

DERBYSHIRE COUNTY COUNCIL

CABINET

20 July 2017

Report of the Director of Public Health

**Re-procurement Derbyshire Integrated Sexual Health Service (DISHS)
(Health and Communities)**

1. Purpose of the report:

To inform and seek Cabinet approval for the

- Final Report: Consultation on the Derbyshire Integrated Sexual Health Service (DISHS) Re-procurement, June 2017: Findings and Recommendations
- Equality Impact Analysis Report, May 2017: Findings and Recommendations

To inform Cabinet of the development of the Derbyshire Sexual Health Strategy 2017-2020.

2. Information and analysis:

2.1 Background

In February 2017, Cabinet gave approval to re-procure the Derbyshire Integrated Sexual Health Service (DISHS) for a contract period of five years commencing on 01 April 2019, with an option to extend the contract for two further periods of two years.

The Council is mandated by the Health and Social Care Act 2012 to ensure provision of open access sexual health services including:

- Contraception
- Testing and Treatment of sexually transmitted infections (STIs)
- Sexual health aspects of psychosexual counselling and
- Sexual health specialist services including young people's services, outreach, HIV prevention and sexual health promotion.

In April 2017 the Commissioner reported Stage 1 Consultation findings to the Meeting with the then Cabinet Member, Health and Communities.

2.1.2 Sexual Health need in Derbyshire

Sexual Health data for Derbyshire has been recently updated in Appendix 1.

In summary Derbyshire maintains a level of good sexual health.

Compared to England currently Derbyshire has

- lower prevalence of STIs and HIV
- lower rates of teenage conceptions and
- higher levels of prescribing of long-acting reversible contraception (LARC), the most cost-effective way of preventing unplanned pregnancy.

However particular challenges remain across the county where the screening coverage of STIs and uptake of testing including HIV could be improved. Chlamydia screening (15-24yrs) is below England.

Sexual health outcomes are poor in some groups compared to the whole Derbyshire population. These include men who have sex with men (MSM); young people, particularly vulnerable young people; and people living in deprived communities.

The data indicates the need for continued support to ensure the service offer is open for all to maximise accessibility for all.

2.2 Findings and Recommendations of the Final Report: Consultation on the Derbyshire Integrated Sexual Health Service (ISHS) Re-procurement (June 2017)

The full Consultation Report is in Appendix 2.

2.2.1 Summary Background

The consultation was delivered in two stages between February and May 2017. The purpose was to inform the further development of the Integrated Sexual Health Service in Derbyshire, in light of what currently works well and what might be improved and to invite comment on service priorities in the future.

The findings and recommendations will be used to inform the development of the service specification for Integrated Sexual Health Services in Derbyshire as part of the pre-tender/ re-procurement process. Information will also support the developing Sexual Health Strategy for Derbyshire (section 2.4).

Key themes were prioritised for inclusion during the consultation:

- exploring the main priorities for the future Derbyshire service
- service accessibility and how barriers to access, perceived or real, can be addressed

- service visibility
- Innovation across service development and delivery

The consultation aimed to reach as diverse a range of responders as possible, including users of sexual health services, and those who may need services but do not currently access them. Various methods of consultation were used including online and postal questionnaires, focus groups and 1:1 meetings on request. Multiple communication channels were also used to maximise response.

People responding to the consultation included the current service providers and service users, professionals commissioning and/or providing services with an association to the sexual health agenda, and the general public, including groups with vulnerability to poor sexual health outcomes.

350 people engaged in both Stage 1 and 2 of the consultation, including:

- 113 responses to the online public survey
- 75 postal submissions to the public survey
- 101 responses to the online stakeholder survey
- 61 participants engaged in focus groups from identified populations with vulnerability to poor sexual health outcomes.

2.2.1 Summary Findings

The main priorities raised are as follows:

- Improved availability of appointments and waiting times for appointments
- Consideration of outreach clinical services to those with a level of vulnerability, who experience barriers in accessing a clinic
- Accessibility of services, particularly in rural locations where travel is a barrier
- Alternative options for service access e.g. online services, postal kits, text messaging, delivery in other settings - General practice
- Address service barriers including stigma, feelings of “being judged,” ensuring trust in confidentiality and anonymity
- A trained workforce to meet service demand
- Exploration of extended community provision through general practice alongside appropriate funding
- Improved service communication and promotion with partners

2.2.2 Summary Recommendations

The report recommends that the Commissioner ensures the findings are:

- reported to the current provider of service to support ongoing development to the contract end March 2019
- considered to develop the service model to be incorporated into the Specification and tender documentation available as part of the tender process - summer 2017
- used to inform the development of the Sexual Health Strategy for Derbyshire

2.3 Equality Impact Analysis (EIA) Report, May 2017

The full EIA report is in Appendix 3.

2.3.1 Summary Findings

The DISHS offers an open access provision for the whole population, although the EIA reiterates some protected groups who are more vulnerable to poor sexual health outcomes compared to the wider population. These groups include:

Protected Groups:

Age: young people and vulnerable young people including NEET, young offenders, LGBT young people, children and young people in care, Care Leavers, young people involved in risky behaviours such as substance misusers are more at risk of poor sexual health outcomes. The EIA reiterates the need to ensure a focus on young people and vulnerable young people through promotion, outreach, cross-working with partners such as schools, children's service teams and suitable training of staff to support their interaction with young people and vulnerable young people eg. use of Your Welcome standards

People living with disability: disabled people (including learning disability and long terms conditions such as HIV) can have difficulty accessing services due to location. In the area of sexual health additional barriers can present such as issues of stigma and perceptions of feeling judged. People living with HIV also require good access to sexual health services to ensure appropriate testing to prevent onward transmission and information about access to support and advocacy services.

Gender: DISHS is open access to all, however the EIA reiterates the need to ensure appropriate promotion appropriate to gender.

Pregnancy and maternity: The EIA reiterates the necessity of pathways across services. This would include clinical pathways between other commissioned health services such as maternity and termination of pregnancy services to ensure accessible routes to contraception provision for new mothers or those at higher risk of unplanned pregnancy, and wider support through DISHS.

Race: Some ethnic groups such as people from the Black African community have a greater risk of poor sexual health due to cultural and behavioural factors. Although the population of Derbyshire is not ethnically diverse, DISHS monitor and report access based on ethnicity of service users, and use best practice guidance to address issues affecting ethnic minority groups. Examples include practice to address issues such as Female Genital Mutilation (FGM) and monitoring the service offer within high areas of ethnic populations such as workplaces with a concentrated workforce from an ethnic minority group.

Sexual Orientation: People identifying as part of the LGBT population include men who have sex with men (MSM). MSM are a vulnerable group at higher risk of poor sexual health outcomes. The EIA reiterates the need to ensure the service offer is accessible for the MSM population. The current service ensures provision through working with a voluntary sector organisation with specific expertise in working across the MSM population. The service offer is accessed through various ways including 1:1, group, outreach, online and visibility at key LGBT events, such as Pride events to raise awareness and deliver STI testing.

Non-statutory groups are identified through the EIA as follows:

Disadvantaged populations: similar to other areas of health and social care services, people living with higher levels of deprivation are at more risk of poor health outcomes. The EIA reiterates the need for the DISHS to ensure service access amongst this population.

People living in rural parts of the county: The EIA highlights this issue as particular for the Derbyshire demographic. The current DISHS offers different modes of delivery in various settings to try to minimise barriers to service access due to rurality. A key element within this is to work through general practice and pharmacy across the county. Respondents to the consultation (Appendix 2) also raised their preference to explore access to DISHS through general practice settings.

2.3.2 Summary EIA Recommendations

Recommendations for further action to support identified groups are detailed throughout the full EIA report. The re-procurement of DISHS will enable service development in response to this EIA. The aim of the re-procurement is to secure a continued improvement of sexual health across the whole Derbyshire population, focusing particularly on people in protected groups and at higher risk of poor sexual health outcomes.

The EIA reiterates the need that commissioners continue engagement with other sexual health commissioners (CCG and NHS England) and commissioners with association to ensure

- the development of an agreed Derbyshire Strategy for Sexual Health 2017-20
- there is no risk or destabilisation to services across the whole sexual health system due to this re-procurement by the Council and other re-procurements by external commissioners.

2.4 Derbyshire Sexual Health Strategy 2017-20

2.4.1. Background

In Derbyshire there is a comprehensive sexual health delivery system commissioned by three organisations:

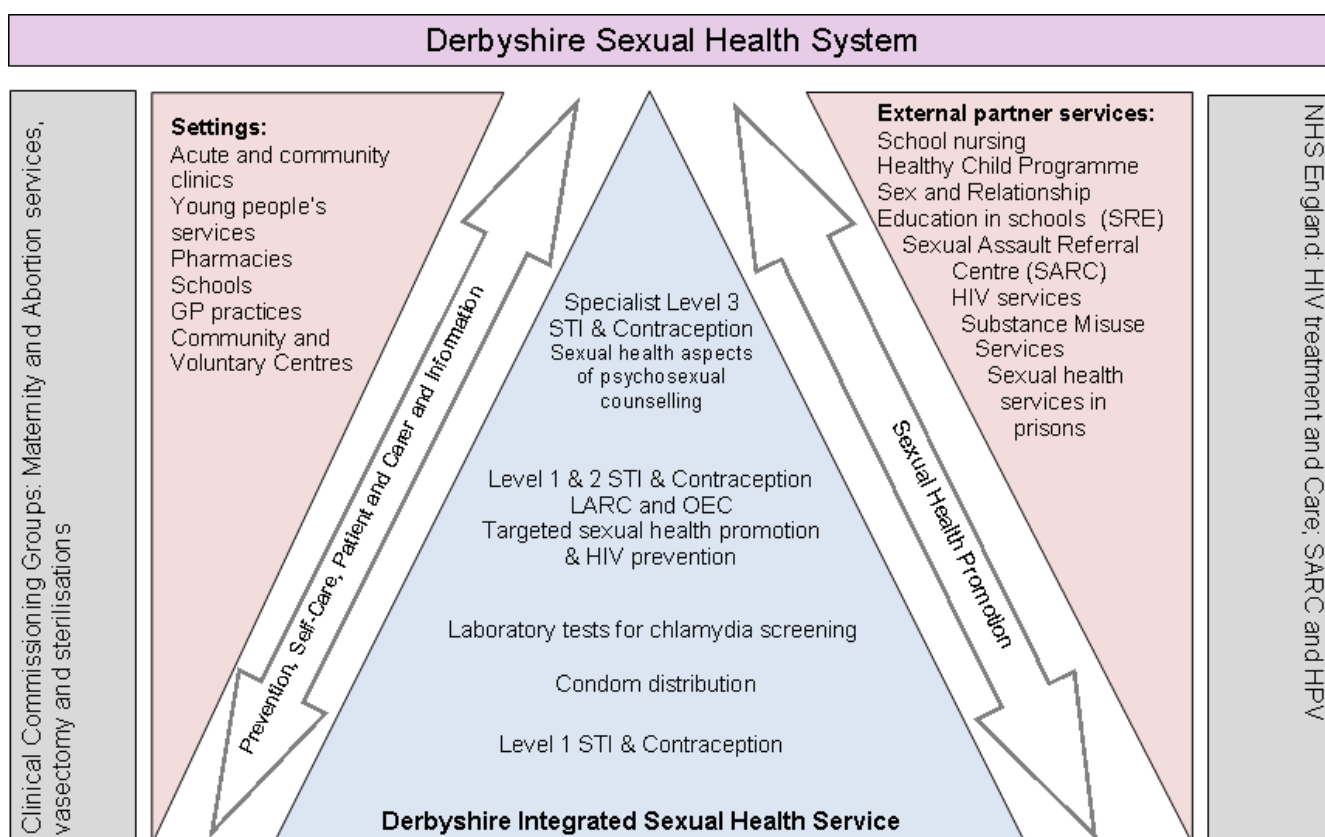
- Derbyshire County Council
- Clinical Commissioning Groups
- NHS England

Appendix 4 outlines the responsibilities of each commissioner, in accordance with the mandated duties under the Health and Social Care Act 2012.

The diagram below outlines the whole sexual health system in Derbyshire and shows the commissioning landscape for sexual health services, external service provision with an interest eg. schools and multiple settings where there is opportunity for delivery of elements of sexual health provision. The service elements within the Derbyshire Integrated Sexual Health Service are outlined across the central triangle.

Key themes underpinning DISHS are reflected in the arrows and are seen as cross-cutting throughout the whole DISHS currently and in the re-procured service. These are themes of

- Prevention
- Self-care and/or management of one's own sexual health and wellbeing
- Service information and promotion for users and carers
- Sexual Health Promotion



The strategy review was initiated in March 2017, with local commissioners of sexual health and other commissioners of associated services, aiming to bring together all elements of the system working within one agreed Derbyshire vision, with strategic objectives. The draft vision for the Strategy is that:

All people in Derbyshire, irrespective of factors such as where they live, their age, gender, ethnicity and sexual orientation have good sexual health, and access to good quality, welcoming sexual health services without fear of stigma or prejudice.

The draft Vision and strategic objectives are detailed in Appendix 5. Emphasis is placed on:

A whole system approach with services that are resilient and effective in their care and support for people to enable them

- to look after their own sexual wellbeing
- to receive accessible and welcoming services which are focussed on prevention, early diagnosis and treatment, reducing inequalities and tackling stigma.

2.4.2 Next Steps for the developing Strategy

The Derbyshire Sexual Health Strategy is undergoing final consultation across partners outlined above and exploring issues of Ownership and Governance. It is proposed that the final Strategy be presented at Health and Wellbeing Board for approval.

An Action Plan will then be developed across the commissioning landscape for delivery over these next 3 years.

3 Social Value considerations:

The re-procurement of the integrated sexual health service offers significant opportunities to include social value requirements within the procurement process, related to the contract value and length, and the inherent opportunities for adding social value resulting from the nature of the service. The re-procurement process will include systematic consideration of social value principles and will utilise appropriate outcomes in line with the Derbyshire Social Value Procurement Framework.

Consultation, engagement and market analysis will be used to identify what social value opportunities could be created and realised through this process.

4. Legal considerations:

The re-procurement of this service will be carried out in accordance with Protocol 1 of the Council's Financial Regulations and the Public Contracts Regulations 2015.

5. Equality of Opportunity considerations:

Some people are more at risk of poor sexual health outcomes compared to the wider population. They include young people and vulnerable young people, men who have sex with men (MSM) and people living with HIV. Additional at risk groups include young heterosexuals, sex workers, people misusing drugs and alcohol, and some black and minority ethnic populations.

Section 2.3 Summary of the Equality Impact Analysis offers further detail with the full EIA report in Appendix 3.

6. Human Resources considerations:

During procurement of the contract for the new integrated sexual health service, consideration will be given on the application of the Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 (TUPE), and further Legal and Human Resources advice considered where necessary.

7. Other considerations:

In preparing this report the relevance of the following factors has been considered: financial, prevention of crime and disorder, environmental, health, property and transport considerations.

8. Background papers:

Cabinet, 14 February 2017 Re-procurement of Derbyshire Integrated Sexual Health Services (DISHS)

Cabinet Member, Health and Communities, 25 April 2017 Re-procurement of Integrated Sexual Health Services: Stage 1 Consultation findings and Recommendations

9. Key Decision:

Yes.

10. Call-in:

Is it required that call-in be waived for any decision on this report?
No.

11. Officer's Recommendation:

For Cabinet to be informed and approve the

- Final Report: Consultation on the Derbyshire Integrated Sexual Health Service (DISHS) Re-procurement, June 2017: Findings and Recommendations
- Equality Impact Analysis Report, May 2017: Findings and Recommendations

For Cabinet to be informed of the development of the Derbyshire Sexual Health Strategy 2017-2020.

Dean Wallace
Director of Public Health

Appendix 1 Derbyshire Health Needs Assessment data (April 2017)

Indicator (Source: Sexual and Reproductive Health Profile, Public Health England)	Period	England	Derbyshire (Admin)	CPFA Neighbours Min	CPFA Neighbours Ave	CPFA Neighbours Max	Trend	Change from previous	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derby
Teenage conceptions & births																
Under 16s conception rate / 1,000 (PHOF indicator 2.04)	15 2014	4.4	3.9	2.5	4.0	5.7	↓	↔	-	-	-	-	-	-	-	-
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	9 2014	22.8	16.2	16.7	20.8	27.2	↓	▽	15.1	19.7	18.7	10.5	16.2	16.6	16.7	15.5
Under 18s conceptions leading to abortion (%)	8 2014	51.1	40.6	35.1	48.0	56.9	↑	▽	29.4	29.6	32.4	61.5	56.3	50.0	32.1	46.4
Under 18 births (%)	13 2014/15	0.9	0.9	0.8	1.0	1.5	↓	▽	-	-	-	-	-	-	-	-
Under 18s births rate / 1,000	10 2014	6.7	5.8	4.8	6.3	8.9	↓	▽	7.1	8.7	6.6	1.6	6.1	3.5	3.0	8.3
Abortions																
Total abortion rate / 1000	17 2015	16.7	9.6	11.5	13.8	16.6	-	▽	-	-	-	-	-	-	-	-
Abortions under 10 weeks (%)	58 2015	80.3	71.1	71.5	77.2	82.2	-	▼	-	-	-	-	-	-	-	-
Abortions over 10 weeks that are medical (%)	59 2015	19.2	36.1	6.0	24.1	75.0	-	▽	-	-	-	-	-	-	-	-
Abortions under 10 weeks that are medical (%)	57 2015	62.7	49.0	48.6	66.7	92.5	-	△	-	-	-	-	-	-	-	-
Under 18s abortions rate / 1,000	12 2015	9.9	Supp.	6.3	8.8	12.2	-	-	-	-	-	-	-	-	-	-
Over 25s abortion rate / 1000	29 2015	14.2	7.9	9.3	11.2	13.3	-	△	-	-	-	-	-	-	-	-
Under 25s abortion after a birth (%)	7 2015	28.2	29.1	22.4	29.8	35.5	-	▽	-	-	-	-	-	-	-	-
Under 25s repeat abortions (%)	5 2015	26.5	23.0	18.9	23.3	27.7	-	△	-	-	-	-	-	-	-	-
Contraception																
Total prescribed LARC excluding injections rate / 1,000	16 2015	48.2	66.1	27.5	55.2	75.4	-	▼	70.9	69.0	77.5	84.7	63.1	57.1	57.4	55.4
GP prescribed LARC excluding injections rate / 1,000	43 2015	29.8	45.1	12.2	40.0	60.6	↑	▼	57.0	47.0	37.3	69.7	41.8	39.2	33.2	43.3
SRH Services prescribed LARC excluding injections rate /	21 2015	18.3	21.1	5.9	15.2	25.1	-	▽	13.9	22.0	40.2	15.1	21.3	17.9	24.2	12.1
Under 25s choose LARC excluding injections at SRH Services	6 2015	20.2	33.3	15.0	25.0	38.4	-	▽	39.9	34.1	35.2	38.0	34.6	20.7	34.4	35.1
Over 25s choose LARC excluding injections at SRH Services	30 2015	35.5	45.9	29.1	41.1	52.4	-	▽	51.3	36.9	40.7	53.6	54.8	43.0	47.9	55.1
Women choose hormonal short-acting contraceptives at SRH	4 2015	47.4	42.0	33.8	46.6	61.2	-	△	37.9	43.8	44.0	32.8	41.8	44.0	40.7	41.0
Women choose injections at SRH Services (%)	3 2015	9.5	9.1	6.0	9.6	17.2	-	△	5.6	12.6	11.1	8.1	5.2	11.6	10.0	2.6
Women choose user-dependent methods at SRH Services (%)	2 2015	63.0	51.7	45.7	58.0	69.4	-	△	49.4	52.0	50.9	44.8	52.1	58.8	48.6	53.7
Sexually transmitted infections																
New STI diagnosis rate / 100,000	31 2015	767.6	482.2	419.1	535.3	702.0	-	▼	441.3	563.8	631.9	336.7	515.6	373.2	448.9	512.3
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	56 2015	814.9	477.8	400.2	547.0	697.4	-	△	423.2	526.8	619.1	322.4	517.4	329.6	437.4	593.9
STI testing rate (exc Chlamydia aged <25) / 100,000	19 2015	15715.4	9847.6	8760.1	10642.5	13341.4	-	△	8780.8	10163.3	13370.7	7575.1	10272.3	8161.7	8909.2	10729.5
STI testing positivity (exc Chlamydia aged <25) %	20 2015	5.2	4.9	3.9	5.1	6.0	-	▽	4.8	5.2	4.6	4.3	5.0	4.0	4.9	5.5
Chlamydia detection rate / 100,000 aged 15-24 (PHOF)	53 2015	1887.0	1540.9	1054.2	1616.5	2246.5	-	▼	1526.0	1903.0	1983.0	1371.0	1553.0	1313.0	1576.0	1067.0
Chlamydia detection rate / 100,000 aged 15-24 (PHOF)	53 2015	1276.0	1056.4	656.9	1083.1	1440.3	-	▼	1526.0	1903.0	1983.0	1371.0	1553.0	1313.0	1576.0	1067.0
Chlamydia detection rate / 100,000 aged 15-24 (PHOF)	53 2015	2492.1	2038.9	1490.7	2180.1	3061.3	-	▼	1526.0	1903.0	1983.0	1371.0	1553.0	1313.0	1576.0	1067.0
Chlamydia diagnostic rate / 100,000	52 2015	361.0	249.9	172.8	262.9	393.1	-	▼	221.9	317.5	344.2	186.6	273.6	211.2	233.5	203.3
Chlamydia diagnostic rate / 100,000 aged 25+	51 2015	178.7	101.5	71.8	102.2	142.7	-	▼	70.6	128.5	152.3	61.5	127.1	74.6	81.4	112.2
Chlamydia proportion aged 15-24 screened	50 2015	22.5	19.6	13.3	19.4	24.8	-	▼	18.1	19.4	26.8	16.1	20.7	18.5	19.7	15.8
Genital herpes diagnosis rate / 100,000	46 2015	57.6	44.0	25.1	45.6	66.5	→	△	37.9	38.9	57.5	16.8	48.2	35.0	45.3	63.0
Genital warts diagnostic rate / 100,000	45 2015	118.9	90.0	74.4	100.1	120.7	↓	△	83.9	97.2	128.5	63.1	90.3	60.2	89.6	98.6
Gonorrhoea diagnostic rate / 100,000	44 2015	70.7	21.4	14.0	27.8	45.9	↑	△	19.4	28.5	24.0	11.2	32.4	12.0	16.1	24.4
Syphilis diagnostic rate / 100,000	18 2015	9.3	5.1	1.1	3.1	4.7	→	△	7.3	6.5	1.0	4.2	6.1	4.4	4.0	7.1
Pelvic inflammatory disease (PID) admissions rate / 100,000	28 2014/15	236.4	219.4	185.8	236.3	351.0	↓	▽	178.6	321.5	263.8	157.5	202.1	347.2	166.2	135.9
Ectopic pregnancy admissions rate / 100,000	49 2014/15	89.6	66.6	62.4	79.3	98.1	→	▽	73.3	92.9	52.8	68.9	79.9	37.9	49.2	76.1

Agenda Item No

Indicator (Source: Sexual and Reproductive Health Profile, Public Health England)	Period	England	Derbyshire (Admin)	CIPFA Neighbours Min	CIPFA Neighbours Ave	CIPFA Neighbours Max	Trend	Change from previous	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
HIV/AIDS																
HIV diagnosed prevalence rate / 1,000 aged 15-59	42 2015	2.3	0.68	0.5	0.9	2.1	↑	△	0.6	0.8	1.0	0.5	0.5	0.9	0.5	0.7 **
HIV late diagnosis (%) (PHOF indicator 3.04)	41 2013 - 15	40.3	50.8	36.1	48.3	66.7	-	△	55.6	50.0	25.0	85.7	57.1	45.5	42.9	50.0 ***
HIV testing coverage, total (%)	38 2015	67.3	62.2	58.2	69.0	76.3	↓	▽	73.4	66.0	52.8	67.5	60.3	55.3	56.7	73.7
HIV testing coverage, MSM (%)	39 2015	88.0	80.2	80.9	86.5	90.2	↑	▽	74.6	79.2	82.7	75.0	74.8	81.7	91.4	83.1
HIV testing coverage, women (%)	37 2015	59.2	55.3	47.1	63.8	74.2	↓	▽	70.1	60.5	47.1	61.8	53.0	45.2	48.5	68.5
HIV testing coverage, men (%)	40 2015	78.3	71.4	68.7	76.4	84.1	↑	▽	77.0	71.9	61.6	73.2	71.0	73.6	67.0	80.3
HIV testing uptake, total (%)	34 2015	76.2	76.6	65.9	76.7	89.0	↓	▽	84.4	77.2	70.1	80.2	86.3	61.4	71.2	83.2
HIV testing uptake, MSM (%)	35 2015	93.4	93.5	91.9	94.2	96.4	→	▽	96.1	96.1	92.9	94.0	95.9	86.9	92.3	94.3
HIV testing uptake, women (%)	33 2015	69.2	72.3	57.5	72.4	88.5	↓	▽	81.5	76.1	66.6	77.0	85.6	50.8	66.2	80.2
HIV testing uptake, men (%)	36 2015	84.8	81.8	75.4	82.4	89.5	↓	▽	87.4	78.1	74.8	83.2	87.0	80.2	76.5	86.8
New HIV diagnosis rate / 100,000 aged 15+	32 2015	12.1	3.2	0.7	4.1	8.9	→	▽	5.7	4.6	1.1	4.9	2.1	1.3	2.4	3.7
Factors relevant to sexual health promotion activity																
Under 16s in poverty (%) (PHOF indicator 1.01ii)	14 2014	20.1	16.8	11.9	15.7	19.1	↓	▲	16.6	22.2	21.9	10.3	18.6	13.9	16.1	13.1
Pupil absence (%) (PHOF indicator 1.03)	23 2014/15	4.6	4.4	4.3	4.5	4.8	↓	△	4.4	4.6	4.6	4.1	4.5	4.5	4.2	4.2
First time entrants to the youth justice system rate / 100,000	48 2015	368.6	181.1	188.7	353.6	510.0	↓	▽	-	-	-	-	-	-	-	-
16-18 year olds not in education employment or training (%)	60 2015	4.2	3.6	2.5	3.9	5.2	↓	▽	-	-	-	-	-	-	-	-
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	22 2015/16	1.7	1.2	1.0	1.6	2.2	↑	△	1.3	1.3	1.5	1.1	1.1	1.2	0.9	1.2
GCSEs achieved (5 A*-C inc. English and maths) (%)	47 2014/15	57.3	55.7	52.7	57.9	61.5	-	△	55.1	47.2	58.5	62.0	56.3	55.9	59.0	51.7
Percentage people living in 20% most deprived areas in	27 2014	20.2	11.9	1.8	11.1	21.9	-	▽	10.3	19.7	29.5	2.3	16.5	4.6	6.0	3.4
Cervical cancer registrations rate / 100,000	54 2011 - 13	9.6	10.3	8.3	10.4	12.0	-	▽	14.6	8.2	5.3	5.7	16.3	10.2	9.6	8.5
Under 18s alcohol-specific hospital admissions rate / 100,000	11 2012/13 -	36.6	45.4	17.6	37.3	58.2	-	△	41.3	53.2	58.7	20.2	37.6	65.0	46.9	37.5
HPV vaccination coverage for one dose (females 12-13 years)	25 2014/15	89.4	92.3	88.6	91.8	97.4	-	-	-	-	-	-	-	-	-	- ****
Proportion of TB cases offered an HIV test (TB Strategy)	24 2015	96.2	Supp.	80.6	93.6	100.0	-	△	-	-	-	-	-	-	-	- *****
Current								Change from previous								
Significantly better							↑	Increasing - improving significantly			△	Increasing - improving				
No significant difference							→	Decreasing - improving significantly			▽	Decreasing - improving				
Significantly worse							↓	Increasing - worsening significantly			△	Increasing - worsening				
Not assessed							↕	Decreasing - worsening significantly			▽	Decreasing - worsening				
							↑	Increasing								
							↓	Decreasing								
Comparison against England except:-								-	Could not be calculated							
*	<1,900	1,900 to 2,300	≥2,300				→	No significant change	Supp.	Suppressed - numbers too small						
**	<2	2 to 5	≥5													
***	<25	25 to 50	≥50													
****	<80	80 to 90	≥90													
*****	<50th	≥50th to <90th	≥90th													
																percentile of UTLAS

Appendix 2 Final Report Derbyshire Integrated Sexual Health Service (ISHS) Re-procurement Consultation Final Report, June 2017

DERBYSHIRE COUNTY COUNCIL

**Derbyshire Integrated Sexual Health Service (DISHS) Re-procurement
Consultation Findings**

June 2017

1.0 Purpose of this report

To provide a summary of the findings of Stage 1 and Stage 2 of the sexual health service consultation, as part of Derbyshire County Council's review of sexual health services.

2.0 Purpose of the consultation

- To identify opportunities to improve the existing Integrated Sexual Health Service in Derbyshire
- To ensure that the service is meeting the needs of Derbyshire residents
- To inform the development of the service specification for Integrated Sexual Health Services in Derbyshire as part of the pre-tender/ re-procurement process
- To inform the development of a Sexual Health Strategy for Derbyshire

3.0 What we wanted to find out

The following key themes were agreed in order to achieve the purpose as set out above:

- What is important - key priorities for sexual health services
- Experience of the current service: what works well and what could be improved
- Barriers to accessing services, particularly for vulnerable groups, and how these can be addressed
- How people would prefer to access services and information
- How accessible and visible sexual health services are
- Innovative ways in which services could be accessed and delivered

Survey and focus group questions have been designed to ascertain stakeholder feedback on these agreed themes.

4.0 Identifying stakeholders to consult

Key stakeholders have been identified as follows:

4.1 Derbyshire residents

4.2 Existing service users

4.3 Identified vulnerable groups at higher risk of sexual ill health, including;

- Men who have sex with men (MSM)
- People living with HIV
- Vulnerable young people
- Homeless
- Teenage parents
- Those who are rurally isolated
- Those not in education, employment or training
- Those with learning disabilities or mental health problems
- Lesbian, gay, bisexual and transgender (LGBT)
- Offenders
- Young people under 25
- Travellers
- Looked after children and care leavers
- Men and women working in the sex industry
- People from some ethnic minority groups
- Injecting drug users
- Victims of sexual assault

4.4 Existing providers of sexual health services, including;

- Sexual health clinic staff and sexual health promotion teams
- Derbyshire Community Health Services management & governance
- All accredited providers of Integrated Sexual Health Services in Derbyshire, including GPs and community pharmacies
- Subcontracted providers of the Integrated Sexual Health Service, including LGBT+

4.5 External organisations and service providers, including;

- Derbyshire County Council
- Public Health England
- School Nursing and Health Visiting Services

- Maternity Services
- Community Midwifery Services
- Gynaecology Services
- Vasectomy Services
- Termination of Pregnancy Services
- HIV treatment services
- Domestic Violence and Sexual Abuse Services
- Groups working with disadvantaged and vulnerable women
- Substance misuse services
- Derbyshire Adult Care Services
- Derbyshire Children's services
- Derbyshire Youth Offending
- Derbyshire Community Safety
- Secondary schools and further education settings
- Police
- Probation
- Leisure services
- Libraries
- Housing and Homelessness Services
- Clinical Commissioning Groups
- Derbyshire Local Pharmaceutical Committee
- Derbyshire Local Medical Committee

5.0 Consulting hard to reach groups

Some groups in the community are identified as '*hard to reach*' and '*at risk*'. We have consulted some of these groups separately in order to increase opportunities to engage in this consultation.

Partner organisations and services known to be working with identified vulnerable groups were contacted to either support in arranging and facilitating focus groups sessions to discuss the key themes of the consultation, or to support in distributing paper copies (plus pre-paid return envelopes) of the public questionnaire.

Returned paper copies of the questionnaire have been inputted onto the online public survey, and the findings of these are reported collectively. A number of focus group sessions took place during the public consultation period, the findings of which are summarised in section 7 of this report.

6.0 Consultation methods

Opportunities to consult and communicate with various stakeholders have been taken as follows:

Stakeholder group	Consultation method					Communication method		
	Online public survey	Postal public survey	Online stakeholder survey	Focus group	Offer of 1:1 discussion (on request)	Posters displayed in some public areas	DCC internal comms channels	Partner organisation comms channels
All residents	x	x				x		
Service users	x	x				x		x
Identified vulnerable groups	x	x		X		x		x
Staff working in the current service	x	x	X		X	x	X	x
Partner organisations	x	x	X		X	x		x

7.0 Stage 1 consultation findings

7.1 Headline summary

7.1.1 Response rate

332 people engaged in Stage 1 of the consultation, including:

- 113 responses to the online public survey
- 75 postal submissions to the public survey
- 101 responses to the online stakeholder survey
- 43 participants engaged in focus groups from identified 'at risk' populations

7.1.2 Emerging themes throughout the Stage 1 consultation

Themes have been identified through the triangulation of feedback from the public survey, the stakeholder survey, and the focus groups. These emerging themes are evidenced by more than one source, with the exception of those specific to the communication and service visibility with partner organisations which are evidenced in the stakeholder survey feedback only.

- Improve the availability of appointments/ waiting times for appointments
- A need for outreach clinical services to those most at risk, who experience barriers in accessing a clinic
- Improve the accessibility of services, particularly in rural locations where travel is a barrier
- Explore alternative options for service access, e.g. online services, postal kits, text messaging
- Address barriers to vulnerable groups
- Ensure the workforce is suitably trained – match competencies to demands on the service
- Ensure absolute confidentiality and anonymity
- Explore extended community provision through general practice alongside appropriate funding
- Improve communication with partners
- Improve the visibility of services to partners and residents

7.2 Public online survey

7.2.1 Introduction

The online public survey was open from the 13th February 2017 to the 13th March 2017 via the Derbyshire County Council public website, available at:

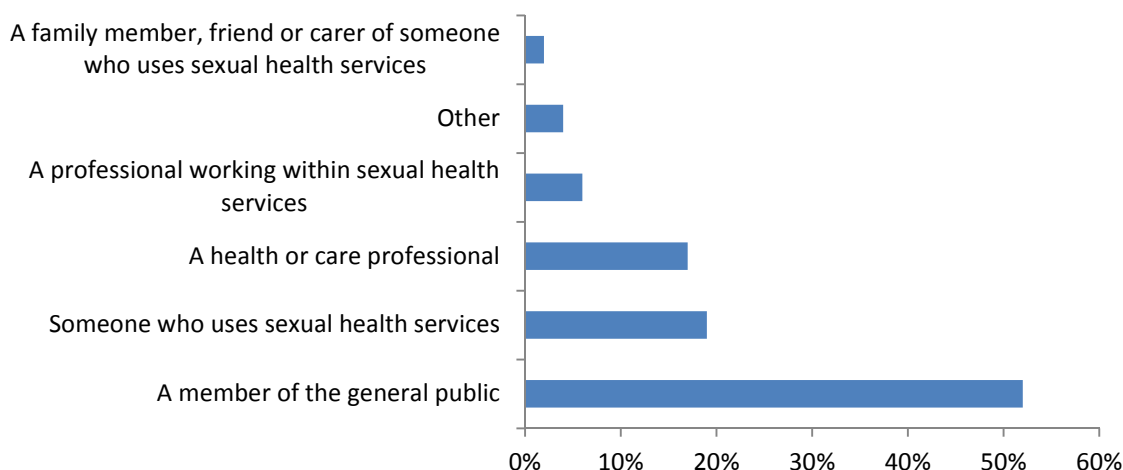
www.derbyshire.gov.uk/sexualhealth

Details of the survey have been publicised via posters displayed in various public areas, including libraries and clinics, and via email distribution across stakeholder organisations.

Paper copies have been made available to existing service users in sexual health clinics and have been distributed via a number of organisations working with identified vulnerable groups.

7.2.2 Response

188 respondents completed the questionnaire before the deadline; this includes 75 questionnaires submitted by post. 65% of the respondents had accessed a sexual health service in Derbyshire.



Summary of demographic questions:

- Gender

74% *Female*

25% *Male*

1% prefer not to say

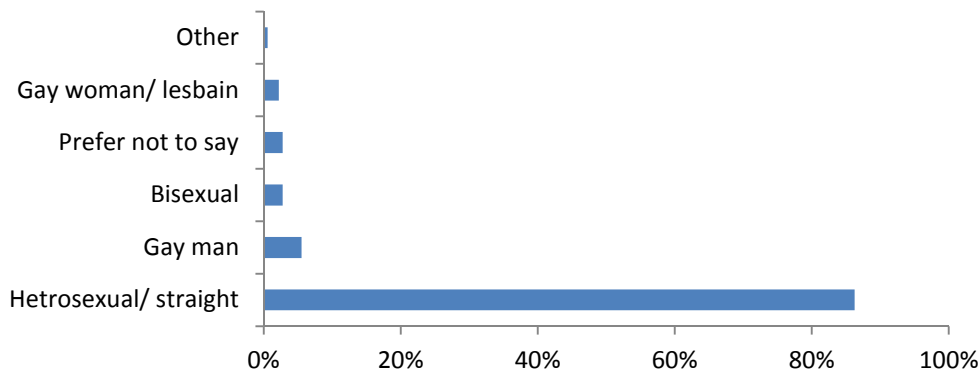
- Disability

8% of respondents considered themselves *disabled*

- Ethnic group

96% of respondents identified as *white*

- Sexuality



7.2.3 Priorities for sexual health services in Derbyshire

Respondents were asked '*how strongly do you agree or disagree with each of these priorities*':

- Improving the sexual health of the local population, especially those at risk of poor sexual health - *95% agree or strongly agree*
- Providing services that are welcoming and confidential - *99% agree or strongly agree*
- Provide open access services – *93% agree or strongly agree*
- Ensuring that services are cost effective and efficient – *88% agree or strongly agree*
- Providing services that are free of charge – *93% agree or strongly agree*
- Ensuring services are delivered by a suitably trained workforce – *97% agree or strongly agree*

When asked are there any other priorities that you feel are important, responses are as follows:

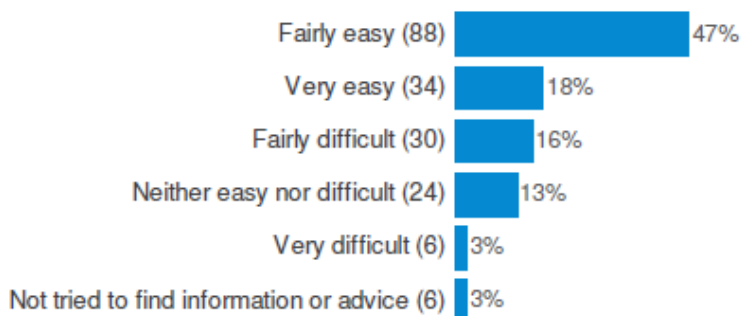
- **Services to be available in a timely manner** (11 comments)
'to be done in a timely manner without waiting over 4 months for the contraceptive coil'
'people are seen in a timely fashion within a few weeks'
- **Services are convenient to access** (11 comments)
'there should be access to services at weekends'
'varied access times to enable working people to access'
- **Service locations** (10 comments)
'would like it available at my GP surgery'

‘access for rural areas or hard to reach areas’

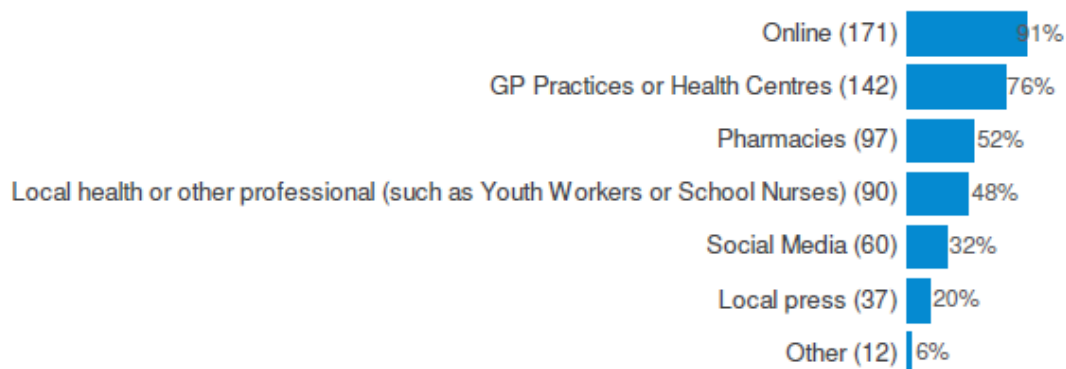
- **Focus on Young People and vulnerable groups** (11 comments)
‘a service that reaches adolescents, LGBT and people with disabilities’
‘outreach to those affected by the sex industry’
- **Appropriately trained staff** (5 comments)
‘a good mix of staff with various grades and skills’
‘getting confidential advice from properly trained staff over the phone’
- **Confidentiality and anonymity** (4 comments)
‘absolute confidentiality...I know of children who would not go in in case they meet people they know in the waiting room’
‘anonymity is a key thing’

7.2.4 Accessing information

How easy or difficult do you think it is to find information on your local sexual health services? (Please select one option only)



How would you prefer to find information on your local sexual health service? (Please select all that apply)

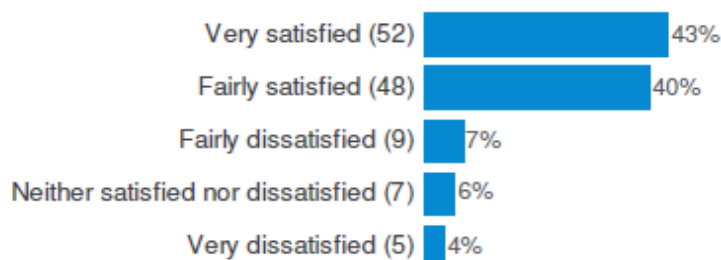


7.2.5 Experience of the existing service

Have you ever accessed a sexual health service in Derbyshire?



If 'Yes', how satisfied or dissatisfied were you with the service? (Please select one option only)



Further details on experiences of the current sexual health service include:

- Appointment waiting times are too long/ difficult to make appointments** (16 comments)
 - 'I find it hard to book appointments'*
 - 'The wait for an appointment is currently four months in Glossop'*
 - 'always a good experience but hard to get appointments'*
- Lack of local appointments - rural/ travel issues** (6 comments)
 - 'I had to travel all the way to Derby 17 miles from where I live'*
 - 'an alternative would be to travel to Ashbourne which is not practical due to the distance'*
 - 'I was able to access the service locally now have to travel about 20 miles'*
- Good experience with staff** (9 comments)
 - 'staff are great, easy to talk to and very nice in general'*
 - 'staff friendly, even when stressed due to busy times and delays'*
 - 'very friendly staff, willing to help & reassure'*
- Positive experience of accessing services at GPs** (5 comments)
 -

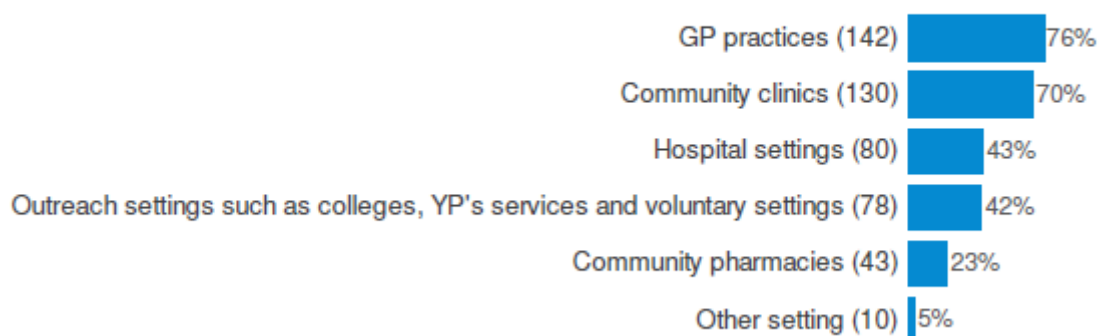
'part of normal GP service therefore no big deal so easy to access'
'it was done by my GP and was a much better experience'

- **Long waiting times in clinics** (4 comments)

'I was told to turn up at the drop in but left after 2 hours of waiting'
'long waiting times to be seen in clinic'

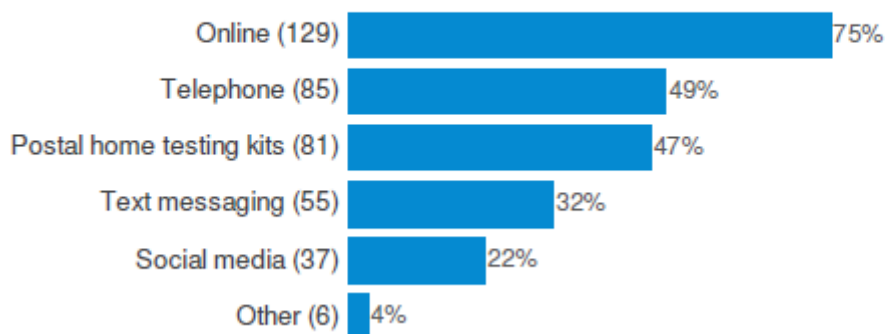
7.2.6 Settings

What settings would you prefer to attend to access sexual health services?
(Please select all that apply)



7.2.7 Other ways to access services

Apart from accessing services through settings, are there any other ways you would like to access sexual health services? (Please select all that apply)



7.2.8 Location of services

95% of respondents stated that it is very important or fairly important to have access to sexual health service near to where they live.

7.2.9 Young People only services

47% of under 25 year olds (27 of 57) would prefer to access services for young people only.

7.2.10 Meeting needs

When asked *'is there anything else you think we should be considering in order to ensure that sexual health services meet your needs'*, responses are as follows:

- **Access to more clinic appointments and at more convenient times** (18 comments)
'more clinics, more appointments'
'access times outside of 9-5 is very important'
'more appointments to fulfil my needs. Chesterfield is too far!'
'ability to make appointments in the future, currently the appointment system doesn't allow you to make appointments 3 months in advance'
'access to services at the weekend'
- **Meeting the needs of vulnerable groups** (11 comments)
'I feel we need to be reaching out to young people, not waiting for them to go to the service'
'men who have sex with men seem to have been forgotten, the old clinic was much easier to access'
'important to keep young people's services accessible to ALL young people'
'improving access and awareness for young people with SEND'
- **Use of GPs** (5 comments)
'sexual health services should be commissioned to GP surgeries'
'appropriately funded GP services for IUCD and implants'
'contraception by my GP where it is timely'
- **Accessing LARC** (4 comments)

'unable to get a coil removed in Buxton'
'coil fitting, I cannot get an appointment after trying for 7 months'

- **Services for 'older' people** (3 comments)
'clinics specifically for issues relating to 'older' people'

7.3 Stakeholder questionnaire

7.3.1 Introduction

The online stakeholder survey was open from the 13th February 2017 to the 13th March 2017 via the following link:

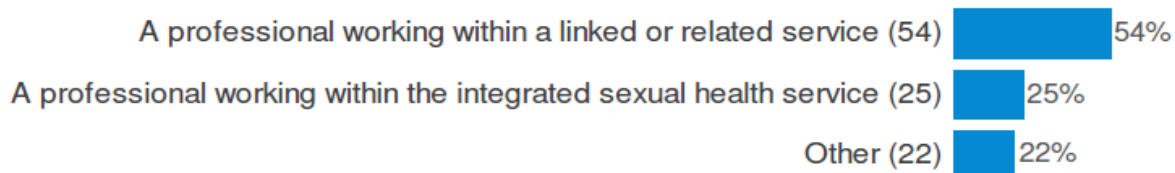
<https://www.snapsurveys.com/wh/s.asp?k=148760929717>

Details of the survey have been distributed via email within Derbyshire County Council and via email distribution within partner organisations.

7.3.2 Response rate

101 respondents completed the questionnaire before, as follows

What do you see as your role within sexual health services in Derbyshire?
(Please select one option only)



7.3.3 Perceptions of the service

- 22% of respondents do not have a good understanding of the services available within the Integrated Sexual Health Service
- 24% of respondents feel that the service is not visible to the population of Derbyshire
- 24% of respondents feel that the service is not accessible to the population of Derbyshire
- 51% of respondents agree that services are good quality (41% neither agree or disagree)

7.3.4 Barriers to accessing services

Do you feel there are any barriers to accessing sexual health services in Derbyshire for those most at risk of poor sexual health outcomes?



When asked what more could be done in relation to barriers to accessing sexual health services for those most at risk, responses are as follows:

- **Accessibility for vulnerable groups**, primarily Young People (14 comments)

'are they [Young People] welcome? I expect they are not.....because of a lack of staff and resources'

'more young people friendly places'

'a focus on people who are classed as vulnerable'

- **Location of services** - rurality issues/ travel/ distance (10 comments)

'I am concerned about Young People in our rural areas, due to transport challenges they don't always have access to the services they need without the knowledge of their communities'

'Rural areas don't get a service'

'Young people want local services'

- **Communication and availability of information** – (10 comments) primarily relating to central booking line, and information available on the website, and information available to professionals

'improve the central booking line so that people can get through and are given appropriate appointment'

'more information to be provided to professionals'

'better communication and information'

'website needs to have correct information and kept up to date'

- **Accessibility** – appointments at accessible times and locations (7 comments)

'improving access through extended clinics which offers a wide range of services, maybe co-locating with other health communities to help reduce stigma'

'being able to get appointments at suitable times'

'not enough appointments available'

- **Appropriate staffing** – matching staff and competencies with service needs (6 comments)

‘clinics need to be staffed correctly in accordance with the booking of appointment so that competencies match each staff to the patients needs’

‘more qualified staff’

‘improve training for frontline’

- **Visibility and awareness of the service** – to residents and professionals (5 comments)

‘As a resident of Derbyshire and an employee of Derbyshire County Council, and working in Children’s Service, I was not aware of this service, it does not seem to be very visible’

I was not well versed in what these service are’

‘may not have an awareness of the services’

- **LGBT and MSM** - lack of targeted services and staff awareness (5 comments)

‘LGBTQ community has been aliented from Sexual Health services by the loss of the gay mens service and separate waiting room – one size doesn’t fit all’

‘The number of MSM has reduced greatly since almalgamating the services and the waiting rooms’

7.3.6 Innovative ways of delivering the service

When asked what other innovative ways services could be accessed or delivered, responses are as follows:

- **Services and service promotion in schools** (15 comments)

‘all secondary schools should offer the service as standard’

‘need to move out of clinics and into schools, community venues’

‘schools need awareness’

‘more C-Card available in schools’

- **Clinical outreach to vulnerable at risk groups** (10 comments)

“you could have an outreach van (mobile service) that can work within the poor areas and try to engage with the at risk client group’

“outreach nurses who are able to deliver services to the most vulnerable clients’

'outreach to women's refuge centres'

'Pop up clinics/ clinic in a box'

- **Community settings and events** – (5 comments)

'community settings eg colleges, youth groups'

'community gatherings'

'at large events such as Ynot and Download festivals'

- **Online and postal services** – (5 comments)

'consider social media'

'online ordering of screens' 'online information'

'greater use of online services'

7.3.5 Meeting the needs of Derbyshire residents

When asked *'is there anything else we should be considering to ensure that sexual health services are meeting the needs of Derbyshire residents'*, responses are as follows:

- **Communication and information** – (7 comments)

'just spreading the word as much as possible is the key'

'make sure information is current and correct and accessible to all'

'keep reminding people you are there'

- **Website and booking line** – (4 comments)

'develop the website so that it is up to date and accurate'

'make central booking line efficient and properly trained'

- **Visiblity** – (5 comments)

'make it more visible'

'more professionals need to be aware'

'needs more publicity to raise awareness'

- **Young people and other vulnerable groups** – (6 comments)

'I would have a vulnerable people's and young people's sexual health nurse'

'outreaching to high risk groups'

'involving young people in the decision making process'

7.3.7 Working effectively across the network

When asked *'what we should be considering to ensure services work effectively across the network of all partner organisations and stakeholders in Derbyshire'*, responses are as follows:

- **Information and communication** – (11 comments)
'communication is key to getting the service known and therefore accessed'
'clear communication and regular marketing and updating of project information'
'more advertising of the services available'
- **Networking with partners**, strategically and with staff on the ground – (11 comments)
'increase inter agency networking, training'
'more sexual health network meetings – extend the membership list'
'a partnership meeting group for ground staff who work with Young People'

7.4 **Focus group sessions with those at greater risk**

7.4.1 Four focus group sessions were held during the public consultation period (13th February – 13th March), during which 43 participants engaged in the consultation from the following identified *'at risk groups'*:

- Vulnerable young people
- Those who are rurally isolated
- Those not in education, employment or training
- Lesbian, gay, bisexual and transgender (LGBT)
- Young people under 25
- Those in recovery and those working towards recovery from alcohol/or drug addiction

7.4.2 Key themes from the focus groups included:

- **None of the groups expressed a preference to access a young person only clinic** – young people only clinics were perceived as a barrier for some (LGBT group and some vulnerable young people)
- **Attending a local service was important to all**, but specifically in Glossop where travel to the nearest alternative clinic is prohibitive due to cost and time

- **Fear of prejudice and assumptions** – one of the most significant issues from the LGBT group
- **Fear of stigma and embarrassment** – one of the most significant issues from the drug and alcohol recovery group – *‘everybody knows why you are there’*
- **The importance of confidentiality and anonymity**
- Some groups reported little or no support or information from the existing Sexual Health Promotion service, despite requests

7.4.3 Key recommendations from the focus groups included:

- **Make clear what you can expect when visiting a clinic** in relation to being non-judgemental and welcoming – to reduce fear of stigma and prejudice
- **Can the service come to those less likely to attend a clinic?** – such as drug and alcohol recovery groups, or in Glossop where access is limited
- **Options on forms to better reflect sexuality/ gender identity**
- **Increase options for booking appointments and contacting services** – for example online booking and texting service
- **Ensure service information on the internet is up to date** – including information on other websites
- **Better training for staff around LGBT issues**
- **Remove stigma of attending sexual health appointment** – could sexual health services be offered as part of other services, e.g. smear test appointments? or a general ‘wellbeing’ clinic appointment - *‘if it was part of other health checks no one would know why you were there’*

7.5 Feedback from the Derby and Derbyshire Local Medical Committee

A written response to the consultation was submitted on behalf of the Derby and Derbyshire LMC (DDLMC). Some of the key points from this are highlighted below.

'We would like to remind the council that sexual health services do not wholly fit within GP contract. As a consequence, it must be remembered that additional services, such as provision, fitting and follow up of long acting forms of contraception requires a level of funding commensurate with the skill of the practitioner and the time taken to perform and document the task'

'We urge the county council to appreciate the role of GP surgeries in providing sexual health services as part of the review'

'We ask that appropriately funded provision of sexual health services remains in general practice in the future'

Derby and Derbyshire LMC (DDLMC)

8.0 Stage 1 recommendations for additional consultation

8.1 That Derbyshire County Council Sexual Health Commissioners deliver Stage 2 of this consultation, which will include;

- Finalising additional consultation activity with a focus on feedback from further vulnerable groups and other commissioners
- Sharing of feedback from Stage 1 with stakeholders

9.0 Stage 2 consultation findings

9.1 Themes and recommendations from Stage 1 of the consultation have been shared via the Derbyshire County Council public website. Report available at: www.derbyshire.gov.uk/sexualhealth

9.2 Feedback from Stage 1 on the existing service has been shared with the service provider.

9.3 Further opportunities for consultation with other commissioning organisations (CCGs, NHS England, Prison Sexual Health) have included:

- Stage 1 findings have informed the development of the Sexual Health Strategy for Derbyshire. Strategy development workshop, involving

CCG commissioners, representatives of the LMC, LPC, Children's Services, and LGBT+ took in place in March 2017.

- Discussions have also taken place with NHS England and Prison Sexual Health commissioners to inform this strategy.

9.4 Identified gaps from the Stage 1 focus groups included; feedback from those with learning disabilities or mental health problems, and from women working in the sex industry.

9.5 Two focus group sessions were held during Stage 2 of the consultation in May 2017. Additionally, Framework, a charity supporting homeless people and preventing homelessness, supported seven individuals in engaging in the consultation.

9.6 18 participants engaged in Stage 2 of the consultation, from the following identified 'at risk groups':

- Those with learning disabilities or mental health problems
- Lesbian, gay, bisexual and transgender (LGBT)
- Vulnerable young people
- Women working in the sex industry
- Homeless people and those at risk of homelessness

9.7 Key themes from Stage 2 feedback:

- **The majority of respondents had some awareness of the services available, including GP provision**
- **Of nine young people responding to the question, four felt that it is important to have young person only clinics**
- **Attending a local service was important to some**, however some respondents happy to travel and aware of the local peripheral clinics, or live locally to a hub clinic, or would visit their GP
- **Online and GPs are the main ways in which respondents would access information** on sexual health services, with a few also accessing information via clinics other professionals

- **The best ways to access sexual health services are GPs and online**, with some respondents also choosing clinics and pharmacies as a way of accessing services
- **Fear of embarrassment can be a barrier** - in case you see someone you know, or you are embarrassed to speak to receptionist
- **Busy waiting areas can be a barrier**
- **Fear of stigma can be a barrier** - fear of '*getting looked down on*' by clients and staff, and of stigma relating to known drug use, with one comment that '*you are treated differently when they know you are a user*'.

9.5 Suggestions from Stage 2 feedback as to how barriers might be addressed:

- **Provide outreach services** for those experiencing the most significant barriers to accessing a clinic (one group discussion)
- **Women's only waiting areas** (one group discussion)
- **No waiting area** (one individual)
- **Sexual health promotion and training for staff** in organisations working with identified vulnerable groups (one group discussion and one individual)

10.0 Recommendations

- 10.1 That Derbyshire County Council Sexual Health Commissioners must ensure that feedback from this consultation is appropriately used to inform the development of the Sexual Health Strategy for Derbyshire and the development of the Integrated Sexual Health Service Specification for Derbyshire.
- 10.2 That Derbyshire County Council Sexual Health Commissioners share feedback on the existing service with the current provider in order to drive service improvement.

Carol Ford, Public Health Manager Sexual Health
Caroline Waller, Public Health Development Worker Sexual Health

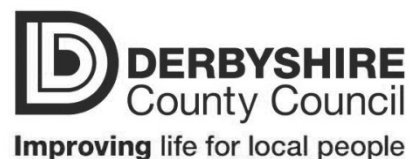
June 2017

Appendix 3 Equality Impact Analysis Report, June 2017

Derbyshire County Council

Equality Impact Analysis Record

Form 2014



Department	Adult Care
Service Area	Public Health: Sexual Health
Changes or proposals	Re-procurement of Derbyshire Integrated Sexual Health Service (DISHS)
Chair of Analysis Team	Mary Hague
Date of Analysis	June 2017
Version	Final

1. Prioritising what is being analysed**a. Description of current service arrangements**

Derbyshire County Council currently commissions the Derbyshire Integrated Sexual Health Service (DISHS), with the contract commencing April 2015 and ending March 2019.

Since April 2013, local authorities have been responsible for commissioning most sexual health services as part of their wider mandatory public health responsibilities, supported through the ring-fenced public health grant (Health and Social Care Act, 2012). The Council's responsibilities include commissioning and ensuring provision of open access sexual health services including:

- Contraception levels 1-3
- testing and treatment of sexually transmitted infections (STIs) levels 1-3
- sexual health aspects of psychosexual counselling and

- sexual health specialist services including HIV prevention and sexual health promotion.

The current model of provision commissioned is through a primary contractor, Derbyshire Community Health Services Foundation Trust (DCHSFT). DCHSFT as primary contractor have subcontracted to other providers including Chesterfield Royal Hospital Foundation Trust (CRHFT), General Practice, Pharmacy and a voluntary sector organisation: LGBT+. The contract delivers against the mandatory commissioning duties outlined above with various providers across a hub and spoke arrangement in multiple settings and through outreach aiming to deliver a free open access service, integrated and as equitable as possible to reach the diverse and wide geographical spread of the Derbyshire population. The current DISHS has a website which indicates the spread of clinics and other delivery sites:

www.yoursexualhealthmatters.org.uk and a central information and booking line for potential users: 0800 328 3383.

The contract requires the service to ensure focus on groups most at risk of poor sexual health and 3 priority groups include:

1. Men who have sex with men (MSM)
2. Young people including vulnerable young people (care leavers, homeless, NEET, young people at risk of multi-risk behaviours)
3. People living with HIV (PLHIV)

Other groups at risk of poor sexual health outcomes include adults with disability, adults with learning disability, substance misusers, Lesbian, bisexual, gay and transgender (LGBT), homeless, certain minority ethnic groups especially those of Black African origin, injecting drug users, sex workers and those in the criminal justice system.

The current service delivers campaigns to support access of DISHS by vulnerable groups. These have included:

- C-Card (condom promotion scheme under 25s)
- Chemsex
- HIV Prevention
- Chlamydia screening campaign

In the full year 201516 (year 1 of the current contract) 28,000 unique users accessed the DISHS with 40,047 interventions delivered. Activity included delivery to identified individuals and groups at risk of poor sexual health outcomes.

Service user consultation is largely based on the Friends and Family Questionnaire which averages at 95% at respondents likely and/or extremely likely to recommend DISHS to others (QTR 3 2016/17) and this currently shows an increasing trend of satisfaction with the service received. Case Studies are included as part of service performance monitoring and are often inclusive of vulnerable individuals and provide learning to the service of their specific needs.

b. Details of proposals or changes

The current service will be re-procured and it will maintain the mandated requirements placed on the Council outlined above (Health and Social Care Act 2012).

Consultation has taken place as part of the re-procurement preparation with inclusion of vulnerable populations outlined above. Stages 1 and 2 of the consultation are complete and the report is attached to the 20 July 2017 Cabinet Report. Themes from the consultation findings are incorporated into this EIA.

These findings will directly inform the development of the Service Specification to be re-procured for commencement April 2019 and may include some changes to the model to maximise access to vulnerable populations.

General themes from the consultation pertinent to vulnerable groups include:

- Training of staff about the specific needs of vulnerable groups to ensure their access to services and maximising care and treatment
- Ensure the service is visible and accessible – engage service users and develop communication and marketing strategies with consideration of needs of vulnerable groups
- Reduce health inequalities and prioritise prevention among vulnerable groups
 - Reduce stigma, fear of prejudice and assumptions – concern raised specifically from LGBT groups and substance misusers/recovery groups
 - Delivery of sexual health as more integral with other health service provision
 - Use of social media, texting, online booking and provision
 - Importance of confidentiality and anonymity – groups having confidence in this

- Consideration of outreach (clinic in a box) type delivery to minimise barriers to access due to travel/ transport issues
- Focus on more delivery within General Practice settings to minimise access barriers due to location
- Maximise opportunities to improve the sexual health and wellbeing of service users and Derbyshire residents including vulnerable groups eg. co-location of services, working with partners engaged directly with vulnerable populations to engender the principle that “sexual health is everyone’s responsibility.”

C. Rationale for proposed changes

- Mandatory duty of local authorities.

The Council has a mandatory duty to commission sexual health services (Health and Social Care Act 2012), thus the Cabinet approval for re-procurement (Cabinet February 2017).

- Strategy and policy direction:

National policy -

The national Framework for Sexual Health Improvement in England (2013) outlines the need to:

- Further reduce unplanned pregnancies (and terminations) by ensuring access to the full range of contraceptive choices
- Enable women with unwanted pregnancies to make early decisions regarding their options
- Increase uptake of HIV testing in high-risk groups because early diagnosis and treatment is associated with near-normal life expectancy
- Increase access to free condoms to reduce STIs
- Improve safeguarding of children from sexual abuse and exploitation
- Reduce prejudice in relation to sexual orientation, and tackle stigma and discrimination in a broader sexual health context
- Improve agency/self-efficacy in matters of choice over sexual behaviours Reduce inequalities in sexual health outcomes

Sexual Health is prioritised in the Public Health Outcomes Framework (PHOF). Three national indicators relate to sexual health:

- under 18 conceptions
- chlamydia diagnosis in 15 to 24 year olds
- people presenting with HIV at a late stage of infection.

The Public Health White Paper Healthy Lives, Healthy People: Our Strategy for Public Health in England¹ highlights a commitment to work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services (STIs, contraception, abortion, health promotion and prevention).

Local policy-

The new service will be in line with a new Derbyshire Strategy for Sexual Health 2017-2020. This strategy is currently in development as part of the re-procurement process but builds on the current vision of the Derbyshire Sexual Health Framework 2013 – 2018:

Your sexual health matters: Working together to achieve good sexual health

Through an Integrated Sexual Health Service model the Derbyshire Sexual Health Framework aims to achieve the following strategic objectives:

- Ensure effective prevention and early diagnosis to minimise harm to individuals, families and communities
- Identify and protect those most at risk from poor sexual health outcomes
- Maximise opportunities to deliver a robust and efficient sexual health service

The developing local strategy will be a response to Derbyshire need and a response to national strategic themes and guidance evidenced for effective sexual health service provision.

- The importance of good sexual health and well-being.

Sexual health is an important part of both physical and mental health and is essential to the general well-being of a population. Good sexual health is aided by access to information and services that help avoid the risks of unintended pregnancy, sexually transmitted infections (STIs) and of harmful relationships.

The consequences of poor sexual health can be serious and costly for the individual, for health and social services and for society as a whole. Unintended pregnancy and STIs have preventable short term and long term effects on health and well-being, which can include:

¹ Department of Health (2010). *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941)

- Pelvic inflammatory disease (PID), pregnancy outside of the womb (ectopic) and difficulty getting pregnant (infertility);
- Cervical and other genital cancers;
- Inflammation of the liver (hepatitis), chronic liver disease and liver cancer;
- Chronic infection, such as human immunodeficiency virus (HIV), or recurrent infection, such as genital herpes;
- Distress over unintended pregnancy;
- Psychological consequences of sexual coercion and abuse;
- Limited educational, social and economic opportunities for teenage parents.

- Supporting good sexual health for the whole population

Some groups are at higher risk of poor sexual health, living with barriers that hinder their access to sexual health services.

Integrated Sexual Health service models aim to address inequalities within populations by providing easily accessible services. This is achieved through providing open access 'one stop shops', where the majority of sexual health and contraceptive needs can be met at one site, over extended opening hours and in accessible locations. As commissioner, the Council will need to ensure firm association across all aspects of sexual health services and across other services which have a clear link to sexual health such as Children and Young People's services.

- Cost effectiveness and efficiency to the Council and the wider social care system.

Sexual health services deliver cost savings not just to the health economy but to the wider economy. Cuts to sexual health services run the risk of increases in unintended pregnancies and in STIs, both of which have associated costs.

For example unplanned pregnancies have significant impact on a variety of public sector costs including social welfare programmes, housing, personalised social services, education, post-natal medical costs and support of families living on low incomes.

2. The team carrying out the analysis

Name	Area of expertise/ role
(Chair) Mary Hague	Sexual Health Commissioning and Public Health expertise, Senior Public Health Manager
Carol Ford Caroline Waller	Sexual Health Commissioning and Public Health expertise, Public Health Manager, Health Development Worker
Clinical expertise	Provider services
Commissioning expertise	Commissioning organisations across Sexual Health Landscape and associated organisations
General public and representation from vulnerable populations	Consultation model

3. Existing information and consultation based feedback

a. Sources of data and consultation used

Source	Reason for using
<p>National surveillance data, managed by Public Health England (Genitourinary Medicine Clinical Activity Dataset v.2 [GUMCADv.2] for STIs.</p> <p>Sexual and Reproductive Health Profiles (annual profiles collating data from various national sources: STI, reproductive health incl. contraception) c. http://fingertips.phe.org.uk/profile/sexualhealth</p>	<p>This data gives information regarding local service provision and performance across a range of sexual health KPIs. Information about service(s) uptake, treatment and diagnosis can be seen in terms of protected groups and local performance can be compared to similar authorities.</p> <p>This data informs the DISHS re-procurement and future commissioning to maximise equality of service for all.</p>
Consultation: Re-procurement of DISHS	Consultation includes specific

Source	Reason for using
Online and postal consultation/general public and service users Online consultation/ professionals, commissioners, organisations with association Focus groups – aimed at vulnerable populations	focus on groups at risk of poor sexual health outcomes
Friends and Family 2015,2016 – service user satisfaction	Information direct from users of services

4. Known impact on different protected characteristic groups

- a. From existing data and information – who is likely to be adversely affected, how, and to what degree? Will anyone gain or benefit from the proposals?

Protected Group	Findings																					
Age including children and families, older people	<p>Young people are most at risk of poor sexual health outcomes. The re-procurement of DISHS aims to ensure good access to young people.</p> <p><u>Under 25s attendances</u></p> <p>Table 1 shows first attendance of Derbyshire residents by age at DISHS across a 18mth period (April 2015 – September 2016). Data is sourced from GUMCADv.2.</p> <p>Table 1: First attendance STIs by age of Derbyshire residents accessing DISHS.</p> <table><tr><th>AGE BANDS</th><th>1st STI attendances</th><th>% of total</th></tr><tr><td><15yrs/15yrs</td><td>664</td><td>2%</td></tr><tr><td>16 - 24yrs</td><td>18,031</td><td>55%</td></tr><tr><td>25 – 44yrs</td><td>12,808</td><td>36%</td></tr><tr><td>45yrs+</td><td>3447</td><td>9%</td></tr><tr><td>unspecified</td><td>19</td><td>0.05%</td></tr><tr><td>TOTALS</td><td>34,967</td><td></td></tr></table>	AGE BANDS	1st STI attendances	% of total	<15yrs/15yrs	664	2%	16 - 24yrs	18,031	55%	25 – 44yrs	12,808	36%	45yrs+	3447	9%	unspecified	19	0.05%	TOTALS	34,967	
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TOTALS	34,967																					

The current picture shows higher service use by under 25s which is positive.

STI rates and screening levels under 25s

STI rates are most common amongst under 25s both nationally and locally. However screening for STIs has decreased nationally (GUMCADv.2 2015 data) and Derbyshire reflects this.

Chlamydia (15-24yrs) (formerly National Chlamydia Screening programme)

Chlamydia is the most commonly diagnosed STI.

Screening rates across 15-24yr olds for chlamydia in Derbyshire are below England at a percentage proportion of 19.6% in Derbyshire (England: 22.5%). This percentage is also below regional peer areas statistically similar to Derbyshire (Lincolnshire and Nottinghamshire).

Chlamydia detection rates (15-24 age group) have decreased in England and Derbyshire again reflects this trend. The Chlamydia detection rate (2015) is below England and is under-performing against the recommended Public Health Outcomes Framework (PHOF) rate (2300 per 100,000 detection rate to reduce prevalence of chlamydia by upto 2%).

Table 2: Chlamydia detection rate per 100,000 aged 15-24yrs PHOF 3.02

	Derbyshire	England
Chlamydia detection rate/100,000 aged 15-24yrs PHOF 3.02	1541	1887

The current service provision of chlamydia has a good positivity rate of 10% (2015/16 performance data) showing that screening is reaching young people at risk. However the data does indicate the need for a stronger balance between an approach with focus on people at high risk and whole population screening to ensure impact on the reduction in prevalence as advised through the PHOF indicator.

Reproductive Health

Reproductive health (2015 data from the Derbyshire Sexual Health and Reproductive Profile c. <http://fingertips.phe.org.uk/profile/sexualhealth>) highlights the continued decreasing trend of conceptions for both under 16s and 18s.

Table 3: Under 16 and under 18s conception rate/1000 PHOF 2.04 (2014 data)

PHOF 2.04	Derbyshire	England
Under 18s conceptions rate/1000	16.2	22.8
Under 16s conception rate/1000	3.9	4.4

Prevention of unplanned pregnancy is a key element across good sexual health outcomes and this is addressed in various ways including the promotion and provision of the full range of contraception in line with national guidance.

Contraception

NICE Guidance evidences the increased use of Long Acting Reversible Contraception (LARC) to reduce the numbers of unplanned pregnancies.

<https://www.nice.org.uk/guidance/cg30?UNLID=881911804201642061>

2015 data highlights that Derbyshire both in Clinic and General Practice provision deliver higher than England percentages of LARC:

- Total prescribed LARC excl. injections rate/1000 – 66.1/1000 compared to England 48.2/1000
- GP prescribed LARC excl. injections/1000 – 45.1/1000 compared to England 29.9/1000

Termination data under 19s

Recent data for repeat terminations across the under 19 age group shows figures although small as higher than England

	<p>percentages in Erewash (12.5%) and Hardwick CCGs (11.8%) (England percentage (10.0%)) (Public Health England c. Department of Health 2015 data). Although actual numbers are small, this data still indicates a need to ensure messages of prevention are still uppermost with young people.</p> <p><u>Long Acting Reversible Contraception (LARC) and Emergency Contraception (EC)</u></p> <p>Current service delivery shows a general maintaining of LARC delivery through general practice based on current service performance data. Delivery of Emergency Contraception (EC) through pharmacy shows opportunity for improvement and greater engagement of pharmacy.</p> <p>Feedback from Consultation specific to young people's needs indicates</p> <ul style="list-style-type: none"> • a need for improved communication and promotion of services and their locations • multi-faceted provision in terms of settings – use of online, texting, collocated services within youth-type settings eg. schools • use of outreach to “where young people are” • a mixed response between “wanting” young people only clinic provision v. all age provision. <p>However the over-riding theme from young people was accessible clinics where they could access the nurse/clinician directly rather than going through perceived barriers “reception and other staff”</p> <p>The EIA recommends the re-procurement of DISHS include:</p> <ul style="list-style-type: none"> • open access to all ages, with a focus on targeting young people and targeting young people most at risk • regular promotion of the DISHS in multiple ways to “engage” the young age group • cross-working with organisations and staff who work with young people and with a focus on other services working with young people at risk • established training of staff to support their interaction with young people and vulnerable young people eg. use of Your Welcome standards
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<p>Disabled people including mobility, sensory, learning, mental health, HIV, and also include carers and relatives</p>	<p>It is a requirement that all DISHS sites are accessible to disabled people.</p> <p>Adults with a learning disability or poor mental health are likely to be at higher risk of poor sexual health. This information is not routinely collected by DISHS but all services are required to be accessible and ensure services are accessible to vulnerable young people and vulnerable adults. Case studies are requested by the commissioners as part of performance reporting and these do include service offer to people with disability and learning is taken to develop service provision.</p> <p><u>People living with HIV</u> are another group identified as vulnerable to poor sexual health outcomes. This group of people require accessible sexual health services with appropriate offers of testing, prevention of onward transmission and enable access to support and advocacy services. This element of the service will remain within the re-procurement as part of the mandatory responsibility of local authorities.</p> <p><u>HIV prevalence, diagnosis and testing coverage in Derbyshire</u></p> <p>2015 data for Derbyshire from the Sexual and Reproductive Health Profile highlights some challenges:</p> <ul style="list-style-type: none"> • decreased HIV testing coverage across men, women and MSM, with Derbyshire below England –although testing coverage to the MSM population shows an increasing trend over the last 5 years • total uptake of HIV testing for Derbyshire is similar to the percentage for England (76.6% in Derbyshire/ 76.2% England). <p>However uptake differs across groups:</p> <ul style="list-style-type: none"> • uptake of HIV testing for women is above England and for MSM similar to England; uptake of HIV testing by men is below England. <p><u>HIV late diagnosis (PHOF 3.04)</u> – Derbyshire is underperforming against the rate. An early diagnosis of HIV is</p>
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	<p>recommended to maximise health outcomes through earlier access to treatment. Numbers of HIV diagnoses and prevalence in Derbyshire are low but DISHS must be mindful of a service that promotes and engages towards earlier diagnosis especially with a focus on MSM groups. (c.http://fingertips.phe.org.uk/profile/sexualhealth)</p> <p>The EIA recommends the re-procured DISHS will remain inclusive to people with a disability through</p> <ul style="list-style-type: none"> • regular Quality inspections by a provider and by the commissioner • access to Carers in the support of a disabled person with the permission of the patient • promotional materials and marketing to be accessible to people with disability including learning disability <p>Further analysis across the area of HIV testing eg. staff training around how tests are offered, access to services for vulnerable groups most at risk ie. MSM, young heterosexuals, consideration of different models of delivery such as online testing.</p>
Gender (Sex) including men and women, boys and girls	<p>Derbyshire Sexual Health services are open access to both men or women.</p> <p>STI first attendance data by gender/Derbyshire residents accessing DISHS shows a 41% male attendance and 59% female attendance (April 2015 – September 2016 c. GUMCAD v.2).</p> <p>There may be a risk to access by males where sexual health services are delivered in an integrated model as currently and in the future, due to males perceiving the service as “family planning” and being deterred from access. This has been commented on in the current service and this EIA would recommend consideration to the marketing of DISHS to ensure access to both genders.</p> <p>The EIA recommends the re-procured DISHS</p> <ul style="list-style-type: none"> • to develop communications, marketing and information about the service to meet the needs of both genders.

Gender reassignment – including impact if any on Transgender people	<p>Data is not routinely collected through providers unless a patient shares this information.</p> <p>However vulnerable young people (including Lesbian, Gay, Bisexual and Transgender) are a priority group within Derbyshire Sexual Health Services as they are considered to be at higher risk of poor sexual health.</p>
Marriage and civil partnership – also include impacts on lone parents and unmarried couples	<p>Data is not routinely collected through providers. DISHS is open access to all.</p>
Pregnancy and maternity – including new mothers/ parents	<p>Data is not routinely collected through providers. DISHS is open access to all.</p> <p>However the EIA recommends the re-procured DISHS</p> <ul style="list-style-type: none"> • ensures clear clinical pathways between other commissioned sexual health services such as maternity to ensure clear routes to contraception provision for new mothers and wider support through DISHS.
Race – including all racial groups, including impact if any on Gypsies and Travellers	<p>Service performance data (2015/16) appears to be generally reflective of the ethnicity of Derbyshire as a whole.</p> <p>Service attendees by race: The predominant attendees reported are White British (average 85%), with other races including any other White background, White and Black Caribbean and Asian/Asian British being reported but in a significant minority (under 2%). Current reporting includes an unknown where patients decline to give their race detail.</p> <p>Research shows that some ethnic groups have a greater risk of poor sexual health due to cultural and behavioural practice. Nationally, Black Africans have a greater prevalence of HIV.</p>

	Although the proportion of people from an ethnic minority population in Derbyshire is small, the service is mindful of issues to be addressed to maximise outcomes for groups. Examples include practice (staff training, awareness, local procedures) to address issues such as Female Genital Mutilation (FGM) and monitoring the service offer within high areas of ethnic populations such as workplaces with a concentrated workforce from an ethnic minority group.																		
Religion and belief including non-belief, including religious minority communities, Humanists	Data is not routinely collected through providers. DISHS is open access to all.																		
Sexual orientation – including the impact if any on LGB people	<p>Table 4 highlights attendance of Derbyshire residents at DISHS, STI first attendance data (April 2015 – September 2016 c. GUMCAD v.2)</p> <p>Table 4: First attendance STIs by Sexual Orientation of Derbyshire residents accessing DISHS.</p> <table><tr><td>Sexual Orientation</td><td>Number</td><td>%</td></tr><tr><td>Heterosexual</td><td>25,862</td><td>74%</td></tr><tr><td>Gay/Lesbian</td><td>1658</td><td>5%</td></tr><tr><td>Bisexual</td><td>534</td><td>2%</td></tr><tr><td>Unspecified</td><td>6913</td><td>19%</td></tr><tr><td>TOTAL</td><td>34,967</td><td></td></tr></table> <p>The current DISHS collects sexual orientation data when declared by the patient and it is largely reflective of the national dataset. However clinicians and staff have been informed by some patients “that having to declare my orientation is off-putting” and may place a barrier to accessing DISHS.</p> <p>DISHS currently works with a voluntary sector organisation that specifically focuses activity on LGBT groups alongside</p>	Sexual Orientation	Number	%	Heterosexual	25,862	74%	Gay/Lesbian	1658	5%	Bisexual	534	2%	Unspecified	6913	19%	TOTAL	34,967	
Sexual Orientation	Number	%																	
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TOTAL	34,967																		

	<p>DCHSFT delivery of the sexual health promotion element with targeted provision to LGBT groups and including MSM. Provision is offered through group sessions, 1:1 intensive activity, outreach (Public Sex Environment work) and in clinic. Training is delivered to raise awareness of needs across the LGBT community and including MSM.</p> <p>DISHS has been involved at key LGBT events, such as Derbyshire Pride, raising awareness and carrying out testing</p> <p>Stage 1 Consultation (LGBT focus group)</p> <p>Needs suggested:</p> <ul style="list-style-type: none"> • fear of stigma, prejudice and assumptions • importance of confidentiality <p>Resolutions suggested:</p> <ul style="list-style-type: none"> • clarity on what to expect when visiting DISHS relating to a reiteration of principles such as a service that is confidential, non-judgemental, welcoming • options on forms to better reflect sexuality/ gender identity • wider menu for access to booking eg. online, texting service • improved training and more for staff to raise awareness of LGBT issues and support staff interaction with LGBT clients. Staff mentioned included support to GPs • DISHS – some elements of services to be offered as part of other health clinics eg. STI screening as part of general health check appointments • LGBT young people feared prejudice from other young people – thus perceived youth only DISHS clinics as a barrier to them and would prefer all-age clinics; open access clinics can provide anonymity <p>EIA recommendations</p> <ul style="list-style-type: none"> • reiteration of DISHS: service confidentiality, non-judgemental and welcoming • options on forms to better reflect sexuality/ gender identity • innovation regarding service access in terms of promotion and booking eg. online, texting service
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	<ul style="list-style-type: none"> • improved training and more for staff to raise awareness of LGBT issues • DISHS – some elements of services to be offered as part of other health clinics eg. STI screening as part of general health check appointments • LGBT young people feared prejudice from other young people – thus perceived youth only DISHS clinics as a barrier to them and would prefer all-age clinics; open access clinics can provide anonymity
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Non-statutory

Poorer and disadvantaged communities and groups, including people who experience financial exclusion	<p>Derbyshire sexual health services are free and open access. However the current service seems to show a level of disproportion of access across Derbyshire based at district level and considering levels of deprivation.</p> <p>Table 5: % attendance unique users (c. DISHS performance data/QTR 3 201617</p> <table border="1"> <tr> <th>District</th><th>% attendance unique users (c. DISHS performance data/QTR 3 201617</th></tr> <tr> <td>Amber Valley</td><td>9.55%</td></tr> <tr> <td>Bolsover</td><td>9.12%</td></tr> <tr> <td>Chesterfield</td><td>32.60%</td></tr> <tr> <td>Derbyshire Dales</td><td>6.36%</td></tr> <tr> <td>Erewash</td><td>9.74%</td></tr> <tr> <td>High Peak</td><td>8.38%</td></tr> <tr> <td>North East Derbyshire</td><td>17.93%</td></tr> <tr> <td>South Derbyshire</td><td>3.38%</td></tr> <tr> <td>unspecified</td><td>2.95%</td></tr> </table> <p>Those in poorer and disadvantaged communities and groups are more likely to be at increased risk of poor sexual health due to access to services.</p> <p>EIA recommendation</p>	District	% attendance unique users (c. DISHS performance data/QTR 3 201617	Amber Valley	9.55%	Bolsover	9.12%	Chesterfield	32.60%	Derbyshire Dales	6.36%	Erewash	9.74%	High Peak	8.38%	North East Derbyshire	17.93%	South Derbyshire	3.38%	unspecified	2.95%
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South Derbyshire	3.38%																				
unspecified	2.95%																				

	<ul style="list-style-type: none"> • Further analysis to offer a level of guidance to support KPIs in the new contract based on estimated service use at district level • Consideration of other service delivery tools eg. technology, postal delivery of elements of services. However such developments need to be mindful of the needs of groups with vulnerabilities who have prioritised the need for face to face delivery with a nurse/ clinician. <p>The current service uses online testing through postal kits for HIV and Chlamydia.</p>
Rural communities	<p>Derbyshire residents that are rurally isolated may be more likely to be at increased risk of poor sexual health due to restricted access to services (transport, travel issues).</p> <p>Sexual health services are open access and the current service is mindful of addressing such access issues due to rurality such as the c-card service for young people, online testing (HIV and Chlamydia) through postal kits and community sites for Chlamydia bins, working with general practice and pharmacy to deliver LARC and EC.</p> <p>EIA Recommendations would consider similar to the above that might meet the needs of income disadvantaged as well as the geographical issues across Derbyshire.</p>

Impact on employees of Derbyshire County Council or prospective employees

Derbyshire County Council is not currently a provider of Sexual Health Services in Derbyshire. There should therefore be no impact on Derbyshire County Council employees.

However, Derbyshire County Council employees do undertake roles that may refer service users into sexual health services such as Childrens Services teams, Adult Care Learning Disabilities, Public Health commissioned Substance Misuse services.

Derbyshire County Council employees therefore need to be aware of the

current service and any changes to services.

The Consultation highlighted direct from professionals the lack of awareness and understanding of service available:

Stage 1 Professional consultation (13 February – 13 March)

101 respondents completed the online questionnaire:

54% professional working within a related service

25% working within DISHS

22% other professional

A general theme arising from professionals' comments was a lack of awareness of the service and therefore lack of understanding of the delivery offer – 48% seemed unaware. 51% of respondents who were aware of the service commented on the good quality of DISHS, however 20% expressed concern of service accessibility.

Stage 2 Professional consultation (20th March – 20th May)

Further opportunities for consultation with other commissioning organisations (CCGs, NHS England, Prison Sexual Health) have included:

- Stage 1 findings have informed the development of the Sexual Health Strategy for Derbyshire. Strategy development workshop, involving CCG commissioners, representatives of the LMC, LPC, Children's Services, and LGBT+ took in place in March 2017.
- Discussions have also taken place with NHS England and Prison Sexual Health commissioners to inform this strategy.

EIA Recommendations:

Priority within the newly re-procured DISHS to work closely with other organisations and frontline professionals to support visibility of DISHS and to ensure improved reach to vulnerable populations

- b. From existing customer and other feedback – who is likely to be adversely affected, how and to what degree? Will anyone gain or benefit?

Protected Group	Findings
Age	Monitoring Information Online Consultation: 188 respondents (incl 75 questionnaires returned by post) 172 declared age:

	<ul style="list-style-type: none"> • 15 – 24yrs: 32% response • 25-44yrs: 40% response • 45yrs+: 28% response <p>Monitoring Information from Focus Group Sessions</p> <p>61 respondents engaged in Focus group sessions which were identified in accordance with vulnerable groups. 3 groups included under 25s</p> <p>The findings are indicated in Section 4.</p> <p>EIA Recommendation</p> <p>The Re-procurement of DISHS will continue to prioritise meeting the needs all ages, with a specific focus on young people and vulnerable young people.</p>				
Disability	<p>Monitoring Information Online Consultation</p> <p>Do you consider yourself to be disabled?</p> <table border="1"> <tr> <th>Yes</th><th>No</th></tr> <tr> <td>15</td><td>169</td></tr> </table> <p><u>People Living with HIV</u> – information are included in Section 4 under Disability section.</p> <p>Data was not collected specifically from people living with HIV (PLHIV) within the Consultation. The current DISHS does work with PLHIV as within the contractual requirements.</p> <p>The re-procured DISHS should not adversely affect PLHIV however from analysis on the service model and how it is delivered, action is recommended.</p> <p>Consultation has involved opportunities for discussion with the NHS England Commissioner responsible for HIV Treatment and Care services, as detailed above under Stage 2 Professionals Consultation. Additionally, focus groups as part of the consultation have included some feedback from the following identified at risk groups:</p> <ul style="list-style-type: none"> • Those with learning disabilities or mental health problems <p>EIA Recommendation</p>	Yes	No	15	169
Yes	No				
15	169				

	<ul style="list-style-type: none">• To feedback to the voluntary sector provider to analyse further the needs of PLHIV• To feedback to commissioners of services to people living with mental ill health and/or a learning disability to further analyse needs.						
Gender (Sex)	<div>Monitoring Information Online Consultation</div> <div>At birth were you described as:</div> <table><tr><td>Male</td><td>Female</td><td>Prefer not to say</td></tr><tr><td>47</td><td>137</td><td>2</td></tr></table> <div>Section 4 covers key themes relating to gender.</div>	Male	Female	Prefer not to say	47	137	2
Male	Female	Prefer not to say					
47	137	2					
Gender reassignment	This data was not collected						
Marriage and civil partnership	This data was not collected						
Pregnancy and maternity	This data was not collected						
Race	<div>Monitoring Information Online Consultation</div> <div>White British: 96%</div> <div>Other (incl. Asian/Asian British; Black/Black British, Mixed, Other): 4%</div> <div>Research shows that some ethnic groups have a greater risk of poor sexual health due to cultural and behavioural practice. Nationally, Black Africans have a greater prevalence of HIV. However the size of this population in Derbyshire is relatively small.</div>						
Religion and belief including non-belief	This data was not collected						
Sexual orientation	<div>Monitoring Information from Online Consultation</div> <div>Sexual orientation:</div> <table><tr><td>Heterosexual</td><td>Gay man</td><td>Gay woman</td><td>Bisexual</td><td>Prefer not to say</td></tr></table>	Heterosexual	Gay man	Gay woman	Bisexual	Prefer not to say	
Heterosexual	Gay man	Gay woman	Bisexual	Prefer not to say			

	86%	6%	2%	3%	3%
<u>Monitoring Information from Focus Group Sessions</u> One Focus group worked with people who identified as LGBT.					

Non-statutory

Poorer and disadvantaged communities	This data was not collected in the Consultation
Rural	<p>Access issues were raised both from the professional and public questionnaire. Respondents offered proposed considerations as follows:</p> <ul style="list-style-type: none"> • Developing outreach not just specific to young people but to all ages with a need and who perceive a geographical barrier to DISHS eg. a bus, a “clinic in a boot” • Use of technology within the model • Improved focus on working with general practice as settings for DISHS <p>EIA recommendations:</p> <ul style="list-style-type: none"> • Consideration of outreach models and enquiry to peer authorities that operate such eg. Lincolnshire • Consideration of a model that prioritises general practice as a setting for delivery • Consideration of other settings in communities eg. pharmacy, other health settings, other non-health settings – community venues

Employees or prospective employees

Data was not collected directly from employees or prospective employees; however the consultation was open to existing providers and the general public.

- c. Are there any **other** groups of people who may experience an adverse impact because of the proposals?

It is not expected that there will be any adverse impact on other groups. The re-procured DISHS aims to increase service provision and access and will remain a free open access service.

The re-procurement aims to utilise the information gathered both from data sources, current service provision and the Consultation processes to fully inform the new model of service.

- d. Gaps in data

What are your main gaps in information and understanding of the impact of your policy and services? Please indicate whether you have identified ways of filling these gaps.

Gaps in data	Action to deal with this
<p>From undertaking this EIA it has highlighted that there are the following gaps within the data:</p> <ul style="list-style-type: none"> Offenders in the community 	<p>Additional discussions and engagement with commissioners and providers of services that work directly with these groups will be required.</p> <p>However the Commissioner has met with the provider of Sexual Health Services in prisons to incorporate comment into the developing Derbyshire Strategy for Sexual Health. Information has been forwarded to the current DISHS provider for improved working across both services.</p>

6. From the consultation you have carried out specifically in relation to proposed changes, what views or issues have been raised by those who have responded? (Include both their views and any issues they have raised which alludes to the likely impact)

- a) Please summarise the consultation which has been carried out

Derbyshire Integrated Sexual Health Service (DISHS) Re-procurement Consultation, June 2017 attached to the Cabinet Report highlights the consultation plan and key findings.

The Stage 1 consultation opened for 4 weeks from 13 February to 13 March 2017. The following methods were offered:

Stakeholder group	Consultation method					Communication method		
	Online public survey	Postal public survey	Online stakeholder survey	Focus group	Offer of 1:1 discussion (on request)	Posters displayed in some public areas	DCC internal comms channels	Partner organisation comms channels
All residents	x	x				x		
Service users	x	x				x		X
Identified vulnerable groups	x	x		x		x		X
Staff working in the current service	x	x	x		x	x	x	X
Partner organisations	x	x	x		x	x		X

Poster for online questionnaire:



Sexual-Health-A4-V4
-WEB.PDF

Stage 2 Consultation took place from 20th March 2017 – 20th May 2017.

Stage 2 involved:

- Additional focus groups with identified vulnerable groups
- Further opportunities for consultation with other commissioning organisations (CCGs, NHS England, Prison Sexual Health) including:
 - Stage 1 findings have informed the development of the Sexual Health Strategy for Derbyshire. Strategy development workshop, involving CCG commissioners, representatives of the LMC, LPC, Children's Services, and LGBT+ took in place in March 2017.
 - Discussions have also taken place with NHS England and Prison Sexual Health commissioners to inform this strategy.

- b) Please summarise the feedback received. This should make clear where those who have responded have highlighted any potential adverse impact as well as their opinions on the proposals.

In total 350 people have engaged in the consultation, this includes:

- 113 responses to the online public survey

- 75 postal submissions to the public survey
- 101 responses to the online stakeholder survey
- 61 participants engaged in focus groups from identified 'at risk' populations (vulnerable young people (NEETS, care leavers); LGBT group, Drug and Alcohol recovery females).

Emerging themes from Consultation:

- Availability of appointments/ waiting times for appointments
- A need for outreach clinical services to those most at risk – taking the service to those who experience barriers in accessing a clinic
- Improve visibility of the service – to partners and the population
- Services need to be more accessible in rural locations where travel is a barrier
- Different ways of accessing the service need to be explored – for example text messaging services, online services, postal kits
- Improve communication with partners
- Services need to better understand barriers to vulnerable groups to reduce the fear of prejudice and stigma
- Suitably trained workforce – matching competencies to demands on the service
- Ensure absolute confidentiality
- Explore extended GP provision and appropriate funding

7. Are there any ways of avoiding or reducing likely possible adverse impact on any groups of people, what are those actions, and how will they assist?

As highlighted any changes as part of the developing re-procured DISHS will be in response to this EIA. The re-procurement's aim is continued improvement of the sexual health across the Derbyshire population and including people in protected groups and at higher risk of poor sexual health outcomes.

EIA recommendations:

Commissioners of DISHS should ensure further discussion with other sexual health commissioners (CCG and NHS England) to ensure there is no risk or destabilisation to services across the whole sexual health system.

Appendix 4 Commissioning Responsibilities Sexual Health Services.

Detail taken from the Health and Social Care Act 2012.

Derbyshire County Council	Clinical Commissioning Groups in Derbyshire	NHS England
<p>Community contraception and including:</p> <ul style="list-style-type: none"> • Long Acting Reversible contraception (LARC) in general practice • Emergency contraception in pharmacy <p>Community STI diagnosis and treatment Targeted Sexual Health Promotion and HIV prevention Free Condom scheme (C-Card) Psychosexual services (sexual health element)</p>	<p>Abortion services Vasectomy and sterilisation services Gynaecology services Psychosexual services (non-sexual health element)</p>	<p>HIV treatment and care including pre and post prophylaxis Contraception and opportunistic provision of STI testing provided under the GP Contract Cervical screening Opportunistic promotion and testing of STIs Sexual health in prisons Sexual Assault Referral Centres (SARC)</p>

Appendix 5 Derbyshire Sexual Health Strategy 2017-2020 DRAFT May 2017

Vision

All people in Derbyshire, irrespective of factors such as where they live, their age, gender, ethnicity and sexual orientation have good sexual health, and access to good quality, welcoming services without fear of stigma or prejudice

Aim

The aim of the Derbyshire Sexual Health Strategy is to enable the Derbyshire sexual health system to work together to support people to look after their own sexual wellbeing and to provide accessible and welcoming services which are focussed on prevention, early diagnosis and treatment, reducing inequalities and tackling stigma.

Strategic Objectives

To develop a coordinated, effective and resilient Derbyshire sexual health system responsive to the needs of local people.

To ensure a continued focus on prevention, early diagnosis and treatment and to reduce health inequalities.

To empower Derbyshire residents to manage their own sexual wellbeing and have confidence in the full range of services as and when they need them.

To reduce the fear of stigma around sexual health and accessing sexual health services.

