**Equality and Health inequality Impact Assessment (E&HIA)**

Eastern AHSN commits that its work and broader activities do not disadvantage individuals or groups who are underserved or have Protected Characteristics defined by [The Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents).

There is clear evidence that improving equality improves life expectancy and reduces disability across the social gradient. Tackling health inequalities is, therefore, core to improving access to services, health outcomes, improving the quality of services, and people's experiences.

The EHIA encourages us to recognise that people are different and look at our plans from different perspectives. We do not set out to discriminate, but that can happen when we do not think about the difference at the start.

The process aims to develop an action plan addressing negative impacts on a particular group of people at a system or project level. We are proactively seeking to include and benefit groups whose health outcomes tend to be lower than the general population and face barriers to accessing health & social care support. These decisions can relate to existing services, policies, and functions, plans for future changes and new projects. We use the assessment to identify potential impacts on protected groups and how/if we can make effective changes to our project plans.

We are using an innovative process to complete our EHIA.

Step one

The project lead carries out an initial investigation and provides a description of the inequality found in the literature.

The information source for the inequality is added to the log

Step two

The ‘mitigation strategy’ and ‘mitigation actions’ are discussed and agreed upon during a brief meeting with the project lead and expert stakeholder or Principal Advisor or where expert stakeholder isn’t available.

Actions uploaded to Verto in the action log section.

**Remember - The key to a successful EHIA is developing an action plan via open and honest discussions.**

| **Ref****no.** | **Protected characteristics/health inequality area** | **Description of the inequality** | **Mitigation strategy (Accept/Avoid/ transfer or reduce)** | **Mitigation actions** |
| --- | --- | --- | --- | --- |
| 1 | Homelessness | * This patient group has challenges accessing healthcare and often experience tri-morbidity (poor mental health, poor physical health and drug addiction). (Bradley, 2018) This makes it more challenging for patients to access appropriate care for their wounds and engage with self-care of wounds.
* During pandemic, reports that this population struggled to get GP appointments and therefore no access to repeat prescriptions exacerbating health access issues and potentially access to wound care prescriptions (Adderley, 2020)
* This cohort is at greater risk for peripheral arterial disease which lower limb wounds are a complication of (Nanjo, et al., 2020)
* People who are homeless are often develop lower limb wounds. This partly due to more common history IV drug use which can cause underlying vascular issues including spontaneous and/or non-healing wounds as a result of trauma (Malik & Geraghty, 2021)
 | Reduce | * Highlight to participating AHSNs the opportunity to support ICSs to develop wider wellbeing services for people who are homeless that includes wound care
* Share examples of existing services - [FLIC](https://www.shp.org.uk/Pages/News/Site/fulfillinglives/Category/flic-news) (Malik & Geraghty, 2021)
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| 2 | Disparity between diabetic foot care and non-diabetic foot care | * There is a disparity in care provided for people with foot ulcers depending on whether or not people have diabetes.
	+ Over half of all major lower limb amputations are in people that do not have diabetes and minor amputations are rising with the increase driven by non-diabetic men (Adderley, 2020).
* Due to budget structures, there can be resistance to open diabetic foot clinics to non-diabetic patients
 | Reduce | * Highlight to AHSNs this disparity and suggest they consider exploring appetite to broaden existing diabetic foot care clinics in ICSs to non-diabetic patients. Where there is resistance, suggestion to focus on establishing separate new clinics
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| 3 | People with addictions and substance misuse problems | * During pandemic, reports that this population struggled to get GP appointments and therefore no access to repeat prescriptions (Adderley, 2020)
* Alcohol abuse can lead to malnutrition which can then lead to slower healing wounds and chronic wounds (Quain & Khardori, 2015)
 | Reduce | * Highlight to participating AHSNs the opportunity to support ICSs to develop wider wellbeing services that includes wound care for people with a history of IV drug use and alcohol abuse through a service targeting people who are homeless given high prevalence of drug use in this community
* Identify existing services that can be shared as exemplars
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| 4 | Older people | * Leg ulceration is more common in older people (Darwin, 2019)
* This cohort is at greater risk for peripheral arterial disease which lower limb wounds are a complication of (NHS, 2017)
* Coastal areas and places in northern England have a higher proportion of people over 65
* Older age remains the strongest single predictor of internet access and use among adults (Stone, 2021)
* Elderly people are at greater risk of being malnourished. (Quain & Khardori, 2015)
 | Reduce | * Advise AHSNs to map age of population to give an indication of level of need for wound care services, particularly where there is a lack of data regarding number of lower limb wounds
* If using digital tools to support self-management education, consider whether target population will be able to access online platforms and provide offline resources
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| 5 | Women | * Leg ulceration is more common among women than men (Darwin, 2019) but this is thought to be related to longer life expectancy of women
* Women are at increased risk of leg ulcers to pregnancy, social factors – responsibilities that involve standing for significant parts of the day
 | Reduce | * The approach to reducing this is to provide preventative advice to women about the increased risk of lower limb wounds
* This advice can be provided in the review appointments by clinicians to women presenting with lower limb wounds
* Outside of this programme, it would be valuable for women who have not yet presented with lower limb wounds to be informed of the increased risks
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| 6 | People from lower socio-economic background | * ‘access to and the quality of support for self-management from health professionals and services is likely to be [lower]’ (Furler, 2011)
* ‘Even with the same access to primary healthcare services, the most disadvantaged patients are less likely to receive quality care including education and support to self manage and prevent complications of their chronic disease’ (Furler, 2011)
* A study showed the lower socio-economic background negatively impact 3 key factors for influencing patient engagement in self-management (Coventry, 2014)
* This cohort is at greater risk for peripheral arterial disease which lower limb wounds are a complication of (positive association with smoking which is more likely in people from lower socioeconomic backgrounds) (Petherick, 2010)
* A PhD thesis demonstrated that people living in or attending practices in more deprived areas were less likely to receive an initial assessment (there was no correlation found between deprivation and healing rates) (Petherick, 2010)
* Leg ulcers in patients from the most deprived areas take longer to heal and are more likely to recur (SIGN, 2010)
* Among working-age adults, those in the lowest socioeconomic groups are more than three times as likely as those in the highest socio-economic groups to not use the internet or to be ‘limited users’ who use the internet for only a few tasks (Ofcom, 2020)
* Evidence shows a clear social gradient to health literacy, and also to digital literacy; and an overlap between these (Rowlands, 2020)
* Challenges taking images of wound due to increased likelihood of poor lighting driven by cost of living crisis and increased likelihood for this cohort to live in crowded housing (number of people or small spaces common in lower quality housing)
 | Reduce | * Consider developing self-management patient resources tailored for people with lower health literacy level
* Consider delivering education through group sessions lead by personalised care staff in primary care and allied health professionals
* Ensure that all wound care clinics include full and timely assessment of patients
* If using digital tools to support self-management education, consider whether target population will be able to access online platforms and provide offline resources
* Ensuring staff are given guidance to take high quality images in a variety of settings
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| 7 | People with low health literacy  | * This group is less likely to engage with self-management (Furler, 2011)
 | Reduce | * Consider developing self-management patient resources tailored for people with lower health literacy level
* Consider delivering education through group sessions lead by personalised care staff in primary care and allied health professionals
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| 8 | People from minoritized ethnic background | * Staff not being familiar with how wounds present in people who are Black and Asian
* Technology not being designed to analyse wounds in patients with darker skin tones
 | Reduce | * Ensure educational materials have images of people from range of ethnicities
* AHSNs to advise ICSs to include selection criteria for WMDS about ability to analyse wounds in patients with darker skin tones where this feature is desired
* Ensuring staff are given guidance to take high quality images in a variety of settings
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| 9 | People living in rural areas | * Regular wound care appointments are required for people who are not able to self care (i.e. change their own wound dressing/hosiery). Those who live in rural areas with long distances to travel to their local clinic and with poor public transport may have lower attendance (Bidmead, 2021)
* The areas with the highest rates of internet non-users are rural ones – in England, Cornwall and the Isles of Scilly, and Lincolnshire are top of the list. (Foundation, n.d.)
* Peer-to-peer and family support are less likely in rural areas due to young people with digital skills migrating to urban areas (Foundation, n.d.)
* It can be difficult to access digital training courses due to transport challenges in rural areas (Foundation, n.d.)
* Additional challenges associated with disability, older age and low income are compounded in rural areas. Seldom heard groups living in rural areas are more likely to suffer from increased social isolation. (Foundation, n.d.)
 | Reduce | * Consider running group sessions about self-management for wound care, especially in localities with rural areas to reduce need for people to visit a clinic to receive care
	+ Aim to hold sessions face to face given potential digital access issues
* Consider whether it is beneficial to local population to establish Leg Clubs
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| 10 | People with disabilities | * Disabled people and those with long–term conditions are 23% less likely to have the essential digital skills for life (Lloyds, 2020)
* This cohort may find it difficult to attend appointments in clinic
 | Reduce | * If using digital tools to support self-management education, consider whether target population will be able to access online platforms and provide offline resources
* Ensure there is provision of at home appointments
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****[**Link to jamboard**](https://jamboard.google.com/d/1sv5PY8Ws5HOkXLEfPSOnk-2lYFRCgSqMAdAuxI9mpHI/viewer?f=6)

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| **Supporting evidence reference and links**  |
| ReferencesAdderley, U., 2020. National Wound Care Strategy Programme: Looking at the impact of COVID-19. *Wounds UK,* Volume 16, p. 2.Adderley, U. a. c., 2020. *Preventing and Improving Care of Chronic Lower Limb Wounds Implementation Case,* England, UK: National Wound Care Strategy Programme.Bidmead, E. a. S. K., 2021. *Health Inequalities in Cumbria - Initial analyses of Survey Responses.,* Carlisle: Centre for Research in Health and Society.Bradley, J. S., 2018. Rapid Response: Health of homelessness. *BMJ,* Volume 360.Coventry, P. A. F. L. K. C. B. P. &. B. P., 2014. Capacity, responsibility, and motivation: a critical qualitative evaluation of patient and practitioner views about barriers to self-management in people with multimorbidity. *BMC Health Services Research,* 14(1).Darwin, E. L. G. K. R. S. &. L.-T. H., 2019. Examining risk factors and preventive treatments for first venous leg ulceration: A cohort study. *Journal of the American Academy of Dermatology.*Foundation, T. G. T., n.d. *Doing Digital Inclusion: Rural handbook.* [Online] Available at: https://www.goodthingsfoundation.org/insights/doing-digital-inclusion-rural-handbook/Furler, J. H. M. &. R. A., 2011. Equity and long-term condition self-management. 7(1), pp. 3-5.Lloyds, 2020. *Lloyds Bank UK Consumer Digital Index 2020,* s.l.: Lloyds Banking Group.Malik, J. & Geraghty, J., 2021. *Misunderstood and Overlooked: Piloting tissue viability wound care and nurse outreach with people experiencing homelessness and multiple disadvantage . London: Fulfilling Lives in Islington and Camden.,* s.l.: s.n.Nanjo, A. et al., 2020. Prevalence, incidence, and outcomes across cardiovascular diseases in homeless individuals using national linked electronic health records. *European Heart Journal,* 41(41), p. 4011–4020.NHS, 2017. *Peripheral arterial disease (PAD)..* [Online] Available at: https://www.nhs.uk/conditions/peripheralarterial-disease-pad/Ofcom, 2020. *Adults’ Media Use & Attitudes report 2020,* s.l.: Ofcom.Petherick, E., 2010. *Leg ulceration: An exploration of the role of socioeconomic factors in the epidemiology, access to health care and outcomes,* s.l.: The University of York, Department of Health Sciences.Quain, A. M. & Khardori, N. M., 2015. Nutrition in Wound Care Management: A Comprehensive Overview. *Index Wounds,* 27(12), pp. 327-335.Rowlands, 2020. *Health literacy and digital literacy: importance and next steps,* s.l.: Newcastle University.SIGN, 2010. *Management of chronic venous leg ulcers: A national clinical guideline,* s.l.: Scottish Intercollegiate Guidelines Network.Stone, D. E., 2021. *Digital exclusion & health inequalities,* s.l.: The Good Things Foundation. |

**Table 2. Groups at risk of inequalities**

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| **Protected characteristics** | **Socio-economic status/Geography** | **Others who face health inequalities:** |
| * Age
* Gender
* Gender reassignment
* Disability: includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.
* Marriage and civil partnership
* Pregnancy and maternity: women before and after childbirth; breastfeeding.
* Race and ethnicity
* Religion and belief
* Sexual orientation
 | * People living in deprived areas
* People who are unemployed
* People with low incomes
* People living in remote, rural and coastal locations.
* People with poor literacy or health literacy
 | * Looked after and accommodated children and young people.
* Carers: paid/unpaid, family members.
* Homeless people or those who experience homelessness: people on the street; those staying temporarily with friends/family; those in hostels/B&Bs.
* Those involved in the criminal justice system: offenders in prison/on probation, ex-offenders.
* People with addictions and substance misuse problems.
* Gypsy, Roma and Traveller populations
* Sex workers
* Vulnerable migrants
* People in other groups who face health inequalities.
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Developed by Eastern AHSN using resources from PHE and NHSE&I organisations.