Equality Impact Assessment (EqIA) Template

In order to carry out this assessment, it is important that you have completed the EqIA E-learning Module and read the Corporate Guidelines on EqIAs. Please refer to these to assist you in completing this assessment.
It will also help you to look at the EqIA Template with Guidance Notes to assist you in completing the EqIA.

Type of Project / Proposal:		**Tick ✓**	**Type of Decision:**		**Tick ✓**
Transformation		✓	Cabinet		✓
Capital			Portfolio Holder		✓
Service Plan			Corporate Strategic Board		✓
Other	New strategic recommendations	✓	Other	Health and Well Being Board	✓

Title of Project:	Sexual Health Strategy 2015-2020 - London Borough of Harrow
Directorate / Service responsible:	Public Health, Community and Wellbeing Directorate
Name and job title of lead officer:	Carol Yarde – Head of Transformation and the Business Support Service
Name & contact details of the other persons involved in the assessment:	Wazi Khan – Senior Health Improvement Specialist, Barnet and Harrow Public Health Service Jeffrey Lake – Consultant in Public Health, Barnet and Harrow Public Health Service Audrey Salmon – Head of Public Health Commissioning, Barnet and Harrow Public Health Service
Date of assessment:	16 October 2014

Stage 1: Overview

1. What are you trying to do? (Explain proposals e.g. introduction of a new service or policy, policy review, changing criteria, reduction / removal of service, restructure, deletion of posts etc)	The new sexual health strategy sets out our future direction to provide an accessible, modern, coherent, cost effective and integrated sexual health and reproductive services to our residents at primary care, secondary care and community level. It does not make recommendations on cutting the existing services and advises on expansion of these services in primary care and community settings with more targeted approach for the key priority groups.

<table>
<tr>
<td></td>
<td colspan="6">The new strategy makes following recommendations;
• Participate in collaborative commissioning of Genitourinary Medicine (GUM) services. It is anticipated that a collaborative commissioning of GUM services will offer the best opportunity to deliver effective contract management, value for money, robust clinical risk management and data collection analysis dissemination and distribution.
• Expand the provision of sexual health and reproductive services in primary care and community settings, especially in hotspot and deprived areas of the borough to facilitate the shift from hospital based services.
• Increase the uptake of screenings for HIV and Chlamydia among high risk groups.
• Launch a robust awareness and signposting campaign targeting key priority groups in Harrow i.e. young people, black and minority ethnic (BME) communities, heterosexual females and men who have sex with men (MSM).
• Map and review current sexual health services and contracts in Harrow to obtain information on user preference in relation to sexual health and family planning services by age, ethnicity, disability and sexual orientation and identify any gaps in the current services.

The recommendations support the delivery of a robust sexual health, family planning services that are better targeted at high risk population while providing value for money for the council.

NB: As this an early stage, any further impact of the recommendations would be also revisited at the implementation stage.</td>
</tr>
<tr>
<td rowspan="3">2. Who are the main people / Protected Characteristics that may be affected by your proposals? (✓ all that apply)</td>
<td>Residents / Service Users</td><td>✓</td>
<td>Partners</td><td>✓</td>
<td>Stakeholders</td><td></td>
</tr>
<tr>
<td>Staff</td><td></td>
<td>Age</td><td>✓</td>
<td>Disability</td><td>✓</td>
</tr>
<tr>
<td>Gender Reassignment</td><td>✓</td>
<td>Marriage and Civil Partnership</td><td>✓</td>
<td>Pregnancy and Maternity</td><td>✓</td>
</tr>
</table>

	Race	✓	Religion or Belief		Sex	✓
	Sexual Orientation	✓	Other			
3. Is the responsibility shared with another directorate, authority or organisation? If so: • Who are the partners? • Who has the overall responsibility? • How have they been involved in the assessment?	The key partners are London North West Hospitals Trust (in delivering genitourinary medicine (GUM) and family planning services), clinical commissioning groups (CCGs), NHS England, local pharmacy services and Women and Children's services. Barnet and Harrow joint public health team is responsibility for commissioning and monitoring of sexual health and reproductive health services. Public health is not responsible for some elements of the services that are commissioned by partner organisations (for details of responsibilities by the organisation please see appendix 1).					

Stage 2: Evidence / Data Collation

4. What evidence / data have you reviewed to assess the potential impact of your proposals? Include the actual data, statistics reviewed in the section below. This can include census data, borough profile, profile of service users, workforce profiles, results from consultations and the involvement tracker, customer satisfaction surveys, focus groups, research interviews, staff surveys; complaints etc. Where possible include data on the nine Protected Characteristics.

(Where you have gaps (data is not available/being collated), you may need to include this as an action to address in your Improvement Action Plan at Stage 7)

Age (including carers of young/older people)	Like many other parts of the UK, sexually active young population (15-24 years old) are one of the key priority groups in Harrow. • In Harrow, 44% of diagnoses of acute sexually transmitted infections (STIs) in 2012 were in young people aged 15-24 years. The rates were higher among young females compared to young males. • Young people are also more likely to become reinfected with STIs. In Harrow, an estimated 16.2% of 15-19 year old women and 8.9% of 15-19 year old men presenting with an acute STI at a GUM clinic during the four year period from 2009 to 2012 became reinfected with an STI within twelve months.

	• Chlamydia is one of the most common STI with a considerably higher disease rates in young sexually active adults (15 – 24 years old). The uptake of chlamydia screening among young people in Harrow is considerably low. In Harrow, a total of 3720 chlamydia tests were carried out among 15-24 years old in 2012. Majority of these tests (74% n=2745) were carried out in **GUM clinics** and the remaining (26% n=975) were carried out in other settings. Of those outside the GUM services, only 24% (n=232) were tested in GP surgeries. This indicates an over reliance on acute hospital services and lack of services in the primary care and community settings. • There is lack of provision and marketing of services that provide free condoms to young people e.g. C-Card schemes in Harrow. The strategy recommends; 1) An expansion of services in the primary care and community settings to provide better access for all and especially for young people. 2) An increase in the number of young people friendly sexual health services, especially at GP practices and pharmacies with 'You're Welcome' accreditation. 3) An awareness and signposting campaign especially targeting young people and those who would not normally consider themselves to be at risk of STIs, but are sexually active. We anticipate the strategic recommendations to have a positive impact on the needs of individuals in all age groups including young people. 1) Public Health England - Sexually transmitted infections by age profile – Harrow Local Authority sexually transmitted infections and HIV epidemiology report (LASER): 2012 2) Public Health England - Sexually Transmitted Infections Annual Data - STI diagnoses & rates by local area, 2009 – 2013 https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables 3) Harrow Sexual and Reproductive Health Profile http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000035/pat/6/ati/102/page/4/par/E12000007/are/E09000003
Disability (including carers of disabled people)	At present, there is a lack of data on the sexual health and reproductive health needs of the people with disabilities. The strategy recommends;

	1) A review of the current services to identify any gaps in service provision especially around the needs of individuals with disabilities. 2) Expansion of services in the primary care and community settings to enable better access by all users including minority groups. We anticipate the strategic recommendations to have a positive impact on the needs of individuals with disabilities.
Gender Reassignment	At present, there is a lack of data on the sexual health and reproductive health needs of the people with gender reassignment. The strategy recommends; 1) A review of the current services to identify any gaps in service provision especially around the needs of individuals. 2) Expansion of services in the primary care and community settings to enable better access by all users including minority groups. We anticipate the strategic recommendations to have a positive impact on the needs of individuals from minority groups.
Marriage / Civil Partnership	At present, there is a lack of specific data on the sexual health and reproductive health needs of individuals in marriage or civil partnership. We anticipate the strategic recommendations to have a positive impact on the needs of individuals from minority groups.
Pregnancy and Maternity	At present, there is a lack of specific data on the sexual health needs of women during pregnancy and maternity time. • In general the numbers of teenage pregnancies in Harrow have been declining in the recent years and are one of the lowest in North West London sector, however, the total number of abortions in Harrow in 2012 was 1,234 at a rate of 24.1 per 1000 females which is higher compared to abortion rates for London 22.4 and England 16.6. • The rate of long acting reversible contraception (LARC) prescribed by GP's in 2012/13 was 17.3 per 1000 females which was lower compared to London 23.2 and England 49.

	The strategy recommends to; 1) Maintain the existing family planning services, especially the out of hour clinics, and provide young people clinics in the evenings. 2) Expand the current primary care contract to include implant component of the long acting reversible contraceptive (LARC) and to enrole more GP surgeries and pharmacies for emergency contraception especially those based in deprived areas of the borough. 3) A review of the current services to identify any gaps in service provision including family planning services. We anticipate the strategic recommendations to have a positive impact on the needs of all individuals in Harrow. 1) Harrow Sexual and Reproductive Health Profile http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000035/pat/6/ati/102/page/4/par/E12000007/are/E09000003
Race	Individuals from black or black African backgrounds are one of the key priority groups in Harrow. • An estimated 8% of Harrow population is from black or black ethnic background, but just below half of all HIV cases (45%) in 2011 were in individuals from black African background. • Based on proportion of acute sexually transmitted infections (STIs) by ethnicity, the highest proportion of acute STIs in 2012 were seen among individuals from white ethnic background (46.8%), followed by black and black British (29.8%) and Asian or Asian British (16.6%) ethnic groups. • However, in terms of rate per 100,000 population, the highest rates of STIs in Harrow in 2012 were among individuals from black ethnic background (2248) followed by white (688) and Asian (243). In comparison, the rates of STIs in England in the same order of ethnic groups were 1833, 532 and 288 respectively. This indicates that based on population size, the individuals from black ethnic background are disproportionately affected by acute STIs. The strategy recommends; 1) A review of the current services to identify specific needs of the minority groups. 2) Uptake of screenings for HIV and sexually transmitted infections among high risk groups by raising awareness and signposting individuals to locally available services.

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	3) Expansion of services in the primary care and community settings to enable better access by all users including minority groups. We anticipate the strategic recommendations to have a positive impact on the needs of individuals from minority groups. 1) Public Health England - Sexually transmitted infections by age profile – Harrow Local Authority sexually transmitted infections and HIV epidemiology report (LASER): 2012 2) Harrow Sexual and Reproductive Health Profile http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000035/pat/6/ati/102/page/4/par/E12000007/are/E09000003 3) Harrow Joint Strategic Needs Assessment report 2012-2016
Religion and Belief	At present, there is a lack of data on the sexual health and reproductive health needs of the people from different religions and believes. The strategy recommends; 1) A review of the current services to identify specific needs of the minority groups. 2) Expansion of services in the primary care and community settings to enable better access by all users including minority groups. We anticipate the strategic recommendations to have a positive impact on the needs of all individuals in Harrow.
Sex / Gender	Heterosexual females are one of the key priority groups for STIs in Harrow. 1) The rates of acute STIs in 2012 were higher among young females compared to young males. 2) Similarly, the rates of reinfection with an STI were also higher among women. In 2012, 13.6% of women and 12.9% of men presenting with an acute STI at a GUM clinic during the four year period from 2009 to 2012 became reinfected with an acute STI within twelve months. Nationally, during the same period of time, an estimated 9.6% of women and 12% of men presenting with an acute STI at a GUM clinic became reinfected with an acute STI within twelve

	months. 3) Heterosexual exposure is the main source of HIV infection in Harrow (75%) with more HIV cases seen in heterosexual females compared to heterosexual males. 4) In terms of reproductive health, Harrow has the lowest rate of teenage conception in North West London sector. In 2012, under 18 conception rate in Harrow was 14.7 per 1000 girls compared with 25.9 for London and 27.7 for England. However, the total number of abortions in Harrow was 1,234 at a rate of 24.1 per 1000 females which is higher compared to abortion rates for London 22.4 and England 16.6. The strategy recommends an; 1) Expansion of sexual health and reproductive services in primary care and community settings to provide better access. 2) Increased screening for sexually transmitted infections (especially HIV) in family planning services on an opt-out basis. 3) Awareness and signposting campaign to provide reliable and consistent information about all available family planning and contraceptive services in the borough. 4) Broader participation in "C-Card" and "Freedom" condom distribution schemes. We anticipate the strategic recommendations to have a positive impact on the needs of all individuals in Harrow. 5) Public Health England - Sexually transmitted infections by age profile – Harrow Local Authority sexually transmitted infections and HIV epidemiology report (LASER): 2012 6) Harrow Sexual and Reproductive Health Profile http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000035/pat/6/ati/102/page/4/par/E12000007/are/E09000003 7) Harrow Joint Strategic Needs Assessment report 2012-2016
Sexual Orientation	Men who have sex with men (MSM) are one of the key priority groups in Harrow. • Between 2009 and 2012, 10.7% (n=303) of the acute STIs in Harrow were diagnosed among MSM (based on the cases in men where sexual orientation was recorded). • 20% of the HIV diagnoses in 2011 were seen in MSM population.

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	The strategy recommends; - A review of the current services to identify specific needs of the minority groups. - Expansion of services in the primary care and community settings to enable better access by all users including minority groups. We anticipate the strategic recommendations to have a positive impact on the needs of individuals from minority groups. 1) Public Health England - Sexually transmitted infections by age profile – Harrow Local Authority sexually transmitted infections and HIV epidemiology report (LASER): 2012 2) Harrow Sexual and Reproductive Health Profile http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000035/pat/6/ati/102/page/4/par/E12000007/are/E09000003
Socio Economic	There is considerable geographic variation in the distribution of sexually transmitted infections (STIs) in Harrow. In 2012, the highest rates of STIs were seen in 1st and 2nd most deprived areas of Harrow indicating a positive correlation between STIs and socio-economic deprivation. The strategy recommends; - An expand the provision of services in the primary care settings especially in relation to screening of all basic sexual health infections by involving more GP surgeries from high incident and deprived areas of the borough. We anticipate the strategic recommendations to have a positive impact on the needs of individuals in all parts of Harrow. 1) Public Health England - Sexually transmitted infections by age profile – Harrow Local Authority sexually transmitted infections and HIV epidemiology report (LASER): 2012

5. What consultation have you undertaken on your proposals?

Who was consulted?	What consultation methods were used?	What do the results show about the impact on different groups / Protected Characteristics?	What actions have you taken to address the findings of the consultation? (This may include further consultation with the affected groups, revising

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			your proposals).
Harrow Heath Watch Team	Awaiting response from them	Awaiting response from them	Awaiting response from them
Clinical Commissioning Groups (CGs)	Awaiting response from them	Awaiting response from them	Awaiting response from them
A broader consultation would be considered at the implementation stage and further updates will be made as appropriate.			

6. What other (local, regional, national research, reports, media) data sources that you have used to inform this assessment? List the Title of reports / documents and websites here.	

Stage 3: Assessing Potential Disproportionate Impact

7. Based on the evidence you have considered so far, is there a risk that your proposals could potentially have a disproportionate adverse impact on any of the Protected Characteristics?

	Age (including carers)	Disability (including carers)	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
Yes									
No	✓	✓	✓	✓	✓	✓	✓	✓	✓

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YES - If there is a risk of disproportionate adverse Impact on any **ONE** of the Protected Characteristics, continue with the rest of the template.

- **Best Practice:** You may want to consider setting up a Working Group (including colleagues, partners, stakeholders, voluntary community sector organisations, service users and Unions) to develop the rest of the EqIA
- It will be useful to also collate further evidence (additional data, consultation with the relevant communities, stakeholder groups and service users directly affected by your proposals) to further assess the potential disproportionate impact identified and how this can be mitigated.

NO - If you have ticked 'No' to all of the above, then go to **Stage 6**

- Although the assessment may not have identified potential disproportionate impact, you may have identified actions which can be taken to advance equality of opportunity to make your proposals more inclusive. These actions should form your Improvement Action Plan at Stage 7

Stage 4: Collating Additional data / Evidence

8. What additional data / evidence have you considered in relation to your proposals as a result of the analysis at Stage 3? (include this evidence, including any data, statistics, titles of documents and website links here)	

9. What further consultation have you undertaken on your proposals as a result of your analysis at Stage 3?

Who was consulted?	What consultation methods were used?	What do the results show about the impact on different groups / Protected Characteristics?	What actions have you taken to address the findings of the consultation? (This may include further consultation with the affected groups, revising your proposals).

Stage 5: Assessing Impact and Analysis

10. What does your evidence tell you about the impact on different groups? Consider whether the evidence shows potential for differential impact, if so state whether this is an adverse or positive impact? How likely is this to happen? How you will mitigate/remove any adverse impact?

Protected Characteristic	Adverse ✓	Positive ✓	Explain what this impact is, how likely it is to happen and the extent of impact if it was to occur. Note – Positive impact can also be used to demonstrate how your proposals meet the aims of the PSED Stage 9	What measures can you take to mitigate the impact or advance equality of opportunity? E.g. further consultation, research, implement equality monitoring etc (Also Include these in the Improvement Action Plan at Stage 7)
Age (including carers of young/older people)				
Disability (including carers of disabled people)				
Gender Reassignment				
Marriage and				

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Civil Partnership				
Pregnancy and Maternity				
Race				
Religion or Belief				
Sex				
Sexual orientation				

11. Cumulative Impact – Considering what else is happening within the Council and Harrow as a whole, could your proposals have a cumulative impact on a particular Protected Characteristic? If yes, which Protected Characteristics could be affected and what is the potential impact?	Yes		No	
11a. Any Other Impact – Considering what else is happening within the Council and Harrow as a whole (for example national/local policy, austerity, welfare reform, unemployment levels, community tensions, levels of crime)	Yes		No	

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could your proposals have an impact on individuals/service users socio economic, health or an impact on community cohesion? If yes, what is the potential impact and how likely is to happen?	

12. Is there any evidence or concern that the potential adverse impact identified may result in a Protected Characteristic being disadvantaged? (Please refer to the Corporate Guidelines for guidance on the definitions of discrimination, harassment and victimisation and other prohibited conduct under the Equality Act) available on Harrow HUB/Equalities and Diversity/Policies and Legislation

	Age (including carers)	Disability (including carers)	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
Yes									
No									

If you have answered "yes" to any of the above, set out what justification there may be for this in Q12a below - link this to the aims of the proposal and whether the disadvantage is proportionate to the need to meet these aims. (You are encouraged to seek legal advice, if you are concerned that the proposal may breach the equality legislation or you are unsure whether there is objective justification for the proposal)

If the analysis shows the potential for serious adverse impact or disadvantage (or potential discrimination) but you have identified a potential justification for this, this information must be presented to the decision maker for a final decision to be made on whether the disadvantage is proportionate to achieve the aims of the proposal.

- If there are adverse effects that are not justified and cannot be mitigated, you should not proceed with the proposal. **(select outcome 4)**
- If the analysis shows unlawful conduct under the equalities legislation, you should not proceed with the proposal. **(select outcome 4)**

Stage 6: Decision

13. Please indicate which of the following statements best describes the outcome of your EqIA (✓ tick one box only)

Outcome 1 – No change required: the EqIA has not identified any potential for unlawful conduct or disproportionate impact and all opportunities to advance equality are being addressed.	✓
Outcome 2 – Minor adjustments to remove / mitigate adverse impact or advance equality have been identified by the EqIA. *List the actions you propose to take to address this in the Improvement Action Plan at Stage 7*	
Outcome 3 – Continue with proposals despite having identified potential for adverse impact or missed opportunities to advance equality. In this case, the justification needs to be included in the EqIA and should be in line with the PSED to have 'due regard'. In some cases, compelling reasons will be needed. You should also consider whether there are sufficient plans to reduce the adverse impact and/or plans to monitor the impact. **(Explain this in 13a below)**	

Outcome 4 – Stop and rethink: when there is potential for serious adverse impact or disadvantage to one or more protected groups. (You are encouraged to seek Legal Advice about the potential for unlawful conduct under equalities legislation)	
13a. If your EqIA is assessed as **outcome 3 or you have ticked 'yes' in Q12**, explain your justification with full reasoning to continue with your proposals.	

Stage 7: Improvement Action Plan

14. List below any actions you plan to take as a result of this Impact Assessment. This should include any actions identified throughout the EqIA.

Area of potential adverse impact e.g. Race, Disability	Action required to mitigate	How will you know this is achieved? E.g. Performance Measure / Target	Target Date	Lead Officer	Date Action included in Service / Team Plan
Addressing lack of data	Patient confidentiality is essential to all health care services; and the recording and reporting of sexual health information is subject to strict data protection regulation. We will ensure our providers offer services that are easy to access and are non-discriminatory, so individuals from all population groups can seek advice and care without any hesitation or disadvantage.				

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Stage 8 - Monitoring

The full impact of the proposals may only be known after they have been implemented. It is therefore important to ensure effective monitoring measures are in place to assess the impact.

15. How will you monitor the impact of the proposals once they have been implemented? What monitoring measures need to be introduced to ensure effective monitoring of your proposals? How often will you do this? *(Also Include in Improvement Action Plan at Stage 7)*	Quarterly reports from service providers
16. How will the results of any monitoring be analysed, reported and publicised? *(Also Include in Improvement Action Plan at Stage 7)*	Yearly audit
17. Have you received any complaints or compliments about the proposals being assessed? If so, provide details.	None identified at this stage. An initial consultation is currently underway via Healthwatch team. Relevant feedbacks would be incorporate in the updated EqIAs.

Stage 9: Public Sector Equality Duty

18. How do your proposals contribute towards the Public Sector Equality Duty (PSED) which requires the Council to have due regard to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between different groups.

(Include all the positive actions of your proposals, for example literature will be available in large print, Braille and community languages, flexible working hours for parents/carers, IT equipment will be DDA compliant etc)

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010	Advance equality of opportunity between people from different groups	Foster good relations between people from different groups
Positive contribution in eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010	Positive contribution in advancing equality of opportunities between people from different groups.	Positive contribution towards fostering good relationships between people from different groups.

Stage 10 - Organisational sign Off (to be completed by Chair of Departmental Equalities Task Group)

<table>
<tr><td colspan="4">The completed EqIA needs to be sent to the chair of your Departmental Equalities Task Group (DETG) to be signed off.</td></tr>
<tr><td>19. Which group or committee considered, reviewed and agreed the EqIA and the Improvement Action Plan?</td><td colspan="3"></td></tr>
<tr><td>Signed: (Lead officer completing EqIA)</td><td></td><td>Signed: (Chair of DETG)</td><td></td></tr>
<tr><td>Date:</td><td></td><td>Date:</td><td></td></tr>
<tr><td>Date EqIA presented at the EqIA Quality Assurance Group</td><td></td><td>Signature of ETG Chair</td><td></td></tr>
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Appendix 1 – Sexual health commissioning responsibilities by organisation from April 2013 *(adopted from "A guide to whole system commissioning for sexual health, reproductive health and HIV"- Public Health England 2014)*[1]

Local authorities' commission;
Comprehensive sexual health services which includes:

1. Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts (such as arrangements formerly covered by LESs and NESs)
2. Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local public health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV
3. Sexual health aspects of psychosexual counselling
4. Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacies
5. Social care services (for which funding sits outside the Public Health ringfenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:
   - HIV social care
   - Wider support for teenage parents

Clinical commissioning groups commission;

1- Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for fetal anomaly by specialist fetal medicine services – see "NHS England commissions")
2- Female sterilisation
3- Vasectomy (male sterilisation)
4- Non-sexual health elements of psychosexual health services
5- Contraception primarily for gynaecological (non-contraceptive) purposes
6- HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)

NHS England Commissions;

1- Contraceptive services provided as an "additional service" under the GP contract
2- HIV treatment and care services for adults and children, and cost of all antiretroviral treatment

3- Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of "essential services" under the GP contract (ie not part of public health commissioned services, but relating to the individual's care)
4- HIV testing when clinically indicated in other NHS England-commissioned services
5- All sexual health elements of healthcare in secure and detained settings
6- Sexual assault referral centres
7- Cervical screening in a range of settings
8- HPV immunisation programme
9- Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks
10-NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B

1- Public Health England (2014) Making it work- A guide to whole system commissioning for sexual health, reproductive health and HIV
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351123/Making_it_work_FINAL_full_report.pdf

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