Nottinghamshire County Council

Report to the Health and Wellbeing Board
4 February 2015

Agenda item 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LOCAL AUTHORITY COMMISSIONING OF COMPREHENSIVE SEXUAL HEALTH SERVICES FROM APRIL 2016

Purpose of the Report

1. The purpose of this report is to advise the Board of:

   a. the health needs and contractual arrangements related to the Council's responsibility for commissioning mandatory comprehensive sexual health services
   b. the extent to which the recently agreed Health and Wellbeing priority for sexual health is dependent on these services
   c. the potential implications and consequential costs of possible reductions in funding which will be determined by the Public Health Committee

Information and Advice

Public health significance of good sexual health

2. Good sexual health is an important part of physical, mental and social well-being, requiring a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences which are free of coercion, discrimination and violence[i].

3. The burden of poor sexual health falls most heavily on disadvantaged groups. There is a clear association between sexual ill health, poverty and social exclusion in Nottinghamshire County. The immediate impact of poor sexual health falls on individuals, but its consequential costs are borne by society through increased burdens on public services.

4. The public health significance of the overall sexual health agenda is underlined by the inclusion of several indicators in the Public Health Outcomes Framework:

   a. **Under 18 conceptions** (Domain 2, Health Improvement): children born to teenage mothers are much more likely to experience a range of negative outcomes in later life, such as developmental disabilities, behavioural issues and poor academic performance.

   b. **Chlamydia diagnoses in people aged 15-24 years** (Domain 3, Health Protection): if untreated, between 10-20% of chlamydia cases result in infertility due to pelvic inflammatory disease.

c. **People presenting with HIV at a late stage of diagnosis** (Domain 3, Health Protection): in the most recent 3-year reporting period, 32 people in Nottinghamshire County were diagnosed with HIV at a late stage of the disease. As a proportion of the population, this is not different to the England average[ii]. Nevertheless, each of these individuals carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed early. In addition to the avoidable, poor health outcomes for the individuals concerned, late diagnosis also yields significant treatment, clinical and social care costs.

5. In recognition of the extent to which good sexual health contributes to health and wellbeing, the Nottinghamshire County Health and Wellbeing Strategy includes the priority to reduce the rates of STIs and unplanned pregnancy.

6. Investment in sexual health services delivers a good return on investment. For example, evidence shows that the economic impact of investment in contraceptive services delivers £11 of benefit to public service budgets for every £1 invested[iii]. NICE guidance relating to various sexual health interventions provide summaries demonstrating their cost effectiveness.

7. Appendix 1 outlines the benefits of investment in effective SH services.

Commissioning responsibilities & interdependencies

8. Since April 2013 responsibilities for commissioning comprehensive sexual health, reproductive health and HIV services have been divided across local government, Clinical Commissioning Groups (CCGs) and NHS England (NHSE).

9. Local Authorities Regulations[iv] mandate that unitary and upper tier local authorities commission confidential, open access services for STIs and contraception, as well as reasonable access to all methods of contraception. Appendix 2 provides a summary of the system wide commissioning responsibilities for sexual health, reproductive health and HIV services.

10. The delegation of commissioning responsibilities for a single patient "pathway" to a number of organisations means that the delivery of an effective overall commissioning system depends on close collaboration between CCGs, NHSE, and other local authorities. This is important both in terms of ensuring satisfactory outcomes at each stage of the patient pathway and to mitigate the unintended consequential costs of changes made to services earlier in the same pathway.

11. Appendix 3 provides insight into three service users' sexual health "journey" and demonstrates the interdependencies and collaborative commissioning arrangements required to ensure seamless access to appropriate services.

12. The consequential costs of poor access to timely testing for STIs, prompt treatment and a full range of contraception are borne by CCGs, NHSE, Nottinghamshire County Council, neighbouring local authorities and other public service budgets. Some of these costs are considerable. For example, national data indicates that the lifetime cost of treatment and social care of the 30 people in Nottinghamshire County diagnosed with HIV in 2010-11 is estimated to be in excess of £8 million[v]. Costs of HIV treatment and care are approximately

double for people who receive late diagnosis. Implications for the local system are that arrangements should be in place to promote and secure early diagnosis, with pathways into treatment which are smooth and seamless for patients (irrespective of the underlying commissioning responsibilities).

13. There are also close dependencies between sexual health and other local authority agendas. For example, the availability and accessibility of "young person friendly" sexual health and reproductive health services makes a critical contribution to Nottinghamshire's ambition to continue to lower teenage conceptions across the whole county and to a greater degree in more deprived areas[vi]. Similarly there are close dependencies with Sex and Relationships Education (SRE) and the Child Sexual Exploitation (CSE) agenda. Good CSE practice is a key priority of the Nottinghamshire Childrens' Safeguarding Board and is being embedded in local sexual health services.

14. Within our current and future commissioning arrangements, there is a need to be mindful that NHS providers (within specialist areas such as sexual health) are key contributors to medical and clinical workforce development and training. In other words, a failure to commission this workforce training represents a threat to the sustainability and future delivery of sexual health services in Nottinghamshire County.

Health needs assessment

15. Nottinghamshire County's Joint Strategic Needs Assessment (JSNA) highlighted significant variation across the county in both the prevalence of STIs and the number of teenage conceptions and identified that addressing sexual ill health and promoting sexual wellbeing is a key step to reducing overall health inequalities.

16. Work is under way to update and refine this assessment of need. Amongst other things, this is likely to confirm the need to address:

    a. integration of sexual health services so that, within a single appointment visit, service users are able to access STI testing and relevant contraceptive advice and provision

    b. sexual health promotion to young people (especially in teenage hot spot areas across the county), to other people who have higher sexual health risks (including men who have sex with men and sex workers) and people at greatest risk of late diagnosis of HIV.

17. In addition to these aforementioned needs and the imperative to tackle the underlying circumstances that *motivate* young people to want to, or to be led passively to become pregnant or young parents at a young age, the Teenage Pregnancy Strategy also highlights the need for all children and young people to have access to good quality Sex and Relationships Education (SRE), and "young person friendly" contraception and sexual health services including specialist services and primary care.

The Council's current sexual health contracts and related cost pressures

18. Notwithstanding the importance of the wider sexual health agenda (e.g. SRE, CSE) and the effective integration of pathways for which commissioning responsibility is split (e.g. HIV diagnosis and treatment), the primary focus of this paper is on the commissioning of confidential, open access services for STIs and contraception, and associated prevention.

19. The total annual cost of the Council's sexual health contracts falling within the scope of this paper is approximately £6.8 million. These contracts are summarised in Appendix 4.

20. In regard to the management of contracts which cover the south of the County, it is critical to work in close collaboration with Nottingham City Council who are also associate commissioners of Nottingham University Hospitals for Genito-urinary Medicine (GUM) and Contraception and Sexual Health (CaSH) services. Dependencies in Bassetlaw are with Doncaster Council whose services are provided by Doncaster & Bassetlaw Hospital.

21. In common with other commissioners of acute healthcare services, the council pays for its GUM services using a simple per-patient tariff which is determined nationally. Therefore there is little scope for reducing the unit price of each treatment. Indeed, looking ahead it is more likely that the tariff will be increased. Furthermore, since the Council must provide equity of access to an open universally available service there is limited scope in the short term for reducing the volume of activity.

22. Payment for Contraception and Sexual Health (CaSH) services are currently transacted through "block" contracts, in which a fixed overall amount is paid to the provider irrespective of the total number of treatments. Exceptions to this arise in respect of residents who are at liberty to access CaSH services in other areas, for which the Council is liable to make payment. Changes to the way pathology costs are recharged to providers may materialise as an additional cost pressure.

23. The Council also commissions Long Acting Reversible Contraception (LARC) from general practice, for which there is evidence of gaps in coverage. Treatments provided are paid according to a pricing schedule which varies across the County. Discussions with primary care to rationalise payment stalled last year due to limited freedom of movement on either side.

24. As part of meeting its obligation to ensure access to a range of contraception, the Council also commissions Emergency Hormonal Contraception (EHC) from 144 Community Pharmacies, who also "signpost" service users to contraceptive and sexual health services and C-Card for young people.

25. The key implications arising from these considerations is that short term scope for reducing costs to the Council is limited and that financial pressures on the current budget are growing.

Future commissioning & prospects

26. All current CaSH and GUM contracts expire on 31/3/2016 and have no further permissible extension periods. This means that some form of procurement will have to be undertaken to commission services for the period from 01/04/2016. This will be a key opportunity to address the recommendations from the needs assessment (e.g. to implement integrated services and improved sexual health promotion across the county) and the goals agreed by the Health and Wellbeing Board (to reduce rates of STIs and unplanned pregnancy).

27. In considering the reprocurement of these services, current and potential providers are unlikely to agree to new arrangements based on block contracts which expose them to risk

of cost pressures if treatment activity increases. Work is under way to quantify the additional financial pressures for the Council of "unblocking" these contracts.

28. Introduction of a new national integrated tariff will provide a payment structure which enables a faster implementation of integrated working. The rate for the per-patient tariff has yet to be determined, but may represent a net additional financial pressure compared to our current pricing arrangements.

Likely consequences of reductions in funding for sexual health services

29. The portion of the Public Health Grant to be allocated to sexual health will not be determined by the Public Health Committee until May 2015.

30. Until that time, public health colleagues are seeking to develop service models which meet the Health and Wellbeing Board's objective to reduce rates of STIs and unplanned pregnancy, the Council's obligation to provide confidential open access sexual health services, and which accommodate the aforementioned cost pressures - and to secure this within a budget which the Public Health Committee may determine should be reduced from its current level.

31. To achieve this, attention will focus on the potential savings which can be realised by improving the service model itself and/or which may be secured through market competition. A planning assumption in this work is that this approach has the potential to offset some or all of the likely cost pressures and to deliver some overall savings. Soft market testing may provide observations by which to provisionally validate the potential scale of such efficiencies and the likelihood of achieving them.

32. Beyond this, greater certainty about the scale of any realisable savings is unlikely to be forthcoming until the end of the procurement process. Until that time, assessments of what savings may be achievable will simply be provisional estimates of how the market will evaluate the opportunity.

33. Depending on the size of the budget to be determined in May 2015 by the Public Health Committee, it may not be possible to identify an affordable service model which meets the objectives of the Health and Wellbeing Board or the needs of the population at the same level as that of current arrangements.

34. In this eventuality, the Board should be aware that evidence indicates that sexual health services with reduced effectiveness or accessibility are likely to result in adverse consequences for patients (unplanned pregnancies in teenagers and adults, onward transmission of untreated STIs, infertility arising from delay in or lack of treatment for Chlamydia infection, and additional complications or early death associated with delayed diagnosis of HIV), CCGs (additional demand for termination of pregnancy, ante- and perinatal services, treatment for infertility and other complications arising from delayed diagnosis and treatment), NHS England (additional costs associated with failure to secure early diagnosis of HIV) and the Council (increased demand for Early Years interventions such as Sure Start, and nursery provision).

35. Accurately quantifying what the scale or timing of these impacts would be in Nottinghamshire is problematic and sensitive to assumptions about the extent to which adverse impacts are mitigated by efficiencies in the model and its procurement. Recent

national level modelling available is subject to similar limitations[vii]. Nevertheless, it indicates that, alongside the impact on health outcomes, the consequential cumulative financial impact might be considerable and that, in part, the burden of this would probably fall on NHS partners, notably CCGs who would have to divert funds to meet the costs associated with additional care.

36. In the meantime, current efforts of the public health team remain focussed on identifying service models and procurement options to mitigate the likelihood and impact of such an eventuality.

Immediate next steps

37. The immediate next steps are for public health to complete the updated needs assessment, the development of options for a proposed future service model and a recommendation about the preferred procurement approach for securing this.

38. Work on the future service model will explore the value of delivering contraceptive and sexual health services in a more integrated way, and other recommendations which emerge from the needs assessment work which will be completed by February. Appendix 5 identifies early emerging themes identified so far.

39. Work on the future service model will be undertaken in collaboration with Nottingham City Council in particular, because of our shared interest in the availability of services which are accessible to people who live or work near to Nottingham.

40. Engagement with CCGs on this agenda is through their participation in the Sexual Health Procurement Group, the Public Health directorate's CCG Engagement Group, and via the CCG Congress which will receive a paper at a forthcoming meeting.

41. As our recommendations develop, Public Health will undertake consultation with relevant stakeholders. This will take place in early 2015.

42. A paper will be taken to the Public Health Committee in May to recommend a procurement approach and to support their decision-making about the portion of the public health grant to be allocated to sexual health services.

Reason for Recommendations

43. Effective arrangements to secure the provision of comprehensive open access sexual health services will be critical to address the Health and Wellbeing priority recently agreed by the Board.

Statutory and Policy Implications

44. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

45. None

RECOMMENDATION

1. The Board is asked to note the information shared in the paper about Nottinghamshire County Council's commissioning of sexual health services and its relevance to the Board's Health and Wellbeing priority to reduce rates of STIs and unplanned pregnancy.

Dr Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Dr Jonathan Gribbin Consultant in Public Health (jonathan.gribbin@nottscc.gov.uk)

Constitutional Comments (SG 05/01/2015)

46. Because this report is for noting only no Constitutional Comments are required.

Financial Comments (KAS 12/01/15)

47. There are no financial implications contained within this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

Electoral Divisions and Members Affected

- All

Appendix 1 Benefits of investment in effective SH services (DH 2014)

Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) =benefit for specified commissioner(s)
Objective: Continue to reduce the rate of under 16 and under 18 conceptions Commissioning intention: Ensure choice and timely access to young people-friendly reproductive health services and all methods of contraception	Control over fertility through increased use of contraception Greater ability to pursue educational and employment opportunities Improved self-esteem Improved economic status/reduction in family and child poverty	Fewer unwanted pregnancies Improved health outcomes for mothers and babies Better educational attainment Better employment and economic prospects	Improved infant mortality rates CCGs Reduced A&E admissions/childhood accidents CCGs Decrease in abortions CCGs Reduced use of mental health services CCGs Reduced use of social services LAs Fewer young people not in education, employment or training LAs Reduction in family and child poverty LAs
Objective: Reduce rates of STIs among people of all ages Commissioning intention: Encourage uptake of chlamydia screening and testing for under 25 year olds	Treatment of STIs Reduced risk of other health consequences (eg pelvic inflammatory disease, tubal-factor infertility, ectopic pregnancy)	Reduction in prevalence and transmission of infection Opportunities to test for other STIs/HIV in those diagnosed with chlamydia Reaching young people with broader sexual health messages Increased uptake of condom use	Reduced use of gynaecology services (to manage other health consequences) CCGs Increased uptake of sexual health services by young people LAs Increase in chlamydia diagnoses enabling more treatment and consequent reduction in prevalence Las
Objective: Reduce onward transmission of HIV and avoidable deaths from it Commissioning intention: Ensure access to high quality reproductive health se4rvices for all women of fertile age	Access to treatment Better treatment outcomes/prognosis Improved ability to protect partner from HIV	Fewer people acquiring HIV Greater contribution of people living with HIV to workforce and society Less illness and fewer avoidable deaths	Lower health and social care costs for HIV NHS England, CCGs and LAs Lower healthcare costs for associated conditions and emergency admissions CCGs Enhanced public

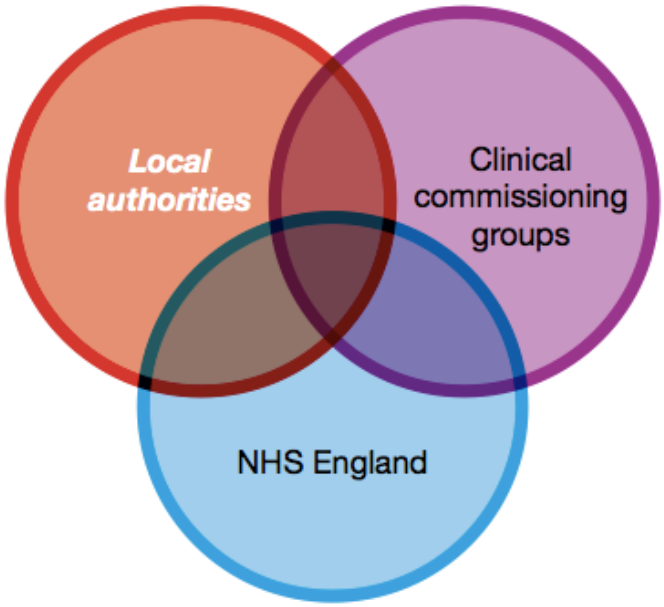
			health/prevention Las
Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) =benefit for specified commissioner(s)
Objective: Reduce unintended pregnancies among all women of fertile age Commissioning intention: Ensure access to high quality reproductive health services for all women of fertile age	Better control over fertility for women at all life stages, through access to choice of full range of contraceptive methods Optimisation of health for women prior to becoming pregnant Fewer abortions and repeat abortions for individual women Improved quality of family life	Fewer unwanted pregnancies Improved pregnancy outcomes Improved maternal health and reduced maternal mortality	Investment in contraception is cost effective in reducing pregnancies and abortions CCGs Lower healthcare costs through reduced antenatal, maternity and neonatal costs due to better management of pregnancy and improved outcomes CCGs Reduced social care costs for infant and child care LAs

Appendix 2

Commissioning Responsibility for sexual health, reproductive health and HIV [viiix]

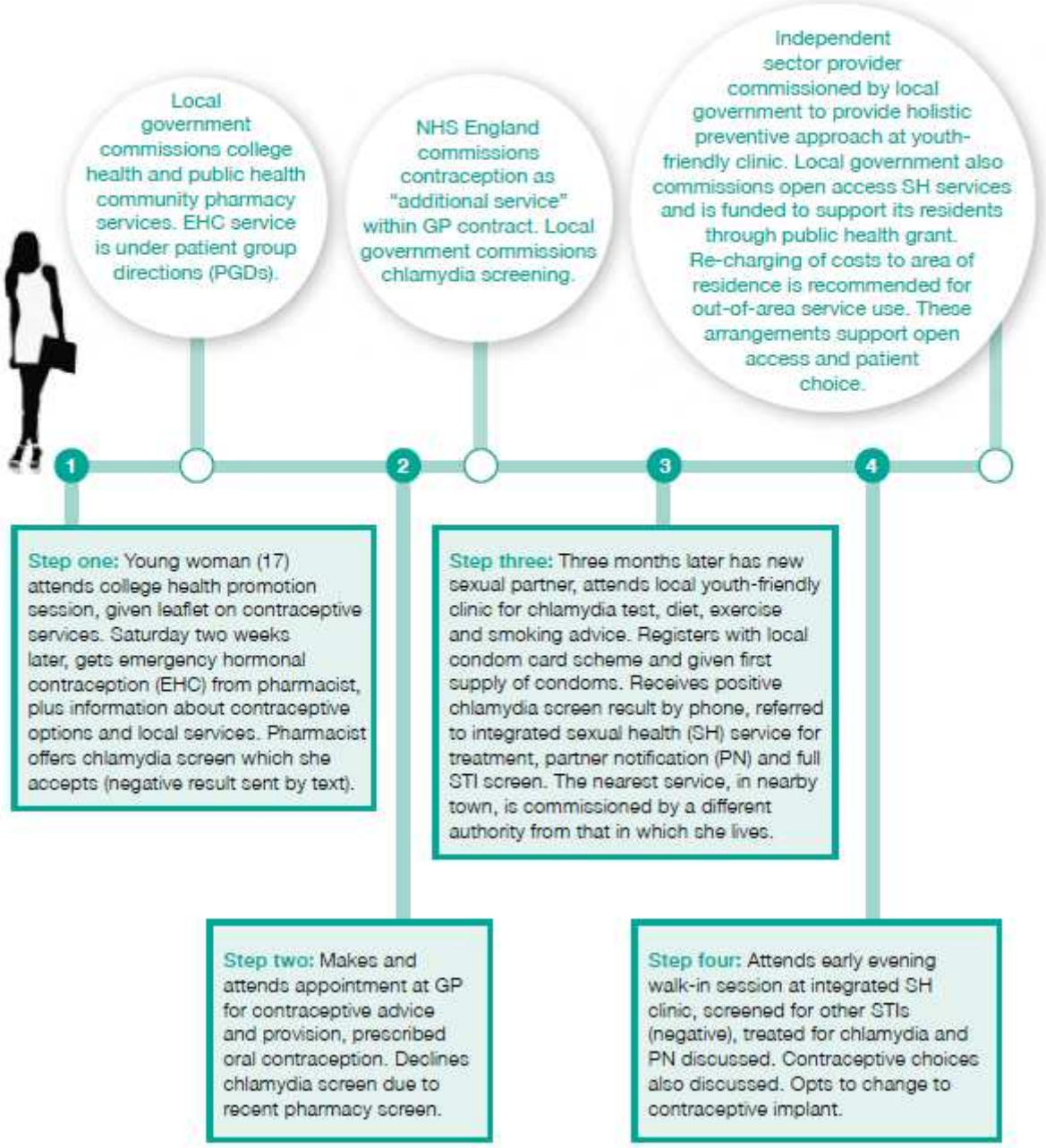
Local Authorities	CCGs	NHS England
• Contraception • STI testing and treatment • Chlamydia testing as part of the National Chlamydia Screening Programme • HIV testing • Sexual health aspects of psychosexual counselling • Sexual services including young people's sexual health, teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies	• Abortion services • Vasectomy • Non sexual health elements of psychosexual health services • Gynaecology including use of contraception for non-contraception purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care including post-exposure prophylaxis after sexual exposure • Promotion of opportunistic testing and treatment for STIs • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening • Specialist fetal medicine
Original Source: Department of Health Commissioning Sexual Health services and interventions: Best Practice guidance for local authorities, 2013		

The Venn diagram illustrates the interface and co-dependency of commissioning sexual health, reproductive health and HIV services[x].



A young woman's journey

The first service user journey describes a young woman's use of open access sexual health services. It illustrates the need to provide information, advice and care that support her positive sexual health. To avoid unwanted pregnancy and treat an STI, she uses services commissioned by two local authorities and NHS England. Her story underlines the importance of open access and confidential, young person-friendly services.



A woman's journey

The third service user journey is that of an adult woman who has an unplanned pregnancy. The services she accesses are commissioned by a CCG and a local authority. She has wider health needs but these are poorly catered for as she is not able to access a range of other, disparate services. The opportunity to meet her needs in an integrated way is therefore lost.

Local government commissions open access integrated SH service.

CCG commissions abortion service.

Local authority and CCG should ensure service and contracting arrangements support an effective integrated pathway for service users.

1

Step one: Woman (37) attends integrated SH service for pregnancy test (positive result), has full STI screen including HIV test (all results negative), and receives advice on choice of contraception. After discussion, seeks referral to abortion service.

2

Step two: Attends abortion service, discussion with clinician identifies problems with alcohol use, opts for termination of pregnancy and given appointment.

3

Step three: Attends for day case abortion, requests condoms, sees counsellor within the service who encourages return to integrated SH service for further contraceptive advice. Also referred to women's alcohol advice service.

4

Step four: Does not return to SH service nor attend appointment at alcohol advice service. No mechanism exists for follow-up between different services and opportunities to support this woman are lost.

A gay man's journey

The second service user journey describes the sexual health needs of an HIV positive gay man. It underlines the importance of linkages and referral pathways between sexual health and HIV services. It also illustrates the wider needs of people living with HIV (PLWH) for treatment information and social support, which they may seek outside their local authority of residence to maintain confidentiality. Flexible funding mechanisms are required which match patterns of service usage.

Local government commissions integrated SH services including HIV testing.

NHS England commissions HIV treatment and care services. These are often provided at same site as local government-commissioned GUM or integrated SH services by same team of professionals.

Local government commissions social and peer support services, PN and STI screens for PLWH. NHS England commissions primary care for PLWH as part of "essential services" in GP contract.

1 2 3 4

Step one: Gay man (early 20s) attends integrated SH clinic. Gonorrhoea diagnosed, treated and managed, HIV test negative.

Step two: Returns to integrated SH clinic 18 months later with new gonorrhoea infection. Tests positive for HIV. Supported by GUM team, counselled by health adviser including issues of disclosure and PN. Urgent referral to specialist HIV outpatient clinic.

Step three: Seen at HIV outpatient clinic for assessment and evaluation, receives treatment information. Referred to voluntary organisation for peer and social support. Agrees HIV service can inform his GP of his HIV status and share details of his treatment and care.

Step four: Initial assessment, then ART initiated. With SH and HIV services delivered by same provider and co-located, PN undertaken, sexual history taken and full STI screen performed during same visit. Advised to return regularly for STI screening.

Appendix 4 Summary of current contracts for Sexual Health Services

Local Authority Commissioned Services – Sexual Health	
Type of Service	**Provider**
CaSH Service	
South County Community CaSH Clinics	Nottingham University Hospitals
Central Nottinghamshire Community CaSH	Sherwood Forest Hospitals Foundation Trust
Bassetlaw CaSH Clinics	Doncaster and Bassetlaw Hospital
GU Med	
City Hospital	Nottingham University Hospitals
KMH and Newark Hospital	Sherwood Forest Hospitals Foundation Trust
Retford Primary care Centre and Reyton Street	Doncaster and Bassetlaw Hospital
CaSH in the city accessed by county residents	
Health Shop Sexual Health Service - accessed by county Service Users, positive engagement with people increased sexual health needs/risks	Nottinghamshire Healthcare Trust (NHT)
LARC - Long Acting Reversible Contraception	
Intra Uterine Contraceptive Devices	LCPHS – GPs and in CaSH
Contraceptive Implants	
Emergency Contraception	
Emergency Hormonal Contraception	Community Pharmacies and in CaSH
HIV Prevention and Testing	
Outreach advice and Point of Care Testing (POCT)	Terence Higgins Trust
Health Promotion and advice Young People	
SEXions – *only commissioned in Central Nottinghamshire	Sherwood Forest Hospitals Foundation Trust
C Card Scheme	Available at various locations across the county and in the city
Out of Area GUM and Out of Area CaSH	Nottinghamshire County residents can access services out of area and the respective provider invoices the relevant LA
Nottinghamshire County residents can access services when out of area and the respective provider invoices the relevant LA	Any CaSH or GUM provider within England
KEY: **CaSH** – Contraceptive and Sexual health Service **GU Med** – Genito-urinary Medicine (sometimes referred GUM) **GPs** – General Practitioners **LCPHS** –Locally Commissioned Public Health Services **C –Card Scheme** access to condoms for young people and signposting to CaSH and GUM	

Appendix 5

An excerpt from a draft of the updated sexual health needs assessment – to indicate some of the emerging themes

8 Unmet needs and service gaps

8.1 Unmet Needs

Nottinghamshire County is similar to the rest of the country when considering key sexual health outcomes. There is significant unmet need in terms of

- Sexually transmitted infections (STIs),
- access to and effective use of contraceptives and
- unplanned pregnancy, including teenage conceptions and terminations.

There is a clear evidence base, as laid out earlier in this document, for effective interventions to address population sexual health need. Actions to tackle the need identified in this section are included in the recommendations for commissioners.

In line with the national picture, there are increasing rates of STI diagnosis, with 3,840 diagnoses in Nottinghamshire County for the most common STIs in 2013. At least 60% of these occur in those aged 15 to 24 years. This indicates unmet need for effective SRE and health education/promotion initiatives to reduce risky sexual behaviour and increase correct, consistent use of condoms.

In addition, there is evidence of persistent risky sexual behaviour in Nottinghamshire County, as seen in rates of reinfection within a 12 month period from first clinic attendance. Re-infection rates in many districts are higher than the national average. The highest rates of reinfection are seen in those aged 15 to 19 years, with around 1 in 10 young people attending with an acute STI within a year of previous infection. Further investigation is needed to understand what is driving higher rates of reinfection and how behaviour change can be encouraged via sexual health services and health promotion routes.

Whilst those under 25 have the highest rates of STI diagnosis, and account for half of all GUM first attendances, it is important to remember that individuals may need sexual health services at any age, and this need may arise unpredictably throughout the life course. There is evidence from previous local analysis that a higher proportion of attendances at CaSH services are occurring in older women in central Nottinghamshire (Mansfield, Ashfield and Newark & Sherwood) as compared to the south. National evidence has also shown an increase in terminations of pregnancy in women aged over 25 (local comparative data unavailable). Effective sexual health services need to be flexible and responsive, taking an appropriate life course approach to provision.

In 2013, nearly 1 in 4 NHS funded terminations (22.8%) were carried out after 10 weeks gestation. Therefore, there is room for improvement in early access to both pregnancy testing and NHS services for termination of pregnancy.

There were 1,830 terminations of pregnancy carried out in Nottinghamshire County in 2013, of which 145 were carried out in those under the age of 18. In women aged under 25 attending for termination of pregnancy, just over 1 in 5 reported having a previous termination at any age. These figures are an indicator of lack of access to good quality contraception services and advice as well as problems with individual use of contraceptive method. Three months data from pharmacy emergency hormonal contraceptive (EHC) services show the key reasons for use of EHC were failed condom, unprotected sex and missed oral contraceptive pill. Previous use of EHC was recorded within the last year, for 38.8% of consultations. GP prescription rates for long acting reversible contraceptives (LARC) were 6.6 per 100 resident female population in 2013. In Nottinghamshire County LARC is provided by CaSH service providers (BHP, SFHFT and NUH) and also by GPs who have a contract with the council for delivery of LARC as a Locally Commissioned Public Health Service. The delivery outlets within CaSH and General Practice help increase access and choice for service users. Evidence has shown that LARC is much more effective in preventing pregnancy than other hormonal methods and condoms, and is also cost effective. In addition, provision of contraception,

particularly LARC methods, supplied or fitted by the termination provider can reduce repeat terminations. There is unmet need in Nottinghamshire County for accessible effective contraception and information about correct contraceptive use.

Poor sexual health outcomes within Nottinghamshire County are broadly associated with levels of deprivation. The more deprived areas have higher rates of diagnosed STIs and teenage conceptions. In particular Mansfield and Ashfield have a higher burden of poor sexual health outcomes than seen elsewhere in Nottinghamshire County. This includes overall rates of STI diagnosis, teenage conceptions, and rates of admission for pelvic inflammatory disease which are significantly higher than national averages in Mansfield and Ashfield. Reinfection rates for acute STIs are also higher than national averages in these areas.

In Nottinghamshire County, the proportion of 15 to 24 year olds screened for chlamydia is 19.5%, i.e. the lowest in the East Midlands and significantly lower than the England average (24.9%). Despite only 19.5% of this age group being screened, the chlamydia diagnoses rate in those aged 15 to 24 years is 2,207 per 100,000 population which is not significantly different from the England average. This could indicate that chlamydia testing carried out in Nottinghamshire is appropriately targeted, identifying those with chlamydia infection, despite screening a smaller proportion of the population. However it could also indicate that there is a high population prevalence of chlamydia infection compared to the England average in the 15 to 24 year old age group, with an asymptomatic proportion remaining undiagnosed.

Despite low coverage of the target chlamydia screening population (ages 15 to 24) Mansfield, Ashfield and Gedling, have high positivity rates in those tested for chlamydia from this age group, and amongst the highest chlamydia diagnosis rates in the East Midlands. Nottinghamshire County also has had a crude rate of admissions for pelvic inflammatory disease (PID) over the past 5 years which is significantly higher than the England average, and in 2013 is in the highest 15% of upper tier and unitary authorities. The rates in Ashfield and Mansfield districts are amongst the worst 5 districts in England. There are a number of possible explanations for this pattern, including that there may be a high level of undiagnosed STI infection (primarily chlamydia and gonorrhoea) in these areas leading to poor long term sexual health outcomes. Further investigation and research is needed to understand the reasons underlying this.

Whilst rates of diagnosis for gonorrhoea remain significantly below the England average in Nottinghamshire County, the rate of increase in diagnosed gonorrhoea infection is greater than for any other county or unitary authority in the East Midlands, with the exception of Nottingham City. This increase is likely to reflect a change in testing patterns which has occurred across England in recent years. The use of more sensitive testing methods, the expansion of testing to include oral and rectal samples and the introduction of dual testing for chlamydia and gonorrhoea have been identified by various reports to be key drivers of increasing gonorrhoea diagnosis rates.[xi] Public Health England has noted that many local authority-commissioned sexual health services have been using dual testing inappropriately, which can result in increased levels of false positive results.[xii] Commissioners will need to assure themselves that PHE guidance on gonorrhoea testing is being appropriately followed by sexual health services and laboratories. Testing procedures which are not aligned with best practice will have an impact on cost effectiveness as well as leading to inappropriate treatment in the case of false positives.

More than 50% of HIV diagnoses in Nottinghamshire were classed as late diagnosis in 2013. This should be taken in context of a very low prevalence of HIV in Nottinghamshire (0.64 per 1,000 among persons aged 15 to 59 years).

A BBV Reference Tool was devised for use by local GP practices in identifying possible individuals with blood borne viruses, specifically HBV, HCV and HIV. This tool was originally devised in 2011 and further reviewed and refreshed in 2014. It now includes assessment for TB risk as well as BBV. The tool has been disseminated to all primary care practices in Nottinghamshire County via their CCGs. It takes an active case finding approach to earlier diagnosis of HIV. Case finding involves actively searching systematically for at risk people, rather than waiting for them to present with symptoms or signs of active disease. Promotion of the use of this tool provides one option for improving early diagnosis of HIV. Further effective strategies for early diagnosis in a low prevalence population need to be considered.

8.2 Service Gaps

As services are re-procured in the future, the commissioners' aim is to develop and commission an evidence-based, responsive, integrated sexual health service (ISHS) which delivers high quality, evidenced based services that are accessible and reflect value for money.

A number of the current services lack integration and there is some evidence of inequitable provision across the county.

An integrated approach to sexual health need and outcomes

Commissioning responsibilities for sexual health are now distributed across a number of organisations, introducing a risk of delivering a fragmented service to clients, which does not address sexual health needs in a coherent and comprehensive way. In particular patient pathways need to be reviewed, in light of new commissioning structures to ensure that they are holistic in meeting sexual health need. For example, incorporation of contraceptive provision and advice into GUM services, termination of pregnancy and maternity pathways.

We know that a significant number of Nottinghamshire County residents access their sexual health services in Nottingham City. So to effectively meet local need, an integrated approach also involves acknowledging close co-dependencies with Nottingham City sexual health services. There is need for close coordination between commissioners for county and city local authorities.

In line with a comprehensive approach to sexual health need, collaborative working across agendas is critical to achieving improvements in sexual health and avoiding consequential costs being displaced across the health and social care system. This includes work on interdependent priorities for child sexual exploitation, teenage pregnancy and sexual violence. This will recognise the opportunities to maximise outcomes for these vulnerable groups.

Implementing an integrated sexual health service model

An integrated sexual health service (ISHS) model aims to improve sexual health by providing easy access to services through open access 'one stop shops', where the majority of sexual health and contraceptive needs can be met at one site, usually by one health professional, in services with extended opening hours and in accessible locations.

An ISHS will need to support delivery against the three main PHOF measures

- Under 18 conceptions
- Chlamydia Diagnosis (15-24 year olds)
- People presenting with HIV at a late stage of infection

An ISHS will also support delivery to a number of local population based outcomes to improve sexual health, these include promoting:

- A culture of good sexual health across the population where individuals enjoy respectful and consensual sexual relationships
- The de-stigmatisation and normalisation of accessing sexual health services
- An increase in knowledge and awareness of issues around sex, relationships and sexual health in young people and those at highest risk of sexual ill health
- A high level of population knowledge about easy access to services providing contraception and sexual health advice for the whole population including information appropriate to all age groups and targeted at those at highest risk of sexual ill health
- Safer sexual behaviours (reduced sexual risk taking behaviours)
- A reduction in sexual health inequalities amongst key target groups including young people, young adults, BME groups, LGBT and those groups at highest risk of sexual ill health
- An increased uptake of effective methods of contraception, including rapid access to the full range of contraceptive methods including LARC (Long Acting Reversible Contraceptive) for all age groups

- A reduction in unintended pregnancies in all ages as evidenced by teenage conception and termination rates, including reduced numbers of repeat terminations
- Early diagnosis and effective management of sexually transmitted infections
- Low rates of sexually transmitted infections and a reduction in re-infection rates
- High uptake of HIV testing with particular emphasis on first time Service Users and repeat testing of those that remain at risk
- Improved wellbeing (social and emotional needs met) for those at highest risk of sexual ill-health

Delivering on Outcomes

Whilst providers will continue to submit activity based monitoring data, consideration needs to be given to requiring sexual health services to demonstrate impact on key outcomes, such as reinfection rates, teenage conceptions, uptake of LARC etc. Careful consideration needs to be given to how this can be effectively achieved without leading to unintended consequences.

Effective approaches to chlamydia screening

Subject to further investigation of the underlying reasons for particularly high rates of chlamydia infection and pelvic inflammatory disease in Mansfield and Ashfield, a review of the effectiveness of the local approach to chlamydia screening is needed. Current chlamydia testing occurs in GUM clinics based on symptomatic presentation, or opportunistically during a sexual health screen. The Department of Health Public Health Outcomes Framework 2013-2016 recommends that local areas aim to achieve a chlamydia diagnosis rate among 15 to 24 year olds of at least 2,300 per 100,000 population. Diagnosis rates in Mansfield, Ashfield and Gedling are currently above this threshold (2,641 and 2,998 per 100,000 respectively). Further work is needed locally to identify an effective evidence based option for chlamydia screening that would represent value for money in our local context.

Service quality

It is essential that the quality of services are assured in all contracts, with service user feedback seen as an essential mechanism that contributes to service developments and improvement. The quality of services are enhanced through the application of evidence-based practice and clinical leadership that is underpinned by professional guidelines, training and competency standards that set out the required training, skills and competencies of the sexual health workforce (for example BASHH and RSRH guidelines). There is a need to be mindful of the responsibilities of the health community to support training and development of the future workforce in the delivery of an integrated sexual health service.

At present not all sexual health providers in the county are meeting “You’re Welcome” standards, quality criteria for young people friendly services.

Child Sexual Exploitation

There is room for improvement in ensuring that all providers are appropriately referring children and young people to safeguarding services, in the event that child sexual exploitation is suspected. Service providers are expected to ensure all staff are appropriately trained and use the new national CSE assessment tool (Spotting The Signs).

Accessibility

Improving accessibility involves understanding the preferences of service users, and utilising mobile and web based communication technology to support engagement and reduce STIs, Teenage Conceptions and unplanned pregnancy. We need to consider how to build in regular awareness messages about sexual health sexual health

services into the county service model. In addition it is important to develop targeted approaches which ensure that services are promoted and are accessible for those at highest risk of sexual ill health.

Sexual Health Promotion

Sexual health promotion and prevention is central to the achievement of good sexual health outcomes. Sexual health promotion and prevention includes information, advice and guidance and training, relationship advice and targeted work with high risk groups in order to develop increased knowledge about healthy, equal and safe relationships and safer sex. The targeting of sexual health promotion messages to people who present as highest risk of sexual ill health remains an important priority.

We know that there are gaps in sexual health promotion in the south of the county and recent feedback from young people (focus group participants aged 15 -24) placed emphasis on their need for sexual health promotion (through a health education model) to address their fears and stigma when accessing sexual health services. Sexual health promotion is a priority for inclusion within an ISHS across the county.

Sex and Relationship Education

Sex and Relationships Education (SRE) is a gap for Nottinghamshire County. All secondary schools in the county are academies, which are not required to provide the council with information about their provision of SRE. So we have no way of knowing which schools offer comprehensive SRE packages. As Ofsted no longer check the quality of SRE many schools no longer prioritise it. We are looking to develop a new package for schools to bring together a range of health topics.

There is evidence that effective contraception and sexual health services in young people friendly settings is important if we want to reduce teenage conceptions.

There are particular groups who are at increased risk of poor sexual health outcomes and teenage pregnancy, including young offenders and those excluded from school. It makes sense to improve access to information and services for these young people. This approach has been re-affirmed through recent consultation work undertaken with young people in Nottinghamshire County

Work is underway to develop a new model of delivery for school health. This will need to address the inconsistency of provision of the sexual health element across Nottinghamshire.

References

[i] WHO Health Topics Sexual Health. Accessed on line on 24.10.2014 at: http://www.who.int/topics/sexual_health/en/

[ii] Public Health Outcomes Framework (2014) http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/4/par/E12000004/are/E10000024 accessed December 2014.

[iii] McGuire & Hughes (1995) The economics of family planning services

[iv] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Accessed on line on 24.10.2014 at: http://www.legislation.gov.uk/ukdsi/2012/9780111531679/contents

[v] HPA: Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas, Colindale, 2011.

[vi] Nottinghamshire County JSNA (2014) Teenage Pregnancy Chapter (including health and wellbeing for young families) 2014

[vii] Development Economics (2013) Unprotected Nation. The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services. A report by Development Economics

[viii] PHE (2014) Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV

[ix] DH (2013) Commissioning Sexual Health Services and Interventions – Best practice guidance for Local Authorities

[x] PHE (2014) Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV

[xi] Use of dual nucleic acid amplification tests for chlamydia and gonorrhoea on samples collected for the National Chlamydia Screening Programme: Results from a national survey of local authority commissioners, Public Health England.

[xii] Public Health England, Guidance for the detection of gonorrhoea in England.