Bristol City Council Equality Impact Assessment Form

(Please refer to the Equality Impact Assessment guidance when completing this form)

Name of proposal	Revised commissioning of sexual health services in Primary Care
Directorate and Service Area	People
Name of Lead Officer	Jo Copping

Step 1: What is the proposal?

Please explain your proposal in Plain English, avoiding acronyms and jargon. This section should explain how the proposal will impact service users, staff and/or the wider community.

1.1 What is the proposal?

Bristol City Council currently commission GP practices and community pharmacies to provide sexual health services that fall outside of their NHS contracts (commissioned by the Clinical Commissioning Group).

These services are commissioned through separate contracts across 48 individual GP practices and 94 pharmacies in Bristol. These contracts have been commissioned as activity based contracts where GPs and pharmacists are only paid based on the number of contracted interventions that they deliver.

GPs currently deliver the following sexual health interventions:

- The provision of long acting reversible contraception (LARC) for women of all ages, and in particular the fitting of intra-uterine contraceptives (IUCs) and the fitting and removal of sub dermal implants (SDI).

- The provision of young people sexual health services. Interventions delivered for this element of the contract include:
  - Teen health checks
  - C Card Registration
  - Seeing unregistered patients (under 25) for any sexual health service except condom distribution
  - Condom distribution under the C-card scheme
  - Distribution of chlamydia screening packs

Pharmacists currently deliver the following sexual health interventions:

- Provision of emergency hormonal contraception (EHC) and associated consultation
- Provision of chlamydia treatment medication and associated consultation
- Condom distribution under the C-card scheme

- Distribution of chlamydia screening packs

Following the public consultation and internal discussions, the following three recommendations are being proposed for primary care sexual health contracts:

1. Direct award these contracts to primary care to March 2022, with the option of plus 2 years, so that they are in line with the specialist sexual health contract (UNITY)
2. Make a 10% saving on the current costs of chlamydia screening in primary care by re-modelling the chlamydia screening programme following outcomes from the forthcoming national consultation on chlamydia screening programmes and/or reduce payments to primary care
3. Cease payments for Teen health checks and for condom distribution

BCC are currently awaiting the publication of the National Chlamydia Screening Programme (NCSP) consultation document. We will be looking to implement recommendations from this consultation and make the required savings from the re-modelled service.

We are also recommending that we cease payments to primary care for condom distribution and teen health checks. However, we will still be commissioning a free condom distribution scheme through our specialist sexual health service contract that will continue to provide condom packs to primary care.

Step 2: What information do we have?

Decisions must be evidence-based, and involve people with protected characteristics that could be affected. Please use this section to demonstrate understanding of who could be affected by the proposal.

2.1 What data or evidence is there which tells us who is, or could be affected?

Current Activity

The table below displays the **activity** from the last full financial year available (2017/18) of GP sexual health services:

2017/18	Activity Total
IUCD Fitting - contraception	2723
IUCD Fitting - gynaecological reasons	359
Implants - insertions	1978
Implants - removal	2015
Teen Health Check	1031
C Card Registration	209
Unregistered patients	135
Condom Pack	183
Chlamydia Screening Programme Tests	10,394

Testing & Treatment for Symptomatic Patients (Student Health Surgery only)	79
Partner Notification for those testing positive for chlamydia and gonorrhoea (Student Health Surgery only)	7
Asymptomatic screening for HIV for patients from high risk groups (Student Health Surgery only)	18
Total	**19,130**

The table below displays the **activity** from the last full financial year (2017/18) of pharmacy sexual health services:

Annual 2017/18	Activity Total
Supply of EHC Medication	4,589
EHC Consultation	4,487
Supply of Chlamydia Medication	373
Chlamydia Consultation	354
C-card Distributed	692
C-card Registered	254
Chlamydia Tests	1,260
Total	**12,009**

Evidence Base

NICE Guidance on preventing sexually transmitted infections (STIs) through condom distribution schemes1 recommends that local authorities consider providing free condoms as part of existing services that are likely to be used by those most at risk, with community pharmacies being cited as specific examples of services. Young people aged between 16 and 24 are at particular risk of STIs, with most diagnoses of chlamydia and genital warts being found in this age group. Condoms are the best way to prevent most infections being passed through sex, and increasing their availability has the potential to significantly reduce STI rates.

The current National Chlamydia Screening Programme (NCSP) guidance recommends that all sexually active under-25 year old men and women be tested for chlamydia annually or on change of sexual partner. Screening should be delivered opportunistically, i.e. sexually active young adults should be offered a test when they attend services such as GPs, community sexual and reproductive health services, pharmacies, and specialist genitourinary medicine services. Additionally services can be provided through outreach or via self-sampling kits ordered through the internet.

Current evidence on the cost-effectiveness of chlamydia screening suggests that screening men and women under 25 years old can be cost-effective. The level of

[1] https://www.nice.org.uk/guidance/ng68

benefit of chlamydia screening depends in part on how chlamydia screening is implemented. The NCSP recommends that chlamydia screening should be commissioned in conjunction with a range of sexual and reproductive health services.[2]

2.2 Who is missing? Are there any gaps in the data?

We do not have accurate equalities data for all protected characteristics, especially where this has not historically been required in statutory reporting from primary care, for instance race, LGBT, and religion.

2.3 How have we involved, or will we involve, communities and groups that could be affected?

An online public consultation recently took place on primary care sexual health services. Responders were asked whether they agreed with making savings to the sexual health contract by up to 10%. The highest response to this question 'strongly disagreed' (40%) followed by 'disagreed' (31%). The survey then asked about what percentage level of savings we should make from the sexual health contract (0%-10%). The highest response was a 0% saving (47% of responders) with the second highest response being a 10% saving (21%) followed by a 5% saving (16%).

Qualitative feedback from the survey identified the following themes:

- Reducing primary care sexual health services risks not tackling health inequalities in areas of high deprivation.
- High proportion of young people in Bristol so important to promote good sexual health and contraception through primary care.
- Risk of pushing costs on to secondary services if reduce primary care service.

As a result of this consultation, a lower percentage was sourced from the primary care sexual health budget (roughly 2.5%) to contribute to the public health savings.

Step 3: Who might the proposal impact?

Analysis of impacts on people with protected characteristics must be rigourous. Please demonstrate your analysis of any impacts in this section, referring to all of the equalities groups as defined in the Equality Act 2010.

3.1 Does the proposal have any potentially adverse impacts on people with protected characteristics?

Sexual health impacts on all stages of the life course so these proposals therefore potentially impacts on all residents in Bristol. The proposed changes to the contract are mainly focussed around the young people elements. There is therefore a greater risk that these proposed changes will have a greater impact on young people (under 25) in Bristol.

1. Direct award these contracts to primary care to March 2022, with the option of

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/740182/Opportunistic_Chlamydia_Screening_Evidence_Summary_April_2014.pdf

plus 2 years, so that they are in line with the specialist sexual health contract (UNITY)

- Do not anticipate any adverse impacts on people with protected characteristics for this recommendation. Primary care is situated within local communities and is therefore accessible to all groups. Agreeing to direct award these contracts until at least March 2022 will therefore sustain the open access to these services during this period.

2. Make a 10% saving on the current costs of chlamydia screening in primary care by re-modelling the chlamydia screening programme following outcomes from the forthcoming national consultation on chlamydia screening programmes and/or reduce payments to primary care. Chlamydia screening includes gonorrhoea testing.

- Age: Bristol has a relatively young population compared to England as a whole and this is predicted to rise. Young people are at an increased risk of poor sexual health due to sexual development at this age and societal changes such as sexualised imagery and social media. There are also particular sub-groups of young people that are vulnerable to poor sexual health. These include looked after children, care leavers and young offenders. If we were to reduce payments around the chlamydia screening there is a risk that there would be a reduction in GPs or pharmacists not signing up to this contract which could risk lowering the detection rate for under 25's.

  Sex:
  Women are at greater risk in acquiring chlamydia than males. The National Survey of Sexual Attitudes and Lifestyles (2012) reported that the prevalence of chlamydia among 16 to 24 year old women was 3.1% (95%CI 2.2%-4.3%) and 2.3% (95%CI 1.5%-3.4%) in men. Any re-modelling of the chlamydia screening programme would need to consider this to effectively target young women.

  Pregnancy and maternity: women's control over their fertility is fundamentally affected by their access to sexual health services for contraception and termination of pregnancy. Unidentified and untreated Chlamydia infection in women can lead to pelvic inflammatory disease. Any re-modelling of the chlamydia screening programme would need to consider this to target young women

  Race: Some BAME groups are at greater risk of poor sexual health, including higher rates of STIs. There are also cultural barriers to some BAME communities accessing sexual health services and support. The highest rates of sexually transmitted infections (STI) diagnoses in Bristol have been found among people of black ethnicity. This high rate of STI diagnoses among black ethnic communities is most likely the consequence of a complex interplay of cultural, economic and behavioural factors. Bristol has a more ethnically diverse population

than England as a whole. 16% of the population describe themselves as BAME, and 22% describe themselves as not 'white British'. The younger population is much more ethnically diverse with 28% of 0-15 year olds described as BAME. Any re-modelling of the chlamydia screening programme would need to consider this to target the BAME population.

Sexual orientation: according to PHE (2014) gay, bisexual and other men who have sex with men (MSM) constitute an estimated 5.5% of the male population in the UK. This diverse population continues to experience inequalities in health and wellbeing and in other areas – such as the experience or fear of stigma and discrimination, despite significant improvements in social attitudes and laws that protect and uphold the rights of LGBT people. According to the latest data from Public Health England (2014a) large increases in STI diagnoses have been seen in MSM. Although only 2.6% of the male English population is estimated to be MSM, in 2013, 63% of gonorrhoea, and 17% of chlamydia diagnoses were reported within this group. Gonorrhoea diagnoses in Bristol rose 26% in this group, nearly double the national rate, which is of particular concern as harder to treat gonorrhoea strains emerge. Any re-modelling of the chlamydia screening programme would need to consider this to target the LGBT population.

Socio- economic factors: there are pockets of high deprivation located in the Inner City, East, South and outer Northern areas of Bristol. Poor sexual health is closely correlated with high deprivation and urbanised areas. Local analysis of Chlamydia data indicates areas of higher chlamydia prevalence which will inform any remodelling of the screening programme.

3. Cease payments for Teen health checks and for condom distribution

Age: ceasing payment for Teen Health Checks will mean that across the city fewer teenagers will have an invitation to have a general health talk with their GP. Some GP practices do not offer Teen checks in a systematic way, this has resulted in teenagers benefiting in some areas but not in others. This is not linked to deprivation.

The C Card scheme will still be operational so young people should still be able to access free condoms but the GP practices will simply not be paid to hand out free condoms.

3.2 Can these impacts be mitigated or justified? If so, how?

As a way of mitigating the impact of a reduced budget, the commissioners will re-negotiate the current interventions to ensure that there is continuity of care whilst still responding to levels of need. Following the withdrawal of the payments of condoms we will write to primary care to encourage them to continue to distribute condom packs given the strong evidence base for this intervention. This should therefore have a relatively small impact on young people's sexual health.

Depending on the proposed changes to the chlamydia screening programme, we will need to ensure that we build in processes that people with protected characteristics do not experience barriers to accessing the chlamydia screening programme.

3.3 Does the proposal create any benefits for people with protected characteristics?
By increasing our engagement with primary care during the service specification development stage it will give BCC the opportunity to more fully understand how we could improve the offer to people with protected characteristics.
3.4 Can they be maximised? If so, how?
During the service specification development stage we will ensure that any re-configuration of services will seek to minimise the impact on people with protected characteristics and potentially create benefits.

Step 4: So what?

The Equality Impact Assessment must be able to influence the proposal and decision. This section asks how your understanding of impacts on people with protected characteristics has influenced your proposal, and how the findings of your Equality Impact Assessment can be measured going forward.

4.1 How has the equality impact assessment informed or changed the proposal?
The public consultation influenced the level of savings that we were required to make from the primary care sexual health budget. Findings from this indicated that we should keep savings from this area to a minimum as this could risk widening health inequalities between groups of people.
4.2 What actions have been identified going forward?
• Await the publication of the new Nation Chlamydia Screening Programme (NCSP) guidelines and ensure that all relevant stakeholders feed in to this process to help shape service delivery at a local level of chlamydia screening. • Discussion about service specification changes will take place with key partners (e.g. LMC and LPC) in primary care. • This equality impact assessment will be updated with any subsequent findings from the results of the NCSP consultation.
4.3 How will the impact of your proposal and actions be measured moving forward?
Equality monitoring will be a key specification for all services provided and data used to inform future service improvements.

Service Director Sign-Off:	Equalities Officer Sign Off:
C A Gray	Duncan Fleming
Date: 15/5/2019	Date: 15/5/2019