Appendix 1

Initial Equality Impact Assessment–Service Change.

Department (s)	Department of Adult Social Services (Commissioning Unit)
Service	Procurement of an Integrated Sexual Health Service
People involved	Jennifer Beturin-Din; Helen Corkin

1. What are the aims of the service and what changes are being proposed?

The overall aim of the service is to provide contraception and STI testing and treatment to the general population, with a focus on reducing health inequalities for those most at risk of sexual ill health. This includes reducing the rates of Sexually Transmitted Infections (STIs) and unplanned pregnancies.

The clinical sexual health services that the Council commission are undergoing reconfiguration in 2016, transforming the previously separate Reproductive Sexual Health (RSH) and Genitourinary Medicine (GUM) services into a fully integrated modernised sexual health service reflecting best practice models. This involves working collaboratively with St George's University Hospitals NHS Foundation Trust to consolidate clinic locations, service delivery timetables and to offer more services in each of these sites. This will be further complemented by an online offer in 2017. The rationale for these changes, including the considerations for moving to an integrated service, can be found in Paper No 16-221.

The agreement with the provider to deliver these services will expire on 30th September 2017. A competitive procurement will be carried out to seek proposals from other potential providers for delivering an integrated sexual health service thereafter. Depending on the winning service provider, this exercise could result in changes to clinic site locations although the areas in which the services will be delivered will be suggested in the service specification. Additionally, all residents will have access to the London e-healthcare services that can send discreet STI tests to their home or work address. It is also anticipated that the winning provider would introduce changes to timetable of service delivery although within the limits defined in the service specification.

2. What is the rationale behind these changes?

The integrated sexual health service is the modern best standard for these services and Wandsworth services until recently have not been delivering this model. The new model requires significant innovation and reconfiguration to deliver successfully for our population. Whilst SGH are making steps towards this direction, it needs to be market tested as to quality and affordability to

meet the needs of the local population over the next few years. Many other boroughs in London and England have been delivering some models of integrated sexual health service for years, minimising the need to attend separate services for contraception and STI testing. This procurement is part of a London programme to ensure consistency or offer to residents across the region by developing local commissioning to have the same standard model reflecting the aims and objectives of the London Sexual Health Transformation Programme (LSHTP) and its various work streams, whilst allowing for a degree of localisation, reflecting differing needs and demographics. The service specification for the (terrestrial) integrated sexual health service/s is subject to clinical review and sign-off to ensure that best practice and professional standards are incorporated into the model of delivery.

The programme is working with neighbouring boroughs Richmond and Merton to achieve the scale residents will benefit from and reflecting that services across London see a significant proportion of residents from other areas/boroughs/regions. Working regionally and with our named neighbours to achieve an integrated service across these boroughs will help improve service pathways for the service users.

The developments described above and in Paper No. 16-417 warrant a re-design of the service specification and further market testing. The new service specification will include the following:

- An integrated sexual health service provision across Wandsworth (and LB Richmond and Merton) based on a hub and spokes model, with the hub delivering up to Level 3 services and spokes delivering up to Level 2.
- Embedding the provisions of the e-healthcare services developed by the LSHTP which includes web-based access and triaging to appropriate level of services (clinical or self-managed testing). Self-managed testing kits, if deemed appropriate, can be accessed online or in specified sites.
- An improved emphasis on communicating the services on offer and locations to patients, prevention of sexual ill health by targeting those most at risk, as well as the general population.
- Other potential developments include working with primary care to improve service access in the community and pathways to benefit patients and staff.

3. What information do you have on the policy and the potential impact of your service change in relation to the following?

	List information you have. Do not put what the information shows you
Race	**Table 1 – RSH* and GUM** Wandsworth Attendances (2014-15) by Ethnicity compared with 2011 Census data. The distinction between RSH and GUM clinics will be removed in line with the planned reconfiguration in Paper No. 16-221**

	Census 2011	**%**	Balham HC	%	Brocklebank	%	Doddington	%	Eileen Lecky	%	QMH	%	Tooting HC	%	CYC	%
White including White Other	**219,216**	**71.40%**	2086	74.7	820	71.2	1231	61.5	721	86	781	66.6	2841	57.1	9764	61
Black African	**14,818**	**4.80%**	91	3.26	66	5.73	186	9.29	10	1.2	109	9.29	429	8.62	1364	8.6
Black Caribbean	**12,297**	**4%**	171	6.12	73	6.34	249	12.4	18	2.1	60	5.12	416	8.36	1864	11.8
Black Other	**5,641**	**1.80%**	33	1.18	10	0.87	31	1.55	4	0.5	13	1.11	77	1.55	274	1.7
Mixed/Multiple ethnic group	**15,241**	**5%**	187	6.7	58	5.03	177	8.84	35	4.2	75	6.39	386	7.76	1272	8
Other ethnic groups	**39,782**	**12%**	224	8.02	125	10.9	128	6.39	51	6.1	135	11.5	827	16.6	1331	8.4

TOTAL			**2792**		**1152**		**2002**		**839**		**1173**		**4976**		**15869**	

***** RSH clinics prior to the reconfiguration

**All Wandsworth GUM attendances have only been added to the Courtyard Clinic (CYC) attendances

Gender

Table 2 – RSH* and GUM Wandsworth Attendances (2014-15) by Gender compared with 2011 Census data. The distinction between RSH and GUM clinics will be removed in line with the planned reconfiguration in Paper No. 16-221**

	Census 2011 %	Balham HC	%	Brocklebank	%	Doddington	%	Eileen Lecky	%	QMH	%	Tooting HC	%	CYC	%
Male	**48**	70	2.51	7	0.61	54	2.7	10	1.2	4	0.34	35	0.7	6275	40
Female	**52**	2722	97.5	1145	99.4	1948	97.3	829	99	1169	99.7	4941	99.3	9578	60
TOTAL		**2792**		**1152**		**2002**		**839**		**1173**		**4976**		**15853**	

***** RSH clinics prior to the reconfiguration

**All Wandsworth GUM attendances have only been added to the Courtyard Clinic (CYC) attendances

Disability	**Census 2011**	Census revealed that the day to day activities of 4.8% of residents are limited a lot with a further 5.8% reportedly seeing day to day activities limited a little. This data is very likely to include people with learning disabilities, physical disabilities, sensory impairments, those with mental health issues as well as those who are elderly frail. Information on Disability is not systematically collected by the services but all providers are required to operate within the Equalities Act 2010. In the future specification we will be requesting this data is monitored and provided.

Age

Table 3 – RSH* and GUM Attendances (2014-15) by Age compared with 2011 Census data. The distinction between RSH and GUM clinics will be removed in line with the planned reconfiguration in Paper No. 16-221**

	Census 2011 (%)	Balham HC	%	Brocklebank	%	Doddington	%	Eileen Lecky	%	QMH	%	Tooting HC	%	CYC	%
24 years and under	**27.6%**	704	25	293	25	548	27	281	33	452	39	1316	26	4913	31
25 years and older	**72.40%**	2088	75	859	75	1454	73	558	67	721	61	3660	73	10918	69
TOTAL		**2792**		**1152**		**2002**		**839**		**1173**		**4976**		**15831**	

***** RSH clinics prior to the reconfiguration

**All Wandsworth GUM attendances have been added to the Courtyard Clinic (CYC) attendances

Faith	**Census 2011**	53.0% Christian. 27.0% stated that they had no religion 8.1% stated they were Muslim Information on Faith is not systematically collected by the services but all providers are required to operate within the Equalities Act 2010.

Sexual Orientation

Table 4 – RSH* and GUM Attendances (2014-15) by Sexual Orientation. The distinction between RSH and GUM clinics will be removed in line with the planned reconfiguration in Paper No. 16-221**

	Balham HC	%	Brocklebank	%	Doddington	%	Eileen Lecky	%	QMH	%	Tooting HC	%	CYC	%
Heterosexual	2154	77.1	922	80	1670	83.4	563	67	1037	88.4	4065	81.7	13524	85
Homosexual	5	0.18	1	0.09	6	0.3	1	0.1	2	0.17	12	0.24	1053	7
Bisexual	4	0.14	6	0.52	14	0.7	2	0.2	14	1.19	27	0.54	1128	7
Not given	629	22.5	223	19.4	312	15.6	273	33	120	10.2	872	17.5	147	0.9
TOTAL	**2792**		**1152**		**2002**		**839**		**1173**		**4976**		**15852**	

	***** RSH clinics prior to the reconfiguration **All Wandsworth GUM attendances have been added to the Courtyard Clinic (CYC) attendances

4. Thinking about each group below please list the impact that the policy will have.

	Positive impacts of service change	Possible negative impacts of service change
Race	People who describe their ethnicity as Black African or Black Caribbean tend to access sexual health services in higher proportion in comparison with local census data. Evidence from national data identifies Sub-Saharan Black African group as at high risk of sexual ill health so the service specification will include a requirement to maintain an extended provision will be in areas with high concentration of BME residents. This will enhance access and encourage greater percentage of BME attendances. The introduction of the e-healthcare service will provide further opportunity to access the service discreetly and easily, which we expect to tackle undiagnosed STIs including HIV seen disproportionally in some communities.	There will need to be a careful consideration of the where the new clinics should be located in terms of accessibility for BME, particularly for those who belong to certain communities where stigma around sexual health is prevalent. The availability of estates or premises in suitable locations may present as an issue however we are exploring financial incentives and support will be provided to the winning provider to encourage investment to secure premises.
Gender	The attendance data provided in Table 2 is based on the previously separate model of GUM and RSH services. With the imminent move towards integration, it is anticipated that the proportion of men attendances will improve as the availability of STI management services will be wider. In addition to more clinical sites providing this service, the introduction of the	Increase in male and transgender attendees at a traditionally heterosexual female environment may require some adjustment by all genders. Failure to mange that adjustment well may impact negatively on attendance. Although in other services in other areas this hasn't presented a significant problem.

	e-healthcare services will further improve access. This will go some way to tackling the higher sexual ill health and lack of health seeking behaviours in men and trans people. Staff will be required to be competent, confident and welcoming to all genders which may have not been the case in female only clinics. Trans * people report feeling excluded from sites where waiting rooms or toilets are divided on a gender binary and images do not reflect the diversity of gender. The specification highlights the need for great trans* awareness and accommodations.	We will ensure the manner in which services are provided take account of the gender issues. In addition, staff will receive regular training on how to address issues that may arise. We will actively encourage feedback from service users, analyse their responses and take appropriate action to ensure services are gender friendly to all.
Disability	The new service specification will continue the support currently provided to people with learning disabilities (LD). A dedicated service for people with LD will facilitate and improves access for this group of people. All clinic sites will be required to have a step-free access and people, who communicate via BSL will have access to interpretation services if required.	The potential changes to the clinic locations may cause initial disruption to services that could impact certain groups of people with disability negatively. The e-healthcare services model will also offer the opportunity to be tested in ones own home should that be possible. To address this we will promote and publicise the new sites, including their accessibility features, in formats that ensure disabled people are informed of the changes. People with LD will need support to familiarise themselves with the new services. We understand current services can prove challenging. We will work with staff delivering the new

		service to facilitate and ensure access to this group of service users by establishing links with patients with disabilities, advocate groups and specialist workers.
Age	Comparison with census data (table 3) reflects a higher proportion of people within the older (over 25) age group accessing services. As young people (24 and under) are considered a high-risk group, the service specification will require the new provider to undertake outreach and 1-to-1 sessions to this age group. Young people consultation feedback supported the continuation of specific clinical sessions for under 25 year olds and so this will be retained in the new service specification. However all service sites and sessions will be measured against the 'You're welcome' criteria to ensure that the young person receives high quality care regardless of whether they attend the young person specific service.	Those aged 25 years and over may turn up to the age restricted clinic sessions and be consequently advised to attend a different session on the same day /different day (as happens currently) or be directed to online services where appropriate for their convince. To avoid any unnecessary steps, we will ensure that the service provider advertises and publicises the services and outline the different opening times for all age groups. With fewer sites, this should be more manageable and less confusing for the service users, and this is supported by patient feedback and engagement form 2015 and 2016.
Faith	Services will be Faith sensitive taking into account the data in table 5 above.	There may be some issues with some people of faith moving from services named "Family planning" to those named "integrated sexual health" and the perceptions that they may have We will highlight this to the new provider regarding naming services and tackling stigma. Some faith groups prefer sex segregated services,

		however this is not generally offered by the wider health services and does not inhibit the delivery of them. We will explore and review delivery with the provider regarding some “women specific “clinical sessions in areas where a need is established.
Sexual orientation	Men who have Sex with Men (MSM) will be offered a service more appropriate to their higher sexual health needs. Initially a clinic session dedicated to MSM will be retained to meet the very specific sexual health needs of this high-risk group. This is in line with a feedback received during the consultation with regards to providing options for different sexual orientation and may be combined on review in the future to encompass LGBT*, if required The service in all aspects will promote an inclusive approach to all individuals including those with higher vulnerabilities or risk including MSM working with individuals to address and minimising their risk where this is necessary. MSM with complex needs and as a high risk group can be directed to Level 3 services nearest to them. All services are expected to be LGBT* competent, confident and welcoming and have literature and marketing that reinforce this message.	MSM may experience sexual health fatigue as they are a group heavily targeted for health improvement; it is thought that the e-healthcare services may support empowerment and choice as well as an option to attend physical services. Targeted work at high risk individuals rather than every MSM may help improve this negative experience. Engagement also revealed that some heterosexual men (particularly in areas or cultures with strongly enforced heteronormativity and higher instances of homophobia) risk becoming disengaged where there is an exclusive focus on the graphic sexual health publicity targeting MSM so this will need to be considered in messaging for services and groups to reflect the range of patients identities and experiences.

5. Is a full EIA required? No

The following questions should help you decide if a full EIA is required. As a guide if you are a frontline service where the impact is unclear or negative you will need to conduct a full EIA. You are unsure call Claire O'Connor on ext 7816.

- Does the policy support a frontline service? **Yes**
- Is it clear what impact the policy will have on all the equality groups? **Yes**
- Overall will the change have a negative impact on any of the equality groups? **No**

Comments - Please give the rationale here for not undertaking a full EIA

As part of the regional London LSHTP work, an EIA has been conducted and appraised. A public/service user consultation and an EIA was carried out between May and July 2015 using a variety of methods including focus groups, engaging with target audience at events and online survey. The main areas identified for significant improvement include:

- Opening times which people said they found too confusing and appointment times too limited. Longer and consistent opening hours across three sites in Wandsworth will therefore benefit all service users regardless of ethnic group.
- Waiting times were considered too long due to staffing issues at some venues and general organisation of the current service model. Concentrating resources in the 3 main sights should address this issue.
- Insufficient publicity and advertisement means some people are un-aware of the services or misdirected. The new service specification as well as a stronger message across London as a result of the launch of e-healthcare services will address this matter.

There is scope to increase access of Black African and Black Caribbean groups living in the Battersea area. In particular. The service change seeks to extend representation to include more BME men and Trans* people.

Overall the change will offer positive impacts on all groups with protected characteristics with the continuation of an integrated service and the incorporation of the e-healthcare services developed across London. As a universal service, it will seek to ensure that all residents, whatever their needs, are fully informed and signposted to appropriate services; targeting vulnerable and higher risk people ; and streamlining patient journeys into appropriate services for their needs.

The potential negative impact could arise from an inability to secure suitable clinic sites for patient needs. This is a risk that has been highlighted across LB Richmond and Merton and can be somewhat mitigated by offering the winning provider the support needed to secure suitable locations for the service in line with evidence of sexual health needs in the Borough.

We are seeking to mitigate the potential negative impacts identified and will monitor and review the service, to ensure a service offer that proactively looks

to general population's needs as well as those with protected characteristics. The ethos of the service and specification are to ensure greater access and equality so that people benefit from this overdue change. In addition the provider, as part of the reconfigured service must demonstrate that they are operating within the Equality Act 2010.

6. Through the initial EIA have you identified any actions that needed to be implemented to improve access or monitoring of the policy? (please list)

- Effective promotion and publication will be put in place to ensure that those who are currently attending a particular clinic are aware of the changes and to raise awareness among people who may wish to access services for the first time.
- Marketing and publicity to explicitly publicise the new service model, locations, outline the different opening times for all age groups. With fewer sites, this should be more manageable and less confusing for the service users.
- Publicity will highlight the accessibility features of the sites and be delivered in different formats to ensure all disabled people are informed of the changes.
- Improve collection of data on people with protected characteristics particularly in relation to disability and sexuality to enable routine monitoring of these groups accessing the service.
- Work with the provider and their staff to ensure access to people with disabilities including L.D. is improved. We will monitor how this is working to ensure we continue to meet the needs of vulnerable patients to enable them to thrive.
- Encourage providers to reflect and address issues that take into account an awareness of gender sensitivities. Staff must receive regular training on how to address issues that may arise.
- Actively encourage service user feedback, analyse their responses and take appropriate action to ensure services are meeting the needs of patients including those in protected categories.
- Ensure preventative options include measures to address STI stigma to reduce the need for people to seek services here or elsewhere.

Signed

Date: 04/10/2016

Approved by

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