Equality Impact Assessment Form

Directorate: Peoples Services

Service area: Integrated Sexual Health Service

Date of assessment: Refreshed April 2019

Name of Director/Head of Service signing it off: Cate Edwynn (Director of Public Health)

Date published on website: May 2019

Derby City Council

PROUD OF DERBY

Equality impact assessment – please read this section first before you do the assessment

This is our equality impact assessment form to help you equality check what you are doing when you are about to produce a new policy, review an older one, write a strategy or plan or review your services and functions. In fact you need to do an equality impact assessment whenever a decision is needed that affects people and **before** that decision is made.

So why do we need to do equality impact assessments? Although the law does not require us to do them now, the courts still place significant weight on the existence of some form of documentary evidence of compliance with the **Public Sector Equality Duty** when determining judicial review cases. This method helps us to make our decisions fairly, taking into account any equality implications, so yes we still need to do them.

The Public Sector Equality Duty is part of the Equality Act 2010 and this Duty requires us as a public body to have '**due regard'** to eliminating discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act. It requires us to advance equality of opportunity and foster good relations between people who share a '**relevant protected characteristic'** and people who do not.

Having 'due regard' means:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people
- Encouraging people with certain protected characteristics to participate in public life or in other activities where the participation is disproportionately low.

The protected characteristics are:

- Age
- Disability
- Gender Identity
- Marriage And Civil Partnership
- Pregnancy And Maternity
- Race
- Religion Or Belief
- Sex
- Sexual Orientation

This completed form should be attached to any Chief Officer Group, Cabinet or Personnel Committee report to help elected members make their decisions by taking the equality implications into account. Equality impact assessments **must be done before** decisions are made. Include the Cabinet or Personnel Committee's decision on the front sheet when you know it.

You'll find that doing these assessments will help you to:

- Understand your customers' and communities needs
- Develop service improvements
- Improve service satisfaction
- Demonstrate that you have been fair and open and considered equality when working on re-structuring
- Make sure you pay due regard to the requirements of the public sector equality duty.

Do not do the form by yourself, get a small team together and make sure you include key people in the team such as representatives from our Diversity Forums and employee networks and you could invite trade union representatives too – the more knowledge around the table the better. You also need to decide how and who you will consult with to help inform the equality impact assessment. Our Lead on Equality and Diversity can help with useful contacts – we have a team of people who are used to doing these assessments and can help with information on barriers facing particular groups and remedies to overcome these barriers.

You'll need to pull together all the information you can about how what you are assessing affects different groups of people and then examine this information to check whether some people will be negatively or positively affected. Then you'll need to look at ways of lessening any negative effects or making the service more accessible – this is where your assessment team is very useful and you can also use the wider community. Against every negative impact you will need to complete the mitigation section to explain how you will lessen the impact.

Agree an equality action plan with your assessment team, setting targets for dealing with any negative effects or gaps in information you may have found. Set up a way of monitoring these actions to make sure they are done and include them in your service business plans.

When you have completed the assessment, get it signed by your Head of Service or Service Director and **send it to our Lead on Equality and Diversity for checking and to publish on our website.** It is a public document so must not contain any jargon and be easy to understand.

Remember, we need to do these assessments as part of our everyday business, so we get our equality responsibilities right and stay within the law – Equality Act 2010.

Equality groups and protected characteristics

These are the equality groups of people we need to think about when we are doing equality impact assessments and these people can be our customers or our employees and job applicants…

- **Age equality** – the effects on younger and older people.
- **Disability equality** – the effects on the whole range of disabled people, including Deaf people, hearing impaired people, visually impaired people, people with mental health issues, people with learning difficulties and people with physical impairments.
- **Gender identity** – the effects on trans people.
- Marriage and civil partnership equality.
- **Pregnancy and maternity equality** - women who are pregnant or who have recently had a baby, including breast feeding mothers.
- **Race equality** – the effects on minority ethnic communities, including newer communities, gypsies and travellers and the Roma community.
- **Religion and belief or non-belief equality** – the effects on religious and cultural communities, customers and employees.
- **Sex equality** – the effects on both men and women and boys and girls.
- **Sexual Orientation equality** – the effects on lesbians, gay men and bisexual people.

Contact for help:

Ann Webster – Lead on Equality and Diversity

Email: ann.webster@derby.gov.uk | Tele: 01332 643722 | Minicom: 01332 640666 | Mobile: 07812 301144

The form

We use the term 'policy' as shorthand on this form for the full range of policies, practices, plans, reviews, activities and procedures.

Policies will usually fall into three main categories:

- Organisational policies and functions, such as recruitment, complaints procedures, re-structures.
- Key decisions such as allocating funding to voluntary organisations, budget setting.
- Policies that set criteria or guidelines for others to use, such as criteria about school admissions, procurement methods, disabled facilities grants, on street parking bays.

If in doubt – it's better and safer to do an Equality Impact Assessment than not to bother! You never know when we may get a legal challenge and someone applies for Judicial Review.

What's the name of the policy you are assessing?

Integrated Sexual Health Service - re-tender

The assessment team:

Representative	Position
Public Health	Public Health Manager
Public Health	Public Health Commissioner
Equalities and Diversity	Lead of Equality and Diversity
Public Health	Consultant in Public Health Medicine
Provider Service	Clinical Lead

Abbreviations:

BME	**Black Minority Ethnic**
BSL	**British Sign Language**
CTAD	**Chlamydia Testing Activity Database**
HIV	**Human Immunodeficiency Virus**
ISHS	**Integrated Sexual Health Service**
LARC	**Long Acting Reversible Contraception**
LRCH	**London Road Community Hospital**
MSM	**Men who have sex with men**
PN	**Partner Notification**
STIs	**Sexually Transmitted Infections**
YSHM	**Your Sexual Health Matters**

Step 1 – setting the scene

Make sure you have clear aims and objectives on what you are impact assessing – this way you keep to the purpose of the assessment and are less likely to get side tracked.

1. **What are the main aims, objectives and purpose of the policy? How does it fit in with the wider aims of the Council and wider Derby Plan? Include here any links to the Council Plan, Derby Plan or your Directorate Service Plan.**

The current contract for the Integrated Sexual Health Service is due to end on 31st March 2020 and we are legally obliged to revisit the market and re-tender for services. As part of the commissioning process a review of the needs of the local population has been undertaken and an enhanced delivery model is being proposed. We did a comprehensive Equality Impact Assessment previously and so are giving it a refresh.

What is the Integrated Sexual Health Service (ISHS)?

Local authorities are mandated to commission comprehensive open access sexual health services, including free STI testing and treatment, notification of sexual partners of infected persons and advice on, and reasonable access to, a broad range of contraception; and advice on preventing unplanned pregnancy. It is an expectation that services may also provide a wider range of services including diagnosis and treatment for non-STI conditions and broader reproductive health services that are set out with the commissioning responsibility of local authorities.

The health risks of STIs and unplanned teenage pregnancies include:

- Pelvic Inflammatory Disease, which can lead to infertility or ectopic pregnancy;
- Chronic infection, HIV, or recurrent infections, such as genital herpes;
- Cervical cancer, including other genital cancers.

Unplanned teenage pregnancy can affect both the parent and their child, and is associated with the following:

- Poor educational achievement;
- Poor physical and mental health;
- Poverty;
- Social isolation for both parent and their children.

An integrated sexual health service model aims to improve sexual health by providing non-judgmental and confidential services through open access, where the majority of sexual health and contraceptive needs can be met at one site, often by one health professional, in services with extended opening hours (evenings after 6pm and weekends) and locations which are accessible by public transport and accessible to disabled people.

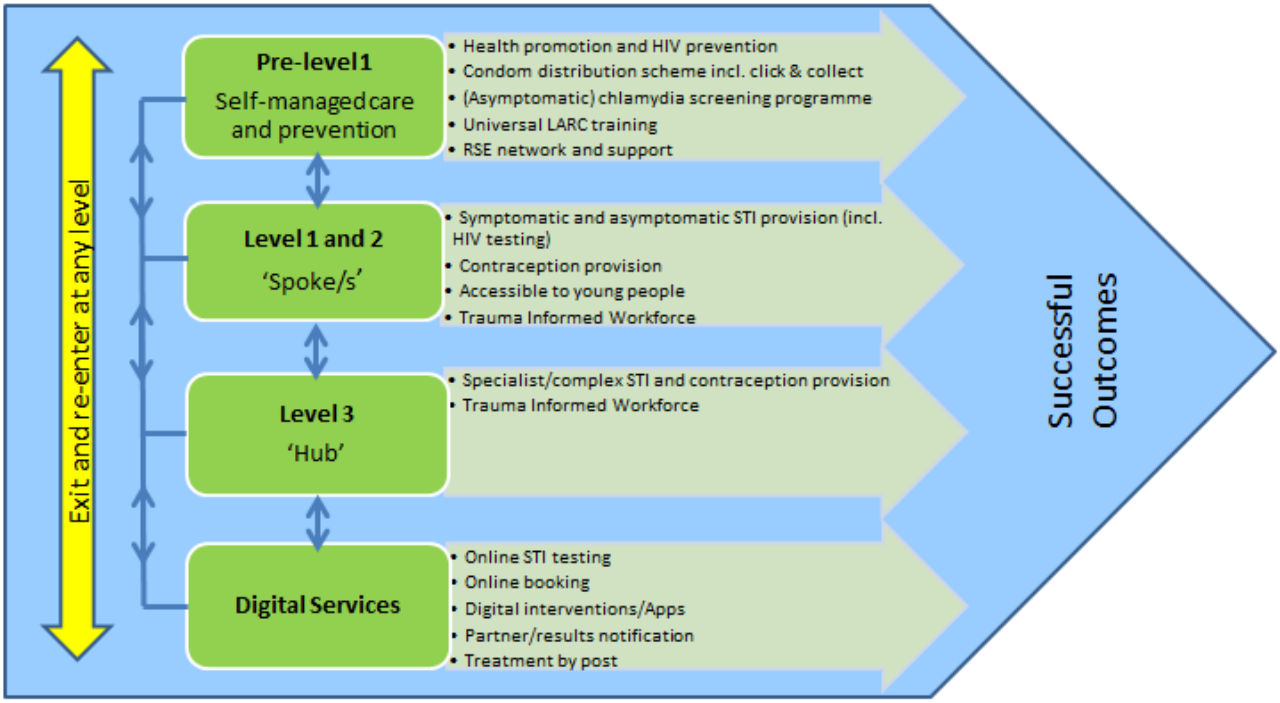
What changes are we proposing?

The current ISHS model is based on a lead provider model and is summarised as:

A 'hub' and 'spoke' model of sexual health service provision, with 3 levels of care for Sexual Health management (as detailed in Appendix A and B). The 'Hub' is consultant-led and offers integrated and co-located services (genito-urinary medicine and contraception) at Level 3 and the co-ordination and leadership of the service (due to its clinical nature, hubs are usually located within an acute trust). The 'spokes, which are located in the community, may be nurse-led, and offer Level 1 and elements/all level 2 services with the potential for some to deliver elements of Level 3 dependent on need and the support of the Level 3 specialists. The service also delivers sexual health promotion (including targeted sexual health promotion via sub-contracting with the voluntary sector), advice and information, condom distribution scheme, chlamydia screening programme for 15-24 year olds, specialist and universal training and outreach provision.

The proposed model builds upon the existing model (all elements included above) with the addition of the provision of digital services (see figure 1).

Figure 1. Proposed delivery model - ISHS



We know that sexual health is not equally distributed within the population. Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups. Similarly HIV infection in the UK disproportionately affects MSM and Black African populations. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

Digital services have been developed with two distinct purposes to date:

- To improve population coverage and increase detection of infection. These services have largely been targeted at particular population groups, for example, online chlamydia screening for 15-24 year olds or HIV home sampling for MSM and Black African communities. Groups at which evidence suggests are at higher risk of poor sexual health outcomes[1]

- To manage demand and improve access to clinic based services. These digital services have been developed as an integral part of clinic based services with appropriate triage processes to identify whether digital or face to face services are most appropriate and with clear pathways into clinic based services where appropriate.

Internet access is now nearly universal among people of reproductive age in the United Kingdom (99% aged 16-44 years, 96.8% aged 45-54 years in 2018)[2] and more than one-third of internet users browse the internet to find information on health-related issues[3]. There is evidence to suggest a demand for online sexual health services with over 100,000 online tests for genital chlamydia infection delivered annually within the English National Chlamydia Screening Programme[4]

Digital services offer an additional access route to some services, as well as the potential to engage users who for whatever reason have previously chosen not to access mainstream services.

Examples of existing services that could be offered without the need to see a practitioner:

- Condom and lube distribution
- Remote chlamydia screening
- Digital self-triage to appropriate services
- STI self-sampling kits for self-declaring asymptomatic residents
- HIV self-sampling (e.g. national HIV self-sampling service) and/or self-testing
- On-line self-care information to support residents to understand and manage their sexual health without the need to attend a clinic.
- Ability to book appointments online
- Results by text message and/or online remote access • Digital Partner Notification that patients can complete remotely

[1] https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
[2] https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2018
[3] http://stakeholders.ofcom.org.uk/binaries/research/media-literacy/adults-2014/2014_Adults_report.pdf.
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713962/hpr2018_AA-STIs_v5.pdf

- Contraceptive provision
- Opportunities to obtain advice and information via phone, instant messaging (web chat) and/or video consultations
- Opportunities for self-managed treatment, including antibiotics and wart treatments, by post or via GPs and community pharmacies
- Robust follow-up of all positive/reactive result to ensure confirmation of diagnosis, access to treatment and completion, and/or partner notification

The provision of this additional component to the service model, will seek to support the council in its duty to improve public health and address inequalities (steps considered appropriate for improving the health of the people in its area) (Health & Social Care Act 2012, s.12) which is aligned with the Derby's vision to be a Safe, Strong and Ambitious city outcome of improving health and well-being.

These changes do not affect existing sexual health services that are commissioned under a separate contract (namely, emergency contraception to under 18s - provided by pharmacies and increased access to Long Acting Reversible Contraception (LARC) provided by general practice).

2. Who delivers/will deliver the policy, including any consultation on it and any outside organisations who deliver under procurement arrangements?

Derbyshire Community Health Services Foundation Trust (DCHS) are the current lead provider for this service, working alongside University Hospitals of Burton and Derby (formerly Royal Derby Hospital). DCHS sub-contract some sexual health promotion activity from Women's Work and Derbyshire LBGT+ (respectively working with women who are sex working/or risk of and Lesbian, Gay, Bisexual and Trans community). The service is funded by Public Health, Peoples Directorate.

The approval to proceed with procurement and contract was agreed and signed on 10th May 2018. The procurement process will be led by Derby City Council's Procurement team alongside Derby City Council Public Health team. The future provider of the service is unknown until the outcome of the procurement process.

3. Who are the main customers, users, partners, employees or groups affected by this proposal?

Sexual health services are mandated to be open access and are available to all persons requiring services, irrespective of where they reside.

Step 2 – collecting information and assessing impact

4. Who have you consulted and engaged with so far about this policy, and what did they tell you? Who else do you plan to consult with? – tell us here how you did this consultation and how you made it accessible for the equality groups, such as accessible locations, interpreters and translations, accessible documents.

A patient satisfaction survey was conducted in 2018 – a total of 158 outpatients completed the survey (106) at London Road Community Hospital (LRCH) and (56) from Peartree clinic:

- 60% of respondents were under 30 years of age (79/131)
- 76% of respondents identified as female (115/151)
- 89% of respondents identified as heterosexual (124/140)
- 13.3% of respondents identified as Black, Asian or from a minority ethnic group (18/135); the majority of respondents, described themselves as white (74%).

A large proportion who attended for either GUM or contraceptive services sought advice and information (29%) or attended for asymptomatic screening (54%), suggesting that digital services would further support the worried well and ensure that the clinic offer is mostly utilised by those requiring level 3 services (LRCH in particular).

The Public Health Team held a 'Reviewing the Model Event in March 2018 and invited a range of stakeholders, such as primary care, ISHS, pharmacies, substance misuse services, midwives etc. The aim was to gain feedback on a number of system-wide issues and look at what works, what could be improved and what we needed to do moving forward – several participants suggested that inclusion of a digital offer: digital/ online testing/ postal treatments will be of value and increase access.

As part of the commissioning process, a Market Engagement event was held at Derby Council on 3rd April 2019. A range of stakeholders from GP's, Integrated Sexual Health Service, Pharmacies, and Substance Misuse Services, Midwifery Services and the Voluntary and Public sector were invited to attend. Feedback on the proposed model demonstrates that there have been many recent improvements to the sexual health digital offer and the target audience is believed to be technically confident at accessing the digital platforms expected; digitalisation therefore presents opportunities to meet unmet demand and support level 1-2 access and relieve capacity for level 3 services. In addition, consideration was given to the findings of local neighbours who have already implemented a digital offer. SH:24 (an online testing service provider) in London and HIV online testing (commissioned by Public Health England via a procurement framework), has shown high return rates for testing. It was also acknowledged that digitalisation could lead to more testing but low positivity rates, however, online testing is much more cost effective in comparison to testing within sexual health clinics and community based settings.

To date the ISHS website: Your Sexual Health Matters (YHSM) has had 93,053 visitors. The top 5 pages visited were:

1. Home
2. LRCH
3. Online booking
4. Clinic Finder
5. Order an online test

In 2018, the Public Health team, led by the Public Health Manager and consisting of, the Consultant in Public Health Medicine, Public Health Analyst, Speciality Registrar and a commissioning manager conducted a Sexual Health Needs Assessment (2018-21). A needs assessment is a systematic process for determining and addressing needs, or "gaps" between current conditions and desired conditions or "wants", including identifying any unmet need. The process involves population profiling, gathering data, an understanding of emerging issues and identifying and assessing sexual health conditions and determinant factors. The current provider and stakeholders participated in the process by providing information/intelligence and/or data.

The outcome of the needs assessment supports the development of future commissioned services and informs service provision and design. In summary, the needs assessment identified a number of issues:

- There is a need to increase STI screening and HIV testing coverage which needs to be sustained with a focus on groups most at risk
- There needs to be a reduction in the waiting times into the service
- Exploration of opportunities to increase screening in high positivity settings in order to achieve the Chlamydia diagnosis rate
- Raise awareness to emphasise the need for repeat regular screening/STI testing as appropriate.
- The number of out of area attendances (where non-residents access Derby City services) has exceeded the number accessing in this way since the opening of the integrated service. This reduces the capacity for local residents to access local services
- Continue to develop creative ways to increase public awareness of where and how to access services

The addition of a digital service will provide an additional mechanism that should address some of the issues that have been identified by the needs assessment.

5. Using the skills and knowledge in your assessment team, and from any consultation you have done, what do you already know about the equality impact of the policy on particular groups? Also, use any other information you know about such as any customer feedback, surveys, national research or data. Indicate by a tick for each protected characteristic group whether this is a negative or a positive impact. If it's negative, fill in the mitigation section as well to explain how you are going to lessen the impact.

<table>
<tr><th colspan="5">AGE</th></tr>
<tr><th>Integrated sexual health Service</th><th>What do we already know?</th><th>Positive Impact?</th><th>Negative impact?</th><th>Mitigation</th></tr>
<tr>
<td></td>
<td>Young people experience the highest diagnosis rates of the most common STIs and this is likely due to greater rates of partner change among 16 to 24 year old people[5]

The Integrated Sexual Health Service (ISHS) provides services/support to patients aged 13 and over (under 13 for sexual health promotion/schools work)

In 2017-18 the percentage of service users by age group was as follows:

<table>
<tr><th>Age Group</th><th>ISHS (2017/18)</th><th>Derby Census 2011</th></tr>
<tr><td>Under 17</td><td>5%</td><td>11%* (12-17yrs)</td></tr>
<tr><td>18 to 24</td><td>36%</td><td>17%*</td></tr>
<tr><td>25 to 44</td><td>47%</td><td>43%*</td></tr>
<tr><td>45 plus</td><td>12%</td><td>29%* (45–60yrs)</td></tr>
</table>
*percentage of the population aged between 12 and 60 years old.</td>
<td>Yes – this proposal supports additional services that are otherwise currently unavailable in a similar format. The proposed changes will improve access for all age groups by offering an additional access route to some services (if clinically suitable). Users of the service will be clinically managed through the appropriate digital service according to their needs and age. E.g. a young person may not be suitable for treatment by post as they would need to be appropriately assessed for competency and understanding as well as an assessment of safeguarding.

The availability of online test kits for chlamydia in young people has been in existence for some time; however the additional</td>
<td></td>
<td></td>
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</table>

[5] Mercer CH, Tanton C, Prah P, Erens B, Sonnenberg P, Clifton S, et al. Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). *The Lancet* 2013; **382**(9907):1781-94.

The percentage of each age group by sex can be seen in the table below:

Attended City Clinics 2017-18			
Age of patient	**Female**	**Male**	**% of patients**
17 & Under	4%	1%	5%
18-24	24%	12%	36%
25-44	28%	19%	47%
45+	5%	6%	12%
Grand Total	**62%**	**38%**	**100.00%**

- In 2017/19 there were 1,921 new sexually transmitted infections diagnosed in Derby, a rate of 749.8 per 100,000 residents (compared to 743 per 100,000 in England). young heterosexuals are disproportionally affected by STIs – 54% of those newly diagnosed STIs in Derby were in young people.
- Chlamydial infection particularly affects young people aged 15-24. In 2017 the chlamydia detection rate remains significantly lower than the national target (1,882 per 100,000 against detection rate of 2,300 per 100,000 population).
- Young people are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload. In Derby, an estimated 13.1% of 15-19 year old women and 11.4% of 15-19 year old men presenting with a new STI at a SHS during the 5 year period from 2013 to 2017 became re-infected with an STI within 12 months. Teenagers may be at increased risk of re-infection because they lack the skills and confidence to negotiate safer sex
- Partner notification is the practice of notifying the sexual

digital services that would be available may provide a further opportunity to provide additional testing of other sexually transmitted infections as well as provide an opportunity to engage young people into mainstream services, allowing for wider health care/safeguarding needs to be assessed. Rapid treatment and partner notification can reduce the risk of STI complications and reduce onwards transmission.

Since 2015, the Chlamydia Testing Activity Database (CTAD) surveillance system has identified NHS/Local Authority commissioned tests ordered through an internet service and positivity remains high in these services (9%) suggesting that they are effectively reaching at risk populations.

Regular testing for HIV and STIs is essential for good sexual health: anyone under 25 who is sexually active should be screened for chlamydia annually, and on change of sexual partner – a digital offer may provide additional support to achieve this through the availability of text

	partners of a person, known as the "index case", who has been newly diagnosed with a sexually transmitted infection that they may have been exposed to the infection and managing subsequent partner notification for those that are positive, in order to prevent the spread of infection. The British Association for Sexual Health & HIV has produced standards for the management of STIs; in cases of Chlamydia diagnosis at least 0.6 contacts per index case should be contacted within four weeks[6]. In 2018/19 the ISHS, on average reached 0.5 contacts per index case. • Teenage pregnancy is associated with negative impacts on parents, child and society. Children born to teenage parents face particular challenges—they are more likely to have poorer educational, behavioral, and health outcomes throughout their lives, compared with children born to older parents. • The number of teenage pregnancies in the city continues on a downward trend with a 57.1% reduction between 1998 and 2011; however it still remains significantly higher the national average. In 2016, the conception rate was 26.0 per 1,000 populations, compared to the national average of 18.8 per 1,000, of which 37.8% ended with abortion compared to the national average (51.8%). • Evidence suggests that a 1/3rd of all pregnancies are unplanned, applied locally: the number of conceptions in Derby in 2016 = 64,098. During the same time period, the estimated number of unplanned pregnancies =	reminding services. In addition, the identification and notification of partners of an index case (partner notification; PN) is an essential element of sexual heath service provision and key to protecting the population and reducing onwards transmission. Digital PN feature would enhance current service provision and increase the partner notification rates Services such as repeat contraception prescription by post may support the efforts to reduce the number of terminations and subsequent terminations in women of fertile age across the city; reduce the number of terminations after a birth in the under 25's as well as improving health outcomes by reducing the number of teenage parents. It also offers the opportunity to engage with women of fertile age and promote the use of LARC In general, whilst the digital offer will not be as comprehensive as		

[6] Society of Sexual Health Advisers (2015) *Guidance on Partner Notification.* London: SSHA. Available at: http://ssha.info/wp-content/uploads/ssha-guidance-on-partner-notification-aug-2015.pdf

	21,152; for under 18 conceptions = 37 and for under 16 conceptions in Derby = 4. • Long Acting Reversible Contraception (LARC) methods are 99% effective at preventing pregnancy; they are also cost effective[7] and its use is recommended by the National Institute for Care and Health Excellence. • According to Public Health England,[8] sexually transmitted infections are on the rise amongst the oldest age categories. In the last decade, STI diagnoses in people aged between 50 and 70 have risen by a third. There may be a variety of reasons for this; ending of a long term relationship or marriage, newly single and unaware of the risks, the emergence and increase of online dating; embarrassment or fear. Locally, we have lower numbers of the older age group accessing services. • During 2017/18, on average 20% of users of the sexual health service waited more than 30 minutes to be seen for a pre-booked, higher than the 5% threshold. Waiting times are important as it could affect subsequent utilisation of services. Patients perceive long waiting times as barrier to actually obtaining services and keeping patients waiting unnecessarily can be a cause of stress for both patient and clinical staff.	clinical services (due to its clinical nature) the use of online digital interventions can be seen as an opportunity to provide a flexible and convenient alternative as well as an additional gateway into mainstream services, reducing barriers such as fear and stigma Users - both younger and older age groups may benefit from digital services which make it easier to make appointments online/ increase access to online self-care information including opportunities for self-managed treatment, including antibiotics and wart treatments Access to online services may support treating the 'worried well' and those who do not require to see a practitioner, resulting in improved capacity within the clinics to see more complex cases and reduce service waiting times.		

[7] https://www.nice.org.uk/Guidance/CG30

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/559993/hpr2216_stis_CRRCTD4.pdf

<table>
<tr><th colspan="5">DISABILITY</th></tr>
<tr><th>Integrated Sexual Health Service</th><th>What do we already know?</th><th>Positive Impact?</th><th>Negative impact?</th><th>Mitigation</th></tr>
<tr>
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<td>
During 2017-2018 the numbers and percentage of users accessing services in the city self-reported their disability status as in the table below:
<table>
<tr><th colspan="3">City Clinics 2017-2018</th></tr>
<tr><th>Disability Status Declared by Patient</th><th>No. of patients attending ISHS Clinics</th><th>% of patients attending ISHS</th></tr>
<tr><td>No</td><td>7445</td><td>36.09%</td></tr>
<tr><td>Not Stated</td><td>1</td><td>0.00%</td></tr>
<tr><td>Yes</td><td>142</td><td>0.69%</td></tr>
<tr><td>(blank)</td><td>13042</td><td>63.22%</td></tr>
<tr><td>Grand Total</td><td>20630</td><td>100.00%</td></tr>
</table>

It is a mandatory requirement within the electronic patient record to record disability status. The table above shows the proportion of users who self-report their disability status. However a large proportion have left the data field blank, it is not known whether there is an unmet need.
All clinics have ease of access, including ramp access. Peartree and LRCH have automatic opening main doors. LRCH clinic is located on the lower ground floor and a lift is available
Adjustments are made to suit the individual where they may require additional support.
The ISHS currently provides a website which

</td>
<td>
Yes – All service users may benefit from digital services which make it easier to make appointments online/ increase access to online self-care information including opportunities for self-managed treatment, e.g. antibiotics and wart treatments

Access to online services may support treating the 'worried well' and those who do not require to see a practitioner, resulting in improved capacity within clinics to see more complex cases and reduce waiting times.

In general, whilst the digital offer will not be as comprehensive as clinical services (due to its clinical nature) the use of online digital interventions can be seen as an opportunity to provide a flexible and convenient alternative to some services as well as an additional gateway into mainstream services, reducing barriers such as fear and stigma
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	provides advice, information and service finder information – this will be linked to the digital service offer. The front page of the current website provides an option of converting text to a listening feature and enlarging text size for hard to hearing groups and the partially sighted. • Within the clinical setting, ISHS can provide British Sign Language (BSL) interpreters if required. • The ISHS staff work with the learning disabilities team as and when required. • All service users as relevant are assessed within the mental capacity act and appropriate action taken if needed. • During 2017/18 on average 20% of users of the sexual health service waited more than 30 minutes to be seen, higher than the 5% threshold.			

GENDER IDENTITY – Trans				
Integrated Sexual Health Service	**What do we already know?**	**Positive Impact?**	**Negative impact?**	**Mitigation**
	The ISHS collect gender identity at birth and present gender at time of presentation; this is recorded in the patient's clinical notes and not currently available as a data extract. Trans people may have sexual partners who are men, women, or both and may also be at risk of unplanned pregnancy. Clinicians ensure that, as well as sexual history assessment, trans people are also asked about their history of breast, HPV, cervical and prostate cancer screening, as well as contraception provision and advice and information given as relevant. Clinicians communicate sensitively with a clear attempt to avoid any stigmatising language The current level 3 service is located at London Road Community Hospital. The service houses a mixed waiting room. Both spokes – currently located at Peartree Clinic and at the Space @Connexions are multi-use buildings. The waiting areas in within these buildings provides a degree of anonymity as to which services are being utilised within the building.	Yes – The digital service offer allows users to test themselves in the comfort and convenience of their own home/environment if they so choose and promotes self-care (note: positive confirmation of diagnosis and ongoing treatments if required, may need to take place within the clinical service) early diagnosis and treatment of STIs is a key intervention for their prevention and control. Yes – Trans people may have unmet needs due to perceived barriers in accessing health services. Users may benefit from digital services which make it easier to make appointments online / increase access to online self-care information including opportunities for self-managed treatment, e.g. antibiotics and wart treatments. It will also promote access into mainstream services. In general, whilst the digital offer will not be as comprehensive as clinical services (due to its clinical nature) the use of online digital interventions can be seen as an opportunity	Data collection: As the service is not yet contracted, it is unknown of the feasibility of collating data in relation to gender identity	Consideration will need to be made as to whether the addition of this data field would be perceived as a barrier to accessing services. The commissioner/service provider should consider focus/groups; use of surveys etc. to ascertain this probability.

	The service adheres to the Faculty of Sexual and Reproductive Healthcare guidance statement regarding contraceptive choices[9]	to provide a flexible and convenient alternative to some services as well as an additional gateway into mainstream services, reducing barriers such as fear and stigma Access to online services may support treating the 'worried well' and those who do not require to see a practitioner, resulting in improved capacity within the clinics to see more complex cases and reduce service waiting times.		

[9] https://www.fsrh.org/documents/fsrh-ceu-statement-contraceptive-choices-and-sexual-health-for/

MARRIAGE & CIVIL PARTNERSHIP				
Integrated Sexual Health Service	**What do we already know?**	**Positive Impact?**	**Negative impact?**	**Mitigation**
	• The services are / will be tailored to all people regardless of their marital status or civil partnership. • During 2017/18 on average 20% of users of the sexual health service waited more than 30 minutes to be seen, higher than the 5% threshold.	Yes – The digital service offer allows users to have tests in the comfort and convenience of their own home/environment, if they so choose. (note: positive confirmations of diagnosis and some ongoing treatments may need to take place within the clinical service). Yes – all service users may benefit from digital services which make it easier to make appointments online/ increase access to online self-care information, including opportunities for self-managed treatment, e.g. antibiotics and wart treatments. Access to online services may support treating the 'worried well' and those who do not require to see a practitioner, resulting in improved capacity within clinics to see more complex cases and reduce waiting times. In general, whilst the digital offer will not be as comprehensive as clinical services (due to its clinical nature) the use of online digital interventions can be seen as an opportunity to provide a flexible and convenient alternative as well as an additional gateway into mainstream services, reducing barriers such as fear and stigma		

		Access to online services may support treating the 'worried well' and those who do not require to see a practitioner, resulting in improved capacity within the clinics to see more complex cases and reduce service waiting times.		

PREGNANCY & MATERNITY				
Integrated Sexual Health Service	**What do we already know?**	**Positive Impact?**	**Negative impact?**	**Mitigation**
	• There is some risk of STI's passing to baby if an infection is present at the time of birth • Data is not available for extract. The data on pregnancy/maternity status is recorded within the clinical notes for patients attending for Genito-Urinary services that advise they are pregnant. Data is not collected when they have just given birth. • Six service users who advised that they may be pregnant accessed the service during 2017-18 • The service does not monitor those attending for contraception purposes after giving birth. This information may be provided (along with breastfeeding and pregnancy history) by the patient and noted within the clinical note and within the female consultation • The ISHS supports women and couples to plan pregnancy and offer preconception health advice and support where appropriate	No impact – pregnant or possibly pregnant women need to be assessed by a healthcare professional. Yes - Users may benefit from digital services such as online appointment booking / increase access to online self-care information. Reducing the burden of unplanned pregnancy (whether this leads to maternity, miscarriage or abortion) requires a sustained public health response and should be based around the following: marketing; easy access to high quality information for informed decision-making; easy access to the full range of contraception (particularly the most effective long-acting reversible contraception (LARC)		

	• Both LRCH and Peartree clinic have private areas that can be utilised as a breastfeeding room • During 2017/18 on average 20% of users of the sexual health service waited more than 30 minutes to be seen, higher than the 5% threshold.			

RACE				
Integrated Sexual Health Service	**What do we already know?**	**Positive Impact?**	**Negative impact?**	**Mitigation**
	• Rates of STIs tend to be highest in the more deprived and inner city areas and disproportionately affect ethnic minorities. • The highest population rates of STI and HIV diagnoses are among Black people but this varies considerably among Black Minority Ethnic (BME) groups. Black Caribbean and Black non-Caribbean/non-African people have the highest diagnosis rates of many STIs of all ethnic groups, while black Africans have relatively lower rates[10][11]. Black Minority Ethnic men and women should have an STI screen, including an HIV test, annually if having condomless sex with new or casual partners. • In 2017/18 the ethnic breakdown of users accessing services (includes LRCH, Peartree & The Space) was as follows:	Yes - There is likely to be a larger impact on White British group as they are more likely to access health services, however online services may be attractive to BME groups who, for a variety of reasons (religious belief, cultural norms etc.) may not access mainstream services; thus providing an opportunity to increase service use by these groups, particularly Asian group as there are lower numbers attending services than representative of the local population. The ability to utilise digital services could release capacity at clinics to see more complex patients and provides opportunity to reduce prevalence and transmission within these populations. Technology is also a crucial way of obtaining information for those in communities where discussion of sexual health remains taboo and where there may also be cultural and language barriers.		

[10] Le Polain De Waroux O, Harris RJ, Hughes G, Crook PD. The epidemiology of gonorrhoea in London: a Bayesian spatial modelling approach. *Epidemiology & Infection* 2014; **142**(01): 211-20. DOI: 10.1017/S0950268813000745.

[11] Furegato M, Chen Y, Mohammed H, Mercer CH, Savage EJ, Hughes G. Examining the role of socioeconomic deprivation in ethnic differences in sexually transmitted infection diagnosis rates in England: evidence from surveillance data. *Epidemiology and Infection* 2016: 1-10. DOI: 10.1017/S0950268816001679.

Ethnic Group	ISHS (2017/18)	Derby Census 2011
White British	60.04%	78%
White Other	5.17%	5%
Asian/ Asian British	5.12%	11%
Black/ Black British	4.88%	3%
Dual heritage	22.94%	2%
Other	1.12%	1%
Rather not say	20.21%	N/A

- With the exception of Asian/Asian British population, most groups that access the service are representative of the local population. It is acknowledged that there may be cultural barriers that exist which may prevent users from access services/local services and that they may attend services outside of the local area.

- In the UK, Caribbean men are less likely to be registered with a general practitioner than white men[12] and evidence suggests less likely to access health services in general

The service will continue to target BME groups in areas of the city where there are higher proportion of BME groups through its sexual health promotion work and prioritise those who are disproportionately affected by higher rates of STIs and HIV

Yes - Users may benefit from digital services which make it easier to make appointments online/ increase access to online self-care information, including opportunities for self-managed treatment, e.g. antibiotics and wart treatments.

In general, whilst the digital offer will not be as comprehensive as clinical services (due to its clinical nature) the use of online digital interventions can be seen as an opportunity to provide a flexible and convenient alternative as well as an additional gateway into mainstream services, reducing barriers such as fear and stigma

Access to online services may support treating the 'worried well' and those who do not require to see a practitioner, resulting in improved capacity within clinics to see more complex cases and reduce waiting times.

Raise awareness and increase access to condom distribution schemes in a way that is more convenient / flexible to potential

[12] https://lx.iriss.org.uk/sites/default/files/resources/HIV-related%20stigma%20-and-%20discrimination_racial%20and%20ethnic%20minorities.pdf

	• Interpretation services are available on request. • The ISHS currently provides level 2 services at Peartree clinic which is located in an area of high deprivation and has a higher proportion of BME residents. • The HIV action group is a multi-agency partnership group which exists to reduce local prevalence of HIV; reduce stigma associated with HIV, increase awareness of HIV and reduce the number of people, locally, who are diagnosed late with HIV (late diagnosis leads to poorer health outcomes). In 2018, the group revised the HIV Lesson plan which is part of the Derby City Scheme of Works; the updated lesson plan was distributed to all secondary schools and colleges. • The Black African population is disproportionately affected by HIV. The rate of new diagnoses amongst the African community in the UK continues to rise. The group has to date, unsuccessfully tried to seek representation on the group from a member of the African community. However despite this, the group continues to work towards raising	service users		

	awareness, particularly amongst at risk populations • Cultural taboos linked to sex and sexually transmitted diseases in Black and Minority Ethnic communities can also impact on people's access to HIV prevention and education, and thus directly increase the vulnerability to HIV infection of those who are not infected.[13] • ISHS Health promotion team attend events at the Derby West Indian Community Association, Multicultural centre and places of community gathering and also worked with Roma Communities. They have also taken part in multi-faith tours around the city. • The ISHS sub-contract elements of sexual health promotion work to Women's Work and LGBT +; both organisations seek to target those most at risk of poor sexual health outcomes (street sex workers/LGBT people) It is likely that users who are from BAME groups that identify as LGBT /sex worker are, due to race and perceived sexuality, further ostracised and discriminated /stigmatised from both outside and			

[13] https://lx.iriss.org.uk/sites/default/files/resources/HIV-related%20stigma%20-and-%20discrimination_racial%20and%20ethnic%20minorities.pdf

	within their own communities. • Those who are HIV positive are more vulnerable to the effects of HIV because they are less likely to access treatment and health services, or choose not to seek treatment for fear of being stigmatised and discriminated • During 2017/18 on average 20% of users of the sexual health service waited more than 30 minutes to be seen, higher than the 5% threshold.			

RELIGION OR BELIEF OR NONE

Integrated Sexual Health Service	What do we already know?	Positive Impact?	Negative impact?	Mitigation
	The table below represents the religion recorded by users of the service during 2017/18.	Yes - online services may be attractive to people who for a variety of reasons (religious belief, cultural norms etc.) may not access mainstream services providing an opportunity to reduce prevalence and transmission within these populations		
	The table below shows the responses regarding religion from local residents who participated in the 2011 Census.	Yes - Users may benefit from digital services which make it easier to make appointments online/ increase access to online self-care information, including opportunities for self-managed treatment, e.g. antibiotics and wart treatments		
		Access to online services may support treating the 'worried well' and those who do		

City Clinics 2017-18

Religion Declared by patient	No. for each religion declared	% for each religion declared
Buddhist	43	0.21%
Christian (all denominations)	3136	15.20%
Hindu	65	0.32%
Jewish	2	0.01%
Muslim	652	3.16%
No religion	15928	77.21%
Other	477	2.31%
Sikh	173	0.84%
(blank)	154	0.75%
Grand Total	**20630**	**100.00%**

Census 2011

Religion	No. Religion	% Religion
Buddhist	822	0.33%
Christian	131,129	52.71%

				not require to see a practitioner, resulting in improved capacity within clinics to see more complex cases and reduce waiting times. In general, whilst the digital offer will not be as comprehensive as clinical services (due to its clinical nature) the use of online digital interventions can be seen as an opportunity to provide a flexible and convenient alternative as well as an additional gateway into mainstream services, reducing barriers such as fear and stigma Raise awareness and increase access to condom distribution schemes in a way that is more convenient / flexible to potential service users		

Hindu	2,198	0.88%
Jewish	110	0.04%
Muslim	19,006	7.64%
No Religion	68,668	27.61%
Other Religion	985	0.40%
Sikh	8,891	3.57%
Religion not stated	16,943	6.81%

- Services are tailored to and sensitive to people's religion or belief.
- Due to the nature of the service it has been difficult to undertake robust health promotion work within religious environments due to religious beliefs and values however, the ISHS health promotion team continue to work hard to break down barriers and provide advice and information through a variety of mechanisms, such as attending events, marketing and promotion etc.
- ISHS staff are required to undertake equality and diversity training as part of their mandatory training
- During 2017/18 on average 20% of users of the sexual health service waited more than 30 minutes to be seen, higher than the 5% threshold.

<table>
<tr><th colspan="5">SEX</th></tr>
<tr><th>Integrated Sexual Health Service</th><th>What do we already know?</th><th>Positive Impact?</th><th>Negative impact?</th><th>Mitigation</th></tr>
<tr>
<td></td>
<td>
The service is available to all persons irrespective of sex.
In 2017/18 54% of attendances at the services were female and 32% male as shown in the table below. Users of the service have the choice of a male/female clinician if requested.
<table>
<tr><th colspan="3">City Clinics 2017-18</th></tr>
<tr><th>Gender Identity</th><th>No of Patients</th><th>% of Patients</th></tr>
<tr><td>Female</td><td>11138</td><td>53.99%</td></tr>
<tr><td>Male</td><td>6586</td><td>31.92%</td></tr>
<tr><td>Not Known</td><td>2257</td><td>10.94%</td></tr>
<tr><td>Not Specified</td><td>649</td><td>3.15%</td></tr>
<tr><td>Grand Total</td><td>20630</td><td>100.00%</td></tr>
</table>
According to the Men’s Health Forum[14] -
For all aspects of health, men are less aware of their symptoms than women, and are more reluctant to seek help; It is also problematic that many people with STIs may remain asymptomatic; therefore compounding the willingness of men to seek help.
Overall 1,921 new sexually transmitted infections (STIs) were diagnosed in residents of Derby in 2017; 48% in men and 51% in women, (a rate of 749.8 per 100,000 residents (compared to 743 per 100,000 in England)
</td>
<td>Yes – men are less likely than women to access health services in general, this includes sexual health services. A digital offer will provide a convenient and alternative access route to services and provide an opportunity to engage more men into mainstream services

Yes - Users may benefit from digital services which make it easier to make appointments online/ increase access to online self-care information, including opportunities for self-managed treatment, e.g. antibiotics and wart treatments

Access to online services may support treating the 'worried well' and those who do not require to see a practitioner, resulting in improved capacity within clinics to see more complex cases and reduce waiting times.</td>
<td>Possibly – if the service user is required to access level 3 services then there is only a mixed waiting room available. Either sex may find this uncomfortable</td>
<td>The clinic providing the level 3 service is located within the acute trust – it is not known whether permission would be available to undertake building works to convert the existing space. In addition there are no available funds to support such works to the internal structure of the building to accommodate two separate waiting areas.

However, the new service specification proposes that the service provider should consider offering specific sessions for male/female/trans etc.</td>
</tr>
</table>

[14] https://www.menshealthforum.org.uk/gender-and-access-health-services-study

	• Reinfection with an STI is a marker of persistent risky behaviour. In Derby, an estimated 8.4% of women and 9.1% of men presenting with a new STI at a sexual health service during the 5 year period from 2013 to 2017 became re-infected with a new STI within 12 months. Nationally, during the same period of time, an estimated 7.0% of women and 9.4% of men presenting with a new STI at a sexual health service became re-infected with a new STI within 12 months • During 2017/18 on average 20% of users of the sexual health service waited more than 30 minutes to be seen, higher than the 5% threshold.	In general, whilst the digital offer will not be as comprehensive as clinical services (due to its clinical nature) the use of online digital interventions can be seen as an opportunity to provide a flexible and convenient alternative as well as an additional gateway into mainstream services, reducing barriers such as fear and stigma Raise awareness and increase access to condom distribution schemes in a way that is more convenient / flexible to potential service users		

<table>
<tr><th colspan="5">SEXUAL ORIENTATION</th></tr>
<tr><th>Integrated Sexual Health Service</th><th>What do we already know?</th><th>Positive Impact?</th><th>Negative impact?</th><th>Mitigation</th></tr>
<tr>
<td></td>
<td>The figure most regularly quoted in the media comes from the UK Department of Trade and Industry[15], which estimated the size of the LGBT population to be between 5-7% of the total adult population. Locally applied this equates to a population of between = 17, 412 – 24, 852.

The table below shows the proportion of sexual orientation recorded by users of the clinics in Derby. This question forms part of the electronic patient record and mandatory completion of this field is required:

<table>
<tr><th colspan="3">City Clinics 2017-18</th></tr>
<tr><th>Sexual Orientation</th><th>No of patients</th><th>% of patients</th></tr>
<tr><td>Bi Sexual</td><td>476</td><td>2.31%</td></tr>
<tr><td>Gay</td><td>1181</td><td>5.72%</td></tr>
<tr><td>Heterosexual</td><td>18547</td><td>89.90%</td></tr>
<tr><td>Lesbian</td><td>54</td><td>0.26%</td></tr>
<tr><td>Not asked</td><td>157</td><td>0.76%</td></tr>
<tr><td>Patient declined to answer</td><td>43</td><td>0.21%</td></tr>
<tr><td>Patient does not know or is not sure</td><td>19</td><td>0.09%</td></tr>
<tr><td>(blank)</td><td>153</td><td>0.74%</td></tr>
<tr><td>Grand Total</td><td>20630</td><td>100.00%</td></tr>
</table>
</td>
<td>Yes - Users may benefit from digital services which make it easier to make appointments online/ increase access to online self-care information, including opportunities for self-managed treatment, e.g. antibiotics and wart treatments.

Raise awareness and increase access to condom distribution schemes in a way that is more convenient / flexible to potential service users

Yes – groups most at risk of STIs due to behaviours such as condomless sex, casual sex facilitated by dating apps/sites, group sex etc., will be appropriately triaged through digital services</td>
<td></td>
<td></td>
</tr>
</table>

[15] Final regulatory impact assessment: Civil Partnership Act 2004. London: Department of Trade and Industry, 2003. http://webarchive.nationalarchives.gov.uk/+/http:/www.berr.gov.uk/files/file23829.pdf

	• The impact of STIs and HIV remains greatest in bisexual, gay and other men who have sex with men (MSM). The increase in the number of condomless sex as a result of behaviours such as HIV sero-adaptive behaviours, group sex facilitated by geosocial networking applications, and 'chemsex' have meant that STI diagnosis in this group remains high. • During the 2017-18 reporting period, 20% of gay or bisexual men presenting to drug treatment, in England, reported problematic use of one of the three substances most commonly used in relation to chemsex (GBL, methamphetamine and/or mephedrone). This proportion was much higher than among heterosexual men (0.4%). Among individuals who used these drugs, rates of current injecting were also much higher among gay/bisexual men than among heterosexual men (37% compared to 19%)[16] • For cases in men where sexual orientation was known, 12.6% of new STIs in Derby were among gay, bisexual and other men who have sex with men (MSM) (Sexual health services [SHS]). • MSM are at increased risk of hepatitis A and B infection during sex; this is demonstrated by the recent outbreaks in 2017/18	and recommendation made of infections to test for. Access to online services may support treating the 'worried well' and those who do not require to see a practitioner, resulting in improved capacity within clinics to see more complex cases and reduce waiting times. In general, whilst the digital offer will not be as comprehensive as clinical services (due to its clinical nature) the use of online digital interventions can be seen as an opportunity to provide a flexible and convenient alternative as well as an additional gateway into mainstream services, reducing barriers such as fear and stigma Raise awareness and increase access to condom distribution		

[16] National Drug Treatment Monitoring System (NDTMS). NDTMS collects activity data from drug and alcohol treatment services in England. Aims of the use of NDTMS data include assessing treatment outcomes, monitoring trends in order to inform future service planning, and measuring the impact of drug treatment as part of the wider public health service. The data in this report refers to individuals aged 18 and over at the start of treatment. Regular statistics from NDTMS, including national alcohol and drug misuse and treatment statistics, and data completeness, can be found at www.ndtms.net

	• MSM should test annually for HIV and STIs and every 3 months if having condomless sex with new or casual partners • In Derby, between 2015 and 2017, 41.7% of HIV diagnoses were made at a late stage of infection (CD4 count =<350 cells/mm^3 within 3 months of diagnosis) compared to 41.1% in England. • The services are tailored to all people regardless of their sexual orientation. • The ISHS attend LGBT events every year to raise awareness of the service, proving chlamydia and HIV point of care testing as a way of engagement. They also sub-contract with Derbyshire + which delivers targeted health promotion activities on their behalf including access to free condoms for their service users. • Each year the ISHS supports Worlds Aids Day and HIV testing Week, amongst others, with local campaigns / social media presence and/or pop up clinics. During Oct-Dec 2018 – 78 vulnerable/HIV persons were referred into mainstream services. • During 2017/18 on average 20% of users of the sexual health service waited more than 30 minutes to be seen, higher than the 5% threshold.	schemes in a way that is more convenient / flexible to potential service users		

Important:

For any of the equality groups you do not have any information about, then make it an equality action at the end of this assessment to find out. This doesn't mean that you can't complete the assessment without the information, but you need to follow up the action and if necessary, review the assessment later. You can get lots of information on reports done from organisations' websites such as the Equality and Human Rights Commission, Stonewall, Press for Change, Joseph Rowntree Trust and so on. Please do not put down that the impact affects 'everyone the same' – it never does!

6. From the information you have collected, how are you going to lessen any negative impact on any of the equality groups? How are you going to fill any gaps in information you have discovered?

Consider engaging with user groups/ patient surveys to inform service design.

Step 3 – deciding on the outcome

7. What outcome does this assessment suggest you take? – You might find more than one applies. Please also tell us why you have come to this decision?

Outcome 1		**No major change needed** – the EIA hasn't identified any potential for discrimination or negative impact and all opportunities to advance equality have been taken
Outcome 2	**x**	**Adjust the policy** to remove barriers identified by the EIA or better advance equality. Are you satisfied that the proposed adjustments will remove the barriers you identified?
Outcome 3		**Continue the policy** despite potential for negative impact or missed opportunities to advance equality identified. You will need to make sure the EIA clearly sets out the justifications for continuing with it. You need to consider whether there are: • Sufficient plans to stop or minimise the negative impact • Mitigating actions for any remaining negative impacts • Plans to monitor the actual impact.
Outcome 4		**Stop and rethink** the policy when the EIA shows actual or potential unlawful discrimination.

Our Assessment team has agreed Outcome number(s)

On reflecting of the information and data available, the public health manager made a provisional decision that the policy would fall under outcome 2.

Feedback from EIA Group
The EIA was shared with the group via email on 23rd/24th April 2019. Comments have been received and acknowledged within the document. As the requested information has now been included, and no further objections were received, the final decision to confirm the outcome was made on (insert date)

Why did you come to this decision?

This decision was agreed upon as although there were some minor negative impacts in a few areas, it was believed that there was no unlawful discrimination. Where possible, mitigations would be put in place to explore opportunities to increase access and acceptability within that particular group

If you have decided on **Outcome 3**, then please tell us here the justification for continuing with the policy. You also need to make sure that there are actions in the Equality Action Plan to lessen the effect of the negative impact. This is really important and may face a legal challenge in the future.

If you have decided on **Outcome 4** then if the proposal continues, without any mitigating actions, it may be likely that we will face a legal challenge and possibly a Judicial Review on the process - it is really important that the equality impact assessment is done thoroughly, as this is what the Judge will consider.

Step 4 – equality action plan – setting targets and monitoring

8. Fill in this table with the equality actions you have come up with during the assessment. Indicate how you plan to monitor the equality impact of the proposals, once they have been implemented.

Equality Action Plan – setting targets and monitoring

Age

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
Continue to assess uptake of service by younger and older age groups	Reduce prevalence and onwards transmission in these age ranges	Public Health Manager	Mobilisation and performance management meetings

Disability

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
Data on self-reported disability is collected. The feasibility and acceptability of inclusion of this data field as part of the digital service is not yet known	No Further Action (NFA)	Assess the viability of this option with new service provider (1st April 2020) Public Health Manager	To be determined
Continue to work closely with other providers of specialist services such as learning disability providers to raise awareness and increase uptake	**NFA**		

Gender identity – Trans

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
Data is collected on sex and birth and sex at point of contact. This is recorded in the patient's clinical notes and is not currently available as a data extract. The feasibility and acceptability of inclusion of this data field within the digital service is not yet known	This enables the correct advice and information to be given according to sexuality/behavioural risk	Assess the viability of this option with new service provider (1st April 2020) Public Health Manager	.

Marriage and Civil Partnership

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
Look at capturing all protected characteristics. The nature of the service may mean that users may be reluctant to provide, additionally, there is a cost implication required to make changes to the IT system – this may not be a feasible option at present	It would provide a greater understanding of the protected characteristics of users of the service and, if necessary, inform future service design	The cost of making this provision and viability of capturing this data will be looked at with the service provider upon contract award.	Mobilisation meetings prior to service start date

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
		Pubic Health Manager	

Pregnancy and maternity

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
Look at capturing all protected characteristics	It would provide a greater understanding of the protected characteristics of users of the service and, if necessary inform future service design	The cost of making this provision and viability of capturing this data will be looked at with the service provider upon contract award – Public Health Manager	Mobilisation meetings prior to service start date

Race

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
Continue to monitor service use by these groups, particularly the digital component to see if uptake has increased. Continue to do targeted campaigns to increase uptake by these groups	Better understanding of local prevalence within these groups – leading to more targeted marketing. Reduce prevalence and reduce opportunities for onwards transmission in the population	Public Health Manager	Mobilisation and performance management meetings

Religion or belief or none

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
This data is currently collected	**NFA**		

Sex

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
Consider provision of men and women only clinics	Inform the future design of service. May encourage more users to attend	Assess the viability of this option with new service provider (1st April 2020) – Public Health Manager	Mobilisation and performance meetings

Sexual orientation

What are we going to do to advance equality	What difference will it make	When will we do it and who will lead	Monitoring arrangements
Currently this data is collected, ensure that online service have the ability to collate this information also	Ongoing assessment of take up of services – targeted marketing to increase uptake Reduce prevalence and onward transmission in the population	Assess the viability of this option with new service provider (1st April 2020) – Public Health Manager	Mobilisation and performance management meetings

Appendix A

Levels for Sexually Transmitted Infections

The management of sexually transmitted infections outlined as Levels 1 – 3 as in the Medfash Levels of Service

Level 1
Sexual history taking and risk assessment including identifying:
• Safeguarding issues in under 18s and vulnerable adults with referral as appropriate
• The need for emergency contraception
• The need for HIV post-exposure prophylaxis following sexual exposure (PEPSE)
• Sexual assault with referral as appropriate
• Signposting to appropriate sexual health services
• Chlamydia screening
• Opportunistic screening for genital chlamydia in sexually active asymptomatic males and females under the age of 25
• STI screening and treatment of asymptomatic infections (except treatment for gonorrhoea and syphilis) in women and men (except MSM). See Note 1.
• Partner notification of STIs or onward referral for partner notification
• HIV testing including pre-test discussion and giving results
• Point of care HIV testing
• Rapid HIV testing using a validated test (with confirmation of positive results or referral for confirmation)
• Screening for hepatitis A, hepatitis B and hepatitis C and vaccination for hepatitis A and B in line with the green book recommendations.
• Appropriate screening and vaccination in at-risk groups
• Sexual health promotion
• Provision of verbal and written sexual health promotion information
• Condom distribution
• Provision of condoms for safer sex
• Assessment and referral for psychosexual problems

Level 2 Incorporates Level 1 plus:

STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM) and women including gonorrhoea if able to perform gonorrhoea cultures with rapid transport to the laboratory

The following should be referred to Level 3:
- men with dysuria and / or genital discharge. See Note 2
- symptoms at extra-genital sites e.g. rectal or pharyngeal
- pregnant women
- genital ulceration other than uncomplicated genital herpes
- gonorrhoea if unable to perform gonorrhoea cultures with rapid transport to the laboratory

Level 3 Incorporates Level 1 and 2 plus:

• STI testing and treatment of MSM. See Note 1
• STI testing and treatment of men with dysuria and genital discharge. See Note 2
• Testing and treatment of STIs at extra-genital sites
• STIs with complications

• STIs in pregnant women
• Gonorrhoea cultures and treatment of gonorrhoea. See Note 3
• Recurrent conditions
• Recurrent or recalcitrant STIs and related conditions
• Management of syphilis and blood borne viruses
Including the management of syphilis at all stages of infection:
• Tropical STIs
• Specialist HIV treatment and care
• Provision and follow up of HIV post exposure prophylaxis (PEP). See Note 4
STI service co-ordination across a network including:
• Clinical leadership of STI management
• Co-ordination of clinical governance
• Co-ordination of STI training
• Co-ordination of partner notification

Note 1: The testing and management of men who have sex with men (MSM) has been defined as an element of specialist care at Level 3 because the majority of infections in this group are in the rectum and/or pharynx rather than the urethra and the management of these infections is more complex and requires specialist provision 1, 2 (see MEDFASH Standard 3). However, for asymptomatic MSM there may be some Level 2 services which have the full range of investigations available, and the necessary clinical and prevention skills, to effectively manage care.

Note 2: The appropriate management of men with dysuria and/or urethral discharge requires immediate microscopy (see Standard 3). This is usually only available at specialist GUM (Level 3) services so the testing and treatment of such men has been defined as an element of care at Level 3. However some other services, at Level 2, may be able to provide immediate microscopy (with the appropriate training and quality assurance) and management of such men would then be appropriate at these services.

Note 3: Gonorrhoea culture is an essential test before treating gonorrhoea or giving empirical antibiotics to people with symptoms (see Standard 3).

Note 4: PEP ‘starter packs’ are often available in other settings such as Accident and Emergency or Occupational Health, but referral to a specialist GUM (Level 3) service is required for ongoing management and provision of antiretroviral drugs**.**

Appendix B

Levels of Sexual and Reproductive Healthcare; FSRH; Quality Standards for Contraception 2014

Level 1 (Every General Practice)

- Sexual History and Risk Assessment
- STI Testing for women
- Assessment and referral of men with STI symptoms
- HIV testing and counselling
- Hepatitis B immunisation
- Provision of oral hormonal contraception
- Information about choice of full range of contraceptive and where available
- Cervical cytology screening and referral
- Pregnancy testing and referral

Level 2 (Primary care teams with a specialist interest)

- Testing and treating STI's
- Partner Notification
- IUD and Implant insertion
- Management of psychosexual problems
- Vasectomy surgery

Specialist level 3 (specialist services)

- Outreach for STI prevention / contraception
- Specialised STI management / partner notification
- Specialist HIV treatment and care
- Highly specialised contraception
- Termination of pregnancy services
- Local co-ordination and back up for sexual assault
- Psychosexual//sexual dysfunction services
- Make sure local guidelines and framework for monitoring and improving practice are in place
- Support clinical governance requirements at all levels
- Provide professional training, designing and updating care pathways and developing new services.

We can give you this information in any other way, style or language that will help you access it. Please contact us on: 01332 643722 Minicom: 01332 640666

Polish

Aby ułatwić Państwu dostęp do tych informacji, możemy je Państwu przekazać w innym formacie, stylu lub języku.
Prosimy o kontakt: **01332 643722** Tel. tekstowy: 01332 640666

Punjabi

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01332 643722

Slovakian

Túto informáciu vám môžeme poskytnúť iným spôsobom, štýlom alebo v inom jazyku, ktorý vám pomôže k jej sprístupneniu. Skontaktujte nás prosím na tel.č: 01332 643722 Minicom 01332 640666

Urdu

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