



# Kirklees Sexual Health Needs Assessment

## Executive Summary

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The Full SHNA is available at [www.mbarc.co.uk](http://www.mbarc.co.uk)

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## 1 EXECUTIVE SUMMARY & RECOMMENDATIONS

### 1.1 INTRODUCTION

NHS Kirklees appointed MBARC to undertake this comprehensive Sexual Health Needs Assessment (SHNA) to gain a full understanding of the needs, demands and gaps in services. The aim of the SHNA is to identify actions that can be undertaken by NHS Kirklees to:

- Enable the people of Kirklees to enjoy safer sex and be more responsible for their sexual health
- Improve access to high quality sexual health services
- Provide support for high risk groups
- Reduce sexual health inequalities in Kirklees.

The methodology applied to this SHNA is in line with Department of Health (DH) guidance. A picture of need has been developed through the analysis of demographic and sexual health service data, gathering insights and perspectives from key informants/local experts and engaging directly and through gate keepers with adults and young people, particularly those vulnerable to poor sexual health.

### 1.2 THE CONTEXT

Since this review was commissioned much has changed in the policy context in which sexual health services operate, most notably with the publication of the Government's White Paper "*Liberating the NHS*" and the Public Health White Paper "*Healthy Lives, Healthy People*". Key amongst these proposals is the proposed replacement of PCTs with GP commissioning consortia for most areas of health care and the transfer of public health responsibility, including aspects of sexual health to local government control. However, there are other changes proposed which will also impact upon the commissioning and delivery of services: this includes a continued focus on tackling health inequalities, putting patients first with increased choice and patient control, and a renewed focus with additional incentives on improving clinical outcomes.

Whilst the NHS has been spared significant cuts in its level of funding in the Comprehensive Spending Review (CSR) the four year funding settlement for the NHS provides for very modest (0.1%) annual increases in funding, considerably lower than historic NHS inflation (driven by demographic and technological change) of 3%. Across England PCTs have been charged with identifying and delivering £20billion of savings by 2013/4. The Department of Health (DH) has stressed the continuing primacy of the "QIPP" (Quality, Innovation, Productivity & Prevention) agenda as a means of addressing this shortfall whilst maintaining and enhancing access and quality.

Local authorities are key players in ensuring good sexual health for their populations. Under the proposed changes local authorities will be responsible for leading Joint Strategic Needs Assessments (JSNA) to inform all health care commissioning. The Government also proposes to establish *Public Health England* with an enhanced role for local government in the delivery of health improvement and prevention activities. Sexual Health has been identified as within the remit of Public Health England. It is expected that most sexual health services will be subject to local authority commissioning, except for primary care delivered contraceptive services. Three sexual health outcomes have been identified in the public health white paper: Teenage pregnancies, late diagnosis of HIV and the prevalence rate for Chlamydia. These changes are subject to primary legislation through the Health and Social Care Bill.

Within this changing environment Central Government funding for local authorities is to be reduced by more than 25% over the next four years and the planning regime for local authorities has changed radically with most targets and requirements for ring-fenced or designated funds removed (although it is proposed that public health funds transferred to local government will be subject to a new ring-fence).

The DH has signalled that it has no plans for a new sexual health strategy (although there will be a supplementary paper detailing arrangements for sexual health arising from the Public Health White Paper) and that the key driver in England for strategic development remains the National Strategy for Sexual Health & HIV (2002) and the Independent Advisory Group's review of this Strategy (2008).

### **1.3 KEY FINDINGS**

#### **1.3.1 TOWARDS AN INTEGRATED SERVICE**

Sexual health is not in crisis in Kirklees: most indicators of sexual ill health are at the same or marginally better levels than other parts of the region and service provision is, in most cases performing adequately with some areas of notable practice and some areas of concern. However, there is considerable scope for improvement in line with the QIPP agenda and an engaged clinical community who we suggest would welcome the challenge of developing and improving services.

There is a lack of integration in the planning and monitoring of sexual health services in Kirklees. This is both within specific disciplines and across disciplines. For example, perhaps reflecting the fact that NHS Kirklees is the successor body to previous PCTs operating at a more local level, TOPS, GUM and Chlamydia have a clear north/south division in terms of service provision. Similarly, there is little evidence of joint working or planning between GUM, CASH and other services.

There is no forum for the joint planning at a strategic or operational level for services between different disciplines. Effective referral between services is hampered by the lack of knowledge of each other's services and opportunities for joint working are not developed. Each service has its own clinical governance arrangements and there is no evidence that this individual effort contributes to the assurance and development of services across the PCT.

### 1.3.2 WORKFORCE DEVELOPMENT

In 2009 the PCT commissioned a workforce development review, however, the results of this were somewhat inconclusive. From the stake holder interviews each of the SH disciplines have raised issues and concerns in relation to workforce development. Certain service areas have not been able to fulfil their potential by a lack of clinical training (particularly for nursing staff) with the possible consequence of certain more basic interventions being undertaken by "over" qualified (and more expensive) staff. Most respondents, however, indicated that LARC training was readily available. A modular approach to training has not yet begun. However it would be: Young People and Risky Behaviour: Level 1. Relationships and Sexual Health: Level 2 (C Card and Chlamydia will be modules as part of level 2) and Clinical Training: Level 3.

The picture in general practice is less well understood with conflicting views of under demand versus lack of provision.

It should be noted that some training (for example to support our recommendation on developing a community based reactive testing programme) is provided free of charge by the pharmaceutical provider. In other parts of the country pharmaceutical companies have been active sponsors of workforce development to support programmes such as tackling late diagnosis of HIV and promoting uptake of Long Acting Reversible Contraceptives (LARC). It should be noted that for small and single-handed GP practices the cost of training itself is not the barrier but the cost of locum or cover arrangements.

### 1.3.3 THEMATIC ANALYSIS

#### 1.3.3.1 STIs

GUM activity is focused on two treatment (GUM) services in acute settings: the Dewsbury District Hospital and the Princess Royal Health Centre. Based upon reported infections it would appear that only a small proportion (10-15%) of residents are using GUM services outside the area<sup>1</sup>. Access targets for individuals to be offered an appointment within 48 hours (98%) and being seen within 48 hours (85%) are being met within Kirklees.

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<sup>1</sup> This is likely to generate additional charges through PbR to Kirklees of around £50,000 per annum. This figure has not been verified by NHS Kirklees finance department and is likely to comprise a number of small charges from a range of other acute hospitals. As GUM is open access it is not possible to demand manage this sum. However, attractive local services will minimise out of area service use.

There appears to be little integration between these providers and an absence of common protocols, co-ordination of opening hours, pooling of governance arrangements etc.

Over the past ten years Kirklees in common with other parts of the Region and England has seen a significant increase in STIs diagnosed and treated. Within Kirklees infection rates have remained largely static between 2006 and 2008 (excepting Chlamydia - see below). In 2008/09 the number of positive diagnoses for a range of STIs excluding HIV was 2,216. The estimated annual spend in 2009/10 is £1,076,767 (CHFT), mid-year £704,949.<sup>2</sup>

There appears to be an absence of primary or community care based (and “off tariff”) GUM activity (e.g. clinic in a box) in Kirklees targeting at risk communities to both improve access and reduce “worried well” interventions. Assuming no change in take up of testing opportunities, shifting 50% of GUM activity to clinic in a box-type arrangement could generate savings of approximately £300,000 - £400,000 per annum at current levels of activity.<sup>3</sup>

### 1.3.3.2 NCSP

The National Chlamydia Screening Programme has set demanding targets for the screening of young people which Kirklees has struggled to meet. Yorkshire and Humber Region is ranked as the fourth best performing NHS region placing it in the top half for England with a testing rate of 23.1% in 2009/10. Locally, Kirklees is performing significantly less well and was ranked 104<sup>th</sup> out of 152 enrolled PCTs (with testing rate of 20.5%) placing it in the bottom third of PCTs in England. The positivity rate (6.3%) for those testing is slightly above the national average (6.0%) and slightly below the regional average (6.6%).

Pharmacies and GP practices are performing significantly less well in delivering the NCSP than their counter parts regionally or nationally. However CASH is delivering above the regional and national figures and the TOPS providers are delivering around twice as much as their counterparts regionally or nationally.

### 1.3.3.3 HIV

HIV prevalence at 0.92 per 1,000 is below both the regional (0.94) and national figures. However, growth in the numbers of people living with diagnosed HIV (after three years of declining numbers) is now increasing in Kirklees more rapidly than most neighbouring areas. Growth in numbers is largely driven by infections in MSM rather than migrant communities. Stakeholders comment that this is from MSM who do not identify as gay. It is worth noting that 30% of Black

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<sup>2</sup> Kirklees PCT

<sup>3</sup> Using the above estimates provided by Kirklees PCT

Caribbean new HIV diagnoses were MSM and 40% of new diagnoses amongst people of Asian origin were MSM.

Late diagnosis of HIV in Kirklees is high and the trend is upward from 25% in 2004 to 32% in 2009. As well as impacting upon the morbidity and mortality of infected people this also increases costs with patients more likely to need in-patient care but most crucially contributes to the risk of HIV transmission (the infectivity of PLWHIV on ART is reduced to close to zero and people knowing their status are more likely to modify their sexual behaviour)<sup>4</sup>.

On current trends the budget for HIV treatment and care is likely to increase from around £2.6 million in 2009 to more than £3.7million by 2013. This excludes costs for both in-patient care and end-of-life care which is made more likely by the high rates of late diagnosis<sup>5</sup>. The Public Health White Paper has suggested that late diagnosis will be a key outcome indicator for Public Health England.

The PCT has recently completed a tender process for community based HIV services. However, the specification may need review in the light of emerging good practice. National pilots are currently underway to test community based approaches to tackling late diagnosis (based on “test and treat”) with preliminary results anticipated in early 2011. NICE has published its commissioning guidance on community based HIV prevention work with African communities in December 2010. Early conclusions from the Vienna Biennial conference on AIDS indicates that views of good practice are shifting to an increased focus on secondary prevention, the central role of ART to the prevention of onward HIV transmission (“test and treat”). Prevention activity focused on MSM from Asian and black Caribbean communities would appear to be an emerging priority.

We were unable to identify a clear care pathway for people living with HIV. Considering this is the part of sexual health provision in Kirklees consuming the greatest level of resource and projected to increase by more than £1 million by 2013 a care pathway review in this area should be a priority. This review should include assessment of the impact of local changes in council policy in relation to vulnerable adults and social care following the removal of the Aids Support Grant ring-fence, the impact of housing and disability benefit changes and the role of clinical and related services in prioritising the secondary prevention agenda.

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<sup>4</sup> It is estimated that people with a late diagnosis infect 3-4 other people with HIV prior to diagnosis. On this basis the 12 people diagnosed late in Kirklees in 2009 may have increased the number of people with HIV by up to 48 prior to diagnosis.

<sup>5</sup> People with a late diagnosis are 15 times more likely to have an in-patient episode than other people living with HIV. 1 in 4 of those with late diagnosis die within the first year of their diagnosis (HPA,2009).

#### 1.3.3.4 Contraceptive Services

The majority of contraception is provided within the range of CASH clinics across Kirklees, including a satellite service located at Huddersfield New College. Contraceptive services are also provided in general practice but stakeholders expressed some concerns about the appropriateness of single-handed male general practices and the accessibility of these services, particularly for South Asian women.

One of the main concerns was around the North-South divide. This was reflected by both service providers and linked services. In particular:

- Different ways of working in each area, which are historical and there is resistance to change - including distinct processes and pathways for some services.
- A sense of competitiveness between the north/south areas as opposed to a sense of coming together to provide a uniform service
- Some interviewees linked this to the lack of any sexual health network and reduced communication following the commissioner-provider split
- A sense that if NHS staff found the different boundaries and pathways of different services confusing at times, it must be extremely challenging for service users
- For some people it was felt that 'personalities' were driving agendas as opposed to clear policies and pathways
- There was a distinct sense that GU providers wanted to control what other service providers (GPs, CASH) would offer and be the 'gate keepers' to what they could or could not provide (e.g. GPs commented that they were required to attend ongoing training which felt more like 'an extra pair of hands' as opposed to an enabling and learning time.

Other concerns are about the pathways between services, the balance of management, clinical staffing and the lack of use of the services by men.

The population of Kirklees as a whole is growing at just under 1% per year and the numbers of people in the most sexually active and fertile age bands (20-34) of the population is projected to grow between 4 and 12% over the four year period from (2008 to 2012) indicating there may be an increased demand for CASH services from this age group. In spite of these demographic trends spending on CASH services is largely static. It is estimated that each £ spent on contraceptive services saves £11 on other sexual health or maternity services<sup>6</sup>; on this basis each percentage reduction in contraceptive spend may generate around £50,000 of spend on other services.

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<sup>6</sup> Audit Commission (2003)

NICE issued guidance in 2005 on increasing the use of Long Acting Reversible Contraceptives (LARC) because of its efficiency and cost effectiveness. However, the number of young women choosing LARC is considerably lower (7.3%) than the regional average (11%) or the national average (11.5%).<sup>7</sup>

### **1.3.3.5 Teenage Pregnancy**

Following the visit by the National Support Team, there has been a complete review of the teenage pregnancy work and a new strategic approach. There have been concerns raised about this new direction and that operational services will be lost and there will be reduced support. There is a significant risk that work to prevent teenage pregnancy may be de-prioritised by the local authority as a result of funding restrictions. However, it should be noted that this is one of the three sexual health outcomes identified in the public health White Paper.

Although there has been a reduction in the rate of teenage pregnancy from the baseline date, since 2001-2003 there has been a yearly increase, especially in the identified hotspot areas. There has been a recent decrease in the overall rate but there are concerns that this rate of decrease is too slow and may not be maintained.

A 10% reduction in teenage pregnancies in Kirklees would save approximately £35,000 for the NHS in the cost of terminations of unwanted pregnancies, maternity care and post birth costs. More substantial savings would be made by the local authority in relation to its services. In the recommendations below we suggest that raising the uptake of LARC to national levels through targeting teenage pregnancy hotspots could be a viable way forward in tackling teenage pregnancies.

### **1.3.3.6 TOPS**

Termination services are provided by three providers. Access to NHS funded terminations is above the NHS target and compares well to other PCT areas in the region. Similarly, repeat terminations (seen by some as an indicator of clinical failure) are below the national and regional averages across all age groups suggesting that clinicians are performing well in ensuring that every woman having a TOP has a viable contraceptive plan on departure. The above average performance in relation to NCSP also indicates that clinicians in TOPS are taking a holistic view of their patients. It should also be noted that TOPS providers are performing well in undertaking terminations at early stages of gestation indicating that access is not problematic.

Concerns have been expressed at the potentially confusing care pathways between North and South Kirklees. One benefit of two pathways is that it leads to different patient experience and

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<sup>7</sup> Data collated from the Sexual Health Scorecard at [www.sexualhealthscorecard.org.uk](http://www.sexualhealthscorecard.org.uk)

choice, however it is difficult for patients to determine which pathway may be more beneficial to their needs and therefore could be confusing for the patient. There are also differences in the practices of the different providers; in North Kirklees 40% of women have surgical TOPS whereas in the South the figure is 6%. At early gestations it is recognised that medical abortion is a safer option than surgical and there has been a national drive to increase the proportion of medical abortions. Kirklees is performing well in relation to this (nationally 60% of abortions are surgical). In the past CHFT did not have provision for surgical abortions which in part will explain the high level of medical abortions. There must also be a question over the extent to which women are given an open choice of procedure.

Access to the abortion procedure is through a pre-abortion assessment service. In North Kirklees this is the Unplanned Pregnancy Assessment and Consultation service provided by KCHS. In South Kirklees, this is the Termination of Pregnancy service provided by CHFT. Women usually self refer or are referred by GP into these services. This arrangement effectively means that access to a CHFT abortion is by self referral.

Provision of the abortion procedure itself within the District is limited to CHFT surgical abortions which take place in Huddersfield. All other procedures take place in Halifax, Doncaster or Leeds.

### **1.3.3.7 SRE/Other Initiatives**

Approximately £250,000 was invested into a PSHE toolkit 2-3 yrs ago. This has been distributed widely across Kirklees secondary schools. The toolkit has also been sold on to other areas. The Health in Educational Setting programme is currently facilitating a health and wellbeing pilot within 2 clusters of schools in North and South Kirklees. The pilots involve school staff, children and young people, parents and local service and organizations. The programme is aiming to clarify local needs, without the pressure of national targets and try to better understand local drivers, issues, needs and possible responses unique to Kirklees. If sexual health is identified as a priority for either cluster of schools, one focus for interventions could be the RSHE curriculum as well as identification of the 'root causes' of sexual health needs or inequalities.

In addition to the Pilots a complementary piece of work is being undertaken in schools by the NHS Kirklees Sexual health team. This involves working with schools on an individual basis to conduct a rapid sexual health needs assessment to ensure that there is a whole school community approach to meeting the sexual health needs of the student population, this includes, RSHE, Services, Services in the local community and Information and Guidance.

Older participants in focus groups identified that they had not benefited from good sexual health education and that this was still needed. For those who are parents and carers, Kirklees College

have been providing an innovative 'Speak Easy' approach to address their needs. Wider sexual health education needs for older people are not addressed elsewhere.

CASH outreach services in FE colleges are well regarded. It was noted that they are particularly good at improving access for young men who do not feel well served by other sexual health services. Huddersfield New College has been accredited as 'You're Welcome' and Kirklees College is KYPF accredited<sup>8</sup> though had not yet achieved the You're Welcome accreditation.

The Youth Offending Team reported having developed a Peer Education process. This has had a positive impact in the promotion of LARC uptake.

### 1.4 RECOMMENDATIONS

Given the context of NHS reform, the proposed replacement of PCTs with GP commissioning consortia, coupled with reforms to the role of local government and the planning structure for local services, any proposed changes will need to be designed to work within these structures. (See section 3.1)

#### 1.4.1 CREATING THE FOUNDATION

**R1 We recommend Kirklees PCT establishes clear criteria for assessing future developments. We suggest that the criteria should be fourfold:**

- 1. Contribute to the integration of sexual health services (meaning improved patient pathways, shared protocols, pooled clinical governance and an end to the North-South split in service provision);**
- 2. Move services towards delivery in community and primary care settings where possible (with appropriate training);**
- 3. Reflect the requirements of QIPP, that is:**
  - a. Maintain or enhance quality;**
  - b. Provide for innovation;**
  - c. Improve productivity and cost effectiveness;**
  - d. Integrate prevention work into all clinical activities; and**
- 4. Are designed to be sustainable in the light of new commissioning and planning structures as these evolve.**

All subsequent recommendations in this report are designed to be aligned with the criteria.

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<sup>8</sup> Kirklees Young People Friendly (KYPF) is the local accreditation scheme that provides a stepping stone towards the national "You're Welcome" standards. Services attaining KYPF accreditation can display a logo to show young people that they can expect the sexual health service to be welcoming, friendly, non judgmental, confidential, free, accessible and safe.

To address the continuing divergence between service models in the north and south of the district and in anticipation of both the move to GP commissioning for some sexual health services and local authority commissioning for others there is a pressing need to establish a vibrant and cross-sectoral Sexual Health Network.

**R2 Full clinical engagement with future developments should be sought through the establishment and servicing of a Sexual Health Network encompassing all providers and commissioners. GP and Pharmacy sectors should be represented on the Network as well as schools. The PCT should seek to engage key local authority officers leading on work within the authority to establish the new local Health & Well-being Board in anticipation of the transfer of Public Health functions. Alongside providing a space to share intelligence and identify areas of mutual interest the terms of reference for the Network should include specific tasks including:**

- 1. Redesigning patient pathways in line with the criteria (at R1 above)**
- 2. Take lead responsibility for developing a workforce plan**
- 3. Developing joint clinical and information governance arrangements**
- 4. Developing patient involvement**
- 5. Overseeing and evaluating the impact and effectiveness of any changes.**

Patient and public involvement has been an area of growing importance for the health service over recent years. It provides opportunities to ensure that services are better aligned with patients' needs and reflect their priorities; as such it is a tool in efficient planning of services. For those with long term conditions such as HIV there is a growing body of evidence that expert patient programmes, such as Living Well contribute to improved clinical outcomes and reduced costs to the NHS. The NHS HWITE Paper and public Health White Paper both identify patient engagement and self-management as important strands to be developed over coming years. In common with most parts of England Kirklees' sexual health services (excepting HIV) have been slow to engage the public and their patients in the planning and design of their services due in part to the stigmatised nature of many services. These recommendations reflect key issues identified from the public consultation elements of this needs assessment, but future patient and public involvement needs to be more systematic. The London Sexual Health Programme has commissioned Thames Valley University to develop guidance on best practice in patient and public engagement in sexual health services which will be published in Spring 2011. We suggest that this may serve as a starting point for engagement.

**R3 The new Network should prioritise public and patient engagement in the planning and design of all sexual health services. The move towards a fully integrated sexual health**

**service will require detailed public engagement from those communities at most risk of poor sexual health.**

#### 1.4.2 TOWARDS AN INTEGRATED MODEL

The PCT will cease to exist in April 2013. From April 2012 there will be shadowing arrangements in place for both those aspects of commissioning which will move to GP consortia and those aspects that will move to local authority commissioning. This provides the PCT and its successors with an opportunity to work together on developing a clear plan for the integration of sexual health services.

This report highlights the need for integration on a number of levels: between the north and south of the District, between clinical disciplines (e.g. GUM and Contraceptive services, and within clinical disciplines (for example addressing the different clinical practice and client pathways in TOPS).

Alongside delivering a more consistent service across Kirklees this integration provides the opportunity to improve client pathways and enhance work across disciplines to prevent sexual ill health, and to develop clear cost savings through innovation and productivity gains. Integration is not possible over-night as there will be need for clinical and other professional engagement (through the proposed) network in reconfigured care pathways and the contracts for some services (such as CASH) will be secured until April 2014.

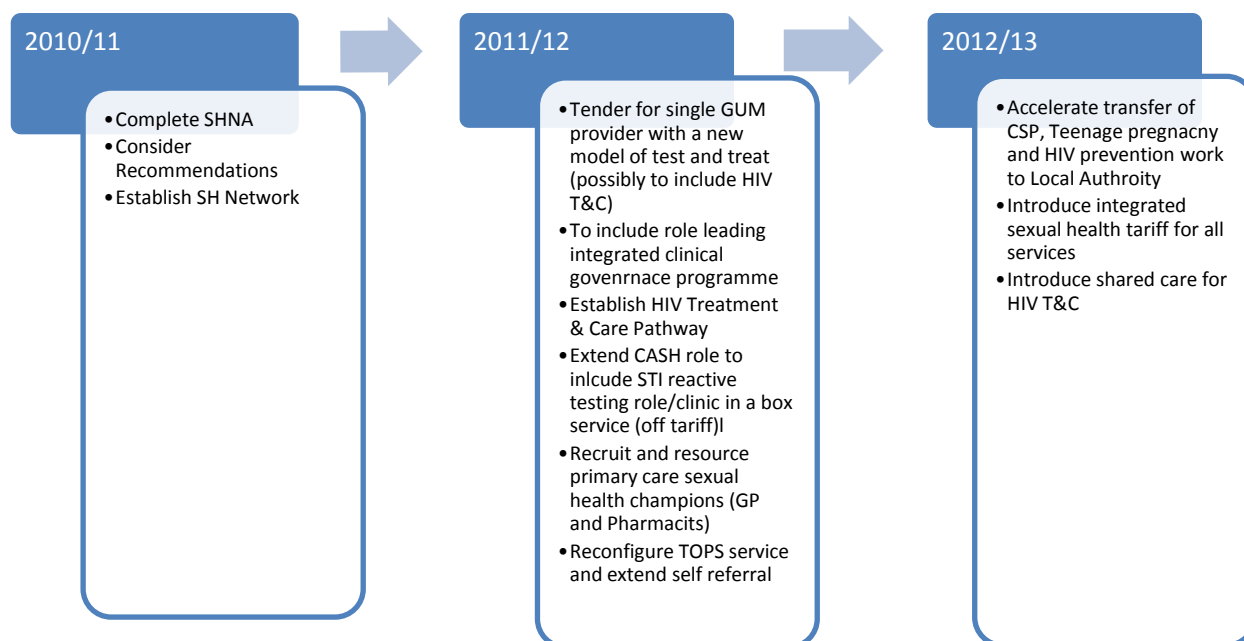
It should be noted that in relation to reconfiguring care pathways much work has been undertaken in other parts of the country which could be adapted for use in Kirklees. For example, as part of its work to develop the integrated sexual health tariff the London Sexual Health Programme has developed around 140 separate pathways and created a range of baskets of activity for tariff purposes.

Commissioning of an integrated service would not necessarily mean a single provider. A consortium including a number of current providers from the NHS and independent sectors would offer considerable strengths. Such a consortium could be subject to a lead contractor with sub-contractor arrangements or separate contracts. However, should separate contracts be issued there should be a lead agency responsible for clinical and information governance across all providers.

**R4 We recommend that NHS Kirklees provides clear commissioning intentions to current providers that they intend to move towards a single integrated sexual health service by April 2014.**

In developing this integrated model for sexual health services it is important to note that both women and young people were keen that services were “discreet”, that is, easy to find for those that needed them but not too identifiable as sexual health services to others. We suggest that the public engagement arrangements suggested in R3 above should be used to tackle this apparent contradiction.

The table below sets out some of the key steps towards tendering for a fully integrated sexual health service across Kirklees in 2014.



Within the context of this broader programme for integration other recommendations focus on individual service areas.

### 1.4.3 GUM & STIs

Kirklees is spending around £1.8 million per annum on GUM services. It is estimated that around half of this figure will be spent on testing and treating individuals with STIs and half on testing individuals who do not have an STI (the tariff rate is the same for both groups of patients). Whilst GUM services are meeting access targets across both sites there was a desire for more flexible and evening opening hours and we consider that there is a strong financial argument for reconfiguring current services. The current tariff for STIs tested and treated in GUM settings is £137 per episode. This compares to the cost of a GP consultation of £32, a pharmacy consultation of £17.75<sup>9</sup> (both excluding pathology costs which vary considerably from hospital to hospital)<sup>10</sup> or an

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<sup>9</sup> Bow Group Health Committee, 2010.

estimated cost of “clinic-in-a-box” outreach services targeting areas of highest need at £70. There may also be scope in the medium term for promoting home-testing models<sup>11</sup> and the use of more self management<sup>12</sup>.

Access could be enhanced by a single provider operating on a hub and spoke model with outlets in each town. This should contribute to the ease of access for the large proportion of the population that live in rural areas. Evening and weekend opening hours was highlighted as a key issue for development by service providers and members of the public.

**R5 We recommend that Kirklees PCT considers tendering GUM provision as a single contract<sup>13</sup> in 2011/12. The specification should include:**

- At least four walk-in and appointment service points across the district
- Extended/evening and weekend opening hours
- Provision of (off-tariff) community based reactive testing services
- Nurse delivered and off-tariff clinic-in-a-box services targeted at communities at greatest risk
- Scope to include promotion of electronic home-testing if this becomes available.

**As part of a clear strategy to reduce the use of GUM services at full tariff by “the worried well” with an aim of generating cost savings of £300k and providing services closer to home, the move to a single contract should be accompanied by an extension of reactive testing by GPs and pharmacies. We also recommend that CASH is funded to deliver a reactive testing service (off tariff).**

Kirklees is performing relatively badly in terms of NCSP. CASH and TOPS are performing above the regional average but GPs and pharmacies are performing well below the average. The programme is changing to a more target approach on positive results and the GP LES will be stopping. This is to be based on 8% positivity per 10,000 screens. The public health white paper indicates that Chlamydia prevalence will be one of three sexual health outcomes assessed by Public Health England.

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<sup>10</sup> The extension of STI testing into primary care and other settings does not envisage full STI diagnostics but the use of simple and low cost reactive test kits. For example, Pasante market a simple HIV test for £7.50 and provide full training at no charge to clinical and AHPs in the use of the test. Where a test is reactive it is envisaged within this model that the practitioner would refer on to GUM.

<sup>11</sup> St George’s Hospital in London is currently developing a mobile phone based home testing kit with reactivity tests across a range of STIs. It is anticipated that this will be available by 2013 with costs below £1 per test.

<sup>12</sup> NHS Direct provides a diagnostic tool/symptom checker on its web-site that may reduce the use of GUM by the “worried well”.

<sup>13</sup> A single contract would not preclude sub-contracting of parts of the service to current or new providers.

**R6** Improvements in the performance of GPs and pharmacies in relation to NCSP should be a priority. GP and pharmacy involvement in the SH Network provides a starting point for the development of initiatives to tackle current under performance. We strongly recommend that the Network recruits a GP champion and a Pharmacy Champion to develop strategies that will fully engage their peers in developing sexual health work. In some localities Sexual Health Networks pay GP and Pharmacists for undertaking similar roles.

#### 1.4.4 HIV

We could not identify a clear pathway for patients living with HIV. Performance in relation to tackling late diagnosis is poor and deteriorating. This impacts upon future rates of infection, the health of those left undiagnosed for long periods and the costs faced by the NHS. The Public Health White paper has indicated that late diagnosis will be one of three key outcome measures for sexual health services. Prevention work has recently been retendered but it is unclear that this meets current best practice in relation to test and treat, the secondary prevention agenda or the rising numbers of MSM who do not identify as a gay (particularly from BME communities). On current trends the costs of supporting people with HIV will increase by £1million over the next four years.

It is expected that a tariff for HIV treatment and care will be introduced by 2013. We suggest that in the interim the PCT should develop a robust model of shared care between HIV treatment centres and primary care<sup>14</sup>.

The PCT should consider including HIV treatment and care in its tender for a single GUM service. However, we are concerned that the current apparent absence of a care pathway could delay the development of a specification for the GUM service.

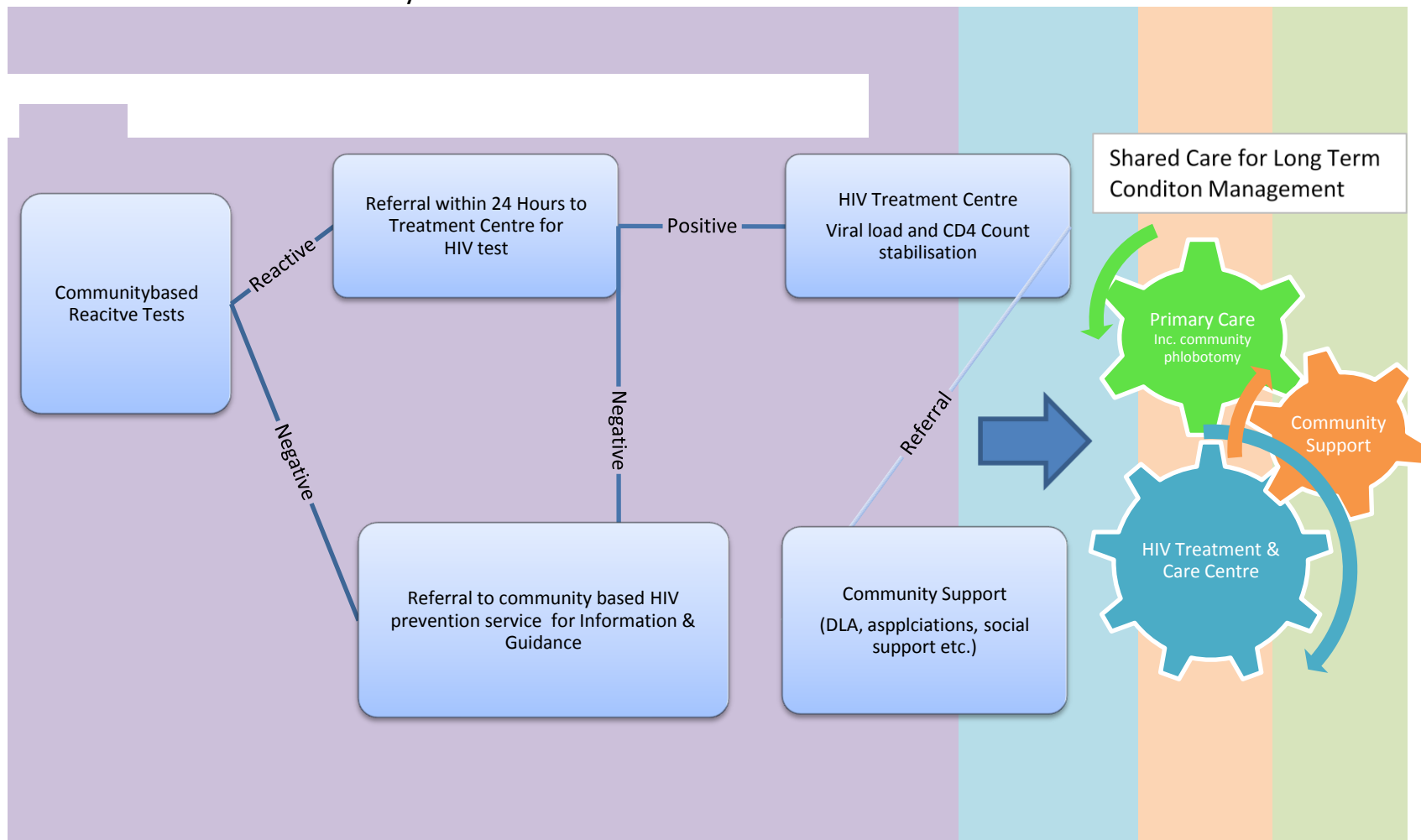
**R7** The SH Network should oversee a review of HIV treatment and care services and prevention services as a priority. A clear care pathway based upon a “shared care” model should be established as soon as possible. The network needs to assure itself that current prevention work is evidenced based, in particular that it is targeted at communities most at risk (including BME MSM) and is based around “test and treat”. A wider review of HIV should include an assessment of the impact of likely cuts in council services and benefits for people living with HIV.

We provide an outline model for HIV treatment & care from point of testing.

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<sup>14</sup> The South London HIV Partnership has developed a robust model of shared care which may provide a model for service reconfiguration in Kirklees.

### HIV Treatment & Care Pathway



#### 1.4.5 CONTRACEPTIVE SERVICES

Funding for contraceptive services is static in spite of a growth in the numbers of those in the most fertile age groups of the local population. This may lead to increased costs in other parts of the NHS in the short term. The proposed review of GUM (at R3 above) provides an opportunity to consider the co-location of CASH services with GUM in the “hub and spoke” locations.

**R8 As part of the review of GUM services, the PCT should consider the possibility of co-location with CASH as part of the longer term move to an integrated service model. Building upon its successful role in delivering the Chlamydia screening programme and as part of the strategy to reduce GUM use by the worried well, CASH should be funded to deliver an “off tariff” reactive testing service for its clients.**

Teenage Pregnancy work in Kirklees has historically underperformed. The services have been subject to a complete review and it is too early to assess the impact of these changes. It should be noted that 80% of TPs are generated in four localities of Kirklees and intensive interventions in these localities may have a positive impact. We have also noted that Kirklees is performing less well than other parts of the region or the country in the uptake of LARC. Promoting the uptake of LARC as a key strategy for reducing teenage pregnancies could be self financing (e.g. a 10% reduction in teenage pregnancies would save c£35,000 - enough to fund a short-term community outreach “uptake campaign”). The YOT team reports success in promoting LARC through peer education.

**R9 We recommend that Kirklees should set itself the target of exceeding the national uptake of LARC over a 12 month target with this work targeted on those communities most at risk of teenage pregnancies.**

All TOPS providers are at least meeting the minimum access targets and indicators. They are also performing well against other targets that provide an indication of holistic service (e.g. relatively low levels of repeat terminations, high take up of Chlamydia screening). However, there are remarkable clinical differences between the services received by women in the north and south of Kirklees. There is an opportunity to further improve access to abortion by introducing self referral throughout the District.

**R10 Pursue improvements in the TOP pathway by working with existing providers as planned.**

The absence of effective SRE for those who are now parents and carers and older people when they were at school is affecting their ability to provide support to their children and to protect

their own sexual health. Kirklees College’s innovative Speakeasy<sup>15</sup> approach may provide a model for replication with parents and carers.

**R11 The SH Network should investigate the ways in which the SRE needs of parents, carers and other adults could be addressed.**

### 1.5 QIPP

The table below summarises these recommendations by the QIPP agenda.

QIPP	Recommendation Number	Summary
QUALITY	R1,2,3 & 4	Provide the foundation for all improvements
	R5	Improves access to GUM
	R6	Improves access to services
	R7	Provides for care closer to home
	R8	Improves Access
	R10	Ensures consistent service across district and improves access
INNOVATION	R1,2,3 & 4	Provide the foundation for all improvements
	R5	Provides a radically redesigned service with improved pathways
	R6	Engages primary care in service delivery
	R7	Provides a redesigned service with improved pathways
	R8	Provides improved pathways
	R9	Allows for targeted and innovative campaign
PRODUCTIVITY	R1,2,3 & 4	Provide the foundation for all improvements
	R5	Generates clear cost savings (c£300m)
	R6	Provides for lower cost interventions
	R7	Provides for lower cost interventions
	R8	Provides for lower cost interventions
	R9	Improvements in outcomes self-financing
PREVENTION	R1,2,3 & 4	Provide the foundation for all improvements
	R5	Faster access to treatment prevents onward infections
	R7	Ensures prevention activity is evidence based
	R8	Faster access to treatment prevents onward infections
	R9	Focuses on preventing unplanned pregnancies
	R11	Long-term impact on tackling poor sexual health

<sup>15</sup> The FPA defines Speakeasy as offering “a non-threatening group-based opportunity for parents and carers to acquire the confidence and skills they need to talk to their children about sex and sexuality”.