Written evidence from Derbyshire Community Health Services (DCHS)

In response to the Health and Social Care Committee’s request for evidence on sexual health, Derbyshire Community Health Services (DCHS) would like to provide the following evidence regarding our experience of providing sexual health services.

1. Commissioning of Services
DCHS is currently commissioned to provide the following sexual health services:

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Service provided</th>
<th>Contract term/awarded</th>
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<tbody>
<tr>
<td>Derbyshire County Council</td>
<td>Integrated Sexual Health Services (ISHS)</td>
<td>Procurement 1: April 2015 to March 2019</td>
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<td>Procurement 2: April 2019 on 5+2+2</td>
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<td>Derby City Council</td>
<td>ISHS</td>
<td>April 2015 to March 2020</td>
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<td>Derbyshire CCGs</td>
<td>Vasectomy</td>
<td>AQP contract to March 2020</td>
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<td>Menopause service (recently decommissioned)</td>
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<td></td>
<td>Psychosexual therapy (recently decommissioned)</td>
<td>Decommissioned August 2018</td>
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<td>NHS England</td>
<td>HPV vaccines for MSM</td>
<td>Recently commenced</td>
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<td></td>
<td>Opportunistic cervical screening</td>
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Whilst the contractual arrangements are with individual commissioners, there is undoubtedly a pressure on DCHS, as a provider, to liaise with multiple commissioners and organisations in the delivery of individual contracts. We must respond to competing demands and local variance in approach to commissioning of sexual health services and collect, compile and report to each commissioner a wide range of performance indicators to illustrate the productivity and effectiveness of our services.

2. Impact of multiple commissioners of sexual health services
DCHS has recently been awarded a new contract for Integrated Sexual Health Services (ISHS) in Derbyshire County, starting in April 2019, under a lead provider model.

As the incumbent, we already deliver the Derbyshire ISHS. The contract requires staff to be dual trained in GUM and contraception services. As lead provider, DCHS sub-contract specialist nurse, administrative and medical staff services from the local NHS acute provider trust, who were previously commissioned to provide the GUM service.

In the new contract, it has been agreed that the staff from the acute trust will TUPE transfer to DCHS, to facilitate harmonious working amongst the integrated team, with staff employed on the same terms and conditions of employment. We envisage that this will ensure a completely integrated service is delivered.

When considering TUPE arrangements for this transfer, the opinion of the commissioners for the HIV Treatment and Care service, which DCHS does not deliver, had to be sought. This was because a number of sexual health staff deliver services in both integrated sexual health and HIV, which are commissioned by different organisations. Historically, GUM staff delivered both sexual health and HIV services.

Since the separation of commissioning responsibilities for these services, any provider organisation that does not deliver both of these services is put in a difficult position regarding the future service stability of the HIV Treatment and Care service. This requires the separate provider organisations to develop arrangements between themselves to sub-contract services (i.e. staff) back to each other, all with the prior permission of all commissioning organisations, and creates a pull between the delivery of the two services through the separation of commissioning arrangements.

Another example of the impact of multiple commissioners in the sexual health system involves the recent request from NHS England to roll out HPV vaccines to men who have sex with men (MSM) and opportunistic cervical screening. This is an area of development that DCHS is really keen to be involved in, and as such we have reached an agreement with NHS England to provide this service from October 2019. As these services are not co-commissioned alongside other sexual health services, it has been required that the contract states that DCHS will only be able to deliver this service in the required geographies for as long as DCHS remains the provider of ISHS in these areas.
Should DCHS no longer deliver integrated sexual health services, all these additional services will need to be separately recommissioned and re-negotiated by commissioners with the new provider. A more joined up co-commissioning approach for all sexual health services would deliver efficiencies, reduce ambiguity and allow for greater focus on delivery of quality services.

3. **Funding**

Having recently been awarded a 5+2+2 year contract for Derbyshire County, we are very pleased to see the length of contract increase from previously (2+1+1). This greater contract term provides improved stability for the service, and a far greater opportunity for us to demonstrate the operational impact of our service delivery and the public health impact of the work we do.

Whilst we applaud that the contract budget of the new service has not decreased within Derbyshire, the static nature of the contract budget still results in increased financial pressure for service providers.

To explain this more clearly, in 2015, at the point of integration in April 2015, Derbyshire County Council reduced the sexual health service budget by 11%. The contract value at 2015 has not increased since, and will remain the same from 2019 onwards throughout the new tender award period of 5+2+2 years. This means DCHS will have received the same income/contract value to deliver increasing levels of activity for up to 13 years. This requires us to absorb all increases year on year in salaries, equipment and estate costs. We seek to do this through innovative efficiencies but over time the ability to absorb this level of increased costs in the service becomes increasingly challenging.

Another issue relating to funding is that as sexual health services are commissioned by multiple commissioners, the funding streams for these different services are equally complex. For example, in Derbyshire we commission GPs and pharmacies to deliver long acting reversible contraception (LARC) and oral emergency contraception (OEC), as part of our provision of the ISHS, commissioned by the local authority. The contract we hold with the local authority (LA) requires these to be pass through costs. On completion of a LARC insertion, we are required to draw down a tariff from the commissioner, which is then split between a payment to the GP for their consultation time, and a payment to the CCG for the consumable cost of the intra-uterine device (IUD), as these are funded through FP10s, for
which CCGs hold the budget. This places an unavoidable and complex administrative burden on DCHS as it is a requirement of the lead provider role.

4. Payment for Out of Area Contraception

Another key issue relating to funding for services is the lack of consistency across the country regarding payment to providers for out of area contraception services.

Derbyshire County Council pays DCHS a contraception tariff for Derbyshire residents who access services within the county boundary. This payment averages £110 per contact. Where a patient living outside of Derbyshire attends a clinic within Derbyshire, DCHS must see the patient under our open access contractual obligations, which are guided by the national framework for sexual health services. We must then invoice the LA where the patient lives. The tariff we invoice this second LA for must be the same as the tariff Derbyshire County Council pay us for Derbyshire County residents seen in Derbyshire clinics and in some instances has been capped at a lower level where this second LA has in place a lower tariff which they have negotiated with their local provider.

An analysis of service delivery data indicates that in 2016-17, 935 non-Derbyshire residents were seen in DCHS Derbyshire County sites of which 9 LA’s refused to pay for 245 of these attendances. This resulted in £12,950 of unrecovered income for DCHS. In 2017-18, 20 LA’s refused to pay for their residents being seen by DCHS creating an unfunded cost pressure of £18,158. For 2018-19 year to date, the amount of unfunded activity has increased further and we are in receipt of more letters from other local authorities refusing payment.

DCHS is therefore contractually obligated to provide a staffing model and associated costs to deliver open access services to accommodate all non-Derbyshire residents who seek treatment in Derbyshire, but is not receiving payment for those services where an external LA refuses to pay.

In summary, this means that neither commissioners (i.e. Derbyshire and the LA where the patient lived outside of Derbyshire) incurred costs for these patients, and did not recognise themselves as the accountable local authority to fund these clinical interventions.
We understand that some local authorities include funding for all contraception costs (regardless of residency) in their contract with their provider organisation. This is not, however, the case in the areas we provide services.

Whilst we know that commissioner to commissioner dialogue and agreements are taking place to agree reciprocal arrangements, until the impact of those discussions on the provider is considered, providers in the same position as DCHS will always be financially penalised by the commissioning arrangements of their own and the LAs of origin of their patients.

The recently published Sexual Health Services: Key Principles for Cross Charging, Updated guidance for commissioners and providers of sexual and reproductive health services in England, August 2018, goes some way to recognise the difficulties around cross-charging for out of area contraception services, but does not mandate any arrangements. We strongly believe that there needs to be a consistent mandatory position agreed that is fair to both commissioners and providers, across the country, to fund service provision wherever a patient chooses to attend.

5. Hard to reach groups

Our service model in DCHS is designed to facilitate access to our services for those from the hard to reach groups. We have focussed on increasing cost effective access points to the service by;

- including subcontracts with 66% of Derbyshire GPs and 72% of Derbyshire pharmacies to deliver LARC and OEC;
- implementing self-testing services which are accessible 24-7 through our website;
- invested in social marketing to identify effective channels of communication to vulnerable and hard to reach groups, including BME, MSM, over 50s and drug and alcohol users;
- developed subcontractor relationships with key voluntary sector organisations who work with vulnerable groups.

The ISHS is designed around a system-based approach, with DCHS leading across the Derbyshire system. We co-ordinate a sexual health network, which includes membership from sexual health services and commissioners, but also the wider system, such as youth organisations, voluntary sector providers, children’s workers, education, social services and drug and alcohol services.
We consider sexual health awareness to be everyone’s business, and therefore promote our “Your Sexual Health Matters” brand across our wider stakeholders. In Derbyshire we have been lucky in that our commissioners have continued to invest in public health services. However, we are aware of the impact in other areas of reduced access to hard to reach groups through government cuts and disinvestment in voluntary sector organisations. This results in a reduced wider system within which to promote sexual health services, often having the biggest impact on the most vulnerable people.

The impact of de-commissioning of certain elements of provision has also presented significant challenges to DCHS as our role as the leader of the sexual health system. For example, until recently DCHS was commissioned to deliver menopause services. This service provided an opportunity to engage over-50s about their sexual health but has now been decommissioned. As a result we have lost this access point into the ISHS. Sexual health services for over-50s are therefore more limited in Derbyshire than previously. In the last 12 months 376 women over-50 attended one of our clinics in our Derbyshire and Derby City services, citing contraception as their reason for attendance. We often find that these women have approached the service for IUS insertion, which during the triage process the reason for their attendance is often divulged to relate to menopause care rather than for contraception purposes.

6. Impact of change on the workforce

The impact of service integration of GUM and contraception services, and the reduction in budget in real terms, has had a significant impact on staff welfare and engagement.

To give the background, to mobilise the integration of sexual health services in Derby & Derbyshire, four separate NHS Trusts were required to undertake staff engagement exercises, in order to bring together four individually delivered sexual health services under one service, with DCHS as the lead provider.

It was apparent prior to, and throughout the integration process, that the impact of the uncertainty created by the change processes was detrimentally affecting staff engagement scores within the service. This could be seen both in morale amongst some teams, pulse check scores (our local measure of staff engagement) and a small but noticeable increase in staff seeking advice from trade union colleagues regarding the potential to raise a grievance.
Throughout this entire time staff continued to deliver excellent care to our patients, which
due to the reasons given above was a particularly difficult time for the staff.

In May 2015 (during the integration process), the sexual health service reported a 57% staff
engagement score, reflecting a feeling that they were being ‘done to’ as a result of the
requirements to deliver the new service model. In March 2018, shortly after having
completing the bidding process for the 2019 Derbyshire service, staff engagement scores
were 74%, reflecting the work that has been done to improve engagement, to ensure staff
feel more involved in decision making processes.

Besides the visible impact of changes to the workforce, we have also experienced the
following hidden costs of conducting workforce changes. These comprised:

- Preparation and costing of a staffing model
- Development and approval through the Agenda for Change evaluation process of
  updated and new job roles within the structure at every level
- Preparation and delivery of staff engagement events including opening, closing
  and if necessary mid-point formal consultation meetings with all affected staff
- Investment in training to fill skills gaps within the existing team to meet the needs
  of the new service requirements.
- Management of the “at risk” process to ensure staff placed at risk of
  organisational change are afforded support to find suitable alternative
  employment
- Reduced service delivery capacity in the early part of the implementation phases
  of the new structures
- Management negotiation with the relevant incoming organisations (3 NHS
  Trusts)
- Risks associated with inconsistent banding/qualifications across organisations,
  which affect pay

7. A dual-trained workforce

All sexual health services we now deliver require an integrated service model, which
requires the workforce to be dual trained; skilled in both contraception and STI interventions.
This has meant that the service has needed to put in place a complex and lengthy training
programme for all clinical staff, in order to upskill. Some have engaged with this process
willingly, but many have not, from the most senior medical staff to entry-level nursing colleagues.

Whilst running training clinics, it is not possible to see the same number of patients in a list as time needs to be given to develop skills and competence for the trainee. This naturally has the consequence of reducing the number of available slots within clinics for patients to be seen face-to-face. The service seeks to minimize the impact of this by staggering training clinics, but the knock-on effect of this approach is that it takes longer to develop the workforce to the required level.

The service has continued to experience difficulty in recruiting and retaining qualified staff. The perception shared with us by many staff is that the breadth of training required is too great, and that the requirement to deliver procedures within the service, i.e. coil and implant fitting, is pushing members of staff beyond their confidence to deliver.

Dual trained staff are a relatively new workforce, introduced alongside the inception of integrated sexual health models. As such, our trained staff are highly sought after across sexual health and primary care services and having invested in dual training we have been hugely disappointed to then lose these staff into other parts of the system where they can command higher salaries or not be required to work as flexibly as our contract with our local commissioner requires. As there is not yet a critical mass of dual trained nurses looking for work in sexual health services, when a specialist nurse leaves, we resort to recruiting entry level nurses and starting them on the extensive training programme to develop the necessary skills. This can take 16-24 months, including many weeks before they are able to see patients. As mentioned previously, until staff are fully trained, appointment lists have to be reduced while staff develop their skills. Our Specialist Nurses are highly committed and assets to the service, but due to our turnover rate of between 15 and 30% for the reasons mentioned above, the cost in terms of time and reduced opportunity for patients to be seen is a concern.

The burden of training costs sits with the provider and this presents two challenges:

- Nationally the training monies through Learning Beyond Registration (LBR) etc have reduced considerably
- An apprenticeship programme for dual trained competencies has not yet been developed and providers will not have the capacity to release staff to develop one at a national level as all capacity in a tendered model is prioritised for front line care and drawing down tariff
• Delivering training clinics within the service requires a reduction in the number of clinical slots on a trainers list which then means a lower level of income/individual tariff activity can be claimed by the provider despite staffing costs for that clinic list still requiring the trainer and the trainee costs to be met.

8. Conclusion
The complex and split commissioning landscape creates system inefficiencies and detrimentally affects patient care.

The impact of integrated systems and dual training requirements on staff needs to be recognised as it has resulted in increasingly challenging recruitment and retention issues for providers.

Out of area funding mechanisms are inherently unfair to a provider and a consistent approach needs to be adopted where either all commissioners fund their local provider for all contraception, or all commissioners agree not to fund their provider for contraception, but instead pay for out of area contraception invoices.

We thank you for the opportunity to add a provider perspective to the Health and Social Care Committee review and hope it provides useful insight. We would welcome the opportunity to be further involved if required.