Open Agenda

Healthy Communities Scrutiny Sub-Committee

Tuesday 26 July 2016
7.00 pm
Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Date: 25 July 2016

Equality Impact Assessment Report	
Date to EIA panel, department, DLT or DMT	TBC
Sign-off path for EIA (please add/delete as applicable)	TBC
Title of Project, business area, policy/strategy	Integrated sexual health services (Genito-urinary medicine and reproductive and sexual health services)
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London Borough of Southwark Full Equality Impact Assessment Report	
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 Southwark 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 improve 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.

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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 Southwark 39.7% of the population belong to the White group, 60.3% 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 Caribbean Southwark residents.

	Sexually Transmitted Infections Where recorded, in 2014 45.6% of new STIs diagnosed in Southwark 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, 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. 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

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	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 Southwark (and Lambeth 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 Southwark residents 7143 new STIs were diagnosed in residents of Southwark in 2014 (4707 in men and 2306 in women), a rate of 2393.3 per 100,000 residents (men 3191.3 and women

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	1527.4) (gender was not specified or unknown for 130 episodes). Reinfection with an STI is a marker of persistent risky behaviour. Southwark women have similar or slightly lower reinfection rates compared to England rates and men significantly higher. In Southwark 6.5% of women and 14.7% of men presenting with a new STI at a GUM clinic during 2010 to 2014 became reinfected with a new STI within twelve months, compared to 7.0% of women and 9.0% of men in England. In Southwark, an estimated 4.8% of women and 15.6% 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. **Sexual Transmitted infections and sexual behaviour** 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 58 transgender people in Southwark. The impact is thus **unknown**
Disability	There is limited data and research available on the sexual and reproductive health needs of people with learning or physical disabilities. There no single recognised data source for prevalence of physical disability. It is estimated that just under 6% of the population in the London Borough of Southwark are disabled, of whom 1.4% have a severe disability. It is clear wards with high levels of deprivation experience higher rates of disability. Approximately 710-810 adults with moderate/severe learning disabilities and 550 adults with mild learning disabilities in Southwark (rounded to nearest 50). People with learning disabilities may find it difficult to access services and have their sexual and reproductive health needs met. However, the number of people living with HIV who are also disabled and/or have a mental health problem in Southwark 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. Online services and clinic receptions will continue to stream residents who are vulnerable and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. 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 Southwark, 26% 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 Southwark, an estimated 13.4% of 15-19 year old women and 14.8% 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 Southwark was 3462.7 per 100,000 population. 39.7% of 15-24 year olds were tested for chlamydia with an 8.7% positivity rate. Nationally, 24.3% of 15-24 year olds were tested for chlamydia with an 8.3% positivity rate. Southwark performs better than both London region and England at detecting chlamydia amongst young people. This is important because chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious

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	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. Young people also experience poorer reproductive health, with high levels of conceptions, abortions and unwanted pregnancies. (See Maternity and Pregnancy section). **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 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). 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 gonorrhoea.* 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

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have improved detection of gonococcal and chlamydial infections in recent years.

Sexually transmitted infections

In Southwark in 2014, for cases in men where sexual orientation was known, 61.3% of new STIs were among MSM.

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)

The incidence of all new STIs amongst MSM is increasing both overall and when compared to heterosexual men.

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 Southwark there are high levels of men and MSM

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	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 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	The National Survey of Sexual Attitudes and Lifestyles (NATSAL 2010) found that 16.2% of pregnancies in the year before the study interview were unplanned. This survey found that: • Pregnancies among 16 to 19 year olds accounted for 7.5% of the total number of pregnancies, but 21.2% of the total number that were unplanned.

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	• The highest numbers of unplanned pregnancies occur in the 20 to 34 year age group. Unplanned pregnancies can end in abortion or a maternity. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children. Restricting access to contraceptive provision by age can therefore be counterproductive and increase costs. **Abortion** The total number of abortions in 2014 was 2,011. A 6.55% decrease since 2011. Southwark has a high number of abortions and repeat abortions. In Southwark the total abortion rate per 1,000 female population aged 15-44 years was 24.7, while in England the rate was 16.5. Among women under 25 years who had an abortion in that year, the proportion of those who had had a previous abortion was 33.5%, while in England the proportion was 27.0%. Among women aged 25 and over who had an abortion in that year, the proportion of those who had had a previous abortion was 50.6%, while in England the proportion was 45.6%. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure. Southwark performs well and amongst NHS funded abortions 83.8% are performed under 10 weeks gestation while in England the proportion was 80.4%. **Contraception** Of all contraceptive methods prescribed in sexual and reproductive health services, the main methods of contraception for residents in Southwark were 24.5% LARC, 6.1% injectable contraception and 69.3% user dependent method (UDM), compared to 23.0% LARC, 12.3% injectable contraception and 64.7% UDM, for residents in England. (PHE LASER Report)

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	Increasing access and uptake of LARC prevents unplanned pregnancies and is cost effective. The majority of LARC for Southwark residents is prescribed within sexual and reproductive health services, with GPs prescribing very low. In 2014 Southwark was ranked 296 out of 326 local authorities in England for the rate of GP prescribed LARCs (1st has the highest rate), with a rate of 13.1 per 1,000 women aged 15 to 44 years, compared to 16.1 in London and 32.3 in England. **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 Southwark: • The under 18 conception rate per 1,000 female aged 15 to 17 years was 30.6, while in England the rate was 24.3. The rank (out of 324*) within England for the under 18 conception rate was 56 (1st has the highest rate).

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Between 1998 and 2013, Southwark achieved a 64.8% 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 70.2%, while in England the proportion was 51.1%. The rank (out of 294*) within England for the under 18 conceptions leading to abortion was 30 (1st has the highest percentage).

Services

There were 24668 attendances by Southwark 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 Southwark residents to SRH Services with more than 10 attendances: 2014

Clinic name	*Number of all attendances*	*% of all 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

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	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 be 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 Southwark which show a positive correlation with wards of greater deprivation.

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	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	Southwark is a very ethnically diverse borough, and for many residents English may not be a first 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.

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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 work stream groups made up of stakeholders. These groups are: • Clinical and service model • Finance and contracts • Primary care Extensive consultation was undertaken in 2013/14 to inform the direction for the model as part of the LSL Sexual Health Strategy development. This included two stakeholder events and focus groups with key target groups (MSM, BME communities and young people). The work endorsed the model.

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	Additional consultation 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)
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)?*	Additional consultation is now being undertaken with service users and residents to involve them in proposed changes to all public health services, including sexual health. This include: • Presenting proposals at all GP Locality Network meetings and all Local Care Network meetings In addition Guy's and St Thomas' will undertake their own extensive patient involvement

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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.	exercise
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.
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

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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).

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Agenda Item 5

Item No.	Classification: Open	Date: 25 July 2016	Meeting Name: Healthy Communities scrutiny committee
Report title:		Cover report on the London Assembly Health Committee's recent work on *'HIV: how late diagnosis hampers prevention'*	
Ward(s) or groups affected:		All	
From:		Julie Timbrell – scrutiny project manager	

RECOMMENDATION

1. That the committee and roundtable participants note the HIV scoping document produced by the London Assembly Health Committee to assist their recent short inquiry into how late diagnosis of HIV hampers prevention , and the resulting inquiry's recommendations, contained in a letter to the Mayor. Both documents are enclosed.

BACKGROUND INFORMATION

2. The London Assembly Health Committee conducted a short inquiry into the 37 per cent of HIV cases in London that are diagnosed late in order to establish why this is the case and the impact on Londoners.

3. The percentage of cases diagnosed late varies from borough to borough, with Islington, the highest performing borough and Croydon the lowest. Southwark has 38% of cases diagnosed late.

4. Late diagnosis disproportionately affects older adults, heterosexuals and black African people. And if people don't find out their HIV status, the risk of unknowingly infecting others increases. The inquiry looked at the barriers that prevent people taking HIV tests and being diagnosed and what can be done to prevent infection in the first place.

5. The London Assembly Health Committee looked at the current landscape of HIV in London and reviewed HIV prevention services and strategies. A meeting on 15 June also addressed HIV awareness, stigma and the future challenges for London. The following experts were questioned :

   • Julie Billett, Public Health Lead on HIV Prevention, The Association of Directors of Public Health (UK)
   • Ian Green, Chief Executive, Terrence Higgins Trust
   • Monty Moncrieff, Chief Executive, London Friend
   • Parminder Sekhon, Executive Director of Programmes, NAZ Foundation

6. Following the meeting on 20th July a letter was sent to the Mayor.

Appendix 1

Health Committee meeting

HIV prevention in London

Introduction

London has high rates of sexual transmitted infections. These present a significant public health risk for London. In particular, the number of people living with HIV continues to increase, and the number living with undiagnosed HIV remains high. The Mayor has made HIV prevention one of his key health priorities. The committee has therefore decided to use its June meeting to examine HIV prevention in London, to determine how the Mayor can support better sexual health across the capital.

HIV in London

Approximately 35,000 people are accessing HIV treatment in London – 40 per cent of the total UK figure. There were over 2,600 new cases diagnosed in London in 2014 of which around 60 per cent were diagnosed in men who had sex with men (MSM). Approximately 30 per cent of new diagnoses occurred through heterosexual sexual transmission.[1] Around 50 per cent of new diagnoses occurred in white people. Black African people make up approximately 22 per cent of new diagnoses. Specific high risk groups in London include sex workers, homeless people, and the prison population. Intravenous drug users are also at higher risk, although this group makes up less than 3 per cent of the London caseload.

Diagnosis

More than one in ten of people living with HIV in London are thought to be unaware of their HIV status. The lack of prompt diagnosis not only affects the health of the individual, but also increases the risk of further onward transmission. Late diagnosis remains a significant problem, particularly among heterosexual people living with HIV. In 2014, 37 per cent of people diagnosed with HIV in London were diagnosed late.[2] Nationally, late diagnosis is twice as likely in heterosexual men as it is in MSM. It is not clear to what extent this is replicated in London. Public Health England has called for expanded and scaled up testing to reduce undiagnosed infection and late diagnosis.

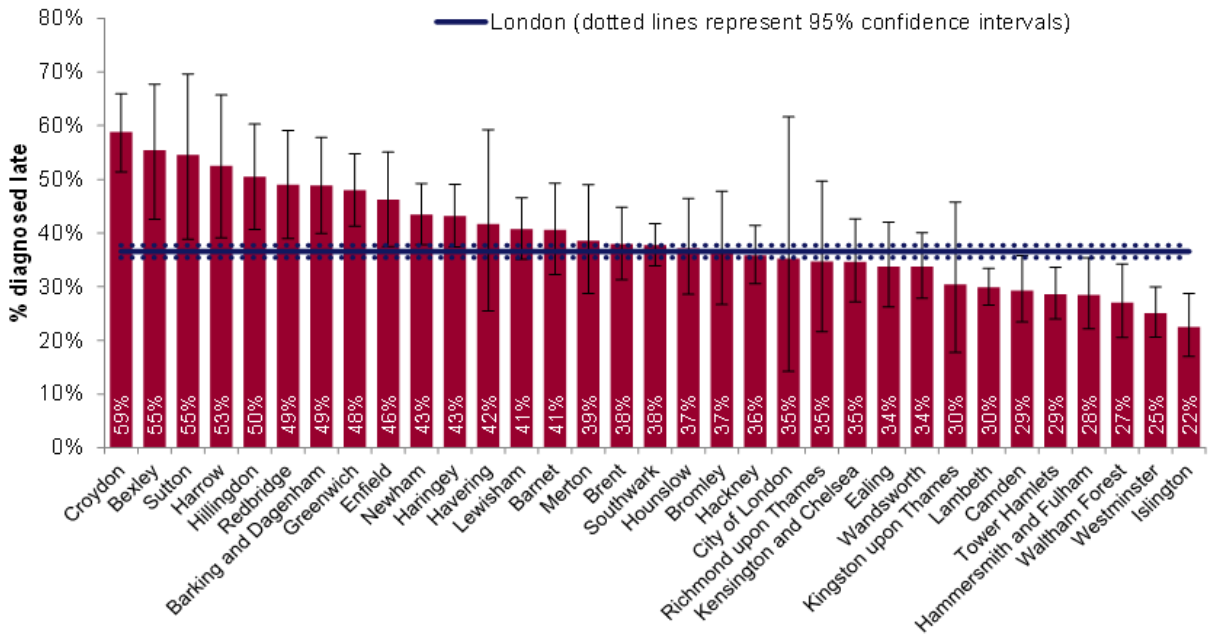
The reasons for late diagnosis are complex. Possible reasons for late diagnosis may include any or all of the following:

- Stigma relating to HIV and wider sexual health issues causing reluctance to get tested
- Lack of access to appropriate diagnostic facilities
- Lack of awareness of risk
- Disconnection between HIV testing and wider sexual/public health services
- Wider determinants of poor sexual health, including deprivation and alcohol/drug dependence

[1] The remaining 10 per cent is split between people who inject drugs (1-2%), and cases where transmission route is undetermined.

[2] Annual epidemiological spotlight on HIV in London: 2014 data (Public Health England)

The percentage of cases diagnosed late varies significantly across London



Source: Annual epidemiological spotlight on HIV in London: 2014 data (Public Health England)

Public awareness of sexual health issues

Poor understanding of HIV transmission routes can mean increased risk that people acquire HIV whether through unsafe sex or unsafe injecting practices. Poor knowledge of HIV can also feed into prejudice and stigma. Along with increasing the burden on people living with HIV, stigmatisation hampers public health efforts, by making people unwilling to get tested, or talk to their partners about sexual health risk.

It is not clear how successful previous efforts to educate Londoners about sexual health, including HIV, have been. The National Aids Trust (NAT) has conducted public surveys on knowledge and attitudes to HIV since 2000. The surveys appear to indicate that knowledge and understanding of HIV transmission is declining. For example, in 2000, 91 per cent of respondents knew that sex without a condom between a man and woman could result in HIV being transmitted. By 2010 this had fallen to 80 per cent. The most recent survey (2014) has also identified that Londoners tend to show lower levels of awareness and understanding of HIV, and lower levels of support for people living with HIV, than people in other parts of the country.[3] NAT has suggested that this may be in part due to the fact that London's younger population have grown up without the high profile public health campaigns about sexual behaviour and HIV risk that were developed when HIV/AIDS first emerged.

[3] http://www.nat.org.uk/media/Files/PDF%20documents/Mori_2014_report_FINAL.pdf

HIV testing
Effective testing, especially of at risk groups, is a key component of prevention strategy. Nationally, PHE evidence has found that HIV testing coverage is generally better for MSM than for other groups. Heterosexual women notably have significantly lower take up of testing services than heterosexual men (62 per cent vs 77 per cent).[4]

HIV test coverage measures the percentage of eligible new STI clinic attendees who had an HIV test. The British Association for Sexual Health and HIV recommends at least 80 per cent coverage for HIV tests offered to people attending GUM clinics. London's testing coverage is variable, depending on both geographical location and sexual preference. PHE figures show that London GUM clinics are achieving higher testing coverage for MSM than they are for heterosexual people.[5] There is also considerable variation in testing coverage across CCG footprints: Hillingdon has the highest coverage (85 per cent) and Bexley the lowest (67 per cent).[6]

PHE has called for expanded testing outside of STI services to increase accessibility amongst populations who do not regularly present to STI clinics.

Commissioning HIV services in London
From 1 April 2013 a range of public health responsibilities, including the commissioning of HIV prevention services, transferred from the NHS to local authorities. A Pan-London HIV Prevention Programme had been jointly commissioned by the London Primary Care Trusts, but was due to come to an end in March 2013.

London Councils commissioned a needs assessment to consider the case for future pan-London commissioning. In light of this work it agreed to commission a three-year £3.4 million London HIV Prevention Programme to deliver a limited number of key HIV prevention services. The services are aimed at MSM and black African communities (the groups at highest risk of contracting HIV) and include media campaigns, condom distribution and some outreach work. There is no guarantee this will continue beyond 2017 and boroughs remain responsible for any additional HIV prevention commissioning required to meet the needs of their communities.

The role of the Mayor

The new Mayor's election manifesto included a pledge to 'renew focus on prevention of and screening for HIV, working with boroughs on collective commissioning and provision of prevention services and ensuring that effective information on HIV reaches the right audiences.' HIV prevention services are the only aspect of public health that London boroughs currently commission collectively. It would therefore be of interest to determine the extent to which these arrangements are working effectively, and how the Mayor,

[4] HIV in the UK- situation report 2015 (Public Health England)
[5] Ibid.
[6] Public Health England
http://fingertips.phe.org.uk/profile/sexualhealth/data#page/3/gid/8000057/pat/6/par/E12000007/ati/102/are/E09000002/iid/91525/age/1/sex/4

through the London Health Board and other channels, could offer practical support to efforts to improve HIV prevention. This could potentially inform future work on other sexual and wider public health services.

The Mayor has a statutory duty to produce a strategy to promote the reduction of health inequalities among Londoners. HIV is linked to health inequality in a number of ways: there are established statistical links between income and educational levels and HIV prevalence, and certain communities are disproportionally affected by HIV: notably men who have sex with men (MSM) and people from some black African communities. There is also evidence of variation in access to appropriate diagnostic and support services across London.

HIV was a priority topic for the previous Mayor's health team. Health team work in this area mainly supported national and international health promotion events, building on existing campaign materials and media coverage. The previous Mayor also appointed Annie Lennox as a mayoral ambassador on HIV, to promote awareness. There may be further opportunities in the future for the current Mayor to expand upon this work

Suggested approach

The committee will hold one meeting on this topic in June. The purpose of the meeting is to establish the current landscape for HIV in London, and to assess whether the current and planned activity to improve prevention and screening uptake is adequate. The committee could also explore the policy levers available to the Mayor to fulfil his manifesto commitment; in particular, ensuring that consistent and effective information on sexual health is reaching all of the right audiences.

Key questions

The committee would seek to address the following key questions:

- What are the current trends in HIV in London and who is most at risk of infection?
- What are the key challenges for HIV prevention?
- What needs to be done to raise public awareness about HIV and reduce stigma?
- How is London's response to HIV being co-ordinated?
- What are the key challenges facing HIV/sexual health services in London?
- How can the Mayor support HIV prevention efforts?

Possible guests

- Paul Steinberg, Programme Lead, London HIV Prevention Programme (can attend)
- Julie Billett, HIV Prevention Lead, Association of Directors of Public Health (can attend)
- Terence Higgins Trust (delivers HIV programme contracts and frontline support)
- Representatives from third sector organisations e.g. NAZ Foundation and London Friend, working with at-risk communities on engagement

Output

The committee will write to the Mayor setting out its key findings and possible areas for mayoral action in the forthcoming term.

LONDONASSEMBLY
Dr Onkar Sahota AM, Chair of the Health Committee

London Assembly
City Hall
The Queen's Walk
London, SE1 2AA

Sadiq Khan
Mayor of London
(Sent via email to mayor@london.gov.uk)

20 July 2016

Dear Sadiq

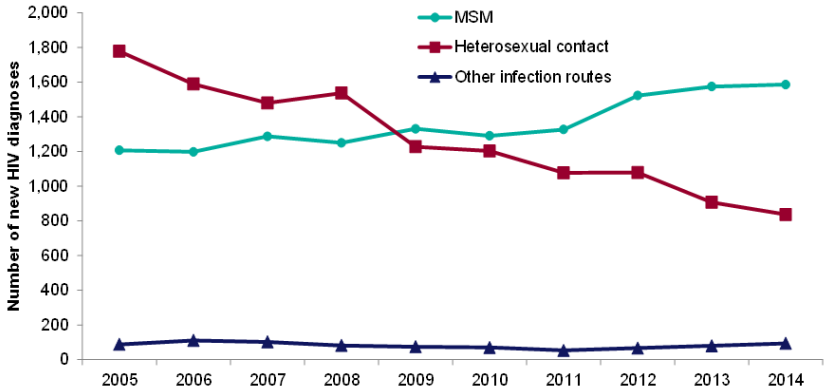
HIV prevention in London

The London Assembly Health Committee has recently held a public meeting into HIV prevention in London. We are writing to draw your attention to a number of specific issues relating to the challenges for HIV prevention in London. The committee welcomes your commitment to championing HIV prevention in London, and we hope our findings will be of use as you develop plans to fulfil your manifesto pledges in this important area.

HIV remains an important public health issue for the capital. London has high rates of HIV compared to the rest of the UK, with over 2,500 new diagnoses last year. There are around 41,000 people living with diagnosed and undiagnosed HIV in London. With advances in HIV treatment and improved life expectancy for people with HIV this figure will continue to rise, with significant implications for both treatment costs and the risk of onward transmission. This is why it is vital that London adopts and maintains a proactive, city-wide approach to HIV prevention and management.

HIV disproportionately affects particular groups within London's communities, notably men who have sex with men (MSM) and people from black African communities. We were concerned to learn that the number of cases among MSM is continuing to rise, despite ongoing efforts to target health interventions for this group. We would also particularly like to draw your attention to the needs of other demographic groups, including trans women, where there is high prevalence.

Figure 4: New HIV diagnoses by probable exposure category (adjusted for missing information), London residents, 2005-2014



Source: Public Health England

Raising awareness is key

The most recent survey by the National Aids Trust shows that Londoners tend to show lower levels of awareness and understanding of HIV, and lower levels of support for people living with HIV, than elsewhere in the country. Lack of awareness increases transmission risk, but also contributes directly to continued stigmatisation of people living with HIV, and prevents people from finding out their HIV status.

More than one in ten of people living with HIV in London are thought to be unaware of their HIV status. The lack of prompt diagnosis not only affects the health of the individual, but also increases the risk of further onward transmission. In 2014, 37 per cent of people diagnosed with HIV in London were diagnosed late. And, across England, late diagnosis is twice as likely in heterosexual men as it is in MSM.

There is a clear public health imperative to get as many people tested as possible. To achieve this, it is vital that more is done to normalise HIV testing as part of routine health checks and we strongly urge you to put City Hall at the heart of efforts to realise this. As HIV campaigners and public health specialists told us, you – as Mayor – have a unique opportunity to reach out to diverse communities and reduce stigma around HIV.

Home testing

We were encouraged to hear that the Terrence Higgins Trust (THT) is beginning a pilot to offer free home testing to 4,500 people at high risk of HIV. Home testing provides a reliable and convenient way for people who are unable or unwilling to access testing through their GP or a sexual health clinic to find out their HIV status. We urge you to monitor this pilot closely and to liaise with THT to determine how home testing could be promoted and provided for more people across London.

We need both local and pan-London prevention efforts

We call on you to work with the boroughs to secure the long-term future of the pan-London HIV prevention programme (LHPP). As it stands, the programme is due to end in March 2017 and we understand that the boroughs are now beginning discussions on the future of this work. We believe it is vital that a co-ordinated pan-London approach to HIV prevention is retained, for a number of reasons:

1) London's local authorities are already experiencing intense funding pressures, and there is little evidence to suggest that the situation will improve in coming years. There are already indications that HIV support services are being eroded due to financial pressures. The proposed removal of the local authority public health budget ring fence in 2018 may lead to further downgrading of sexual health services across London as councils seek to make additional savings. This would clearly be a backward step for HIV prevention in London.

2) The programme represents one of the very few examples of how joint public health commissioning works across London. To lose this programme would therefore represent not only a loss of effective services but also a valuable and hard-fought mechanism for co-operation and collaboration between local authority public health teams. We believe that as Mayor, you should be championing programmes and initiatives which encourage and enable greater joined-up working across borough boundaries.

3) London's population is highly diverse and highly mobile. The way in which people are choosing to engage with health services is changing to reflect this – for example, people may need to access services near where they work, rather than where they live. A strategic pan-London approach can help ensure that high quality services remain available across the city to all those who need them, and that service provision reflects the reality of how people live their lives.

It is clear that there is no one size fits all approach to improving HIV prevention in London. There are differing needs within and between the communities most affected by HIV. A pan-London approach should complement, rather than replace, a local approach which is based on the best available needs assessments at borough level. But services working with MSM in particular have highlighted the changing nature of how and where the LGBT community congregates. Understanding the specific needs of this community – and sub-communities within it – will therefore help local authorities to commission the most appropriate services.

Chemsex

We heard that patterns of sexual behaviour among some MSM were changing due to the rise of chemsex. Drug and alcohol support services are now reporting seeing higher levels of people using specific chemsex related drugs which are contributing to increasingly risky behaviour. This includes unprotected sex with multiple partners and injecting drug use (which in itself also increases the risk of HIV transmission). Lambeth, Southwark and Lewisham have collaborated on a study to understand chemsex in their local areas and the implications for sexual health in their populations. But it is not clear to what extent sexual health services across London are geared up to deal with this emerging issue for MSM. We hope that, in championing HIV prevention in London, you will make use of this important study and encourage other local authorities to review changing patterns of behaviour within communities so that they can tailor services appropriately.

We should educate and empower people to make informed choices about their own sexual health

The best HIV prevention services are those that do not focus just on HIV. The choices that people make and the behaviours they engage in are often linked to other issues, such as mental health and wellbeing, or drug and alcohol dependency. It is important that services take a holistic, non-judgemental and person-centred approach to sexual health. Fear and stigma will continue to act as barriers to people engaging with HIV prevention activity if they do not receive tailored, culturally appropriate and accessible information about their choices, and the consequences of their choices. We believe that you, as Mayor, can provide real leadership in this area by encouraging informed conversations about HIV and sexual health. We therefore urge you to look at ways in which HIV education and prevention activity can be incorporated into your wider health and community engagement work, through existing mayoral programmes such as Healthy London Schools and the London Workplace Charter, and through the work of the London Health Board.

We remain concerned that, without a clear focus on this issue from the Mayor, sexual health services will become increasingly marginalised by commissioners. Investing in HIV prevention will bring clear benefits in terms of reducing treatment costs to the NHS as well as improving the health of Londoners. We therefore look forward to hearing more about your plans to champion HIV prevention and to working with you on this important issue.

In particular, we encourage you to:

• Publicly endorse the London HIV Prevention Programme's Do it London campaign.
• Work with the campaign to augment messaging that particularly targets heterosexual people to encourage them to get tested.
• Hold an annual sexual health testing event at City Hall to ensure that this issue remains in the public eye.
• Work with TfL, Public Health England and HIV charities to maximise the use of the transport network to encourage testing uptake and promote positive messages around HIV prevention.
• Consider appointing one or more community HIV and sexual health ambassadors to support greater community engagement on this issue.

We would be grateful to receive a response to the points raised by 1 September. Please copy this to Lucy Brant, Scrutiny Manager, via lucy.brant@london.gov.uk

Yours sincerely

Dr Onkar Sahota AM
Chair of the Health Committee

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HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE
MUNICIPAL YEAR 2015-16

AGENDA DISTRIBUTION LIST (OPEN)

NOTE: Original held by Scrutiny Team; all amendments/queries to Julie Timbrell Tel: 020 7525 0514

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