NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Equality and health inequalities assessment (EHIA)

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What is the EHIA?

The equality and health inequalities assessment (EHIA) is the systematic identification, assessment and consideration of equality and health inequalities issues across the guidance development process and identifying areas for action to promote equality and reduce health inequalities. This supports NICE's commitment to reducing health inequalities, which is enshrined in its Principles.

To support individuals involved in the development or maintenance of NICE guideline content, NICE has developed an EHIA form to:

- demonstrate due consideration of equality and health inequalities issues at each stage of the guideline development process (recognising that the proposed 'living guideline' approach may require the EHIA to be revised accordingly in due course)
- identify priority actions to try to promote equality and reduce health inequalities at each stage of the guideline development process.

The EHIA form is also designed to support NICE's compliance with its legal duties outlined in the Equality Act 2010, Health and Social Care Act 2012 and Health and Care Act 2022 to promote equality and reduce health inequalities and provides the Guidance Executive of NICE with assurance that NICE is meeting its duties.

The EHIA form should be considered in conjunction with the Promoting Equality, Reducing Health Inequalities guidance support document[1], which provides greater detail on equality and health inequalities issues, how to address them, and helps to put the EHIA in context.

What characteristics should be considered when completing the EHIA?

Health inequalities are systemic, unfair and avoidable differences in health across the population, and between different groups within society. These differences in health arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good mental and physical health. This means that some people are dying many years earlier than they should, while others are living with illness and disability that could have been prevented.

There are four main dimensions of health inequalities to consider, which are often overlapping and may result in experiences of cumulative disadvantage:

[1] "K:\4-Health Inequalities\EHIA & GSD\GSD Draft - Promoting equality reducing health inequalities v12_clean.docx"

- protected characteristics as defined by the Equality Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation)
- socioeconomic deprivation (for example, variation by area deprivation such as Index of Multiple Deprivation, National Statistics Socio-economic Classification, employment status, income)
- inclusion health and vulnerable groups (for example, vulnerable migrants, people experiencing homelessness, people in contact with the criminal justice system, sex workers, Gypsy, Roma and Traveller communities, young people leaving care and victims of trafficking)
- geography (differences between areas within England, for example, geographical differences in epidemiology or service provision in urban/rural areas, coastal areas, north/south regions)

Health inequalities can be measured through examining differences in five areas:

- health status, for example, life expectancy and prevalence of health conditions
- behavioural risks to health, for example, obesity, diet and physical activity
- wider determinants of health, for example, income, employment, build environment
- access to care, for example, availability of screening services and treatments
- quality and experience of care, for example, levels of patient satisfaction

How should the EHIA be used?

The EHIA should be used to:

- guide the identification, recording and communication of equality and health inequalities issues raised at any stage of the guidance development process
- demonstrate that these issues have been given due consideration by explaining how these issues have been explored, what evidence has been reviewed in relation to these issues, what impact the issues have had on the guideline recommendations or updates, and provide an explanation if the issues do not impact the guideline recommendations or updates.
- give assurance that the recommendations are not expected to adversely affect any of the groups covered by the four dimensions of health inequalities
- ensure consideration of health inequalities appropriately informs recommendations

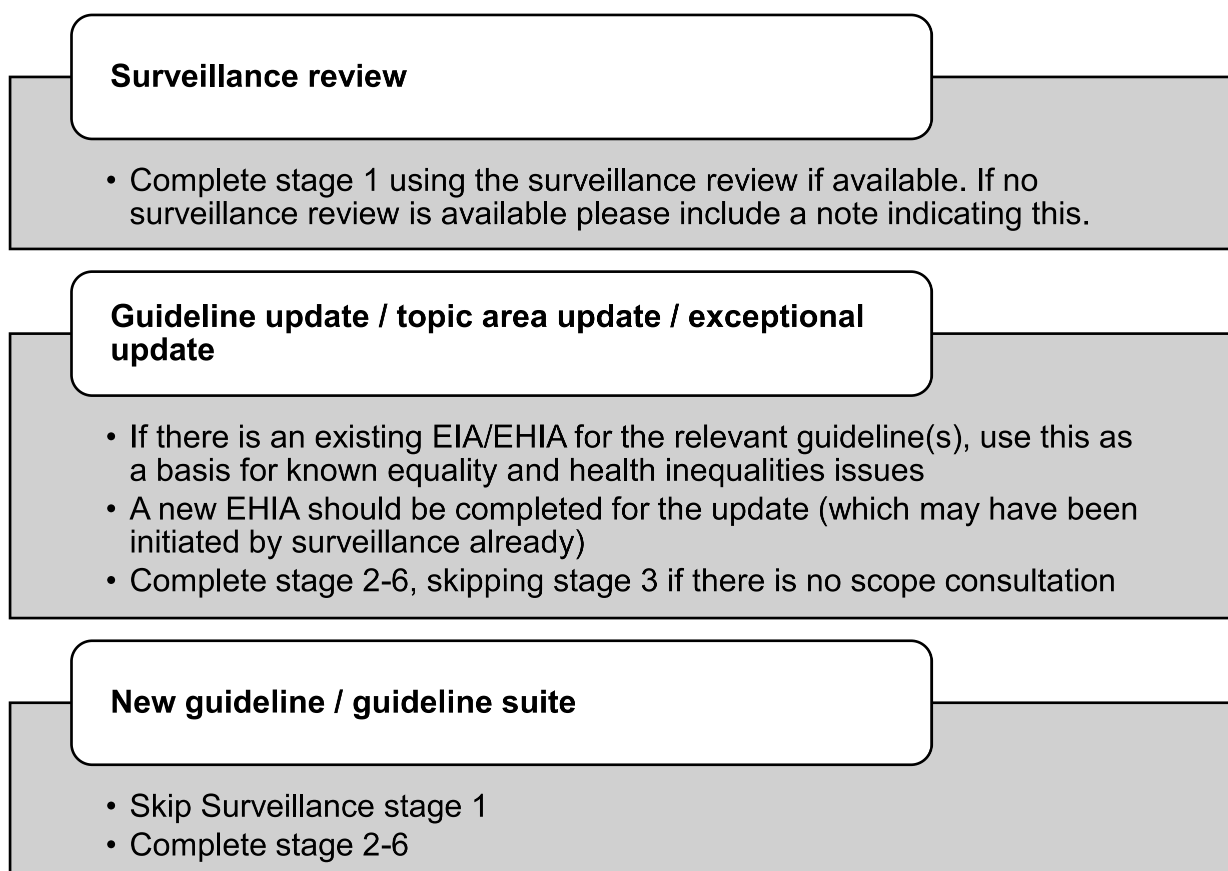
- support development of recommendations aimed at promoting equity and reducing health inequalities

When should the EHIA be completed?

Due consideration of equality and health inequalities is embedded across the guidance development process. Completion of the EHIA form is an iterative process that should be revised repeatedly throughout development and maintenance.

The form is in six sections; some of these stages and questions therein may not be relevant in some contexts. However, the aim should be to complete as much of the EHIA as is relevant so that there remains a systematic and transparent approach to NICE's consideration of equality and health inequalities issues for all types of guideline development work. The following flow diagram clarifies which sections should be completed and when. Further guidance can be found in the GSD.

As part of NICE's transformation, surveillance reviews are currently undertaken on a case-by-case basis. At this stage, the consideration of health inequalities depends on their relevance to the specific topic. For instance, a surveillance review or potential topic update may be triggered by significant health inequality concerns such as the implications of the EMBRACE report for NICE's maternity guidelines.



Stage 1 should be completed by the technical analyst. They can either paste the health inequalities text from the relevant surveillance review into this section or if no surveillance review exists add a note to say it was not conducted. If a surveillance review was conducted but contains no information on health inequalities this should be noted. Where there is an update and for new guidelines, stage 2 to 5 should be completed by the topic team with input from committee members as required and approved by the committee chair. Stage 6 is only completed if applicable. The Clinical, Nursing, or Social Care Adviser should review the EHIA, and a Senior Topic Adviser or topic hub Associate Director sign-off the completed EHIA, before the form is published on the NICE website.

Who will use the EHIA?

There are different audiences and users of the EHIA which include:

- NICE topic teams, committees and committee chairs: those responsible for developing the scope/guidelines
- NICE surveillance team
- NICE staff responsible for quality assurance or sign-off: senior topic advisers and associate directors in the CFG topic hubs, technical advisers in the CFG professional team, health economic advisers in the methods and economic team, clinical and social care advisers in the clinical team, and pharmacist clinical advisers in the medicines optimisation team.
- NICE corporate offices for auditing purposes
- NICE guidance executive who approves the guideline
- External stakeholders who provide important insights on equality and health inequalities issues that inform the EHIA: particularly those with lived experience or those who work with those with lived experience of the four dimensions of health inequalities
- Users of NICE guidance

Key principles for completing the EHIA form

- Assessment of equality and health inequalities issues should happen at the earliest opportunity at the surveillance and topic selection stages and should continue throughout guideline development.
- Equality and health inequalities issues should inform the production of scopes, surveillance reviews, review protocols, evidence reviews, committee discussions and development of recommendations.
- Consider the suggested text for each question when completing the form.

- The scoping EHIA (Stage 2) should be circulated to stakeholders with the draft scope consultation if carried out for feedback and additional information.
- The guideline EHIA (Stage 4) should be circulated to stakeholders with the draft guideline consultation for feedback and additional information.
- Standard questions for stakeholders about equality and health inequalities issues should be included in the consultation process at each stage of guideline development. Additional bespoke questions could also be considered where relevant.
- The committee chair should highlight the need to consider equality and health inequalities issues throughout the development process. Equality and health inequalities should be on the agenda for development and quality assurance meetings (including guideline progress meetings if held), particularly scoping meetings, scoping workshops, committee meetings for discussion and at the final meeting before consultation on the draft guideline.
- Each section of the EHIA should be signed off by the appropriate topic hub senior topic adviser or associate director and committee chair.

Naming and storing the documents

Once each stage of the EHIA is completed, save the document denoting the appropriate stage, using the naming convention below, with clear version control for different drafts. For surveillance reviews, the EHIA should be saved in the surveillance review folder, using the same file name as the surveillance report but prefix with EHIA.

- Surveillance review: EHIA Stage 1
- Informing the scope: EHIA Stage 2 v1.0, v.1.1 etc.
- Finalising the scope: EHIA Stage 3 v1.0
- Guideline development: EHIA Stage 4 v.1.0
- Final guidance: EHIA Stage 5 v1.0
- Post guidance executive: EHIA Stage 6 v1.0

When completing the next stage, use the same document (with the previous stages completed) and save as the next stage. In this way, considerations and actions at each stage is collated together and recorded in one final document.

For updates, a new EHIA should be completed. If there is an existing EIA/EHIA, use this as the basis for known equality and health inequality issues. The new EHIA should be saved as a separate document from any previous EIAs or EHIAs, with a clear and distinct filename to differentiate it from previous versions, for example:
EHIA Stage 6_update_ [expected publication date] v1.0
EHIA Stage 2_update_ [expected publication date] v1.1

For full guideline updates, the new EHIA will replace any previous EIA/EHIAs.

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NICE guidelines

Equality and health inequalities assessment (EHIA) template

[Title of guideline/suite/topic area]

The considerations and potential impact on equality and health inequalities have been considered throughout the guidance development, maintenance and update process according to the principles of the NICE equality policy and those outlined in Developing NICE guidelines: the manual.

This EHIA relates to:

[TITLE OF FULL UPDATE OR LIST OF TOPIC AREAS TO BE UPDATED]

May 2025 and August 2025 exceptional surveillance of prostate cancer: diagnosis and management (NICE guideline NG131)

STAGE 1. Surveillance review

Date of surveillance review: May and August 2025

Focus of surveillance review: Localised and locally advanced prostate cancer

No inequalities were noted specifically around active surveillance or treatment for non-metastatic prostate cancer. However, black men and men from socio-economically deprived areas represent groups at higher risk of late diagnosis and poor overall survival.

Completed by technical analyst: Sarah Boyce

Date: 24 April 26

Approved by NICE CFG topic hub senior topic adviser or associate director:
Sara Buckner

Date: 27 April 2026

STAGE 2. Informing the scope

(to be completed by the topic team, and submitted with the draft scope for consultation, if this is applicable)

Prostate cancer: diagnosis and management

Date of completion: 24/04/26

Focus of guideline or update: Diagnosis of clinically significant prostate cancer; localised and locally advanced prostate cancer

2.1 Check existing EIAs or EHIAs at the very beginning of scoping (during early preparation stages). Note any equality and health inequality issues identified.
Ethnicity and age were identified as equality issues which needed specific attention. This is because there is a higher incidence of prostate cancer and prostate cancer–related mortality in Black men compared to men of other ethnic groups. With regards to age, incidence of prostate cancer and mortality from prostate cancer increases with increasing age. Stakeholders identified that transgender people should be represented within this guideline. The stakeholder also highlighted that sexual dysfunction for gay & bisexual men is an area that required specific discussion in terms of treatment pathway and informed consent.

2.2 What additional approaches have been used to identify potential equality and health inequalities issues during the check for an update or during development of the draft scope?
The published evidence from a literature search of studies assessing equalities and health inequalities in people with suspected or confirmed prostate cancer was reviewed. Other relevant sources of intelligence during the scoping process included the information identified in the 2025 surveillance reviews (see stage 1). The advice and expertise of the topic advisor and chair were sought in a scoping meeting to discuss the equality and health inequality issues identified from the literature search. They were also asked if there were any other issues they were aware of that should be considered during the guideline update.

2.3 What potential equality and health inequalities issues have been identified during the check for an update or during development of the draft scope?
1. *Protected characteristics outlined in the Equality Act 2010:* *a) Age:* The risk of being diagnosed with prostate cancer increases with age and mainly affects men aged 50 years and older (Prostate Cancer UK, 2024), with incidence rates being highest in men aged 70 years and older (Cancer Research, UK; Tan et al., 2024). A higher survival rate often reflects of a high burden of disease, particularly in the management of cancer survivorship in aging populations (Tan et al., 2024). Older men diagnosed with prostate cancer are more likely to receive poorer quality of care and support compared to younger men, for example they are less likely to be told about treatment side effects and offered fewer treatment options compared to younger men (UCL Institute of Health Equity, 2015). The National Prostate Cancer Audit (NPCA, 2025) revealed that older men were less likely to receive treatment intensification with men aged 75 or younger receiving nearly 60% treatment intensification compared to only 17% of men aged over 75. Treatment intensification therapies generally involve men receiving more aggressive therapies such chemotherapy (e.g. docetaxel) or androgen receptor pathway inhibitors (e.g. abiraterone or apalutamide). Older men, particularly those aged 80 years and older, are more likely to be diagnosed with metastatic disease (NPCA, 2022). One study found that older men more commonly reported that side effects of prostate cancer treatment were explained in a way they could not understand, and they did not feel that they were involved in decisions or that their views were considered (Morris, 2024). *b) Disability:* There is limited evidence on specific prostate cancer equality and health inequalities around disability. However, many of the well-established barriers to timely cancer diagnosis are also likely to be applicable to prostate cancer. People with physical disabilities may experience delays due to practical obstacles within diagnostic pathways, including medical environments and equipment that are not always accessible, such as examination facilities that do not adequately accommodate wheelchair users. In addition, there is a risk that symptoms may be incorrectly attributed to an individual's existing disability, leading to potential missed or delayed recognition of cancer-related symptoms. People with learning disabilities are more likely to live with multiple long-term health conditions compared to the general population, which can further complicate diagnosis. New or changing symptoms may be misinterpreted as part of a pre-existing condition rather than prompting investigation for a new illness. Additional challenges, such as limited access to suitable transport and the availability of carers to support attendance at appointments, have also been associated with delays in cancer diagnosis for people with learning disabilities. *c) Gender reassignment:* More than a quarter of trans-gender people often avoid GP visits for anything related to gender specific care such as prostate cancer

(TransActual, 2021). Trans-women reported a fivefold lower risk of prostate cancer compared to men, however diagnosis is often more severe, because the cancer is more aggressive or detected late leading to higher mortality rates. (Bertoncelli, 2022; Giblin, 2023). Nonetheless, it is recommended that trans-women are still offered the same screening as men, which is particularly important for people with a genetic predisposition to prostate cancer (Giblin, 2023). While men with an inherited risk of prostate cancer are offered prostate specific antigen testing, the efficacy of these types of testing for people who take exogenous hormones have been questioned (Giblin, 2023). Similarly, digital rectal examination may have limited use due to prostate atrophy following genital reconstructive surgery (Gliblin, 2023).

d) Pregnancy and maternity: Not relevant.

e) Race: Prostate cancer is the most commonly diagnosed cancer for men in the UK. Black men are more likely to get prostate cancer than other men, with about 1 in 4 Black men getting prostate cancer in their lifetime. In this population, prostate cancer mainly affects Black men over 45 years of age. (Prostate Cancer UK, 2024). Black African and Caribbean men were at least twice as likely as White men to develop prostate cancer and twice as likely to die from it (Christie-de Jong, 2025). Black men were also more likely diagnosed at a younger age, had the highest age-adjusted prostate cancer incidence rate (149 per 100,000 person-years) and had the highest proportion of localised prostate cancer (74%) (Haider, 2025). Black men and men with mixed ethnicities have higher prostate-specific antigen levels and a higher prostate cancer incidence compared to White men specifically for those aged 60 years and older (Down, 2024). Men from Black ethnic backgrounds were less likely to receive intensive or radical treatment for metastatic prostate cancer compared to white men (National Prostate Cancer Audit, 2024 and 2025; Dodkins, 2025). For example, 67.8% of Black men received radical treatment compared to 81.6% of white men. Black African men and black Caribbean men between the ages of 65-84 were also more likely to be diagnosed with stage 3 or 4 prostate cancer compared to White men (National Prostate Cancer Audit, 2024). In contrast a previous report (National Prostate Cancer Audit, 2022) found that White men were more likely (16.9%) to be diagnosed with metastatic prostate cancer compared to Asian men (13.2%) and Black men (11.7%).

Although it is believed that some of these discrepancies could be due to genetic factors (Prostate Cancer UK, 2024), nearly 25% of Black men believe that discrimination has prevented them from being tested for prostate cancer and one third believed that discrimination has stopped them being tested or being treated for any medical problem (Prostate Cancer Research, 2024). Some emotional barriers to access care and prostate screening have also been reported for Black men, as prostate cancer was linked to perceptions about masculinity and sexuality and

feelings of shame and fear (Willis, 2022). Furthermore, there is a lack of knowledge about prostate cancer for Black men and research has highlighted the need for prostate cancer communication to use language that Black men can identify with, particularly as discussing intimate or sensitive issues was reported to be difficult for Black men (Christie-de Jong, 2025). Morris et al (2024) also reported that Black men felt that side effects of their treatment were not explained in a way that they could understand or that they were involved in the decision making.

f) religion or belief: No potential issues identified.

g) sex: Not relevant.

h) sexual orientation: It is estimated that 90% of gay men have never talked about prostate cancer with their healthcare professional (MacMillan Cancer, 2024). Gay men with prostate cancer also have different social support system compared to heterosexual men. For example, older gay men are more likely to live alone and not have children, and they are also less likely to include their partners in their consultations (MacMillan Cancer, 2024). Standard advice and information may not address specific issues for gay men for example that the prostate can be considered an area of sexual pleasure for gay men (MacMillan Cancer, 2024). Treatments, such as radiotherapy to the prostate, may cause bowel problems which could be a sensitive area for gay men receiving anal sex (MacMillan Cancer, 2024).

i) marriage and civil partnership: Studies have shown that men who were unmarried or widowed had worse overall survival rates for prostate cancer compared to married men (Chen, 2024). It is believed that social support can help support a healthy lifestyle including increasing healthcare seeking behaviour (Salmon, 2021).

2. *Socioeconomic deprivation*
   People living in more deprived areas of high-income countries have lower cancer survival rates than those living in more affluent areas (Ingleby, 2022). Men from socioeconomically deprived areas were less likely to receive intensive treatment (National Prostate Cancer Audit, 2025). Men from more deprived areas were less likely to receive radical local treatment (Parry, 2023). Men from the most deprived areas of England were more likely to be diagnosed at advanced stages of prostate cancer (Somathilake, 2025). There has also been some indication that men from more deprived areas did not feel like they were very involved in the decision making of treatment (Morris, 2024).

3. *Geographical area variation*
   Metastatic prostate cancer incidence varies greatly depending on geographic location. For example, a higher incidence of metastatic cancer was observed with a

lower overall prostate cancer incidence and in more socioeconomically deprived neighbourhoods (Dodkins, 2025). In London just 1 in 8 men with prostate cancer were diagnosed with metastatic disease, while in Scotland 1 in 3 men with prostate cancer were diagnosed late (Prostate Cancer UK, 2024). Data has also shown variation in treatment depending on the type of hospital. Patients in public hospital were nearly 46% more likely to be presented following screening compared to those in private hospitals. People from urban areas were also 34% more likely to present following screening compared to those in rural areas (Gordon, 2024).

4. *Inclusion health and vulnerable groups*

There is limited evidence on specific prostate cancer equality and health inequalities related to inclusion health and vulnerable groups; however, existing research highlights significant barriers to cancer prevention, screening, and care for inclusion health and other vulnerable groups. Migrants, refugees, asylum seekers, seasonal workers, and undocumented migrants often face difficulties accessing healthcare due to identification requirements, language and cultural barriers, limited understanding of the healthcare system, financial constraints, and fear of potential NHS charges or immigration enforcement. These challenges may delay presentation with cancer symptoms and reduce participation in screening. Limited or unverifiable family health history can further complicate cancer risk assessment for migrants, adopted individuals, and those in state or foster care.

People experiencing homelessness have higher cancer incidence and mortality, driven by greater exposure to risk factors such as smoking, substance use, poor diet, and environmental hazards, alongside significant mental and physical health needs. Gypsy, Roma, and Traveller communities may encounter additional barriers including low literacy, language difficulties, poor knowledge of health services, frequent mobility, and general mistrust of authorities. Cultural beliefs around privacy, modesty, and cancer as a taboo subject may also limit engagement with screening and early diagnosis.

2.4 How can the identified equality and health inequalities issues be further explored and considered at this stage of the development process?

The aim is that the membership of the committee will represent various perspectives and expertise so that equalities issues are adequately considered throughout the development of the guideline. Different viewpoints and backgrounds will be covered by appointing lay members with different perspectives, expertise and lived experiences of prostate cancer. This will be futher enriched through open consultation on the guideline update. The guideline will aim to give special consideration to the subpopulations identified in box 2.3 by taking these groups into consideration when developing review protocols and making recommendations. The committee will consider whether evidence specific to the subpopulations should be sought and whether any data identified should be analysed separately. The committee will consider whether separate recommendations are required for specific subpopulations to promote equity for each topic area.

2.5 Do you have representation from stakeholder groups that can help to explore equality and health inequalities issues during the consultation process including groups who are known to be affected by these issues? If not, what plans are in place to address gaps in the stakeholder list?
Registered stakeholders include Black Beetle Health, Black Health Agency, BME cancer communities, Cancer Black Care and LGBT Foundation.

2.6 How will the views and experiences of those affected by equality and health inequalities issues be meaningfully included in the guideline development process going forward?

The views and experiences of those affected by equality and health inequalities issues will be included in the guideline development process through the following mechanisms:

- Committee expertise: The guideline committee will include at least 2 lay members with direct experience of prostate cancer. These appointments will consider the breadth of the issues the guideline needs to cover as far as their direct experience allows. To facilitate lay members participation in the committee meetings, the team will consider offering additional support, depending on their situational needs

- Committee discussions: The committee will be encouraged to consider equality and health inequalities implications throughout their discussions and decision-making processes.

- Consultation feedback: The team will respond to feedback received during the consultation phase that addresses equality and health inequalities issues.

These approaches should ensure that the guideline development process meaningfully includes the views and experiences of those affected by equality and health inequalities issues, even without additional specific measures beyond the standard NICE process. However, if during the development process it becomes apparent that certain perspectives are underrepresented, additional steps (such additional expert input) will be considered.

2.7 If applicable, what questions will you ask at the draft scope stakeholder consultation about the guideline/update and potential impact on equality and health inequalities?
No questions that relate to health inequalities will be asked in the scope consultation

2.8 Has it been proposed to exclude any population groups from the scope? If yes, how do these exclusions relate to any equality and health inequalities issues identified?
No groups have been excluded from the scope.

Completed by topic team: Carlos Sharpin

Date: 27 April 2026

Approved by committee chair: Rajeev Shah

Date: 28 April 2026

Approved by NICE CFG topic hub senior topic adviser or associate director: Sara Buckner

Date: 27 April 2026