NHS England: Equality and Health Inequalities Impact Assessment (EHIA) template

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)[1]:

2. Brief summary of the proposal in a few sentences

The Evidence-based Interventions (EBI) programme began as an NHS England (NHSE) initiative in 2018/19 – at its heart, it is a programme designed to tackle over-medicalisation by not offering, or reducing the number of tests, treatments and procedures which are of no or little clinical value.

The workstream moved into the Elective Recovery Programme at NHSE in November 2021. Led by the Academy of Medical Royal Colleges (AoMRC), EBI now sits against the backdrop of the Elective Recovery Plan for tackling the elective backlog and, as such, it is well placed to focus and assist in propelling efforts to:

- maximise NHS capacity and where possible free up clinical time for new patients and those with greatest clinical need,
- transform the way we provide elective care, for example through streamlined pathways enabling shorter waits,
- ensure there is better information and support provided to patients about the most appropriate care available to them and reducing unwarranted variation and health inequalities.

The programme has published a suite of 58 interventions in total. The proposal is to include 3 additional interventions:

1. PSA testing for men aged over 80 years old and above.
2. Transurethral resection of bladder tumor (TURBT) single post instillation of mitomycin C (SPI-MMC)
3. Investigation and onward referral of women with recurrent urinary tract infections (rUTIs)

These specific recommendations have been drafted in close collaboration with specialist societies, Royal Colleges, and an Expert Working Group (EWG), signed off by the independent Expert Advisory Committee (EAC) prior to the EBI Programme board, which includes clinical and non-clinical leaders from the AoMRC, NHSE, NHS Commissioners, the National Institute for Health and Care Excellence (NICE), NHS Confederation and The Patients Association.

[1] Proposal: We use the term proposal in the remainder of this template to cover the terms initiative, policy, proposition, proposal, or programme.

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.	This guideline aims to compliment NICE Guidance NG12 by providing detail on the principles that should inform a shared decision-making process in men over 80 who are considering, or who have had, a PSA test - we would therefore expect it to have a positive impact. PSA testing is a highly complex and contentious area, and it is important that primary care clinicians and patients are appropriately supported to allow shared decision-making. There is a particular risk of over-diagnosing and over-treating prostate cancer in men over 80 where the prevalence of cancer is highest, but the proportion of cancers that are clinically significant is lowest. The diagnosis and radical treatment of prostate carries a significant risk of side effects that can negatively impact quality of life and it is important that these are avoided where treatment will not improve quality of life or survival. Individuals need to live at least 10 years to benefit from radical treatment for localised prostate cancer and this will not be true for many, with the median life expectancy only 8 years for a man turning 80 in the UK.	Before a PSA test is performed a shared decision-making process should take place between the patient and the primary care clinician where the limitations of the test and the possible consequences of an abnormal result are discussed The clinician should consider discussing the following points: • PSA can commonly be raised in the absence of prostate cancer (false positive) and occasionally be normal where cancer is present (false negative). • Prostate cancer confined to the prostate gland is typically asymptomatic – LUTS are not a reliable symptom of localised prostate cancer for men over 80 years old. • Prostate cancer confined to the prostate gland is common, but many cancers diagnosed in this age-group will be clinically insignificant meaning they won't cause symptoms in an individual's lifetime or shorten their life expectancy. • An individual must live for at least 10 years to benefit from radical treatment of prostate cancer

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
		when it is confined to the prostate gland and radical treatment can be associated with side effects, (e.g., incontinence and erectile dysfunction) that impact quality of life. • In men over 80, PSA testing should be encouraged where there are symptoms suggestive of metastatic prostate cancer (such as bone pain, unintended weight loss and fatigue). • In men over 80 without signs of metastatic disease the benefit of PSA testing is uncertain. A PSA test should only be performed in men who want one after an appropriate shared decision-making process (see above). The potential benefits are greater in those with a life expectancy of more than 10 years.
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	We would not expect the guidance to have an adverse impact on disability. Furthermore, no feedback was submitted/ no questions were raised during the consultation/ engagement period.	An accessible patient resource which uses the shared decision-making principles of Choosing Wisely UK is in development for each intervention to support informed patient decision-making, including for those who struggle with poor understanding of the health service and who would benefit from simple communication. These materials consider BRAN and will be key tools to involving patients in decisions about their care: **BRAN:** • What are the **Benefits**? • What are the **Risks**? • What are the **Alternatives**? • What if I do **Nothing**?

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
Gender Reassignment and/or people who identify as Transgender	There is no routinely collected data on gender reassignment or people who identify as transgender available to include in our analysis. It is therefore not possible to definitively assess the impact of EBI on gender reassigned or transgender individuals; however, the guidance has no specific reference to or known impact on gender reassignment or transgender individuals or issues and, during the consultation/ engagement period, no feedback was submitted/ no questions were raised which referenced gender reassignment or transgender people. **PSA Testing for men aged 80 years old and above** relates to those who have a prostate, this includes: • Cismen (men who identify as male and were assigned male at birth) • Trans women (women who identify as female and were assigned male at birth) • Non-binary people who were assigned male at birth. • Some intersex people. The information has been developed based on guidance and evidence in men. For trans woman, male-assigned non-binary or intersex, some of this information is still relevant — but the experience may be slightly different.	**Increasing Positive Impacts:** The EBI programme explicitly recommends that any savings from the programme are reinvested back into the system which delivered them. Using this resource, systems may be better placed to redesign, transform, and invest in services which address the specific needs for gender reassigned or transgender individuals.

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
Marriage & Civil Partnership: people married or in a civil partnership.	While data is unavailable with respect to this characteristic, we would not expect there to be any associated adverse impact from the implementation of this guidance. In addition, no feedback was submitted/ no questions were raised relating to marriage & civil partnership during the consultation/ engagement period.	
Pregnancy and Maternity: women before and after childbirth and who are breastfeeding.	Data relating to this characteristic is unavailable; however, we would not expect the guidance to have an adverse impact on pregnancy and maternity. Furthermore, no feedback was submitted/ no questions were raised during the consultation/ engagement period.	**Increasing Positive Impacts:** The EBI programme explicitly recommends that any savings are reinvested back into the system which delivered them. Using this resource, systems may be better placed to redesign, transform, and invest in services which address the needs of women at any stage in the maternity process. Given the presence of the well-established, national Maternity Transformation Programme, the additional resources generated from EBI could be used to support tangible transformation projects which will positively impact on quality and safety outcomes in pregnancy and maternity services.
Race and ethnicity[2]	We would not expect the guidance to have an adverse impact on race and ethnicity. In addition, no feedback was submitted/ no questions were raised during the consultation/ engagement period.	An accessible patient resource which uses the shared decision-making principles of Choosing Wisely UK is in development for each intervention to support informed patient decision-making, including for those who struggle with poor understanding of the health service and who would benefit from simple communication. These materials

[2] Addressing racial inequalities is about identifying any ethnic group that experiences inequalities. Race and ethnicity includes people from any ethnic group incl. BME communities, non-English speakers, Gypsies, Roma and Travelers, migrants etc.. who experience inequalities so includes addressing the needs of BME communities but is not limited to addressing their needs, it is equally important to recognise the needs of White groups that experience inequalities. The Equality Act 2010 also prohibits discrimination on the basis of nationality and ethnic or national origins, issues related to national origin and nationality.

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
		consider BRAN and will be key tools to involving patients in decisions about their care: **BRAN:** • What are the **Benefits**? • What are the **Risks**? • What are the **Alternatives**? • What if I do **Nothing**?
Religion and belief: people with different religions/faiths or beliefs, or none.	No feedback was submitted/ no questions were raised during the consultation/ engagement period and we would not expect the guidance to have an adverse impact on religion and belief.	
Sex: men; women	The clinical guidance (**PSA Testing for men aged 80 years old and above**) relates to those who have a prostate, this includes: • Cismen (men who identify as male and were assigned male at birth) • Trans women (women who identify as female and were assigned male at birth) • Non-binary people who were assigned male at birth. • Some intersex people. The information has been developed based on guidance and evidence in men. For trans woman, male-assigned non-binary or intersex, some of this information is still relevant — but the experience may be slightly different.	

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
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.	It is not possible to quantitatively assess the relationship between sexual orientation and healthcare usage given the lack of data; however, no feedback was submitted/ no questions were raised during the consultation/ engagement period relating to this characteristic and we would not expect an adverse impact on this group.	

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

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[3]	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	N/A - The guidance applies to adults only.	
Carers of patients: unpaid, family members.	There is no routinely collected data by intervention on carers, so we cannot definitively assess, at a national level, if there will be any adverse or positive impacts; however, we would not expect there to be an adverse impact on this group.	
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	There is no routinely collected data by intervention on homeless people, so we cannot definitively assess, at a national level, if there will be any direct adverse or positive impacts on this population; however, we would not expect there to be an adverse impact on this group.	
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	There is no routinely collected data by intervention on people involved in the criminal justice system, so we cannot definitively assess, at a national level, if there will be any direct adverse or positive impacts on this population; however, no feedback was submitted/ no questions were raised referencing the impact on people involved in the criminal justice system during the	

[3] Please note many groups who share protected characteristics have also been identified as facing health inequalities.

Groups who face health inequalities[3]	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
	consultation/ engagement period and we would not expect there to be an adverse impact on this group.	
People with addictions and/or substance misuse issues	There is no routinely collected data by intervention on people with addictions and/ or substance abuse issues, so we cannot definitively assess, at a national level, if there will be any direct adverse or positive impacts on this population; however, no feedback was submitted/ no questions were raised referencing the impact on people with addictions and/ or substance misuse issues during the consultation/ engagement period.	
People or families on a low income	No feedback was submitted/ no questions were raised referencing the impact on people or families on a low income during the consultation/ engagement period and we would not expect there to be an adverse impact on this group.	
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).	We would not expect there to be an adverse impact on people with poor literacy or health literacy and no feedback was submitted/ no questions were raised relating to this group during the consultation/ engagement period.	An accessible patient resource which uses the shared decision-making principles of Choosing Wisely UK is in development for each intervention to support informed patient decision-making, including for those who struggle with poor understanding of the health service and who would benefit from simple communication. These materials consider BRAN and will be key tools to involving patients in decisions about their care: **BRAN:** • What are the **Benefits**? • What are the **Risks**?

Groups who face health inequalities[3]	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
		• What are the **Alternatives**? • What if I do **Nothing**?
People living in deprived areas	No feedback was submitted/ no questions were raised referencing people living in deprived areas during the consultation/ engagement period.	
People living in remote, rural and island locations	No specific impact on people living in remote, rural and island locations was identified**.**	
Refugees, asylum seekers or those experiencing modern slavery	No feedback was submitted/ no questions were raised regarding refugees, asylum seekers or those experiencing modern slavery during the consultation/ engagement period – we would not expect an adverse impact on this group.	
Other groups experiencing health inequalities (please describe)	There is no routinely collected data by intervention on other groups experiencing health inequalities, so we cannot definitively assess, at a national level, if there will be any direct adverse or positive impacts on this population. No feedback was submitted/ no questions were raised during the consultation/ engagement period which identified an issue with/ impact on other groups experiencing health inequalities.	

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	Public engagement	A stakeholder mapping exercise was undertaken to identify the appropriate clinical, patient, and lobbying groups with an interest in the proposed guidance. This was completed via desk-based research and discussions with Royal Colleges, AoMRC Patient & Lay Committee, members of the EWG and existing AoMRC stakeholders. An engagement exercise (focused on clinical groups, medical societies, charities, and patient and advocacy groups) was subsequently launched to raise awareness of the up-coming public engagement. A public engagement toolkit was also prepared (consisting of a feedback form, coding presentation and survey questions, and branded guidance) which was made publicly available on the AoMRC website at the launch of the public engagement. This enabled comments to be submitted/ concerns to be raised in relation to the 3 proposals.	**July – Sept 2023**
2			
3			

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 Equality Impact Assessments	
Consultation and involvement findings	Responses to the EAC/ EBI/ GIRFT consultation exercise.	
Research	**PSA testing for men aged over 80 years old and above:** • NPCA-Annual-Report-2021_Final_13.01.22-1.pdf • About prostate cancer | Prostate Cancer UK • Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries - Bray - 2018 - CA: A Cancer Journal for Clinicians - Wiley Online Library • Overview | Suspected cancer: recognition and referral | Guidance | NICE • Prostate cancer risk management programme: overview - GOV.UK (www.gov.uk) • The diagnostic impact of UK regional variations in age-specific prostate-specific antigen guidelines - PubMed (nih.gov) • Urinary symptoms and prostate cancer—the misconception that may be preventing earlier presentation and better survival outcomes | BMC Medicine | Full Text (biomedcentral.com) • National life tables – life expectancy in the UK - Office for National Statistics (ons.gov.uk) • Fifteen-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Prostate Cancer | NEJM • Prostate cancer screening with prostate-specific antigen (PSA) test: a clinical practice guideline | The BMJ • Overtreatment of men with low-risk prostate cancer and significant comorbidity - PubMed (nih.gov) • NHS England » Shared decision-making • Prostate cancer - Should I have a PSA test? - NHS (www.nhs.uk) • Patient-Reported Outcomes after Monitoring, Surgery, or Radiotherapy for Prostate Cancer | NEJM • Cancer statistics, 2022 (wiley.com) • Age and racial distribution of prostatic intraepithelial neoplasia - PubMed (nih.gov) • Mortality and prostate cancer risk in 19,598 men after surgery for benign prostatic hyperplasia - PubMed (nih.gov) • The development of human benign prostatic hyperplasia with age - PubMed (nih.gov) • Lead times and overdetection due to prostate-specific antigen screening: estimates from the European Randomized Study of Screening for Prostate Cancer - PubMed (nih.gov) • Outcomes of localized prostate cancer following conservative management - PubMed (nih.gov)	

Evidence Type	Key sources of available evidence	Key gaps in evidence
	• EAU-EANM-ESTRO-ESUR-ISUP-SIOG-Guidelines-on-Prostate-Cancer-2023.pdf (d56bochluxqnz.cloudfront.net) • Follow-up of Prostatectomy versus Observation for Early Prostate Cancer (nejm.org) • Screening for prostate cancer - PubMed (nih.gov) • Radical prostatectomy versus watchful waiting in early prostate cancer - PubMed (nih.gov) • Time, symptom burden, androgen deprivation, and self-assessed quality of life after radical prostatectomy or watchful waiting: the Randomized Scandinavian Prostate Cancer Group Study Number 4 (SPCG-4) clinical trial - PubMed (nih.gov) • Radical prostatectomy versus watchful waiting in localized prostate cancer: the Scandinavian prostate cancer group-4 randomized trial - PubMed (nih.gov) • Radical prostatectomy versus watchful waiting in early prostate cancer - PubMed (nih.gov) • Development and validation of a life expectancy calculator for US patients with prostate cancer - Chase - 2022 - BJU International - Wiley Online Library • Clinicians are poor raters of life-expectancy before radical prostatectomy or definitive radiotherapy for localized prostate cancer - PubMed (nih.gov) • The assessment of patient life-expectancy: how accurate are urologists and oncologists? - PubMed (nih.gov) • Discordance between patient-predicted and model-predicted life expectancy among ambulatory patients with heart failure - PubMed (nih.gov) • Using PSA to Guide Timing of Androgen Deprivation in Patients with T0–4 N0–2 M0 Prostate Cancer not Suitable for Local Curative Treatment (EORTC 30891) - ScienceDirect • Ability of serum prostate-specific antigen levels to predict normal bone scans in patients with newly diagnosed prostate cancer - ScienceDirect • Determination of the optimal cut-off value of serum prostate-specific antigen in the prediction of skeletal metastases on technetium-99m whole-body bone scan by receiver operating characteristic curve analysis - PMC (nih.gov) **Transurethral resection of bladder tumor (TURBT) single post instillation of mitomycin C (SPI-MMC):** • Systematic Review and Individual Patient Data Meta-analysis of Randomized Trials Comparing a Single Immediate Instillation of Chemotherapy After Transurethral Resection with Transurethral Resection Alone in Patients with Stage pTa-pT1 Urothelial Carcinoma of the Bladder: Which Patients Benefit from the Instillation? - PubMed (nih.gov) • Urology_2021-12-10_Guidance_Bladder-cancer.pdf (gettingitrightfirsttime.co.uk) • 1 Recommendations | Bladder cancer: diagnosis and management | Guidance | NICE • Immediate post-transurethral resection of bladder tumor intravesical chemotherapy prevents non-muscle-invasive bladder cancer recurrences: an updated meta-analysis on 2548 patients and quality-of-evidence review - PubMed (nih.gov)	

Evidence Type	Key sources of available evidence	Key gaps in evidence
	• A single immediate postoperative instillation of chemotherapy decreases the risk of recurrence in patients with stage Ta T1 bladder cancer: a meta-analysis of published results of randomized clinical trials - PubMed (nih.gov) • Systematic Review and Individual Patient Data Meta-analysis of Randomized Trials Comparing a Single Immediate Instillation of Chemotherapy After Transurethral Resection with Transurethral Resection Alone in Patients with Stage pTa-pT1 Urothelial Carcinoma of the Bladder: Which Patients Benefit from the Instillation? - PubMed (nih.gov) • EAU-Guidelines-on-Non-muscle-Invasive-Bladder-Cancer-2023_2023-03-10-101110_jued.pdf (d56bochluxqnz.cloudfront.net) • Bladder Cancer: Non-Muscle Invasive Guideline - American Urological Association (auanet.org) • Cancer Quality Performance Indicators (QPIs) (healthcareimprovementscotland.org) • Trial-based Cost-effectiveness Analysis of an Immediate Postoperative Mitomycin C Instillation in Patients with Non-muscle-invasive Bladder Cancer - PubMed (nih.gov) **Investigation and onward referral of women with recurrent urinary tract infections (rUTIs):** • Epidemiology of urinary tract infections: incidence, morbidity, and economic costs - PubMed (nih.gov) • EAU-Guidelines-on-Urological-Infections-2022.pdf (d56bochluxqnz.cloudfront.net) • Overview | Urinary tract infection (recurrent): antimicrobial prescribing | Guidance | NICE • Incidence and Management of Uncomplicated Recurrent Urinary Tract Infections in a National Sample of Women in the United States - PubMed (nih.gov) • The epidemiology of urinary tract infection - PubMed (nih.gov) • Recurrent Lower Urinary Tract Infections Have a Detrimental Effect on Patient Quality of Life: a Prospective, Observational Study - PubMed (nih.gov) • Evaluation of post–flexible cystoscopy urinary tract infection rates | American Journal of Health-System Pharmacy | Oxford Academic (oup.com) • Recommendations | Urinary tract infection (lower): antimicrobial prescribing | Guidance | NICE • Infectious Diseases Society of America Guidelines for the Diagnosis and Treatment of Asymptomatic Bacteriuria in Adults | Clinical Infectious Diseases | Oxford Academic (oup.com) • Guideline of guidelines: management of recurrent urinary tract infections in women - Kwok - 2022 - BJU International - Wiley Online Library • Recurrent Uncomplicated Urinary Tract Infections in Women: AUA/CUA/SUFU Guideline | Journal of Urology (auajournals.org) • Common Questions About Recurrent Urinary Tract Infections in Women - PubMed (nih.gov)	

Evidence Type	Key sources of available evidence	Key gaps in evidence
	• The 2017 Update of the German Clinical Guideline on Epidemiology, Diagnostics, Therapy, Prevention, and Management of Uncomplicated Urinary Tract Infections in Adult Patients: Part 1 | Urologia Internationalis | Karger Publishers • Guidelines for the diagnosis and management of recurrent urinary tract infection in women (nih.gov) • Diagnostic yield of cystoscopy in the evaluation of recurrent urinary tract infection in women - Pagano - 2017 - Neurourology and Urodynamics - Wiley Online Library • Flexible cystoscopy findings in patients investigated for profound lower urinary tract symptoms, recurrent urinary tract infection, and pain - PubMed (nih.gov) • Cystoscopy in women with recurrent urinary tract infection - PubMed (nih.gov) • Evaluation of the diagnostic workup in young women referred for recurrent lower urinary tract infections - PubMed (nih.gov) • Value of urologic investigation in a targeted group of women with recurrent urinary tract infections - PubMed (nih.gov) • Do Intravenous Urography and Cystoscopy Provide Important Information in Otherwise Healthy Women with Recurrent Urinary Tract Infection? - MOGENSEN - 1983 - British Journal of Urology - Wiley Online Library • The role of excretory urography and cystoscopy in the evaluation and management of women with recurrent urinary tract infection - PubMed (nih.gov) • Clinical significance of video-urodynamic in female recurrent urinary tract infections - PMC (nih.gov) • Recurrent urinary tract infections in postmenopausal women - PubMed (nih.gov) • Methenamine hippurate compared with antibiotic prophylaxis to prevent recurrent urinary tract infections in women: the ALTAR non-inferiority RCT - PubMed (nih.gov)	
Participant or expert knowledge For example, expertise within the team or expertise drawn on external to your team	EAC members EAC/ EBI Clinical Lead The Patients Association (informed patients). Various national and local voluntary sector organisations. Various specialist societies and Royal Colleges.	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	There is a lack of national data to support the assessment of the impact of each EBI on protected characteristic groups and groups who face health inequalities.	The EBI team has developed a proposal with the following objectives to evaluate health inequalities in the implementation of the programme: • To develop a monitoring tool to analyse potential inequalities in the implementation of the EBI programme available for NHS organisations. • To investigate potential inequalities in the implementation of the EBI programme employing epidemiological research methods in procedures where descriptive evidence suggests inequalities in the implementation. This work is currently being piloted for the urology interventions in previously published clinical guidance together with those detailed in this guidance. It is important to note that this work will continue to need to be supported by local intelligence and data in light of the limited routinely collected data at a national level.

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 consultative approach – considering a wide range of information sources and stakeholder views – has allowed us to identify and provide mitigations for the small number of equality suggestions.

In addition to the wide-ranging evidence, we have deployed to mitigate against potential impacts, the programme 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 unwarranted variation. This is intended to create consistency in policies across England, replacing the variation caused by individual clinician and system discretion.

While the result of this proposal will be to create national policy, ICBs will be responsible for local implementation. They will need to assess the impact on their local population from an equality's perspective, using this EHIA to support their efforts.

11. Contact details re this EHIA

Team/Unit name:	Elective Recovery – Transformation & Programme Delivery
Division name:	Elective Recovery
Directorate name:	Chief Operating Officer
Date EHIA agreed:	
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 the Patient Equalities Team (england.eandhi@nhs.net).

Yes:	**No: x**	**Uncertain:**

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:	
Contact officer e: mail address:	
Contact officer mobile number:	

Team/Unit name: Elective	Division name:	Directorate name:
Name of senior manager/ responsible Director:	Post title:	E-mail address:

15. Considered by NHS England, Board or Committee[4]

Yes:	No:	Name of the Panel, Board or Committee:

[4] 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.

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:	No:	N/A:
Summary comments:			
Proposal gave regard to reducing health inequalities?	Yes:	No:	N/A:
Summary comments:			

16. Key dates

Date draft EHIA completed:	
Date draft EHIA circulated to PE Team:[5]	
Date draft EHIA cleared by PE Team: [6]	
Date final EHIA produced:	
Date signed off by Senior Manager/Director:[7]	
Date considered by Panel, Board or Committee:	
Date EHIA published, if applicable:	
EHIA review date if applicable [8]:	

[5] If the team producing the proposal has important unresolved issues or questions in relation to equality or health inequalities issues, the advice of the PE Team 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's Gateway process.
[6] If the PE Team raises concerns about the proposal, the EHIA should state how these concerns have been addressed in the final proposal.
[7] The Senior Manager or Director responsible for signing off the proposal is also responsible for signing off the EHIA.
[8] This will normally be the review date for the proposal unless a decision has been made to have an earlier review date.