

# QUARTERLY REPORT HEALTH IMPROVEMENT DIRECTORATE

March 2008

## **1.0 Overview of Report**

1.1 This report provides an update relating to three key areas of work for which the Health Improvement Directorate is the lead. These areas are;

- Chlamydia Screening Programme
- HIV
- Obesity

## **2.0 Chlamydia Screening Programme**

### **2.1 Background**

Chlamydia is the most commonly diagnosed sexually transmitted infection in the UK. It affects both sexes and is generally asymptomatic. If left untreated, infection can result in complications including pelvic inflammatory disease, ectopic pregnancy and infertility. The impact of chlamydia and its consequences is estimated to cost the NHS more than £100m per annum.<sup>1</sup>

Tackling chlamydia in young people through the National Chlamydia Screening Programme is a key commitment of the DoH white paper "Choosing Health".<sup>2</sup> In order to increase coverage of Chlamydia Screening nationally, and reduce the numbers of undetected and treated infections, a Public Sector Agreement (PSA11d) was introduced in 2006/07. This has led to Primary Care Trusts and StHA producing trajectories demonstrating how they will achieve the 15% national screening target, to opportunistic testing of 14-25 year olds; in Pan Birmingham this equates to screening 28,254 young people.

The Birmingham and Solihull Chlamydia Screening Programme (CSP) is run by a locally commissioned team based in central Birmingham. The team comprises a clinical nurse manager, nurse coordinator, chlamydia screening nurse and an administrator. It co-ordinates & implements the programme and collects data for BEN, HOB, Solihull and South PCTs. A multidisciplinary steering group oversees this work.

All participating screening sites (including primary care) have been given a start up grant of £500, then £2 per test. Sites opt whether to test and carry out treatment, follow-up and partner notification (Option 1) or test only (Option 2).

### **2.2 Current achievement**

During the first three quarters of 2007/8, CSP's chlamydia screening activity was 8,374 (from a population of 188,361 15-24 year olds). This equates to **4.45%** - less than one-third of 15% target, and is the subject of considerable concern. In BEN, a total of 2,425 screens were carried out, equating to 4.3%. This was higher than South (2,289), HoB (2,111) or Solihull (1,549) and is shown in Figure 1, below.

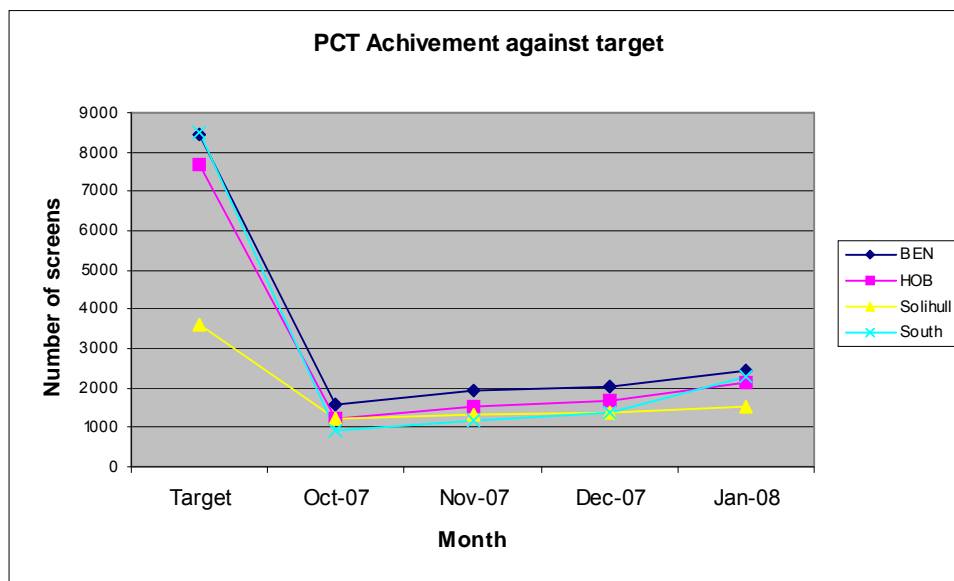


Figure 1. Total chlamydia screening achievement against annual target, by PCT, October 2007 to January 2008.

A total of 1,238 (15%) of CSP's total screens were carried out in general practice, 3,284 (39%) by Birmingham Brook, 292 (3%) by Terrence Higgins Trust, 781 (9%) by Family Planning and 2,914 (34%) at a range of other sites. The "other" sites included NHS walk-in, Healthy Gay Life, Birmingham University Guild of Students, Base K/S, Here 4 U, Solihull young peoples clinics and promotional chlamydia screening days.

It is significant that CSP's end-of-year achievement is likely to be ranked highest or second highest in the country, and no PCT in the UK is expected to achieve the 15% target. Despite this, the national target will rise to 17% in 2008-9.

### 2.3 Local GP Engagement

GP practices accounted for a relatively small proportion of total screens. Levels of engagement varied widely between practices in all PCTs.

BEN PCT achieved 665 GP screens (mean 17.5); screening numbers for individual BEN practices ranged from 0-273. In all, 19 BEN practices carried out less than 10 screens during the period.

### 2.4 Changes To Current Service

To accelerate progress towards the national target the CSP has undergone considerable process redesign to focus the service away from a delivery model solely dependant on Primary Care screening, to a community based model, delivering screening within social settings aimed at young people and including young people most at risk who do not access other testing (and treatment) services.

There has been a shared understanding as to the importance of the target, and for the last 5 months commissioners have held weekly monitoring and performance meetings with the provider arm (HoB) to ensure service delivery of the redesign model. Furthermore, commissioners have sought to accelerate numbers of opportunistic Chlamydia screens by market development; clearly these approaches have so far proved successful and have addressed a number of performance-related concerns, including:

- General under performance against target
- Low numbers of young men screened
- Lack of targeted interventions to opportunistically capture specific at risk groups
- General low numbers of young people from BME communities
- General low number of tests undertaken at family planning in Birmingham
- Disparity between numbers of tests undertaken in individual PCTs – relatively good coverage in some PCTs contrast poor test numbers in others
- Specimen type – majority cervical swab, potential under-utilisation of urine samples
- A need to establish alternative screening sites in non-clinical settings
- A need to evaluate/utilise more fully already established screening sites and build in capacity and support for these sites to do more

A number of mitigating factors that have hampered progress/performance have been recognised, and additional investment has been made available to the Chlamydia screening programme 2007/08 to support achievement of the 15% LDP target, with a commitment to further investment to achieve the 2008/09 LDP target.

## **2.5 The Way Forward**

The objectives of the CSP are to ensure that the local programme is:

- Cost effective
- Sustainable
- Accessible to all sections of the target group including vulnerable groups
- Contributing to the strategic aims & objectives of Pan Birmingham Sexual Health Strategy
- Working within parameters set by the Health Protection Agency

Clearly the learning and knowledge gained from refocusing of the programme has yielded increased numbers of tests, and this focus will be continued into 2008/09 to enable the following:

- Chlamydia Screening in clinical and non-clinical settings
- A strong youth focus designed to link primary care with youth services to ensure targeted interventions and ease of access for all young people
- Improved choice and access to sexual health services for those at greatest risk of poor sexual health
- Integration into the National Chlamydia Screening Programme
- Delivery of LDP target
- Partnership and capacity building across sectors
- Health Promotion Interventions

The expected increase in LDP target will require the current workforce in the Chlamydia screening office to focus more closely on programme delivery and organisational centre from which the program is managed delivering the following:

- Rapid non-invasive testing for Chlamydia using approved equipment and NAATS testing, based in a community setting
- Treatment for all those vulnerable clients who test positive for Chlamydia and would otherwise be lost to follow up if asked to access main stream services
- Linking in with the local CSO Partner Notification programme across the country
- Sexual health information, contraception and advice around a range of other STIs
- Referral to GUM and any other appropriate local services for clients needing further advice and management regarding sexual health
- Quality assured service providing governance to all stakeholders

A commissioners meeting was held on Thursday 14<sup>th</sup> February 2008, to consider options for the Commissioning of Chlamydia Screening Services in 2008/09. The following proposals were supported by the group:

- All Option 2 sites be removed from programme - Heart of Birmingham teaching PCT (HoB) will serve notice, however letter to General Practice must be forwarded to commissioners for approval prior to distribution.
- The appointment of a Band Seven Primary Care Worker - to actively manage Chlamydia Screening in Primary Care.
- The core team should focus on providing support, training, treatment, partner notification and governance.
- The responsibility of inputting Health Protection Agency (HPA) required data be transferred out of the Birmingham Chlamydia Screening Programme (CSP) offices to the laboratories, along with the responsibility to advice the service of all 'trace and treats' - must be included in the contract.
- A mandatory requirement - to be made explicit in the service level agreement, going forward all laboratories will operate a direct (software) link into the Birmingham CSP offices for data movement.
- If possible all GPs will be encouraged to apply stickers (to confirm that the patient has consented to this test being included in the Chlamydia Screening Programme) for all relevant Chlamydia (triple) tests they submit to the labs.
- Commissioners should secure increased numbers of Chlamydia Screens from all directly commissioned sexual health services - introducing delivery targets against which performance monitoring can be introduced - all sites to introduce Chlamydia testing as a routine to target population - opt out vs opt in.
- To continue use of 3<sup>rd</sup> Sector organisations seeking and providing opportunities for opportunistic testing.
- Screening sites in clinical and non clinical settings, at varying times including evenings and weekends to ensure best possible access, located across each PCT area.
- The Birmingham CSP will be required to submit to the lead commissioner, activity and performance monitoring data using data sets and intervals as currently agreed (fortnightly activity reports) - these will be reported to the Joint Commissioning Group on a monthly basis. This arrangement will be formalised in 2008/09 SLA.

With regard to Options for Commissioning of Chlamydia Screening in 2008/09, the following agreement was reached:

- Contract with HoB Sexual Health Directorate for the delivery of the whole 17% target, however we would look to re-tender the whole service in September 2008.

- The Chlamydia Screening Programme will be required to sub contract with 3<sup>rd</sup> Sector Providers to deliver the program.
- Tony Ruffell to pick up issues regarding under spend against budget with finance.

**References**

1. Department of Health. *Effective Commissioning of Sexual Health and HIV Services*. London: DoH, 2003.
2. Department of Health White Paper. *Choosing Health: Making healthier choices easier*. London: DoH, 2004.

**3.0 Human Immunodeficiency Virus (HIV) in BEN PCT**

**3.1 Introduction**

Acquired Immunodeficiency Syndrome (AIDS) was first recognised in 1981. The Human Immunodeficiency Virus (HIV) can develop into AIDS. Most commonly passed on by sexual contact, the virus attacks infection-fighting cells of the immune system which eventually weakens and becomes unable to defend the body against bacteria, viruses and germs.<sup>1</sup> HIV is a life-threatening and incurable condition, though drug therapies have improved and prolonged the lives of many.<sup>2</sup>

In 2001, the National Strategy for Sexual Health and HIV<sup>3</sup> set out aims for tackling HIV, and an Implementation Action Plan<sup>4</sup> included goals for reducing the transmission of HIV and prevalence of undiagnosed HIV and STIs, reducing unintended pregnancies, improving health and social care for people with HIV and reducing stigma. Further HIV related guidance has since been published.<sup>5</sup>

**3.2 Epidemiology**

**3.2.1 Incidence**

HIV Incidence means the number of new HIV diagnoses. In BEN PCT, incidence peaked at 50 in 2004, falling gradually thereafter to 23 in 2007 (Figure 1). Because of the fairly long lag between diagnosis and reporting, these data remain provisional for a fairly long time. Numbers of cases for 2006 are likely to rise as further reports are received, and 2007 data are still incomplete.

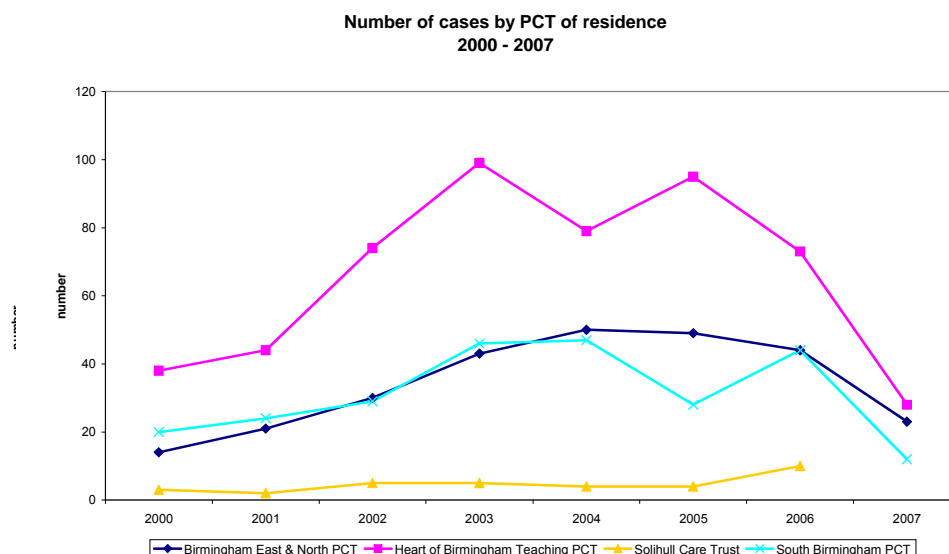


Figure 1. - Number of new HIV diagnoses 2000-2007 Birmingham & Solihull, by PCT (2007 data missing for Solihull).

Incidence is declining in all PCTs except Solihull, where it remains low. The majority of cases have historically been in males, though in 2007, BEN females outnumbered males by 14 (61%) to 9 (39%). Most cases were diagnosed in the 25-34 age group, followed by 35-44; there were similar numbers in both the 20-24 and 45-54 age groups. The highest number of cases were diagnosed in Black African residents, followed by Whites. Almost 60% of HIV was transmitted through heterosexual intercourse, and almost 30% through MSM (sex between men).

**3.2.2 Prevalence**

HIV prevalence refers to the number of people living with HIV (Figure 2). Improved therapies have led to longer survival, and thus higher prevalence. Prevalence is currently 274 in BEN PCT, and rising in all PCTs. In BEN, prevalence has trebled since 2002. In Figure 3, darker areas represent higher HIV prevalence. Five distinct high prevalence and two higher prevalence areas can be seen, mainly within BEN and HoB PCTs. Areas of highest prevalence within BEN include Kingstanding, Erdington and Stockland Green. It is significant that the areas of high and very high prevalence cross more than one Ward – analysis on individual Ward numbers would therefore be misleading. In all, 60% of BEN’s prevalent cases were in males, in contrast with only 39% of incidence. Around 60% of prevalent males were White, while 60% of females were Black Caribbean.

Around 42% of prevalent cases were aged 35-44, followed by 25-34 (27%) and 45-54 (15%) – this contrasts with the age groups of incident cases. There is a far higher rate (per 10,000) of Black African residents living with HIV than any other ethnic group.

Diagnosed HIV patients by PCT of residence and survey year

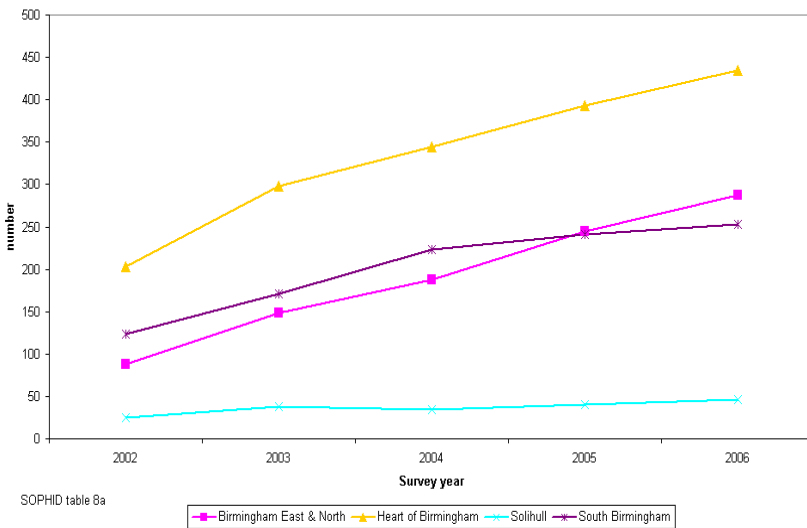


Figure 2. Diagnosed HIV-infected patients in contact With services, by PCT and year.

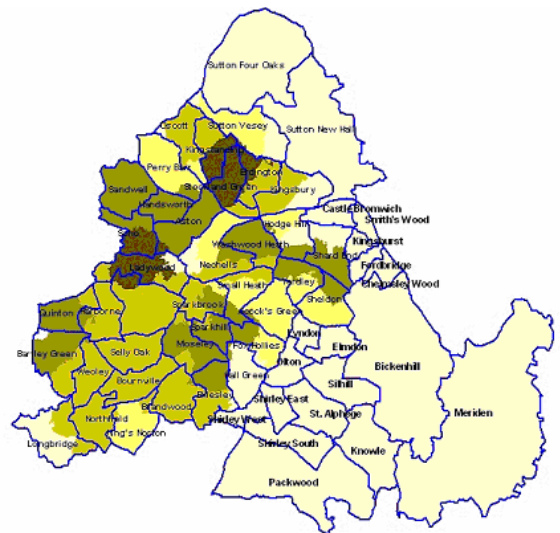


Figure 3. Diagnosed HIV-infected patients by postal district of residence 2006. Source: SOPHID Numbers in Wards withheld, to protect patient anonymity

### **3.3 Access to services**

BEN PCT's HIV services are commissioned through the Birmingham & Solihull Sexual Health JCB.

#### **3.3.1 Primary Care**

GPs do not generally offer specialised HIV services, though North Birmingham Sexual Health Clinic (NBSHC) operates from the Oaks Practice and Streetly Road Surgery. Clients can self-refer to either site or go through their GP. A number of practices are also part of the Sexual Health in Practice (SHIP) scheme, which provides extra sexual health training for GPs, nursing and reception staff.

#### **3.3.2 Secondary Care**

HIV medical services are provided mainly through HEFT and UHB. Genito-Urinary Medicine clinics offering HIV testing and treatment are located at Hawthorn House and Whittall Street Clinic. Over 55% of BEN residents received their HIV care from HEFT, with most of the remainder from UHB. Most children with HIV are treated by HEFT.

#### **3.3.3 Social Care and Voluntary Agencies**

HIV Specialist Social Workers are based at both hospitals. Social care services used most often included emotional support, counselling referral, and advice on benefits, housing & finance. A wide range of services from voluntary agencies are available, some of which cater for specific population groups. Those accessed most frequently by BEN residents were Freshwinds, Terrance Higgins Trust and Barnardo's SOFAH project. Women and those aged <20 were more likely to access voluntary HIV services, while MSM were far less likely.

#### **3.3.4 Health Promotion**

The Sexual Health Promotion Service based at St Patrick's Centre provides a range of activities including the World Aids Day campaign. SHIP trains doctors and nurses to deliver HIV-related health promotion, and several of the voluntary agencies also provide this.

### **3.4. Drug Treatment**

HIV is now a long term condition, so more patients will need expensive drugs for longer, which will increase cost pressures. This is, however, less expensive than costs of frequent hospitalisation and treatment of AIDS defining illnesses. Most BEN residents on antiretroviral drugs received triple therapy. Post-exposure prophylaxis after sexual exposure was provided by both hospitals, in accordance with local protocols.

### **3.5 Secondary Care Activity**

Treatment activity is rising year-on-year. HEFT treated 166 patients during 2006, and UHB saw 102. Numbers for both Trusts have increased threefold since 2002.

### **3.6 Service User Views**

Healthy Gay Life (HGL) undertook a user satisfaction survey in 2006. No other such work appears to have been done, though some providers have indicated that they are planning surveys in the future.

### **3.7 Late Diagnosis of HIV**

The CMO recently recommended that HIV testing should be offered and encouraged in all healthcare settings.<sup>6</sup> It is estimated that late diagnosis accounts for >35% of HIV-related deaths and 31.7% of UK HIV infection is undiagnosed.<sup>6</sup> This is higher in heterosexual men (37.3%), especially those not born in Africa (44.8%).<sup>7</sup> The proportion of patients severely immunosuppressed at presentation (a marker of late diagnosis) fell from 34.3% in 2000 to 27.9% in 2007, though Black African and Black Other ethnic groups were more likely to present with severe immunosuppression than White or Pakistani ethnic groups. Patients attending GUM clinics are at particular risk of HIV, and offering testing in this setting is especially important. HIV testing in primary care can speed up referral to specialist services.

### **3.8 Expenditure on HIV services**

BEN PCT will spend around £3m on HIV services during 2007-8. All costs are rising year-on-year. HIV drugs for BEN residents cost almost £2.1m in 2006-7. Additional investment has increased substantially between 2005-7. A substantial overspend of around £180,000 on HIV drugs is predicted for 2007-8 for BEN.

The annual pathology cost of a new patient at HEFT is currently £2,127, and £1,488 for existing patients. The average cost of access in voluntary agencies ranged from £155 to £741. A total of 17 HIV patients were seen in primary care (NBSHC) at an average cost of £212.64; this is considerably less than the 2005/6 national average of £655.

### **3.8 Recommendations**

The current model of HIV care and service provision appears to be appropriate, though rising prevalence means it will be inadequate for future needs. No significant mismatch of services by population group or geography is evident. There is little to suggest that secondary care resources are being used inefficiently.

The following actions have been recommended to the Sexual Health JCB:

- Ensure that funding is adequate for future demand, especially regarding drug costs.
- Determine, identify and target specific population groups for prevention.
- Agree and implement targets and indicators for early diagnosis of HIV, especially people in high risk groups. Encourage general practices to offer opportunistic HIV screening to patients presenting for sexual health related conditions.
- Ascertain user views on all HIV services — both NHS and voluntary agencies.

#### **References**

1. NHS Direct (2007). *HIV and AIDS*. Online at: <http://www.nhsdirect.nhs.uk/articles/article.aspx?articleid=196> Accessed 12/09/2007.
2. DoH (2007). *HIV*. Online at: <http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/HIV/index.htm> Accessed 12/09/2007.
3. Department of Health (2001). *The national strategy for sexual health and HIV*. DoH, London.
4. Department of Health (2002). *The national strategy for sexual health and HIV implementation action plan*. DoH, London.
5. Department of Health (2004). *Children in need and bloodborne viruses: HIV and hepatitis*. DoH, London.
6. Chief Medical Officer (2007). *Improving the detection and diagnosis of HIV in non-HIV specialties including primary care*. DoH.
7. The UK Collaborative Group for HIV and STI Surveillance (2006). *A complex picture. HIV & other Sexually Transmitted Infections in the United Kingdom: 2006*. London: Health Protection Agency, Centre for Infections.

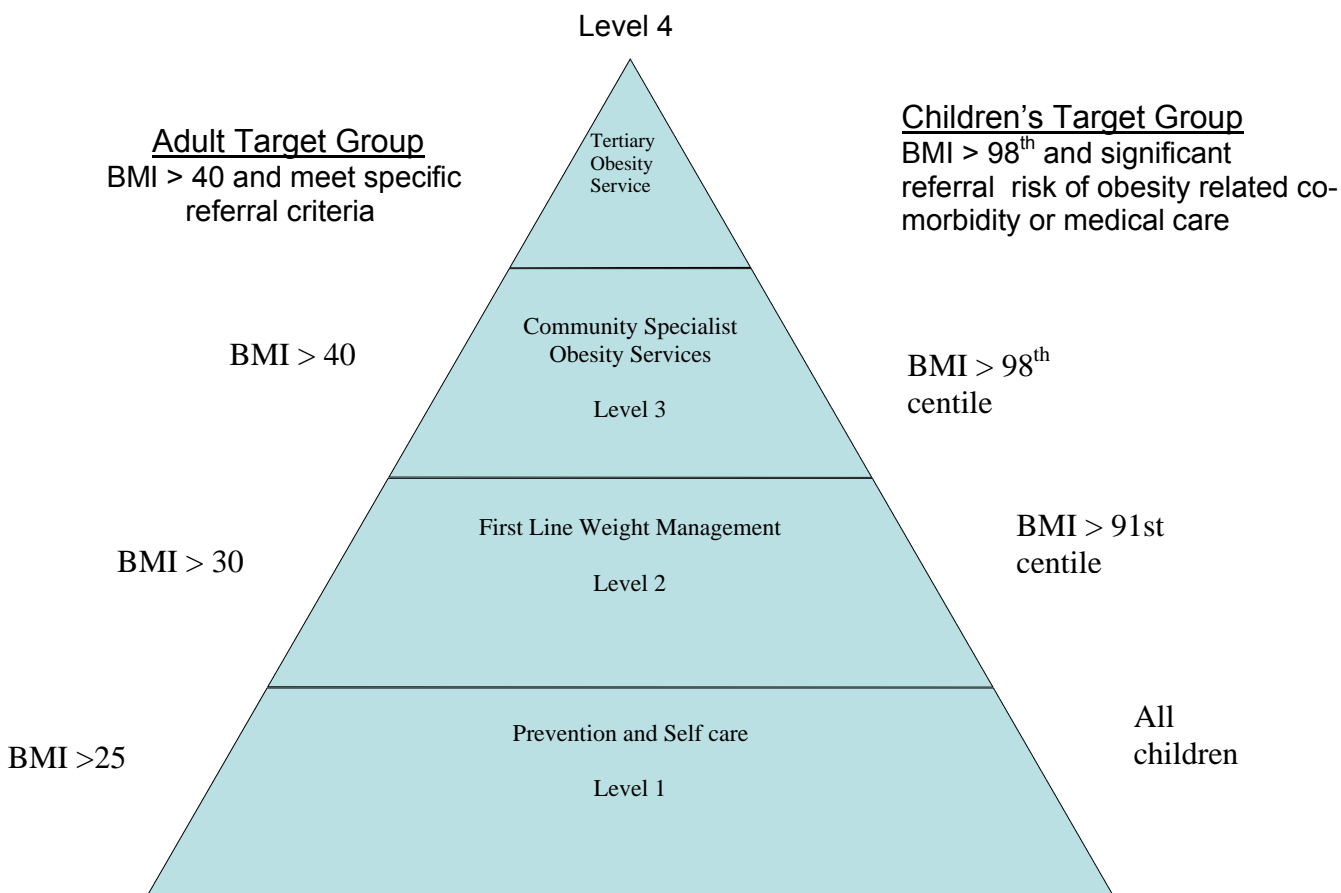
**4.0 Obesity**

**4.1** Obesity has become a key priority for PCTs. The prevalence of obesity is increasing in adults and in children such that nationally almost 23% adults and 15% children are obese. A recent report by Foresight, the Government Think Tank estimated that if no action is taken to address the epidemic of obesity, 90% of adults and 66% of children will be overweight or obese by 2050. Obesity has significant health, psychological, social and economic costs to individuals and the nation.

The Government published Healthy Weight, Healthy Life: A Cross-Government Strategy for England to tackle obesity in January 2008. This report recognised the multi-agency response required to reduce the obesity epidemic and set out plans to tackle the problem at all levels to achieve the PSA target of reducing the proportion of overweight and obese children to 2000 levels by 2020 in the context of tackling obesity across the population.

**4.2** Birmingham East and North PCT has a strategic framework for the prevention and management of obesity, which includes care pyramids for adult and childhood obesity.

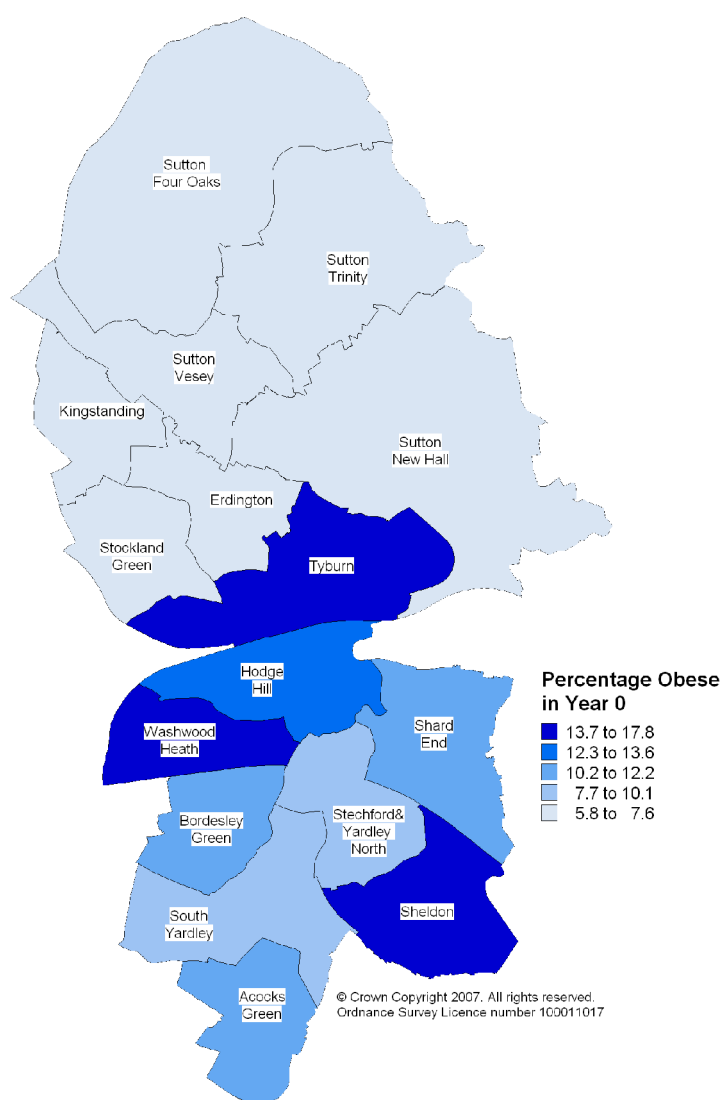
Both care pyramids have 4 levels:

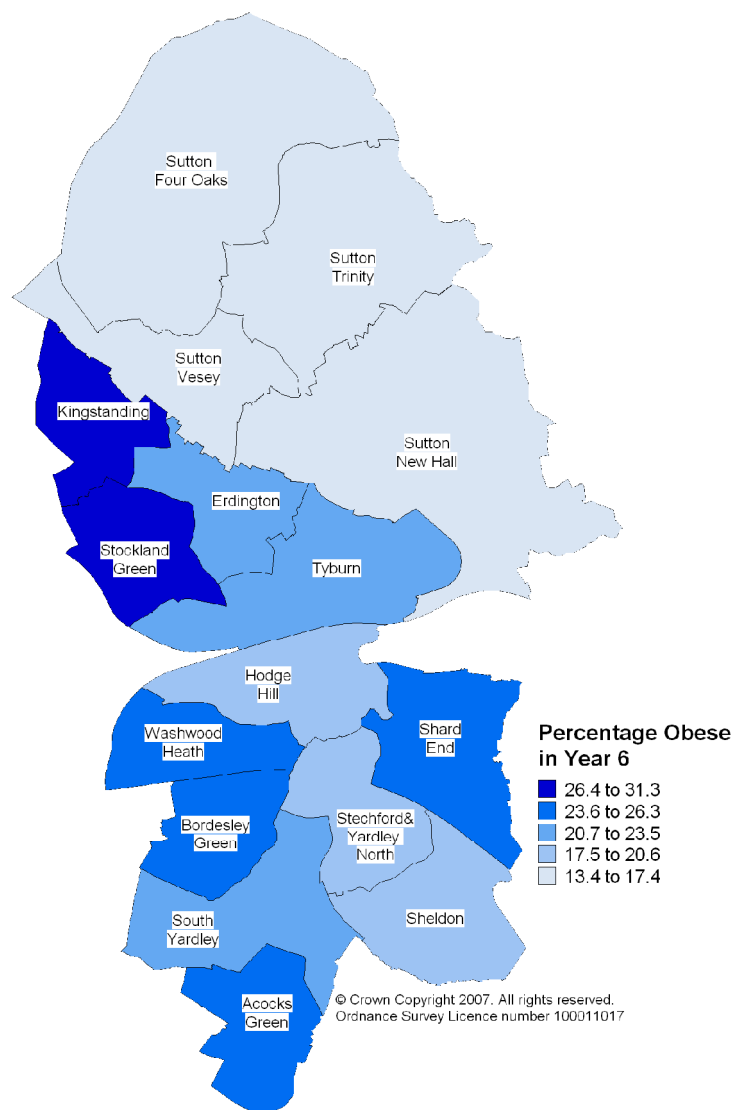


### 4.3 Examples Of Services Being Developed Within The PCT To Tackle Obesity

#### 4.3.1 Childhood Obesity

The PCT measured the height and weight of 87% of school children in reception year and year 6 as part of the National Child Measurement Programme. This measurement rate was above target and has provided for the first time local data on obesity prevalence in children, however, the results are alarming, 10% of children in BEN PCT start school obese and 20% are obese by the time they reach year 6 (10-11year olds). The following maps show the breakdown by ward.





**4.4** The PCT has agreed to fund three new services to contribute to addressing this:

**4.4.1 Villa Vitality**

Villa Vitality supports the prevention of obesity in children by working in partnership with schools, the Health Education Unit, Heart of Birmingham PCT and Aston Villa Football club. 60 school children per week (one day per week) go to Villa Park where they will participate in fitness coaching sessions, healthy eating activities, healthy cooking session and a healthy lunch before developing and recording a radio programme on what they have learned. A teacher pack with follow up activities in schools builds on the enthusiasm and learning.

The project objective is to ensure that 2160 school children per year within BEN PCT area receive a full day's tuition, outside of the school environment, in aspects of:

- healthy lifestyle
- diet and nutrition
- physical activity
- anti-smoking

The initiative uses football as the motivating factor and assists children to produce and record their own short radio show based around the above key areas in partnership with 'The Villain' Radio Station.

This initiative has just secured further funding from the football association premier league over the next 3 years. This will enable the programme to be further developed to a two day programme with a school project in between to facilitate learning being embedded into the curriculum. This support from the FA will also fund a villa vitality bus which will visit schools between visits to Villa Park to maintain enthusiasm, undertake outreach activities in schools and engage with parents

The programme will be evaluated using tools developed with support from Coventry University.

#### **4.4.2 Schools Nutrition Post**

The PCT Has agreed to invest in a post to support schools to develop a whole school food policy. This post will quality assure and evaluate Villa Vitality as well as building on the enthusiasm created by Villa Vitality to support schools to implement sustainable initiatives to create a healthy school environment.

#### **4.4.3 Service To Treat Obesity In Children**

The PCT will be establishing a weight management service for obese children and their carers. This service will provide group and individual support addressing diet, physical activity, and self esteem using a behavioural approach. Similar services elsewhere in the UK have demonstrated a sustained reduction in body mass index.

#### **4.5 Adult Obesity.**

##### **4.5.1 Specialist Obesity Service**

In 2006 the PCT developed a specialist obesity service for people with a body mass index over 40 who had tried to lose weight without success. Many of the referrals to this service are for people who have an emotional relationship with food. The service is run by a specialist dietitian, a psychologist and a GP with an interest in weight management. Results after 1 year indicate an average weight loss of 11%. Client satisfaction is also good with 86% of patients believing that this service has allowed them to achieve what they wanted to achieve and 92% of patients stating that they would recommend this service to others.

#### **4.5.2 Pilot Of Weight Watchers On Referral**

There is a recognition that different services work for different individuals and the PCT is trying to ensure a range of options are available to support local people to lose weight. As part of expanding the range of services, the PCT has just started a pilot of weight watchers on referral. This will be compared to current NHS services in terms of effectiveness, value for money and client satisfaction.

#### **4.5.3 Development Of Weight Maintenance Service**

Supporting people to lose weight is only effective if they are able to maintain weight loss. A frequent pattern is for people to lose weight but then regain. The PCT has plans to work with Birmingham Own Health to develop a weight maintenance service to support those who lose weight to maintain that weight loss.

#### **4.6 Prevention of Obesity**

NHS services aim to support the population to avoid weight gain and to help those who are obese to lose weight. The PCT is also contributing to work with other agencies to create an environment less conducive to the development of obesity.