Appendix 1

Initial Equality Impact Assessment–Service Change

Department (s)	Department of Adult and Social Services (Commissioning Unit)
Service	Reconfiguration of sexual health services provided by St. George's Hospital
People involved	Jennifer Beturin-Din; Richard Wiles

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

The overall aim of these services is to reduce health inequalities and improve the sexual health outcomes of the local population. This includes reducing the rates of Sexually Transmitted Infections (STIs) and unplanned pregnancies, especially those that result in terminations.

Currently Reproductive Sexual Health (RSH) services are provided at the following 7 sites:

Clinic Sites	**Locality**
Balham Health Centre	Wandle
Brocklebank Health Centre	Wandle
Doddington Health Centre	Battersea
Eileen Lecky Health Centre	West Wandsworth
Queen Mary's Hospital	West Wandsworth
Tooting Health Centre	Wandle
Courtyard Clinic at St. George's Hospital	Wandle

- Genito-Urinary Medicine(STI/GUM Level 1-3) which involves STI testing and treatment is done at 2 sites:

  - Queen Mary's Hospital

  - St. George's Hospital (Courtyard Clinic)

- STI and contraception services (Level 1 – 3) specific for young

people are delivered at

- Queen Mary's Hospital
- Stormont Health Clinic, Battersea
- Courtyard Clinic, Tooting

It is proposed that the existing service provision of GUM and RSH provided by the St. George's University Hospitals Foundation Trust should be reconfigured to deliver an Integrated Sexual and reproductive service with more hours to be delivered on three sites. This will involve:

- Introducing a Level 2 or non-complex sexually transmitted infection (STI) sexual health clinic alongside the RSH clinic at:
  - Doddington HC, opening for 8.5 hours (walk-in) and 2 hours (appointment) a week.
  - Roehampton at QMH, open for 8.5 hours (walk-in) and 2 hours (appointment) a week.
- Maintaining the CYC at St. George's as the sexual and reproductive health services 'hub' for the borough, with integrated provision comprising both a full STI level 1-3 service and RSH Level 1-3 services, open six days per week. Additionally, the dedicated clinic for men who have sex with men (MSM) will be maintained.
- Relocating "The Point"(young people Integrated clinic) from Stormont Health Clinic to Doddington Health Centre whilst retaining the current branding so that all young people 'Point' services are delivered alongside the mainstream RSH and GUM. Both of these clinics are located in Battersea and are within 1.1 miles away from each other (20 minutes walk or 15 minutes bus ride).

2. What is the rationale behind these changes?

RSH is delivered in small bursts for clinical hours at multiple sites. This results in restricted hours and therefore restricted access. Attendances by local residents at GUM clinics have been stable but attendances at services outside Wandsworth have risen sharply e.g. Chelsea and Westminster Hospital has reported 20% increase in activity over the last year. These contractual arrangements are fragmented and represent inefficient use of resources. It impacts negatively on service user experience and access, particularly

around opening hours and waiting times, as well as service user confusion as to what is available at each site and when the clinic session is running. On average last year (2015/16) around 25% of patients at GUM services have had to wait more than 15 minutes of appointment time or more than 1 hour after walk-in.

If a patient requires contraception and a suite of asymptomatic STI testing, there is limited and fragmented offer in the current model.

In addition to the current GUM clinics, chlamydia and gonorrhoea screening for 15-24 year olds screening is available at the RSH and Point clinics. One RSH site is also piloting HIV and syphilis testing which as a stand alone has not proved popular. Outside of GUM and the Point, RSH services are perceived as women's family planning and the lack of men using the service reflects this which is an access issue. Similarly, the need to make separate visits to two different services rather than a fully integrated service is highlighted as an access issue creating barriers and time delays.

Different service user groups were consulted during the spring/summer period last year (2015). They stated a clear preference for a more consistent and extended opening hours. This can best be achieved through concentrating services in fewer sites and widening the scope of services (i.e. including both RSH and elements of STI testing and treatment). This proposed reconfiguration will increase the total number of hours of availability of services from 43 to 49 per week. The service users also provided comments on how the current services could be improved. Extended later opening hours and reduced waiting times were the most cited as areas needing significant improvement. The intended outcomes for the proposed reconfiguration are in line with the issues identified by the service users in the consultation.

Local as well as Public Health England (PHE) surveillance data identify Battersea as an area with high prevalence of sexual ill health and so introducing a Level 2 sexual health service (in addition to the existing contraception service) is intended to improve accessibility and outcome for residents living in the Battersea area including those with HIV. Similarly, certain groups such as MSM and young people continue to be disproportionately affected by sexual ill health and so continuing sessions dedicated to MSM and young people is hoped to improve the groups' sexual health inequality outcomes.

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 Attendances (2014-15) by Ethnicity compared with 2011 Census data**

	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	690	66.2
Black African	**14,818**	**4.80%**	91	3.26	66	5.73	186	9.29	10	1.2	109	9.29	429	8.62	76	7.3
Black Caribbean	**12,297**	**4%**	171	6.12	73	6.34	249	12.4	18	2.1	60	5.12	416	8.36	85	8.1
Black Other	**5,641**	**1.80%**	33	1.18	10	0.87	31	1.55	4	0.5	13	1.11	77	1.55	13	1.2
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	86	8.2
Other ethnic groups	**39,782**	**12%**	224	8.02	125	10.9	128	6.39	51	6.1	135	11.5	827	16.6	93	8.9
TOTAL			**2792**		**1152**		**2002**		**839**		**1173**		**4976**		**1043**	

Gender	**Table 2 – RSH Attendances (2014-15) by Gender**

	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	3	0.3
Female	**52**	2722	97.5	1145	99.4	1948	97.3	829	99	1169	99.7	4941	99.3	1041	99.7
TOTAL		**2792**		**1152**		**2002**		**839**		**1173**		**4976**		**1044**	

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.

Age

Table 3 – RSH Attendances (2014-15) by Age compared with 2011 Census data

	Census 2011 (%)	Balham HC	%	Brocklebank	%	Doddington	%	Eileen Lecky	%	QMH	%	Tooting HC	%	CYC	%
Under 16	**16.60%**	12	0.43	2	0.17	6	0.3	1	0.1	8	0.68	29	0.58	2	0.2
16-17 years	**1.50%**	40	1.43	38	3.3	31	1.55	16	1.9	16	1.36	118	2.37	21	2
18-24 years	**9.50%**	652	23.4	253	22	511	25.5	264	31	428	36.5	1169	23.5	351	34
25 years and older	**72.40%**	2088	74.8	859	74.6	1454	72.6	558	67	721	61.5	3660	73.6	669	64
TOTAL		**2792**		**1152**		**2002**		**839**		**1173**		**4976**		**1043**	

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 Attendances (2014-15) by Sexual Orientation

	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	893	86
Homosexual	5	0.18	1	0.09	6	0.3	1	0.1	2	0.17	12	0.24	2	0.2
Bisexual	4	0.14	6	0.52	14	0.7	2	0.2	14	1.19	27	0.54	1	0.1
Not given	629	22.5	223	19.4	312	15.6	273	33	120	10.2	872	17.5	147	14
TOTAL	**2792**		**1152**		**2002**		**839**		**1173**		**4976**		**1043**	

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. The proposed changes will offer a wider scope of service provision in Battersea where there is a high proportion of BME groups. Evidence from national data identifies Sub-Saharan Black African group as at high risk of sexual ill health so it is positive that extended provision will be in areas with high concentration of BME residents. This will enhance access and encourage greater percentage of BME attendances.	The reduction of the number of sites from 7 to 3 may well impact on attendance levels of BME groups who have high attendances in Brocklebank and Tooting Health centres. Similarly, the high attendances in Balham and Eileen Lecky HC by White British, Irish and Other White groups could mean that restricting the choice of clinic for this group. However considering the close proximity of these clinics to QMH and CYC respectively, the anticipated impact on travelling would be minimal. The restricted choice of clinic venues may result in a proportion of people from BME and other communities seeking out of borough services because of the stigma associated with some of these services e.g. STI. The renewed focus on preventative options will include measures to address this stigma and reduce the need for people to seek services elsewhere. We will conduct a promotion and publication to ensure that people from all protected characteristics groups are aware of the changes including the enhanced services provided at the main sites.

Gender	The data in Table 2 reflects the fact that accessing reproductive sexual health services is overwhelmingly a female activity. Whereas in GUM, 42% of attendances are male. Integrating the element of STI management to the contraceptive clinic in Doddington HC and QMH is likely to improve the overall proportion of men attending these clinics compared with the current RSH and GUM separate service model. This provides an opportunity to discuss preventative options. It was also highlighted during the consultation that there is little incentive or reason for men to visit a sexual health clinic. Concentrating a new integrated service rather than just contraception in 3 main locations will enable services to be more focused and more welcoming to patients of all genders including men and transgender people whose primary needs aren't contraception. Patients with Level 3 needs will need to be directed via triage and effective marketing to the correct service. Effective managed referral pathways will need to be in place with SGH Courtyard clinic/ Kingston hospital as the closest Level 3 sites to facilitate seeing the patient in the most appropriate service.	Increase in male and transgender attendees at a traditionally heterosexual female environment may require some adjustment by all genders. Failure to adjust may impact negatively on attendance. 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.
Disability	The new service will continue the support currently provided to people with learning disabilities (LD) as part of the Acorn service. This dedicated	The limited choice of venues means that some disabled people will have to travel further to obtain a service which can act as a

	service ensures that people with LD are assessed on the phone and are signposted to the nearest and most appropriate service. This facilitates and improves access to this group of people. All clinic sites have step-free access and people, who communicate via BSL will have access to an interpreter if required.	disincentive to attend clinics. We will promote and publicise the reconfigured sites, including their accessibility features, in formats that ensure disabled people are informed of the changes. People with LD will need to familiarise themselves with the new configuration of services which can prove challenging. We will work with the people who deliver the ACORN service to ensure access this group of service users continues to run smoothly.
Age	Comparison with census data (table 3) reflects a higher proportion of people within the16-24 age group accessing services. As this is considered a high-risk group hopefully greater use of the services will be achieved by the change. Young people consultation feedback supported the continuation of specific clinical sessions for under 25 year olds. St George's will retain the Point clinics for under 25 year olds as part of the wider service provision. All age groups are welcome to access the service should they need it for their contraception or STI screening needs.	Those aged 25 years and over may turn up to the age restricted clinic sessions. We will advertise and publicise the services outline the different opening times for all age groups. With fewer sites, this should be more manageable and less confusing for the service users.
Faith	Services will be Faith sensitive taking into account the data in table 5 above.	The limited choice of venues may have a negative impact on attendance of people with a faith background particularly in relation to STI

		and contraceptive medicine. For instance, anecdotally Asian women from certain Muslim background may prefer women only sessions. As CYC waiting rooms are separated, this may offer mitigation. A focus group will be carried out to engage this group to the changes and seek mitigations.
Sexual orientation	As the reconfigured service will offer more than just contraception, LGBT groups, particularly MSM will be offered a service more appropriate to their wider sexual health needs. A clinic session dedicated to MSM will be set up 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. The service in all aspects will promote an inclusive approach to all of the above categories (particularly working with individuals to address minimising their high risk exposure). MSM with complex needs and as a high risk group can be directed to Level 3 services nearest to them which will include SGH Courtyard Clinic, Kingston Hospital as well as Dean Street and Guys and St. Thomas Hospital.	MSM may experience sexual health fatigue as they are a group heavily targeted for health improvement. This is turn could affect attendance level. Engagement also revealed that some heterosexual men in general (particularly in areas or cultures with strong enforced heteronormativity) risk becoming disengaged where there is an exclusive focus on graphic sexual health publicity targeting MSM. The clinics will ensure that publicity materials are appropriate for those who do not identify as MSM and/or homosexual/gay.

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 Clare 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

A public/service user consultation 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 the three sites will therefore benefit all service users regardless of ethnic group.
- Waiting times were considered too long due to staffing issues at some venues. Concentrating resources in the 3 main sights should address this issue.
- Insufficient publicity and advertisement means some people are unaware of the services. Reconfiguration 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 policy change seeks to extend this representation to include more BME men and transgendered people.

Overall the change will have a positive impact on all groups with protected characteristics. The reconfigured service will incorporate the management of non-complex STIs with the contraceptive clinical service in Roehampton and Battersea. This service was previously not delivered. This is in line with best practice and reduces the need for clients to undergo multiple attendances. QMH will see an increase in opening hours for those who have STI related needs and can be seen alongside RSH or contraception needs.

As a universal service, it will seek to ensure that all residents, whatever their needs, are fully informed and signposted to appropriate sexual and reproductive health services.

We are seeking to mitigate the potential negative impacts identified and will monitor the service to ensure a universal service offer that proactively looks to the needs of people with protected characteristics. The ethos of the service and specification are to ensure greater access and equality so that people benefit from this 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 used to 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.
- Adverts and publicity to explicitly publicise the reconfigured sites, 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.
- Improved collection of data particularly in relation to faith and sexuality groups to enable routine monitoring of these groups accessing the service.
- Facilitated focus group to advise on changes that are required to ensure services reflects the need to respect the faith of individuals.
- Work with the people who deliver the ACORN service to ensure access to people with LD continues to run smoothly. We will monitor how this is working to ensure we continue to meet the needs of learning disabled people.
- Organise services in a manner that takes account of gender sensitivities. Staff will 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 gender friendly.
- Ensure preventative options include measures to address STI stigma to reduce the need for people to seek services elsewhere.

Date: 13/06/2016

Approved by: Clare O’Connor

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