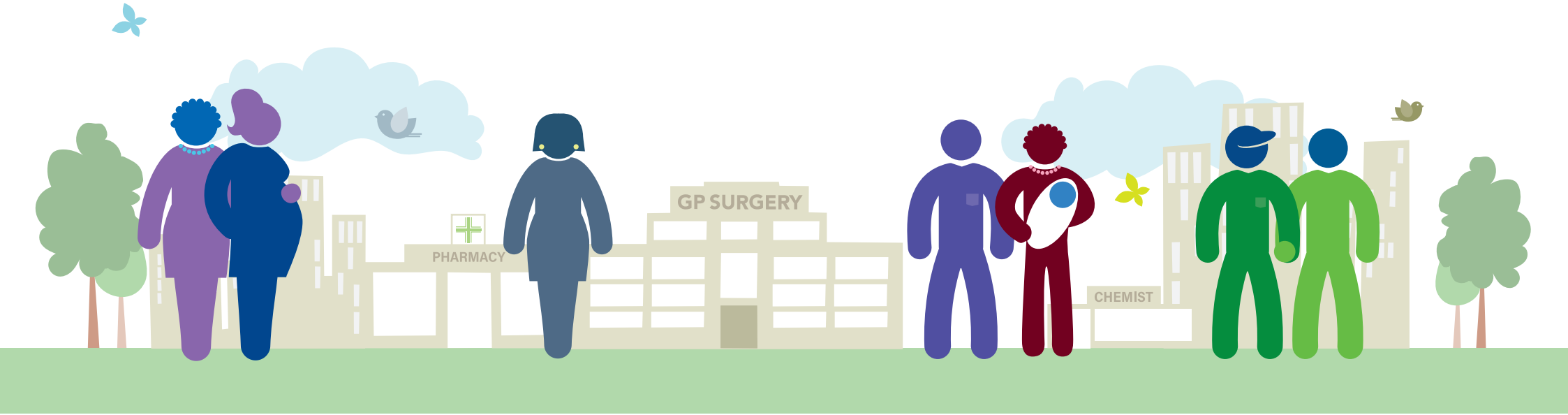
THE RICHMOND SEXUAL HEALTH STORY 2020

Service delivery in primary care settings



LONDON BOROUGH OF RICHMOND UPON THAMES

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

The Richmond Sexual Health Story is a report of the sexual health services delivered in general practice GP surgeries and pharmacies in Richmond. The story aims to examine service demand and provision during 2018-19 and act as a resource for commissioners to manage sexual health programmes and inform procurement of services in primary care for 2020 and beyond.

Chapter one outlines the changing national and local level health and social care landscape that has been taking place over the last seven years. This includes the transition of some sexual health commissioning functions into local authorities, the mobilisation of a new integrated sexual health service and more recently the introduction of the NHS Long-Term Plan. Despite this changing context, Richmond Council has continued to provide high quality, outcomes-based, accessible and sustainable sexual health services for residents.

Chapter two considers the methodology used and details the services that are delivered across primary care. In Richmond there are 20 GP surgeries and 5 pharmacies contracted by the local authority to deliver sexual health services for residents. GP surgeries deliver Chlamydia screening and long acting reversible contraception (LARC), which includes coils and implants. Pharmacies deliver Chlamydia screening and treatment and oral emergency contraception (Oral-EC).

Chapter three sets out the findings and outcomes. Richmond is similar to London and better than England for the percentage of population screened for Chlamydia, but the detection rate (the measure of Chlamydia control activity in England (DR), is lower than both. The proportion of under 18s conceptions leading to abortion in Richmond is lower than London but higher than England and for under 25s repeat abortions, Richmond is doing better than London and England. Total prescribed LARC (excluding injections) is increasing and Richmond is higher than London but lower than England.

Service Snapshot Cards, which summarise the key findings and outcomes for each service are provided. These show that during 2018-19 there were a total of 2,189 sexual health interventions delivered in a primary care setting. This includes 1,769 LARC administered by GP surgeries. In pharmacies, there were 305 presentations for Oral-EC and 13 young people who tested positive for Chlamydia through the National Chlamydia Screening Programme (NCSP) were referred to a pharmacy for Chlamydia treatment. Across both settings in primary care, 108 young people were screened for Chlamydia with 11 positive cases identified – a positivity rate of 10%.

Chapter four includes the key findings, discussion and recommendations. The report finds that the commissioning of sexual health services in GP surgeries and pharmacies is inconsistent and limited in geographical reach leaving gaps in provision in some areas of the borough. Among commissioned providers, activity varies with a small number inactive. Chlamydia screening is being delivered effectively and the Oral-EC conversation rate (the percentage of service users receiving an Oral-EC consultation who screen for Chlamydia) is good, indicating that pharmacies are implementing the MECC approach. LARC activity increased in relation to the previous year and not all GP surgeries delivered the recommended minimum number of insertions required within a given period. Almost 40% of Oral-EC service users were aged 18 or under. More women than men are accessing sexual health services in primary care and Black, Asian and Minority Ethnic (BAME) users of the Oral-EC service are slightly over-represented in comparison with the borough profile for age range.

The Richmond Sexual Health Story recommends that sexual health services should continue to be provided in GP surgeries and pharmacies. However, commissioning from 2020 should look to strengthen the accessibility of services and equity of access, so that they are commissioned more consistently with greater geographical reach, are situated in areas where they are most needed, where demand is highest and provided by those who have demonstrated that they are best able and motivated to deliver services to residents consistently.

Ways to maximise the primary care offer for sexual health should be explored, such as extending Chlamydia treatment in pharmacies beyond the NCSP. In response to the number of young people accessing Oral-EC, ways to promote safer sex messaging and strengthen access to LARC and the combined oral contraceptive pill, should be considered. Consideration should be given to the demographic characteristics of service users and the

positive and negative drivers of the overrepresentation of particular groups. This includes differences in the demand and utilisation of services between male and female, specific age groups and BAME and White service users. Campaigns to promote services to young people including men should be delivered. Actions should be taken by commissioners to improve the data capture of LARC and Chlamydia treatment to support improvements in the monitoring of service user demographics.

Qualitative work should be undertaken to compliment and contextualise the quantitative findings. Methods such as feedback from providers, consultation with service user groups, and mystery shopping exercises would add further value to the story by incorporating the patient and practitioner voice.

Commissioners should regularly assess the continually changing landscape seeking opportunities that may arise for service development and contractual delivery following the maturation of Primary Care Networks (PCNs), the transformation of Clinical Commissioning Groups (CCGs) and implementation of the NHS Long-Term Plan. Financial resources and expertise should be optimised through cross-divisional spending agreements between public health and commissioning departments within the Directorate of Adult Social Services and Public Health (DASCPH) in the council and collaborative commissioning opportunities with other councils across South West London should be scoped.

The recommendations are summarised below:

1 **Strengthen accessibility and equity of access of sexual health services in GP surgeries and pharmacies**
- Increase the number of GP surgeries commissioned to deliver LARC
- Increase the number of pharmacies commissioned to deliver Oral-EC

2 **Maximise the primary care offer for sexual health**
- Facilitate a channel-shift of routine and/or non-complex LARC from the Integrated Sexual Health service (ISH) to GP surgeries
- Work with specific GP surgeries needing to increase LARC to meet NICE recommended minimum number of insertions within a given time period
- Scope commissioning of quick-start oral contraception in pharmacies
- Scope the scale-up of Chlamydia treatment in pharmacies beyond those testing through the NCSP

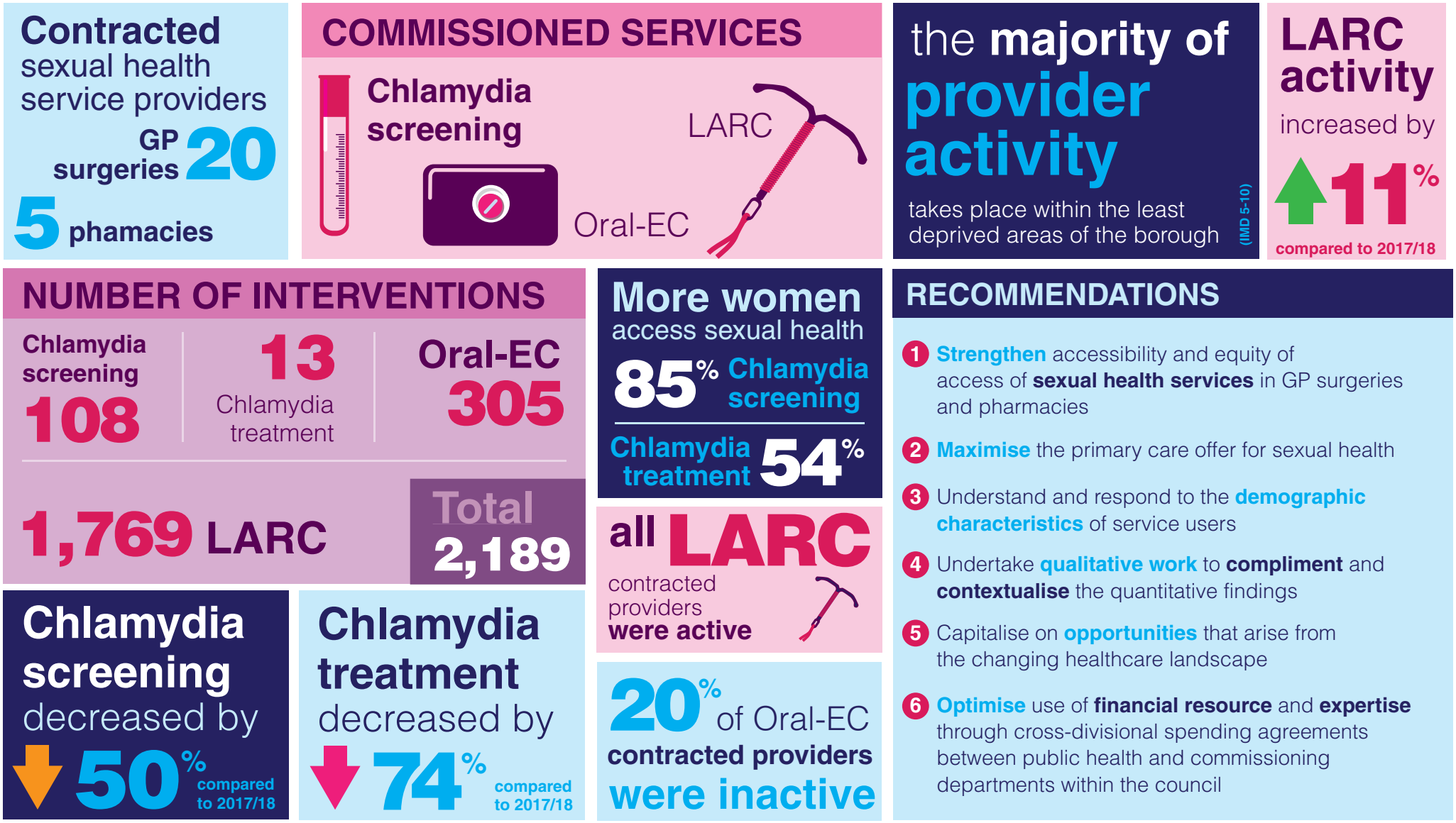
3 **Understand and respond to the demographic characteristics of service users**
- Improve the data capture of LARC and Chlamydia treatment
- Explore the over-representation of BAME users of the Oral-EC service
- Coordinate a campaign aimed at promoting services to young people including men in the borough

4 **Undertake qualitative work to compliment and contextualise the quantitative findings**
- Seek feedback on services from practitioners, pharmacists and practice managers
- Seek feedback from service users
- Commission or coordinate mystery shopping exercises

5 **Capitalise on opportunities that arise from the changing healthcare landscape**
- Keep abreast of any impact on sexual health commissioning models and pathways following the decision in 2020 to dissolve Public Health England (PHE)
- Continue to link with relevant representatives from the reorganised South West London CCG
- Move in parallel with the maturisation of PCNs and explore opportunities to commission services at a PCN level

6 **Optimise use of financial resource and expertise through cross-divisional spending agreements between public health and commissioning departments within the council's DASCPH and by working collaboratively with councils across South West London**
- Implement cross-funding agreements to support any increase in primary care delivered activity following channel-shift from ISH
- Deliver on service alignment commitments with sexual health commissioners across South West London including the development of South West London service specifications, PGDs and standardised tariffs
- Scope opportunities to commission services in primary care collaboratively with councils across South West London

Figure 1: Infographic - Key points of Interest and Recommendations



ACRONYMS AND KEY TERMS

Activity – refers to the delivery of LCSs and is measured through the collection and collation of data

BAME – Black, Asian and Minority Ethnic

CLCH – Central London Community Healthcare is the commissioned provider of the ISH service in Merton, Richmond and Wandsworth

Chlamydia Detection Rate (DR) – is a measure of Chlamydia control activity in England, aimed at reducing the spread of infection and the incidence of reproductive sequelae (a condition which is the consequence of a previous infection). In 2013 the Department of Health (DoH), now known as the Department of Health and Social Care (DHSC), published the recommended Chlamydia detection rate of >2,300 per 100,000 population. The NCSP still recommends local authorities work towards achieving this level

Clinical effectiveness – is defined as the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients

Conversion rate – is the percentage of service users receiving an Oral-EC consultation who screen for Chlamydia

Cu-IUD – Copper Intrauterine Device which is inserted into the uterus (womb) and releases copper to prevent pregnancy

DASCPH – Department of Adult Social Care and Public Health within Richmond Council

DHSC – Department of Health and Social Care

E-Services – provides free and easy access to sexual health testing via the internet

GP surgeries – the business or premises of a medical doctor working in general practice

High activity – refers to the degree of spend of the available financial resource

IMD – Index of Multiple deprivation (given in deciles throughout the report) provides a set of relative measures of deprivation for small areas (Lower Super Output Areas) across England, based on seven domains of deprivation.

Integrated Sexual Health Services (ISH) - an ISH service provides open access to confidential, non-judgemental services including STI testing, treatment and management, the full range of contraceptive provision, health promotion and prevention

IUD – Intrauterine Devise also known as a coil, is a birth control devise that is inserted into the uterus (womb) to prevent pregnancy

IUS – Intrauterine System that releases hormones into the uterus to prevent pregnancy

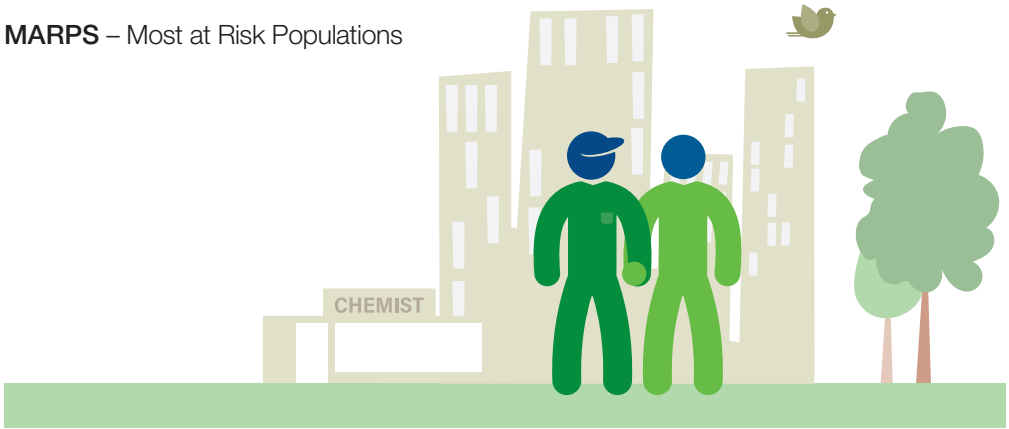
KPI – Key Performance Indicator is a quantifiable measure used to evaluate the success of a programme or service

LARC – Long Acting Reversible Contraception includes IUDs/IUSs and SDIs

LCS – Locally Commissioned Service

LSOA – Lower Super Output Area is a geographical area used in the reporting of small area statistics in England and Wales

MARPS – Most at Risk Populations



MECC – Making Every Contact Count is an approach to behaviour change that uses day-to-day interactions that organisations and people have with other people to support them to make positive changes to their physical and mental health and wellbeing

MSM – Men who have Sex with Men, including gay and bi-sexual men

NCSP – National Chlamydia Screening Programme

New Patient Registration – is a formal process undertaken when a new patient joins a GP surgeries patient list

NICE – National Institute of Clinical Excellence

Oral-EC – emergency contraception pill taken by mouth up to five days post UPSI to prevent pregnancy

Out of Borough – refers to people who do not live in the borough or are not registered with a GP in the borough who use services in accordance with The Local Authorities Regulations 2013 which require open access sexual health services

Patient Group Direction (PGD) – provides a legal framework that allows some registered health professionals to supply and/or administer specified medications to a pre-defined group of patients, without them having to see a prescriber such as a doctor or a nurse

Pharmacy – a shop or hospital dispensary where medicinal drugs are prepared or sold

Primary Care – healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. This includes GP surgeries and pharmacies

PCN – Primary Care Network where introduced into the NHS in England as part of the NHS Long-Term Plan, published in January 2019

Provider – refers to either a commissioned GP surgery or pharmacy

PHE – Public Health England is an executive agency of the Department of Health and Social Care in the UK that began operating in 2013

Sexual Health London – is an e-service commissioned by Wandsworth Council to provide testing for a range of STIs via samples that can be collected at home

Sexual Health System – this encompasses all elements of programme delivery including NHS services, Primary Care, voluntary sector and E-Services

STI – Sexually Transmitted Infection

Sites – refers to GP surgeries and pharmacies within the borough

SDI – Sub-Dermal Implant is a contraception device that is placed underneath the skin

UPSI – Unprotected Sexual Intercourse which is any sex without contraception or a condom

AUTHORS NOTE

The authors would like to note the following: basic epidemiological terms and concepts were used in the development of this work and are referenced throughout the story. However, no significance or confidence testing was applied. The story accepts the findings at face value; however, the authors acknowledge that factors impinging on service delivery in primary care settings are varied and complex and it is outside the scope of the story to explore these in their entirety.

The story does not replace the 2018 sexual health needs assessment, strategy and related action plan but should be read and understood in conjunction with these existing works and used to enrich understanding of primary care delivered elements of sexual health in the borough. Acknowledging its limitations, the authors hopes that the story can be used to generate thought and discussion amongst stakeholders and inform next steps to commissioning from 2020.

Finally, the authors would like to thank all those who helped inform and shape this work as well as providers of sexual health care in GP surgeries and pharmacies for their contribution to the sexual health of Richmond residents.

CHAPTER ONE – INTRODUCTION

AIM

The Richmond Sexual Health Story is a report of the public health commissioned sexual health services delivered in GP surgeries and pharmacies in Richmond. The story aims to examine service demand and provision during 2018-19 and act as a resource for commissioners to manage sexual health programmes and inform procurement of services in primary care for 2020 and beyond.

BACKGROUND

Sexual health services in primary care are delivered through locally commissioned health and wellbeing contracts, individual sexual health service specifications and patient group directions (PGDs) where required. These key documents are informed by NICE and Faculty of Reproductive and Sexual Health best practice guidance and support programme management, performance monitoring and optimum care outcomes for service users.

GP surgeries and pharmacies are health, social and community assets so make ideal settings in which sexual health services can be delivered. This is due to their geographical reach, clinical infrastructure and expertise, access to patient lists, long opening hours, potential to screen opportunistically and offer value for money.

GP surgeries and pharmacies are an integral component of the sexual health system in Richmond. They complement delivery in other settings, including ISH settings and e-services and reduce the demand placed on them. GP surgeries and pharmacies are particularly effective in supporting the non-complex and routine sexual health needs of residents and in signposting service users to other more specialised services where required.

The Richmond Sexual Health Story was developed following the production of the 2018 Richmond Sexual Health Needs Assessment, the Richmond Sexual Health Strategy refresh (2019-24) and Richmond Sexual Health Action Plan (2019-24). It is recommended that it is read, understood and used within the context of this wider work. While the Richmond Sexual Health Strategy (2019-24) addresses sexual health in Richmond from a total system perspective, which includes sexual health services delivered by NHS services, the voluntary sector and e-services, the Richmond Sexual Health Story focuses solely on the provision of sexual health services in GP surgeries and pharmacies.

Local authority commissioned sexual health services are governed by a range of national and local policies, strategies and guidelines and funded through the annual public health grant allocation. Delivering sexual health services in primary care supports efforts to improve the sexual health of the local population and contributes to improved sexual health outcomes at both a local and national level through the provision of high quality, evidence-based services.

Services are demand led. This means that service activity will not be consistent throughout the year and will vary based on the needs of service users at any one time. For the purpose of The Richmond Sexual Health Story, sexual health service activity refers to utilisation of the available financial resource and all data is from 2018-19. Budgets are allocated to individual services based on a number of factors including local need, intended outcomes and historical activity.

THE CHANGING HEALTH CARE LANDSCAPE

Over the last seven years the landscape in which sexual health services operate has changed considerably. Following the introduction of the Health and Social Care Act in 2013, the local authority became responsible for sexual health services. This includes the screening and treatment of sexually transmitted infections (STIs) (excluding HIV treatment), contraception provision, sexual health promotion and prevention services.

The sexual health offer provided by Richmond Council has multiple components:

- In 2017 a new ISH service was commissioned by Merton, Richmond and Wandsworth Councils to deliver a comprehensive STI and contraception service, including walk-in clinics. The ISH service operates a hub (Falcon Road clinic in Wandsworth) and spoke model across the three authorities (Patrick Doody clinic (Merton), Wide Way Medical Centre (Merton), The Medical Centre (Richmond) and Danebury Avenue (Wandsworth). The ISH service is currently provided by Central London Community Healthcare (CLCH).
- Richmond Council is part of the Pan-London Sexual Health e-Service called 'Sexual Health London', which enables residents to self-sample and screen for STIs via postal kits, without the need for a face-to-face appointment.
- Routine, non-complex sexual health services are provided by a number of commissioned GP surgeries and pharmacies across the borough.
- Sexual health services are provided on a community outreach basis by voluntary organisations who act as tier-two providers of the ISH service and sub-contracted by CLCH. This includes METRO Charity who are responsible for coordination of the local Chlamydia screening programme and C-Card (condom distribution) scheme.
- More recent changes include the NHS Long-Term Plan published by NHS England in January 2019. The plans set out the priorities for healthcare over the next 10 years and shows how the NHS funding settlement will be used and changes in the primary care architecture. A key part of the NHS Long-Term Plan was the formation of PCNs. The aim of PCNs is to bring GP surgeries together to work at scale to provide the structure and funding for services to be developed locally in response to the needs of the patients they serve. This will allow for staff to operate at various locations within a PCN potentially adding further expertise and appointment availability. At the time of writing this document the full future potential of PCN commissioning implications for local authorities has not been analysed and is currently unclear. Operationalising PCNs was due by X 2021? and wider NHS transformation took place in 2019/20 to
- From 1 October 2019, the new Community Pharmacy Contractual Framework for 2019-20 to 2023-24 will help to deliver the ambitions set out in the NHS Long Term Plan and underlines the critical role of community pharmacy as an agent of improved public health and prevention, as they are embedded in the local community. The contract commits almost £13 billion to pharmacies across the country and is in line with the GP surgery contract, providing five-year stability and reassurance to pharmacies. This should allow pharmacies to make long-term business decisions and support the delivery of both core and locally commissioned services including sexual health services.
- In addition, Public Health and commissioning colleagues working within the DASCPH have taken steps to adapt and streamline commissioning arrangements to strengthen service pathways, improve resource management, drive efficiencies and improve service user outcomes. This work will continue as opportunities arise. Work to align services, including service specifications, PGDs and tariffs across South West London is also taking place and opportunities to commission collaboratively are being scoped.

CHAPTER TWO – METHODOLOGY AND SERVICE DELIVERY

The Richmond Sexual Health Story was developed from the collection, analysis and interpretation of available data. The basic data collection was from sources highlighted below which typically provide the information for quarterly invoicing payments and hence reflect accurate provider activity as well as providing additional service user demographics. To provide a basis for outcome comparisons at borough and UK level, government data sources listed below were utilised where possible.

STAGE ONE - DATA COLLECTION

Data was collected and compiled from 2018-19. Consideration was given to providing a two-year look back to include activity from 2017-18. The decision was taken to exclude 2017-18 due to inconsistencies in data availability between the two years resulting from improved data system search and report functionality. Data was collected for the following services;

- **Chlamydia screening**
- **Chlamydia treatment**
- **LARC**
- **Oral-EC**

The following data sources were used to extract the relevant service area data:

- **PharmOutcomes:** this is a web-based system used by pharmacies for Oral-EC and Chlamydia treatment to help provide service and allow commissioners to audit and manage these services
- **Vision+:** this is a digital clinical system used to record LARC activity in GP surgeries for patient record management and information sharing between providers and the Council.
- **PreventX:** is an integrated diagnostics service which provides the postal testing kits for the Chlamydia screening programme and is managed by METRO.

STAGE TWO - DATA ANALYSIS:

The data was converted into tables and graphs and analysed for trends, key findings and service outcomes. Regional sources and national data sets were also reviewed for wider system context including:

- PHE Fingertips Data
- Chlamydia Testing Activity Database (CTAD)
- PHE HIV and STI Web Portal
- DataRich - a free and open website designed so that users can easily access local data relevant to the London Borough of Richmond

For all services, data was used to monitor service activity at both a service and provider level. Service user profile information including age, gender, ethnicity and Index of Multiple Deprivation (IMD) (given in deciles) was analysed.

The following indicators were used to measure outcomes for each service:

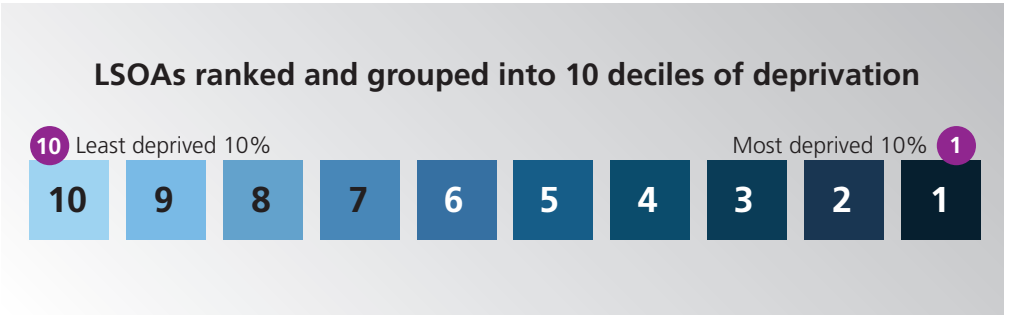
Service	Outcome indicator measurements
Chlamydia Screening	• The number of Chlamydia screens in primary care • The number of positive cases of Chlamydia in primary care • The Chlamydia screening positivity rate in primary care • The cost per positive Chlamydia screen • Utilisation of available resource • The percentage of active and non-active providers

Service	Outcome indicator measurements
Chlamydia Treatment	• The number of Chlamydia treatments in primary care • The average cost per Chlamydia treatment • Utilisation of available resource • The percentage of active and non-active providers
Oral-EC	• The number of Oral-EC consultations in pharmacies • The percentage of all Oral-EC consultations taking place within 72 hours of UPSI • The Oral-EC to Chlamydia screening conversion rate • The average cost per Oral-EC consultation • Utilisation of available resource • The percentage of active and non-active providers
LARC	• The number of LARC insertions taking place within GP surgeries • The number of LARC removals taking place within GP surgeries • The percentage of GP surgeries where LARC activity meets the minimum activity threshold • Utilisation of available resource • The percentage of active and non-active providers

INDEX OF MULIPLE DEPRIVATION

The IMD 2019 provide a set of relative measures of deprivation for small areas (Lower Super Output Areas) across England, based on seven domains of deprivation. The domains were combined using the following weights to produce the overall Index of Multiple Deprivation:

- **Income Deprivation (22.5%)**
- **Employment Deprivation (22.5%)**
- **Education, Sills and Training Deprivation (13.5%)**
- **Health Deprivation and Disability (13.5%)**
- **Crime (9.3%)**
- **Barriers to Housing and Services (9.3%)**
- **Living Environment Deprivation (9.3%)**



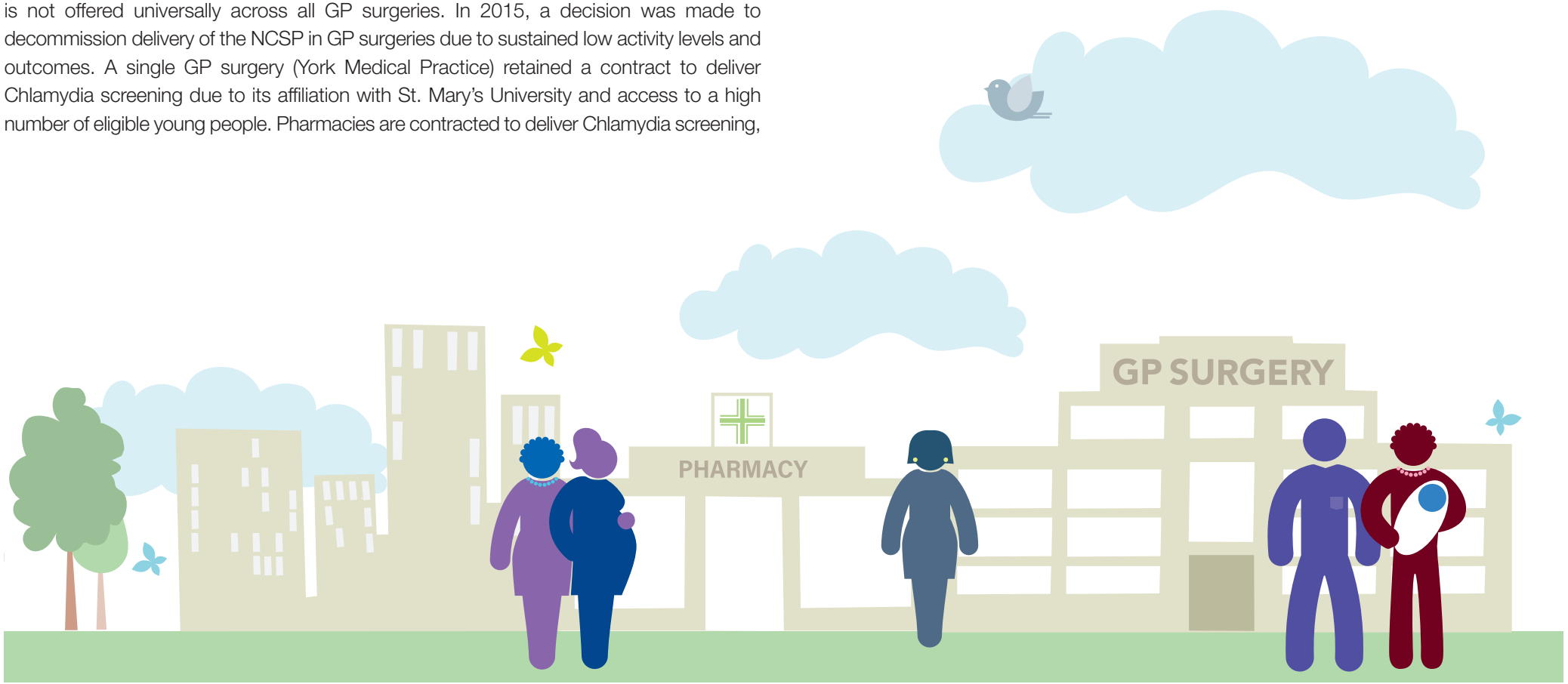
Deprivation is measured in a broad way to encompass a wide range of aspects of an individual's living conditions. Deciles are calculated by ranking the 32,844 small areas in England, from most deprived to least deprived, and dividing them into 10 equal groups. These range from the most deprived 10 per cent of small areas nationally to the least deprived 10 per cent of small areas nationally.

Richmond ranks 297 out of 317 local authorities in England and within the 10% least deprived local authorities in England. Richmond was the least deprived London borough in 2019 and within the least deprived half of London boroughs across all deprivation indices.

SERVICE DELIVERY

In Richmond there are 20 GP surgeries and five pharmacies contracted by the local authority to deliver sexual health services for residents. The services GP surgeries are contracted to deliver are Chlamydia screening and LARC. Due to historical contractual arrangements LARC is not offered universally across all GP surgeries. In 2015, a decision was made to decommission delivery of the NCSP in GP surgeries due to sustained low activity levels and outcomes. A single GP surgery (York Medical Practice) retained a contract to deliver Chlamydia screening due to its affiliation with St. Mary's University and access to a high number of eligible young people. Pharmacies are contracted to deliver Chlamydia screening, treatment and Oral-EC. Services are demand led. This means that service activity will not be consistent throughout the year and varies based on the needs of service users at any one time.

In total, there are 25 contracted providers in Richmond. Residents are typically registered to a GP surgery local to their home address and PCNs operate to offer appointments between 8am and 8pm as well as at weekends. All residents are within 1,200m (3/4 mile) of a pharmacy.



CHAPTER THREE – FINDINGS AND OUTCOMES

GENERAL

During 2018-19 there were a total 2,195 sexual health interventions delivered in a primary care setting. This includes 1,769 LARC procedures undertaken by GP surgeries. In pharmacies, there were 305 presentations for Oral-EC and 13 young people who tested positive for Chlamydia through the NCSP were referred to a pharmacy for Chlamydia treatment. Across both settings in primary care, 108 young people were screened for Chlamydia with 11 positive cases identified – a positivity rate of 10%.

PUBLIC HEALTH OUTCOME FRAMEWORK

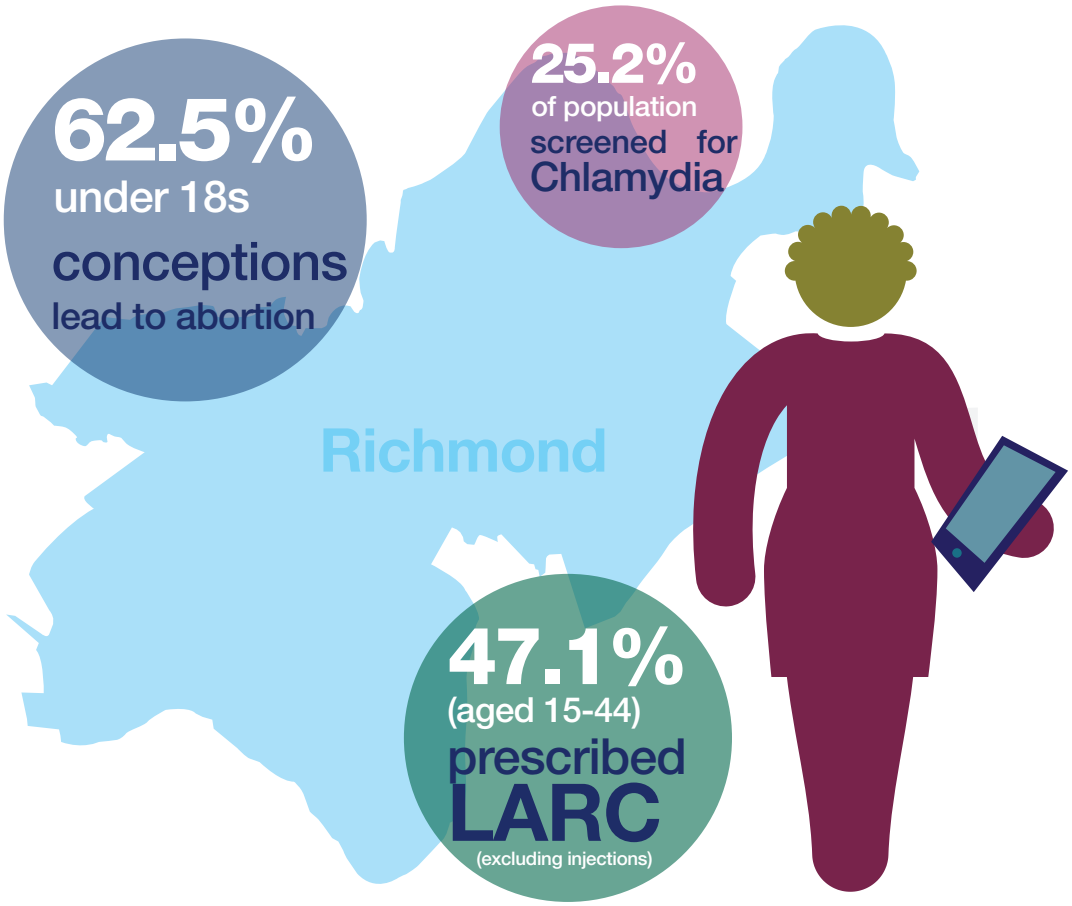
The locally commissioned services have agreed annual outcomes and Key Performance Indicators (KPIs). These are performed managed by commissioners within the Directorate of Adult Social Care and Public Health. The outcomes and KPIs used are those found in The Public Health Outcomes Framework (PHOF), PHOF data enables local authorities to benchmark and compare their own outcomes with other local authorities as well as nationally. They are a useful monitoring tool for commissioners of the services and also indicate trends over a three-year time span. This can provide an indication of where resources may be directed. The indicators and outcomes for each of the sexual health services are presented below in more detail.

Overall, Richmond is similar to London and better than England for Chlamydia screening (the percentage of eligible population screened (25.2% vs 26.4% and 19.6%). There is no significant change in the Chlamydia detection rate (DR) however the DR in Richmond is lower than London and England (1,949/100,000 vs 2,610 and 1,975).

Termination of pregnancy (abortion) rates (TOPs) are used as a proxy measure for unplanned pregnancies. The proportion of Under 18s Conceptions leading to Abortion in Richmond is lower than London but higher than England (62.5% vs 64.9% and 53.0%). For Under 25s Repeat Abortions, Richmond is doing better than London and England (24.1% vs 30.7% and 26.8%).

Total Prescribed LARC (excluding injections) is increasing and Richmond is higher than London but lower than England (47.1/1,000 vs 38.6 and 49.5%).

Further information relating to the local sexual health picture can be found in Part 4 of the Richmond Sexual Health Needs Assessment 2018.



SERVICE SNAPSHOT CARDS

Data from each service is presented and discussed in the Service Snapshot Cards below.

CHLAMYDIA SCREENING - PHARMACIES

What is the aim?

To identify Chlamydia infection in young people aged 15-24 by achieving the Detection Rate (DR) outcome measurement. The Department of Health set a national DR of 2,300 per 100,000 population in the target age group. The DR indicator reflects the importance of early treatment as well as repeat screening annually and on change of sexual partner.The NCSP is delivered locally in Richmond in both GP surgeries and pharmacies. The programme is coordinated locally by METRO who are a sub-tier contractor within the wider ISH service. METRO Charity have been responsible for the local programme since October 2017. Chlamydia treatment for NCSP service users testing positive for Chlamydia is available in pharmacies.

What do we offer in pharmacies?

In Richmond five of 45 Pharmacies are contracted to deliver the NCSP to young people aged 15 to 24. Three are located in Twickenham, one in Ham and one in Whitton. Service users must be a resident or registered with a Richmond GP surgery. In addition to being offered to eligible service users opportunistically, Chlamydia screening is offered during Oral-EC consultations.

Who uses the service?

- 85% of service users were female
- 80% were aged between 18-24 (the inclusion criteria being 15-24)
- 23% were BAME
- 94% of all activity was undertaken within pharmacies situated within the least deprived areas of the borough*

* LSOAs ranked amongst the 50% least deprived nationally (deprivation deciles 6 – 10) on the Index of Multiple Deprivation 2019

What does this tell us?

The programme is disproportionally utilised by some groups in comparison to the borough's demographic profile. More than four-fifths of service users are female, where the borough has a near equal proportion of males and females and the percentage of BAME service users reflects the borough profile for age range.

What are the outcomes?

- There were 102 Chlamydia screens undertaken by the 5 contracted pharmacies
- Two pharmacies (40%) delivered 89% of all activity
- One of the commissioned pharmacies (20%) was non-active during the period
- The percentage of positive tests was 9.9% (10) which is higher than the borough wide figure (7.6%) but lower than the figure (16%) attributed to the commissioned GP surgery (16%)
- The conversion rate between Oral-EC and Chlamydia screening is 33%. This is the number of patients offered and accepted a Chlamydia screen at the time of an Oral-EC consultation in relation to the total number of Oral-EC consultations that took place.
- Percent of population tested in pharmacies is 0.58% compared to 24.8% tested by all Richmond specialist and non-specialist sexual health services
- Total LCS tariff cost per positive test is £101

What does this tell us

The commissioned provision of the NCSP in Richmond is limited in its geographical reach. Three-fifths (60%) of contracted pharmacies (including a non-active site) are based in Twickenham within several hundred feet of one another. Activity varies across the five commissioned pharmacies with the available financial resource underused. Two pharmacies demonstrated a consistent commitment to the programme during the reporting period. The positivity rate is high, indicating the effectiveness of pharmacy screening. Efforts to screen service users presenting for Oral-EC are demonstrable and the conversion rate is significantly higher than other South West London boroughs. This suggests that pharmacies are implementing the MECC approach.

CHLAMYDIA SCREENING - GP SURGERIES

What is the aim?

To identify Chlamydia infection in young people aged 15-24 by achieving the Detection Rate (DR) outcome measurement. The Department of Health and Social Care set a national DR of 2,300 per 100,000 population in the target age group. The DR indicator reflects the importance of early treatment as well as repeat screening annually and on change of sexual partner.The NCSP is delivered locally in Richmond in both GP surgeries and pharmacies. The programme is coordinated locally by METRO Charity who are a sub-tier contractor within the wider ISH service. METRO Charity have been responsible for the local programme since October 2017. Chlamydia treatment for NCSP service users testing positive for Chlamydia is available in pharmacies.

What do we offer in GP surgeries?

In Richmond a single (one) GP surgery is commissioned to deliver the NCSP to males and females between the ages of 15-24. In addition, service users must be a resident or registered with the GP surgery. In 2015 a decision was made to decommission the majority of GP surgeries following a prolonged period of consistently low activity levels and service outcomes.

Who uses the service?

- 83% were female
- 100% were aged between 18-24
- 0% were BAME
- The commissioned GP surgery is situated in IMD 8*

* LSOAs ranked amongst the 50% most least deprived nationally (deprivation deciles 6-10) on the Index of Multiple Deprivation 2019

What does this tell us?

Due to being operated by a single provider affiliated to St. Mary's University, the demographic characteristics of service users may not be representative of the wider borough.

Young people resident in Richmond not registered to the commissioned GP surgery will not be able to screen for Chlamydia through the NCSP via GP surgeries.

What are the outcomes?

- There were six screens
- Activity decreased by 50% in comparison with 2017-18
- Positive test rate is 16% which is higher than both pharmacy (9.9%) and borough wide (7.6%) rates, however due to the small sample size, the findings lack power
- The total LCS tariff cost per positive test is £60 which is less than pharmacy

What does this tell us?

Due to provision by only a single provider, small sample size and low activity, it is difficult to draw conclusions from the findings.

A comparison of activity in 2019-20 should be undertaken to determine service effectiveness and value.

CHLAMYDIA TREATMENT

What do we offer?

In Richmond five pharmacies are contracted to deliver Chlamydia treatment to males and females between the ages of 15-24, as well as their partners of any age. Service users do not need be a resident or registered with a Richmond GP surgery. Service users testing positive for Chlamydia are referred to pharmacies for treatment by METRO, which is the commissioned provider of the NCSP locally. The service is not available on a walk-in or opportunistic basis.

What is the aim?

The aim of this service is to provide access to free treatment for asymptomatic Chlamydia in pharmacies as part of efforts to prevent and control Chlamydia through early detection and treatment.

Who uses the service?

- 54% of service users were female
- 77% were aged between 19-24
- Ethnicity data of service users was not recorded
- 54% of users were from the 20% least deprived areas of the borough

What does this tell us?

There is a roughly equal split between male and female service users and just over three-quarters of service users were aged 19-24.

Although the sample size is small the demographic characteristics of service users largely reflect the eligibility criteria.

The reasons why ethnicity data is not being recorded should be explored.

What are the outcomes?

- 13 Chlamydia treatments were delivered in pharmacies
- Activity decreased by 74% during 2018-19 in comparison with 2017-18. One provider was inactive.
- Doxycycline was introduced as the first line of treatment towards the end of the 2018-19 financial year extending the window of opportunity for Oral-EC post UPSI.
- The total LCS tariff cost per treatment is £16.32

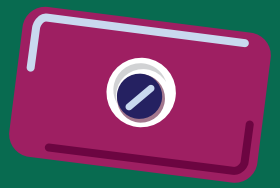
What does this tell us?

The data suggests that twelve percent (12%) of all service users screening through the NCSP via primary care are being referred back to pharmacy for treatment. However, it is not possible to determine the settings in which all pharmacy referred Chlamydia-positive service users were screened.

As the number of pharmacy treatments is higher than the number of service users testing positive for Chlamydia subsequent to a pharmacy screen, it is likely that service users are being referred by METRO from a range of screening settings. The commissioner of this service should try to establish this information.

Treatment in pharmacies is more cost effective in comparison with treatment delivered by the ISH service. Commissioners should look to increase the utilisation of pharmacy delivered Chlamydia treatment by extending the offer beyond NCSP screening.

ORAL-EC



What do we offer?

In Richmond, five pharmacies are contracted to deliver Oral-EC which can be offered up to 5 days post unprotected sexual intercourse (UPSI) via Levonorgestrel and Ulipristal Acetate PGDs. Three are located in Twickenham, one in Ham and one in Whitton.

The service is available for women between 13-24 and there is no requirement to be a Richmond resident or registered with a Richmond GP surgery. As part of every Oral-EC consultation pharmacies are required to inform service users that the Cu-IUD is the most effective form of Oral-EC and are encouraged to discuss longer acting forms of contraception including where to access them.

A Chlamydia screen should be offered to every service user presenting for Oral-EC in accordance with the NCSP eligibility criteria.

What is the aim?

The aim of this service is to reduce the number of unplanned pregnancies leading to abortion and repeat abortions by providing free and timely access to emergency contraception within pharmacies across the borough.

Who uses the service?

- 37% were aged between 13-18
- 29% were BAME
- 28% were registered to addresses in the most deprived areas of the borough*
- 17% were not resident in the borough

* LSOAs ranked amongst the 50% most deprived nationally (deprivation deciles 1 – 5) on the Index of Multiple Deprivation 2019

What does this tell us?

Almost 40% of all service users were under the age of eighteen and nearly 20% were not resident in the borough.

The BAME population is slightly overrepresented in comparison to the borough profile for age range (22%) and almost a third of service users were registered in the most deprived areas of the borough.

What are the outcomes?

- There were 305 presentations for Oral-EC
- Two (40%) of the five pharmacies accounted for 95% of all Oral-EC consultations
- 20% (one) of sites were non-active
- Levonorgestrel accounted for 93% of all prescribed medication
- The conversion rate between Oral-EC and Chlamydia screening is 37%

What does this tell us?

The commissioned provision of Oral-EC in Richmond is limited in its geographical reach. Three-fifths (60%) of contracted pharmacies (including a non-active site) are based in Twickenham within several hundred feet of one another.

This means that almost 100% of Oral-EC activity is attributed to a single location within the borough. It is not known whether the clustering of activity is a supply or demand issue however commissioners should consider the public health benefits ofwidening the scope of Oral-EC provision in the borough to include underserved areas.

The active sites demonstrated a consistent commitment to the programme during the reporting period and the conversion rate is significantly higher than other South West London boroughs. This suggests that pharmacies are implementing the MECC approach.

LARC

What do we offer?

In Richmond 20 GP surgeries (68% of total GP surgeries) are contracted to provide LARC to females aged 15-54 who are resident or registered with a Richmond GP.

LARC includes the Copper Intrauterine Devices (Cu-IUD) often referred to simply as the 'copper coil', Intrauterine System (IUS) often referred to by its brand name Mirena or called the 'hormonal coil' and Sub-Dermal Implants (SDI).

The different LARC systems are not commissioned uniformly across all Richmond's GP surgeries. A system for inter-GP referring is in place but is not utilised.

What is the aim?

The aim of this service is to support the ongoing work to reduce the number of unplanned pregnancies leading to abortion and repeat abortions by providing free access to a range of LARC devices.

Who uses the service?

Demographic data was not available from the Vision+ template during the 2018.19 financial year for reporting purposes

What does this tell us?

No conclusions can be made.

What are the outcomes?

- There were 1,769 LARC procedures
- 1,154 were insertions, 204 removals and 411 six week checks
- Activity increased by 11% in comparison with 2017-18
- five GP surgeries provided 47% of all combined insertions and one GP surgery 20% of Nexplanon removals
- All contracted providers were active during the year
- Three GP surgeries delivered less than the minimum number of IUS/Cu-IUD insertions required within a 12-month period and five GP surgeries for Nexplanon insertions

What does this tell us?

GP surgeries are ideally placed to deliver routine, non-complex LARC and the service is more cost effective in comparison with LARC delivered by the ISH service.

There is inconsistent provision amongst contracted GP surgeries with 36% of all activity delivered by 10% of providers.

The inter-GP surgery referral system is not being utilised and 15% of GP surgeries delivered less than the NICE recommended minimum number of insertions required within a 12-month period.

CHAPTER FOUR – KEYNOTES, DISCUSSION AND RECOMMENDATIONS

The key findings from The Richmond Sexual Health Story are as follows:

- Sexual health services are not commissioned universally across GP surgeries and pharmacies with gaps in provision in areas of the borough
- A small number of providers were inactive and there is wide variation in activity between providers with the majority being attributable to particular GP surgeries and pharmacies
- Contraception activity is increasing although not all GP surgeries are commissioned to deliver all types of LARC device
- Commissioned provision of Oral-EC is limited in its geographical reach and over 90% of all Oral-EC activity is taking place in Twickenham
- The Oral-EC to Chlamydia screening conversion rate in pharmacies is good indicating pharmacies are implementing the MECC approach
- Chlamydia screening is provided in a single GP surgery and activity was low
- More women than men are accessing Chlamydia screening
- Almost 40% of Oral-EC service users were aged eighteen or under
- BAME users of the Oral-EC service are slightly overrepresented in comparison with the borough profile for age range

GENERAL

The commissioning of sexual health services in GP surgeries and pharmacies is limited in its geographical reach. Services are not commissioned universally leaving gaps in provision in some areas of the borough. This is the result of the council inheriting legacy contracts following the Health and Social Care Act (2012), when public health teams joined local authorities and subsequent historical commissioning decisions enacted in 2015 which resulted in a reduction in the number of commissioned providers.

Among commissioned providers, activity varies with a small number inactive. The reasons for this are not fully established and it is unclear whether this is caused by a lack of supply or demand. In terms of supply, the reasons may include the limited number of providers, the size of each GP surgery patient list, as well as operational issues such as degrees of engagement, staffing levels, interest and expertise and financial resource and prioritisation. Demand may be affected by the demography and population sparsity of an area, low need or lack of awareness of service availability.

CHLAMYDIA SCREENING

A single GP surgery and five pharmacies are commissioned to deliver this service. The limited scale of commissioning of this service means there are gaps in provision in some areas of the borough. Of the contracted providers, GP surgery activity was low, almost 90% of pharmacy activity was undertaken by two providers and one pharmacy was inactive.

The screening undertaken was effective with a 9.9% positivity rate attributed to pharmacy screening. The rate for GP surgeries was 16% although the sample size means this finding lacks power. The Oral-EC to Chlamydia screening conversion rate is good, suggesting pharmacies are implementing the MECC approach. The effectiveness of screening suggests

that scaling-up commissioning of this service and working with providers to increase activity could further improve outcomes.

The majority of activity is taking place within GP surgeries and pharmacies situation in the least deprived areas of the borough. More than four-fifths of service users were female.

CHLAMYDIA TREATMENT

There are five pharmacies commissioned to deliver this service. Offering this service within pharmacies supports rapid access to treatment for NCSP service users and their partners testing positive for Chlamydia which is one of the core aims of the NCSP pathway. Treatment in pharmacies is more cost effective in comparison with treatment delivered by the ISH service. Commissioners should look to increase the utilisation of pharmacy delivered Chlamydia treatment by extending the offer beyond NCSP screening. Commissioners should also work with the data system provider to capture the demographic characteristics of service users.

ORAL-EC

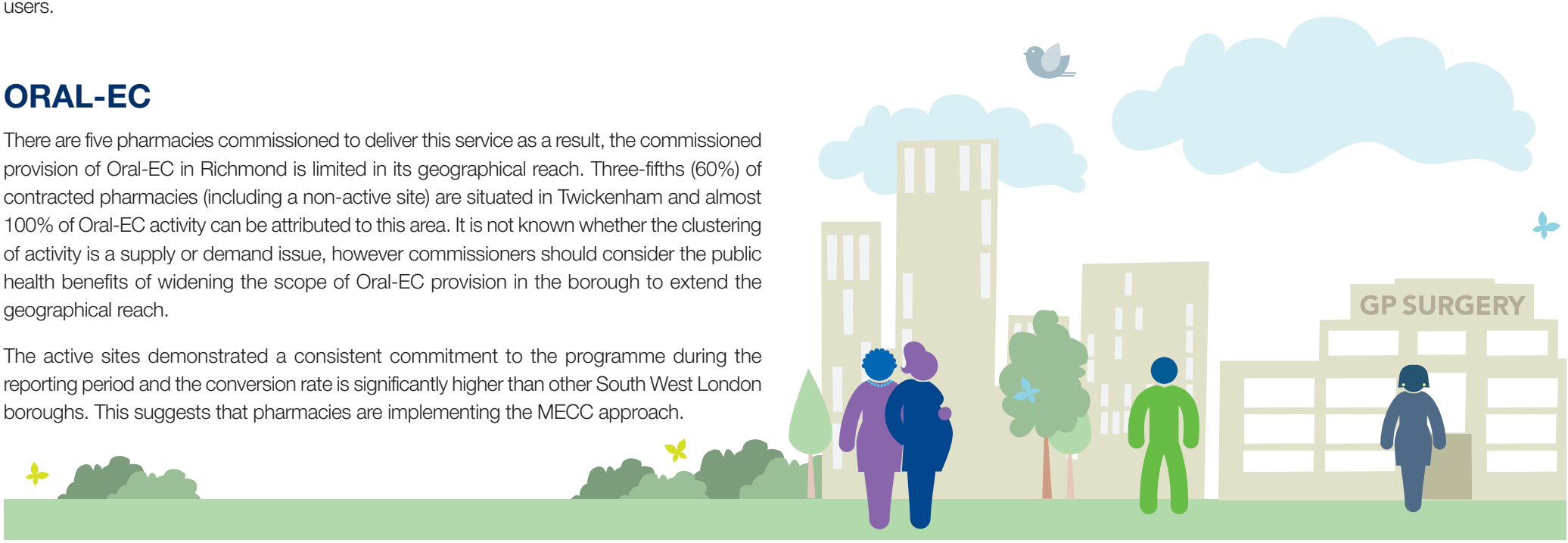
There are five pharmacies commissioned to deliver this service as a result, the commissioned provision of Oral-EC in Richmond is limited in its geographical reach. Three-fifths (60%) of contracted pharmacies (including a non-active site) are situated in Twickenham and almost 100% of Oral-EC activity can be attributed to this area. It is not known whether the clustering of activity is a supply or demand issue, however commissioners should consider the public health benefits of widening the scope of Oral-EC provision in the borough to extend the geographical reach.

The active sites demonstrated a consistent commitment to the programme during the reporting period and the conversion rate is significantly higher than other South West London boroughs. This suggests that pharmacies are implementing the MECC approach.

Almost 40% of all service users were under the age of eighteen. Of all service users 93% presented for Oral-EC within 72 hours of UPSI. The BAME population is slightly overrepresented in comparison to the borough profile for age range. Nearly 20% of service users were not resident in Richmond and almost a third were registered in the most deprived areas of the borough.

LARC

There are 20 GP surgeries commissioned to deliver this service. GP surgeries are ideally placed to deliver routine, non-complex LARC and the service is more cost effective in comparison with LARC delivered by the ISH service. However, the different LARC systems are not commissioned uniformly. Of all GP surgeries, 68% are commissioned to provide this service. There is inconsistent provision amongst contracted GP surgeries with 36% of all activity delivered by 10% of providers.



HEALTH INEQUALITIES AND ACCESS

The World Health Organization (WHO) defines sexual health as

> A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.
>
> **(WHO, 2006a)**

Sexual health needs vary according to factors such as age, gender, sexual orientation, ethnicity, socio-economic circumstances and levels of deprivation. At a national level, the impact of STIs remains greatest in young heterosexuals aged 15-24 years, black ethnic minorities and men who have sex with men (MSM). The Teenage Pregnancy Prevention Framework recognises that young people also have higher rates of abortions and outcomes for young parents and their children are still disproportionately poor.

In responding to sexual health needs, there are certain core elements common to everyone. This includes high-quality information and education and access to high-quality services, treatment and interventions. Beyond these core elements it is important to know the needs of specific individuals, communities, and populations related to sexual health and HIV.

Access to health services refers to the availability of services that are timely, appropriate, sensitive and easy to use. Inequitable access can result in particular groups receiving less care relative to their needs, or more inappropriate or sub-optimal care, than others, which often leads to poorer experiences, outcomes and health status.

Inequitable access might mean that a group faces particular barriers to getting the services that they need, such as real or anticipated discrimination or challenges around language.

Access to services can be measured by service availability and uptake. More deprived areas tend to have fewer GP surgeries per head and lower rates of admission to elective care than less deprived areas, despite having a higher disease burden.

Different social groups might also have systematically different experiences within the services that they use, either perceived or actual. This may include the quality of care received and whether they are treated with dignity and respect.

The Richmond Sexual Health Story shows that BAME users of the Oral-EC service are slightly over-represented in comparison with the borough profile for age range. More women are accessing the NCSP in primary care than men and almost 40% of Oral-EC service users were aged eighteen or under.

As the report has shown, the commissioning of sexual health services in primary care is limited in its geographical reach and there is inconsistent commissioning of LARC within GP surgeries. This means there are gaps in provision across the borough which may limit access to services in primary care.

Further information on service user demographics can be found in Appendix 3 and 4.

RECOMMENDATIONS

Sexual health services should continue to be provided in GP surgeries and pharmacies. This is to ensure that services remain accessible throughout the borough, support demand across the system and contribute to improving sexual health outcomes locally.

The commissioning of sexual health services primary care from 2020 should consider service coverage, including the limited geographical reach of Oral-EC, and inconsistencies in provision of LARC. Commissioners should also review contractual arrangements with non-active providers and those where activity was very low. Services should be placed within GP surgeries and pharmacies that are situated in areas where they are most needed, where demand is highest and provided by those who have demonstrated that they are best able and motivated to deliver services to residents consistently. Actions should be taken by commissioners to improve the data capture of LARC and Chlamydia treatment to support improvements in the monitoring of service user demographics.

For contraception, work should be done to increase the total number of prescribed LARC in GP surgeries. This means enabling opportunity to GP surgeries who are not currently contracted to deliver LARC but who have the skill and resource to do so. It also means exploring the development of contraception pathways between the ISH service into GP surgeries as well as promoting use of the inter-GP surgery referral system. GP surgeries who are not meeting the NICE recommended minimum number of insertions within a given time period should be instructed to address the issue.

Rapid access to Oral-EC in pharmacies should be maintained to support the reduction of unplanned pregnancies and repeat abortions and consideration should be given to increasing the geographical reach of this service to include areas that may be underserved. Commissioners and Public Health should also explore the high utilisation of Oral-EC in those under 18 and consider ways to promote safer sex messaging and enable ease of access to LARC and quick start oral contraception methods. Work should also be undertaken to scope scaling-up Chlamydia treatment in pharmacies beyond those screening through the NCSP.

Commissioners and Public Health should consider and respond to the demographic characteristics of service users. This includes differences in the demand and utilisation of services between male and female and BAME and White service users. Differential activity between different groups may have both positive and negative drivers. These should be better understood, and appropriate response mechanisms applied. Campaigns to promote services to young people including men should be delivered in line with the existing sexual health strategy action plan.

Qualitative work should be undertaken to compliment and contextualise the quantitative findings. Methods such as feedback from providers, consultation with service user groups, and mystery shopping exercises would add further value to the story by incorporating the patient and practitioner voice.

Commissioners should regularly assess the continually changing landscape seeking opportunities that may arise for service development and contractual delivery following the maturation of PCNs, the transformation of CCGs and implementation of the NHS Long-Term Plan. Financial resources and expertise should be optimised through cross-divisional spending agreements between public health and commissioning departments within DASCPH and collaborative commissioning opportunities with other local authorities across South West London should be scoped.

The recommendations are summarised below:

1 **Strengthen accessibility and equity of access of sexual health services in GP surgeries and pharmacies**
- Increase the number of GP surgeries commissioned to deliver LARC
- Increase the number of pharmacies commissioned to deliver Oral-EC

2 **Maximise the primary care offer for sexual health**
- Facilitate a channel-shift of routine and/or non-complex LARC from the ISH to GP surgeries
- Work with specific GP surgeries needing to increase LARC to meet NICE recommended minimum number of insertions within a given time period
- Scope commissioning of quick-start oral contraception in pharmacies
- Scope the scale-up of Chlamydia treatment in pharmacies beyond those testing through the NCSP

3 **Understand and respond to the demographic characteristics of service users**
- Improve the data capture of LARC and Chlamydia treatment
- Explore the over-representation of BAME users of the Oral-EC service
- Coordinate a campaign aimed at promoting services to young people including men in the borough

4 **Undertake qualitative work to compliment and contextualise the quantitative findings**
- Seek feedback on services from practitioners, pharmacists and practice managers
- Seek feedback from service users
- Commission or coordinate mystery shopping exercises

5 **Capitalise on opportunities that arise from the changing healthcare landscape**
- Keep abreast of any impact on sexual health commissioning models and pathways following the decision in 2020 to dissolve PHE
- Continue to link with relevant representatives from the reorganised South West London CCG
- Move in parallel with the maturisation of PCNs and explore opportunities to commission services at a PCN level

6 **Optimise use of financial resource and expertise through cross-divisional spending agreements between public health and commissioning departments within the council's DASCPH and by working collaboratively with councils across South West London**
- Implement cross-funding agreements to support any increase in primary care delivered activity following channel-shift from ISH
- Deliver on service alignment commitments with sexual health commissioners across South West London including the development of South West London service specifications, PGDs and standardised tariffs
- Scope opportunities to commission services in primary care collaboratively with councils across South West London

APPENDICES

Appendix 1: National Policy Context

Multiple stakeholders are involved in the commissioning of sexual health services, sexual health commissioning responsibilities are split between council's, CCG, and NHS England.

Across England, public sector services have been under financial pressure in recent years. There have been new innovations in sexual health which improve access and help to achieve better value for money.

In the last six years, the government has published a range of guidance for sexual health improvement including 'A framework for sexual health improvement in England' (DoH 2013), 'Commissioning Sexual Health Services and Interventions – best practice guidance for local authorities (DoH 2013), the 'National Teenage Pregnancy Prevention Framework (PHE 2018) and the LGBT Action Plan (GEO 2018). Further information can be found within the Richmond Sexual Health Strategy 2019-2024.

Appendix 2: Local Policy Context

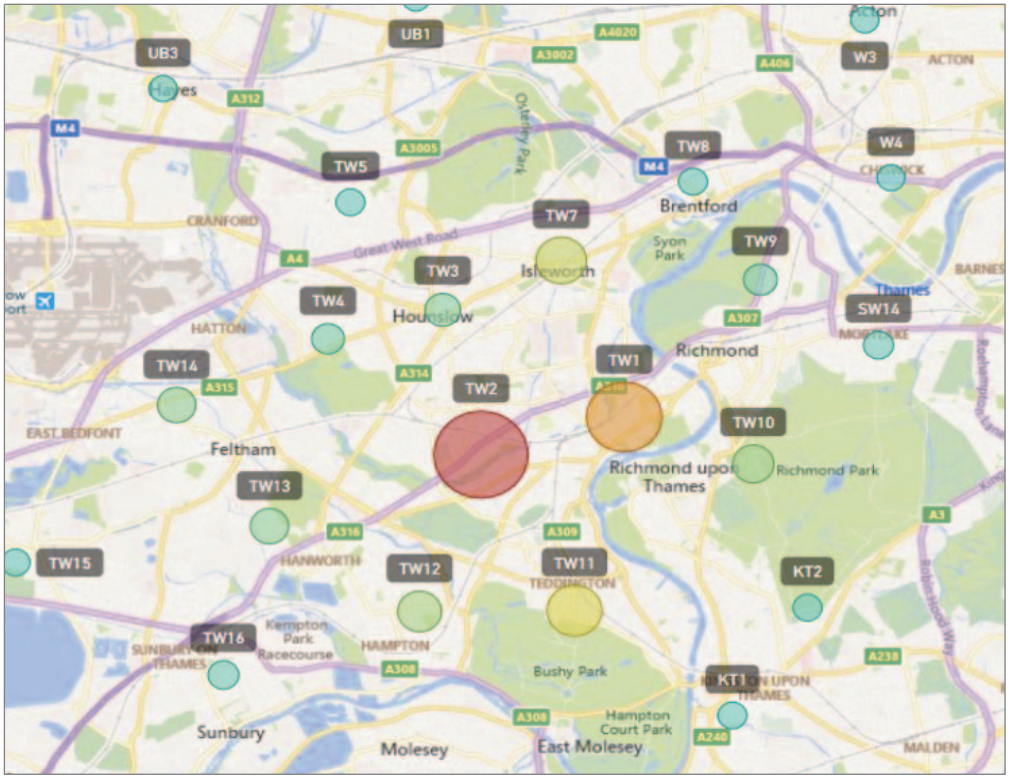
The Richmond Sexual Health Strategy was refreshed in 2019. This strategy was informed by a rapid sexual health needs assessment, engagement with stakeholders and public consultation. From this work emerged the following five priorities:

- **Priority 1:** Reduce rates of sexually transmitted infection with targeted interventions for at-risk groups.
- **Priority 2:** Reduce unintended pregnancies.
- **Priority 3:** Continue to reduce under 18 conceptions.
- **Priority 4:** Working towards eliminating late diagnosis and onward transmission of HIV.
- **Priority 5:** Promote healthy sexual behaviour and reduce risky behaviour.

In order to meet these priorities an associated action plan was developed with ownership across the local sexual health system. Included within this action plan was the development of a Richmond Sexual Health Story.

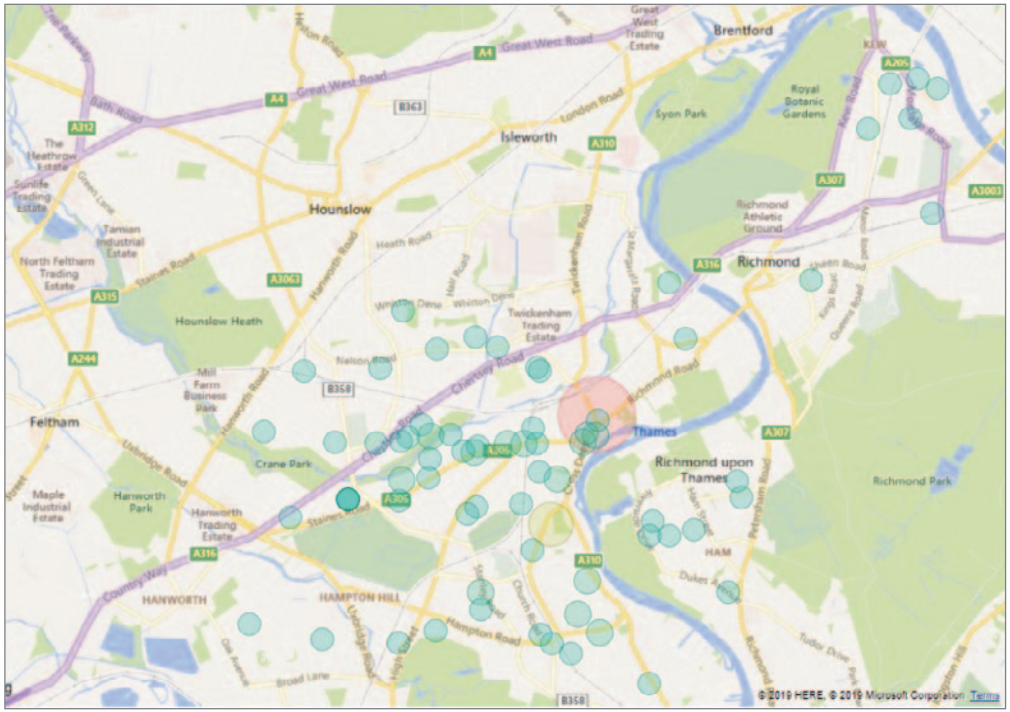
Appendix 3: Maps

Map 1 - Oral-EC activity by user postcode



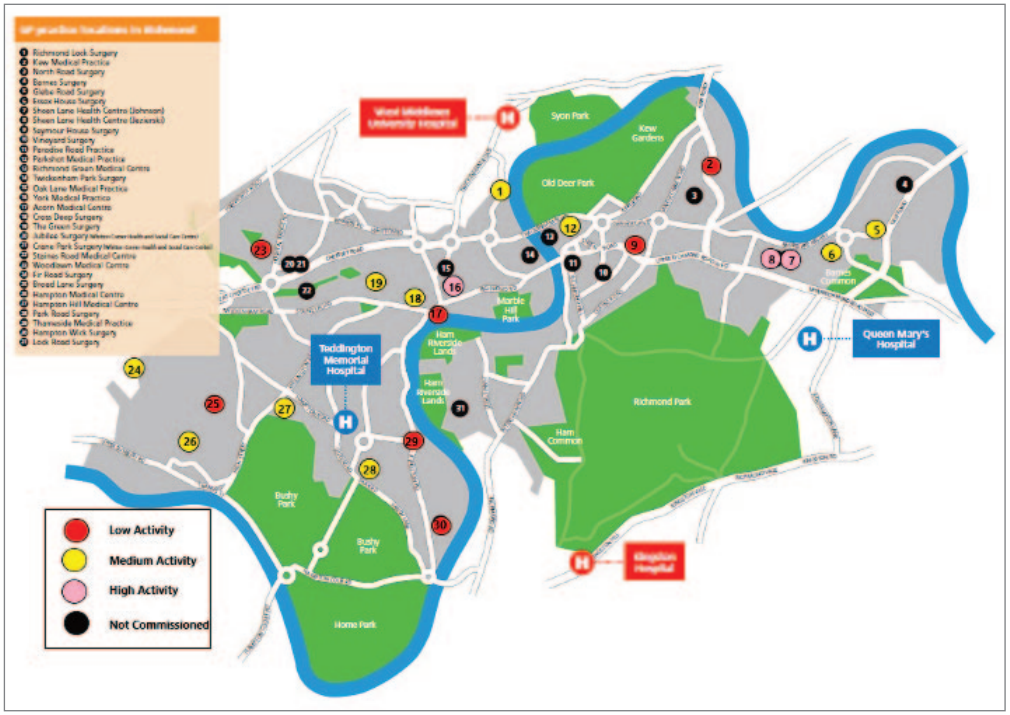
Source 1: PharmOutcomes

Map 2 - Chlamydia Screening pharmacy activity by user postcode



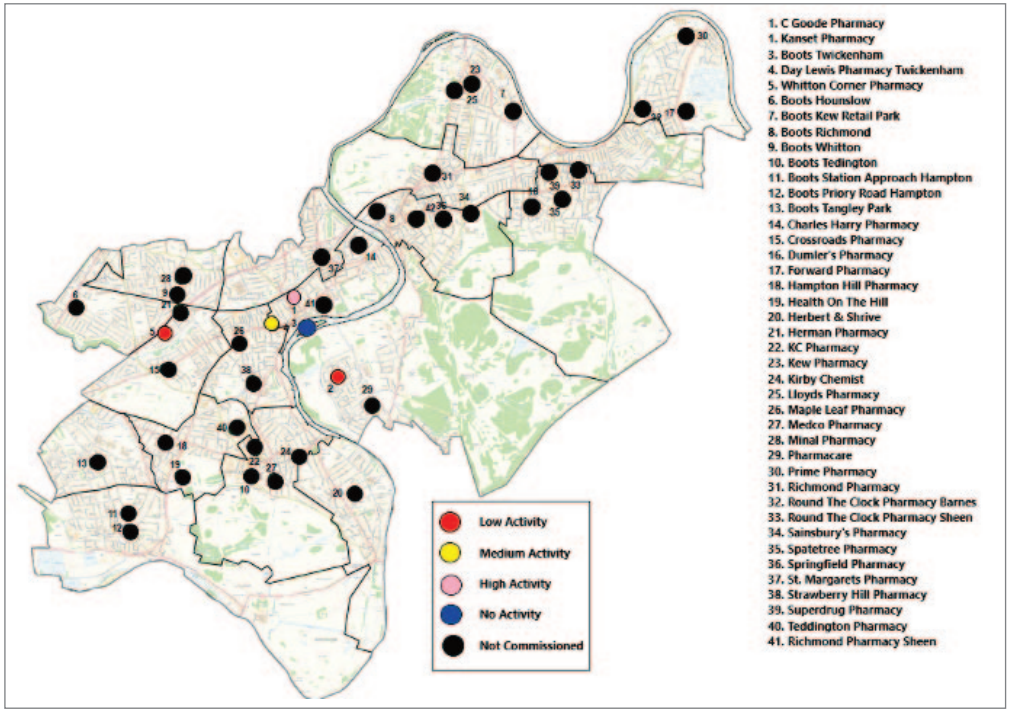
Source 2: Metro Charity

Map 3 - LARC activity by provider



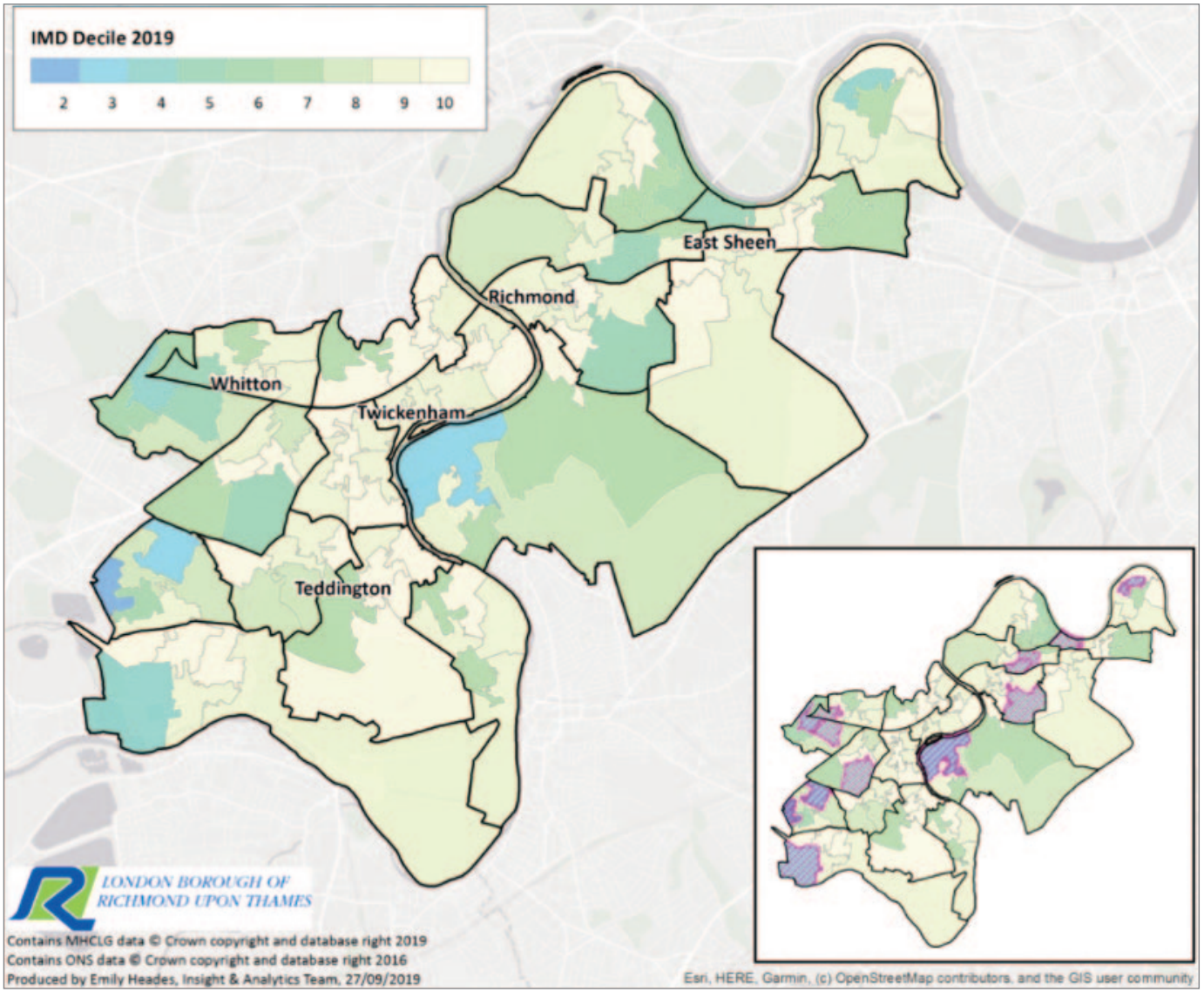
Source 3: Vision

Map 4 - Oral-EC activity by provider



Source 4: PharmOutcomes

Map 5 - Richmond LSOAs mapped by IMD decile



*The hatched areas in the inset depict LSOAs amongst the 50% most deprived in England (deciles 1-5)

Key:

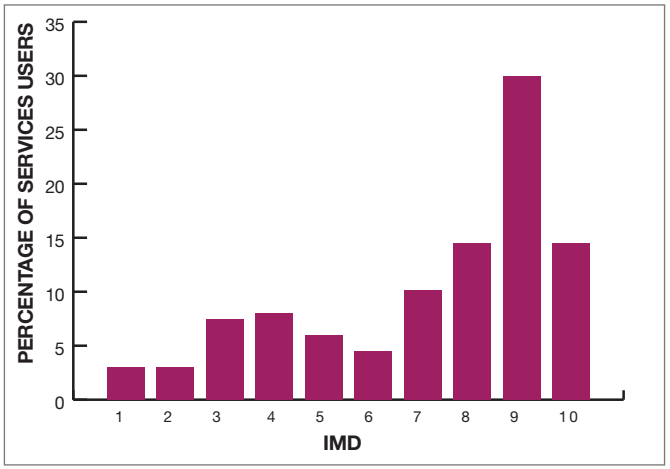
More deprived

Less deprived

Source 5: DATARICH- (Richmond Council)

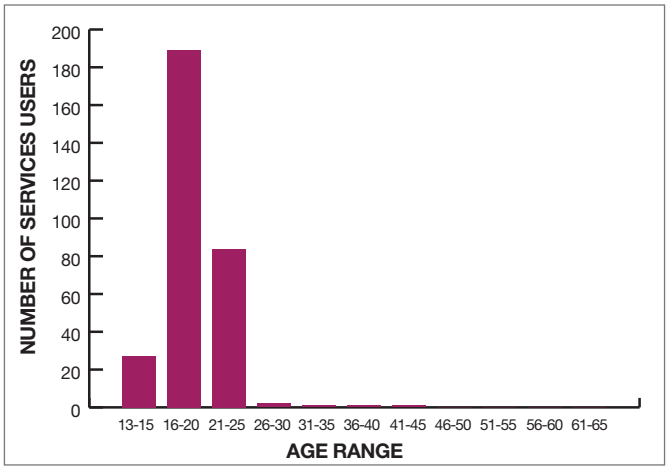
Appendix 4: Charts

Chart 1 - Oral-EC activity by user IMD



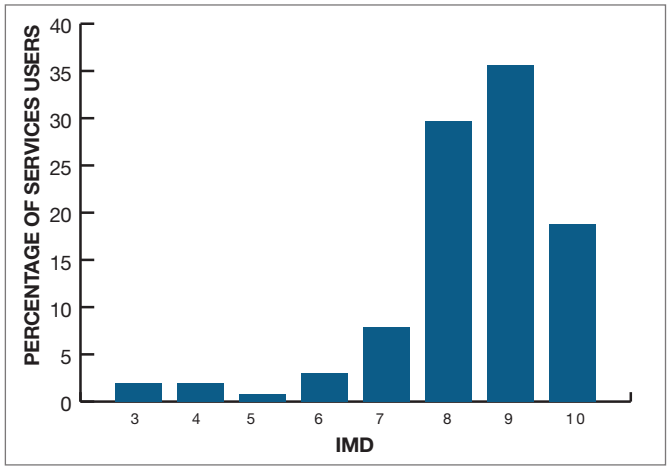
Source 6: PharmOutcomes

Chart 2 - Oral-EC activity by age



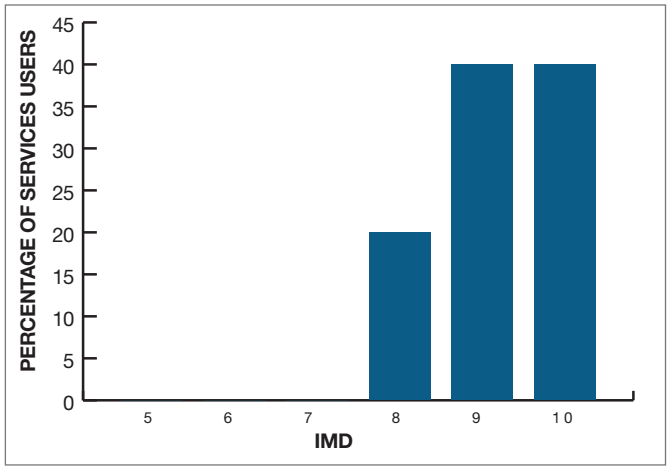
Source 7: PharmOutcomes

Chart 3 - Pharmacy Chlamydia Screening activity by user IMD



Source 7: Metro Charity

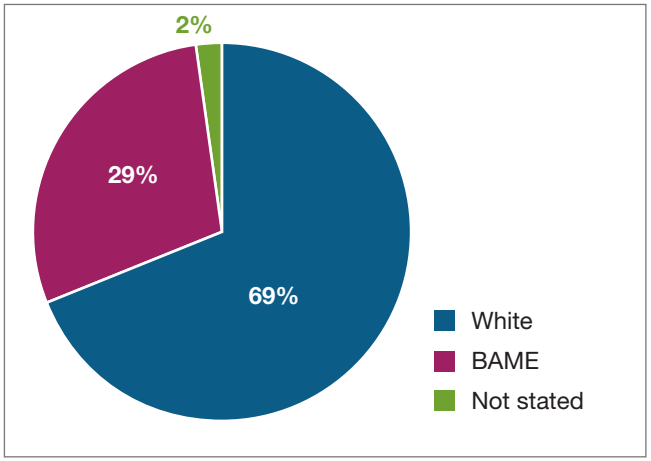
Chart 4 - GP surgery Chlamydia Screening activity by user IMD



Source 8: Metro Charity

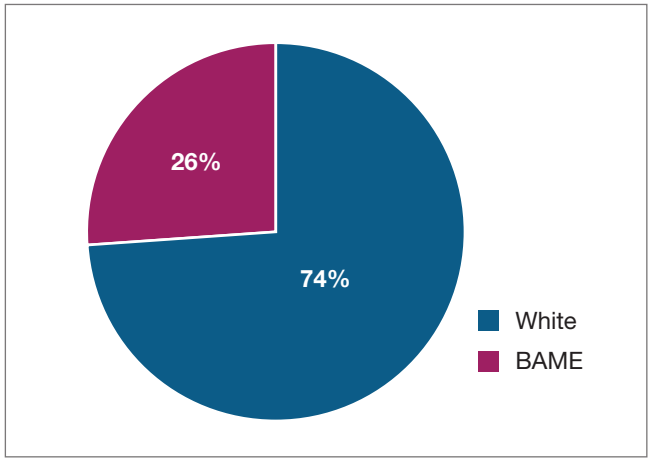
Appendix 5: Pie Charts

Pie Chart 1 - Oral-EC activity by user ethnicity



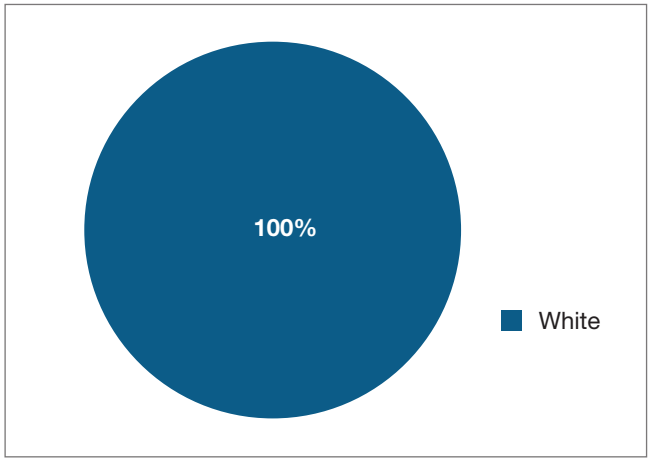
Source 10: PharmOutcomes

Pie Chart 2 - Pharmacy Chlamydia Screening activity by user ethnicity



Source 11: Metro Charity

Pie Chart 3 - GP surgery chlamydia screening activity by user ethnicity



Source 12: Metro Charity

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