1. Executive Summary

1.1. This written evidence is based upon a roundtable discussion held in Parliament on 6th September 2018, chaired by The Baroness Walmsley and The Baroness Barker, on the subject ‘Chlamydia screening and the future of sexual health in England’. The arrangement of the roundtable was funded by Becton, Dickinson and Company (BD). BD is a Fortune 500 medical technology innovator and a long-standing partner to national and local health authorities in the UK, providing diagnostic solutions for STIs. BD exerted no editorial control over the discussion or the recommendations agreed by the attendees.

1.2. The roundtable brought together representatives from Public Health England (PHE), local government, clinical services, screening providers, charities, and professional bodies. The aim of the discussion was to provide a set of recommendations to stakeholders at both national and local levels on how best to improve the prevention and diagnosis of chlamydia, and sexually transmitted infections (STIs) more broadly.

1.3. The group was presented with qualitative research undertaken by consultancy APCO Worldwide, commissioned by BD, into the greatest hindrances to local authorities aiming to meet the annual diagnosis targets set by PHE. The research was based on Freedom of Information Requests distributed to every commissioning local authority in England.

1.4. The research demonstrated that whilst spending constraints were a major challenge to authorities attempting to hit PHE targets, a lack of public awareness of services and demographic factors like population distribution were greater challenges. The local authorities surveyed reported that better marketing, opportunities for partnership work, and better access to data would be the most useful resources in improving screening rates.

1.5. The group recommended a series of actions for policy-makers at multiple levels, including:

1.5.1. establishing new partnerships between local authorities, service providers, clinicians and academics;
1.5.2. improving commissioners’ access to relevant data on a local level;
1.5.3. including dedicated content around STIs, sexual health, service provision and the importance of screening in relationships and sexual health (RSH) curricula;
1.5.4. providing at national level adaptable digital and/or printed assets to raise awareness of services;
1.5.5. examining new commissioning models based on regional footprints, commonalities in need, economies of scale, and avoidance of duplication;
1.5.6. prioritising pilot prevention programmes to reduce reinfection with increased partner notification and repeat testing;
1.5.7. developing and piloting new models for integration with primary care and pharmacy services;
1.5.8. advancing best practice to meet emerging challenges in sexual health, such as mycoplasma genitalium (M-Gen).

2. The challenge of chlamydia

2.1. Chlamydia infection has been one of the most persistent public health challenges in recent history. It remains the most prevalent sexually transmitted infection STI in England. National recommendations for chlamydia screening have been in place since 1998; and the National Chlamydia Screening Programme (NCSP) began in 2003. Originally managed by the Department of Health, the NCSP is currently the responsibility of PHE. After 15 years of the programme, there is no strong empirical evidence that chlamydia screening has resulted in a fall in prevalence.

2.2. The Health and Social Care Act of 2012 placed the responsibility for public health with local authorities. This includes sexual health promotion, STI diagnosis, treatment and care, including chlamydia screening. Over the past six years, local authorities have come under increasing pressure with decreasing public health budgets, increasing need and competing priorities.

2.3. Only one in five local authorities achieves the recommended detection rate of 2,300 diagnoses per 100,000 population set by PHE. Data from the NCSP has shown a decline in the number of people being tested for chlamydia in recent years, although the while the number of diagnoses has not declined as much.

2.4. PHE reports that between 2016 and 2017 there was an 8% decline in the number of chlamydia tests, continuing the trend of the previous year; most of this decrease in testing took place in sexual and reproductive health (SRH) services, where chlamydia testing has fallen by 61% since 2015, likely reflecting a reduction in service provision. During the same time period, there were 2,361 fewer chlamydia diagnoses made among 15 to 24 year olds, a reduction of only 2%.

3. What stands in the way of local authorities?

3.1. To better understand the challenges facing authorities in reaching the recommended screening rate, BD commissioned APCO Worldwide, a research, insight and communications agency, to carry out a qualitative and quantitative research based upon Freedom of Information requests distributed to every commissioning local authority in England.

3.2. Local authorities were invited to respond to two key questions: “What have been the biggest challenges in reaching the national chlamydia screening targets?” and “Thinking about chlamydia screening and treatment specifically, what resources does [Local Authority] need the most to effectively control chlamydia through early detection and treatment of the infection?”

3.3. Contrary to expectation, funding issues were not reported as the most common challenge. Lack of public awareness and the need for marketing was cited by 35% of respondent as the biggest challenge, followed by populational and geographic factors (population density, age, demographics, etc) at 23% and then “cost pressures” at 22%.
3.4. Similarly, whilst 19% of respondents cited increased funding as a resource needed to effectively control chlamydia, the need for marketing resources was the most popular response (38%), followed by the need for effective partnerships (25%), better targeting of services (25%) and better use of data and intelligence (22%).

4. **Addressing the challenges**

4.1. These findings were presented to a group of stakeholders in sexual health and chlamydia policy on 6th September 2018, at a roundtable in the House of Lords chaired by The Baroness Walmsley and The Baroness Barker. The group comprised: Dr Kevin Dunbar, Director, National Chlamydia Screening Programme, PHE; Kate Folkard, Programme Manager, National Chlamydia Screening Programme, PHE; Camila Azevedo, External Affairs and Standards Officer, Faculty of Sexual and Reproductive Health (FSRH); Robbie Currie, Sexual Health Programme Lead for the London Borough of Bexley and Chair of the English HIV and Sexual Health Commissioners Group; Lisa Hallgarten – Head of Policy and Public Affairs – Brook; Cary James, Associate Director, APCO Worldwide; Dr Raj Patel, Consultant in genito-urinary medicine, Southampton University Hospitals; Greg Quinn, Director, Public Policy & Advocacy UKI, BD; Dr Alan Tang, Secretary, British Association for Sexual Health and HIV (BASHH); Marc Thompson, National Strategic Lead for Health Improvement, Terrence Higgins Trust (THT).

4.2. The purpose of the discussion was to develop a series of recommended actions for stakeholders at a local and national level – as well as in clinical and commissioning settings – to improve the national response to chlamydia. The following recommendations were agreed unanimously.

4.3. **Recommendation 1:** Establish partnerships with academics, clinicians, public health and service providers to provide better evidence and understanding of the role of digital technology and its dynamic with face-to-face services in sexual health screening and health promotion to best serve the needs of young people and other affected groups.

4.3.1. PHE’s Dr Kevin Dunbar noted that in 2003, when the NCSP was inaugurated, it was not possibly simply to order a testing kit to be delivered to one’s home with a smart phone. There was a consensus that the chlamydia response must adapt to reflect the impact of new technology. However, the panel agreed that there is a misconception that online services are a replacement for face-to-face services, when in fact they must be considered an important part of the chlamydia response alongside traditional clinical services.

4.3.2. FSRH and BASHH are working in partnership to develop service standards for online providers, but the group agreed that there was a need for more evidence of efficacy and effectiveness of digital service models.

4.4. **Recommendation 2:** Explore how PHE, local authorities, clinics and providers can better access and utilise data especially on a local level to optimise and target programmes in a more precise and impactful manner.
4.4.1. A key challenge in tackling chlamydia is the fact that it is not as highly concentrated in particular areas or amongst particular demographic groups as many other STIs. It is prevalent in both urban and rural areas, for example.

4.4.2. Age is the strongest indicator of chlamydia risk and the second strongest is deprivation, so targeting populations geographically can be very useful. But precision is important, as there are pockets of deprivation even within local authorities. These pockets may also cross the borders of local authorities.

4.5. **Recommendation 3:** All stakeholders should work to ensure dedicated content about STIs, sexual health, local services, and the importance of screening are included in the Relationships and Sex Education (RSE) curriculum to ensure young people have the knowledge, skills, and confidence they need to maintain good sexual health.

4.5.1. There was consensus that the introduction of mandatory RSE in schools is a great opportunity to increase young people's knowledge and confidence of sexual health and accessing screening services. Unfortunately, it was felt the draft guidance is too non-specific and there is no link to local public sexual health priorities in the curriculum. There was concern by many members that sexual health will not feature strongly enough in the final guidance and it will be an issue local authorities will need to take up on a local level to ensure these issues are included in individual school's curriculum.

4.6. **Recommendation 4:** Consider the provision of a national social marketing and awareness raising campaign which includes digital/printed assets which can be adapted for local use. Materials should be “sex positive” in their approach and be inclusive of people in relation to sexuality, gender, age, and physical ability.

4.6.1. It was noted that it was very costly for local authorities to each produce their own range of sexual health marketing and informational materials. National resources which can be adapted locally (like those PHE makes available for health conditions like flu) would be extremely cost-saving because the local authorities do not need to pay the costs of the creative development and production – only for adaptation and printing.

4.6.2. Most agreed it is not only where the message appears, but the content, language, and tone of those messages which is important. Some felt that it needed to not just be a campaign, but a new national conversation around sexual health from a “sex positive” perspective that empowered young people to be advocates and peer educators.

4.6.3. There were several contributions to the discussion on the importance of remembering groups who are often overlooked. Specifically, women who can experience the worse health outcomes from undiagnosed infection; people with disabilities – who can find accessing services difficult; and Lesbians who’s needs in terms of sexual health are often unknown by primary care or misunderstood.

4.7. **Recommendation 5:** Consider new commissioning models based on regional footprints, commonalities in need, economies of scale, and avoidance of duplication.
4.7.1. Members involved in the delivery of services agreed that one of the most positive partnerships to emerge in recent years has been the integration of sexual health and contraceptive services. Others reported that regional partnerships have also been very effective.

4.7.2. An example which was highlighted was that London has brought together 27 local authorities for a combined HIV prevention and testing service with a forward-facing brand. It was asked if something similar be done with chlamydia programmes. There was general agreement that the challenges can be significant but not insurmountable.

4.8. **Recommendation 6:** Prioritise and pilot prevention programmes to increase partner notification, promote repeat testing and reduce re-infection with particular emphasis on the needs of women (as those who experience the most severe negative health outcomes as a result of chlamydia infection) and including setting which yield high positivity rates including contraception, termination, and cervical screening services.

4.8.1. PHE, through the NCSP, focuses on diagnosis, and measures success based upon the number of diagnoses made, rather than the number of tests taken. It is felt that positivity should not be the primary indicator of success because it could result in a service which incentivises the testing of those with symptoms at the expense of those who don’t – but still need access to services.

4.8.2. Those involved in delivering services to young people pointed out that chlamydia screening is not just a way of identifying infection, it is also the first contact for many young people into sexual health services. They can later go on to learn about contraceptive or other services. It was noted that having tested positive for chlamydia, is a strong indicator of future infection, so re-testing is key to early diagnosis to prevent the infection being passed on to others.

4.8.3. The group agreed that the elevated positivity rates in people who have been tested as a result of partner notification make this highly effective intervention, but it has been an ongoing challenge to consistently implement these programmes on a national or local level.

4.9. **Recommendation 7:** Further development and piloting of models for partnership work and integration with primary care and pharmacy services.

4.9.1. There was agreement that primary care and pharmacy should be considered as important partners in this work. It was said that working closely with primary care is of paramount importance because they have contact with young people beyond sexual and public health settings. Pharmacies have added contact with young women who are accessing contraception.
4.9.2. One member pointed out that sometimes the local structures can be an obstacle. The speaker said Clinical Commissioning Group (CCG) and now Sustainability and Transformation Plan (STP) footprints could be a great vehicle for engaging primary care, but they are currently solely focused on health and not on public health. The benefits of creating these partnerships were recognised by the whole group and could be of significant benefit in evolving the chlamydia response.

4.10 Recommendation 8: Meet the emerging challenges in sexual health, such as rising rates of M-Gen through closer collaboration across the sexual health system to learn the lessons of other STI responses, share best practice, optimise performance and fully utilise resources across the system.

4.10.1 The group recognised that sexual health is in competition with many other local authority priorities. There was concern that with the potential loss of the ringfence and the reduction of the public health grant, local authorities are under extreme financial pressure along with a constantly changing set of needs which must be met.

4.10.2 It was widely recognised that there is a real challenge in prioritising resources within limited sexual health budgets with emerging conditions like M-gen which need to be addressed. It was also reported that areas are trying to look at how to make the most of the limited resources they have. There was general agreement that there are opportunities to make funding go further if it is deployed in different ways and lessons are learned from the other STI responses like chlamydia.

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