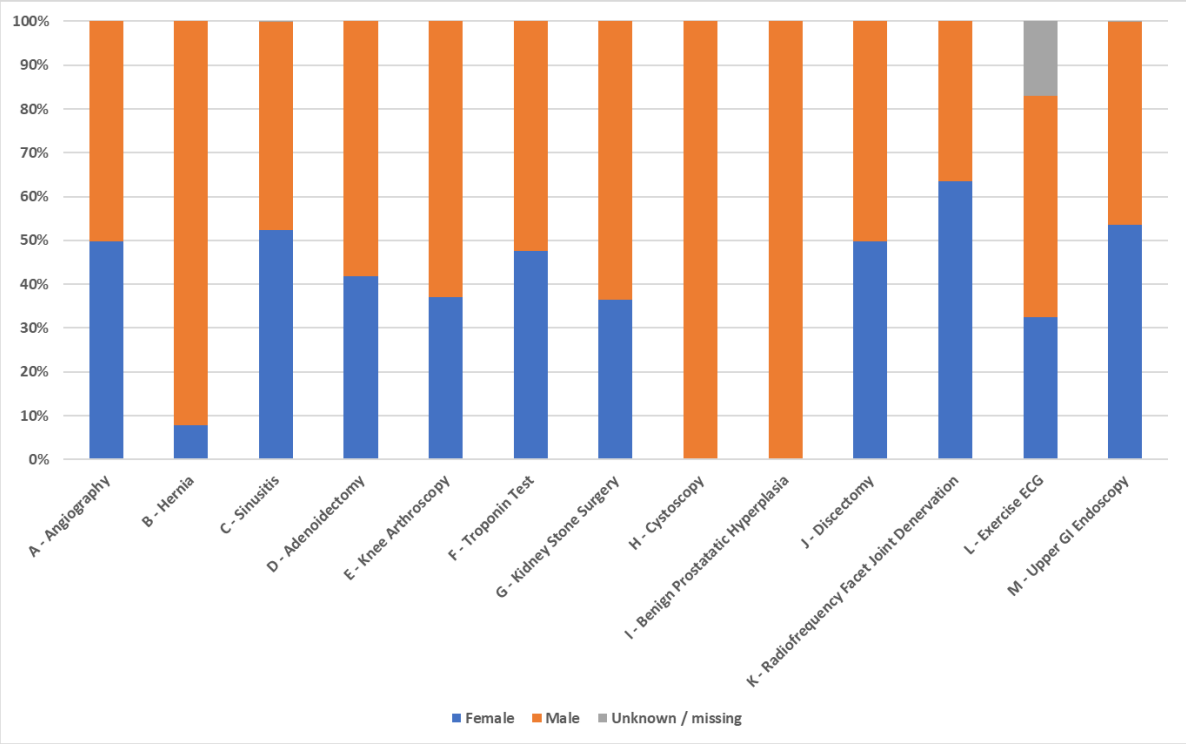
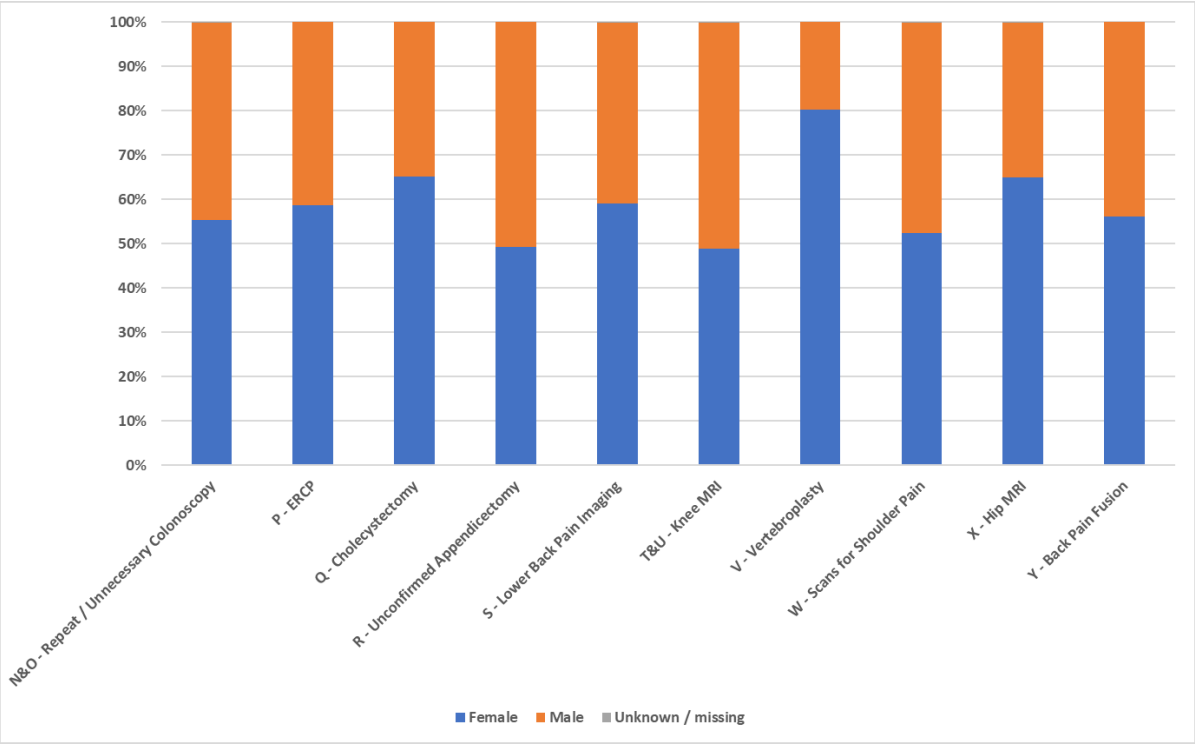


Figure A4. EBI list 2 interventions by sex as a proportion of total spells for 2018/19 data (continued).



Ethnicity:

Our data analysis shows that ethnicity varies across the interventions:

- For all interventions, the White British group were mostly represented. This ranged from back pain fusion (87.8%) to knee MRI (42.9%).
- For the Asian population, the interventions that are most represented include: exercise ECG (8.8%); scans for shoulder pain (8.2%) and troponin test (6.8%).
- For the Black African/Caribbean population, the interventions that are most represented include: back pain fusion (4.9%); scans for shoulder pain (3.9%); troponin test and angiography (both 2.8%); hip MRI and exercise ECG (both 2.7%).
- For the White Other population, the interventions that are most represented include: kidney stone removal (7.2%); unconfirmed appendicectomy (6.9%); sinusitis (5.9%); scans for shoulder pain and hip MRI (both 5.6%).
- For the Mixed/Multiple Ethnic Group population, the interventions that are most represented include: exercise ECG (1.1%) knee MRI and scans for shoulder pain (both 1.0%) and upper GI endoscopy (0.9%).

Figure A5. EBI list 2 interventions by ethnicity as a proportion of total spells for 2018/19 data.

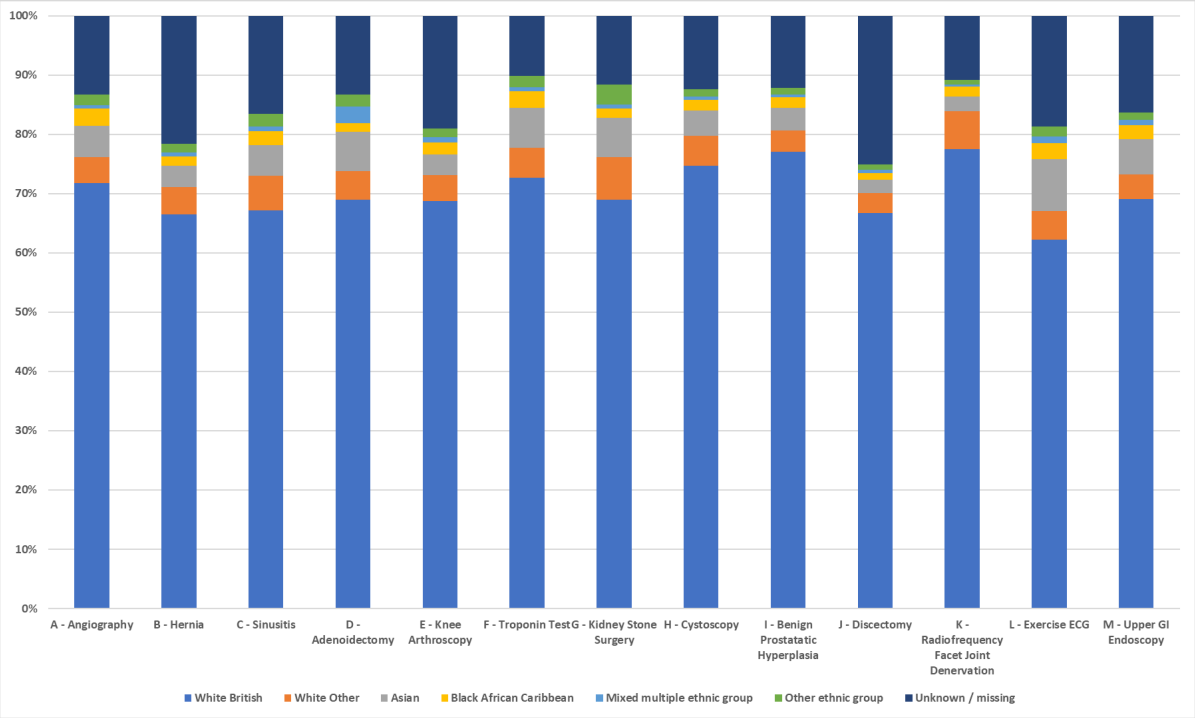
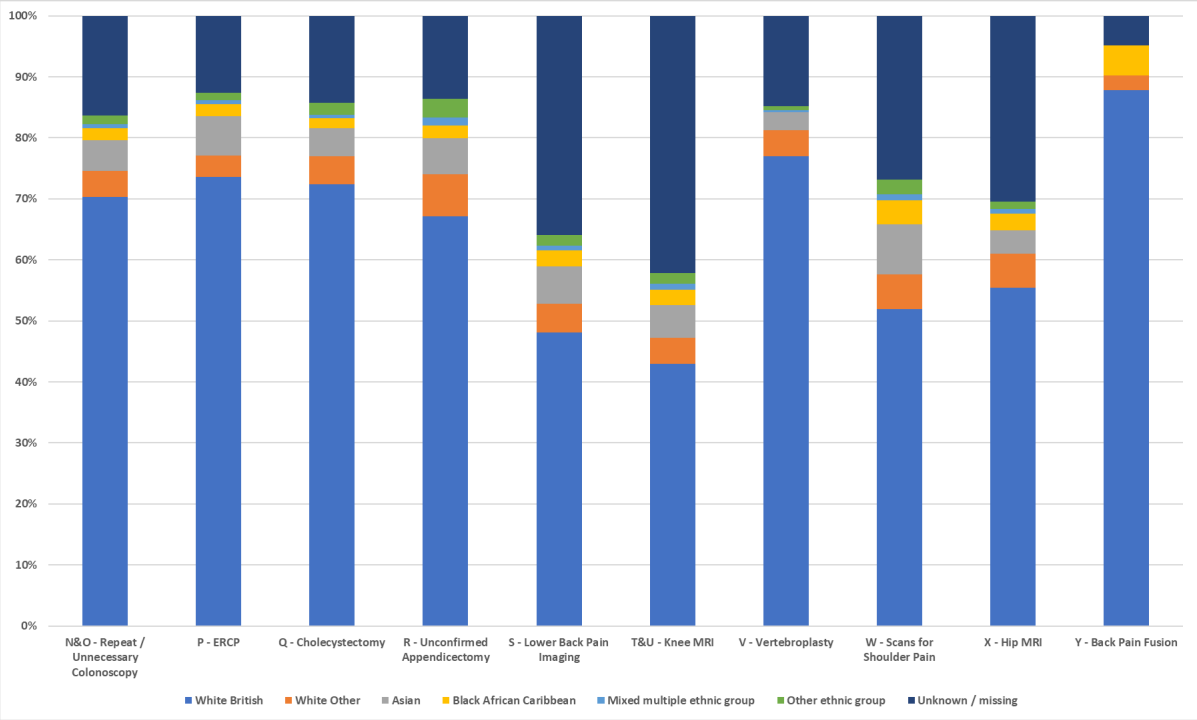


Figure A6. EBI list 2 interventions by ethnicity as a proportion of total spells for 2018/19 data (continued).


100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
N&O - Repeat / Unnecessary Colonoscopy
P - ERCP
Q - Cholecystectomy
R - Unconfirmed Appendicectomy
S - Lower Back Pain Imaging
T&U - Knee MRI
V - Vertebroplasty
W - Scans for Shoulder Pain
X - Hip MRI
Y - Back Pain Fusion
White British
White Other
Asian
Black African Caribbean
Mixed multiple ethnic group
Other ethnic group
Unknown / missing