Written evidence from Calderdale Metropolitan Borough Council (CMBC), including the views of Sexual Health Stakeholders in Calderdale.

1. Executive Summary

1.1 The paper: -

- Sets the context of Sexual Health Services (SHS), CMBC (in a Local Authority in the North), which supports most of the statements made around the enquiry (see trends section).
- Provides a look back on commissioning and service changes over recent years and identifies the main benefits and threats to Sexual Health.
- Advocates for action at a National level, which will improve Sexual Health.

2. Introduction

2.1 The submission has been produced by Kate Horne, Senior Programme Manager, Public Health, Calderdale Metropolitan Borough Council (CMBC) - Sexual Health Commissioning Lead for Calderdale since 2008.

2.2 The submission of evidence is made on behalf of Public Health, CMBC and Calderdale Risk and Resilience Group (the multiagency local sexual health stakeholders). Contributions have been made by relevant stakeholders accordingly.

2.3 The purpose of submitting the evidence is to share a situation report for a Local Authority to help advocate for action at a National level, which will benefit the sexual health of the population and that of residents in the North of England. The report provides a look back on commissioning and service changes following the implementation of the NHS Act, 2012 and the impact this has had on the state of the sexual health in Calderdale to help inform future action.

3. Background

3.1 In Calderdale, SHSs serve one of the smallest metropolitan districts in terms of population, but one of the largest in terms of area. Most of the area is classified as rural and up to a quarter of the population live in these rural areas. Calderdale consists of six main towns; Halifax, Elland, Brighouse, Sowerby Bridge, Hebden Bridge and Todmorden, as well as a number of villages. Over a third of households in Calderdale do not have access to a car or van. This means that services need to be accessible from a number of different locations and by public transport. The Calderdale population 2017 was 209,454 (Office of National Statistics, 2017).

3.2 SHS provision in Calderdale was provided by one separate Genitourinary Medicine (GUM) clinic and one Contraception and Sexual Health (CaSH) clinic, previous to 2012. The provider was Calderdale and Huddersfield Foundation Trust (CHFT). Each clinic had a hub in central Halifax, with CaSH having three spoke clinics around Calderdale (Brighouse, St John’s (near to Halifax Town) and Todmorden). HIV treatment was also provided in the GUM clinic, by CHFT at this time.

3.3 GUM and CaSH services first integrated (the services were provided in the same building, indicated by a blue vertical line on graph 1) in November 2012 to become Calderdale Integrated SHS (ISHS). The service provider remained as CHFT and the hub was relocated to Broad Street, opposite the main bus station on a main road in Halifax Town Centre, which is underneath a Cinema and shopping complex (previous to this the services would have been found off a main road, behind flats). The service is in the
same building as other hospital services such as Physiotherapy and Children’s Therapy. Over the following two years the provider worked hard to truly integrate both SHSs by adapting practice, such as dual training staff.

3.4 Following the Health and Social Care Act (2012) which included moving Public Health into the Local Authority the ISHS was procured by open tender in 2015, as a block contract for three years with a possible annual extension for up to another three years. The ISHS now includes not only GUM and CaSH services, but a fully embedded Chlamydia screening programme, Condom and C card scheme and other health improvement services, which were previously provided by other local ISHS providers. The HIV service in Calderdale is also provided from the same main clinic hub at Broad Street. CHFT won the ISHS tender. There is still one hub on Broad Street, Halifax and the three existing spoke clinics (which now also included level 2 SHSs). Work has taken place to provide a spoke clinic in North Halifax, which has been sporadic until this year, when permanent premises have now been secured.

3.5 HIV prevention and support services have always been provided across Calderdale (and Kirklees) by a third sector provider, the Brunswick Centre. These services have been out to open tender on two occasions (once in 2011 and again in 2014).

4. Recent trends

4.1 The peak of SHS attendance in Calderdale (illustrated in Graph 1), can be linked with the service integration in 2012. Changes such as moving to a visible location, nicer building and all patients now undergo a full sexual health history and appropriate screening or counselling and comprehensive information for contraception and Long Acting Reversible Contraceptives (LARCs) in the same appointment. Hence the service diagnosed more STIs and increased partner notification and reduced return visits for contraception, following the service changes. Graph 2 illustrates an increase in STI diagnoses following the integration of SHSs in Calderdale, which increased at a more significant rate to that of England’s.

Graph 1

4.2 New attendances have continued to increase slightly, but number of patients has reduced along with follow ups. Calderdale have made an effort to reduce unnecessary follow ups and conduct follow up phone calls to check compliance with medication etc.

4.3 Relevant to the inquiry, in Calderdale: -
• The STI diagnosis rate peaked in 2014 and has reduced since then, increasing slightly in 2017 (Graph 2).
• Syphilis has increased by approximately 45% from 2016 to 2017 (Graph 3), but this number must be interpreted with caution due to the small numbers diagnosed.
• Gonorrhoea has decreased slightly between 2016 and 2017 (Graph 4).
• In 2017 Calderdale was conducting 5% less Chlamydia tests (15-24 year olds) than 2016. The number of Chlamydia tests has reduced in Calderdale since it peaked in 2014 (Graph 5).
• Graph 5a illustrates there was an increase in the Chlamydia detection rate, in Calderdale during 2016-17. Graphs 5b and 5c indicate the Chlamydia diagnosis rate has not significantly increased.

Graph 2

4.4 It is important to note that in Calderdale the peak in the STI diagnosis rate in 2014 is likely linked with the integration and relocation of SHSs.

Graph 3

4.5 The increase in Syphilis in Calderdale is sharper than the increase in England, but the Calderdale figures should be interpreted with caution due to the small numbers diagnosed in Calderdale.
4.6 In Calderdale the diagnosis rate for Gonorrhoea increase between 2013 and 2014, this was due to false positive from the diagnostic test. This has since reduced with the introduction of supplementary testing to remove the false positives. This is in contrast to the England increase of late. Calderdale ISHS introduced dual testing of Gonorrhoea in 2013 alongside all Chlamydia testing and this may explain why this trend conflicts against the National trend. Provisional results from 2018 suggests an increase in gonorrhoea rates focussed within the MSM population.

Graph 5

4.7 Whilst the proportion of 15-24 year olds screened for Chlamydia has reduced since it peaked in 2014, Chlamydia detection and diagnosis rates in Calderdale increased slightly between 2016 and 2017. The
increase is not significant enough to draw conclusion from this trend (Graph 5). The recent rise in Chlamydia detection rate (graph 5a) could be linked to the recently new health advisor role and the increase in contact tracing. The reasons for the overall reduction in Chlamydia proportion Screened is unclear. The ISHS have informally fed-back, it is due to fatigue from the target audience and limited capacity. There is less outreach testing going on and the ISHS have reduced the number of unnecessary repeat tests.

Graph 5a

[Graph showing Chlamydia detection rate / 100,000 aged 15–24 (PHOF indicator 3.02) – Calderdale]

Graph 5b

[Graph showing Chlamydia diagnostic rate / 100,000 – Calderdale]
5. Prevention

5.1 Calderdale sexual health stakeholders meet on a regular basis (Risk and Resilience Group) to ensure a partnership approach is applied to sexual health work, which includes prevention at all levels. The partnership work was first driven by the Teenage Pregnancy Strategy (1998). The success of this partnership work can be illustrated through the reduction in teenage conceptions by over 50%, in Calderdale (Graph 6).

Graph 6
5.2 This could not have been achieved to this extent without the National Teenage Pregnancy strategy and the Central Government funding for this work. Calderdale in particular used the money to coordinate and support Relationships Sex Education (RSE), pump prime Long Acting Reversible Contraceptives (LARCs) (using the money to ensure primary care staff were training to deliver LARCs in the community), implement social marketing of contraception and initiate Emergency Hormonal Contraceptive provision in pharmacies. All of these interventions have improved knowledge and access to SHSs in Calderdale. This provision has been essential to improve community service provision, in a Borough where most of the area is classified as rural and over a third of households do not have access to a car or van making access to a main SHS more difficult. The legacy of this work continues, but sustained funding for such SHSs is essential.

5.3 For example, CMBC welcome the new RSE regulation, 2018, which will improve primary prevention to sexual ill-health. In Calderdale children and their parents and carers have stated they would like an external professional to deliver RSE in schools (Qa Research, CMBC, 2018). This finding concurs with National evidence. However, support to schools to deliver good quality RSE (Relationships, Sex Education) by an external professional will be limited, unless the Local Authority or schools are funded sufficiently.

5.4 HIV prevalence in Calderdale is low in comparison to England and HIV diagnostic rates are low (Graphs 7 and 7a).

5.5 CMBC commission the Brunswick Centre to conduct HIV prevention and support work in Calderdale. The Brunswick Centre know the community well and conduct specialist outreach work with vulnerable
groups and on cruising sites and though social media and phone apps outside the clinical setting. The organisation do a lot of work to educate and empower those people living with HIV to improve their condition and prevent onward transmission. They work closely with the HIV clinicians supporting and engaging patients with multiple and complex health and social care needs including dual diagnoses (mental health, co-infection, alcohol and substance use). They have led the way on prevention and harm reduction work around Chem-sex pulling together an inter-agency partnership. During 2017-2018 the organisation provided 20,600 condoms on cruising sites, worked with 81 people living with HIV in Calderdale and provided baby milk to 11 mums in Calderdale and Kirklees. The provision of this locally costs around £3k pa. If these babies were to contract HIV through breast feeding there is the potential for this to cost a minimum of £4.2 million in lifetime treatment costs (based on the £380k lifetime treatment costs, see aidsmap.com). Unfortunately without the current public health funding level in Calderdale, CMBC would be forced to review provision against the Public Health Functions in the NHS Regulation, 2013 and would likely have to reduce Sexual Health Prevention and Service provision and where provision falls outside of the clinical setting. This will have an impact on the vulnerable groups who do not always access mainstream services.

**Commissioning and delivery of SHSs.**

6. **Demand and access**

6.1 Although demand for SHSs has fluctuated (graph 1), the ‘Percentage of clients accessing the ISHS to be seen within 48 hours of contacting the service,’ has always remained above the 85% threshold; and ‘Percentage of people offered an appointment, or walk-in, within 48 hours of contacting the ISHS’ has generally remained above the 98% threshold. Breach has only occurred immediately after major service changes, such as the integration. One major practice implemented by the provider to ensure they meet these targets has been the appropriate triage of patients, in combination with the provision of the right staffing skill mix. For example patients complete a self-assessment of their sexual history and the “worried well” or asymptomatics are seen initially by a healthcare assistant, rather than the Consultant.

7. **The fragmentation of SHSs**

7.1 Following the NHS Health Act 2012 changes in commissioning responsibilities caused some fragmentation of the system, due to the disconnect between the commissioning of different elements of SHSs. This has inhibited some commissioners from being more proactive in working in partnership, for example where timelines and priorities for partners do not align. As commissioner of SHSs, CMBC have extremely limited contact with NHS England concerning other SHSs (such as HIV Treatment) than previously, when commissioning responsibilities previously lay with the Primary Care Trust (PCT).

7.2 Fragmentation of HIV and PrEP is less of an issue for Calderdale. Fortunately for Calderdale, HIV treatment and ISHS are both being delivered in an integrated manner, in the same building by the same NHS provider, CHFT. This has only occurred by accident through successful bidding by CHFT. The provision of both HIV treatment and ISHS in the same building, provided under the leadership of the same Consultant, brings great benefits and efficiencies in provision for the patients. Locally this has been a major benefit for the Sexual Health needs of people with HIV. Having the HIV service embedded within the ISHS supports seamless collaborative management with the maternity services of pregnant women with HIV and syphilis, a one stop shop for HIV patients requiring sexual health including STI testing and management, contraception and cervical screening in addition to their HIV management. This all happens in a familiar environment with a team that they know and are comfortable with. Continuity of care is an essential component to HIV care provision.

7.3 CMBC strive to provide SHSs to meet the patients’ needs. One example of good collaborative working is where the ISHS continued to provide cervical screening to ensure patient choice (although the commissioning responsibility fell outside of the Local Authority). This has been made possible through good
partnership working between the commissioners; CCG, NHS England and CMBC; and the provider CHFT. NHS England are now at a point where they commission this activity.

7.4 There is no doubt that the procurement of ISHS has enabled Calderdale to improve quality and access to SHSs along with improved value for money. Patients comment today how great the SHSs are, two example quotes:

“I came to support my son and was very impressed with the clinic. I like the way it is on the main road, accessible and not hidden away (in shame!) like I remember sexual health clinics in the past. I feel this encourages people to seek help and not feel embarrassed.”

(Patient 1, ISHS comments and compliments log, CHFT 2016).

“I have used this service over the years and your efficiency and outstanding practice what other PCT, NHS, GPs need to follow. A leading establishment to be proud of....”

(Patient 2, ISHS comments and compliments log, CHFT 2016).

7.5 Savings have been made through integration of services (colocation, dual training of staff, review of staffing skill mix, efficiencies in pathway provision and improved technology). The open tendering of SHSs has demonstrated to CMBC that the market for provision of ISHS is small. Not many providers who registered an interest to tender at the Pre-Qualification Questionnaire (PQQ) followed through to the Invitation to Tender (ITT) stage. One main reason cited was the cost of redundancy and pension contribution rights of NHS staff who would be subject to Transfer of Undertakings Protection of Employment (TUPE). If ISHS are continually re-procured to obtain further value for money and improve quality, this will drive down quality. The short-term contract lengths (3-5 years) driven through re-procurement, will destabilise providers and this may impact workforce stability, as long-term job contracts will not be offered under these circumstances. Economies of scale will be forced by even further integration of services, which will drive out smaller providers, such as third sector providers who know and work with vulnerable groups really well, but have insufficient reserves to take on the workforce.

8. Governance

8.1 The commissioning and procurement of SHSs through the Local Authority has enabled the commissioners to pull out SHS provision from two large Trust contracts. This has given the commissioners of the service the ability to ensure tighter governance and better scrutiny of a standalone contract, rather than the ISHS being lost amongst a whole host of hospital services in a large Trust contract.

8.2 Calderdale have been in a fortunate position to have an NHS provider, with strong clinical leadership for ISHS. CHFT have been able to produce and sign-off PGDs, have the Quality Governance structures in place and retained staff, necessary for a clinical service like the ISHS. The NHS provider has been intrinsic in providing opportunities to participate in research within the ISHS including prevention of STIs study (SAFETEXT) and the introduction of the PREP IMPACT trial over a year in advance of local non-NHS providers. Within West Yorkshire there is only 1 other provider providing PrEP at this time. The strong clinical leadership, within a large NHS provider has been instrumental in delivering consistently good quality clinical services and driving service changes in clinical practice provision to deliver service redesign within a fragmented system.

9. Funding
9.1 The following chart illustrates Calderdale spend on ISHS. Following the procurement CMBC realised a 25% saving in SHSs spend. Quality and provision of SHSs will suffer if CMBC are forced to squeeze spending any further due to the national austerity programme impacting on Public Health budgets.

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2016/17</th>
<th>2017/18</th>
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<tbody>
<tr>
<td>Total</td>
<td>£2,238,795</td>
<td>£1,675,139</td>
<td>£1,691,014</td>
</tr>
<tr>
<td>Percentage change</td>
<td>25.18%</td>
<td>24.48%</td>
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9.2 Spend increased slightly in 2017/18, due to the non-contracted out of area spend, which CMBC have limited control over and is currently a risk to Public Health. The out of area attendances for SHSs, has caused endless debate, administration and has been a huge time and cost burden on CMBC and Local Authorities in Yorkshire and Humber, without making a significant improvement in sexual health (if evidence is required, it is recommend to review the Yorkshire and Humber Sexual Health Community of Interest Minutes, 2015 to 2018 (available on request)). The access and quality of SHS provision varies within neighbouring Local Authorities (depending on budget and spend). CMBC would welcome legislation to include a line on out of area provision and recommend that out of area charging is removed and that central Government utilise the HIV web portal for flow of patients to uplift budgets appropriately.

10. Workforce issues

10.1 Calderdale have been fortunate and able to fill posts in SHSs and have a relatively low turnover of staff. This is due to the main provider being an NHS organisation and the advantage of having HIV treatment integrated into service. The provider of the ISHS and HIV Prevention and Support Service found it difficult over the procurement periods as they were not able to go out to advert for posts, due to the uncertainty around the contract award, which has had an impact on capacity within the services.

10.2 One of the challenges for the future of Calderdale SHSs, will be replacement of Consultants. Two of the Calderdale Consultant posts are split over two organisations (CHFT and Locala, the provider of Kirklees ISHS), so there will not be a full-time equivalent job to advertise. Other future workforce challenges for Calderdale are that there are now very few SRH trainees/consultants. The recruitment to GUM training posts is problematic, due to the unfilled training numbers and the now limited career progression for nurses. Calderdale workforce issues reflect those found across Yorkshire and Humber (Yorkshire and Humber workforce audit, PHE 2017).

11. Action at a National and local level to improve SHSs

11.1 Calderdale Sexual Health Stakeholders and CMBC: -

- Request that the Public Health grant is ring-fenced beyond this time of austerity and not reduced any further.
- Welcome the new RSE regulation to address inconsistent quality of provision and recommend funding to follow to support educational provision.
- Welcome a statutory line/ regulation on out of area SHS attendance or even better to remove the burden of cross charging.
- Recommends NHS England continue to work more collaboratively with Local Authorities, using Public Health England (PHE) facilitated Sexual Health Community of Improvement groups, as a conduit.