Haringey Council

Equality Impact Assessment

Name of Project	General Practitioners Services Framework for Prevention Services	**Cabinet meeting date** ***If applicable***	
Service area responsible	Public Health		
Name of completing officer	Christopher Sartori / Sarah Hart	**Date EqIA created**	17/08/2016
Approved by Director / Assistant Director	Susan Otiti	**Date of approval**	

The Equality Act 2010 places a '**General Duty'** on all public bodies to have '**due regard'** to:

- **Eliminating discrimination, harassment and victimisation and any other conduct prohibited under the Act**
- **Advancing equality of opportunity between those with 'protected characteristics' and those without them**
- **Fostering good relations between those with 'protected characteristics' and those without them.**

In addition the Council complies with the Marriage (same sex couples) Act 2013.

Haringey Council also has a '**Specific Duty'** to publish information about people affected by our policies and practices.
All assessments must be published on the Haringey equalities web pages. All Cabinet papers MUST include a link to the web page where this assessment will be published.

This Equality Impact Assessment provides evidence for meeting the Council's commitment to equality and the responsibilities outlined above, for more information about the Councils commitment to equality; please visit the Council's website.

Stage 1 – Names of those involved in preparing the EqIA	
1. Project Lead – Christopher Sartori	5.
2. Equalities / HR -	6.
3. Legal Advisor (where necessary)	7.
4. Trade union	8.

Stage 2 - Description of proposal including the relevance of the proposal to the general equality duties and protected groups. Also carry out your preliminary screening (Use the questions in the Step by Step Guide (The screening process) and document your reasoning for deciding whether or not a full EqIA is required. If a full EqIA is required move on to Stage 3.

Equality impact assessments (EIAs) are our chosen way for working out the effect our policies, practices or activities (might have on different groups before we reach any decisions or take action. They are an important service improvement tool, making sure that our services are as effective as they can be for everyone Haringey serves. They also help to prevent us from taking action that might have outcomes we did not intend.

I. Description of the current proposal features and rationale:

This document assesses the impact of the proposed procurement of GP delivery of key public health prevention services on residents who are defined as having protective characteristic under the Equality 2010 Act. The aim is to identify any possible inequalities and propose an action plan to address or narrow them. The services to be commissioned are listed below; they are not services that GPs would ordinarily provide under their NHS contract.

- Health checks
- Smoking cessation
- Long acting reversible contracetion (LARC)
- Shared care/ Opiate substite prescribing (OSP)
- GP with special interest (GPSI)

- GP lead for sexual health
- GP lead for making every contact count (MECC)

GPs currently provide the services above except for the GP champions for sexual health and MECC. There is national guidance that directs councils to consider using GPs as a way to deliver prevention services. In some instances the activity can form part of a patient consultation i.e. someone seeing their GP for a chest infection being offered smoking cessation advice, a patient would like to move from oral contraception to LARC. Due to quality and cost considerations, not all GPs use a consultation to provide opportunistic prevention services so there is an expectation that they have a referral pathway for other practices. Public health is expected, in its commissioning, to ensure that GPs wanting to provide these prevention services are selected according to where the need is.

Smoking Cessation

Currently the Council funds GPs, pharmacies and One You Haringey to support around 959 smokers per year in stopping smoking. The key performance indicators target groups are: “routine and manual” groups, people with mental health problems, pregnant women and Black and Ethnic Minority (BME) groups.The service is based upon behavioural support and pharmcotherapy where appropriate with success assessed at 4 weeks. Methods of smoking cessation include the use of nicotine replacement therapy (NRT) and pharmacotherapies including varenicline or bupropion. Electronic cigarettes, and other nicotine devices, while representing future potential when medically licensed and regulated do not currently form part of smoking cessation services. Support is provided by trained advisers through one to one advice or group work and there are specialist stop smoking advisers to support people with, for example, mental health problems.

In 2015/16 8 GPs practices successfully support 99 residents to quit against target of 120. Within the new framework there will be 16 practices delivering smoking cessation the target will be155 quits.

Rationale for service	• Smoking is one of the major contributors to ill-health and early mortality • Smoking as a risk factor is not evenly distributed within the population. • Smoking prevalence is higher in deprived communities compared with other more affluent communities, and changes with age • GP practices have contact with many patients who smoke
Which GPs can sign-up to the contract	• All GP practices are invited to bid to provide a Stop Smoking Service • Accepting patients from other practices • Targeted at residents registered with GP practices based primarily in the east of the borough
KPIs include	• At least 85% of all quits should be CO-monitored and >25% quitters from routine and manual occupations • The ratio of lost to follow up activity will be no more than 2 clients lost to follow-up or back to smoking for every 1 successful quit • Looking to increase target to around 150

Health checks

The NHS Health Checks service is a mandatory health service which local authorities are expected to provide and the programme has been running since 2010 in Haringey. Health checks include measurement, recording and assessment of the following parameters to make a risk assessment – age, gender, ethnicity, smoking status, family history of coronary heart disease, blood pressure, body mass index (BMI), physical activity (GPPAQ questionnaire), alcohol use, cholesterol level, cardiovascular risk score (a score relating to the person's risk of having a cardiovascular event in the ten years following the health check), dementia awareness (for those aged 65 to 74) and blood tests targeted at diabetes and kidney disease for those identified as being at risk.

Currently health checks are primarily provided by GPs but also within the community by the One You Haringey service. The overall number of health checks completed was 5714 (4214 by GPs) Due to a reduction in budget the target number of health checks was reduced in 2016/17 to 3500 (3200 via GPs) Within the framework there will be 23 practices delivering health checks with a target of 3200

Rationale for service	• Mandatory requirement
Which GPs can sign-up to the contract	• Service primarily focused on the east of the borough/ and or where there are pockets of deprivation (some in central and south east Haringey)

Key features of the service	• Targeted at residents registered with GP practices based primarily in the east of the borough • Aged 40-74 without any pre-existing condition. • Checks patients for risk of developing a disabling vascular disease • Data and activity must be completed for submission to Public Health England • Accepting patients from other practices
Any changes to contract in 2017/18	• Target of overall Health Checks halved in 2016-2017 to reflect budget restrictions • Each practice will be given a set target based on population size

Long-acting reversible contraceptives (LARC) are methods of birth control that provide effective and cost effective contraception for an extended period without requiring user action. They include injections, intrauterine devices (IUDs) and subdermal contraceptive implants. They are the most effective reversible methods of contraception because they do not depend on patient compliance. So their 'typical use' failure rates, at less than 1% per year, are about the same as 'perfect use' failure rates. .

Haringey is part of a London-wide programme to improve the sexual and reproductive health of our residents; the London Sexual Health Transformation Programme. In line with this programme from April 2017 we plan to re-focus LARC provision within community based services, developing a new specialist clinic and increasing provision within GPs from 11 to 19 practices.

Rationale for service	• This service aims to ensure that the full range of LARC contraceptive options is provided by GP practices to patients
Which GPs can sign-up to the contract	• All practices, which have a GP or nurse trained to provide this service, are invited.
Key features of the service	• Accepting patients from other practices • Ability to provide a minimum of 6 implants and 12 IUCDs per annum (ensures skill level maintained) • Fitting, monitoring, checking and removal of intra-uterine contraceptive devices (IUCDs) as appropriate • Production of an up-to-date register of patients fitted with an IUCD • Provision of adequate equipment (as special equipment is required for fitting IUCDs) • The use of levonorgestrel intrauterine system for the management of menorrhagia in primary care as

	part of a care pathway
Any changes to contract in 2017/18	• We are looking to increase uptake of this service from practices in central and east Haringey

Substance misuse - Opiate substitute prescribing (OSP) is the National Institue of Clinic Excellence (NICE) approved treatment for opiate users. Managing substance misuse in primary care has been nationally advocated since the lates 1990s[1]. Nationally substance misuse treatment in primary care seems to be popular amongst substance misusers, with high satisfaction levels. In Haringey an opiate user would first go into The Grove (specialist drug service). If they become stable then they will have the option to move into shared care with a GP. Shared care is a partnership between the GP and the drug service, with the former prescribing and the latter offering key working. In 2015/16 there were 102 residents in shared care.

Rationale for service	• Aims to normalise substitute prescribing for stable drug users in primary care, through supporting GPs to provide non-specialist care and treatment
Which GPs can sign-up to the contract	• Any GP with level 1 Royal College of General Practitioners Certificate (RGPC)
Key features of the service	• Treatment of opiate dependent drug users, with support from The Grove support workers • Provision of General Medical Services (GMS) or equivalent for drug users • Physical review of each patient every 12 months • Testing (or referral for testing) for blood borne viruses including HIV and hepatitis C and immunisation for hepatitis B for at-risk individuals and their families • Harm reduction advice for drug users and their families • GPs should ensure appropriate monitoring of alcohol use via use of breathalyzer/ urine drug testing as per The Grove prescribing policy

[1]Drug misuse and dependence: guidelines on clinical management. Department of Health. London: HMSO, 1999.

Any changes to contract in 2017/18	• £10,000 saving needs to be made – this will be achieved through reducing the GPSI time and number of places from 80 to 74

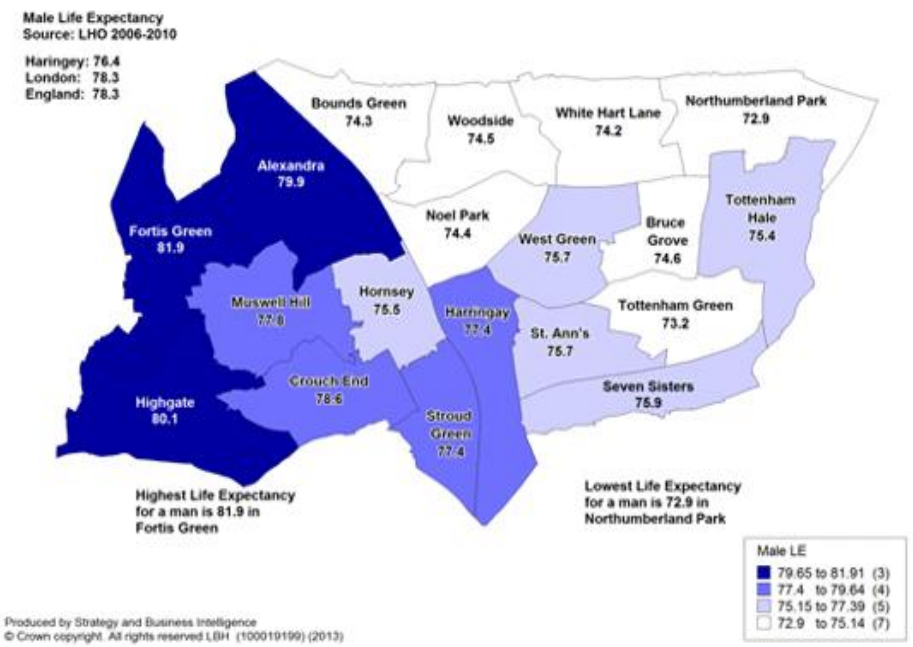
GPSI and leads

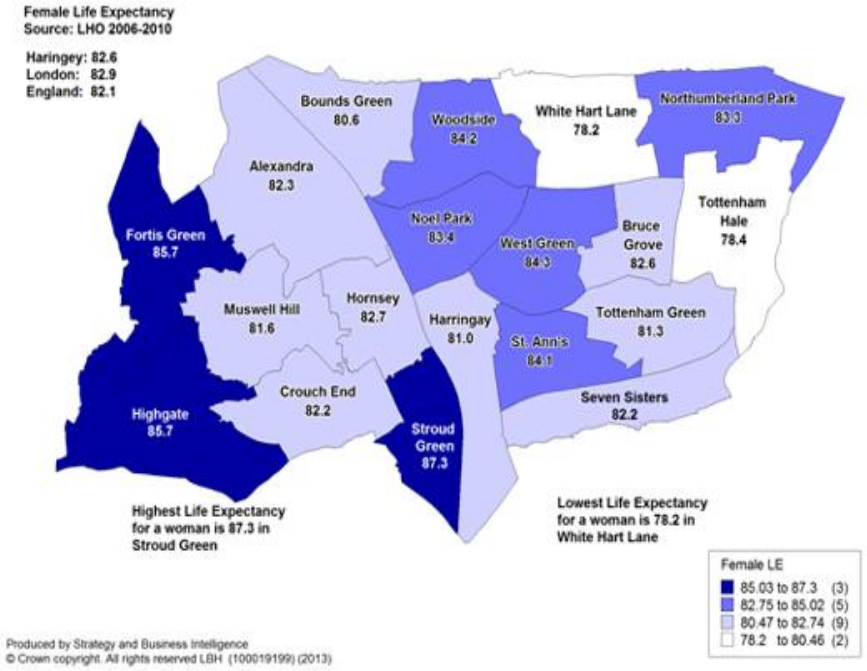
Haringey shared care scheme has been led by GPSIs for over 8 years. Their role has been to recruit other GPs onto the scheme and offer support. They have also represented a mechanism for the Public Health team to discuss substance misuse issues with GPs and develop new guidance. We now wish to extend this to have a small amount of GP time to promote LARC and MECC.

II. Relevance of the proposal to the general equality duties and protected groups

Healthy life expectancy at birth quantifies the average age that a baby can expect to reach and remain healthy. Healthy life expectancy (HLE) in Haringey for males is 59.5 years compared to 60.1 years for females (both of which are significantly lower than the England average). In addition men in Haringey only live 75.4% of their lives in good health and for women the proportion of life spent in good health is only 71.8%

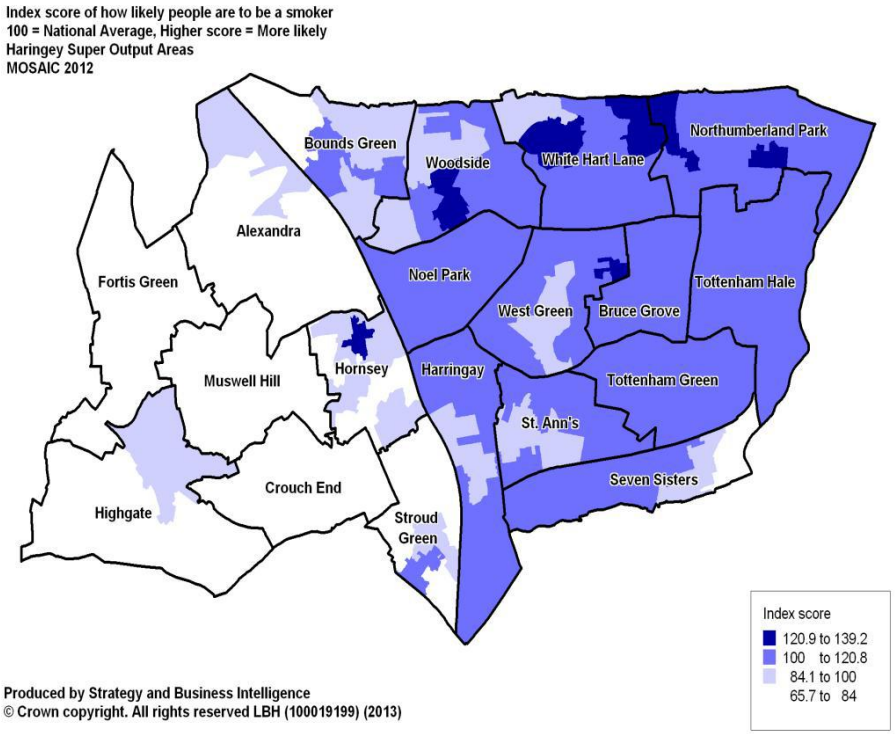
Geographical variation in life expectancy (male & female)





The social gradient between the least and most deprived deciles by deprivation (Slope Index of Inequality) in Haringey in men is 7.7 years. For females it is 3.4 years. This suggests that life expectancy, particularly in males in Haringey is closely linked to levels of deprivation.

Smoking: Nearly one in five adults in Haringey smoke. Reducing smoking rates is a key priority for Outcome 2 of the Haringey Health and Wellbeing Strategy (HWS): a reduced life expectancy gap across Haringey. 50% of the gap in life expectancy is due to smoking, and for those who smoke, quitting is often the single most effective action you can take to improve health and prevent illness. Smoking is a key driver of health inequalities. Smoking rates (prevalence) are highest in deprived communities and yet reductions in smoking prevalence have been slower in these communities than other population groups.

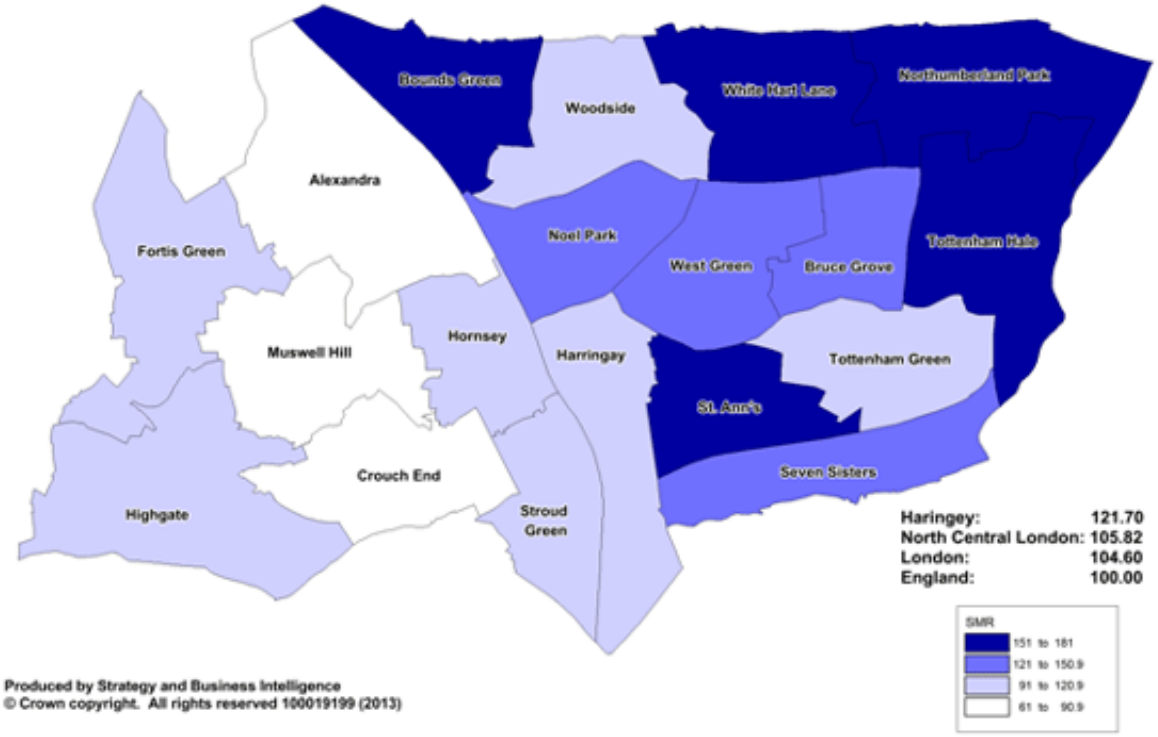


The map above shows an index score of how likely people are to be a smoker arranged by geographical area. 637 deaths were atributed to smoking in 2010-12. Reducing the prevalence of smoking in low income groups, certain black and minority ethnic (BME) groups, and disadvantaged communities will help reduce health inequalities more than any other measure to improve the public's health.

Health Checks: The NHS Health Check programme aims to help prevent diabetes, heart disease, kidney disease, stroke and dementia by screening people aged between 40-74 years who are not known to already have one of these conditions, to identify potential risks early. More than 1 in 20 people in Haringey are living with undiagnosed diabetes, and data suggests in the north east GP collaborative more than half of the number of expected cases of CHD remain undiagnosed.

The top 3 classes of disease contributing to the life expectancy gap within Haringey are circulatory diseases, cancer and respiratory diseases.

The map below identifies premature mortality from circulatory disease, 2006-2010



LARC

- Unplanned pregnancy – the highest numbers of unplanned pregnancies occur in the 20-34 year age group. Unplanned pregnancies can end in abortion or a maternity, with many unplanned pregnancies that continue becoming wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children.
- In 2014 the total abortion rate per 1,000 female population aged 15-44 years was 23.0, while in England the rate was 16.7 per 1,000. Of those women under 25 years who had an abortion in that year, the proportion who had had a previous abortion was 29.4%, while in England the

proportion was 26.5%.

- In 2014, the under 18 conception rate per 1,000 females aged 15 to 17 years in Haringey was 22.6, while in England the rate was 22.8.
- LARC is the most effective and cost efficient method of contraception. In 2014 the rate of LARC prescribed in sexual and reproductive health services per 1,000 women aged 15-44 years was 48.6 for Haringey, 33.0 for London and 31.5 for England. Since 2013 LARC prescribing by GPs has been falling and GPs need to substantially increase levels to reach the England rate (15.07 per 1,000 compared to 32.34 in England).
- Females aged 19 and under in haringey are less likely to choose LARC as their method of contraception than the national average (5.2 rate per 1,000 compaed to 7.7)

Substitue opiate prescribing - Haringey has a significant drug problem, in 2015 the estimated prevalence of crack cocaine and opiate users was 1,847 or 10.0 per 1,000 (Haringey Health Profile, 2015) whereas the national rate for England was 8.4 per 1,000. Those most vulnerable to problematic drug use, especially heroin use, are more likely to live in deprived areas, suffer from mental ill health, live in poor housing and be involved in criminal activity (National Treatment Agency, Oct 2011). Haringey's profile of those in drug treatment reflects this, with the majority entering treatment coming from the most deprived wards. Around 27% of adults entering drug treatment are women. Local data shows 6% of those currently in drug and alcohol treatment identify as lesbian, gay, bisexual or transgender (LGBT).

Stage 3 – Scoping Exercise - Employee data used in this Equality Impact Assessment **Identify the main sources of the evidence, both quantitative and qualitative, that supports your analysis. This could include for example, data on the Council's workforce, equalities profile of service users, recent surveys, research, results of recent relevant consultations, Haringey Borough Profile, Haringey Joint Strategic Needs Assessment and any other sources of relevant information, local, regional or national.**	
Data Source (include link where published)	**What does this data include?**
EqIA Profile on Harinet	Age, gender, ethnicity, disability information – for the Council and the Borough

Stage 4 – Scoping Exercise - Service data used in this Equality Impact Assessment **This section to be completed where there is a change to the service provided**	
Data Source (include link where published)	**What does this data include?**
Joint Strategic Needs Assessment for Smoking on Harinet	Age, gender, deprivation, ethnicity, pregnancy, mental health information
Population profile of Haringey on Harinet	Gender, Age structure, Ethnic profile of residents of Haringey, Ward level population, Population projections, Births and deaths, Mortality, Life Expectancy
NICE guidelines - Stop smoking services https://www.nice.org.uk/guidance/ph1/chapter/1-recommendations	Priorities, Considerations and Recommendations in regard to service delivery
Facalty of Sexual and Reproductive Health http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf	Guidnce on LARC and recommendation to increase womens access to LARC and to use GPs as a mechanism
Haringey JSNA on sexual and reproductive health	Trends in sexual and reproductive health
Trends in Consultation Rates in General Practice 1995 to 2006: Analysis of the QRESEARCH database.	Trends in consultations by age and sex between 1995 and 2006
Health and Social Care Information Centre – Statistics on Smoking: England 2013	Smoking patterns in adults and children, Smoking-related costs, ill health and mortality, Behaviour and attitudes to smoking
Encouraging people to have NHS Health Checks and supporting them to reduce risk factors NICE advice [LGB15]	Facts and Figures, Support for Planning
NHS Health Checks Haringey 2011-2014 - Michael Fox, Mobola Alex-Oni	Data report evaluating service between 2011 and 2014
Action on smoking and health (ASH) - Smoking: LGBT Community	Smoking in the LGBT Community
Improving Health and Lives – Learning Inequalities & People with Learning Disabilities in disabilities observatory - Health the UK: 2010	Health inequalities and data on disease rates and smoking for those with learning disability

Stage 5a – Considering the above information, what impact will this proposal have on the following groups in terms of impact on residents and service delivery: **Positive and negative impacts identified will need to form part of your action plan.**				
	Positive	**Negative**	**Details**	**None – why?**
Sex	**Smoking** – In 2008/09, the Omnibus Survey found there were no statistically significant differences in the percentage of men and women smokers who reported wanting to stop smoking. **Health Checks** – Health checks will be available to both men and women and both cohorts present to GP surgeries, and IT systems will be in place to invite groups of patients for screening and health checks at GP practices. **LARC-** Ease of access for women wanting to transfer from GP providing oral contraception to LARC **OSP**- Drug services are a very male dominated environment and can be highly stigmatised. Receiving care within a GP practice is less threatening for some women. It offers anonymity as it does not identify the reason for visiting.	**Smoking** – There needs to be targeting of male smokers to access and use services due to a slightly higher incidence of smoking and higher rates of smoking related negative outcomes. Data suggests GP consultation rates for females tend to be higher than those for males in general (aside from extremes of age). **Health Checks** – Participation and enagegement with the GP is lower among men and the incidence and prevalence of the chronic diseases screened for in the health check for men is higher. Some targeting toward male patients would need to be incorporated. **LARC** – Young women are currently not choosing LARC at the rate for England. There may be barriers to them using a GP i.e. seen as the family Dr, wanting to see someone used to working with young people, opening hours.	**Smoking** – Nationallly more males (20.0%) than females (19.0%) smoke. The prevalence of smoking is 4% higher for men than women in Haringey, with more women accessing stop smoking services than men. Males and females have similar success rates at stopping smoking, although fewer male smokers than expected may access the service. **Health Checks** – NHS Health Checks were not delivered proportionally to both genders between 2011 and 2014, with 56% of checks for women and 44% for men for the 3 years measured. Gendered access inequalities were also higher in some ethnic groups **LARC** – Current levels of take up within GPs is low compared to England **OSP -** 1:3 within the current services are women. Their use of drugs is often linked to a history of domestic abuse.	

		OSP – Fear of being stigmatised means some female drug users may prefer not to see their own GP or their own GP may not prescribe so provision to see a GP in another practice may be preferable		
Gender Reassignment	No evidence was found relating the levels of risk for Transgender residents. As with the general population for some having these services within primary care will be more comfortable and less stigmatising.	Transgender residents may feel that accessing GP services they could face discrimination or hostility. We will help to ensure that all services are inclusive as possible.		
Age	**Smoking** – There are more children in the east of Haringey, which has higher levels of deprivation than the west. Services targeted to the west of the borough to try and reduce influential pull of smoking in households where young children and people live. As GPs frequently look after the health of households, reducing the number of smokers within a household is a feasible aim. **Health Checks** – Access to cohort information to make specific invites to health checks for targeted population. **OSP** – Drug related deaths due to heroin overdose have risen and users	**Smoking** – Accessibility to the GP for children and young people may be a problem, often confounded by presentations to the GP accompanied by parents or other family members, which may interfere with opportunistic smoking cessation consultations. According to the Health and Social Care Information Centre – pupils aged 11-15 who smoked in 2012 were 10 times more likely to seek help from a friend or family member (22%) as opposed to visit the GP (2%) for help with stopping smoking. **Health Checks** – Difficulty of organising appointments with a	**Smoking** - The highest prevalence of smoking in adults is in the 25-34 year age group and the lowest in those over 65 years. Young people are more likely to smoke regularly if they live with other people who smoke and this increases the greater the number of smokers in the household. Smoking before the age of 18 is a key risk factor. The lowest rates of smoking were seen in those over 65 years of age. **Health Checks** – The 2011 ONS Interim Sub National Population Projections predict that the 18-64 population in 2021 will account for 69.5% of the Haringey population, and that the 65+ population in 2021 will	

	are also dying of long term conditions. This is in part due to an aging population of drug users. It is therefore beneficial for treatment for drug use to be provided alongside treatment of other health conditions within primary care. This includes access to health checks and smoking cessation.	GP, if limited out of hours (OOH) access as the service is targeting people of working age. **LARC** – Young women may find the opening hours unsuitable	account for 9.4% of the Haringey population **LARC –** Uptake of LARC is lower in young females **OSP** – Numbers of drug users dying in treatment are rising, this is not only due to heroin overdose but long term conditions often linked to smoking.	
Disability	**Smoking/health checks/LARC** – Patients with disability will have care plans and regular reviews by their GP which puts them in a good place to raise issues around smoking or other risk factors. GPs also perform home visits, allowing targeted advice to those at particular risk, or who wouldn't be able to leave their homes and access the wellness centre. Literature available will be provided in Easy Read format to reach out to those with learning disability. There is also an opportunity to reach out to carers of those with disabilities. In particular learning disability will need to be of focus.	**Smoking** – Accessibility to practices that offer smoking cessation may be an issue, as not all GP practices would have a stop smoking service. Knowledge and onward recommendation for all local GPs and good transport links and accessibility to the integrated wellness centre will be crucial. **Health Checks** – People with learning disabilities may be less likely to have poor bodily awareness and lack communication skills. **LARC –** Females with learning disability may not wish to talk to their own GP about their reproductive lives and should be able to access another GP.	**Smoking** – Insifficient data available in regard to uptake and delivery of service among cohort of patients with disability. Smoking is also more than twice, and up to three times as prevalent among people with mental health disorders than in the general population, and this has changed little over the past 20 years. Fewer adults with learning disabilities who use learning disability services smoke tobacco or drink alcohol compared to the general population, but rates of smoking among adolescents with mild learning disability are higher than among their peers. **Health Checks** – Coronary heart disease is a leading cause of death amongst people with learning disabilities (14%-20%) and the prevalence of dementia is higher amongst older adults with learning disabilities compared to the general	

			population (22% vs 6% aged 65+).	
Race & Ethnicity	**Smoking** – Those GP surgeries taking on health checks are concentrated to the east of the borough and would be well placed to also advise on or deliver stop smoking services, by increasing contact with local population and aiming to make every contact count. **Health Checks** – The health check uptake by ward in 2011-2014 was highest in White Hart Lane (13.2%), Northumberland Park (10.36%) and Tottenham Hale (8.93%) and lowest in Highgate (0.15%), Fortis Green (0.34%) and Muswell Hill (0.44%), reflecting the targeted approach toward minority ethnic groups and deprivation in the Borough. **OSP-** Drug use is highly stigmatised and having care within a GP practice makes the service more discrete.	**Smoking** – In Haringey there is data to suggest lower access rates for people from Mixed, Black, or Chinese ethnicities and success rates for smokers from Black ethnicities are almost 10% lower than smokers from a white background, and more information is needed in regard to the barriers to accessing the service and remaining compliant with treatment. **Health Checks** – there is no clear evidence around targeting specific ethnic groups and the most at risk groups may not still be accessing services. **LARC –** currently there is no data on ethnicity of those accessing LARC. It may be that BME females are more used to using family planning clinics and a targeted awareness campaign may be needed.	**Smoking** – The prevalence of smoking is highest amongst white, and mixed ethnic groups. In Haringey, smokers from White and Asian ethnicities are most likely to access the service; smokers from Mixed, Black, or Chinese ethnicities are significantly less likely to use services. Locally there is some evidence that there are high rates of smoking amongst Turkish men. • NICE guidance recommends targeting of NHS Stop Smoking Services toward minority ethnic and socioeconomically disadvantaged communities in the local population. Over 50% of current smokers across London come from a BME background **Health Checks** – From 2011 to 2014 there were gender access inequalities among different ethnic groups. There were more women than men accessing health checks from Asian-Indian (64% vs 36%), Asian-other (61% vs 39%), Black-other (59% vs 41%), Black-Caribbean (64% vs 36%) & Mixed White & Black Caribbean (64% vs 36%). Ethnic groups where the service was offered to more men than women included Other-Arab (35% vs 65%) and Asian-Bangladeshi (45% vs 55%).	
Sexual			**Smoking** – Data from the Integrated	

Orientation	**Smoking/health checks** – More data is needed in regard to sexual orientation and access to GP services in relation to stop smoking services. There may be cases where, due to historic reasons, LGB people may not disclose their sexual orientation **OSP-** 6% of those using the drug service identify as LGBT. Offering through GP surgeries represents another option of care for those not wishing to stay within the main treatment service.		Household Survey shows that lesbian and gay people are much more likely to smoke than the general population and are more likely to experience health inequalities. Young lesbian, gay and bisexual (LGB) people are more likely to smoke, start at a younger age and smoke more heavily **OSP**- There are concerns regarding MSM drug and alcohol users but this is generally not heroin use so not applicable to this service	
Religion or Belief (or No Belief)	N/A	N/A	We do not expect discriminating factors or inequalities anticipated based on religious belief in terms of service access, although worth noting that advice and signposting toward services could be delivered within places of worship.	We expect the impact on this group to be neutral.
Pregnancy & Maternity	**Smoking** – Offering services through the GP creates additional contact through which smoking cessation services could be offered to improve access. The GPs role extends, often, to the health of the entire family as they may all be registered and attend the same practice. Opportunity may also present itself as GP often consult on patients planning pregnancy, or who have discovered they are pregnant – frequently being the first point of contact prior to antenatal services. The continuity of care offered before, during	**Smoking** – Worth bearing in mind that midwives tend to be the most common source of information in regard to smoking cessation, so encouragement or onward referral by GPs is necessary. **OSP** – Due to the risk to the unborn baby of OSP pregnant women, management would remain in specialist care.	**Smoking** - NICE recommendation is to target women who smoke and who are either pregnant or are planning a pregnancy, and their partners and family members who smoke. PHE data suggests only 4.3% of Haringey mothers smoke at the time of delivery, compared to 5.7% in London and 12.7% in England. (2012/13 data, latest TC profile) However there may be under-reporting, and targeting this remains a local priority.	

	and after pregnancy makes GPs well placed to deliver smoking cessation services, with established links between services focussed on contraception, fertility and ante- and postnatal care. **LARC** – New mothers are likely to be linked into their local GP service and LARC may be a good option for them, which can be offered and discussed at their 6 week check.			
Marriage and Civil Partnership	N/A	N/A	No discriminating factors anticipated based on marriage / civil partnership in terms of service access.	We expect the impact on this group to be neutral.

Stage 5b – For your employees and considering the above information, what impact will this proposal have on the following groups: Positive and negative impacts identified will need to form part of your action plan.				
	Positive	**Negative**	**Details**	**None – why?**
Sex	N/A	N/A	N/A	N/A
Gender Reassignment	N/A	N/A	N/A	N/A
Age	N/A	N/A	N/A	N/A
Disability	N/A	N/A	N/A	N/A
Race & Ethnicity	N/A	N/A	N/A	N/A
Sexual Orientation	N/A	N/A	N/A	N/A
Religion or Belief (or No Belief)	N/A	N/A	N/A	N/A
Pregnancy & Maternity	N/A	N/A	N/A	N/A

Marriage and Civil Partnership (note this only applies in relation to eliminating unlawful discrimination (limb 1))	N/A	N/A	N/A	N/A

Stage 6 - Initial Impact analysis	Actions to mitigate, advance equality or fill gaps in information
1. For all groups with protective characteristics the EQIA has identified gaps in data collection, some groups more than others including disability and sexual orientation. 2. Sex - males generally have lower access rates to GPs in general and also suffer with a higher prevalence of smoking and smoking related illness 3. Gender reassignment – no anticipated or limited literature to suggest that this group is open to discrimination and lack of knowledge when accessing services focussing on smoking cessation or health checks 4. Age – Well defined age group targeted for Health Checks, whereas smoking cessation and LARC needs to remain focused on specific age groups who are less likely to receive the service. Consider joint delivery of smoking cessation and sexual and reproductive health services for young adults 5. Disability – access to home visiting for delivery of services and how far people need to travel and access the services needs to be taken into consideration. Need to consider access to booking and invitations for appointments via a variety of accessible media. 6. Race and ethnicity – Mixed, Black and Chinese ethnicities are significantly less likely to use stop smoking services, with gender disparities in healthcare uptake in general in certain ethnic groups. 7. Sexual orientation – Young lesbian, gay and bisexual (LGB) people are more likely to smoke, start at a younger age and smoke more heavily but more data is needed in regard to access and uptake of these services. 8. Religion and belief – No discriminating factors anticipated based on religious belief in terms of service access, although worth noting that advice and signposting toward services could be delivered within places of worship.	**Stop smoking services** • Consider concentrating the GP surgeries offering stop smoking services in the deprived wards such as Northumberland Park and Tottenham Hale. • Targeted social marketing campaigns to increase access to the service for men, young smokers, and smokers from black, mixed, Chinese and Turkish ethnicities – highlighting services available at the GP surgery / Wellness Centre. • Adverts for services should reflect the diversity of the population and include imagery relating to the target groups. • Appointing and utilising health champions representative of the population targeted – i.e Black and minority ethnic, male community members to provide advice and support from within GP practices. • Working with local community organisations and faith centres to increase both awareness and access to the services available. **Health Checks** • Focussed effort toward the central and eastern wards in the borough would improve targeted service access. Use of IT systems to invite target cohorts of patients – with increased accessibility of appointments – e.g. some out of hour's slots. • Advertising / information within GP practices, integrated wellness centre and pharmacies. Consideration of drop-in service if feasible, as well as home visit health checks where needed / appropriate. • For both of the above, further data collection to assess impact of disability on accessing services • Having a well located all-purpose practice with a prevention wellbeing focus aimed at all ages and working in a whole family way could be a mechanism for reaching harder to engage residents. • The GP lead and Public Health team can play a role in ensuring that health checks links into other wellbeing services i.e. health trainers, social prescribing **LARC** • Maximise access across Haringey, recognising this is a universal need in women of reproductive age. GPs, however, need to be providing this service regularly to maintain

9. Pregnancy and maternity – relationship with GP and midwives is strong in this group and therefore real opportunities for promotion of LARC and smoking cessation. 10. Marriage – no impact anticipated or identified for either of the services in this EqIA.	competency. • Ensure the service is advertised to younger females and review access for BME females • Ensure females can access a GP independent of their own GP **OSP** • Greatest need is in the east of the borough, but some access is needed within the west. Recognition that access to an independent GP may be attractive to some is needed. • Ensure that the offer ties in smoking cessation and health checks for older drug users.

Stage 7 - Consultation and follow up data from actions set above	
Data Source (include link where published)	**What does this data include?**
More than half (53%) of participants would consider using a GP as an alternative to sexual health services. The majority of those surveyed were attending an appointment for contraception.	Health Watch completed a waiting room survey within St Anne's sexual health clinic. A London survey also captured data from Haringey residents using clinics outside of London.

Stage 8 - Final impact analysis
Except for shared care, all of these services need to be targeted to reach at risk groups, which have implications for those with protective characteristics. It will therefore be important to collect data in a timely way to ensure that those most in need are accessing the service and to act rapidly if they are not.

Shared care - there was an excellent response from GPs and the desired number and location of practices was achieved. The GP champion should be used to enhance care of older drug users and to ensure that GPs are linking drug users into health checks and smoking cessation.

LARC - The procurement process was able to achieve an increase in the number of GP practices offering LARC. Ongoing work will be done to ensure that women, especially young women are getting accessing this service in a timely manner.

Health Checks – the response from GPs supported targeted work in the east of Haringey. Although the target is by age it will be important to ensure that those with protective characteristics are not less likely to be offered or receive the service i.e. homeless people without a permanent address. It will be important to ensure that this service is linked into targeted programmes organised by the community provider.

Stop smoking – the procurement was successful in recruiting new GPs onto the scheme. The majority of practices are in the most deprived areas. The GP selected to be the lead will play a strong role in working with the Public Health team to promote the service especially amongst high prevalence groups. Monitoring will need to ensure that practices are employing advisors from BME groups.

Stage 9 - Equality Impact Assessment Review Log

Review approved by Director / Assistant Director		Date of review	
Review approved by Director / Assistant Director		Date of review	

Stage 10 – Publication

Ensure the completed EqIA is published in accordance with the Council's policy.