Equality Impact Assessment Report	Please enter responses below in the right hand columns
Date to EIA panel, department, DLT or DMT	21 June 2016
Sign-off path for EIA (please add/delete as applicable)	Corporate EIA Panel
Title of Project, business area, policy/strategy	Integrated sexual health services (Genito-urinary medicine and reproductive and sexual health services)
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SLB Sponsor	

London Borough of Lambeth Full Equality Impact Assessment Report	Please enter responses below in the right hand columns.
1.0 Introduction	
1.1 Business activity aims and intentions *In brief explain the aims of your proposal/project/service, why is it needed? Who is it aimed at? What is the intended outcome? What are the links to the cooperative council vision, corporate outcomes and priorities?*	To transform integrated sexual health services (Genito-urinary medicine services and reproductive and sexual health services) as provided to residents of Lambeth and to all London residents (given the services are, by statute, open access) by Guy's and St Thomas' Hospital Trust and Kings College Hospital Trust within the boroughs of Lambeth and Southwark by: • Extending the reach and use of online sexual health services already provided in Lambeth and Southwark and integrating the digital sexual health service (SH24), which is offered online, on smart phones and other digital platforms, into the terrestrial clinical service to deliver basic sexual health and contraception services • Developing the targeted terrestrial clinical service offer to imprive access to those who are most at risk and the most vulnerable – these being primarily, but not exclusively: BME communities; young people; and men who have sex with men. • Providing self-sampling services at clinics and self-sampling 'click and collect' services • Reviewing sites with the aim of amalgamating sites and staff where the outcome will be an improved service offer ie improved access to a range of clinicians skilled to deliver on range of needs, including the most complex, at times that best meet the needs of residents. • Improving access to long-acting reversible contraception (LARC) The proposed changes are aligned with those taking place in sexual health services throughout London. Alignment is overseen by the London Sexual Health Transformation Programme. Alignment is key given the open access nature of the services.
2.0 Analysing your equalities evidence	
2.1 Evidence	

Protected characteristics and local equality characteristics	**Impact analysis**
Race	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 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 their levels of high-risk sexual behaviour may be similar to those of other communities, they run 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 Lambeth 56% of the population belong to the White group, 44% to Black, Asian and Minority Ethnic group. The evidence below demonstrates the inequalities in sexual health faced by Black and Minority Ethnic groups, in particular, black African and black Carribean Lambeth residents **Sexually Transmitted Infections** Where recorded, in 2014 42.7% of new STIs diagnosed in Lambeth were in people born overseas.

HIV

An estimated 107,800 people were 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, 3646 adult residents (aged 15 years and older) in Lambeth received HIV-related care: 3020 (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 acceptiblity of the available methods; logistical issues such as location and opening times; and language barriers.

Health Inequalities and BME Comnmunities

Evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy Section 3.1 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) also 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 Lambeth (and Southwark and Lewisham) 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. The impact on race is thus **positive**
Gender	The evidence below demonstrates the inequalities in sexual health related to gender in Lambeth residents **Sexual Transmitted infections and sexual behaviour** 9178 new STIs were diagnosed in residents of Lambeth in 2014 (6437 in men and 2586 in women), a rate of 2920.7 per 100,000 residents (men 4095.3 and women 1646.5) (gender was not specified or unknown for 155 episodes). (PHE LASER Report)

	Reinfection with an STI is a marker of persistent risky behaviour. In Lambeth, an estimated 7.3% of women and 16.7% of men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became reinfected with a new STI within twelve months. Nationally, during the same period of time, an estimated 7.0% of women and 9.0% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months. In Lambeth, an estimated 6.6% of women and 17.0% of men diagnosed with gonorrhoea at a GUM clinic between 2010 and 2014 became reinfected with gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 8.0% of men became reinfected with gonorrhoea within twelve months. Please also see **Sexual orientation** for rates on MSM **Conceptions and terminations** For evidence and assessment in relation to young women please see please see **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 on gender is thus **positive**
Gender re-assignment	Although there is a lack of evidence the little that is available indicates that trans people experience health inequalities (eg Transgender Sexual and Reproductive Health: Unmet Needs and Barriers to Care April 2012 National Center for Transgender Equality), including sexual health inequalities which may include higher rates of STIs, and difficulties accessing services and relevant information. It has been estimated that there are 20 transgender people per 100,000 population, meaning that there are approximately 50-60

	transgender people in Lambeth. The impact is thus **unknown**
Disability	There is limited data and research available on the needs of people with learning disabilities or physical disabilities. There are approximately 17,000 moderately or severely disabled people of working age in Lambeth and around 33,000 with a common mental disorder. However, the number of people living with HIV who are also disabled and/or have a mental health problem in Lambeth is unknown. Despite the success of anti-HIV treatments which result in PWHIV being able to live long and healthy lives small numbers, especially those diagnosed late, will become ill and may become disabled. In addition evidence indicates that PWHIV experience higher rates of mental health illness (eg Psychological support services for people living with HIV, National AIDS Trust, 2010) than their peers. 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. The impact on disability is thus **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. Young people aged between 15 and 24 years experience the highest rates of new STIs. In Lambeth, 18% of diagnoses of new STIs made in GUM clinics were in young people aged 15-24 years. Young people are also more likely to become reinfected with STIs,

	contributing to infection persistence and health service workload. In Lambeth, an estimated 14.2% of 15-19 year old women and 15.2% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became reinfected with an STI within twelve months. Teenagers may be at risk of reinfection because they lack the skills and confidence to negotiate safer sex. The chlamydia detection rate in 15-24 year olds in Lambeth was 4225.1 per 100,000 population. 43.9% of 15-24 year olds were tested for chlamydia with a 9.6% positivity rate. Nationally, 24.3% of 15-24 year olds were tested for chlamydia with a 8.3% positivity rate. Since 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. **Sex and relationships education (SRE)** Evidence also indicates that access to high quality sex and relationships education (SRE) is instrumental in delaying the onset of first sex and promoting relationship skills (UNESCO 2009, NICE 2010, Kirby, 2007) Evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy and from research, (eg Health Promotion, Inequalities and Young People's Health: A systematic review of research, Oliver S et al, Institute of Education, 2008) indicates that these sexual health inequalities are driven factors

	including: • Skills and confidence in negotiating safer sex • Gender roles and assumptions • Difficulties in accessing sexual health services • Difficulties in accessing information about HIV and HIV prevention • Deprivation • Stigma around STIs Reproductive and Sexual Health Services in Lambeth (and Southwark & Lewisham) 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). The speed at which the Digital services and clinic receptions will stream those young 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. **The impact on young people is thus positive**
Sexual orientation	The evidence below demonstrates the inequalities in sexual health related to sexual orientation

The number of STI diagnoses in 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.

Sexually transmitted infections

In Lambeth in 2014, for cases in men where sexual orientation was known, 69.2% (n=3905 – number rounded up to the nearest five) of new STIs were among MSM. In 2010, the proportion of new STIs among MSM was 46.0% (n=1645 – number rounded up to the nearest five). Please note that the numbers for MSM presented in this report include homosexual and bisexual men.

Unfortunately due to small numbers of syphilis and gonorrhoea cases in many local authorities it has not been possible to provide a breakdown of these by sexual orientation in this report. In England, 70% of gonorrhoea cases and 88% of syphilis cases were in MSM.

(PHE LASER Report)

Substance misuse

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.

Health Inequalities and MSM

	Evidence gathered locally during the consultation on the past Lambeth, Southwark and Lewisham Sexual Health Strategy Section 3.1 and from research including also indicates that these health inequalities are driven by factors including: • Difficulties in accessing services, including HIV testing services • Difficulties in accessing information about HIV and HIV prevention • HIV stigma • Increased risk taking behaviour Of those using the GUM and resident in Lambeth there are high levels of men and MSM Data from the digital sexual health service (SH24) indicates that the service is highly popular with young people. 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. There is evidence to show that for many MSM the internet is a prefered 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 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
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**
Pregnancy and maternity	**Abortion** In Lambeth upper tier local authority, the total abortion rate per 1,000 females population aged 15-44 years was 24.1, while in England the rate was 16.5. Of those women under 25 years who had an abortion in that year, the proportion of those who had had a previous abortion was 30.7%, while in England the proportion was 27.0%. **Contraception** The rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care was 19.4 for Lambeth, 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 34.6 for Lambeth, 33.0 for London and 31.5 for England. (PHE LASER Report) **Teenage conception** Most teenage pregnancies are unplanned and around half end in an abortion. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term

	poverty. In addition to it being an avoidable experience for the young woman, abortions, live births and miscarriages following unplanned pregnancies represent an avoidable cost to health and social care services. Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems. In 2013, in Lambeth: • The under 18 conception rate per 1,000 female aged 15 to 17 years was 24.7, while in England the rate was 24.3. The rank (out of 324*) within England for the under 18 conception rate was 126 (1st has the highest rate). Between 1998 and 2013, Lambeth achieved a 71.1% reduction in the under 18 conception rate, compared to a 47.8% reduction in England. • Among the under 18 conceptions, the proportion of those leading to abortion was 72.4%, while in England the proportion was 51.1%. The rank (out of 294*) within England for the under 18 conceptions leading to abortion was 22 (1st has the highest percentage). **Services** There were 24668 attendances by Lambeth residents to SRH services in 2014. The top three providers were Streatham Hill Centre, King's College Hospital (Denmark Hill) and Brook London. **Percent of all attendances by Lambeth residents to SRH Services with more than 10**

attendances: 2014

Clinic name	*Number of all attendances*	*% ofall attendance*
Streatham Hill Centre	6385	25.9
King's College Hospital (denmark Hill)	5062	20.5
Brook - London	3929	15.9

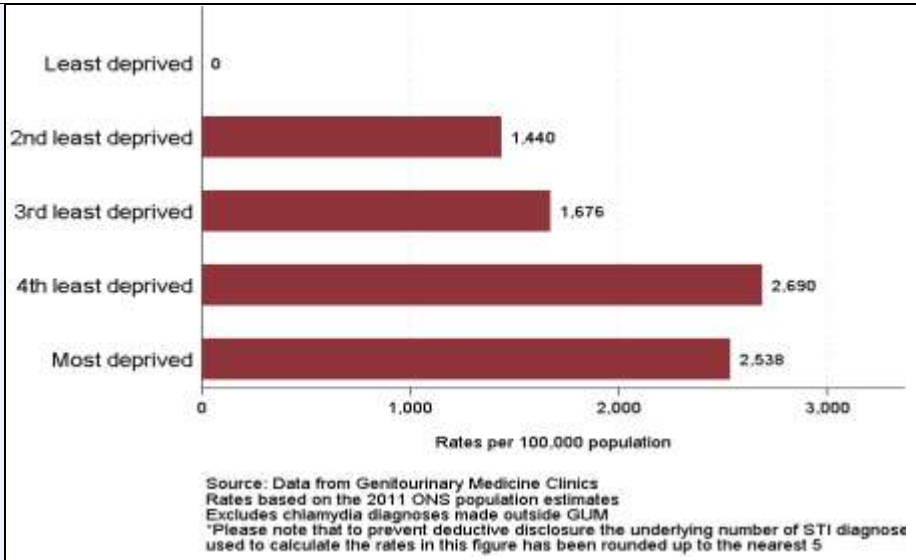
Evidence indicates that the risk of unplanned pregnancy is associated with:

- age (being under 18)
- alcohol consumption
- deprivation

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 Council is working with the CCG to pilot online simple contraception (the CCG commissions most simple 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. Improved access to LARC will form the part of the contracts with GP Federations for 2016/17. A central booking system for LARC to by managed by BPAS and to be introduced in 2016 in LSL will also increase access to LARC.

	The impact on pregnancy and maternity is thus **positive**
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**
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. This is mirrored in the rates of STIs in Lambeth which show a positive correlation with wards of greater deprivation. ***Rates* of new STIs by deprivation category in Lambeth (GUM diagnoses only): 2014 (underlying numbers have been rounded up to the nearest five, do not use this figure if the total number of STIs in a deprivation group in Table 5 is <100 as rates will be distorted by rounding)***

	 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**
Language	Lambeth is a very ethincally diverse borough, and for many residents English may not be a fist language. However, there is a lack of robust evidence on the links between language and sexual health promotion. Clinics have access to translators and produce sexual health information in languages other than English

	However, given the lack of research the impact is thus **unknown**
Health	For the impact with regards to sexual health and groups of people, see **sections above.**
2.2 Gaps in evidence base *What gaps in information have you identified from your analysis? In your response please identify areas where more information is required and how you intend to fill in the gaps. If you are unable to fill in the gaps please state this clearly with justification.*	There are gaps in: • Sexual health and transgender • Language • Religion and belief • Marriage and Civil Partnership There is a lack of evidence and research in these areas in relation to sexual health. Transformed services will have the ability to monitor in relation to transgender and language needs. Services are provided to all irrespective of religion and belief and marriage and civil partnership.
3.0 Consultation, Involvement and Coproduction	

3.1 Coproduction, involvement and consultation *Who are your key stakeholders and how have you consulted, coproduced or involved them? What difference did this make?*	Key stakeholders are: • Kings College Hospital NHS Trust • Guy's and St Thomas' Hospital NHS Trust • Brook Lambeth and Brook Southwark • British Pregnancy Advisory Service • Marie Stopes International • The London Sexual Health Transformation Programme • General Practice and Community Pharmacy in LSL • LMC • LPC • LB Southwark • LB Lewisham • LB Bromley LSL Sexual Health Transformation Programme has been in place since April 2015 and has been co-producing and designing the transformed services. The Programme consists of a Steering Group chaired by the Integrated Director of Commissioning and comprising of representatives from all stakeholder groups The proposed new service has been designed and contract and finance agreed via workstream groups made up of stakeholders. These groups are: • Clinical and service model • Finance and contracts • Primary care Extensive consuslation was undertaken in 2013/14 to inform the direction for the model as part of the LSL Sexual Health Stategy development. This included two stakeholder events and focus groups with key target groups (MSM, BME communities and young people). The work endorsed the model. Additional consulation with the public and service users was undertaken in summer 2015 when with public events held in Lambeth, Southwark and Lewisham and focus groups in all boroughs to identify views on residents in accessing sexual health services online and

	via primary care. The subsequent report identified that residents were happy to access services via both channels, the main barriers being practical (ie being unaware of the digital service. Being unable to book convenient appointments in primary care) – the LSL Transformation Project has taken these in to account in its planning (eg freeing up appointments in general practice by providing digital access to simple contraception) Additional consulation on all the public health changes was undertaken in April – May 2016 with service users and residents, including sexual health. This include: • 2 x Drop in events • Healthwatch-led public meeting • Presenting proposals at all GP Locality Network meetings and all Local Care Network meetings • Public survey Results of the survey demonstrated that: • 61% of respondents were in favour of extending the availability of online testing for STIs, 19% were against and 22% had no opinion • 57% of respondents were in favour of greater use of GPs and pharmacies to provide sexual health services, 24% were against and 19% had no opinion Written feedback indicated that online services would be particularly popular with young people and that the increased access to testing may improve rates. Others felt that the anonymity of the service would encourage people to test and, in this context, there was considerable support for click and collect test kits. However, others felt that the current service (SH24) was not promoted enough, particularly to gay men. Some people felt that although the service may prove helpful for most of the population they were concerned that vulnerable people and those that may not have access to the Internet may find it difficult to access, along with those who struggled with self-administering a blood test. People were also concerned about access to prevention information via online services and to support following any positive results. There was concern that, whilst online testing was a great opportunity to extend reach, it should be evaluated.

	A number of people felt that primary care was a good point of access for sexual health services. Pharmacies, in particular were felt to be easy to access. However, many felt that GPs were already overloaded and would not have the capacity to do extra – as well as it proving hard to get appointments with them. Others felt that, whilst primary care was a good place for these services, they needed to be better promoted or more welcoming – with some concerned about the expertise they may have to deliver sexual health services or the stigma or embarrassment that may be experienced in such services when sexual health or HIV is mentioned – noting that a more sex positive environment should be encouraged. Others felt that sexual health promotion might be missed by primary care when delivering such a service.
3.2 Gaps in coproduction, consultation and involvement *What gaps in consultation and involvement and coproduction have you identified (set out any gaps as they relate to specific equality groups)?*	In addition Guy's and St Thomas' will undertake their own extensive patient involvement exercise

Please describe where more consultation, involvement and/or coproduction is required and set out how you intend to undertake it. If you do not intend to undertake it, please set out your justification.	
4.0 Conclusions, justification and action	
4.1 Conclusions and justification *What are the main conclusions of this EIA? What, if any, disproportionate negative or positive equality impacts did you identify at 2.1? On what grounds do you justify them and how will they be mitigated?*	Further work needs to be done to address are gaps in relation to: • Transgender • Language There is a lack of evidence in each of these areas. Sexual health and transgender, and language are all important elements of promoting good sexual health. As a result of the consultation click and collect will definitely form part of the offer. The service will ensure that vulnerable people and those most at risk have access to a clinic appointment and will not have to use the Internet to arrange this– this will be emphasised in clinic specifications and promotion. Those who are unable to manage blood tests will also be directed to clinics. Those testing positive for HIV and gonorrhoea will be directed into clinics for management of the result and for information on prevention. The online service will also offer online information on prevention and access to online 'chat' with a clinician, including that on prevention. The service will be provided on smart phones as well as on computers for those who only have access to smart phones. A detailed academic evaluation of SH24 is currently being undertaken and will report later this year. Most other boroughs are planning on commissioning online sexual health services and it is likely that data from these can inform an assessment of performance across London in the next one to two years

	The focus for primary care will be for GPs to deliver more long-acting reversible contraception (LARC). They are currently doing this but the aim is to step this up. This would form part of any routine consultation on contraception that they already undertake – and would offer a woman more choice. Thus it is unlikely that GP consultation time will need to increase greatly. The focus is also to skill up those pharmacies and GPs in areas of greatest need and who are best placed to deliver on basic sexual health services and contraception. Training and support is being planned to ensure they provide services in a non-stigmatising and patient centred way. It should be noted that three GP practices in Lambeth already provide a range a basic sexual health services and this model can be built upon.

4.2 Equality Action plan

Please list the equality issue/s identified through the evidence and the mitigating action to be taken. Please also detail the date when the action will be taken and the name and job title of the responsible officer.

Equality Issue	**Mitigating actions**
Transgender	Monitor service uptake and use Include specific questions concerning transgender issues in service quality/feedback surveys
Language	Monitor service user language requirements and develop materials/services to meet requirements

5.0 Publishing your results	
The results of your EIA must be published. Once the business activity has been implemented the EIA must be periodically reviewed to ensure your decision/change had the anticipated impact and the actions set out at 4.2 are still appropriate.	
EIA publishing date	
EIA review date	
Assessment sign off (name/job title):	

All completed and signed-off EIAs must be submitted to equalities@lambeth.gov.uk for publication on Lambeth's website. Where possible, please anonymise your EIAs prior to submission (i.e. please remove any references to an officers' name, email and phone number).