Equality Impact Assessment (EQIA) - Clinical and Patient-facing Policies

For more information about the equality impact assessment process in commissioning, please see the EQIA Guidance located **in *Y:\HULLCCG\Corporate Templates and Forms\Equality and Diversity Information* before completing your EQIA**.

Clinical / Patient-facing Policy Equality Impact Assessment	
1. What is the name of the policy?	Access to Gamete Storage Policy
2. Briefly describe the purpose of the policy (or cross reference to relevant section within policy)	The policy sets out how the CCG will support gamete storage in relation to the impact of medical interventions / treatments where premature infertility / sub-fertility is a normally anticipated outcome. This policy does not cover routine gamete storage associated with the normal systems and processes relating to sub-fertility treatment.
3. Who is the policy lead?	Deputy Director of Commissioning
4. Date of assessment	April 2020
5. Date of next review	Next planed refresh of the policy 2023

6. Who is likely to be affected by this policy?	This policy will impact upon individuals who are undergoing treatment or clinical interventions where it is anticipated that premature infertility or sub-fertility will be an outcome. Gamete storage can occur for eligible individuals where premature infertility or sub-fertility is a likely clinical outcome for the clinical treatment / intervention being undertaken. Gametes can be removed from the body (harvested) and stored (cryopreservation). This then enables the individual in discussion with their lead clinical to preserve their chances of being able to have a child at a later date. Storage is initially agreed for 10 years.
	
	Common treatments / interventions which may lead to premature infertility / sub-fertility include:
	• Chemotherapy for both cancer and non-cancerous conditions
	• Surgery; for example:
	  • Orchiectomy
	  • Removal of ovaries
	  • Rectal/lower bowel surgery which may impact upon a male's ability to sustain an erection or ejaculate
	  • Prostate surgery

7. Needs and issues (a) What do you currently know about the needs or issues affecting people from different protected characteristic groups, relevant to your policy? *Population demographic and health needs information resources can be found on the CCG website, here: https://www.hullccg.nhs.uk/health-information-and-resources-3/*	Coping with disease processes that may lead to premature infertility or sub-fertility is difficult without the additional worries of preserving fertility. Whilst there are no specific age limits associated with gamete storage it should be noted that a degree of physical maturity will be required in order for the body to be able to produce viable gametes and, conversely, this policy refers to early infertility / sub-fertility and, as such, it does not cover the natural loss of fertility which is associated with the female menopause and with male gaining. Individuals who are undergoing gender reassignment surgery who choose as part of that process to undergo ovarian removal / orchiectomy are covered by this policy. Attempted harvesting and storage will be offered to clinically appropriate individuals in consultation with their lead clinical as harvesting and storage of gametes is not a decision that should be taken lightly and may not be a solution that everyone wishes to seek. There are also a number of legal issues relating to the storage of gemmates, and where created embryos, especially in relation to 'ownership' of the gametes should the individual not survive their clinical condition or, if an embryo has been created, if either party withdraws their consent for storage / usage of the stored items. These considerations must be fully explored prior to attempting harvesting. Storage of gametes / embryos does not automatically give permission for NHS funded fertility treatment to occur. Funding will need to be applied for, if required, when the individual seeks to utilize the gametes. Over the last 2 years 2 requests have been received by the CCG for gamete storage not associated with cancer treatments. Both of these requests were supported.	
	Race	The latest Census data from 2011 shows that the population of Hull was mostly White British, comprising 89.7% of the populace. Further to this, 4.1% of the population identified as Other White. The rest of the population was made up of: 2.5% Asian / Asian British; 1.4% Mixed/Multiple Ethnic Group; 1.2% Black / African / Caribbean / Black British; 0.8% Other Ethnic Group, and 0.3% White Irish / Irish Traveller.[1] As evidenced above, Hull's BME population is diverse with relatively small numbers of people from a wide range of different BME groups. There is little evidence that race per-se impacts upon the need for gamete storage.

[1] https://www.nomisweb.co.uk/census/2011/local_characteristics

		At this time, based upon existing evidence bases, it is assumed that race does not in itself have a specific impact upon fertility, but racial genetic pre-disposition to certain diseases may impact upon fertility.
	Disability	Based on the 2011 Census, 17.9% of men and 20.2% of women in Hull have an illness or disability that limited their daily activities[2]. There is no evidence to suggest that individuals with disabilities have a greater need to have gametes harvested and stored than other protected groups. However there is limited evidence available and no local evidence. As evidence becomes available this will be reviewed and the impact assessment refreshed if required.
	Gender / Sex	The mid-2018 population estimates for Hull[3] estimate the population to be 260,645 with a male population of 131,329 (50.39%) and a female population of 129,316 (49.61%). There is limited/no evidence to suggest that individual's gender / sex impacts upon the likelihood that an individual will require gamete storage. Whilst there are cancers which impact on one or other gender these tend to balance out as both testes and ovaries can be affected by cancer, as can both reproductive tracts. There is no evidence, at present, of gender impacts upon the effectiveness of current treatments therefore there is no known treatment bias between the genders. As evidence becomes available this will be reviewed and the impact assessment refreshed if required.
	Gender identity (gender reassignment)	There are no official statistics nationally or regionally regarding transgender populations, however, GIRES (Gender Identity Research and Education Society)[4] estimated that, in 2007, the prevalence of people who had sought medical care for gender variance was 20 per 100,000, i.e. 10,000 people, of whom 6,000 had undergone transition. 80% were assigned as boys at birth (now trans women) and 20% as girls (now trans men)[5]. However, there is good reason, based on more recent data from the individual gender identity clinics, to anticipate that

[2] https://www.nomisweb.co.uk/census/2011/local_characteristics

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

[4] www.gires.org.uk

[5] https://www.gires.org.uk/wp-content/uploads/2014/10/Prevalence2011.pdf

		the gender balance may eventually become more equal. For the purpose of this policy individuals who are undergoing gender reassignment are classified as prematurely infertile / sub-fertile and will be offered gamete storage if clinically appropriate. There are also links to the policy around sub-fertility treatments
	Sexual orientation	There are no statistics relating to the sexual orientation of people who live within Hull, however 2017 Government estimates suggest that that 2% of the national population aged 16 and over is lesbian, gay or bisexual[6]. There is no evidence that sexual orientation impacts upon the requirement for gamete storage. If any evidence becomes available this will be reviewed.
	Religion or belief	In the 2011 Census, 54.9% of the population of Hull identified themselves as Christian while 34.8% of people stated 'No religion'. Other religions made up 3.1% of the population as follows: Buddhist: 0.30% Hindu: 0.20% Jewish: 0.10% Muslim: 2.10% Sikh: 0.10%, Other Religion: 0.30% 7.2% of the population did not state a religion. Religion or belief could potentially have an impact on willingness to access gamete storage as a number of religions believe that this type of intervention is not compatible with their system of beliefs. These religious stances may impact whether an individual is willing to discuss / accept gamete storage. There is no evidence that religion / belief impacts upon the requirements for gamete storage. .

[6] https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2017

	Age	Based on 2018 estimates[7], the population of Hull is broken down as follows: 0-19 - 24.27% (63,248); 20-34 - 24.87% (64,835); 35-49 - 18.22% (47,499); 50-64 - 17.67% (46,066); 65+ - 14.96% (38,997). Life expectancy at birth: For 2014-15 life expectancy at birth for Hull men was 76.3 years, and for Hull women it was 80.1 years[8]. The policy refers to premature infertility / sub-fertility, it does not address sub-fertility due to increasing age and, as such, the more mature embers of the population may not be covered by this policy due to naturally occurring reductions in fertility. Similarly there is no lower age limit however young children may not be physically able to produce viable gametes nor may they be in a position to make informed decisions. Therefore when considering fertility preservation in children and young people specific attention needs to be given to the biological limiting factors that may be present.
	Pregnancy and maternity	There are no statistics for relating to the pregnancy and maternity status of people who live within Hull. However, based on 2018 estimates, there were around 3,311[9] live births to women living in Hull. If an individual is already pregnant the protection of the pregnancy already being carried will be the main focus, gamete harvesting is unlikely during pregnancy / the post-partum period. Once a woman is out of the post-partum period the conservation of future fertility can then be discussed.
	Marriage or civil partnership	Based on the 2011 Census[10], 37.5% of the population of Hull are married, 42.1% are single and have never married or been in a

[7] Hull JSNA Summary, October 2019, Population, pg.7
[8] http://www.hullcc.gov.uk/pls/hullpublichealth/assets/JSNA2018_c20.pdf
[9] Hull JSNA Summary, October 2019, Population, pg.7
[10] Census data taken from Local Characteristics tables, https://www.nomisweb.co.uk/census/2011/local_characteristics

		registered same sex partnership, 10.3% are separated or divorced and 6.9% are widowed. There is no evidence that marriage or civil partnership has an effect on the need for gamete storage.
	Socio-economically disadvantage	The Index of Multiple Deprivation (IMD) 2019[11] provides statistics on relative deprivation within England for each lower-layer super output area (LSOA), providing average levels of deprivation within each LSOA. There are 166 LSOAs within Hull following the 2011 Census, with 75 (45.2%) within the bottom 10% most deprived LSOAs in England. Among CCGs nationally, the average score ranks the population that NHS Hull CCG is responsible for as the 5th most deprived. The IMD 2019 index is based on seven domains which are weighted according to their relative importance in relation to the overall score (weights in brackets): (i) income deprivation (22.5%); (ii) employment deprivation (22.5%); (iii) health deprivation and disability (13.5%); (iv) education, skills and training deprivation (13.5%); (v) barriers to housing and services (9.3%); (vi) living environment deprivation (9.3%); and (vii) crime (9.3%). In terms of Health Deprivation and Disability domain, the population for which NHS Hull CCG is responsible for ranks 17th out of 191 in terms of average score. 39.2% of the LSOAs within the remit of NHS Hull CCG are within the 10% most deprived LSOAs nationally in terms of Health Deprivation and Disability. The Health Deprivation and Disability Domain measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation. NHS Hull CCG needs to be aware of the areas of deprivation, in particular with regards to health and disability to ensure equality of access to services.

[11] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

			It is estimated that half of the 63,500 smokers in Hull live in the eight most deprived wards with a prevalence of 37.4% - 48.4%[12]. In addition, Hull is estimated to have over 55,000 people that are classified as obese While more information is required, particularly in relation to Hull, the associated prevalence in the city of smoking, drinking alcohol and obesity which represent risk factors for a range of clinical conditions, including cancers, which may cause premature infertility / sub-fertility. Therefore, theoretically, there may be an increased need for gamete storage. However no evidence has been found that directly links socio-economic disadvantage with the need for gamete storage.
(b) Do you have gaps in understanding about the needs of different groups, and how will you fill these?		There is a lack of local knowledge on the impact of sub-fertility on the different groups across the city.	
8. **How does your policy promote equality and / or help the CCG meet its equality objectives?**		This policy outlines how the CCG will implement the policy in regard to gamete storage and sets out wider clinical groups than previously identified who will be eligible for gamete storage. This helps reduce the inherent bias that was in place when the clinical conditions considered as providing eligibility for gamete storage was more restrictive.	
9. **Communication and Engagement** (a) How are you going to engage with different groups and communities and show that their feedback informs your service review?		There has been no specific consultation around the gamete policy at present This will be aligned with planned involvement / engagement work around sub-fertility but with a specific focus on transgender interest groups for this aspect.	
		Locally we are in the process of identifying a consultation /engagement plan to ensure that those areas where the new policy differs from the existing policy have had local consideration and the local perspective is understood	
(b) Is information provided appropriate and accessible?		This policy will be available on the NHS Hull CCG website	
8. Impact	Will your policy have a	**Race**	Based on the available data and the composition of the population of

[12] Hull JSNA Summary, October 2019, Smoking, pg.39

	disproportionate or negative impact on a particular protected characteristic group? Will there be a positive impact?		Hull, this policy is unlikely to have a disproportionate or negative impact based on Race.
		Disability	Based on the available data and the composition of the population of Hull, this policy is unlikely to have a negative or disproportionate impact based on Disability.
		Gender / Sex	Based on the available data and the composition of the population of Hull, this policy is unlikely to have a negative or disproportionate impact based on Gender / Sex.
		Gender identity (gender reassignment)	This policy accepts that gender reassignment can negatively impact upon fertility and accepts this. This is a positive impact of the policy.
		Sexual orientation	Based on the available data, this policy is unlikely to have a disproportionate or negative impact based on Sexual Orientation.
		Religion or belief	Based on the available data and the composition of the population of Hull, this policy is unlikely to have a disproportionate or negative impact based on Religion or Belief.
		Age	Based on the available data and the composition of the population of Hull, this policy will have an impact upon individuals who are outside the identified age ranges associated with normal biological fertility progression. However this impact is not seen as being disproportionate.
		Pregnancy and maternity	Based on the available data, this policy is unlikely to have a negative or disproportionate impact based on Pregnancy and Maternity status.
		Marriage or civil partnership	Based on the available data, this policy is unlikely to have a disproportionate or negative impact based on Marriage status.
		Any other relevant groups (e.g. carers, veterans, asylum seekers and refugees, socio-economic disadvantage)	Based on the available data, this policy is unlikely to have a disproportionate or negative impact based on any other relevant group.
	If Yes, is how is this impact justifiable?	Any potentially disproportionate or negative impact is as a result of the policy around gamete storage is closely linked into normal biological processes regarding human reproduction. There is no evidence it arises from any bias within the policy itself, if any bias is identified at a later date the policy and this EIA will be reviewed.	
	What measures have been put in place to	In order to mitigate any potentially disproportionate impacts of this policy, the CCG will ensure that the policy is to be applied equitably to the population of Hull, and ensure that access to sub-fertility management is based on clear clinical evidence and need.	

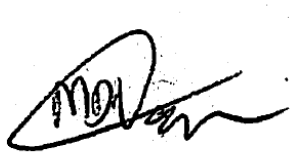
	mitigate any potential impact?	

Follow up actions		
Action required	**By whom?**	**By when?**
Review local evidence and insight, following planned engagement activity	Karen Ellis Colin Hurst	December 2020

Signoff

EIAs to be sent to the Equality and Diversity (E&D) Inbox at hullccg.equalityanddiversity@nhs.net at least 10 days before the document deadline date (Please do this as early as possible).

Following review your EQIA will be returned with any comments included, please action these and return the updated fully formatted document to the E&D Inbox for sign off.

Signed off by: **Name & Role**	Mike Napier, Associate Director of Corporate Affairs 	**Date**:	27.07.20