LONDON BOROUGH OF RICHMOND UPON THAMES

Equality Impact and Needs Analysis (EINA)

Directorate:	Adult Community Services
Service Area:	Public Health
Name of service/ function/ policy/ being assessed:	Sexual Health Commissioning Strategy 2014-18
Officer leading on assessment:	Hannah Gill, Senior Public Health Lead
Other staff involved:	Anna Bryden, Consultant in Public Health Kate Parsley, Senior Public Health Lead Aslam Baig, Public Health Lead

PREPARATION FOR THE EQUALITY IMPACT AND NEEDS ANALYSIS

SUMMARY OF THE KEY FINDINGS

1. **Set out the key findings from the equality impact needs analysis of the service/ function/ policy. Key questions to consider when completing this section:**

   - *Are there findings of unlawful discrimination?*
   - *Can you address any identified adverse impact?*
   - *Can you mitigate any negative impact?*
   - *Please provide rationale if you are unable to address any adverse impact.*
   - *Have you identified any ways of advancing equality in this area? For example, meeting diverse needs?*
   - *Is there a need for any actions to promote understanding between different protected groups?*

Update

This EINA has been updated to consider the London Sexual Health Transformation Programme (LSHTP) and the 2016 procurement of an Integrated Sexual Health Service for Richmond, Wandsworth and Merton, which can be considered as part of the implementation of the Sexual Health Commissioning Strategy.

The Sexual Health Commissioning Strategy 2014-18 is a joint strategy between London Borough of Richmond upon Thames (LBRuT) and NHS Richmond Clinical Commissioning Group (CCG) with the purpose to identify commissioning actions that can be taken to support improvements in sexual health within Richmond borough. The strategy will be used to inform the re-commissioning of services.

A detailed Joint Strategic Needs Assessment (JSNA) was undertaken and was used to inform the strategy. The JSNA is available at:
http://www.datarich.info/resource/view?resourceId=167

This EINA was carried out to assess the impact of the new sexual health strategy on equality with respect to protected characteristics. The EINA summarises inequalities in sexual health needs, outcomes and service use using information from the JSNA and outlines how the strategy and the subsequent procurement of an Integrated Sexual Health (ISH) Service in Richmond, Wandsworth and Merton, along with the LSHTP work alongside the strategy's aims to reduce these inequalities.

Age, race/ethnicity, sexual orientation and gender assignment are highly relevant characteristics that influence the overall pattern of sexual health outcomes and use of services. The other protected characteristics are also relevant, particularly disability and gender/sex.

There are a number of equality issues relating to sexual health needs, outcomes and service use. However, the main groups of people at higher risk for poor sexual health are young adults, people from black ethnic groups and men who have sex with men (MSM) – this is found at a local and national level. These groups may be particularly at risk due to one or more of the following factors – higher levels of risky behaviour, a higher prevalence of STIs and HIV in certain groups and certain areas of the world (e.g. areas that people may visit regularly), variation in access to services or vulnerability due to social, physical, mental or emotional issues.

The EINA found that there is no discrimination arising from the strategy or the LSHTP or procurement of the ISH service. Instead, one of the explicit outcomes of the strategy is to reduce inequalities in sexual health.

Equality is promoted through the strategy in a number of ways:

- A particular focus on prevention and sexual health promotion among young people – for example, improving sex and relationships education and ensuring provision of free contraception.
- A specific objective to ensure that services meet the needs of people from high risk groups, including young people, people from black ethnic groups, LGBT people and people with disabilities.
- Strengthening community-based services and consideration of alternative methods of service delivery, such as online services and self-testing – with the aim of reducing stigma and encouraging greater use of services, particularly by men and young people.
- An objective to ensure that robust safeguarding arrangements are in place, which includes issues such as sexual assault and FGM.

The EINA highlighted some gaps in data collection on protected characteristics. Although the specialist sexual health services do routinely collect data on age, ethnicity and sexual orientation/gender assignment, some services (e.g. GP practices providing sexual health services) are not commissioned to routinely collect and report this data. In addition, most services do not routinely collect data on disability, religion and marriage/civil partnership status. The strategy recommends that the recording of equality data by all sexual health services is reviewed.

2. Briefly describe the service/ function/ policy:

The Sexual Health Commissioning Strategy 2014-18 identifies commissioning actions that can be taken to support improvements in sexual health within Richmond borough. The strategy was always intended to be used to inform the re-commissioning of services.

The strategy supports the achievement of the following high-level outcomes:

- Reduce the rate of unintended pregnancies, particularly among young people
- Reduce the rate of STIs and HIV
- Reduce inequalities in sexual health

There are three commissioning priorities within this strategy.

- Increase the focus on prevention and sexual health promotion
- Strengthen community-based sexual health services
- Commission high-quality services

The procurement of an Integrated Sexual Health Service falls under all of the three commissioning priorities of the strategy.

Update

This EINA has been updated to consider the 2016 procurement of an Integrated Sexual Health Service, which can be considered as part of the implementation of the Sexual Health Commissioning Strategy.

The procurement is part of a London programme to ensure consistency of 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 programme is working with neighbouring boroughs Wandsworth 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.

There is no hospital located within the borough, Richmond is not the lead commissioner for any GUM service and is therefore not in a position to re-design or procure GUM services on its own. However as part of the wider London programme (LSHTP) Richmond has been working alongside partners on the re-design of an integrated sexual health service for Wandsworth, Richmond and Merton. The new provider has been awarded the contract for the three boroughs. At present it is not known that there are any changes to other services in neighbouring boroughs that would impact on Richmond residents.

In addition to the re-design and commissioning of integrated sexual health services, all Richmond residents will have access to the London e-healthcare services that can send discreet STI tests to their home or work address. The e-healthcare services are an online 'front-door' to GUM services, including information about sexual health, triage, signposting to the most appropriate service and potentially the ability to book appointments; enable residents to order STI testing kits that can be used at home; and a new partner notification service. GUM clinics will be open longer hours and will be linked with a network of integrated local one stop shops. They will also work closely with primary care.

These services offer key benefits to Richmond borough. The primary aim of the online services will be to ensure that high volume, low risk predominantly asymptomatic activity is controlled and managed where appropriate out of higher cost clinic environments. An improved partner notification system will ensure that resources are targeted at the highest need groups, such as the LGBT population and young people.

Some Press attention has been gained from a small group of protestors, suggesting that the new jointly procured service provides a reduced service offer to the population, including young people and that this will pose risks to the health of people living in the borough. All queries from the Press and others, have been responded to with appropriate feedback about the plans for implementation and have been included in records and risk registers where appropriate. As a preventative measure, the Commissioners are working hard to ensure that there are minimal delays to the new service and any issues are bottomed out immediately.

3. Why is the equality impact and needs analysis being undertaken?

Update

This EINA is updating the previous EINA which was carried out to assess the impact of the sexual health strategy on equality with respect to protected characteristics. It has been agreed that whilst the procurement of an Integrated Sexual Health Service falls under all of the three commissioning priorities of the strategy, it is a significant service change and an updated EINA would be conducted.

The EINA summarises inequalities in sexual health needs, outcomes and service use using information from the JSNA and outlines how the procurement of an Integrated Sexual Health Service implements the commissioning priorities from the strategy with the aim to reduce these inequalities.

Key questions are:

- What is the current pattern of sexual health needs, outcomes and service use among groups with protected characteristics?
- Does the proposed Integrated Sexual Health Service take account of these characteristics to ensure appropriate access to services and support achievement of good sexual health outcomes across all groups?

4. Has this service/ function/ policy undertaken a screening for relevance?

If so, which protected characteristics and parts of the duty were identified as of high or medium relevance and why? Please attach screening for relevance as an appendix to this EINA.

If not, make an assessment of which protected characteristics and parts of the duty are of high or medium relevance and explain why:

The JSNA provided an analysis of needs, outcomes and service use by protected characteristics. This demonstrated the need to improve access to sexual health services across the whole population, and particularly within certain high-risk groups.

Age, race/ethnicity, sexual orientation and gender reassignment are highly relevant characteristics that influence the overall pattern of sexual health outcomes and use of services. Nationally, the main groups of people at higher risk for poor sexual health are young adults, people from black ethnic groups and men who have sex with men (MSM) – these same groups are at higher risk locally.

Disability and gender/sex are also relevant – inequalities in sexual health needs, outcomes and service use are experienced across these characteristics.

Prengnancy/maternity, Marriage/civil partnership and religion/belief have some relevance for this EINA, although not as significant as the other characteristics.

Protected characteristic	Assessment of relevance
Age	High
Race/ethnicity	High
Sexual orientation and gender	High

reassignment	
Disability	Medium
Gender/sex	Medium
Pregnancy and maternity	Medium/Low
Religion and belief	Medium/Low
Marriage and civil partnership	Low

5. **What sources of information have been used in the preparation of this equality impact and needs analysis? For example, this could include equalities monitoring information, performance data, consultation feedback or needs assessment. Please provide the details in the table below:**

   The strategy was informed by a detailed JSNA, which used equalities information from a range of sources:

Information source	***Description and outline of the information source***
DataRich	• Demographic profiles
Office for National Statistics	• Conception and abortion data • 2011 Census data
Public Health England	• Public Health Outcomes Framework data • PHE Sexual and Reproductive Health Profiles (Fingertips Data) • National Chlamydia Screening Programme (NCSP) Data • HIV and STI Web Portal data • Detailed data on HIV service users • Detailed data on STI diagnoses and rates
Information obtained from local engagement	• Surveys of GP practices and community pharmacies • Annual health and wellbeing survey of school-aged children • Sexual health peer research project carried out by Richmond Youth Council • User surveys for individual services
Consultation	• Feedback from public consultation on the draft strategy • Feedback from consultation and engagement as part of the LSHTP

ANALYSING IMPACT, NEEDS AND EFFECTS

It is important that the analysis addresses each part of the duty assessed as relevant to the area being examined (see further Guidance on RIO).

6. **Key questions to consider:**

   a. **What does the data tell you about the groups identified as relevant to the area being assessed?**

   b. **What does customer feedback, complaints or discussions with stakeholder groups tell you about the impact of the service/ function/ policy on the protected characteristic groups, where assessed as relevant to area being examined?**

      Other questions to consider:

- How well are diverse needs met?
- Have any differences in access to services/functions been identified for any group?
- Has the area identified any disadvantages experienced by groups, which need to be addressed?
- Have there been any complaints about a failure to receive an appropriate and fair service?
- Is there any other evidence of differential impact or different outcomes which needs to be addressed?
- Is there any evidence that participation in areas of public life is disproportionately low for any particular relevant protected characteristic group?
- Have the needs of disabled people been identified and addressed where these are different from the needs of non-disabled people?
- Have you identified any need to tackle prejudice or promote understanding between different relevant protected characteristic groups?

Remember that equality analysis is not simply about identifying and removing negative effects of discrimination but it is also an opportunity to identify ways to advance equality of opportunity and to foster good relations.

1. Age

An assessment of inequalities in sexual health outcomes by age is provided throughout section 2 in the JSNA and summarised in section 2.4.1, and service use data is provided in sections 3-9. There are clear inequalities in the sexual health of different age groups.

Young adults are at particularly high risk of poor sexual health outcomes – over 40% of acute STI diagnoses are among those aged 15-24. Although the teenage pregnancy rate is low in Richmond, it is generally associated with poorer health, education and economic outcomes for young parents and their children.

However, the needs of adults older than this age group should not be overlooked. Women aged 35 or over account for around one-quarter of abortions, community service attendances and STI diagnoses, which reflects the age structure of the local population. There is also an ageing of the cohort of people diagnosed with HIV.

One of the three commissioning priorities in the strategy is around increasing the focus on prevention and sexual health promotion (section 5.1), and this particularly addresses the needs of young people. This includes some next steps to improve sexual health promotion initiatives for young people, the need to ensure provision of free contraception and increase knowledge about contraception options, particularly among young people.

Update

There is also a specific objective within the strategy about ensuring that services meet the needs of people from high risk groups (section 5.3.3). In addition, the strategy recommends considering alternative methods of service delivery, including online services and smartphone apps (section 5.3.2). This is important in delivering a modern service, especially considering the age profile of service users.

The e-healthcare service will be open access and looks to provide innovation and easy online access to services for residents, this can be seen in response to strategy section 5.3.2 and the three next step recommendations set out.

The changes to sexual health clinics as part of the re-commissioning of Sexual Health Services in London (in particular the ISH services in Richmond, Merton and Wandsworth) all require services to continue to meet the needs of people from high risks groups, which is also a specific objective within the strategy (section 5.3.3).

Services are required to continue to be open access which is defined as ensuring *"individuals can access the provisions within the service via self-referral, not limited by age, sexual orientation, place of residence or GP registration".*

The changes to the new ISH service are required to continue to provide an open access service that meets the age appropriate needs of the population. This will improve for young people in particular, when the new Twickenham service opens, which is near to a popular youth focussed service at OFF the Record, that is well used and will assist in raising awareness of the service.

The geographic spread of the new service means that the previous limited offer in Whitton no longer exists, which may have an impact on young residents living within the deprived parts of this ward. This is expected to balanced out however given the increased offer in Twickenham, in close proximity, in the next ward. An additional clinic is now provided in Sheen, where previously this area was underserved, although it is a limited service, it does extend the reach to this part of the borough.

The changes to the e-service are expected to provide a greater opportunity for a wider range of people to access the service, including but not limited to younger people.

Comparison with census data (table 3) reflects a higher proportion of people within the older (over 25) age group accessing services. 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.

2. Race/ethnicity

An assessment of inequalities in sexual health by age is provided throughout section 2 in the JSNA and summarised in section 2.4.3, and service use data is provided in sections 3-9.

People from black ethnic groups are at higher risk of poor sexual health outcomes – both at a national and a local level.

People from black ethnic groups (mainly black African women) account for 20% of all HIV diagnoses in Richmond, whereas black ethnic groups only account for less than 1% of the total population. In addition, the STI rate among people from black ethnic groups is more than double the overall rate, although numbers are relatively small.

The strategy emphasises ensuring universal access to sexual health services across the whole borough while supporting the specific needs of high-risk groups, including people from black ethnic groups. This is addressed within section 5.3.3. In particular, there is a recommendation to review HIV prevention services to ensure that they are meeting the needs of the Richmond population - these services work primarily with Black African communities, but activity levels for Richmond are low.

Update

The changes to sexual health clinics as part of the re-commissioning of Sexual Health Services in London (in particular the ISH services in Richmond, Merton and Wandsworth) all require services to continue to meet the needs of people from high risk groups, which is also a specific objective within the strategy (section 5.3.3). The service specification specifically refers to the need to ensure that sexual health needs of BME populations are a service priority. A targeted approached has been identified as required to reduce the health inequalities that this population faces.

In addition, the e-services and partner notification system, as part of the e-healthcare, will ensure that resources are targeted at the highest need groups and at populations who may benefit from different opportunities to access services, which include, but is not limited to people from black ethnic groups.

The changes to the new ISH service are required to continue to provide an open access service and the needs to the BME population has been identified as a service priority.

The geographic spread of the new service means that the previous limited offer in Whitton no longer exists, which may have an impact on BME residents within this area, although the extended offer in the nearby Twickenham ward and the additional Sheen service extends the reach, as in Section 1.

The changes to the e-service are expected to provide a greater opportunity for a wider range of people to access the service, including but not limited to people from BME populations.

3. Sexual orientation and Gender reassignment

An assessment of inequalities in sexual health by sexual orientation (lesbian, gay, bisexual and trans people) is provided throughout section 2 in the JSNA and summarised in section 2.4.2, and service use data is provided in sections 3-9.

LGBT people experience a number of health inequalities and national research indicates that a relatively high proportion of LGBT people have never been tested for STIs.

Men who have sex with men (MSM) are at a particularly high risk of poor sexual health – MSM account for 63% of people diagnosed with HIV in Richmond and 15% of all STI diagnoses. However, the strategy highlights that the specific needs of lesbians and transgender people must also be considered as part of the re-development of local services.

There is a specific objective within the strategy about ensuring that services meet the needs of people from high risk groups (section 5.3.3), including LGBT people. The focus of HIV prevention services is currently on Black African communities, and the strategy recommends that the services are reviewed to ensure that the needs of the Richmond population are met – this is particularly important due to the high level of sexual health needs among MSM.

Update

The changes to sexual health clinics as part of the re-commissioning of Sexual Health Services in London (in particular the ISH services in Richmond, Merton and Wandsworth) all require services to continue to meet the needs of people from high risk groups, which is also a specific objective within the strategy (section 5.3.3). In particular, men who have sex with men (MSM) has been highlighted as a higher risk group where a targeted approached is required to reduce the health inequalities they face. In addition, the sexual health needs of trans* people are identified as a service priority.

In addition, the e-services and partner notification system, as part of the e-healthcare, will ensure that resources are targeted at the highest need groups and at populations who may benefit from different opportunities to access services, which include, but is not limited to people from the LGBT population.

The changes to the new ISH service are required to continue to provide an open access service that meets the appropriate needs of the population. From the widening of the offer to an ISH service, removing the family planning focus, is likely to improve the relevance and of use by the LGBT population, meaning they will no longer need to travel out of borough to West Middlesex and Kingston hospitals.

The geographic spread of the new service means that the previous limited offer in Whitton no longer exists, which may have an impact on LGBT residents within this area, although the extended offer in the nearby Twickenham ward and the additional Sheen service extends the reach, as in Section 1.

The changes to the e-service are expected to provide a greater opportunity for a wider range of people to access the service, including but not limited to the LGBT population.

4. Disability

An assessment of inequalities in sexual health relating to disability is provided in section 2.4.5 of the JSNA and this characteristic is included in the commissioning priority about ensuring that services meet the needs of people from high risk groups (section 5.3.3 of the strategy).

People with disabilities have the same sexual health needs as other people but they may face barriers that make sexual relationships more difficult, as well as barriers to sexual health information and services. There is limited data available locally to assess the sexual health needs and service use of people with disabilities.

Most people with disabilities can benefit from sexual health services designed to reach the general community. However, the strategy does recommend that the specific needs of people with disabilities should be considered as part of re-development of services and outlines some initial ideas. These include consideration of practical steps such as easy-to-read leaflets and the introduction of appointment slots into walk-in services, using national guidelines and examples of best practice, and learning from other areas that have introduced sexual health services specifically for people with disabilities.

There is no routine monitoring for disability status in sexual health services, although some professionals may record this information as part of their client assessment.

Update

The changes to the new ISH service are required to continue to provide an open access service that meets the appropriate needs of the population. In particular the specification requires the service to provide *"equitable access to all members of the population, including (but not only): those with physical, mental health, sensory and learning disabilities; various levels of literacy; varying levels of IT literacy and access; and people who require interpretation services."*

In particular, people with a disability have been highlighted as a higher risk group within the service specification for the new ISH service where a targeted approach is required to reduce the health inequalities they face.

The geographic spread of the new service means that the previous limited offer in Whitton no longer exists, which may have an impact on disabled residents within this area, although the extended offer in the nearby Twickenham ward and the additional Sheen service extends the reach, as in Section 1.

The changes to the e-service are expected to provide a greater opportunity for a wider range of people to access the service, this may also include people living with a disability as some services can be accessed from home.

5. Gender/Sex

An assessment of inequalities in sexual health by gender/sex is provided throughout section 2 of the JSNA and service use data is provided in sections 3-9. Gender/sex is also a relevant factor in section 11.7 on safeguarding.

The sexual health needs of people vary according to their gender, particularly as regards the provision of contraception and abortion services. Historically, community based services have been more focused towards contraception used by women but there has been an increased emphasis in recent years on encouraging men to use community-based services. One of the three priorities in the strategy is to strengthen community-based services (section 5.2), which includes consideration of introduction more widespread STI and HIV screening, which would be used by both men and women.

Update

In addition, the strategy recommends considering alternative methods of service delivery, including online services and smartphone apps (section 5.3.2). This may help to encourage more men to use services, as it is likely to reduce the stigma that may be associated with using sexual health services in person.

The changes to sexual health clinics as part of the re-commissioning of Sexual Health Services in London (in particular the ISH services in Richmond, Merton and Wandsworth) all require services to continue to meet the needs of people from high risk groups, which is also a specific objective within the strategy (section 5.3.3).

The e-healthcare service will be open access and looks to provide innovation and easy online access to services for residents, this can be seen in response to strategy section 5.3.2 and the three next step recommendations set out.

The geographic spread of the new service means that the previous limited offer in Whitton no longer exists, which may have an impact on residents within this area, although the extended offer in the nearby Twickenham ward and the additional Sheen service extends the reach, as in Section 1.

Another aspect of sexual health services where there are likely to be inequalities between genders is sexual violence, exploitation and abuse. Professionals working in sexual health services are well placed to identify issues of safeguarding. This includes the issue of female genital mutilation, which is a key area of gender inequality. The strategy includes an objective to ensure that robust safeguarding arrangements are in place (section 5.3.4) and recommends updating safeguarding arrangements for sexual health services and ensuring that robust referral pathways to support services are in place.

Sex workers are also included in the section on inequalities in the JSNA (section 2.4.7) and under the strategy objective to ensure that services meet the needs of people from high-risk groups. Although sex workers form a diverse group, some will be at higher risk of poor sexual health, may be vulnerable to sexual abuse and may experience barriers in accessing services.

The ISH service specification specifically refers to the need to ensure that sexual health needs of sex workers and victims of gender violence are a service priority. A targeted approach has been identified as required to reduce the health inequalities that these groups face.

6. Pregnancy and maternity

Although pregnancy and maternity are closely intertwined with the topic of sexual health, it is unlikely that there are any major inequality issues in terms of sexual health service use or outcomes that are not covered in other sections of this EINA. For example, teenage pregnancy is included under age.

The reduction of unintended pregnancies, particularly among young people, is one of the three key outcomes in the strategy and there are a number of recommendations that underpin the achievement of this outcome.

Nationally, just over half of women having an abortion have previously had a live or stillbirth; this data is not available at a local level but emphasises the importance of maternity and health visiting services in providing advice on contraception.

Update

The ISH service specification covers the needs of women of all ages to have contraceptive and maternity advice and services and to ensure that they are linked to the appropriate pathways or other services.

7. Religion and belief

Religious and cultural views can influence attitudes towards abortion, contraception and sexual relationships. For example, pre-marital sex and same-sex relationships are prohibited by some religions. Some religions require patients to be treated by a doctor or nurse of the same sex, and beliefs may influence an individual's willingness to discuss sexual health issues or access treatment.

It is important to ensure that professionals have an awareness and understanding of how faith and culture can impact on the choices that people make, and that sometimes they may choose not to follow the options available to them through their faith or cultural beliefs.

There is no routine monitoring for religion & belief of clients in sexual health services, although some professionals may record this information as part of their client assessment.

Update

The ISH service specification required the provider to *"Acknowledge and respect a service user's gender, sexual orientation, age, physical or mental health ability, race, religion, culture, social background and lifestyle;"*

8. Marriage and civil partnership

There are unlikely to be any major inequality issues relating to this protected characteristic that are not covered in other sections. Pre-marital sex is prohibited by some religions, so people may be encountering sexual health services for the first time when they become married. Issues relating to same-sex relationships through civil partnership are included within the section on sexual orientation.

There is no routine monitoring for marriage/civil partnership status in sexual health services, although some professionals may record this information as part of their client assessment.

Update

Please see previous sections on sexual orientation, gender reassignment, sex, gender for more information.

9. All Protected Groups

Update

Overall the LSHTP and ISH changes 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; vulnerable and higher risk people are targeted for services; and there are more streamlined patient journeys into appropriate services for their needs.

Overall the LSHTP and the procurement of integrated sexual health services meet a large number of the next step recommendations identified within the Sexual Health Strategy. As such the proposed service changes are meeting identified requirements as set out in the strategy to ensure that sexual health services meet the diverse needs of all protected groups.

The next step recommendations addressed are:
5.3.1 Ensure that services are delivered at accessible locations and times
- Review locations and opening times when developing service specifications as part of re-procurement of community-based services, particularly for young people.
5.3.2 Consider alternative methods of service delivery, including online services and self-testing
- Consider introducing self-testing services for STIs and HIV within the community for people without any symptoms.
- Consider options for expanding online STI and HIV screening, using learning from other areas and from the 'freetest.me' website for Chlamydia screening.
- Explore the use of technological innovations to support sexual health prevention and marketing of local services.

5.3.3 Ensure that services meet the needs of people from high-risk groups
- Work with local partners and use the JSNA, national guidelines and learning from other areas to re-develop services so that they better meet the needs of people from high-risk groups

5.3.5 Ensure comprehensive, evidence-based management of STIs, including partner notification
- Consider how partner notification will be carried out when developing STI and HIV screening opportunities outside of GUM services.

A potential negative impact could arise from an inability to secure suitable clinic sites for patient needs. This is a risk that has been highlighted 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.

7. Have you identified any data gaps in relation to the relevant protected characteristics and relevant parts of the duty? If so, how will these data gaps be addressed?

Gaps in data	***Action to deal with this***
Some services are not commissioned to routinely collect and report data: • Age • Ethnicity • Sexual orientation / gender assignment Most sexual health services do not routinely collect and report data on : • Disability status • Religion • Marriage/civil partnership status	• The strategy recommends that the recording of equality data by all sexual health services is reviewed (section 5.3.3). This has been reviewed as part of re-procurement and re-development of service specifications to ensure that key gaps are minimised. There is a limited amount of data that can be collected due to confidentially required for services and to install confidence in service users that all services are confidential when

	accessing them.
There is limited data available on sex workers within Richmond borough.	• The commissioners will continue to work closely with the Community Safety team to explore options of improving access to, and increasing awareness of, sexual health services.

CONSULTATION ON THE KEY FINDINGS

8. What consultation have you undertaken with stakeholders or critical friends about the key findings? What feedback did you receive as part of the consultation?

A range of stakeholders were engaged in the process of developing the sexual health commissioning strategy, such as the local network of sexual health professionals and the Community Involvement Group (CIG).

The strategy was put out for public consultation in July (both the full version and a summary version were available on the consultation website). Around 25 responses were received through the consultation. No major issues were flagged up through the consultation, but there were some helpful comments and minor amendments were made to the strategy documents. Protected characteristics were not identified as a predominant concern, except for a greater emphasis on the needs of LGBT people. This has been reflected to some extent in the revised strategy, but comments will be mainly used to inform the detailed re-development of service specifications.

Update

In regards to the LSHTP there has been wide engagement with service users, clinicians and sexual health service providers.

ACTION PLANNING

9. What issues have you identified that require actions? What are these actions, who will be responsible for them and when will they be completed?

Issue identified	Planned action	Lead officer	Completion Date
Continued implementation of the strategy	The strategy implementation plan will be updated to ensure all work is captured	Hannah Gill / Kate Parsley, Senior Public Health Lead	December 2017
Assess equality aspects of procurement process	Work alongside the LSHTP and DCU throughout the procurement and commissioning process	Anna Bryden, PH consultant	December 2017

MONITORING AND REVIEW

10. How will the actions in the action plan be monitored and reviewed? For example, any equality actions identified should be added to business, service or team plans and performance managed.

Progress will be monitored as part of the ongoing work of the LSHTP and as part of the SSA

work with the DCU to ensure procurement of the integrated sexual health service. This will be monitored through the Public Health Board as well as other specific forums such as the SCoSH.

PUBLISHING THE COMPLETED ANALYSIS

11. When completed, the equality impact and needs analysis should be approved by a member of DMT and published on the Council's website. Please provide details below:

Approved by	Clare O'Connor
Date of approval	21st December 2017
Date of publication	21st December 2017

DECISION-MAKING PROCESS

12. Has a copy of this EINA or summary of key findings been provided to key decision-makers to help inform decision making, for example as an appendix to a Cabinet or Committee report?

- **If so please provide the details including the name of the report, the audience i.e. Cabinet/ Committee, the date it went, and the report author.**
- **Please also outline the outcome from the report and details of any follow up action or monitoring of actions or decision taken:**

This updated EINA has been used to inform the Sexual Health Commissioning Strategy. It will be included as an appendix to the strategy document that will be taken to Cabinet and CCG Governing Body for approval in autumn 2014.