NHS England and NHS Improvement: 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]**:** Clinical Commissioning Policy Proposal: Fostemsavir for multi-drug resistant HIV-1 infection (adults). URN 2108.

2. Brief summary of the proposal in a few sentences

This Clinical Commissioning Policy outlines the commissioning criteria for the use of fostemsavir in multi-drug resistant (MDR) HIV-1 infection. Fostemsavir is a first in class, glycoprotein 120 attachment inhibitor (gp-120), which is targeted to the HIV viral envelope. Fostemsavir causes a confirmation change, which inhibits the virus entering the host cells. Multi-drug resistant HIV-1 infection affects a minority of people living with HIV, but in whom there are limited remaining approved and fully active antiretrovirals (ART) to form a viable ART regimen which induces viral suppression. This could be as a result of drug resistance (screening or historical resistance or both) and/or additional factors (e.g. ART tolerability, ART availability, ART safety concerns and/or drug contraindications) which affect the ability to use remaining ART drugs. The aim of fostemsavir is to supress the virus, reducing the consequences of immunosuppression which include increased mortality, morbidity and poor health related quality of life. If the virus is supressed, the ability for an individual to transmit the virus is negligible.

The clinical policy was developed through conducting an externally conducted evidence review and by a Policy Working Group (PWG) consisting of HIV experts, a public health specialist and specialised commissioner for NHS England. This policy recommends that fostemsavir is made available as an option for adults if they have multi-drug resistant HIV-1 infection, and meet the criteria outlined in the policy.

[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.	The age profile of newly diagnosed individuals with HIV demonstrates different risk profiles within patient population groups. There has also been a change in the age profile of newly HIV diagnosed individuals over the past 10 years, with males over 50 years increasing, whilst other at risk groups in younger age brackets decreasing. Older individuals feature as a higher proportion presenting late with HIV, and subsequently have a higher mortality. This is important for the intervention proposed as with age also increases medical complexity. This can limit the available suitable antiretroviral (ART) options, making HIV (for a small number of patients), more difficult to treat. Children do not feature as a significant proportion of individuals with multi-drug resistant (MDR)-HIV-1 infection, with the	Children are not included within the fostemsavir policy due to the safety profile of the drug not being established in this population. If approved, post-adolescent children and young adults could access the intervention as per the NHS England Policy 170001/P Commissioning Medicines for Children in Specialised Services. The population of individuals with multi-drug resistance (MDR) is estimated to be small in the UK and is often associated with complexity of care including treatment experience and other patient factors (other medical conditions) which limit the number of ART agents available. The paediatric data suggests that the predominant of children are virally suppressed. This suggests the impact of the policy to exclude children would be minimal.

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
	predominant of children being virally suppressed on ART. This summary is supported by Public Health England (PHE) 2019 data in HIV populations.[2] Overall, in 2018, 34% (246/724) of men were aged 50 years or over at the time of their diagnosis, in comparison to 23% (187/826) of women. These figures compare to 19% (253/1,320) and 10% (184/1,916) in 2009, respectively. The proportion of HIV diagnoses made at a late stage of infection increased with age largely due to the longer delay before diagnosis as well as a more rapid decline in CD4 counts among older persons. In 2018, 28% (133/473) of people aged 15 to 24 years were diagnosed late compared to 58% (449/770) and 64% (107/166) among those aged 50 to 64 years and over 65 years, respectively.	The patient pathway recommends regular review every 3-6 months, to ensure that fostemsavir still meets the needs of the individual. This allows for adaptions and new approaches if the health circumstances of an individual change. The pathway suggests a multi-disciplinary team (MDT) approach to capture a holistic assessment of the individual and their treatment options. This policy, if agreed and published, will be reviewed at a future specified date to consider the results of longer-term outcomes from ongoing clinical trials to ensure the commissioning criteria reflect the most up to date evidence base.

[2] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)

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	One-year mortality among people diagnosed late in 2017 was 23.62 per 1,000, compared to 2.01 per 1,000 among people diagnosed promptly. One-year mortality was particularly marked among people aged 65 years and over, at 89.29 per 1,000 (5 deaths among 56 people diagnosed late in 2017). The paediatric summary is supported by the Collaborative HIV Paediatric Study (CHIPS): [3] Viral suppression on ART: among patients on ART through 2017 (n=571) and 2018 (n=436), the proportions with confirmed virological suppression <400 copies/ml were 84% and 90% and < 50 copies/mL 75% and 81% respectively.	
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	Disability is not known to be a risk factor for MDR-HIV-1 acquisition, however if HIV is not virally suppressed it can lead to complex medical conditions which increase an individual's risk of mortality and also	This policy outlines that fostemsavir provision should be initiated and reviewed by a specialist multi-disciplinary team of professionals who are responsible for ongoing patient care. The decision for fostemsavir

[3] The collaborative HIV Paediatric study (CHIPS). 2020. Annual report 19/20 [online]. Available at: Annual Report for London HIV Commissioners (chipscohort.ac.uk)

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
	can create morbidity. In addition, other health co-morbidities can limit the use of some ART drugs, which may limit an individual's treatment options for HIV, making it MDR, by nature of the limited treatment that can be provided. This could mean that individuals with MDR-HIV-1 infection may have other complex or long-term health conditions including other physical, sensory, or additional needs. The decision for receiving fostemsavir as an intervention should be holistic, and patient focused, considering the impact it may have upon concurrent health needs.	provision is dependent on shared decision making with the patient and MDT assessment of suitability, which considers an individual's long-term health conditions and their unique circumstances and concurrent health needs.
Gender Reassignment and/or people who identify as Transgender	PHE 2019[4] data demonstrates that from 2015, 67 new HIV diagnoses have been recorded among trans[5] people: 11 diagnoses in 2018, 16 in 2017, 16 in 2016 and 24 in 2015. Six trans people diagnosed in 2018 were aged 35 to 49 years, 6 were white and 7 were diagnosed late. The data is not aggregated to	All patients who meet the inclusion criteria would be considered for fostemsavir treatment. The policy is therefore not considered to have an adverse impact on this protected characteristic group.

[4] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)
[5] Trans is an umbrella term that refers to all people whose gender identity is different to the gender given at birth, this includes trans men, trans women, non-binary, and other gender identities

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
	demonstrate if these individuals are MDR HIV-1 infected.	
Marriage & Civil Partnership: people married or in a civil partnership.	There should be no direct negative or positive impact on this group as marriage/civil partnership has not been identified as a high risk group.	Not applicable
Pregnancy and Maternity: women before and after childbirth and who are breastfeeding.	Uptake of HIV screening in pregnant women who engage with antenatal care remains high. During the financial year 2017/2018, coverage exceeded 99% with 657,231 pregnant women tested for HIV. Positive HIV diagnosis remained low and 14.3 per 100,000 women were newly diagnosed with HIV during pregnancy. [6] The majority of these pregnant women newly diagnosed in 2018 were born outside the UK (78%; 88/113) and just over half of those born abroad (56%; 49/88) were of black African ethnicity. [7] There is not a high risk association with pregnancy and maternity increasing risk factors for developing MDR-HIV-1 infection. Pregnancy would be a key time	Fostemsavir has a limited amount of data for use in pregnancy (less than 300 pregnancy outcomes). The summary of product characteristics (SmPC) advises as a precautionary measure it is preferable to avoid the use of fostemsavir during pregnancy. The policy suggests that individuals' suitability is assessed and discussed by a HIV specialist MDT. This could assist with the clinical challenges of considering fostemsavir use in pregnancy for this complex cohort as MDR-HIV-1 infection (which by definition is not virally suppressed) places an individual and also child at increased risk of complications and also the child of vertical transmission.

[6] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)
[7] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)

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
	to achieve viral suppression to reduce vertical transmission to the child. Women with HIV-1 infection are not encouraged to breast feed, in order to avoid HIV transmission. The risk of transmission is higher in individuals who are not virally suppressed as in the case of MDR-HIV-1 infection.	As breast-feeding is a potential risk factor for transmission and individuals with MDR-HIV-1 by definition are not virally suppressed, it would not be recommended to breast-feed. The SmPC data suggests the effects of fostemsavir excretion into breast milk are unknown. Given these factors, the policy is not thought to exclude this patient cohort after appropriate discussion regarding the risks.
Race and ethnicity[8]	Race and ethnicity can have an impact on MDR-HIV-1, as there are different prevalence rates for HIV and MDR HIV-1 globally. This can impact, particularly new migrants to the UK, who may have been exposed to a greater risk of HIV acquisition and/or different levels of healthcare and treatment access, which can increase the risk of MDR HIV-1 acquisition. The MDR-HIV-1 data is not broken down into race and ethnicity groupings.	All patients who meet the inclusion criteria would be considered for fostemsavir treatment. The proposal is therefore not considered to have an adverse impact on this protected characteristic group.

[8] 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
	Race and ethnicity data are collected in new diagnosis of HIV and in some ethnic groups a higher rate of new diagnosis of HIV is seen, as well as a slower rate of decline in new cases compared to other ethnic groups. Overall, there has been a reduction in HIV diagnosis over the past 10 years. Race and ethnicity data are important to capture as some groups experience health inequities in access to care and support for HIV. These summary statements are supported by PHE data[9]: In 2018, 71% of newly diagnosed gay and bisexual men (GBM) were of white ethnicity, and the number of new diagnoses among white GBM declined by 49% since 2014 (2,478 to 1,276). The overall numbers of black, Asian and minority ethnic (BAME) GBM newly diagnosed with HIV were lower, and declines were also observed relative to 2014 among black men (34%, 154 to 101) and Asian men (30%, 194 to 136). New	

[9] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)

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
	diagnoses among GBM of other/mixed ethnicity have remained stable (0%, 273 to 273). Black African men and women accounted for 44% (643/1,477) of new HIV diagnoses among adults who acquired HIV heterosexually in 2018, compared to 61% (1,961/3,219) of new diagnoses in 2009, representing a 67% decline (1,961 to 643). Over the same time, diagnoses among black Caribbean men and women who acquired HIV heterosexually also declined, from 141 in 2009 to 46 in 2018 (67% fall). Men and women who acquired HIV heterosexually and were of white ethnicity accounted for 38% (555/1,477) of new diagnoses in 2018, compared to 24% (773/3,219) in 2009.	
Religion and belief: people with different religions/faiths or beliefs, or none.	There should be no direct negative or positive impact on this group as religion and belief have not been identified as high risk groups.	Not applicable.
Sex: men; women	Sex is not determined to be a risk factor for MDR-HIV-1 infection, however in the UK, the new diagnosis of HIV, includes more	The policy is inclusive of all individuals if they meet the inclusion criteria.

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
	men than women so this population could be reflected more in the MDR-HIV-1 patient population. In 2018, 4,453 people were newly diagnosed with HIV in the UK (3,266 men and 1,185 women).[10]	
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.	Sexual orientation has been identified as a risk factor for HIV acquisition and therefore some communities may also have a higher rate of MDR-HIV-1 infection. The number of new HIV diagnoses among GBM was on the rise at the beginning of the decade, alongside simultaneous increases in testing rates and observed increases in incidence among GBM. The number of new HIV diagnoses among GBM in 2018 (1,908) was 30% lower than the number reported in 2009 (2,709) and 40% lower than in 2014 (3,165). [11] In 2018, using observed data, 724 men and 826 women who were reported as having acquired HIV through heterosexual	The policy is inclusive of all individuals, if they meet the inclusion criteria to use fostemsavir.

[10] New HIV diagnoses totals for men and women are based on gender identity and include trans people. The overall total includes people who identify as non-binary, in another way, and those with gender identity not reported.
[11] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)

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
	sex were newly diagnosed in the UK, and 22% (333/1,550) of these had been previously diagnosed outside the UK. The number of newly diagnosed men and women who acquired HIV heterosexually peaked in 2004, and halved between 2009 and 2018, from 3,236 to 1,550. [12]	

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[13]	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	There should be no direct negative or positive impact on this group as looked after children and young people have not been identified as high-risk group for MDR-HIV-1 infection.	Children with HIV-1 infection are managed in a specialist HIV child-focused service. As outlined, the safety data for fostemsavir does not include children, therefore this policy is adult focused, but would allow post-puberty access, for children and young adults meeting the inclusion criteria.

[12] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)
[13] Please note many groups who share protected characteristics have also been identified as facing health inequalities.

Groups who face health inequalities[13]	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
		It is proposed that by use of the specialist HIV MDT to determine suitability for fostemsavir the individual health, emotional and developmental needs of the child are taken into consideration if fostemsavir was proposed as a treatment option.
Carers of patients: unpaid, family members.	Carers may be indirectly affected by this policy. If the use of fostemsavir is successful, it has the potential to improve an individual's health status if they can achieve viral suppression. This can reduce the risk of the individual transmitting HIV. Individuals in whom the virus is not suppressed have increased morbidity and mortality. Fostemsavir, if it improves an individual's health status may increase their active participation, which may reduce their care needs allowing them to participate more in activities of daily living. This policy may benefit carers who support patients with MDR HIV-1 infection by reducing the assistance required to complete work, family, and personal tasks. The use of fostemsavir may require ongoing carer support to facilitate these	The policy recommends that the suitability of fostemsavir as an intervention is assessed by the MDT team. This includes considering the support and care mechanisms a patient would require undergoing the intervention. If this policy is adopted, a commissioning plan will set out the pathway of provision for fostemsavir which will include access at appropriately staffed centres.

Groups who face health inequalities[13]	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
	sessions to attend follow-up appointments. This might be offset by a reduction in emergency and unscheduled care or prolonged admissions to address the consequences of advanced immunosuppression.	
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	This group may be less likely to enter the patient pathway, due to access issues (e.g., not registered with a General Practitioner). The lack of a permanent base for which follow-up appointments could be co-ordinated may be challenging in this cohort of patients. If identified, those who are homeless could be at risk of adverse outcomes, due to lack of access to services, incomplete follow-up as well as environmental conditions which may exposure individuals to infection or potentially exacerbate underlying health issues with MDR HIV-1 infection.	NHS England is producing the fostemsavir policy to increase access for anyone who may benefit from the intervention. Commissioned providers should work with the patient and other relevant agencies (e.g. GP, Local Authority, charities) to mitigate the risk for homeless patients.
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	In 2018/19, 57,635 people newly arriving into or transferring between prisons were tested for HIV, an increase of 39% since 2017/18. This	All individuals who meet the inclusion criteria can be considered for treatment with fostemsavir.

Groups who face health inequalities[13]	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
	testing identified 665 HIV infections in 2018/19, a test positivity of 1.2%. [14] This data is not disaggregated for MDR HIV-1 infection. All patients who met the inclusion criteria would be considered for treatment. This group is not identified at high risk for MDR HIV-1 infection.	
People with addictions and/or substance misuse issues	Drug use, particularly injection is a risk factor for HIV acquisition. The number of individuals with MDR-HIV1 infection related to drug use is not known, however other health concerns such as co-infection with hepatitis (also higher in individuals with addiction issues) can limit some available ART options. Individuals with HIV and concurrent injecting drug use are at a higher rate of mortality. This summary is supported by PHE data: [15]	All patients who met the inclusion criteria would be considered for treatment.

[14] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)
[15] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)

Groups who face health inequalities[13]	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
	The number of people who probably acquired HIV through injecting drug use has fallen by a third since 2009 (140 to 94) and comprised 2% of all new HIV diagnoses in 2018 (94/4,453). Of these 94 individuals, 80% (75/94) were men, 85% (80/94) were aged between 25 to 49 years, 89% (84/94) were of white ethnicity. The mortality among people diagnosed with HIV who injected drugs was much higher, at 23.61 per 1,000.	
People or families on a low income	This policy will promote access to fostemsavir regardless of economic status. Low economic status is not known to be a risk factor for MDR HIV-1 infection.	The policy will facilitate access to fostemsavir if approved (as it is not currently available in the NHS).
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).	This group may find it hard to understand their condition and the benefits and risks associated with different treatment options. It may also be harder for these individuals to understand and follow the drug directions.	Shared decision making is mandated within this policy and so clinicians will need to ensure that patients are well informed, this can be through various mediums including verbal as well as written shared decision-making tools, translated and Easy Read materials. The provision of fostemsavir involves face-to-face assessment and verbal instruction, this can assist those with poor health or literacy skills.

Groups who face health inequalities[13]	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
		It is proposed that a holistic MDT assessment of an individual is undertaken to assess their suitability for fostemsavir.
People living in deprived areas	A national commissioning policy attempts to ensure there is equal access to treatment regardless of location, it will reduce variation in practice. The PHE data demonstrates that some local authorities have a higher number of people living with HIV, and therefore those services may see a greater number of individuals with MDR HIV-1 infection. The PHE data also suggests that areas outside London may have a greater proportion of patients who are currently undiagnosed with HIV. Overall, 84 of 317 local authorities in England had a "high-diagnosed-prevalence" (greater than 2 per 1,000 population aged 15 to 59 years) in 2018. Of these, 19 had an "extremely-high-diagnosed prevalence" (defined as greater than 5 per 1,000 population aged 15 to 59 years) including 17	The policy will increase HIV centres to access fostemsavir which is not currently available.

Groups who face health inequalities[13]	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
	London local authorities, Manchester, and Brighton and Hove. [16] Twice as many people with undiagnosed HIV infection in England lived in England outside of London. [17]	
People living in remote, rural and island locations	A national commissioning policy attempts to ensure there is equal access to treatment regardless of location.	If adopted, a commissioning plan will determine the local arrangements, which may include specialist oversight, to improve access for patients. The low incidence of MDR HIV-1 infection (estimated to be 70 individuals) may mean that some centres have no eligible patients. The provision of fostemsavir will be within NHSEI Specialised Commissioned HIV services to ensure standards, expertise and satisfactory overall service delivery. The geographic area of the UK requires a significant number of services to allow for realistic access for patients. This allows for ongoing support and supervision of services, if the appropriate expertise is available and remote technology can facilitate this.

[16] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)
[17] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)

Groups who face health inequalities[13]	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
Refugees, asylum seekers or those experiencing modern slavery	In 2018, almost half (47%, 698/1,475) of men and women diagnosed with HIV in the UK who acquired HIV heterosexually were born in a country of high HIV prevalence[18] and 31% (452) were born in the UK. Nearly one quarter (23%) 445/1,908) of new HIV diagnoses in GBM in 2018 were known to have been previously diagnosed outside the UK. [19] Individuals who are refugees, asylum seekers or those experiencing modern slavery could be more vulnerable to sexual violence and exploitation which may increase their risk of HIV acquisition. This group may be less likely to enter the pathway, due to access issues (e.g. not registered with a General Practitioner). The lack of a permanent base for which HIV care and follow-up and/or review appointments could be co-ordinated	NHS England is producing fostemsavir policy to increase access for anyone who may benefit from the intervention. Commissioned providers should work with the patient and other relevant agencies (e.g., GP, Local Authority, charities) to mitigate risk for refugees, asylum seekers and those experiencing modern slavery.

[18] Proportions presented where data on country of birth are known. Data completeness for country of birth among new diagnoses was 85% in 2018 and 96% in 2009

[19] Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)

Groups who face health inequalities[13]	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
	may be challenging in this cohort of patients. If identified, those who are refugees, asylum seekers or those experiencing modern slavery could be at significant risk of adverse outcomes due to lack of access to services, incomplete follow-up as well as environmental conditions which may exposure individuals to be more vulnerable due to their MDR-HIV-1 status.	
Other groups experiencing health inequalities (please describe)	Not applicable	Not applicable.

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	No X	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	Stakeholder testing (planned)	This will involve clinical staff, professional groups, patients, patient groups and industry groups who have expressed an interest in this topic area	November 2021
2	Public consultation (planned)		Not required
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	An external review of available clinical evidence was undertaken to inform this policy.	Cost analysis of the intervention. Factors to identify subgroups of patients who may benefit more than others.
Consultation and involvement findings	Planned	
Research	No pending research is known.	Not applicable
Participant or expert knowledge For example, expertise within the team or expertise drawn on external to your team	A Policy Working Group was assembled which includes HIV specialists, a public health specialist and patient and public voice representatives.	

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	
The proposal may support?			X

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	Consensus on the eligibility criteria within the wider specialist HIV community	Stakeholder testing and public consultation
2	Consensus on the patient pathway within the wider specialist HIV community	Stakeholder testing and public consultation
3		

10. Summary assessment of this EHIA findings

This Policy does not unfairly discriminate those with a protected characteristic. The Policy could provide a treatment option for patients who are currently experiencing the consequences of HIV-1 infection which has currently limited or no treatment options to control the virus. These patients have a large unmet need for an effective intervention and may experience the

consequences of unregulated viral control with advanced immunosuppression, AIDS defining illness and also increased mortality. This policy is informed by the evidence base and the clinical expertise of the Policy Working Group. A national commissioned policy will reduce variation in clinical practice promoting an equity of care for those in which this intervention is indicated.

11. Contact details re this EHIA

Team/Unit name:	Specialised Commissioning
Division name:	Blood and Infections Programme of Care
Directorate name:	Finance
Date EHIA agreed:	
Date EHIA published if appropriate:	