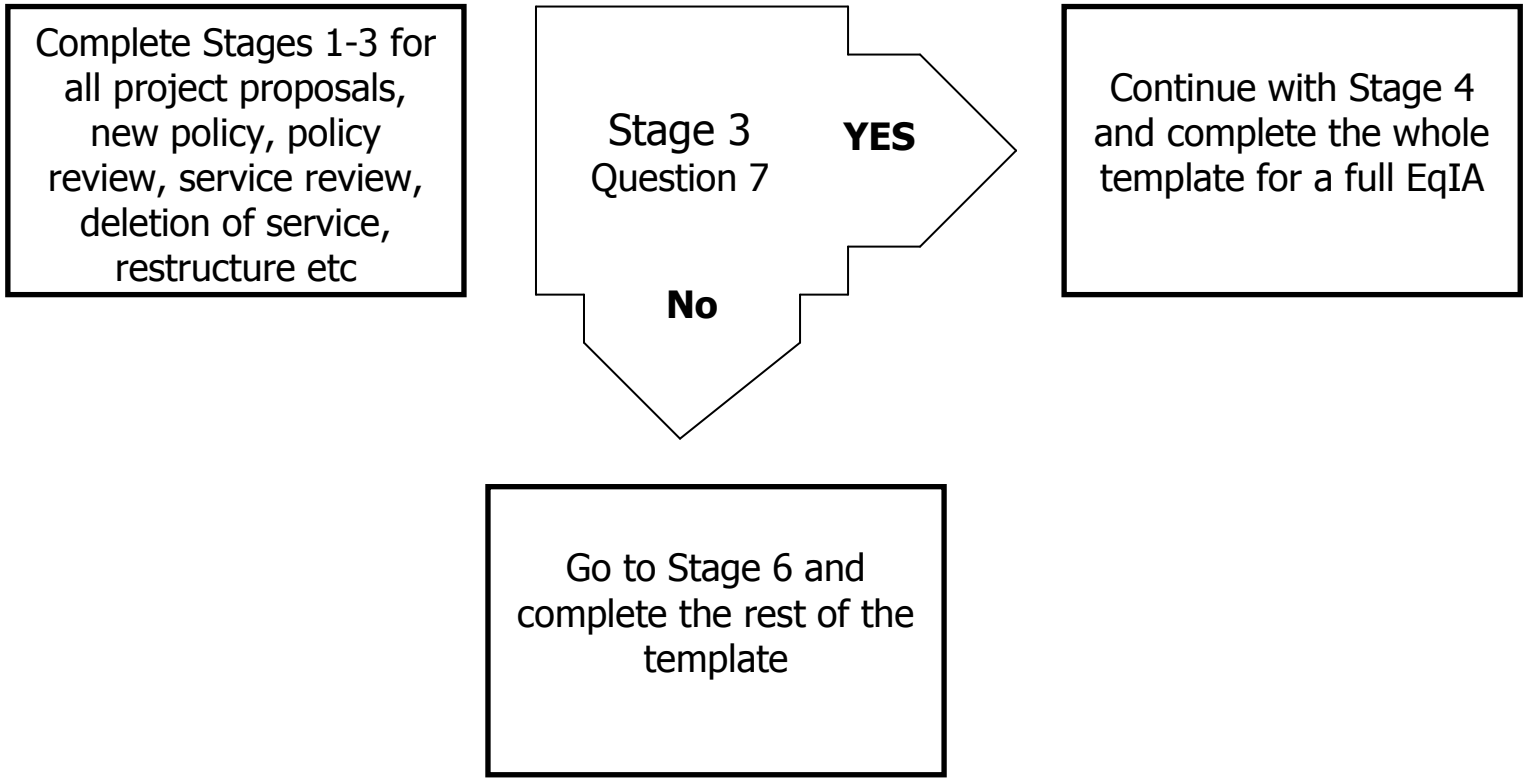
Appendix 3 - Equality Impact Assessment Template

The Council has revised and simplified its Equality Impact Assessment process. There is now just one Template. Project Managers will need to complete **Stages 1-3** to determine whether a full EqIA is required and the need to complete the whole template.



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:	London Sexual Health Transformation
Directorate / Service responsible:	Public Health, People Directorate
Name and job title of lead officer:	Audrey Salmon, Head of Public Health Commissioning
Name & contact details of the other persons involved in the assessment:	
Date of assessment:	26 October 2015

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 proposal is to develop a networked system of Sexual Health services on a Pan London and sub-regional basis.** An integral component of this networked system will be a Pan -London Sexual Health On-Line portal. The front door into services will be through a web-based single platform; providing patients with information about sexual health, on-line triage, signposting to the most appropriate service for their needs and the ability to order self-sampling tests. A single database will be developed with the highest levels of confidentiality and security, enabling greater understanding of the patient flows and with a focus on prevention and specialist services for those most in need.

The Pan-London Online Portal will incorporate the following elements (see figure 1 below for graphic representation):

- Triage and Information ("Front of house");
- Self-Testing;
- Partner Notification; and
- Appointments (Booking system) (dependent on ability to interface with existing clinic systems).

There is an expectation that all major clinics will offer patients the opportunity to triage and self-sample on site, in addition all services will be required to ensure that results are available electronically to patients within 72 hours. Patients who are diagnosed with an STI will be offered an appointment within 48 working hours or will be fast tracked if they present to a walk in service. Improved systems for identifying and notifying contacts of patients with an STI will ensure that resources are targeted at the highest need groups.

Centralisation of partner notification data along with the use of a single patient identifier system / technology to ascertain attendance at clinic of those notified of infection would support the reduction of rates of re-infection and repeat attendance.

The primary aim of this system will be to ensure that high volume, low risk and predominantly asymptomatic activity is controlled and managed where appropriate outside of higher cost clinic environments. By shifting testing of asymptomatic patients away from costly clinical environments through this model; it is estimated that considerable savings will be released.

Locally, the vision is to **develop and coordinate an integrated system of sexual health provision linked to a network of pan London and regional services**. This enables each Council to achieve its objectives set out in the Sexual Health Strategy to improve sexual health outcomes. A lead provider

<table>
<tr><td></td><td colspan="6">model will be developed to coordinate and manage all elements of the system including clinical, primary care, and the third sector. The whole system will be designed to ensure that evidence based practice drives changes, and resources will be focused on groups with the highest risk. It is important that the new system is flexible and responsive to changes in demography and local need.</td></tr>
<tr><td rowspan="5">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>
<tr><td>Race</td><td>✓</td><td>Religion or Belief</td><td></td><td>Sex</td><td>✓</td></tr>
<tr><td>Sexual Orientation</td><td>✓</td><td>Other</td><td></td><td></td><td></td></tr>
<tr><td>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?</td><td colspan="6">Barnet and Harrow Joint Public Health Service (B&HJPHS) have overall responsibility for commissioning sexual health services for both boroughs.

As part of the Interagency Authority Agreement between Barnet and Harrow Council, the monitoring and procurement of Public Health services for both boroughs are undertaken by Harrow and Barnet Joint Public Health Services with the support of Harrow Council, as the host authority.

Local Partners include: Harrow Service Providers – London North West Healthcare Trust; Barnet – The Royal Free and Central London Community Healthcare Trust. GPs and Pharmacies.
Other partners include: 22 London Borough as part of the London Sexual Health Transformation project.

B&HJPHS are also leading the sub-region procurement for Outer North West London (for Harrow, Ealing and Brent) and participating in the North Central London sub-regional procurement for (Barnet, Camden, Islington and Haringey).</td></tr>
</table>

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)

	-To assess the current state of acute sexual health services (GUM - Genitourinary Medicine) in London, The London Sexual Health Transformation Project (LSHTP) Team undertook a needs assessment, an analysis of patient flow data, interviews with commissioning and public health leads in each participating council. Initial consultation with prospective providers was undertaken to assess the market's ability and capacity to respond to the forthcoming procurement. A waiting room survey was also undertaken as part of LSHTP; results indicated that up to 50% of GUM service users do not have symptoms and could access sexual health services through local community and primary care services. A service review was undertaken in the London Borough of Barnet between May and October 2015. Key stakeholders and local residents were invited to participate in the service review, which comprised of focus groups, interviews and surveys. To date, a series of surveys have been completed by a variety of stakeholders: service user staff (20), GPs (21), pharmacies (6), service users (147) and young people (135). Focus groups were also undertaken with young people, black and ethnic minority males and females and Lesbian, Gay, Bisexual and Transgender (LGBT). A service review was also undertaken in the London Borough of Harrow during the same period. Key stakeholders and local residents were invited to participate in the service review, which comprised of focus groups, interviews and surveys. To date, a range surveys have been completed by a variety of stakeholders: service provider staff (62), GPs (12), pharmacies (8), service users (239) and young people (132). Focus groups were also undertaken in Harrow. See appendix 1 and 2 for results of Barnet's and Harrow's Service User and Young People's Surveys. Full report will be circulated to key stakeholders shortly. A needs assessment was also undertaken to map needs and examine demand. This data has been extracted from Harrow Local Authority Sexually Transmitted Infections and HIV Epidemiology Report (LASER): 2013, Public Health England. The local service review for both Barnet and Harrow set out to identify the strengths of the current sexual health

	provision and to highlight gaps and areas for improvement and development. These findings along with the needs assessment will inform the new service model. The proposed new integrated sexual health service will target resources more effectively at high risk and vulnerable groups, whilst diverting low risk residents to cost effective services in the community. The new service provider will be required to ensure improved access to high risk and vulnerable groups.
Age (including carers of young/older people)	The following data highlights the need for services to be targeted more effectively at the under 25s. **Harrow** has a significant prevalence of sexually transmitted diseases (STI's) in the population - with 1607 acute STI diagnoses in 2013, representing a 4% increase on 2012. This is particularly relevant for young people in Harrow - 60% of cases are in those under 25. The rates for gonorrhoea, genital warts, genital herpes and syphilis rank Harrow among those authorities in England with the highest rates. In Harrow, the gonorrhoea diagnoses rate (63.9 per 100,000) compared to England as a whole (52.9 per 100,000). Harrow is ranked 40th highest (out of 326 local authorities in England[1]) placing Harrow among 25% of local authorities with high gonorrhoea diagnoses rates, which is a marker for high levels of sexual activity. Evidence from the Needs Assessment in Harrow reflects the national picture, where STI's disproportionately affect women aged 15 to 19 and men aged 20 to 24. In 2013 there were 334 chlamydia diagnoses in young people under 25 in Harrow, representing 61% of the total chlamydia diagnoses (all ages). Public Health England (PHE) recommends local authorities should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 population. Harrow did not achieve this target with a rate of 1,087 per 100,000 population, which is significantly lower than the London rate 2,179 per 100,000 and the England rate of 2,016 per 100,000. This needs to be addressed in order to contribute to lowering the prevalence of chlamydia amongst young people. The proportion of 15-24 years tested is almost 10% lower in Harrow than across England. The proportion of women prescribed emergency hormonal contraception is greater in those under 25, suggesting while there may be good overall provision of contraception, there is a continued need to target young people. 70% of all emergency contraception was prescribed to women under 25, higher than London (59%) and similar to England (72%). **Barnet** has a significant prevalence of sexually transmitted diseases (STIs) in the population - with 2680 acute STI diagnoses in 2013. Barnet is ranked 105 out of 326 local authorities in England and 44 out of 326 local authorities for gonorrhoea infection, with a diagnosis of 60.2 per 100,000 higher than the England average of 52.9 per 100,000. In Barnet the highest rates of diagnoses are in those aged 20-24 and 25-34 years of age.

[1] 1st rank has the highest diagnoses rates.

	Young people are disproportionately affected by sexual ill-health; given 11.8% of Barnet population is aged 15-24 years the data suggests that there is needs for targeted interventions to further engage this high risk group. The prevalence among women aged 15-19 years is significantly greater than in men of the same age and disproportionately greater in comparison to the proportion of the female population aged 15-19 years in Barnet. Similarly the prevalence among men aged 25-34 years is disproportionately greater than in women of the same age. In 2013 there were 485 chlamydia diagnoses in young people under 25 in Barnet, representing 49% of the total chlamydia diagnoses (all ages). Public Health England (PHE) recommends local authorities should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 population. Barnet did not achieve this target with a rate of 1,098 per 100,000 population, which is significantly lower than the London rate 2,179 per 100,000 and the England rate of 2,016 per 100,000. This needs to be addressed in order to contribute to lowering the prevalence of chlamydia amongst young people. The proportion of women prescribed emergency hormonal contraception is greater in those under 25, suggesting while there is good overall provision of contraception, there is a continued need to target young people. 64% of all emergency contraception was prescribed to women under 25, higher than London (59%) and lower than England (72%). This has a direct correlation to teenage pregnancies and their outcomes. Areas of high prevalence are defined by PHE as areas with more than two people diagnosed with HIV per 1,000 (aged 15-59 years).[2] Data from the Survey of Prevalent HIV Infections Diagnosed (SOPHID) shows the diagnosed HIV prevalence rate for Barnet in 2013 was 3.0 per 1,000 population aged 15-59 years. The new service provider will be required to ensure improved access to high risk and vulnerable groups.
Disability (including carers of disabled people)	There is a lack of data on the sexual health and reproductive health needs of the people with disabilities in both boroughs. There was a poor response from this group to the service user survey; therefore there is a need for further research in this area. However, it is anticipated that the proposed service will have a positive impact on the needs of this group. The new service provider will be required to ensure improved access to high risk and vulnerable groups.
Gender Reassignment	There is a lack of data on the sexual health and reproductive health needs of the people with gender reassignment in both boroughs. However, it is anticipate the proposed service will have a positive impact on the needs of this group.

[2] HIV in the United Kingdom: 2014 Report

Marriage / Civil Partnership	There is a lack of specific data on the sexual health and reproductive health needs of individuals in marriage or civil partnership, in both boroughs. However, it is anticipated that the proposed service will have a positive impact on residents with these characteristics. The new service provider will be required to ensure improved access to high risk and vulnerable groups.
Pregnancy and Maternity	There is a lack of specific data on the sexual health needs of women during pregnancy and maternity time, in both boroughs. **Harrow** 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. GP-prescribed LARC rates are an important public health measure and Barnet's rate of GP-prescribed LARC is significantly lower than across London and England. 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. **Barnet** Similar to Harrow, teenage pregnancy rates have continued to decline. Barnet as the 7th lowest rate of under 18 conceptions in England. However, the proportion of all under-18 conceptions in Barnet 76% resulted in abortions. This is significantly higher than London (66%) and England as a whole (51%). As a proportion of all under 18 conceptions, in Barnet three quarters (76.2%) resulted in abortions, significantly higher than London (65.7%) and England as a whole (51.1%). In 2013 repeat abortions in women aged under 25 accounted for almost one third of all abortions performed. This is broadly in line with London (32%) and England (27%). The rate of Long Acting Reversible Contraception (LARC) prescribed by Contraception and Sexual Health (CASH) services aged 15-44 years was 27.6 per 1,000. This is lower than London (33.4 per 1,000) and England (32.2 per 1,000). The Barnet rate of GP-prescribed LARC is 19.5 per 1,000 registered female population aged 15-44 years (1,582 LARCs), in comparison London has an average of 25.1 and England 52.7. In 2013 Barnet was ranked 314 out of 326 local authorities in England for GP-prescribed LARC. It is anticipated that the proposed new service will have a positive impact on the needs of this group. The new service provider will be required to ensure improved access to high risk and vulnerable groups.
Race	Individuals from Black African backgrounds are one of the key priority groups in both boroughs. **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 amongst 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. **Barnet** 61.8% of STI diagnoses are from the white community; who represent 64.1% of the entire population. 8.6% of the STI diagnoses are from the Black African communities, who represent 5.4% of the total population of Barnet. STI diagnosis rates amongst the Asian community are particularly low at 2.8%; whilst they represent 7.8% of the population. HIV continues to be a real issue for high-risk groups including men who have sex with men (MSM) and people from black African communities. In Barnet, the diagnosed HIV prevalence rate is 3.0 per 1,000 in those aged 15-59 years, which is higher than the England of 2.1 and with a diagnosed rate of 2 or greater per 1,000 in those aged 15-59 considered to be high prevalence. Late diagnoses of HIV remains a public health issue and the proportion of people being diagnosed from 2011 to 2013 with late-stage HIV infection in Barnet is 52%, higher than the England average of 45%. This is a key Public Health Outcomes Framework (PHOF) target that will require Barnet to work towards increasing early diagnosis. We anticipate that the proposed new service will have positive impact on the needs of this group. The new service provider will be required to ensure improved access to high risk and vulnerable groups.
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 beliefs. We anticipate that the proposed new service will have positive impact on the needs of this group. The new service provider will be required to ensure improved access to high risk and vulnerable groups.

Sex / Gender	**Harrow** The rates of acute STIs in 2012 were higher among young females compared to young males. Similarly, the rates of reinfection with an STI were also higher among women. In 2012, 13.6% of women and 12.9% of m en 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. **Barnet** The prevalence among women aged 15-19 years is significantly greater than in men of the same age and disproportionately greater in comparison to the proportion of the female population aged 15-19 years in Barnet. Similarly the prevalence among men aged 25-34 years is disproportionately greater than in women of the same age. The prevalence among women aged 15-19 years is significantly greater than in men of the same age and disproportionately greater in comparison to the proportion of the female population aged 15-19 years in Barnet. Similarly the prevalence among men aged 25-34 years is disproportionately greater than in women of the same age. In 2013 there were a total of 2,680 acute STI diagnoses in Barnet (1,440 in males and 1,236 in females[3]), all acute STIs now include diagnoses of new HIV infections, this represents a 8.2% reduction compared with the previous year (2,919 in 2012). The acute STI diagnoses rate in Barnet was 736.4 per 100,000 compared to 810.9 across England,[4] (812.9 male and 661.7 female diagnoses). This ranks Barnet 105 out of 326 local authorities in England for diagnoses rates per 100,000 population, with the 1st ranked local authority having the highest rates. The new service provider will be required to ensure improved access to high risk and vulnerable groups.
Sexual Orientation	Men who have sex with men (MSM) are one of the key priority groups in both boroughs, as there is a disproportionate prevalence of STI diagnoses amongst this group. **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). Heterosexual exposure is the main source of HIV infection in Harrow (75%) with more HIV cases seen in

[3] Figures for males and females taken from the Barnet Local Authority Sexually Transmitted Infections and HIV Epidemiology Report (LASER): 2013, PHE and are not equal to the total number of acute STI diagnoses

[4] Barnet Local Authority Sexually Transmitted Infections and HIV Epidemiology Report (LASER): 2013, PHE

	heterosexual females compared to heterosexual males. In Harrow - 20% of the HIV diagnoses in 2011 were seen in MSM population. **Barnet** In 2013 there were 343 new STI diagnoses in MSM (this includes homosexual and bisexual men) this equates to just over one quarter (26.5%) of all acute STI diagnoses. The prevalence of gonorrhoea is greater amongst MSM than the general population at 44.1% followed by chlamydia at 33.2%. It is anticipated that the proposed new service will have a positive impact on the needs of this group. The new service provider will be required to ensure improved access to high risk and vulnerable groups.
Socio Economic	Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from the GUM clinics show a strong correlation between rates of acute STIs and the index of multiple deprivation across England. 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. **Harrow** - There is considerable geographic variation in the distribution of sexually transmitted infections (STIs) in Harrow. The highest rates of STIs are found in the most deprived wards in Harrow: Wealdstone, Roxbourne, Greenhill and Marlborough. This illustrates the correlation between STIs and socio-economic deprivation. **Barnet** - Colindale, West Hendon and Burnt Oak, the most deprived wards in Barnet; the highest rates of STI can be found in these areas. It is anticipated that the proposed new service will have a positive impact on communities living in these wards. The new service provider will be required to ensure improved access to high risk and vulnerable groups.

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 your proposals).
See section 4 for details.	See section 4 for details.	See section 4 for details.	The findings will inform the design of the

			new integrated sexual health service.

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.	See above.

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	✓	✓	✓	✓	✓	✓	✓	✓	✓

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 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) 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?	Yes		No	**No**
	If these proposals are approved, the new integrated system will improve services for all residents, particularly for those with protective characters and as a result improve outcomes for these groups.			

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

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.

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)			
The completed EqIA needs to be sent to the chair of your Departmental Equalities Task Group (DETG) to be signed off.			
19. Which group or committee considered, reviewed and agreed the EqIA and the Improvement Action Plan?			
Signed: (Lead officer completing EqIA)	Audrey Salmon, Head of Public Health Commissioning (Barnet and Harrow)	Signed: (Chair of DETG)	Mike Howe, Service Manager - Policy & Partnership
Date:	November 2015	Date:	November 2015
Date EqIA presented at the EqIA Quality Assurance Group	2 November 2015	Signature of ETG Chair	Mike Howe