Plymouth City Council welcomes the opportunity to respond to the Health and Social Care Committee’s inquiry into sexual health.

1. Recent Trends

Rates of sexually transmitted infections (STIs) in Plymouth are high when compared to other areas. In 2017 the rate of all new STI diagnosis was the 28th highest out of 326 local authorities in England. The rate of gonorrhoea has more than doubled in the last 4 years and the chlamydia detection rate in 15-24 year olds is significantly higher than all other areas in the South West and all nearest neighbour areas (e.g., Sheffield, Derby and Sunderland).

The estimated diagnosed prevalence of HIV in Plymouth is low when compared to England. Late diagnosis is the most important predictor of HIV related morbidity and short term mortality. Between 2014 and 2016 40.5% of new HIV diagnoses in Plymouth were late diagnoses.

There has been a determined focus on reducing teenage conceptions over the last decade. The rate of teenage conceptions in Plymouth has fallen significantly from 54.7 per 1,000 females aged 15-17 in 1998 to 19.6 in 2016.

In 2017 the total abortion rate per 1,000 female population aged 15-44 years was 16.2 which is slightly lower than the England rate. Of those women under 25 years who had an abortion in 2017 22.1% had had a previous abortion – this is lower than most nearest neighbour areas.

2. Prevention

Prevention is an essential element of improving sexual health outcomes in the population. In Plymouth the commissioned Integrated Sexual Health Service has an enhanced focus on prevention throughout all levels of provision. This includes structured brief interventions to address risk taking behaviours and lifestyle issues, targeted health promotion packages and outreach services for individuals and groups not using mainstream services and individuals and groups engaging in high risk behaviours. This work is directed to education, building resilience and supporting people to make informed choices in relation to their sexual and reproductive health.

Prevention goes beyond specialist sexual and reproductive health services. A number of services including General Practice, Community Pharmacies, School Nursing Services, Maternity Services and a range of community services are well placed to integrate sexual and reproductive health and wellbeing into their core provision. Plymouth City Council is concerned that financial and staffing pressures in these services compromise their capacity to deliver sexual and reproductive health prevention.

Plymouth City Council welcomes the government announcement for mandatory sex and relationships education (RSE) in all schools in England but is concerned that the implementation of this has been extended to 2020.

Recommendation
It is essential that credible guidance and support is issued to provide a framework for RSE that ensures equity of provision for all young people. The curriculum for RSE must be given comparable status to other core subjects and schools must be adequately funded and staffed to deliver RSE.

3. Commissioning and delivery of sexual health service

Due to the fragmented division of commissioning responsibilities for sexual, reproductive and HIV services there is a significant risk that local services are disjointed and inaccessible to the local population.

In acknowledgement of the risks of service fragmentation the Public Health Team in Plymouth City Council has worked collaboratively with the local Clinical Commissioning Group, NHS England representatives and local authority commissioning leads from neighbouring areas to ensure the efficient use of limited resources and overcome geographical and commissioning boundaries.

During 2016/17 Plymouth City Council employed an innovative procurement approach to working with the providers of specialist sexual health services in the city to develop a new integrated service model – Sexual Health in Plymouth (SHiP). Using best available evidence and informed by engagement with local residents and service users Public Health commissioners and sexual health service providers worked collaboratively to design an Integrated Sexual Health service to;

- Prioritise prevention and health promotion
- Provide an integrated ‘front door’ with a central telephone number and online system for advice, information, self-management and appointment bookings
- Use new technologies and treatments including online testing for sexually transmitted infections
- Offer services from a number of accessible sites across the city

Due to reductions in the Public Health Grant annual financial efficiencies have been built into the contract for this new service. This has created extremely challenging conditions for both the commissioners and providers of specialist sexual health services and has introduced unnecessary stress and risk into the system. To date there have not been any notable reductions in overall service capacity but the system is experiencing unprecedented pressure in mobilising the new service model at the same time as managing demand.

Continued financial pressures will mean that the service will not be able to operate at current capacity. This could compromise the quality of services and lead to reduced service availability, longer waiting times for some services and ultimately poorer outcomes for the local population.

In addition to commissioning the Sexual Health in Plymouth (SHiP) service, Public Health in Plymouth City Council commissions a number of General Practices in the city to deliver Long Acting Reversible Contraception. Due to continued increase in overall demand for General Practice and difficulties in recruiting and training staff it is difficult to guarantee the delivery of these services. This in turn puts additional pressure on specialist sexual health services.
**Recommendation**

It is essential that national guidance directs the provision of integrated sexual health services locally. Revision of current guidance should consider the benefits of pooled budgets, cross border commissioning models and local lead commissioning arrangements.

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4. **Funding**

Sexual health services are funded from the Public Health Grant allocation that has been awarded to Plymouth City Council since 2013/14. The initial grant allocation was £12,276,000 or £43 per head of population for Plymouth, compared to a national target allocation of £55 per head of population. This position means that Public Health in Plymouth was underfunded by £3 million from time it took on these responsibilities in April 2013.

In 2015/16 the Public Health Grant in Plymouth was subject to an in year cut from central government of £920,000. Since then annual reductions in the grant allocation have been applied, amounting to £1.3 million in 16/17, £400,000 in 17/18, £405,000 in 18/19 and a further £405,000 in 19/20. An indicative allocation for 20/21 illustrates a further reduction of £400,000. Current work by SIGOMA [a campaigning network of urban local authorities] demonstrates that Public Health in Plymouth is 21.9% underfunded based on need.

The Public Health Grant allocation from central government is being cut despite well-established evidence of the need to move towards a more preventative approach to improving health and wellbeing and is counter to policy directives that prioritise prevention and promote integrated approaches to improving population health and wellbeing. The cuts are also being made despite the significant evidence for the cost effectiveness of prevention and early intervention. It is shown that for every £1 spent there is a return on investment of £14 and that cuts to Public Health services are likely to generate substantial additional costs to the healthcare system and wider economy.¹

Investing in sexual health services can deliver significant cost savings for the NHS and local authorities. Quality services and interventions that focus on prevention, screening and prompt treatment and partner notification can control disease, prevent unwanted pregnancies and avoid costly health complications and treatments.

Cuts to sexual and reproductive health services are counterproductive; every £1 cut from sexual and reproductive health services could cost the wider public sector £86². Cuts to sexual and reproductive health services are likely to have a disproportionate impact on individuals living in the most deprived areas³ and undermine efforts to reduce health inequalities.

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Every case of HIV that is prevented can save the NHS over £350,000. If the estimated 4,000 UK-acquired HIV infections diagnosed in 2011 had been prevented £1.9 billion in lifetime treatment and clinical care costs could have been saved.

Up to one third of births in Britain are unplanned often leading to adverse impacts for the mother and child. Effective contraception and planning for pregnancy is essential to improving overall health outcomes for women and children. Investment in contraception is cost effective; every £1 spent on contraception saves over £11 of costs elsewhere in the NHS. Every £1 spent preventing teenage pregnancy saves £11 in healthcare costs.

The National Institute for Health and Care Excellence (NICE) suggests that the costs of increased provision of long acting reversible contraception (LARC) are more than offset by the costs of unplanned pregnancies. It estimates that the NHS in England could save £100 million each year by increasing the use of long-acting reversible contraception.

**Recommendation**

Urgent consideration should be given to reversing the cuts to the Public Health Grant. The recommendations of the 2015 Advisory Committee on Resource Allocation (ACRA) review (‘Public Health Grant: Proposed Target Allocation Formula for 2016-17”) should be implemented in full.

5. **Out of Area Payments**

National guidance sets out the responsibilities for payment of out of area Genito-Urinary Medicine (GUM) costs for people accessing these services outside of their normal area of residence. There is currently no clarity within national guidance regarding the responsibility for payment of out of area contraception services.

Due to the inadequacies of current national guidance there are significant inconsistencies in the tariffs charged for out of area GUM Service activity. Alongside this some local authority areas will not pay for out of area contraception activity. This in turn creates a funding shortfall for some providers and undermines the sustainability of some services. Furthermore current bureaucratic systems of cross charging for this activity are burdensome and inefficient and direct resources away from service provision.

**Recommendation**

The national guidance for out of area payments should be reviewed and extended to include contraception services. A single national approach would enable more consistency and fairness around out of area cross charging.

6. **Workforce Issues**

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Delivering high quality services relies on a suitably qualified and experienced workforce. There have been some challenges locally in recruiting and maintaining an appropriately trained specialist sexual health workforce. There is some anecdotal evidence that financial pressures and changes to service configuration have acted as a disincentive to professionals interested in working in this area.

Some specialist training including that for Long Acting Reversible Contraception is complex, costly and time consuming. It is difficult to engage in this when there are so many financial and capacity pressures both in specialist sexual health and General Practice services.

**Recommendation**

Nationally there needs to be a planned approach to developing the specialist workforce for sexual health services. This should include a training needs analysis and the development of a workforce strategy that promotes integrated training models and is backed up with specific investment for continued professional development.