AGENDA ITEM 5

BRISTOL CITY COUNCIL
HEALTH & WELLBEING BOARD
17TH February 2016

REPORT TITLE: Sexual Health Re-commissioning

Ward(s) affected by this report: Citywide

Strategic Director: **Alison Comley, Strategic Director, Neighbourhoods**
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Purpose of the report:
To update the Health and Wellbeing Board on the process that has been followed and progress made with the commissioning process, including the initial consultation outcomes and for the Mayor to approve the procedure to be adopted for the commissioning of the new services in conjunction with partner agencies, including delegating authority to the Director of Public Health and the section 151 officer.

RECOMMENDATION for the Mayor's approval:

The Mayor is asked to agree;

1. to the proposed joint working arrangements (and that a formal agreement be entered into to record these),
2. to Bristol City Council acting as lead in connection with the procurement, and
3. to the delegation of powers to the Director of Public Health (as the Council representative on the Project Board) and the section 151 officer for Bristol City Council, for all aspects of the proposed procurement process, (including determining the appropriate procurement procedure, finalising the service specification, selection and contract award)

The proposal:

1. Executive Summary

Commissioning sexual health services became a mandatory function of the local authority in April 2013. The value of the services is such that under EU procurement law we are required to put the services out to tender to ensure we are getting best value for money. We are currently in the "pre-procurement" phase of the process and draft specifications have been consulted upon between November 2015 and January 2016. It is proposed

that we go out to tender for these services in April 2016.

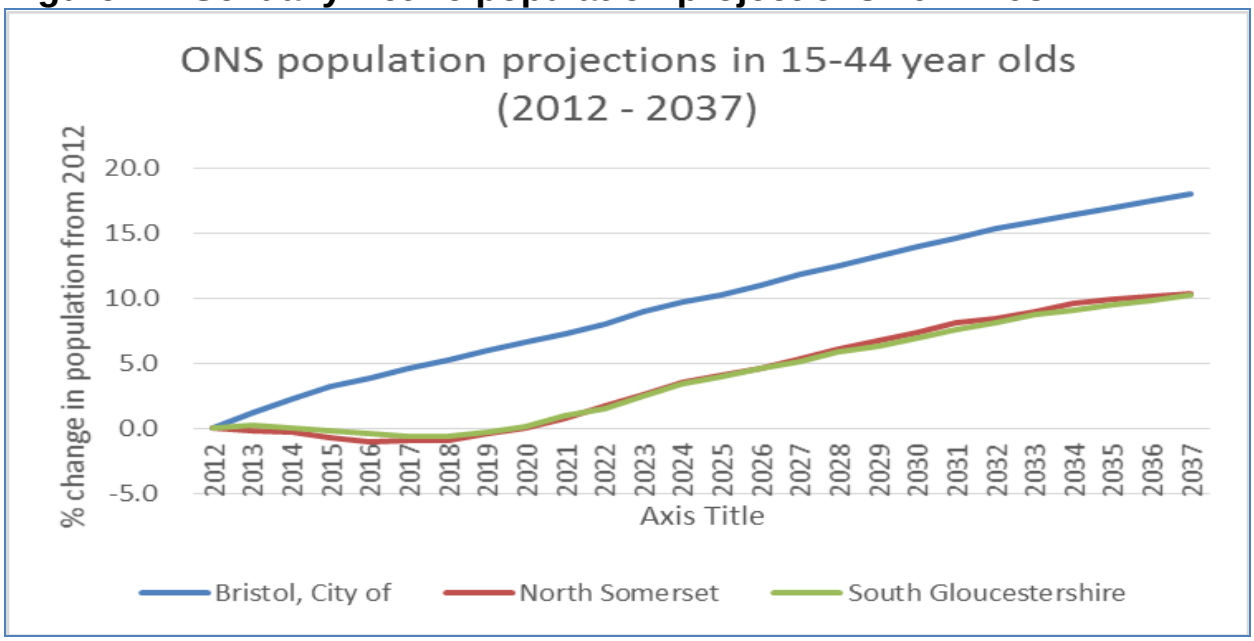
2. Context

Sexual health is one of six mandatory services which local authorities must provide for. From April 2013, contracts which were already in place with service providers were transferred under a Transfer Scheme from Primary Care Trusts to local authorities. Bristol City Council is the lead commissioner of specialist sexual health services provided by University Hospitals Bristol (UHB) Trust with North Somerset and South Gloucestershire as co-commissioners through a shared contract. Each local authority public health team also commissions other sexual health services in partnership and independently for example, from the voluntary sector and primary care contractors (GPs and Pharmacists). It is proposed that at we jointly re-commission sexual health services across the wider BNSSG area.

The current services are provided across a range of public and voluntary sector providers. Detailed health needs assessments were carried out in each area which highlighted the needs for better pathways and signposting between services, better marketing and better use of technology. The service specification has been drawn up to reflect the needs highlighted in the reports (see section 4).

The sexually active population is increasing year on year, which will increase the demand on the services (see figure 1). We therefore need to increase the emphasis on prevention and early intervention, using new technologies to provide better reach and utilising more cost effective early interventions.

Figure 1 – Sexually Active population projections 2012-2037



3. The Commissioning Process

Each local authority has updated their local sexual health strategies and has undertaken local health needs assessments for sexual health in preparation for further improvements in commissioning and delivering services. From this, Bristol developed a Sexual Health Commissioning Plan which was consulted on between August and October 2015. A service specification was drawn up incorporating the initial feedback, which has been out for consultation across Bristol, North Somerset and South Gloucestershire (BNSSG) between November 2015 and January 2016. The findings from this consultation will be incorporated into the final specification. By the end of March 2016, we will be in a position to sign off the service model and specification with a view to service procurement commencement in April 2016. Decisions about the procurement options and route will be taken following detailed analysis of the responses from the consultation. This will include what is in scope and what is excluded from the process. It is anticipated that the procurement process will be complete and new services in place by March 2017. See attached Programme Timeline (Appendix A).

4. Specification

A draft service specification (see link below to consultation where the service specification can be accessed) has been developed which includes our vision for future services and what the service model must include (see appendix B for proposed service model). The feedback from the consultation will inform the final draft of the specification which will be agreed by the programme board in March 2016.

The key principles for the new services are as follows:-

- **Prioritise prevention** of sexual health problems, with a systematic approach to provision of information, education and advice to the population of BNSSG and service users, developed in collaboration with local organisations and local people.
- **Promote self-management** by pro-actively providing opportunities for people to manage their own sexual health either independently or with support, promoting the use of technology, online and telephone advice, self-testing and referral.
  Deliver high quality and cost effective services, ensuring sexual health services are delivered in the most appropriate settings using the most appropriate skill mix.
- **Increase visibility of services**, exploiting online technology, innovative media and marketing techniques to engage service users, increase knowledge and support behaviour change, particularly tailored to high risk communities.

- **Adaptive service**, able to proactively respond to changes in new risk factors, changing patterns of behaviour and use of technology in service delivery.
- **Focus on outcomes,** continuously improving sexual health outcomes and reducing inequalities with an immediate priority of reducing late stage HIV diagnosis; halting the rise in STI infection and reinfections; reducing the rate of repeat terminations; and maintaining a continued reduction in teenage conception rates.
  Proactive service, anticipating ongoing needs of service users with particular regard to those experiencing repeated episodes of sexual health problems.
- **Evidence based**, with decisions based on good information and intelligence, using audit and evaluation to identify issues and promoting research to fill knowledge gaps.
  Easy access for young people and vulnerable groups, ensuring services are provided in a way that these groups want.
- **Timely service**, with rapid and easy access to services for the prevention, detection and management (treatment and partner notification) of sexually transmitted infections, provision of contraception and services.
  Streamlined service with clear pathways reducing duplication of services and increasing the quality of referrals, ensuring clarity for service users.
  Services user views will be at the heart of service delivery and development, driving the design of preventative initiatives, pathways and modes of delivery.
- **Address the wider determinants of health,** with a structured and proactive approach to multiple risk behaviour, underpinned by brief interventions and close partnership working with other services.
- **Strong clinical leadership**, with delivery of sexual health services supervised and assured by consultants through expert clinical advice, clinical governance, clinical systems and training within the organisation and across the wider sexual health network.
- **Skilled wider workforce**, upskilling clinical and non-clinical workforce across the wider sexual health network to maximise opportunities for prevention.

5. Consultation and Scrutiny Input

We have received feedback and views from all key stakeholders including current and future providers, service users and other partners. The consultation ended on 31st January and a full report is currently being pulled together. The full report will be available at the HWB meeting, and will be presented to the board, explaining how the findings will be incorporated into the service specification.

The consultation commenced on 9th November 2015. The link to the consultation can be found here (click here).

a. External consultation:

Provider events
A market warming event for current and potential providers took place on 10th November. A further event took place on 16th December enabling some networking between providers. A further event took place on 20th January to share the latest thinking around the procurement process and allow further networking.

Focus Groups
We commissioned Healthwatch to set up and run a number of focus groups between November and January to get the views of particularly hard to reach groups. The Care Forum also hosted an event for providers on 9th December. Brook Young People's Service has talked to young people about the proposals.

b. Internal consultation:

Bristol City Council Specific Consultation and scrutiny input:
The re-commissioning has been discussed at the following meetings:

- Cabinet agenda conference January 2016
- Neighbourhoods Scrutiny Commission January 2016
- Presented to Health and Well Being Board in August 2015 for information on procurement process and progress to date and in December 2015 for an update
- Discussed with Assistant Mayor(s) July 2015, January 2016
- Neighbourhoods Leadership Team July 2015 and January 2016
- Discussed at Senior Leadership Team August 2015 and January 2016

c. Other organisations input:
Clinical Commissioning Group Governing Body December 2015
All other LA areas have had similar meetings

A full report of the consultation is attached at Appendix C (TBA).

6. Governance Arrangements
There is a collaborative commissioning arrangement across Bristol, North Somerset and South Gloucestershire (BNSSG) to jointly commission sexual health services. It is proposed that this collaborative approach will be used to

re-procure the services. Relevant services which are commissioned by the Clinical Commissioning Groups will also be in scope. NHS England also commissions some sexual health services, but they will not be part of the re-procurement collaboration, although they are being kept fully informed.

A Project Board has been set up which oversees the whole process and ensures that appropriate decision making is taken within their respective organisations, which consists of senior representatives of each participating organisation. A Project Steering Group with relevant sub groups working on different aspects of the procurement and reporting to the Project Board is also in place. All interested parties are represented on the Group and on appropriate working groups. Bristol is the lead commissioner for the re-procurement and a Collaborative Commissioning Agreement is in place.

7. Risk management / assessment

The key risks of re-commissioning sexual health services are set out below, together with actions to mitigate risks. One of the biggest risks currently is that our public health grant has been reduced during this financial year, with further reductions likely in the future. Our partner LAs are planning to reduce their investment across all programme areas to manage the reduction in funding. We will be in a better position to understand our financial position before the bidding process commences, but reduced funding might compromise the level of services we can expect.

Table 1

Risk	Mitigation
Existing providers withdraw from service provision due to uncertainty of future commissioning intentions	All providers will be engaged in the process through stakeholder events and regular meetings with commissioners
No interest in the market to provide the services	Stakeholder events will include a wide range of providers both in the local area and national organisations
New service(s) not in place by April 2017	Allow for extension period to existing contract to cover any slippage
All bids exceed funding available	Declare funding available as part of tender. Tailor specification to funding available
Challenge from unsuccessful suppliers	Seek advice from procurement to ensure process is compliant and fair
Poor specification	Allow sufficient time in the process to ensure a robust consultation with all stakeholders
Selected supplier becomes insolvent	Ensure finance involved in

	assessment of eligible bidders
Funding is not available to support this work	Ensure funding requirements included in MTFP

The key opportunities arising from the process include ensuring the right services are provided in the right places to the right people and that we look for economies of scale through a joint procurement and ensure the services provide the best value for money.

8. Resource and Legal Implications

The current level of expenditure on these services is as follows:-

Table 2

Organisation	**Funding @ 15/16 levels**
Bristol City Council	£4,206,720
South Gloucestershire Council	£1,033,321
North Somerset Council	£1,302,114
Bristol CCG	**£1,055,080**
South Gloucestershire CCG	£330,902
North Somerset CCG	£282,828
Total	**£8,211,025**

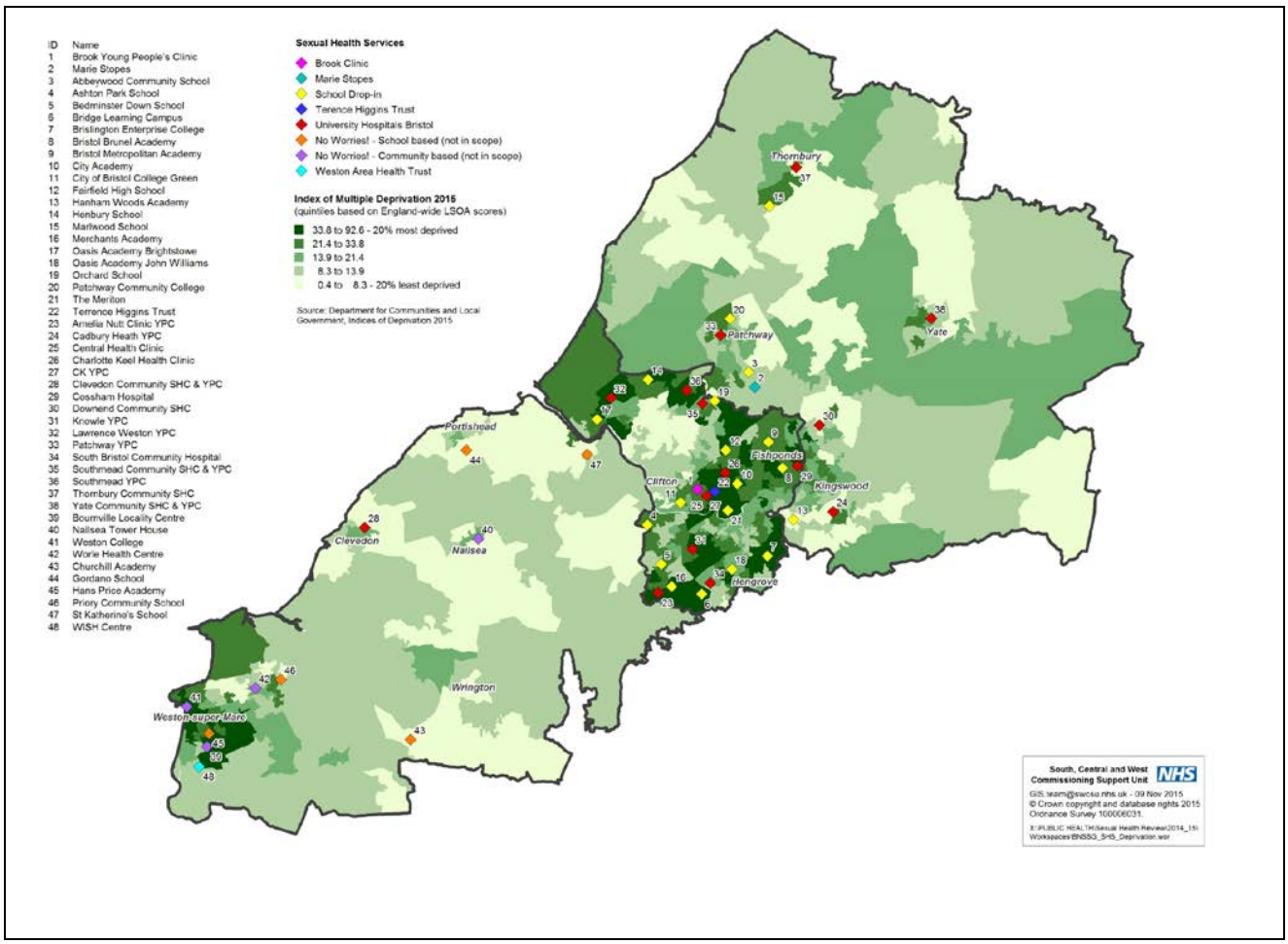
The funding available by the commencement of the new service may be less than the above due to reductions in the public health grant and should some services be considered “out of scope” following consultation. The total amount available will be published with the service specifications at the commencement of the bidding process.

The current levels of funding reflect the different demography of each area. A large proportion of the expenditure is demand led and currently paid for on a “cost per case” basis. Bristol’s population is much less affluent than its neighbours with much higher levels of teenage pregnancy and risk taking behaviour among the younger population. A finance group is looking at proposed contractual arrangements for the future which will ensure that the new provider(s) deliver services proportionally across the patch according to need and investment levels. This will be particularly important for services being delivered to high risk groups such as young people, men who have sex with men and people from black and minority ethnic groups. Figure 1 shows the numbers of 15-49 year olds in the population across BNSSG and Figure 2 shows the spread of current services across BNBBG and the relative levels of deprivation.

Figure 1- BNSSG Populations in the 15 to 49 age group

2014	Female		Female Total	Male		Male Total	Grand Total	% split
Estimated Pop.	**15-24**	**25-49**		**15-24**	**25-49**			
Bristol, City of	36,560	81,367	117,927	36,186	86,536	122,722	240,649	54%
N Somerset	10,183	32,318	42,501	10,565	30,935	41,500	84,001	19%
S Gloucestershire	15,866	45,623	61,489	17,825	45,180	63,005	124,494	28%
Grand Total	**62,609**	**159,308**	**221,917**	**64,576**	**162,651**	**227,227**	**449,144**	

Figure 2 - Current services and deprivation spread across BNSSG



a. Financial (revenue) implications:

As explained in section 8 of the report, the revenue funding available for the re-commissioned service from April 2017 is expected to be less than that available in 2015/16 due to the reductions in the public health grant. Public Health will need to decide the level of revenue funding to commit as part of developing the service model and specification.

Advice given by: Robin Poole (Finance Business Partner)
Date: 28th January 2016

b. Financial (capital) implications:

There are no capital implications arising from this report

Advice given by: Robin Poole (Finance Business Partner)
Date: 28th January 2016

Comments from the Corporate Capital Programme Board:
None

c. Legal implications:

The contractual value of the services is in excess of £590,000, which means they are covered by the "Light Touch" regime set out in the Public Contracts Regulations 2015, regulations 74 to 77.
Whilst it is still necessary to comply with the Treaty principles of transparency and fairness, there is more flexibility to tailor the procurement process to cater for the needs of the authorities.

Before making his decision the Mayor should satisfy himself that a proper consultation process has been followed. The mayor should take the outcome of the consultation into consideration when making his decision. The consultation should:

- Be undertaken when the proposals are in their formative stage so that consultees have a genuine opportunity to influence the outcome.
- Identify those likely to be affected and take steps to bring the proposals to their attention and invite their comments
- Give sufficient information about the proposals to enable consultees to give proper consideration to the matter
- Give enough time to enable the consultees to properly respond

The Mayor should consider the outcome of the equalities impact assessment and the need to promote equality for persons with the following "protected characteristics": age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. He should have due regard to the need to:

i) Eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2010.

ii) Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it.

iii) Foster good relations between persons who share a relevant protected characteristic and those who do not share it. This involves having due regard, in particular, to the need to tackle prejudice; and promote understanding.

Advice given by: Eric Andrews, Team Leader, Corporate Legal Team
Date: 8th February 2016
Nancy Rollason Service Manager, Legal Services
8th February 2016

d. Land / property implications:
None

Advice given by:
Date:

e. Human resources implications:
The staff in the current Chlamydia Screening Service are Bristol City Council employees, therefore there are TUPE implications for those staff should the service be commissioned.

Advice given by: Sandra Farquharson
Date: 5th February 2016

Public sector equality implications:
An overview of sexual health services currently provided and their impact on equalities groups has been carried out and can be found at Appendix D (see page 1 of Appendix D for a list of the equalities groups affected). This will be updated to a full Equalities Impact Assessment to take account of the findings from the consultation which has just ended and will include any mitigating actions where appropriate. This will be available before the bidding process commences on 1st April 2016. Throughout this consultation, we have actively sought views and engaged with equalities groups to ensure that their views are taken into account and services are commissioned to meet their needs. Specifically, Healthwatch were commissioned to undertake targeted focus groups with the vulnerable groups the Department of Health identified as more likely to experience poor sexual health outcomes i.e.:-

1. Certain ethnic groups
2. People with learning disabilities
3. Vulnerable young people
4. Particular risk groups:
   - Lesbian, Gay, Bisexual and Trans (LGBT)
   - Men who have sex with men (MSM)

5. Sex workers
6. Those experiencing domestic and sexual violence
7. Substance and alcohol misusers
8. Offenders
9. Those living in areas of higher deprivation

The service specification includes reference to meeting the needs of groups who are most vulnerable and least reached. As part of the feedback from the consultation, we have asked for specific questions that could be used as part of the bidding process. This will be incorporated into our tender evaluation process.

Eco impact assessment:
An environmental checklist, verified by the Sustainability City Group, has been completed.

Appendices:
Appendix A - Programme Timeline
Appendix B - Service Model
Appendix C - Consultation Report (TBA)
Appendix D - Equality Impact Assessment and Analysis

Access to information - other documents which relate to this report
- Sexual Health Commissioning Plan
- BNSSG Sexual Health Service Specification

Appendix A – Programme timeline

• BNSSG Service specifications out to public consultation	Nov 2015 to Jan 2016
• Approval to go out to tender	Feb 2016
• Tender is advertised	Apr 2016
• Bidding period (out to tender)	Apr 2016 to July 2016
• Evaluation of bids	July 2016
• Award contracts	Sep 2016
• Mobilisation of contracts	Sep 2016 to Mar 2017
• New service(s) commence	Apr 2017


Prevention & Self-management
Non-clinical outreach and targeted health promotion and prevention.
Proactive partnership working
C-card scheme
Clinical training
Service Leadership
Clinical and systems leadership
Pathway development
Research and evaluation
Single IT system and brand
Clinical governance
Training and capacity building
Sustained focus on prevention, young people and vulnerable groups
Performance management
Chlamydia screening programme
Training and Capacity Building
Clinical and non-clinical training for Primary Care, Pharmacists, third sector and other staff in contact with at risk populations
Links with universities
Technology
Point of care testing
Appointment booking
Remote consultations
Social marketing
Outcome tracking
Brief interventions
Termination of Pregnancy
Clinical assessment
Booking
Medical and surgical procedures
Contraceptive follow-up
Brief interventions
Community based services
Level 1 and 2 provision for routine cases
Equitable access in each Local Authority
Clinical outreach services
Holistic provision of care
Brief interventions
Specialist sexual health services
Level 3 for complex STI and contraception
Partner notification
1 physical base in each of North Somerset, South Glos and Bristol.
Brief interventions

APPENDIX D

INITIAL EQUALITY IMPACT ASSESSMENT AND ANALYSIS (EqIAA)

Re-procurement of Sexual Health Services for Bristol, North Somerset and South Gloucestershire

Please Note:-

This document describes an initial analysis of equalities impacts in relation to the re-procurement of Sexual Health Services across Bristol, North Somerset and South Gloucestershire.

The authorities have a statutory duty to consider the impact of its actions in relation to the following protected characteristic groups:-

Age
Disability
Gender Reassignment
Marriage and Civil Partnership
Pregnancy and Maternity
Race
Religion or Belief
Sex
Sexual Orientation

Therefore, we wish to hear and proactively consider any comments in relation to how any aspect of the issues presented may impact on any sections of the community as listed above. Any feedback in relation to equalities and any point raised within this document will inform a full Equality Impact Assessment and Analysis of the Statement of Licensing Policy 2016 – 2021.

You can find out more and tell us your views:

Online: www.sexualhealthconsultation.co.uk

Email: **sexualhealthconsultation@bristol.gov.uk**

Phone: **01179 224 066**

SECTION 1 INTRODUCTION

This Equality Impact Assessment and Analysis (EqIAA) is concerned with investigating the re-procurement of Sexual Health Services across Bristol, North Somerset and South Gloucestershire, which seeks to take place during 2015/16 in preparation for an April 2017 new service start.

The aim of the EqIAA is to ensure that:

- The re-procurement programme has effectively assessed the needs of those groups which evidence and research show have need for sexual health services;
- The re-procurement programme includes plans to address the risk of any potentially negative impacts on an on-going basis.
- The re-procurement programme includes plans to advance access to sexual health services for those with a need for the services regardless of protected characteristic groups.

Why are we re-procuring sexual health services?

While the current delivery of sexual health services contains many examples of achieving positive and innovative outcomes, there is a need for improved outcomes in several areas:

- BNSSG area overall continues to have a comparatively high rate of late HIV diagnosis
- The Chlamydia Screening Programme needs to target higher risk people more effectively, this will be evident if the diagnosis rate increases
- Rising rates of Sexually Transmitted Infections need to be addressed
- Reductions in teenage pregnancy rates need to be sustained
- Better access to contraception will reduce abortion and repeat abortion
- Some groups are at higher risk of poor sexual health, and this inequality must be reduced

Future sexual health services will need to adapt to changes in society. Services will need to rapidly adapt to the opportunities provided by online technology, trends in risky sexual behaviour, and emerging groups at high risk. Populations in each area are predicted to rise while pressure on budgets will require an increased focus on prevention and delivering cost effective services.
The aim of the services is to provide an integrated sexual health service network delivering a high quality, cost effective, timely and equitable service to the populations of Bristol, North Somerset and South Gloucestershire, improving outcomes and reducing inequalities.

What is the re-procurement process?

Following a comprehensive needs assessment, a draft service specification has been developed. This will be included in a wider public consultation about future services, focus groups with vulnerable populations, and potential providers and stakeholders are also being asked to contribute their views. The service specification will be adjusted to take feedback into account. The selection of which provider will deliver the service will be made according to criteria including the provision of evidence about how they would meet the needs of vulnerable groups whilst meeting comprehensive equalities in procurement requirements.

SECTION 2 RESEARCH AND CONSULTATION

The Department for Health *Framework for Sexual Health Improvement* (2013) identifies the following groups as more likely to experience poor sexual health outcomes:

1. Certain ethnic groups
2. People with learning disabilities
3. Vulnerable young people
4. Particular risk groups:
   – Lesbian, Gay, Bisexual and Trans (LGBT)
   – Men who have sex with men (MSM)
5. Sex workers
6. Those experiencing domestic and sexual violence
7. Substance and alcohol misusers
8. Offenders
9. Those living in areas of higher deprivation

The increased risk for these population groups may be due to high risk sexual health behaviours, a higher prevalence of sexually transmitted infections, poorer access to services or vulnerability due to a combination of various factors, including social, physical, mental or emotional.

Further details about these population groups and the reasons they are more at risk are shown below:-

Ethnicity

Ethnicity plays an important role in sexual health. Black and minority ethnic populations continue to be disproportionately affected by poor sexual health. The groups affected and their experiences of HIV and STIs vary greatly, reflecting the diversity present in the migration patterns, socio-economic situations and their experiences of disadvantage and discrimination in these populations[1].

People with learning disabilities

In England as a whole, there are roughly 1.4 million people living with a learning disability. It has been reported that young people with learning disabilities do not find it easy to access sex and relationship education and find it difficult to access sexual health services[2]. People with learning disabilities have the right to experience fulfilling emotional and sexual relationships, including having access to knowledge, information and appropriate services[3].

Vulnerable young people

Sexual activity and the development of relationships usually begin between the ages of 16 and 24, although those aged 11 to 16 are increasingly becoming sexually active. Young people in these age groups have significantly higher rates of poor sexual health, including STIs and termination of pregnancies, than older people.

There are sub-groups of vulnerable young people within the whole population of young people. These sub-groups will usually be at a higher risk of experiencing poor sexual health outcomes than the wider population of young people.

[1] Department of Health (2013) A Framework for Sexual Health Improvement in England
[2] Change (2010) Talking about sex and relationships: the views of young people with learning disabilities
[3] Department of Health (2013) A Framework for Sexual Health Improvement in England

Looked after children, those that are in the care of the local authority, are amongst the most vulnerable people in society. Children and young people may become 'looked after' because they have suffered abuse, neglect or family dysfunction. Such trauma early in a young person's life increases health risks, with higher rates of mental health issues, emotional disorders, hyperactivity and autistic spectrum disorder conditions[4]. Risks for those in care also include an increased risk of being sexually active at a younger age, higher rates of teenage pregnancy and a possible higher risk of sexual exploitation.

Particular risk groups

Lesbian, Gay, Bisexual and Transgender (LGBT) individuals often experience very specific health challenges and are often exposed to various forms of stigma discrimination. Negative experiences may affect the uptake of services and attendance at sexual health clinics by LGBT individuals.

People with same-sex partners tend to have a higher risk of contracting certain conditions, for instance lesbians/gay women may have a higher risk of breast cancer and gay men are at higher risk of HIV. Gay men, lesbians/gay women and bisexual people may also be less likely to attend screening and other health checks, so health problems may not be picked up as early as they could be.

At a national level 1.5% of the population are estimated to be LGBT[5], although estimates range from 0.3% to 10% depending on the measures or sources used.

Men who have sex with men (MSM) are at higher risk of a number of poor sexual health outcomes including higher rates of sexually transmitted infections. Specifically, men who have sex with men are unequally impacted by HIV. HIV diagnoses amongst MSM continue to surpass the number among heterosexuals[6]. Evidence suggests that gay and bisexual men who use particular illegal drugs (as well as alcohol) are more likely to engage in risky sex[7]. It is very difficult to estimate the percentage of the population who are MSM, but a crude estimate can be made by assuming that at least half of those identified as LGBT are men who have sex with men.

Sex workers

Commercial sex work is a growing industry. The majority of the sex work population is female, accounting for up to 90% of workers. All sex workers are at an increased risk of poor sexual health outcomes including STIs and sexual violence. The level of risk is dependent on the type of sex work being engaged in, but all sex workers are at a generally raised level of risk when compared to the general population.

Those experiencing domestic and sexual violence

Victims of sexual assault will experience many and varied health needs. These will include the physical health consequences of sexual violence and for rape, a risk of pregnancy in 5% of cases, contraction of STIs and HIV, and for all victims, longer-term health issues such as increased rates of chronic illnesses, poor perceived health and increased use of medical services[8]. It is estimated

[4] NICE guidance for looked after children and young people
[5] Office for National Statistics (2012) Integrated household survey
[6] Public Health England (2014) Promoting the health and wellbeing of gay, bisexual and other men who have sex with men
[7] Stonewall (2011) Gay and Bisexual Men's Health Survey
[8] NHS (2013) Securing excellence in commissioning sexual assault services for people who experience sexual violence

that there are around 400,000 female victims of sexual offences each year and, of these, around 85,000 are victims of rape or sexual assault by penetration[9].

The victims of sexual violence are usually female and predominantly aged between 14 and 21 years. Offenders are more likely to be male, aged 16 to 34 and as with the victims, are likely to come from vulnerable or marginalised groups living in areas of deprivation[10].

Child sexual exploitation (CSE) Perpetrators and victims of CSE come from all age ranges and ethnic groups. Most sexually-exploited children live at home when their abuse begins. The sexual health of a victim of CSE will be intrinsically affected by their earlier personal experiences.

Female Genital Mutilation (FGM) All acute hospitals must now report the prevalence of FGM and at a national level 500 new cases per month are being recorded. It has been estimated that 103,000 women aged 15 to 49 with FGM were living in England and Wales in 2011, compared with the estimated 66,000 in 2001. In addition there were an estimated 24,000 women aged 50 and over with FGM and nearly 10,000 girls under the age of 14 who have undergone or are likely to undergo FGM. Combining these figures provides an overall estimate of 137,000

Substance and alcohol misusers

An estimated 2,200 people who inject drugs were living with HIV in the UK in 2012, of which 300 were unaware of their infection. The prevalence of HIV amongst this population was 13 per 1,000 nationally. Although this represents a low prevalence, transmission is on-going.

Offenders

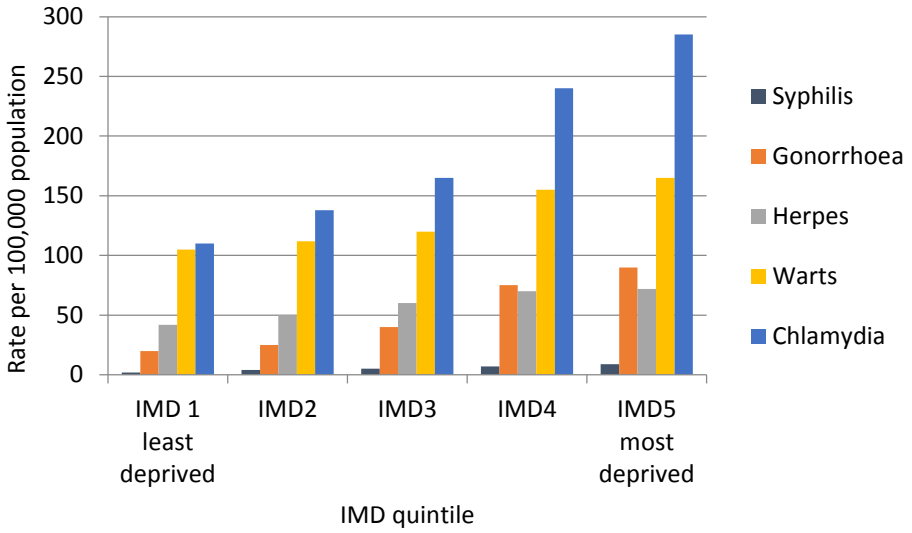
Offenders, particularly young offenders, are often from the poorest and most socially excluded groups of society. Young offenders are at higher risk of poor sexual health outcomes, including high rates of sexually transmitted infections.

Those living in areas of higher deprivation

Poor sexual health is not equally distributed across the population. Socio-economic deprivation and the local environment or neighbourhood has been shown to affect sexual health outcomes. Nationally there is a clear association between deprived groups and an increased risk of teenage pregnancy. There is also a strong relationship between the rate of STIs and deprivation across England. This is shown in Figure 3:

[9] Department of Health (2013) A Framework for Sexual Health Improvement in England
[10] Department of Health (2013) A Framework for Sexual Health Improvement in England

Figure 3: Rates of diagnosis of STIs by deprivation quintile using the Index of Multiple Deprivation for England in 2013[11]



In addition to the Department for Health *Framework for Sexual Health Improvement* (2013) information and data, which shows the national picture, Bristol, North Somerset and South Gloucestershire Public Health teams have all undertaken comprehensive needs assessments which show the local picture. These are available to be read in conjunction with this EqIAA at www.sexualhealthconsultation.co.uk .

Consultation

Bristol, North Somerset and South Gloucestershire Public Health teams all undertook comprehensive needs assessments, which included interviews with professionals currently providing sexual health services, as well as professionals working with vulnerable groups. These are available to view at: www.sexualhealthconsultation.co.uk

There were also interviews and focus groups with vulnerable groups in some areas, and more of these focus groups in other areas are planned for November 2015 – January 2016. Feedback from the last phase of focus groups will inform the development of the service specification and will provide information to feed into this EqIAA.

A full public consultation is taking place in relation to the draft service specification and direction of travel. Consultation starts on 9 November 2015 and runs until 24 January 2016.

This section will be further developed as a result of consultation feedback.

[11] Genitourinary Medicine Clinic Activity Dataset (GUMCAD)

SECTION 3 IDENTIFICATION AND ANALYSIS OF EQUALITIES ISSUES AND IMPACTS

The research shown above highlights a range of groups with protected characteristics which are more likely to experience poor sexual health outcomes and therefore have a need to access sexual health services,

The draft service specification is key to ensuring that the new services are designed and delivered in the most effective ways to meet the needs of those requiring access to services. The re-procurement process includes the negotiation of a new service specification with service users, potential service users, professionals and current and potential providers. The development of the service specification is key to ensuring that the new service meets the needs of the whole community, but in particular to ensure that providers find appropriate ways to reach the most vulnerable local groups and individuals. As such, a draft set of key principles has been developed. These are currently out for consultation, but the **draft principles** are as follows:

- **Prioritise prevention** of sexual health problems, with a systematic approach to provision of information, education and advice to population of BNSSG and service users, developed in collaboration with local organisations and service users.

- **Promote self-management** by pro-actively providing opportunities for people to manage their own sexual health either independently or with support, promoting the use of technology, online and telephone advice, self-testing and referral.

- **Deliver high quality and cost effective** services, ensuring sexual health services are delivered in the most appropriate settings using the most appropriate skill mix.

- **Increase visibility of services**, exploiting online technology, innovative media and marketing techniques to engage service users and increase knowledge, particularly tailored to high risk communities.

- **Adaptive service**, able to proactively respond to changes in new risk factors, changing patterns of behaviour and use of technology in service delivery.

- **Focus on outcomes,** continuously improving sexual health outcomes and reducing inequalities with an immediate priority of reducing late stage HIV diagnosis; halting the rise in STI infection and reinfections; reducing the rate of repeat terminations; and maintaining a continued reduction in teenage conception rates.

- **Proactive service**, anticipating ongoing needs of service users with particular regard to those experiencing repeated episode of sexual health problems.

- **Evidence based**, with decisions based on good information and intelligence, using audit and evaluation to identify issues and promoting research to fill knowledge gaps.

- **Easy access for young people and vulnerable groups**, ensuring services are provided in a way that these groups want.

- **Timely service**, with rapid and easy access to services for the prevention, detection and management (treatment and partner notification) of sexually transmitted infections, provision of contraception and services.

- **Streamlined service** with clear pathways reducing duplication of services and increasing the quality of referrals, ensuring clarity for service users.

- **Services user views** will be at the heart of service delivery and development, driving the design of preventative initiatives, pathways and modes of delivery.

- **Address the wider determinants of health,** with a structured and proactive approach to multiple risk behaviour, underpinned by brief interventions and close partnership working with other services.

- **Strong clinical leadership**, with delivery of sexual health services supervised and assured by consultants through expert clinical advice, clinical governance, clinical systems and training within the organisation and across the wider sexual health network.

- **Skilled wider workforce**, upskilling clinical and non-clinical workforce across wider sexual health network to maximise opportunities for prevention.

The provider should ensure the service has

- **Simple access**, with a single telephone number and online system, including social media, for information, booking appointment and receiving advice across all services.

- **Single IT system** enabling patient records to be available regardless of point of entry, reducing the need for service users to give the same information in different settings and enabling outcomes to be monitored.

- **Single brand** across all organisations, using multiple organisational logos only in situations where it is advantageous to engaging users.

- **Young people friendly,** with all organisations delivering sexual health services having achieved or actively working towards full accreditation.

The most relevant sections of the current draft service specification which include requirements to reduce inequalities and mitigate against risk of impact on vulnerable groups are:

Embedding prevention across the pathway

A communications strategy will be developed for the sexual health system. It will take account of the range of communication technology available (including websites, apps, social media), and the mass media, to raise awareness of the availability of sexual health services and good sexual health. This should include information about STI prevention, testing and treatment; PEPSE; contraceptive choice; consent; sexuality; and issues relating to stigma, prejudice and discrimination. In collaboration with the commissioner, the sexual health system will support national campaigns e.g. HIV awareness week.

Information will have to be appropriate for those at risk, particularly young people and vulnerable groups, and should be developed in close collaboration with these groups. Material and advice should also be appropriate for young people, those who are not yet sexually active to support development of healthy relationships. This will include provision of 1:1 advice on the telephone, online or in person. Close links with organisations providing Sex and Relationship Education in schools will be developed.

A condom distribution scheme will be co-ordinated and delivered to vulnerable groups with a focus on young people (c-card), men who have sex with men, people from ethnic minorities at high risk, homeless people and people with learning difficulties or disabilities.

Consideration will be given to the development of targeted health promotion packages for young people and vulnerable groups. This will be considered in conjunction with any outreach services developed.

Technology

Expanding online and other technology can transform the way sexual health services are delivered, with potential to increase knowledge, access to services, and reduce costs. A focus on use of technology to maximise opportunities for early intervention before a crisis develops is essential.

The online service will be available 24 hours a day, 7 days and week, 365 days of the year. In the event of technical failure, the provider must ensure the website is fully functional within 48 hours of the fault being identified. Communication technology for booking appointments will be offered in conjunction with a telephone service to provide a seamless service.

Development of the content and method of communication will respond to the changing preferences of service users. User involvement in the development of communication methods is essential, with a particular focus on young people and vulnerable groups**.**

Sexual Health Network

The sexual health network will operate an open access policy regardless of residence of the patient. The services will be made available via a range of methods including online, telephone, and face to face. A mix of booked and walk-in appointments, and evening and weekend appointments will be offered.

The location(s) selected for service delivery should be easily accessible to the population from both public and private transport. Particular consideration should be given to accessibility issues for young people and vulnerable groups.

Young people and vulnerable groups must be prioritised within the service. The service should also be accessible and accessible to young people who have not yet had sex. The service should systematically identify barriers to these groups accessing services, and adapt service delivery to facilitate access. Any additional support required by vulnerable groups, e.g. assistance for those with learning disabilities, interpreters should be provided as part of the service.

Provision of specialist services, such as a dedicated young people's service for under 19s, and outreach services should be considered to meet population need. These will work seamlessly with the other components of the system.

- **Training**

Staff will ensure they are aware of national and local policies and guidance related to female genital mutilation, child sex exploitation, coercion, violence and safeguarding and should be proactive in their approach to addressing these issues.

- **Outreach Services**

Clinical and non-clinical outreach services can be developed where there is clear evidence that the client group is not currently and would not access mainstream services. Outreach services will

work as part of the local sexual health system, and will be developed in partnership with the communities of interest.

Outreach services will take a holistic approach to the needs of the population, ensuring delivery of services is co-ordinated with other organisations who have contact with the vulnerable population to reduce duplication.

Outreach services will employ a range of techniques to engage the community, such as use of peer educators and delivering person-to-person interventions. Outreach services can be provided in settings such as youth clubs, schools, saunas and parlours, public sex environment, community venues, determined according to local need.

Outreach services will be responsive to emerging trends in risky sexual behaviour and act rapidly to develop interventions to meet the changing needs. Where possible, health promotion and other interventions should be co-produced with the population at risk.

Co-ordination of point of care testing for STIs in the community will be a key element of the outreach service. Testing should be offered to communities at high risk of STI and HIV. Referral pathways to other services in the sexual health system should be developed for treatment, partner notification and management following a positive test.

Where appropriate, the service should support clients in the transition to accessing community sexual health services for ongoing sexual health needs. Outreach services should identify systematic barriers to access of community sexual health services, and through training and partnership working, be proactive in plans to address related access issues.

The specific requirements of outreach services should be tailored to needs of the population but could include:

- Advice, counselling and advocacy
- Condom distribution
- Contraceptive provision, including emergency contraception
- Point of care testing, including HIV
- Sexual health promotion and prevention
- Support in response to outbreaks

Outreach can be considered for any vulnerable group, with particular consideration given to:

- Commercial sex workers
- Men who have sex with men
- BME groups at high risk of sexual health problems
- People at risk of trafficking and sexual exploitation
- People with learning disabilities
- Vulnerable young people, including looked after children and care leavers

Audit, Evaluation and Research

Audit, evaluation and research will be needed to continuously improve the quality, efficiency, effectiveness and cost-effectiveness of interventions aimed at reducing health inequalities. Service users will be provided with clear information about the use of their data for service improvement in accordance with best practice. The provider will operate an opt-out model of consent for use of information.

DRAFT Local Outcome Indicators

Contraception

Through improved provision of effective contraceptive methods, organisations across the sexual health network will contribute to reducing the:

- Rate of termination and repeat termination
- Proportion of repeat conceptions in the under 20s
- Sexual health inequalities in termination rates among groups at high risk of including
– Young people;
– Looked after children;
– Women living in deprived areas;
– BME groups with high rates of terminations and teenage conceptions;
– Other vulnerable groups to be agreed by the commissioner.

Sexually transmitted infections

Through improved prevention and treatment, organisations across the sexual health network will contribute to reducing the:

- Rate of HIV, STI and blood borne viruses;
- Number of people treated repeatedly for STIs;
- Inequalities in STI rates, with a focus on:
– Young people;
– Men who have sex with men;
– People living in deprived areas;
– BME groups with high rates of STIs;
– Other vulnerable groups to be agreed by the commissioner.

Outcome Monitoring

A set of indicators demonstrating how the principles of service delivery are being realised will be agreed with the commissioner. These, in conjunction with the national and local outcomes, will form the basis of a performance monitoring framework that will be monitored quarterly. Potential indicators could include, but are not limited to

<u>Health Promotion</u>
- Proportion of service users receiving a brief interventions and referral to related services such as substance misuse, alcohol and domestic abuse services.
- Improved awareness of sexual health services among young people and vulnerable groups.

<u>Service user views</u>
- Evidence of use of patient feedback in service design including active involvement of service users groups of young people and vulnerable groups.

<u>Meeting the needs of vulnerable groups</u>
- Improved rates of access to services for vulnerable groups.
- Hepatitis B vaccination uptake rates for high risk groups identified in the Green Book such as commercial sex workers and sexual partners of intravenous drug users.
- Increased uptake of HIV testing with particular emphasis on first time service users and repeat testing of those that remain at risk.

SEXCTION 4 Equality Impact Assessment and Analysis OUTCOME

This section will be completed post-consultation.

SEXTION 5 ACTIONS TO BE TAKEN AS A RESULT OF THIS EqIAA

The following are draft actions and which will be amended in-line with consultation feedback:

Ensure that outcome monitoring required includes all protected characteristics as set out by The Equality Act 2010 in order that robust monitoring information is collected, analysed and services are continuously monitored for success and development opportunities.

Ensure that the commissioning process specifically incorporates the intended actions which providers will deliver that will result in positive engagement and outcomes for those groups identified within Section 2 of this EqIAA.

SECTION 6 EVIDENCE INFORMING THIS EqIAA

Department of Health (2013) A Framework for Sexual Health Improvement in England
Census 2011 data
Public Health England (fingertips.phe.org.uk/profile/learning disabilities)
Change (2010) Talking about sex and relationships: the views of young people with learning disabilities
NICE guidance for looked after children and young people
Office for National Statistics (2012) Integrated household survey
Office for National Statistics (2011)
Public Health England (2014) Promoting the health and wellbeing of gay, bisexual and other men who have sex with men
Stonewall (2011) Gay and Bisexual Men's Health Survey
NHS (2013) Securing excellence in commissioning sexual assault services for people who experience sexual violence
Sexual Health Needs Assessments for Bristol, North Somerset and South Gloucestershire 2015
Sexual Health Quarterly Outcome Indicator Reports for Bristol, North Somerset and South Gloucestershire Q1 2014/15
Genitourinary Medicine Clinic Activity Dataset (GUMCAD)