Equality and Equity impact assessment initial screening framework

Guy's and St Thomas' NHS
NHS Foundation Trust

1 The framework provides a consistent and systematic way to complete EEIAs. The questions not only offer structure, but a prompt to help you to make the best possible policy decisions. Many questions would need to be answered as part of good policy development.

2 The questions are not exhaustive, so as you complete the template, there may be additional questions that need to be asked and answered. The framework provides an outline of the sort of information needed to satisfy our legislative requirements. Although the template addresses all of the legislative strands of equality, policy managers are also urged to think about specific demographic groups that may be at risk of being disadvantaged by a decision.

Single identity or multiple identities – what makes most sense?

"There is little that unites LGBT needs. Rather there are a range of overlapping communities which make more sense if considered in relation to other demographic categories such as gender or race. Thus, there are Black Gay men and Lesbians, Older Gay men and Lesbians, Lesbian and Bisexual women etc. When seeking to define needs and develop models of community development for the LGBT population of Lambeth, it is worth using this model of communities rather than seek to identify a single over-arching community."
Lambeth LGBT matters research (Sigma 2006)

Initial screening template

1. Policy aims

1.1	Proposal, service, programme, strategy or procedure being assessed	□ Offering patients looking for Sexual and Reproductive Health (SRH) services a “one stop shop" approach, with fewer clinic sites but open longer and offering a fuller range of interventions □ Promoting the use of online services available 24/7 in order improve accessibility and reduce waiting times □ 7 day working across SRH staff (except medical secretaries and Junior doctors) □ 1 in 4 weekend working □ Opening hours harmonisation and increased hours at weekends □ Sites consolidation driven by budget reductions □ Reduction of Workforce (clinical and non clinical) driven by budget reductions
1.2	Name of person responsible (policy manager) and contact details	□ Robert Cook, General Manager Specialist Ambulatory Services, GSTT □ Dr Anatole Menon-Johansson, Clinical Lead for Sexual and Reproductive health Services, GSTT □ Dr Kate Langford, Deputy Medical Director, GSTT
1.3	Is this a new, existing or revised policy/function	□ New public consultation

1.4	What does this policy, service, programme, strategy intend to achieve?	We know that demand for SRH services is growing and is likely to continue to grow, but we do not know at present what funds will be available in future years to fund this growth in activity. We do know that councils have experienced reductions in Public Health grant and have passed some of these reductions on to service providers. The Government requires SRH services to have an open access policy and it is clear that we must run these services in a different way, so we can continue to provide care to people who need it most and manage the expected growth within reducing budgets. To do this we propose to: 1. Refer more patients who do not have symptoms (asymptomatic patients) and attend clinics for tests for sexually transmitted infections (STIs) to 'home (self)-testing' by expanding and developing the existing online testing service already provided by SH:24 2. Reduce the number of sexual health centers from 6 to 3. 3. Align the opening hours of the 3 remaining clinics on weekdays and increase the opening hours to provide longer weekday and weekend opening hours 4. Continue to offer a combination of 'walk-in clinics' and 'advance booking appointments' 5. Increase awareness and make better use of SRH services that are already offered by other healthcare providers, including GPs and pharmacies We do not propose to reduce the number of patients we manage within the services as we expect the changes we are proposing to enable us to maintain the required capacity. We propose to retain the following clinics: • Burrell Street • Streatham Hill Health Centre • Walworth Road We propose to close the following clinics: • Artesian Health Centre • Lloyd Clinic (at Guy's Hospital)

		Vauxhall Riverside Health Centre

1.5	How does this fit into wider strategic objectives/priorities?	Since 2013, local councils have been responsible for Public Health. Like other councils, Lambeth and Southwark receive a Public Health grant from the government, which is used to fund a range of services to improve the health and well-being of local residents, including SRH health services (testing, treatment and contraception). The proposed changes are part of a London wide process of transforming SRH services which Lambeth and Southwark councils are signed up to alongside 28 other London boroughs which will see simpler/low risk testing activity shift online and clinic sites rationalised. Papers on these wider strategic objectives were approved by both council Cabinets in the autumn of 2015 and are available online. In 2015/16 and 2016/17, the Government significantly reduced the amount of money it gave to Lambeth and Southwark councils to fund Public Health services and there will be further cuts over the next 3 years. In addition, the councils are under significant financial pressure because of the rising demand for open access sexual health services. In particular, the money they spend on genitourinary medicine (GUM) has increased every year since 2013. A new London-wide tariff for Sexual & Reproductive Health services will be introduced in April 2017. The tariff determines the price paid to services for the care and treatment of patients. It is possible this new tariff will present further financial challenges for the Trust in the coming years. All London boroughs are struggling to maintain the same level of funding for these services and most sexual health commissioners are looking for ways to change sexual health services in the same way that we are in Lambeth and Southwark. Like other healthcare providers, Guy's and St Thomas' NHS Foundation Trust must continue to provide services with far less money. Between now and 2020.

2. Evidence base

3 To make good, defensible decisions, it is critical that evidence is identified and reviewed. There are a number of different places from which to gather evidence, both internally (i.e colleagues, reports, bulletins) and externally (i.e research, other professionals, reports). Both qualitative and quantitative evidence is useful and will help to provide the evidence base that will help to make better assessments.

4 The minimum legal standard for completing EEIAs is to assess the impact of a policy decision on ethnicity, gender and disability. We do not want to just meet the minimum standard, we want to go beyond that and assess across the **REGARDSS** strands (**race, ethnicity, gender, age, religion/belief, disability, sexual orientation, socioeconomic inequality**).

5. This EEIA also takes into consideration our role as a representative of the state, and our delegated responsibilities to ensure the **human rights** of staff, the public and our patients are protected and enshrined in everything that we do.

2.1	What qualitative and quantitative information and evidence would enable you to makes the best assessment and what do they say regarding equality? (consider health needs assessments, public health input, research, consultations, stakeholders, local and national reports etc)	**Scope of assessment**: We provide services for clients across London and England. Of those who have visited our services in 2015, the breakdown around borough of residence is 25% Lambeth, 29% Southwark, 35% other London Boroughs, 5% outside London and 7% unknown. This assessment relates to the 54% of service users who are Lambeth or Southwark residents, **RACE** **General:** Nationally, ethnicity has a key effect on the level of risk of poor sexual health between particular groups of people. For example, there is a higher prevalence of Sexually Transmitted Infections (STIs) among African and Caribbean communities and a lower prevalence among Asian communities, when compared with the white British population (Shahmanesh et al., 2000; Low et al, 2001). The HPA report *Sexually transmitted infections in black African and black Caribbean communities in the UK: 2008 report* highlights the following: • Black African and black Caribbean communities in the UK are disproportionately affected by STIs. The higher prevalence of STIs in both the black African and the black Caribbean populations means that, even though the levels of high-risk sexual behaviour may be similar to those of other communities, there is an increased risk of acquiring an infection. • The black Caribbean community is disproportionately affected by bacterial STIs, especially gonorrhoea. Data from the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) in 2007 shows that, among heterosexuals diagnosed with gonorrhoea at 26 GUM clinics, 26 per cent were black Caribbean and 6 per cent were black African. In Southwark: 39.7% of the population belongs to the White group, 60.3% to Black, Asian and Minority Ethnic groups. In Lambeth: 56% of the population belongs to the White group, 44% to Black, Asian and Minority Ethnic groups. Attendances at our Sexual Health Centres belong 46.8% to the White group, 36% to Black, Asian and Minority

		Ethnic groups (with 17.2% race not collected or was refused) The evidence below demonstrates the inequalities in sexual health faced by Black and Minority Ethnic groups, in particular, black African and black Caribbean residents. **Sexually Transmitted Infections (STIs):** Of the Sexually Transmitted infections diagnosed within our services in 2015; 51% belonged to the White group, 35% to the Black, Asian and Minority Ethnic Groups (with 14% race was not collected or was refused) **HIV:** An estimated 107,800 people are living with HIV in the UK in 2013. Along with men who have sex with men (MSM), black Africans are the groups most affected by HIV infection. (LASER 2014) In 2014, 2932 adult residents (aged 15 years and older) in Southwark received HIV-related care: 2195 (number rounded up to nearest 5) men and 740 (number rounded up to nearest 5) women. Among these, 51.2% were white, 28.6% black African and 4.9% black Caribbean. With regards to exposure, 57.0% probably acquired their infection through sex between men and 38.4% through sex between men and women. Southwark has a higher proportion of HIV diagnosis in heterosexual men and women compared to London and England rates. In 2014, 3,646 adult residents (aged 15 years and older) in Lambeth received HIV-related care: 3,020 (number rounded up to nearest 5) men and 630 (number rounded up to nearest 5) women. Among these, 61.3% were white, 17.6% black African and 5.7% black Caribbean. With regards to exposure, 68.0% probably acquired their infection through sex between men and 27.1% through sex between men and women. (PHE Laser Report) Nationally the proportion of undiagnosed HIV remains particularly high amongst black African men (38%). **Termination of Pregnancy:** There appears to be considerable variation in abortion rates by ethnic group. An analysis of abortions performed by local providers for Lambeth, Southwark and Lewisham between 2008 and 2013 (excluding privately funded abortions) shows that the rates are much higher in the Black and 'other' ethnic groups. The

		reasons for this are not currently well understood and may relate to barriers to accessing contraceptive services. These may include: a lack of awareness of contraceptive methods available; cultural acceptability of the available methods; logistical issues such as location and opening times; and language barriers. **Health Inequalities and BME Communities** Evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy and from research, (eg African Health and Sex Survey, 2013-14, Sigma Research, LSHTP, A Review of research Among Black African Communities Affected by HIV in the UK and Europe, Medical Research Council) indicates that these health inequalities are driving factors including: • Late Diagnosis of HIV • Difficulties in accessing services, including HIV testing services • Difficulties in accessing information about HIV and HIV prevention • Deprivation and immigration status • HIV stigma Reproductive and sexual health services in Southwark and Lambeth have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations. In 2012-13 black residents in those boroughs were twice more likely to use the service than others. (LSL Sexual Health Strategy and Epidemiology Report) Reproductive and sexual health services in Lambeth and Southwark have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations. In 2012-13 black residents in those boroughs were twice more likely to use the service than others. (LSL Sexual Health Strategy and Epidemiology Report) The transformed services will continue to target BME communities given the burden of sexual ill health that these communities carry. Online services and clinic receptions will stream those BME residents who are vulnerable and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. Self-sampling ‘click and collect’ services will provide quick and easy access to testing for those who seek anonymity. There is no anticipated reduction in the capacity of the service. Access will be improved for BME residents as the online service will free up appointments within the clinic service. Translators and language line are available for service users who may need further assistance with accessing

		the service and to offer support to negotiate the pathway The impact on race is thus **positive** **GENDER** Attendances to our services show 55% are female and 45% are male. We have over 4,500 attendances for LARC (Long Action Reversible Contraceptives) and Medical Gynaecology. Nationally in 2015 newly diagnosed Sexually Transmitted Infections (STIs) were attributed to 53% female and 47% Male. Locally 57% were Male and 43% Female Locally within our services in 2015 57% of those with new diagnosed STIs were Male and 43% female. Our attendances from females are largely focused on Pregnancy and Maternity. Data from the digital sexual health service (SH24) indicates that the service is more popular with women than with men (63% of users are women). Online services and clinic receptions will stream those women who are vulnerable and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for women both via the digital service and via increased capacity in clinics to see the most in need. The impact upon gender is **Positive** **AGE** Nationally there are clear inequalities in the sexual health of young people. It has been shown that they have relatively high rates of unintended pregnancies and sexually transmitted infections (STIs), with the exception of HIV. Locally in our Centres we see 22,657 clients between the ages of 15-34 (71.4% of our total attendances) of those tested they make up 67.56% of all positive tests for STIs.

		Chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The detection rate is not a measure of prevalence. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in Chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it, other areas should work towards it. Such a level can only be achieved through the ongoing commissioning of high-volume, good quality screening services across primary care and sexual health services. Reproductive and Sexual Health Services in Lambeth and Southwark have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations. In 2012-13, the community sexual health services reached 8% of 15-24 years old residents in Lambeth and Southwark. Data from the digital sexual health service (SH24) indicates that the service is highly popular with young people (35% of users are under 24). Feedback on the service indicates that young people value the anonymity, the confidentiality and the speed at which the service delivers results. Test kits will not have to be delivered to young people's homes but via a 'click and collect' service thus guaranteeing confidentiality. Research indicates that digital technology is the most preferred route for young people to access many services, including health services (Use of Digital Technology, RCN, 2016). Digital services and clinic receptions will stream those young service users who are vulnerable (including all under 16) and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for young people both via the digital service and via increased capacity in clinics to see the most in need. It is also worse noting that service users can access the service via smartphones and mobile sites, and this is how most young people access online information. The impact on young people is thus **positive** **SEXUALITY** The number of STI diagnoses in Men who have Sex with men (MSM) has risen sharply in England

		in recent years. Gonorrhoea is the most commonly diagnosed STI among MSM and, given recent increases in diagnoses, is a concern due to the emergence of antimicrobial resistance in *Neisseria gonorrhoeae.* Several factors may have contributed to the sharp rise in diagnoses among MSM including condomless sex associated with HIV seroadaptive behaviours and the use of recreational drugs during sex (chemsex). More screening of extra-genital (rectal and pharyngeal) sites in MSM using nucleic acid amplification tests (NAATs) will also have improved detection of gonococcal and chlamydial infections in recent years. Attendances showed in 2015 75.8% of our clients were heterosexual, 15.6% were homosexual/bisexual males and 8.3% were homosexual/bisexual females. (8.3% was not recorded or clients refused) of STI's detected across our Service 28.49% were in men who have sex with men (MSM). There is specific concern around increasing sexual risk taking behaviours in MSM associated with recreational drug use and correlated with a rise in HIV and STI diagnoses. There is evidence to show that for many MSM the internet is a preferred route for access to services and health interventions and a key platform for delivering STI and HIV interventions (eg The Health and Wellbeing of BME, gay and other MSM, 2014, PHE). The current London HIV Prevention Programme delivers a raft of digital sexual health and HIV prevention interventions targeted at MSM that have been well evaluated. Lambeth and Southwark's current digital sexual health service is well used by MSM (14% of users are MSM) but still not as popular as clinics. The service will be adopting marketing that is more suitable and targeted at MSM with the aim of increasing uptake. This will be done by advertising in specialist press, local venues, research studies recruitment targeted at MSMs Digital services and clinic receptions will stream those MSM who are vulnerable (and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for MSM both via the digital service and via increased capacity in clinics to see the most in need. The impact on sexual orientation is thus **positive** **PREGNANCY AND MATERNITY**

		The rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care was 16.1 for London and 32.3 per 1,000 women in England. The rate of LARCs prescribed in sexual and reproductive health (SRH) services per 1,000 women aged 15 to 44 years was 33.0 for London and 31.5 for England (PHE LASER Report). Digital services and clinic receptions will stream those women who are vulnerable and at risk into clinics to access contraception advice and interventions. Those who have complex contraception needs (ie either as a result of physiological, medical, social or psychological need) will find it easier to access an appropriately qualified clinician. Digital services will provide (as SH24 currently does) detailed and easy to read information on the range of contraception available, where to access it and the best methods to meet need. The Councils are working with the CCG to pilot online simple contraception (the CCG commissions the simplest contraception). This will have the benefit of increasing access to simple contraception and freeing up clinical consultation time in both sexual health clinics and general practice. It is particularly important to consider the groups of women who are most at risk of not having contraception – those who use substances/different ethnic – this group will be engaged with to consider whether the pilot might meet their needs The impact on pregnancy and maternity is thus **positive** **SOCIO-ECONOMIC FACTORS** Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from GUM clinics show a strong positive correlation between rates of acute STIs and the index of multiple deprivation across England. There is also evidence of greater domestic violence in areas of deprivation, particularly during recessions, which also has a relationship with poor sexual health. The relationship between STIs and SED is probably influenced by a range of factors such as the provision of and access to health services, education, health awareness, health-care seeking behaviour and sexual behaviour.

		Digital services and clinic receptions will stream those who are most vulnerable and at risk into clinics to access help. As well as screening for sexual risk the clinic will screen (as is current practice) for domestic violence and drug use. Those with the greatest sexual health need will find it easier to access the help they need and clinicians will have more time to spend with those with more complex needs. The impact on Socio-economic factors is thus **positive**

2.2	If there are gaps in the evidence how will this be generated?	**Gender Reassignment** We have very little national or local data in relation to gender re-assignment, although ~~I~~it has been estimated that there are 20 transgender people per 100,000 population suggesting that of the 89,000 clients we saw in 2015 approximately 16-18 were transgender. The impact is thus **unknown** **Disability** There is limited data and research available on the needs of people with learning disabilities or physical disabilities. Disabled people who may find it hard to travel to clinics will be able to access digital services and, if they require it, have test kits delivered to the door. Those disabled people who cannot access digital services will be able to access services via the clinic reception and will be streamed into clinic services as appropriate. Using digital services also allows for the use of assistive technology software to be used to improve access to information, advice and guidance – particularly for people who are sensory impaired. Promotion of the changes to Sexual and Reproductive Health services will be shared with the 3 boroughs community learning disabilities team, and discussed with their patients and carers. The impact on disability is thus **positive** **Religion and Belief** There is limited evidence on the relationship between religion and belief and sexual health. However, evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy indicates that: • The role faith leaders play is important in relation to delivering work in the sexual health promotion and HIV prevention work in the community • Involving local faith organisations eg churches and mosques is important in relation to delivering work in the sexual health promotion and HIV prevention work in the community The impact is thus **unknown**

		Marriage and Civil Partnership There is a lack of evidence on the relationship between marriage and civil partnership and sexual health. Data is collected in all sexual health services on marriage and civil partnership and future research eg service reviews, can capture information on service use and the characteristic. The impact is thus **unknown**

2.3	Does the evidence show that there are different population groups who have different needs or who are suffering inequality (i.e. consider health inequalities, poorer progression for staff, difficulties in retaining certain staff, differing experiences of the service etc) across the **REGARDSS** strands	There is no evidence that shows that as a result of these changes and this policy any group will be disadvantaged. Staffing is not considered as part of this assessment; please refer to staff specific assessment.

2.4	**Internal Involvement and Consultation:** (e.g. with Departments, Staff (including support groups), academic partners, local authorities) *Does this initiative affect the experiences of staff? How? What are their concerns?* *How have you consulted, engaged and involved internal stakeholders in considering the impact of this proposal on other public policies and services?* *What forms of consultation, engagement and involvement have been most effective?* *What positive and adverse impacts were identified by your internal stakeholders?*	*Staffing is not considered as part of this assessment, please refer to staff specific assessment*. **Patient and Public consultation activities to date**: Together with the Councils, the Trust has sought and will continue to seek the views of:- □ Patients / service users (current) □ Healthwatch and their membership □ Local residents □ Community voluntary organisations (as bodies who both support service users and providers SRH services) □ Staff □ Patient-public Foundation Trust Governors □ Overview and Scrutiny Committees in both boroughs Between April and June both Lambeth and Southwark councils undertook a public consultation on the proposed changes to public health services commissioning in response to a significant reduction in the Public Health Grant designated to local authorities by central Government. This included a reduction in funding for clinic-based sexual and reproductive health services delivered by Guy's and St Thomas's NHS Foundation Trust In order to meet its legal 'duty to involve' and seek further insight from service users with which to inform the further development of the commissioning proposals, Guy's and St Thomas', in consultation with commissioners, undertook the following: - □ 6 user focus groups (1 at each clinic site, facilitated by an independent researcher and a Trust officer) □ A user questionnaire (made available online and paper and distributed across all clinic sites)

		Positive and adverse impact raised by stakeholders Stakeholders identified the following key positive impacts: - We are not reducing capacity of the service but developing alternative delivery methods of care. - On line services appeal to over 50% of the current service users - Increased access to same day appointments and walk in service - Increased/Harmonized opening hours across all 3 remaining sites - 7 day opening at Burrell Street with increased opening hours and access - One stop shop service Potential adverse impacts are: - Anxiety surrounding using an online STI self care system - Streatham Hill SRH service will be closed at the weekend and Burrell Street is a longer distance to travel for Lambeth patients than previously. - Waiting times if needing to access primary care services for contraception and emergency contraception **Further Planned Stakeholder engagement on the planned changes:** The findings of both the council's and the Guy's & St Thomas' NHS Foundation Trust patient and public engagement activities will inform the final stage of the process, when both the Trust and Lambeth Council (as lead commissioner) in collaboration with Southwark Council, will undertake a 4-week 'documentary consultation' on the final proposals which we anticipate will commence on or around 22 August (pending the outcome of internal staff-side pre consultation), consisting of face to face and online activities, including:- - 6 x 'drop-in discussion forums' in the open waiting rooms of each clinic, led by service staff - A public information display and accompanying consultation questionnaire installed in each site for the duration of the consultation period - An online consultation document and questionnaire that will be publicized more widely and directed to key stakeholders, including community interest groups

3. Assess the impact on equality and human rights

6 Considering the information above, what is the impact of this policy or function on the differing strands of equality? Don't only think about single REGARDSS strands; consider the fact that people have multiple identities. On closer inspection, a very specific demographic may be suffering greater inequality than the headline figures may show. It is important to interrogate these assumptions to reduce the risk of enacting a policy that inadvertently increases inequality.

3.1	What opportunity is there to promote equality of opportunity, good relations or increase participation?	□ The services are focusing on continuing to deliver optimal care targeting vulnerable and hard to reach populations (young people, MSM, BME, LGBTQ…) □ The priorities of the service are also to promote service delivery to the local communities and therefore working in partnership with local other service providers (GPs, Pharmacies, Commissioners and local governments) to ensure this is achieved □ Online testing will promote quick access to care to a new and existing service users but also promote on site access to patients who have more complex needs – the use of technology will support more assistive technology software to make information more accessible for people who are sensory impaired. A simple 'how to use the online site tutorial' could be been considered for development □ Geographically, the 3 proposed sites are situated in a manner that most Southwark and Lambeth residents will be able to access one of the clinics easily. They also have good transport links □ Provide a one stop-shop model of care where patients' experience will be enhanced and also promotes the expertise of the healthcare professionals

3.2	What are the potential negative or adverse effects?	□ A proportion of existing service users who are attendees to visit a specific site that has been proposed to close may choose to attend other clinics in London out of Boroughs □ Online testing for asymptomatic patients may be a deterrent for testing in some populations (Lack of trust in home testing, anxiety around validity of results, no access to internet, patients for whom English is not their first language, for example) □ Risk of missing vulnerable adults as no face to face consultation in online testing (risk of CSE, gangs, Drug use, DV for example) □ Service users may feel that if there are less clinics and potentially less staff the waiting times may be longer and that their care may be delayed □ Some of the proposed sites will need some alterations/work and therefore financial investment to ensure that we are able to deliver a level 3 service in each centre.
3.3	What is the potential for negative or adverse effects assess likelihood (1 = unlikely, 5 = certain) severity (1 = very mild, 5 = very severe/ risk of death) numbers of people affected (1 = very few, 5 = almost everyone)	 **3** **3** **3**
3.4	Is there public concern about possible discrimination/ unfairness/ inequality?	No concerns identifying discrimination unfairness and inequality raised by patients and public. A patient survey was conducted for 3 weeks in June 2016 and 588 questionnaires were returned. Also Focus groups were held across the 6 sites.

3.5	How much evidence is there to support these conclusions? 1 = none 2 = little 3 = some 4 = substantial	**4**
3.6	What ability do we have to; 1. Alleviate or change unfair, adverse or discriminatory effects? 2. Promote and enhance positive effects	. 1. Engage service users in the consultation process and showcase our innovations in care delivery 2. Educate patients and assist them through the process of online testing. The services plan to have IPads in situ to help patients that have attended to negotiate this new care pathway 3. Promote Click and collect 4. Ensure the online service comprises a robust assessment to ensure any vulnerable service user is captured and referred to appropriate care provider 5. Promote the use of the virtual queuing system that will be operational in all sites 1. Engage and work in partnership with all stake holders by holding meetings and introduction forums to the new service and transformation project 2. Encourage staff in clinics to engage with patients and answer questions and assist them through the care pathways

Human Rights

3.7	Could the policy or function affect an individual's human rights? Consider specifically the articles below of the Human Rights act (1998): Article 2 – Right to life Article 3 – Right not to be tortured or treated in an inhumane/degrading way Article 5 – Right to liberty Article 7 – Right to no punishment without law Article 9 – Right to respect for private and family life and correspondence	No aspect of the proposals has been identified to compromise any individual's human rights
3.8	What steps can be taken to negate this?	Not applicable as no risk identified

4. Screening assessment and next steps

Based on the answers above, a decision needs to be made on how to proceed. This will require a decision to be taken on whether a detailed and full EEIA is required; if further information is required and will definitely include an action plan that will, at a minimum, monitor the impact of the policy.

4.1	Give an overview of the action that needs to be taken now?	□ Launch of the Staff consultation on 22nd August 2016 □ Followed by Public consultation on 25th August 2016 □ Engage service users and the public with one to one interviews to be facilitated by staff in September 2016 across all 6 existing venues □ Ensure that the proposed sites are fit for purpose □ Changes to be effectively communicated to patients, public and stakeholders via different avenues ensuring the information reaches all target groups □ Ensure that the implementation of the proposal is effective by 1st April 2017
4.2	Complete an action plan to highlight the next steps that need to be taken	

Action	Responsibility	Timescale
Launch full public consultation	Andrea Carney - Trust public and engagement manager	25th August 2016
Facilitation with service users interviews across all existing sexual and reproductive services	Jay Jarman – Lead Health Advisor Robert palmer – Lead psychotherapist	All 6 current sites completed by 30th September 2016

To collate the information from the public consultation and derive analysis and report findings.	Andrea Carney - Trust public and engagement manager Anatole Menon Johansson – Clinical Lead for Sexual and Reproductive Health Robert Cook – General Manager for Specialist Ambulatory Services	Analysis Period : TBC Consultation period with stakeholders:

Marketing campaign launched reaching existing service users, public, stakeholders and local referral services.	Matt Akid – Head of Media and Corporate Communications Anatole Menon Johansson – Clinical Lead Sexual and Reproductive Health	Ongoing
Work commences to ensure three departments fit for purpose and able to deliver the ideal clinic model providing level 3 services.	Anatole Menon Johansson – Clinical Lead Sexual and Reproductive Health	To be implemented by 31st March 2017
Full implementation of proposed changes		1 April 2017

4.3	Does the screening show either; That there could be differential or adverse effects on different population groups The evidence so far supports the potential for differential effects There is not enough evidence to rule out differential effects There is substantial public concern about differential effects If the answer is yes, a full EEIA is required.	As the screening and assessment demonstrate above, the evidence show that the proposals will not have a negative impact on the public and will not affect negatively their human rights
4.4	Is this policy or function a lawful positive action initiative?	Yes
4.5	If a full EEIA is not required, please summarise your reasons	We do not consider that the consultation will cause affected the publics and service users to suffer inequality or discrimination in terms or REGARDSS (Race, Ethnicity, Gender, Age, Disability, Sexual orientation, Socioeconomic). There will be no impact on human rights However, this will be monitored on an ongoing basis and appropriate action taken to mitigate against any possible inequality

Assurance

Name of lead	Robert Cook, General Manager Specialist Ambulatory Services, GSTT
Lead director	Dr Kate Langford, Deputy Medical Director, GSTT