Written evidence from Derbyshire County Council

Executive Summary

Derbyshire County Council welcome this opportunity to present a local authority perspective regarding the Sexual Health agenda.

Sexual Health responsibility under the local authority mandate is very positive. Multiple opportunities present in Derbyshire to raise the profile of sexual health and to work more closely with departments who have a strong association with sexual health due to the population groups they serve such as Children’s Services.

However it is our experience that there are 3 significant challenges that present risk to sexual health locally:

- Funding is not sufficient. Locally the sexual health budget has been protected since 2015, remaining static within a reducing total Public Health (PH) budget amidst increasing spend overall. The proportion allocated to sexual health from the whole PH grant is increasing but this is only due to the decreasing nature of the overall wider PH budget. No uplift can be given to meet rising provider costs and promote innovation to meet changing need and demand.
- Out of Area (OOA) charging is currently managed through locally bespoke tariffs nationwide. Differing cross-charging terms result in loss of income for providers such as non-pay for OOA contraception. Managing constant OOA challenges has placed significant administrative expense on the Council, which would be better placed in patient care. OOA activity is demand-led, placing large financial pressure on the Council due to the static budget.
- The commissioning landscape offers both opportunity and challenge. Opportunity of a whole system approach that should reap benefits of cost-savings, efficiencies, innovation and the best service for patients. However endeavours to work collaboratively are hindered within a system of multiple partners, differing priorities, lack of clarity around accountability and all within a financially constrained system.

1. Introduction

Derbyshire County Council covers an estimated residential population of over 786,000 people. The county has a 2-tier administration with 8 district/borough councils and is a key part of the Sustainability and Transformation Partnership (STP) that includes Derby City Council, 4 clinical commissioning groups (CCGs) and a range of health and social care partners.

The county is largely rural, with a mix of semi-urban/urban settings and is bordered by larger urban centres such as Derby, Nottingham, Sheffield and Manchester. This demography presents a challenge to both commissioners and providers to ensure the local service offer is accessible to residents and especially to those most at risk of sexual ill-health.

2. Sexual Health Need in Derbyshire

There were 3813 sexually transmitted infections (STIs) diagnosed in Derbyshire in 2017, a rate of 485/100,000. This rate is lower than both the national and regional rates and is one of the lowest rates when comparing with statistical neighbours.
Derbyshire has had a similar rate of STI diagnoses over the last 2 years. For young people/ under 25s the diagnosis rate for new STIs (excl. chlamydia) is 504/100,000 in 2017, significantly below the England rate.

Derbyshire’s diagnoses rate for the total new STIs remains at a similar level over the last 2 years. However increased rates are seen at an individual STI level.

As the national picture, local STI testing has decreased between 2017 and 2016.

2.1 Individual STI diagnoses in Derbyshire area:
Syphilis and Gonorrhoea diagnosis rates show an increase of 36% and 23% respectively (2016-17). However both rates remain below the England average.

Genital warts and Genital Herpes diagnosis rates are similar in the last 2 years, 91/100,000 and 43.2 per 100,000 respectively. Both rates are below the England average.

Chlamydia is the most common STI in Derbyshire, with higher rates amongst younger adults. Performance to prevent chlamydia is measured by the Public Health Outcomes Framework (PHOF indicator 3.02) where a higher detection rate is used as a marker for effective control of chlamydia and improved outcomes.

As cited in Table 1, the Derbyshire detection rate is 1527/100,000 (2017), below the England rate and the recommended PHOF target of 2300/100,000. The positivity rate, reported from local contractual KPIs is between 10% and 13%. This reflects an emphasis on a targeted approach locally with low screening coverage. High positivity might be understood in terms of the “right high risk” groups being screened. However it may also indicate a prevalence issue requiring greater prevention action through increasing screening coverage.

HIV – the 2017 new diagnosis rate (15yrs+) is 30/ 100,000, similar to previous years and below England rates.

HIV prevalence reports at a rate of 0.77/1000 (15-59yrs) population, equating to an estimated 350 people living with HIV. Local prevalence is significantly lower than England but is showing increasing rates since 2011.

Testing coverage for HIV remains at a similar number of tests accepted by eligible patients newly attending the integrated service although the % proportion of 59% has steadily decreased over the last 3 years and is below the England average. HIV testing coverage for MSM is 82.7% with an increasing trend over the last 3 years of tests being accepted.

Local performance against the PHOF for late HIV diagnosis (3.04) reports a decreasing trend with an average 51.2% of presenting patients receiving a late HIV diagnosis (2013 – 2017).

2.2 Contraception
Long Acting Reversible Contraception (LARC) - Derbyshire continues to achieve high LARC prescribing rates/1000 women (15-44yrs), with total prescribed LARC excluding injections at a rate of 62.3/1000, above the England rate of 46.4/1000. Recent 2016 data shows 33.1% of women (under 25s) chose LARC as their preferred method of contraception – a percentage significantly above England (20.6%). Within this
total, LARC rates in Sexual and Reproductive Health (SRH) services and general practice (GP) are above England. However a decreasing trend is seen in GPs locally (2016 – 17).

2.3 Teenage Conception
Teenage pregnancy rate in Derbyshire is significantly lower than England at a rate of 16.9/1000.

2.4 Abortion data
In 2016-17 the total abortion rate/ 1000 reported at 11.4/1000, similar to previous years and below the England rate of 17.2/1000. Repeat abortion rates for under 25s are below England and maintain a similar rate over previous years.

The percentage of NHS abortion procedures under 10 weeks reports at 77.6%, similar to the national percentage. This shows an improving percent achieved under 10 weeks in the last 2 years (2016 – 17).

2.5 Data summary headlines
Table 1 summarises Derbyshire performance measured against a range of indicators for STI and contraception.

Table 1 Summary Performance: Sexual Health in Derbyshire

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Derbyshire</th>
<th>England</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia detection rate/ 100,000 (15-24yrs) 2017 (PHOF 3.02)</td>
<td>1527</td>
<td>1882</td>
<td>🔻</td>
</tr>
<tr>
<td>HIV late diagnosis (%) 2014-16 (PHOF 3.04)</td>
<td>50%</td>
<td>41.1%</td>
<td></td>
</tr>
<tr>
<td>Under 18s conception rate/1000 2016 (PHOF 2.04)</td>
<td>16.9</td>
<td>18.8</td>
<td>🔻</td>
</tr>
<tr>
<td>Total prescribed LARC excl. injections rate/1000 2016</td>
<td>62.3</td>
<td>46.4</td>
<td></td>
</tr>
<tr>
<td>GP prescribed LARC excl. injections rate/1000 2016</td>
<td>42.4</td>
<td>28.8</td>
<td>🔻</td>
</tr>
<tr>
<td>SRH prescribed LARC excl. injections rate/1000 2016</td>
<td>19.9</td>
<td>17.6</td>
<td></td>
</tr>
<tr>
<td>Under 25s choose LARC excl. injections</td>
<td>33.1%</td>
<td>20.6%</td>
<td></td>
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3. Demand

3.1 STI services

3.1.1 Demand based on Derbyshire residents accessing STI interventions in and out of Derbyshire has decreased by 3% since the start of the integrated service (data across April-December period 2015-17). An average of 42% of Derbyshire residents accessing sexual health services did so out of area (OOA), 39% of this total accessed services in Derby City (2015 – 17) and the remainder accessing largely in bordering authorities of Nottingham, Nottinghamshire, Staffordshire, Sheffield and Greater Manchester including Stockport.

Table 2 Demand for STI services from Derbyshire residents

<table>
<thead>
<tr>
<th>April - Dec</th>
<th>Derbyshire residents attending IN/OUT of Derbyshire</th>
<th>Attendance IN Derbyshire</th>
<th>Attendance OUT of Derbyshire (OOA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>16,044</td>
<td>8966 (56%)</td>
<td>7078 (44%)</td>
</tr>
<tr>
<td>2016</td>
<td>17,145</td>
<td>10,388 (61%)</td>
<td>6759 (39%)</td>
</tr>
<tr>
<td>2017</td>
<td>15,628</td>
<td>8907 (57%)</td>
<td>6721 (43%)</td>
</tr>
</tbody>
</table>

3.1.2 Total patients accessing Derbyshire services for STI interventions increased by 8% in the same time period, with a 15% increase in contacts/activity. An average 82% of these patients resided in Derbyshire.

3.2 Contraception services incl. Long Acting Contraception (LARC)

3.2.1 An average 11% decrease in demand from Derbyshire residents for local services based on resident contacts is reported (2015/16 - 201/17) totalled from 17,200 to 15,300 contacts. However for total contacts (Derbyshire and OOA residents) demand on the local service has increased in recent years.

3.2.2 The flow of Derbyshire residents accessing contraception in/out of Derbyshire in 2017 shows an increased proportion accessing in-area compared to OOA with 92% in-area and 8% OOA.

4. Local Issues and challenges

4.1 Funding

During the first year of the Public Health grant in the local authority, the sexual health budget represented 21% of the total ring-fence (2014/15). However prior to this, reflecting back to the days of Primary Care Trusts (PCTs), there never was an actual PH budget as we define
the PH grant today. Thus in the preparations of the move into local authorities, it was very difficult to absolutely understand the true spend on sexual health services.

In 2014/15 a local reduction of 11% was placed on the budget going into 2015/16. However this was applied for robust reasons to maximise spend and was done alongside contractual changes into the new integrated service moving from block to tariff (payment by activity). Public Health learnt a great deal from local authority commissioning, applying a stronger business-like approach to give reassurance about spend and realise efficiencies.

The present budget equates to £6,594,096 per annum, representing 16% of the overall Public Health budget. This is split between a £5m allocation for the local integrated service to deliver all elements under the mandate to local authorities and an allocation of £1.6m for OOA costs (Derbyshire residents choosing to access OOA services) (c. Table 3). Derbyshire County Council has awarded a new contract to begin April 2019 for a length of 5 years with the option to extend (2x 24mth periods). The contract value maintains a flat rate of £5m per annum. Due to ongoing cuts we cannot afford additional uplift and this places significant risk to maintain a service that is governed by demand alongside the need to ensure an innovative, efficient service to meet population health.

Although the contract value is protected locally at a flat rate, the overall PH budget is reducing, with an overall increasing PH spend.

Table 3 Summary of Derbyshire allocation for the integrated sexual health service 2017/18 and 2018/19.

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
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<tbody>
<tr>
<td><strong>STI testing and treatment (payment by local tariff)</strong></td>
<td></td>
<td></td>
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<tr>
<td>STI testing and treatment incl chlamydia</td>
<td>1,763,097</td>
<td>1,963,097</td>
</tr>
<tr>
<td>Online STI pilot project</td>
<td>60,137</td>
<td>60,137</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,763,097</td>
<td>2,023,234</td>
</tr>
<tr>
<td><strong>Contraception incl. LARC (payment by local tariff)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraception (not in primary care)</td>
<td>1,437,435</td>
<td>1,237,435</td>
</tr>
<tr>
<td>LARC in general practice</td>
<td>913,364</td>
<td>913,364</td>
</tr>
<tr>
<td>OEC in Pharmacy</td>
<td>80,000</td>
<td>80,000</td>
</tr>
<tr>
<td><strong>Contraception TOTAL</strong></td>
<td>2,430,799</td>
<td>2,230,799</td>
</tr>
<tr>
<td><strong>Sexual Health Promotion and HIV Prevention (payment by block)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Health Promotion and HIV Prevention</td>
<td>425,000</td>
<td>425,000</td>
</tr>
<tr>
<td>Free condom scheme</td>
<td>50,000</td>
<td>50,000</td>
</tr>
<tr>
<td><strong>SHP/HIV TOTAL</strong></td>
<td>475,000</td>
<td>475,000</td>
</tr>
<tr>
<td><strong>Lead Provider management (payment by block)</strong></td>
<td></td>
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</tbody>
</table>
Total | 300,000 | 300,000
---|---|---
Out of area allocation (payment on various bespoke provider tariffs) | | |
Out of Area/ cross charging allocation (GUM/ Contraception mix) | 1,600,000 | 1,600,000

The Tariff-based allocation represents 84% of the contract value.

4.2 Out of Area charging and cross-charging

As stated above, we allocate a flat rate of £1.6m to pay OOA where Derbyshire residents access SRH services out of county and respective providers invoice the Council accordingly. The provider of the Derbyshire service treats OOA patients in its’ service and invoices the respective commissioning Councils.

OOA charging/ cross-charging presents significant challenge and risk especially with NO national solution to the process. Despite recent national guidance (August 2018), the overall message is still to continue under local solutions.

Our experience shows local charges vary “wildly”. For example:
- Anything from £160.00+ for a STI first appointment to £135.00 for the same procedure
- Refusal to pay for OOA contraception or pay if reciprocal

Administration costs to manage OOA payments are extensive locally (est. £20,000 per annum) when really we would want this money directed into patient care.

Speaking on behalf of our local integrated sexual health service provider – they are experiencing loss of income due to non-payment for contraception, placing financial pressures on them as well as the ethical and moral position that service provision should be paid for.

This OOA challenge requires a national solution NOT local. We have a concern that should such continue, a real risk will be placed on the open access nature of sexual health services and ultimately a risk to population sexual health. We have experienced letters where statements have been made that patients will be denied treatment due to non-payment of charges.

4.3 The commissioning landscape

The Health and Social Care Act 2012 mandated differing commissioning responsibilities across local authorities, NHS England and Clinical Commissioning Groups. The Derbyshire Sexual Health System is shown in this diagram, stating the 3 main commissioners but also organisations with strong association to sexual health.
This system risks presenting a disjointed landscape for sexual health commissioning and provision through a significantly large number of partners with
- differing agendas and priorities
- multiple commissioned services within different borders
- differing commissioning cycles with risk of service destabilisation eg. HIV treatment and care services
- no clarity of who is accountable for what
Again this is all set within a system of increasing financial constraint

There are real risks of “collapse” across the system when one partner decommissions a service, putting pressure on another element in the system and/or another area in the wider Health and Social Care system.

As a Council we have prioritised working in collaboration, aiming to use opportunities to achieve a “joining together” across the system and this may include co-commissioning in future years.
The Derbyshire Sexual Health Strategy, approved at our Health and Wellbeing Board in November 2017 drives our work with emphasis on a Resilient system, Prevention, Self-management, Service access and Reduction of barriers into services experienced by some of our most at risk populations.

The Health and Wellbeing Board locally add significant strength to whole system working, risk and harm reduction.
Sexual Health being part of Derbyshire County Council allows for positive opportunities of closer working across departments including Childrens as a key area to explore commissioning/ providing options to promote prevention and improve health.

However a system of financial constraint is a barrier to a collaborative approach. Public Health and the Council generally need to be funded properly to ensure sexual health – a vital service meets population need and through that significant cost-savings will be made to the wider Health and Social Care system.
5. In conclusion: Things we would like to make the Committee aware of

- Sexual Health is an integral part of all our health. With poor sexual health, financial costs due to unplanned pregnancies and STI transmission will soar for the NHS and Social Care alongside the risk of far-reaching consequences on lives. We reiterate the need to fund Sexual Health properly.
- A whole system way of working needs to be given proper opportunity without barriers of funding constraint, differing priorities and unclear responsibility within the system. We reiterate the need for a clearer, understandable landscape properly financed to ensure commissioners and providers can truly join together to maintain and improve population sexual health.
- We reiterate the need for a national solution to the current position on OOA charging. We urge that both commissioners and providers work together on this. We feel that if the current position continues through “bespoke” local charging, there will be a real risk to the open access nature of sexual health services alongside significant financial pressure for both commissioners and providers.

Finally we want to thank the Committee for offering this opportunity to submit a local authority perspective.

Appendix 1 includes some examples of developing practice locally.

October 2018
### Appendix 1

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Action</th>
<th>Evidence of impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service-specific areas</strong></td>
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</table>
| Service access                                 | Multiple modes of delivery approach – use of digital technology       | **Online STI testing**: $73\%$ return rate; $43\%$ reactive ($84\%$ chlamydia, $7\%$ gonorrhoea, $6\%$ HIV, $3\%$ syphilis)  
12mth HIV online offer: $59\%$ return rate, $2\%$ reactive tests.  
Reviewed website, Youtube videos. |
| Needs of at risk groups                        | $15.5\%$ maintained budget allocation for Sexual Health Promotion and HIV prevention workforce training across whole system | Increased STI diagnosis rates:  
52\% increase/ gay males  
26\% increase/ bisexual males  
*GUMCADv.2 2015 to 2017* |
| Whole system approach – support to staff working with at risk groups | Sexual Health Network                                                  | 2 events per annum - topics covered included HIV prevention, Learning Disabilities, LGBT needs, young people and vulnerable young people |
| Chlamydia detection (15-24yrs)                 | Derbyshire Chlamydia Care Pathway (CCP) working group established under PHE national framework tool | This approach has been recognised as good practice by PHE and is the subject of a national Chlamydia Screening Programme (NCSP) case study to be published |
| Increase HIV testing coverage                  | Online HIV testing offer. Training by Clinical Lead with clinicians to promote HIV test. | 12mth HIV online offer: $59\%$ return rate, $2\%$ reactive tests.  
Local KPI Full screen with HIV uptake shows $43\%$to $46\%$ increase (2015/16 - 2017/18) |
| Teenage conceptions                            | Multiple action (incl. C-Card)                                         | Teenage conceptions more than halved locally over last decade.  
Agreed strategic priority/ whole system approach. |
| SRH commissioning landscape: challenge and opportunity | Derbyshire Sexual Health Strategy                                   | Strategic working group; processes for accountability agreed.  
New opportunities for collaboration across the whole system.  
New projects – LARC training to specialist midwifery; whole system response to RSE consultation. |
<table>
<thead>
<tr>
<th>Out of area budgetary challenge</th>
<th>Derbyshire OOA Terms of Reference based on national cross-charging guidance (August 2018)</th>
<th>Reciprocal arrangements for contraception agreed. Decrease in some OOA spend to individual providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OOA patient flow</td>
<td>Joint commissioner/provider analysis of border flow</td>
<td>Evidence of decreasing flow to some bordering authority areas</td>
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</tbody>
</table>