Salford NHS
Primary Care Trust

The Salford Sexual Health Strategy 2006 to 2010

Acknowledgements

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Executive Summary

Sexual health is a significant public health priority in the United Kingdom (UK), and, against a background of rising incidence of the Human Immunodeficiency Virus (HIV) and sexually transmitted infections (STIs) and family planning services not meeting demand, there is a strong national policy imperative driving change in sexual health services. Sexual health represents a significant health inequality in Salford, and local drivers include the need for a greater understanding of need, equity and demand, and population changes which necessitate a responsive service. The consequences of poor sexual health can be serious. Unintended pregnancies and STIs can have a long lasting impact on people's lives. The number of visits to genito-urinary medicine (GUM) clinics nationally has doubled over the last decade and now stands at over a million a year. In Salford GUM capacity has been significantly less than that required to meet expected demand.

This report presents a clear and responsive strategic approach to sexual health, reflecting the vision of Salford Primary Care Trust's (SPCT), with five focused strategic objectives, and highlights the needs of particular groups, particularly Salford's gay and bisexual community.

The strategic aims are:

1. To improve the sexual health of the population of Salford as a whole.
2. To narrow sexual health inequalities.

The practical objectives are:

1. To reduce the transmission and prevalence of HIV and STIs by focusing HIV prevention and sexual health promotion that also prevents unintended pregnancy, on local need.
2. To provide high quality, comprehensive integrated sexual health services for Salford people that reduce stigma and are supportive to sexual well-being.
3. To link to the Teenage Pregnancy Strategy to ensure sexual health services are accessible to young people and dedicated teenage sexual health services are networked into the whole.
4. To commission appropriate specialist HIV services.
5. To provide adequate and equitable access to NHS Termination of Pregnancy (TOP) services

Salford has a particularly high incidence of HIV and STIs, and epidemiological data suggest that, with the exception of syphilis in men, the incidence of STIs in Salford is currently well controlled, albeit against a background of historically high rates.

With effective and efficient commissioning, sexual health services in Salford will be provided through an integrated "hub and spoke" model which will maximise the potential of available resources and provide the right treatment to the right people at the right time and place. Young people will benefit from a restructured programme approach implemented through appropriate networks. Prevention strategies, community-based interventions and pro-active screening programmes will be at the heart of activity.

Progress towards teenage pregnancy targets is steady, and continued and developing action through the networked service is required if Salford is to meet national targets.

HIV represents a particular challenge, as patients live longer and the resource required to treat them increases. Local services, split between the voluntary and statutory sectors, are comprehensive.

Introduction

There is no part of the UK that is unaffected by HIV and other sexually transmitted infections, although there are large differences in the impact of the infections in different areas of the country. While the incidence and prevalence of HIV, gonorrhoea and syphilis vary considerably, the more common STIs such as chlamydia, genital warts and herpes simplex virus are much more uniformly distributed. Regional differences in HIV infections and STIs highlight the importance of the contribution of local services to prevention.

A recent report from the Health Protection Agency (HPA), the body responsible at a national level for communicable disease control, made the following conclusions: (1)

- There is a continuing high incidence of STIs in young people.
- There is increasing prevalence of HIV infection, especially in men who have sex with men and in persons from sub-Saharan Africa.
- There is evidence that heterosexual transmission of HIV within the UK is increasing.
- Rapid access to diagnostic and treatment services for STIs remains a major problem with less than half of all genitourinary medicine clinic attendees being seen within the recommended 48 hours.
- There has been steady progress with some major screening and prevention initiatives.
- The priority being given to the prevention of sexually transmitted infections including HIV is wholly justified by the high and still rising costs of treatment, and by the severe social costs, especially among poor and marginalised communities.
- Transmission of HIV and STIs are not being controlled by current efforts.
- More needs to be done at a local and at a national level if we are to prevent these infections.

For the purpose of this strategy, sexual health is not only concerned with disease or infection but with promoting positive sexual health in a wider context inline with the following definition by the World Health Organisation (2).

"A state of physical, emotional, mental and social will-being related 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."

This definition acknowledges the need to consider family planning as part of the sexual health agenda. Approximately 4 million people in the UK use family planning services each year. Roughly three quarters see a GP and the remainder attend specialist family planning clinics. NHS Family planning services are available, free of charge, to all those in need, regardless of gender [(3)]. Contraception contributes to better maternal and child health and to the stability of family life. Contraceptives are available on the National Health Service (NHS) without a prescription charge. The cost benefit of family planning services has been estimated at £11 for every £1 spent [(2)].

Specialist Family Planning Services currently do not meet demand. There are a number of factors that contribute to this situation for example, the number of male general practitioners, where the majority of women seeking contraceptive advice would prefer a female practitioner. There has been little or no research in to demand for Family Planning Services. The Faculty of Family Planning and Reproductive Health Care (FFPRHC) of the Royal College of Obstetrics and Gynaecology noted that the majority of funding attached to the "National Strategy for Sexual Health and HIV" and "Choosing Health" may be used to cut waiting times in acute services. Salford PCT will be the first area in Greater Manchester to address the problems faced by Family Planning Services delivering integrated community based service sexual and reproductive healthcare in line with national policy, best practice, health needs and evidence based clinical practice.

Erectile dysfunction occurs in 10% of men, with prevalence rising to over 50% in men aged over 50. It is also associated with some diseases such as diabetes mellitus. A number of effective interventions are available to manage this condition [(4)]. The decision has been made to include Erectile Dysfunction and Psychosexual services in the integration and this will allow a true "one-stop" service for all aspects of sexual health. Erectile Dysfunction and Psychosexual medicine are low volume, part-time services that will be supported by the availability of staff from the rest of the new service. Although they are important, they are not central to service redesign within Salford.

SECTION 1

STRATEGIC VISION AND OBJECTIVES

1.1 Strategic Vision

This strategy incorporates elements of both traditional *rational* planning, i.e.:

- Where are we?
- Where do we want to be?
- How do we get there?

- and also more contemporary *strategic* planning, i.e.:

- Recognising and addressing problems as they emerge
- Having a clear vision based on explicit and shared values
- Designing systems to cope with uncertainty
- Valuing participation

As an organisational strategy, this report communicates the strategic principles of the organisation:

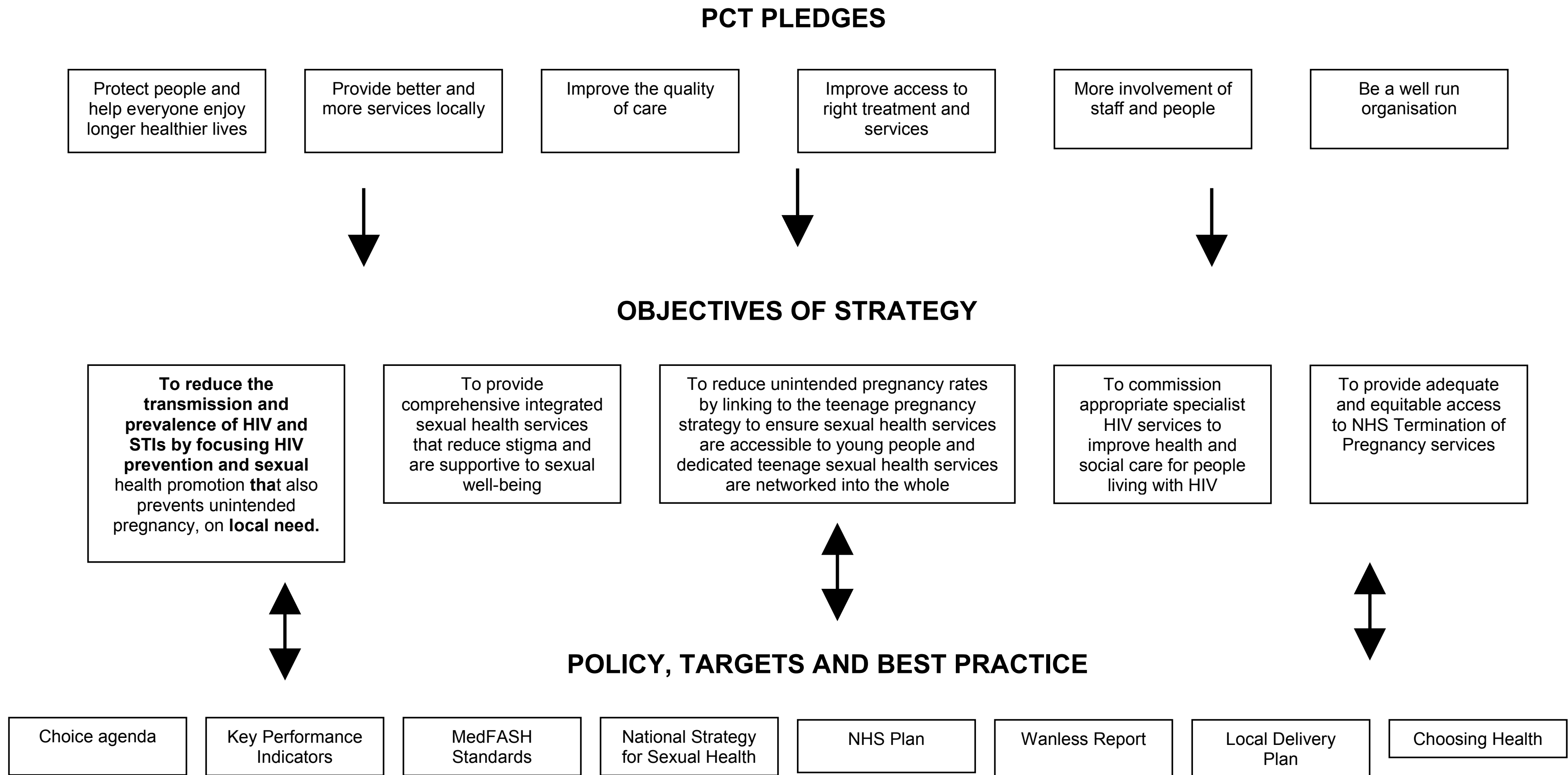
1. Commitment to partnership working
2. Health improvement
3. Improved services
4. Tackling health inequalities

The development and implementation of this strategy are focused on achieving these principles through a framework based on the PCT's six pledges, i.e. to:

1. Protect people and help everyone enjoy longer healthier lives
2. Provide better and more services locally
3. Improve the quality of care
4. Improve access to right treatment and services
5. More involvement of staff and people
6. Be a well run organisation

Figure 1 demonstrates how these pledges inform the core objectives of the strategy and how the objectives address the requirements of the key policy documents and standards. It is important to understand the importance of assessment of need, analysis of available resources and identification of the most appropriate partners in the making this process successful.

Figure 1 **The Strategic Planning Process**



1.2 Objectives

The broad strategic objectives of this strategy are:

- a) **To improve the sexual health of the population of Salford as a whole**
- b) **To narrow sexual health inequalities.**

The practical objectives of the strategy are:

- a) **To reduce the transmission and prevalence of HIV and STIs by focusing HIV prevention and sexual health promotion that also prevents unintended pregnancy, on local need.**

- b) **To provide high quality, comprehensive integrated sexual health services for Salford people that reduce stigma and are supportive to sexual well-being**
- c) **To reduce unintended pregnancy rates by linking to the Teenage Pregnancy Strategy to ensure sexual health services are accessible to young people and dedicated teenage sexual health services are networked into the whole**

- d) **To Commission appropriate specialist HIV services to improve health and social care for people living with HIV**
- e) **To provide adequate and equitable access to NHS Termination of Pregnancy (TOP) services, that are safe, legal and guideline driven.**

Objective a) - To reduce the transmission and prevalence of HIV and STIs by focusing HIV prevention and sexual health promotion that also prevents unintended pregnancy, on local need.

<u>Prevention outputs</u>

- Local community based prevention initiatives and health improving programmes of work linked to:
    - Locally supported national education campaigns
    - Local co-ordinated education campaigns based on evidence
- Evidence-based prevention initiatives with specific at risk groups (gay men and lesbians, young people, sex workers, drug users) with local campaigns and outreach work
- Comprehensive links to the Salford Teenage Pregnancy Strategy

<u>Screening and Protection Outputs</u>

- Local Chlamydia screening programme
- Hepatitis B vaccination programmes
- Maximum opportunities for HIV testing to reduce undiagnosed HIV infection
- HIV outreach services as appropriate

Objective b) – To provide high quality, comprehensive integrated sexual health services for Salford people that reduce stigma and are supportive to sexual well-being

<u>Outputs for local integrated sexual health services</u>

- Information on local services to promote equitable access (clinical care available, when and where services are provided, pathways of care and access criteria)
- Integration of local specialist services (GUM, Family Planning, Teenage Pregnancy Team, HIV services, young peoples clinics, erectile dysfunction/psychosexual medicine, termination of pregnancy)
- Teenage P
- pregnancy services to network with other services through appropriate pathways

Objective c) – To reduce unintended pregnancy rates by linking to the Teenage Pregnancy Strategy to ensure sexual health services are accessible to young people and dedicated teenage sexual health services are networked into the whole

Outputs

- Dedicated teenage pregnancy services networked into sexual health services e.g. meeting clinical governance framework, part of care pathways
- Sexual health services appropriate for teenagers

Objective d) - To Commission appropriate specialist HIV services to improve health and social care for people living with HIV.

Outputs

- Sector approach to service delivery and spread of good practice
- Clear commissioning arrangements for HIV treatment and care both locally and on a zonal basis
- Clear commissioning arrangements for funding of HIV treatment and care managed locally or at the specialist centre

Objective e) - To provide adequate and equitable access to NHS Termination of Pregnancy (TOP) services, that are safe, legal and guideline driven.

Outputs

- Equitable and timely access to services
- Clear referral pathways
- Monitoring and audit of referral pathway

SECTION TWO

SEXUAL HEALTH IN SALFORD

2.1 Data issues

Any study of the incidence and prevalence/epidemiology of disease is to a degree dependent on the availability of and quality of data. Some areas of sexual health in Salford have limited or missing data. In these cases, national or regional data have been used to extrapolate local figures. This does introduce a weakness in that some local characteristics will be overlooked, however it does constitute a reasonably robust method given the nature of the data.

2.2 Epidemiology of Sexually Transmitted Infections

Nationally, each year more than 1.5 million new episodes of STIs are seen in UK clinics and current trends suggest the figures are set to rise. The most common conditions now are Chlamydia, non-specific urethritis and wart virus infections, and almost all STIs are becoming more common. In addition, the number of visits to departments of genito-urinary medicine (GUM) in England has doubled over the last decade and now stands at over a million a year. Diagnoses of genital chlamydia also almost doubled during the 1990s, with a particularly marked increase in men and women aged under 20. Recent surveys of women indicate chlamydia infection rates of up to 12% and there are more reports of outbreaks of syphilis [(1)].

Statistics on incidence clearly show that STIs disproportionately affect communities already suffering from considerable inequalities relating to their sexual orientation, ethnicity and gender. Sexual ill health is not equally distributed among the population, with the highest burden being borne by women, gay men, teenagers, young adults and black and minority ethnic groups. There is also a strong link between social deprivation and STIs.

Sexual behaviour is a major factor determining the incidence of STIs. The 2nd National Survey of Sexual Attitudes and Lifestyles, or “NATSAL 2000” [(5)], shows that there have been notable changes in sexual behaviour since the first survey in 1990. These include: a greater number of lifetime partners; lower median age at first intercourse; a greater proportion of the sample with concurrent partnerships; a greater proportion with two or more partners in the past year who did not use condoms consistently. However, there has also been an increase in the proportion that uses condoms at first intercourse.

2.3 Salford

Salford is a complex city when social, economic and health related factors are considered. However, in terms of health inequalities Salford has some of the most challenging health problems in the country. The City of Salford is a typical inner-city conurbation. It has a registered population of 234,240. The city has been heavily affected by the downturn in the mechanical and engineering industries over the last 20 years. Salford is ranked 23rd most deprived Local Authority district in England and the 7th in the North West in the latest analysis (1998) of the Department of Environment, Transport and the Regions (DETR) [(6)].

2.4 Sexually Transmitted Infections in Salford

HIV and STIs tend to be more common in urban areas, and Greater Manchester has the highest incidences of HIV, HIV related illness and STIs outside of London and the South East. Other factors include [(1)]:

- Sexual risk behaviours, with high-risk groups including men who have sex with men (MSMs),
- Population demographics,
- Social deprivation, and
- Associations with and immigration from high prevalence countries, e.g. Sub-Saharan Africa

Sexual ill health is a particular health issue in Salford as it is nationally, with recent high teenage pregnancy rates and increases in new incidence of syphilis, Chlamydia and gonorrhoea. Salford also has difficulties with clinical capacity to deal with the rising rates of infection.

2.5 Trends in incidence

Table 1 and figures 2 to 6 illustrate the changing pattern of incidence of new cases of the five most common STIs (excluding HIV which is dealt with separately) in Greater Manchester from 2000 to 2004. Data for Salford PCT alone are not available in this manner and Greater Manchester should represent a good indicator of patterns in Salford.

2.5.1 Chlamydia

Rates of chlamydia infection show a gradual rise over the five years with evidence of a recent dip in 2004. Males and females exhibit similar trends. It is notable that the rise in rates is most marked in the 20-24 year age group.

2.5.2 Gonorrhoea

Gonorrhoea rates showed a slight increase up to 2003, particularly in males, but this trend is not continued into 2004.

2.5.3 Syphilis

A dramatic rise is seen in rates for men, particularly in the 20-44 age group, suggesting that concentrating prevention in this particular population sub-group, and in particular MSMs, will be an appropriate strategy (this is discussed in more detail in section 7). Rates in females are unremarkable.

2.5.4 Genital Herpes

A small rise is seen in females between 2002 and 2004, however there is nothing to suggest as yet that this represents a significant trend.

2.5.5 Genital Warts

There is little remarkable seen other than small year on year variation that is likely to represent normal variation.

2.6 Comparison with national rates

Table 2 illustrates the stark difference in incidence of STIs in Greater Manchester in comparison with the United Kingdom as a whole. With the exception of herpes, all STIs show a markedly higher rate of incidence in Greater Manchester. This represents a significant health inequality.

2.7 Summary

Epidemiological data suggest that, with the exception of syphilis in men, the incidence of STIs in Salford is currently well controlled, albeit against a background of historically high rates. Rates of incidence of Chlamydia infection have been rising in recent years, however most recent figures show a fall. Subsequent figures will demonstrate if this is sustained.

Table 1 Rates of new episodes of Sexually Transmitted Infections, per 100,000 population, Greater Manchester 2000-2004

		2000			2001			2002			2003			2004		
STI	AGE	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Chlamydia	<16	5.7	99.4	51.5	15.0	147.0	79.7	13.1	141.2	75.7	11.1	205.7	105.8	13.0	172.2	90.4
	16-19	371.4	1240.5	802.1	408.7	1453.0	923.2	401.0	1446.5	913.5	589.2	1794.7	1179.0	579.6	1611.6	1084.1
	20-24	726.5	1030.0	879.2	801.8	1248.9	1027.9	884.5	1274.3	1081.4	1142.4	1465.4	1305.3	1201.8	1306.1	1254.3
	25-34	359.0	273.5	316.1	358.9	352.9	355.9	406.1	334.0	370.0	465.7	379.2	422.4	462.7	306.0	384.2
	35-44	119.6	62.4	90.8	116.7	74.7	95.6	130.5	76.6	103.5	166.4	75.5	120.8	124.8	64.0	94.3
	45+	12.7	5.5	8.8	15.1	5.9	10.2	16.4	5.9	10.8	14.9	4.5	9.4	15.7	3.9	9.4
	Total	143.4	179.9	162.1	151.8	221.9	187.6	169.2	224.0	197.2	211.3	266.7	239.6	209.6	236.3	223.2
Gonorrhoea	<16	7.6	23.9	15.5	5.6	25.5	15.4	13.1	39.2	25.9	5.6	23.5	14.3	11.1	25.4	18.1
	16-19	225.3	256.3	240.7	194.5	226.8	210.4	211.4	212.3	211.8	230.8	227.7	229.3	193.2	199.1	196.1
	20-24	341.1	148.9	244.4	338.1	139.7	237.8	388.0	148.8	267.2	429.0	181.0	303.9	345.0	143.0	243.2
	25-34	194.6	40.7	117.5	191.4	45.5	118.3	218.9	47.6	133.1	212.3	52.3	132.2	189.8	38.0	113.8
	35-44	77.5	15.3	46.2	101.5	14.5	57.8	88.0	13.7	50.8	115.1	9.9	62.4	78.7	12.4	45.5
	45+	12.2	0.8	6.1	13.3	0.0	6.2	14.6	1.8	7.7	17.8	1.6	9.1	13.7	1.4	7.1
	Total	80.2	32.0	55.5	81.5	29.9	55.1	89.6	31.6	60.0	97.5	34.4	65.4	80.1	29.7	54.4
Syphilis	<16	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	16-19	0.0	0.0	0.0	4.6	1.6	3.1	11.7	3.0	7.4	8.5	1.5	5.1	5.5	2.9	4.2
	20-24	3.8	0.0	1.9	38.5	1.2	19.7	26.5	1.2	13.7	26.8	2.3	14.4	34.0	1.1	17.5
	25-34	10.6	0.5	5.6	22.8	0.0	11.4	33.3	2.2	17.8	25.4	1.1	13.2	33.0	0.6	16.8
	35-44	9.4	0.5	5.0	15.7	0.0	7.8	21.7	0.5	11.1	20.4	0.5	10.4	31.1	0.0	15.5
	45+	0.0	0.0	0.0	2.3	0.0	1.0	3.1	0.0	1.5	3.3	0.0	1.6	5.7	0.0	2.7
	Total	3.3	0.2	1.7	9.8	0.2	4.9	11.9	0.6	6.1	10.3	0.5	5.3	14.3	0.3	7.2
Herpes	<16	0.0	9.9	4.9	0.0	25.5	12.5	0.0	17.7	8.6	0.0	31.3	15.3	0.0	19.6	9.5
	16-19	20.2	142.4	80.8	30.4	154.8	91.7	23.3	136.5	78.8	32.6	184.8	107.1	15.2	173.1	92.4
	20-24	72.3	177.7	125.3	84.5	166.4	126.0	77.1	160.6	119.3	74.6	145.5	110.4	70.4	167.6	119.4
	25-34	65.9	87.3	76.6	74.0	76.9	75.4	58.3	91.4	74.9	65.5	83.8	74.7	61.5	90.8	76.2
	35-44	36.5	32.8	34.7	32.6	39.2	35.9	32.9	29.6	31.2	28.3	31.8	30.0	33.7	34.6	34.1
	45+	8.2	6.9	7.5	8.6	5.9	7.1	7.4	4.5	5.8	7.8	5.1	6.3	8.6	7.4	8.0
	Total	24.1	38.6	31.5	26.2	38.4	32.4	23.0	37.2	30.2	23.5	39.1	31.5	22.9	42.1	32.7
Warts	<16	9.5	57.7	33.0	7.5	54.9	30.7	5.6	62.8	33.5	13.0	80.3	45.8	5.6	93.9	48.5
	16-19	259.5	807.0	530.8	350.9	774.2	559.5	291.6	779.3	530.7	373.9	897.4	630.0	354.7	828.2	586.2
	20-24	827.9	740.9	784.1	829.1	779.9	804.3	819.4	687.4	752.7	918.6	764.2	840.7	888.6	720.6	803.9
	25-34	409.5	215.3	312.1	438.3	244.1	341.0	367.2	217.7	292.4	431.8	245.3	338.4	381.8	228.8	305.2
	35-44	136.2	60.2	98.0	151.4	88.7	119.9	149.0	72.9	110.9	182.6	92.2	137.3	144.5	78.9	111.6
	45+	27.0	10.8	18.3	28.6	13.7	20.6	23.7	16.4	19.8	30.5	17.4	23.5	28.7	12.6	20.2
	Total	159.5	132.3	145.6	171.9	143.9	157.6	157.6	136.2	146.7	186.2	156.3	171.0	170.4	145.9	157.9

Source: Health Protection Agency

Figure 2 Rates of new Chlamydia infection, Gtr Manchester 2000-2004

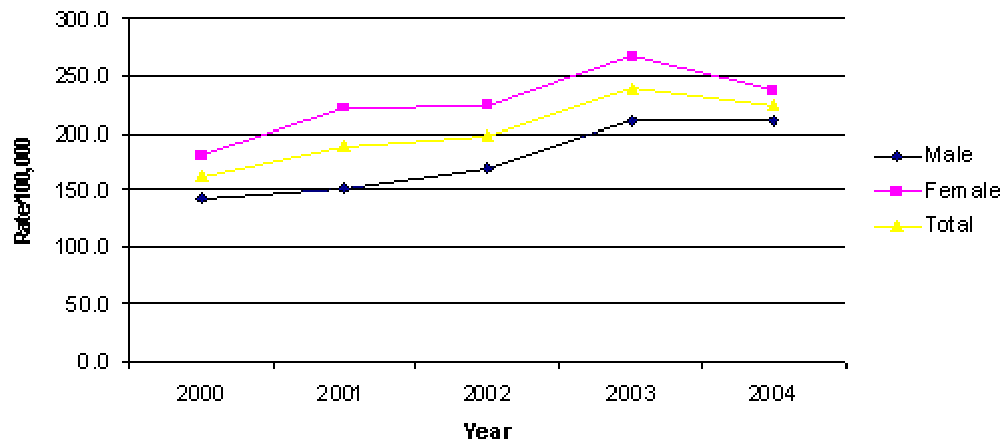


Figure 3 Rates of new Gonorrhoea infection, Gtr Manchester 2000-2004

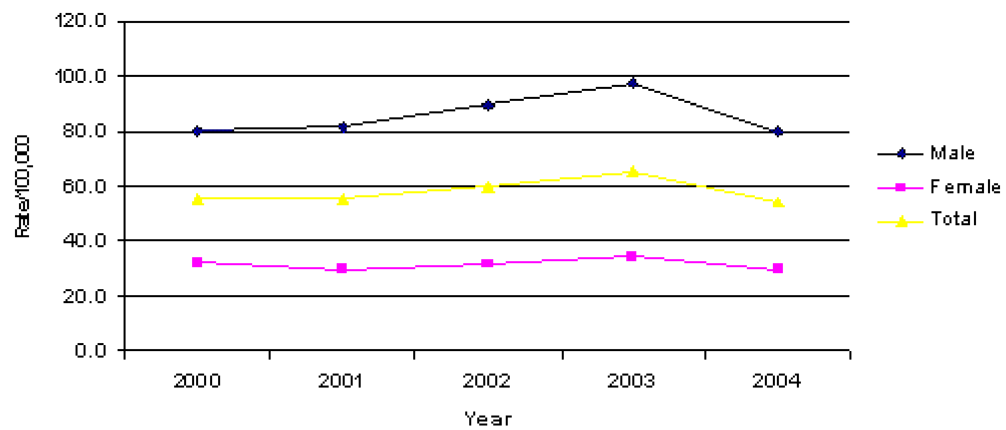


Figure 4 Rates of new Syphilis infection, Gtr Manchester 2000-2004

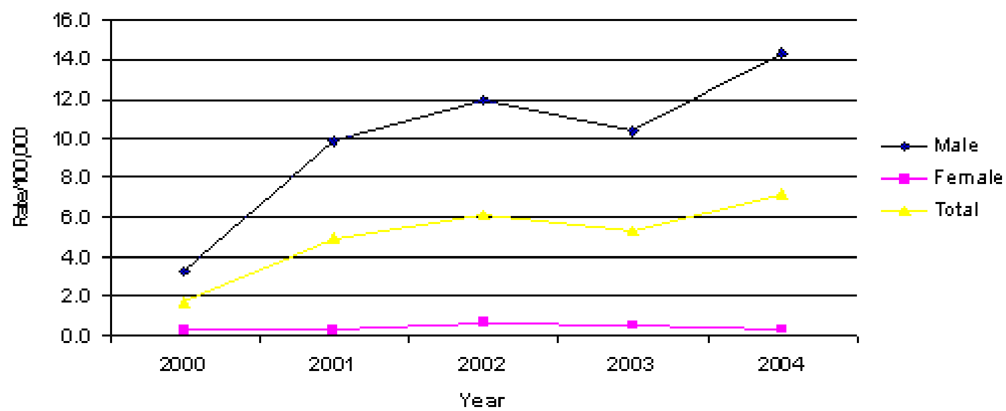


Figure 5 Rates of new Genital Herpes infection, Gtr Manchester 2000-2004

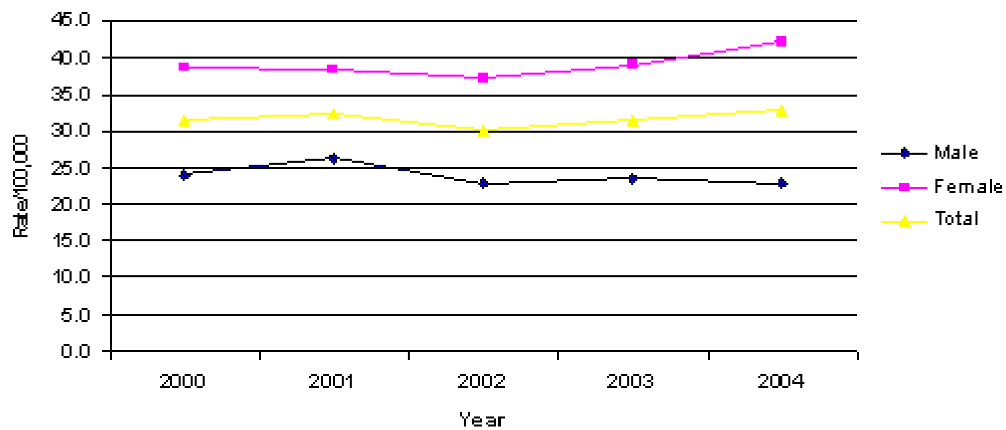


Figure 6 Rates of new Genital Wart infection, Gtr Manchester 2000-2004

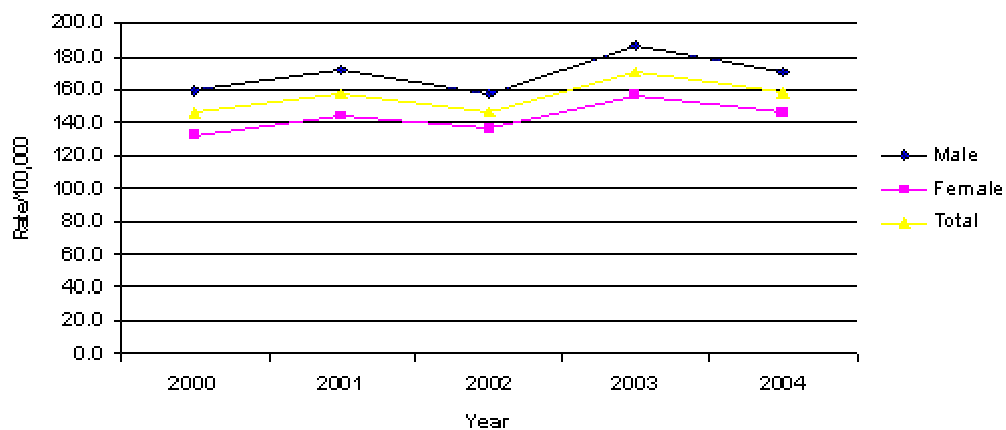


Table 2 Comparison in STI incidence – UK and Greater Manchester 2004

	Gtr Man total rate 2004	UK total rate 2004
Chlamydia	223.2	174.1
Gonorrhoea	54.4	37.3
Syphilis	7.2	3.8
Herpes	32.7	31.7
Warts	157.9	133.2

Source: Health Protection Agency

2.8 Black and Minority Ethnic Communities

Salford is a city in transformation, moving into an exciting future as a thriving cultural, economic and residential location. Salford is made up of diverse communities, including people from over 70 different countries**.** Working with such diversity and health inequalities inevitably raises particular sexual health issues and challenges to individuals, health care providers and promoters alike.

Research has shown that compared with the population as a whole people from ethnic minority groups tend to suffer from poorer health and greater levels of socio-economic deprivation. Salford's Social Services Director Anne Williams suggested that the 1991 census grossly underestimated the ethnic minority population in Salford. At that time it was recorded that the non-white population total was 4,810 (2.2 per cent) of a 220,463 resident population. However, the census was not translated into other languages, and the 'white' included Jewish, Eastern European and Irish, whilst 'black other' and 'other other' categories included Yemeni, Iraqi and other Middle Eastern groups.

There is also a Jewish community in Broughton, estimated at 10,000; an Asian community also in Broughton; a Yemeni community in Eccles; a Chinese community which is spread evenly; and an Asian community in Irlam o'th' Height.

There is a disproportionate increase in diagnosed STIs among Black and Minority Ethnic communities in the UK. This creates the need for cultural sensitivity when dealing with the diverse needs of Salford people and militates against a "one size fits all" solution to sexual health work in this area. This is discussed in Section 7.

2.9 Lesbian, Gay Bisexual and Transgender Issues

The North West Development Agency (2003) suggests that the size of the Lesbian, Gay, Bisexual and Transgender (LGBT) communities is between 5-7% of the population with an estimated 400,000 LGBT people in the North West of England, the majority of these residing in Greater Manchester. It is equally acknowledged that Greater Manchester has the largest Lesbian, Gay and Bisexual community in Britain outside of London. 84% of all infections diagnosed in 2003 that were acquired in the UK were in men who have sex with men (MSM) [(7)]. Rates of STIs amongst MSM have also increased notably since the 1999 Syphilis epidemic in Greater Manchester. This particularly affects Salford where we have a quantity of cheaper and public housing stock, which still affords easy access to the recreational and social facilities offered in Manchester's "Gay Village". This significantly affects our HIV reporting, with over 80% of Salford's HIV cases being gay men.

2.10 Young People

Salford has higher teenage conception rates than the regional and national averages. On average 6 young women in a Salford High School year 11 group will be pregnant before they are 18, 4 of them will go on to have babies, and 2 opt for termination of pregnancy.

Nationally STIs are considered to be a major public health concern in young people aged 16-24 years, with high incidence rates and Salford is no exception to this. There has been an increase in HIV and sexually transmitted infections amongst young people. On average 10% of young people are infected with Chlamydia.

Additionally, The University of Salford has a student population of over 18,000, including more than 15,000 undergraduates. Salford also has one of the highest numbers (at 560) of Looked After Children in the UK; The Greater Manchester’s total is 1400.

SECTION 3

TARGETS AND BEST PRACTICE

This section of the strategy considers the quality of service that Salford PCT aims to provide to its patients.

1.2 National Policy

1. National Strategy for Sexual Health [8]

The first national strategy for sexual health and HIV was published for consultation on 27 July 2001, with the aims of:

- Reducing the transmission of HIV and STIs;
- Reducing the prevalence of undiagnosed HIV and STIs;
- Reducing unintended pregnancy rates;
- Improving health and social care for people living with HIV; and
- Reducing the stigma associated with HIV and STIs.

2. Choosing Health

'Choosing Health – Making Healthy Choices Easier' [9] highlights the need for:

- Sexual health services to be delivered in a range of community settings targeting hard to reach and vulnerable groups
- Enhanced services in the new general medical services contracts and more primary care practitioners working alongside sexual health care experts
- The need for prevention services to be developed and modernised
- Fast access to GUM services that patients expect of other NHS treatments

3. The Wanless Reports [10]

The Wanless reports of 2004 clearly state that the NHS will be bankrupt if we strive to focus on sickness services and do not change the way the NHS is run. This requires a refocus so that illness is prevented in the first place and people are fully engaged in keeping themselves healthy and influencing service commissioning and provision. The role of technology to support care closer to home in operational settings and smaller highly specialist hospitals is central to this vision.

4. Choice and Payment by Results

Booking specialist care at the point of referral and having a choice of the provider of care is another key policy test. All influence how services are commissioned and provided. Payment by Results means that the payment will follow the patient. GUM services have always been open access and people have been able to choose to go out of Salford for care. This may extend to other services such as family planning.

5. Other key documents:

- The Nations Public Service Agreement Targets [11]
- Effective commissioning of Sexual Health and HIV Services: a sexual health and HIV commissioning tool kit for Primary Care Trusts and Local Authorities [12]
- Social Exclusion Unit Teenage Pregnancy Report [27]
- The Local Delivery Plan (LDP)

3.2 Targets

There are two main Key Performance Indicators (KPIs) for Sexual Health Services:

1. Guaranteed Genito-Urinary Medicine (GUM) appointment availability within 48 hours for all patients referred to the service (including self-referral)
2. 25% reduction in the number of newly acquired HIV and gonorrhoea infections by 2007

In addition, National Teenage Pregnancy targets comprise:

1. To reduce the rate of teenage conceptions with the specific aim of halving the rate of conceptions among under-18s and to set a firmly established downward trend in the rate of conceptions among under -16s, by 2010
2. To increase the participation of teenage parents in education, training and employment to 60% by 2010, to reduce their risk of long-term social exclusion.

3.3 Standards

1. There are recommended standards for sexual health services [13] (MedFASH, 2005), which include:
    a. Ten standards developed with the aim of enabling people to have prompt and convenient access to consistent, equitable and high quality sexual health care
    b. A tool for planning, developing and evaluating local services as well as for local performance management
2. The Independent Advisory Group for Sexual Health and HIV Annual Report 2004/2005 [14] recommends the following:
    a. Sexual Health should be explicitly prioritised within NHS Planning and Priorities Framework
    b. That there are nationally co-ordinated and targeted HIV prevention programmes for Gay Men and African communities

SECTION 4

COMMISSIONING AND REDESIGN

4.1 Commissioning

Commissioning, purchasing and contracting are not the same activities, despite the terms often being used interchangeably.

"The purpose of commissioning is to maximise the health of a population and minimise illness by purchasing health services and by influencing other organisations to create conditions which enhance people's health." [15]

The commissioning of sexual health and HIV services in Salford PCT is in line with national policy priorities including:

- The promotion of clinical quality and service improvements
- The development of multi disciplinary and multi-agency partnerships
- Improved access to quality services for treatment, care, support and health promotion
- Targeted health promotion interventions, including outreach and information
- A reduction in health inequalities
- Bridging the gap between health and social care provision of services
- Increased contribution from GPs and practice/school/community nurses and health advisers
- The development of more patient centred services with greater user and community participation in service planning and evaluation.

The key commissioning processes for sexual health and HIV services include:

- Needs assessment
- Local priority setting dependent on need and epidemiology
- Local plans agreed across consortia and/or partnership boards
- Specifications for service delivery with all service providers across treatment, care, prevention, health promotion and support
- Service level agreements with the range of statutory and voluntary providers
- Service monitoring and evaluation to ensure progress to recommended standards outputs and outcomes against success criteria outlined in service level agreements (SLAs)

4.2 Partnership Working and the Greater Manchester Sexual Health Network

The Greater Manchester Sexual Health Network (GMSHN) is the UK's first comprehensive Sexual Health Network and includes amongst others HIV, genito-urinary medicine, family planning, contraception, conception, teenage pregnancy and abortion services provided by the statutory, community and voluntary sectors [16].

The Greater Manchester Sexual Health Network was constituted with the following aims which will support Greater Manchester co-operation when commissioning HIV and Sexual Health Services:

- In accordance with national policies, guidance and strategy, to develop a shared vision and long-standing strategy for sexual health services across the network, ensuring compatibility between the network-wide and individual sector plans.
- To ensure that appropriate mechanisms and structures are implemented to ensure a co-ordinated and integrated approach to the provision of Sexual Health Services that encourages the active involvement and participation of all key stakeholders.
- To ensure that the strategy is based on the philosophy of providing high quality, equitable services designed to improve the health and well being of the population.
- To establish a mechanism to oversee the collective commissioning and service development arrangements for Sexual Health Services for the Network.
- To ensure that appropriate mechanisms are developed and implemented which will support the monitoring of service provision and provide robust assurance that services are appropriate, based on current evidence based practice and clinically safe.
- Development of a culture within the Network that is dynamic, innovative and creative and which seeks to embrace the views and expert knowledge of service users, carers and support organisations.
- To engender a culture of continuous improvement in service provision through active research, training, teaching, learning and education, workforce development and the dissemination of good practice.
- To attract and secure funding from national investment streams and ensure mechanisms are in place to influence local delivery plans and performance & priorities frameworks.

The primary purpose of GMSHN is to facilitate - by collaboration with all stakeholders - a greater profile of and presence for all prevention, treatment and care services by improving clinical outcomes, patient experience and equality of access to all Sexual Health Services.

The Network will support the implementation of the National Strategy for Sexual Health and HIV with the aims of:

- Reducing the transmission of HIV and Sexually Transmitted Infections;
- Reducing the prevalence of undiagnosed HIV and STIs;
- Reducing unintended pregnancy rates;
- Improving the health and social care of people living with HIV; and
- Reducing the stigma associated with HIV and STIs.

The organisations involved in the Network include:

- 14 Greater Manchester Primary Care Trusts (financial sponsoring bodies)
- 14 Greater Manchester Acute NHS Trusts
- Greater Manchester Strategic Health Authority
- Health Protection Agency
- 10 Local Authority Organisations (Social Services, Education, Drug Action Teams etc.)
- Salford University
- 4 Community and Voluntary Sector Agencies (George House Trust, Lesbian and Gay Foundation, Barnardos and Black Health Agency).
- Royal College of Obstetrics and Gynaecology/Faculty of Family Planning
- British Association of Sexual Health and HIV
- British Association of HIV

The Greater Manchester Sexual Health Network is accountable to the 14 Greater Manchester PCTs through the Association and follows the PCTs Accountability Framework. In August 2003, the Association of Greater Manchester Authorities (AGMA) made the development of a Network for Sexual Health Services a key priority action that would attract national funding and increase health care professionals. Six monthly performance reports have been sent to all Greater Manchester PCTs, AGMA and Strategic Health Authority Board.

Salford PCT Sexual Health Services have a good history of partnership work with the voluntary sector, 2004-05 brought a consolidation of commissioning arrangements with the establishment of an HIV voluntary sector-commissioning group, now run through the GMSHN. The work supported a common monitoring system to ease the burden of the voluntary sector completing monitoring for numerous health and local authority agencies.

4.3 Costs

Sponsoring bodies of the GMSHN include all Greater Manchester PCTs. 1st Year (July 2003 to July 2004) joint funded by GM SHA and 14 PCTS (£60k), 2nd and 3rd years (July 2004 to July 2006) solely funded by 14 Greater Manchester Primary Care Trusts (£80k).

4.4 Integration of Services and Plurality/Contestability of Provision

Salford PCT is integrating health and social care services where it is most appropriate e.g. learning difficulties, and at the same time commissioning of elective care provision is being extended to providers other than the NHS.
Voluntary Sector organisations are currently commissioned to provide HIV prevention and care services and at the same time have charitable status so provide services outside of contractual arrangements e.g. The Terence Higgins Trust.
Voluntary sector organisations e.g. Brook also provide contraceptive advice services.
Your Health, Your Life, Your Say was the recent consultation on care outside of hospitals. Expected in early 2006 it will outline a vision for Primary Care which may include strengthening of practice-based commissioning, plurality of provision and a greater separation between the commissioning and providing aims of the PCT.

In conclusion, the following policy drivers have implications for Salford's Sexual Health Strategy:

- The emphasis on prevention.
- The emphasis on enabling individuals to make healthy choices about their sexual health.
- Practice-based commissioning influencing choice of provisions, either locally between clusters or outside of Salford.
- Local sexual health services will have to "attract" sufficient patients in the new payment by results regime.
- Integration of health and social care for people with HIV.
- Salford PCT may not be the main provider of services in the future

4.5 Planning Sexual Health Services in Salford

The Sexual Health Steering Group (SHSG) exists to provide strategic and managerial leadership in the implementation, at a local level, of the National Strategy for Sexual Health and HIV, objectives and anticipated outputs by 2007 – 2010. This group reports to the Healthy City Forum Executive.

The SHSG set a number of priorities for action and initially focused on the modernisation and development of primary and community Sexual Health services within Salford, promoting the redesign of services, which comply with best practice and national and local policy. The Steering Group has also developed and supported appropriate "short-life" Action Groups to develop appropriate responses to specific need, reflecting the emergent nature of the strategic process as outlined in Section 1.

The SHSG works with and is currently reviewing services and contracts inherited from the organisational structures put in place by Salford and Trafford Health Authority. A number of these issues are being addressed through the GMSHN.

4.6 Economic implications

Apart from the ethical reasons for averting infections, the economic arguments are substantial. The economic costs go far beyond the costs of diagnosing and treating the infections themselves. Left untreated, STIs can have long-term effects on health; for example, Chlamydia can result in pelvic inflammatory disease, which can lead to ectopic pregnancy and infertility. The costs associated with these conditions should be considered in the context of their potential long-term economic impact

Average lifetime treatment costs of each HIV positive patient £180,000 and each case HIV infection prevented saves £500,000 to £1,000,000 in terms of individual health benefits and treatment costs

The Department of Health has carried out a cost/benefit analysis on a series of interventions [17] and has shown that the following interventions are cost-saving:

- Condom provision for high risk groups
- Condom subsidy schemes
- Outreach health promotion and safe sex programmes for high risk groups and hard to reach groups
- High quality integrated Sex & Relationships Education

The following interventions are outstandingly cost-effective:

- Wide variety of routes for condom distribution
- Short access times for GUM services

The following interventions are averagely cost-effective:

- Highly Active Antiretroviral Therapy (HAART)
- Routine HIV screening for STD clinic attendees

There are certain activities that are carried out routinely in GUM services but that are possibly not cost effective, for example screening and suppressive therapy for genital herpes

4.7 Summary of Key Issues

- Prevalence of STIs and HIV is increasing and local services require smarter investment, coordination and modernisation to meet the increasing demand
- A greater understanding of need, equity and demand for local GUM, contraception and abortion services are required.
- Population changes (decrease in young families, increase in students etc) and changes in population behaviour (e.g. increase in crack use) will affect the demand in services over time and need to be understood and considered with the development of the strategy

4.8 Prioritisation of activity

To develop a strategy that encompasses the sexual health needs of Salford's registered and visiting population is not viable, given it size and complex needs. Consequently, the following groups and areas have been prioritised.

- Service Development
- People with Learning Disabilities
- Young People (including the Teenage Pregnancy Strategy)
- Gay/Bi-sexual Men and men who have sex with men (MSM)
- Black and Minority Ethnic communities
- Prisoners
- Vulnerable Groups:
    - Sex Workers
    - Injecting Drug Users
    - Lesbians
    - People with Mental Health Problems
    - Victims of sexual assault
    - Victims of domestic violence

Note - The Teenage Pregnancy Team is currently mainly located at Hope Hospital. The Making It Real, Making It Happen consultation on the future of paediatric, maternity and neo-natal services across Greater Manchester and the surrounding areas is to include five options for future provision of services. Continued provision of obstetric services at Hope Hospital is included in only one of these options. The outcome of the consultation may thus have a significant impact on the operation of the Teenage Pregnancy Team.

SECTION 5

PREVENTION OF HIV, STIs and UNWANTED PREGNANCIES

5.1 Introduction

This section of the strategy is crucial to the PCT's first pledge, i.e. *To protect people and help everyone enjoy longer healthier lives*

The Department of Health reports that in the last ten years the following changes in sexual behaviour in the UK have been reported [18]**:**

- Age of first intercourse reduced in the last 10 years;
- Increase in unprotected sex – associated with alcohol and binge drinking;
- Number of lifetime partners increased in the last 10 years;
- Concurrent relationships increased;
- Condom usage increased, but offset by number of sexual partners;
- 44% of HIV+ men have sex with new partners in the last month, of who 40% reported no or inconsistent condom use.

All of these behaviours can contribute to increased spread of STIs and as such represent a mandate to take action to improve prevention and prevention services.

5.2 Prevention and sexual behaviour

STI incidence in a population is the result of:

- the prevalence of STIs within the population
- the number of exposures
- the average probability of transmission.

Sexual behaviour is therefore a key factor in determining the incidence of STIs. Sexual behaviour may be influenced by a number of personal and structural 'determinants of risk', including:

- Low self-esteem;
- Lack of skills in using condoms;
- Lack of skills to negotiate safer sex, e.g. to say 'no' to sex without condoms;
- Lack of knowledge about the risks of different sexual behaviours;
- Availability of resources, such as condoms or sexual health services;
- The opinions of peers and social pressures;
- Attitudes (and prejudices) of society, which may affect access to services.

For most individuals and populations, there will be multiple determinants of risk. Some interventions are delivered across several levels and aim to address a range of these determinants simultaneously.

5.3 Prevention strategies for STIs and HIV

There are a number of strategies for reducing exposure to STIs, including increased condom use, reduction in partners, abstinence and screening and treatment.

STI prevention interventions ultimately aim to influence sexual behaviour (and hence incidence) by addressing the determinants outlined above within a programme of activities where interventions are delivered at different levels, namely:

- Individual, e.g. partner notification, risk counselling;
- Group, e.g. group work, and school sex education;
- Community, e.g. community development, campaigns;
- Socio-political e.g. legislation, resource allocation, professional development.

The impact of single, small-scale interventions should be evaluated by measuring changes in 'health promotion outcomes' such as knowledge, skills, access to resources, or peer norms (i.e. effectiveness in changing determinants of risk). This will then inform whether they may be usefully included as part of a large-scale, multi-level, multi-component intervention or programme. It is unrealistic to expect most single, small-scale interventions to have a significant impact on behaviour on their own.

Although some single interventions may have a large enough impact on a major determinant of risk to result in measurable changes in behaviour, behavioural outcomes should normally be reserved for measuring the success of large-scale, multi-level, multi-component interventions or programmes.

Where used, behavioural outcomes should be clearly defined and include contextual variables (e.g. long-term or new partner) to measure STI 'risk' meaningfully.

The Department of Health recommends that the following actions should be taken to reduce HIV and STI prevalence [19]:

1. Investment into existing GUM services to reduce waiting times and improve access to STI screening, diagnosis and treatment

   This has been identified as a priority area in Salford and is being implemented urgently. GUM clinic waiting times have been increasing. Planned initiatives outlined in the Sexual Health and HIV Strategy such as HIV testing promotion, chlamydia screening and Hepatitis B screening will severely exacerbate the lack of GUM capacity due to the resultant increased demand. In Salford we are relocating sexual health care into primary care and developing a community based sexual health service to meet these increased needs (Section 6).

2. Timely implementation of population based screening for genital chlamydia infection among young women

   The government's proposal to implement a national screening programme for *Chlamydia trachomatis* infection is welcome, and implementation is a priority. The DH funded Chlamydia Pilot Study has confirmed the feasibility and acceptability of opportunistic screening in a context of increasing high-risk behaviours and rising STIs. Salford PCT is supporting and participating in the Greater Manchester Chlamydia Screening Programme and this service will be launched in the year starting 06/07.

3. Target interventions with population sub-groups vulnerable to sexual ill health

   Available surveillance and research data confirm significant inequalities in the distribution of STIs and HIV in the England and Wales. Young people, gay men and ethnic minorities in particular, appear to be at substantially increased risk of poor sexual health outcomes. Funds are being made available to support innovative, evidence based and participatory prevention interventions with population sub-groups at increased risk.

4. Tackle regional variations in sexual health outcomes

   STI and HIV surveillance data confirm the disproportionate burden of STIs in 'hot-spots' - socio-economically deprived, inner city areas in Britain. In such settings, STI rates are among the worst in Western Europe, rivalling levels seen in deprived areas in the US and some developing countries. Plans to roll-out sexual health provision outside of GUM clinic sector in these areas are unlikely to be successful as general practice services are also overstretched. It is therefore recommended that consideration be given to increasing the capacity (i.e. increasing GUM clinic sessions, clinics etc.) in the worst affected areas with the piloting and evaluation of innovative models of GUM service provision and partner notification.

5. Sustain and improve HIV and STI surveillance

   There is a need to maintain and enhance the surveillance effort as the HIV epidemic grows in size and complexity on the large scale necessary for the unlinked anonymous programme. The ability to contribute locally to evaluation and monitoring of outcomes for prevention programmes at a national level is a priority.

5.4 Prevention Strategies for Unintended Pregnancies

Low self-esteem, lack of skills in using condoms, lack of skills to negotiate safer sex, lack of knowledge of or difficulty in accessing contraception services all affect the potential of individuals and couples to plan pregnancy.

Provision and promotion of good family planning services within the sexual health service is of paramount importance. The multiple determinants that affect sexual behaviour and contraception use are similar to those within HIV and STI prevention interventions.

5.5 Defining interventions and approach to evidence of effectiveness:

Salford PCT should be supporting interventions that include the following features:

- Use of sound and evidence based theoretical models
- Targeted and tailored (in terms of age, gender, culture, etc), making use of needs assessment or formative research
- Provision of basic, accurate information through clear, unambiguous messages
- Use of behavioural skills training, including self-efficacy.

In view of the existing evidence base, there is a need for community-based services, and a programme approach to health improvement which serve as the model for sexual health in Salford. Sexual health education for young people is provided through schools and the Teenage Pregnancy Strategy, and for gay and lesbian people through contracts with the Lesbian and Gay Foundation (LGF). It is recognized that there is a gap in provision for other members of the general population and that this is an area requiring action.

All sexual health promotion work commissioned by Salford PCT will include awareness raising, education and information giving, the development of services and service providers and developing skills and capacity building in individuals, groups and communities. Such capacity building enables vulnerable individuals, groups and communities to take greater control over their sexual health and offers the opportunity to gain key skills such as negotiation, communication and assertiveness as well as enhancing their self-esteem, emotional well-being and mental health.

5.6 Strategic Objectives

5.6.1 To provide local community based prevention initiatives and health improving programmes of work linked to:

- Locally supported national education campaigns
- Local co-ordinated education campaigns based on evidence
- Evidence-based prevention initiatives with specific at risk groups (gay men and lesbians, young people, sex workers, drug users) with local campaigns and outreach work
- Comprehensive links to the Salford Teenage Pregnancy Strategy

5.6.2 Provide appropriate Screening and protection

- Local Chlamydia screening programme.
- Hepatitis B vaccination programmes.
- Maximum opportunities for HIV testing to reduce undiagnosed HIV infection.
- HIV outreach services as appropriate.

5.7 Local Initiatives and Actions

Salford provides health improvement interventions within community based programmes. Sexual health activities should be added to these programmes.

5.7.1 Plans include local responses to the new national STI advertising/media campaign, which covers the following messages:

- Targeting younger men and women.
- Risks of unprotected sex in terms of STIs and unintended pregnancies.
- Promoting benefits of condoms.

5.7.2 A Sexual Health Promotion and Primary Prevention Sub Group of the Sexual Health Steering Group has been established and is driving this work forward.

5.7.3 Community-based prevention initiatives:

A major partner in the primary prevention of STI's and HIV is the LGF. Services are commissioned from this organisation because 80% of Salford's known HIV positive population are gay men. Their residency in Salford is due to the cheaper housing and proximity of social and recreational facilities in Manchester city centre, (The Gay Village, centred around Canal Street). The initiatives carried out by the LGF are described in Section 7.2.5.

Another key initiative is work on teenage pregnancy, which is described in Section 8.

5.7.4 Costs

Please note: All developments will be subject to the PCT LDP planning process. The majority of funding for PCT Sexual Health Services has been committed to service development and to Greater Manchester provided initiatives. An application has been submitted to the NRF Challenge panel for £135,000 to pump-prime initiatives in this area)

5.8 Hepatitis B vaccination programme

Whilst HIV is the most serious of the blood-borne viruses that cause infection worldwide, blood-borne hepatitis viruses are more common:

- Chronic hepatitis B infection is estimated to affect about 0.3% of the UK population (180,000).
- It is estimated that around 0.4% of the UK population (250,000) are chronic carriers of Hepatitis C
- (Chronic carriers of either virus may develop chronic liver damage, cirrhosis or liver cancer)

The viruses are transmitted by direct blood-to-blood and body fluid contact (e.g. contaminated needles, unprotected sexual intercourse, medical and surgical procedures if hygienic precautions are not observed).

Measures to reduce the impact of these diseases are based around blood screening, selective immunisation (for hepatitis B) and awareness raising to change behaviours in order to reduce opportunities for transmission The burden of illness for both has steadily increased and is projected to increase further [21].

In 1999, the Department of Health recommended immunisation against hepatitis B for the following groups:

- current injecting drug users;
- those who inject occasionally;
- those who may 'progress' to injecting, for example, people who are currently smoking heroin and dependent stimulant users;
- non-injecting drug users currently living with injectors (particularly women who are living with male injectors)
- close household contacts (particularly sexual partners) of injecting drug users.

One of the Department of Health Sexual Health and HIV Strategy targets is to increase the uptake of hepatitis B vaccine among homosexual and bisexual men. The specific targets are:

- All homosexual and bisexual men attending GUM clinics to be offered hepatitis B immunisation at their first visit by the end of 2003;
- Uptake of the first dose of the vaccine, in those not previously immunised, to be 90% by the end of 2006
- Uptake of the three doses of vaccine, in those not previously immunised, within one of the recommended regimens to be 70% by the end of 2006.

The Department of Health provided extra doses of hepatitis B vaccine free of charge to GUM clinics for the next three financial years (2002-2003 to 2004-2005). This has increased the immunisation rate among first-time attendees. The DoH requires that these targets be routinely monitored. Current surveillance of GUM clinic attendees, based on the KC60 statistical return, is unable to provide data for monitoring these targets because it only collects data on the total number of complete courses given to homosexual men. No data are collected on how many men were offered, were immunised already, received only a partial vaccination course or refused. Furthermore, the total number of homo/bisexual men attending clinics is not recorded; therefore, it is not even possible to calculate the percentage that received a full course of vaccine.

5.8.1 Current situation in Salford

GUM routinely offers Hepatitis B vaccination to gay men attending for the first time. Data to assess uptake is currently unavailable. Contacts of known infections are routinely offered vaccination.

There is a need to maintain and enhance the surveillance effort as the Hepatitis epidemic grows in size and complexity. The ability to contribute locally to evaluation and monitoring of outcomes for prevention programmes at a national level is a priority.

5.8.2 Action Plan

A subgroup of The Sexual Health Steering Group will be established in 2006 to review the current situation and develop a suitable local response. This group will work closely with the Health Protection agency.

This work is not currently costed, although the routine vaccinations are currently met within existing sexual health and vaccination budgets.

5.9 Chlamydia screening programme

From April 2006 GMSHN will be rolling out a Chlamydia Screening Programme across Greater Manchester in accordance with the programme core requirements. Chlamydia Screening will be promoted amongst asymptomatic sexually active men and women under the age of 25, in the following settings:

- Termination of Pregnancy (TOP) clinics
- Family Planning/Contraception Clinics/“Walk-in” Centres providing emergency contraception
- Young Persons clinics and appropriately trained School Nurses
- Antenatal clinics
- Gynaecology clinics
- Interested GPs (Those GPs providing contraception will be actively encouraged to participate)

All positive patients and their partners are to be offered treatment in a GUM or clinic that has T2 status (community clinics staffed by those with some GUM experience where an STI screen and HIV test can be offered and chlamydia treated in accordance with national guidelines.)

Training delivered by Programme Coordinators who will oversee the delivery of the programme for the Sexual Health Network will support the screening programme.

The screening programme will be supported with a document pack containing fast track referral forms, confidentiality statement, partner notification slips, data collection forms and patient information leaflets.

The Network will appoint programme leads/coordinators to implement the programme. The Network will support them.

In Salford Chlamydia Screening has been included as an integral part of the sexual health service redesign. Salford PCT has agreed to participate in the Greater Manchester Chlamydia Screening Programme, with delivery coming via the modernised Salford PCT provided sexual health services.

Costs

It is proposed that costs for the Chlamydia screening programme may be met through the indicative allocation for “Choosing Health”. However, PCTs in Greater Manchester have not all approved ring fencing of the Choosing Health allocation. The financing of the Chlamydia screening programme has been submitted to the Greater

Manchester LDP planning process for collaborative support for 2006/7. It will be subject to a prioritisation process with all other collaborative developments. Salford PCT Sexual Health services has proposed a contribution of £90,000 for the front loading, equipment and recruitment costs. Costs that were not contributed to include those of the sector co-ordinator, the Chlamydia Co-ordinator and the medical advisor posts. This decision reflects the amount of work that has gone into Salford Sexual Health Services redesign.

As part of the contribution to the Greater Manchester Chlamydia Screening Programme, in year monitoring on the proposed budget and recovery of any significant under spend are required.

This arrangement will be reviewed at the beginning of the new financial year.

SECTION 6

INTEGRATED SEXUAL HEALTH SERVICES

6.1 Policy Context

'Choosing Health – Making Healthy Choices Easier' [9] highlights the need for:

- Sexual health services to be delivered in a range of community settings targeting hard to reach and vulnerable groups. This means a bringing together of the disparate sexual health services (GUM, family planning etc)
- Enhanced services in the new general medical services contracts and more primary care practitioners working alongside sexual health care experts
- The need for prevention services to be developed and modernised
- Fast access to GUM services that patients expect of other NHS treatments

6.2 Current Situation in Salford

In the past the components of sexual health services have been separate. In the main these have included GUM clinics at Hope Hospital and Family Planning services in primary care. The latter were delivered either by GP practices, or more recently in Salford, specialist family planning services delivered by the PCT.

There have also been a number of specialist sexual health services such as the psychosexual service (tertiary service).

Specialist Family Planning Services in Salford are under pressure to meet demand. There are a number of factors that contribute to this situation for example, most women seeking contraceptive advice would prefer a female practitioner, and there are cultural sensitivities that also need addressing. This particularly affects the Jewish community in Broughton; an Asian community also in Broughton; a Yemeni community in Eccles and an Asian community in Irlam o'th' Height.

Currently the number of people (cases) attending GUM clinics in Greater Manchester and nationally is equivalent to a population prevalence of 2.7% and 3.9% respectively. In Salford, at current capacity, the putative population prevalence based on cases attending GUM clinics is 1.7%. From this we can deduce that our GUM clinics are not meeting demand. To demonstrate this:

- Salford calculated at prevalence 1.7% = 3696 cases p.a. (current capacity)
- Salford calculated at prevalence 2.7% = 5832 cases p.a. (- 2163)
- Salford calculated at prevalence 3.9% = 8542 cases p.a. (- 4846)

Further to this, Salford GUM Service currently operates a "week capped" appointment system. This was introduced across Greater Manchester in April 2005.

This measure was introduced to cut non-attendance (DNA) rates. The current DNA rate in Salford is approximately 5% (1 or 2 appointments per day). The previous system allowed for appointments to be made up to four weeks in advance. DNA rates start to rise rapidly after the first week. At the three and four week mark DNA rates rise to approximately 25% to 35%. The major problem with this system is that there is no measure for unmet demand.

One of GUM's primary functions should be preventing further spread of sexually transmitted infections. The current waiting times and capacity at Salford GUM are such that this primary function will be compromised.

6.3 Proposed Service Modernisation

6.3.1 We have a vision to redesign current services to implement a primary care based *integrated sexual health service* delivering Family Planning, GUM and Sexual Health, Young Peoples, HIV and Erectile Dysfunction/Psycho Sexual Services in Salford. The modernisation will increase access to sexual health services (both GUM and FPS) for the population of Salford. These services have been brought under the management of Salford PCT.

6.3.2 This supports delivery of three levels of service provision as proposed by the National Sexual Health Strategy [8].

- Level 1 – General Practitioner (GP) practice provision
- Level 2 – Primary care based, more specialist provision
- Level 3 – Specialist provision

The current sexual health services, enhanced to provide specialist sexual health and family planning, will be based at the proposed Health and Social Care Centre in Swinton. This will act as a hub to redesigned community based sexual health clinics to replace the current family planning clinics.

6.3.3 The service will include the development of specialist GPs providing level 2 services at local health centres.

6.3.4 Opportunities will be sought via PMS and GMS to develop robust level 1 services in Primary Care, which will be the foundation for Salford Sexual Health Services.

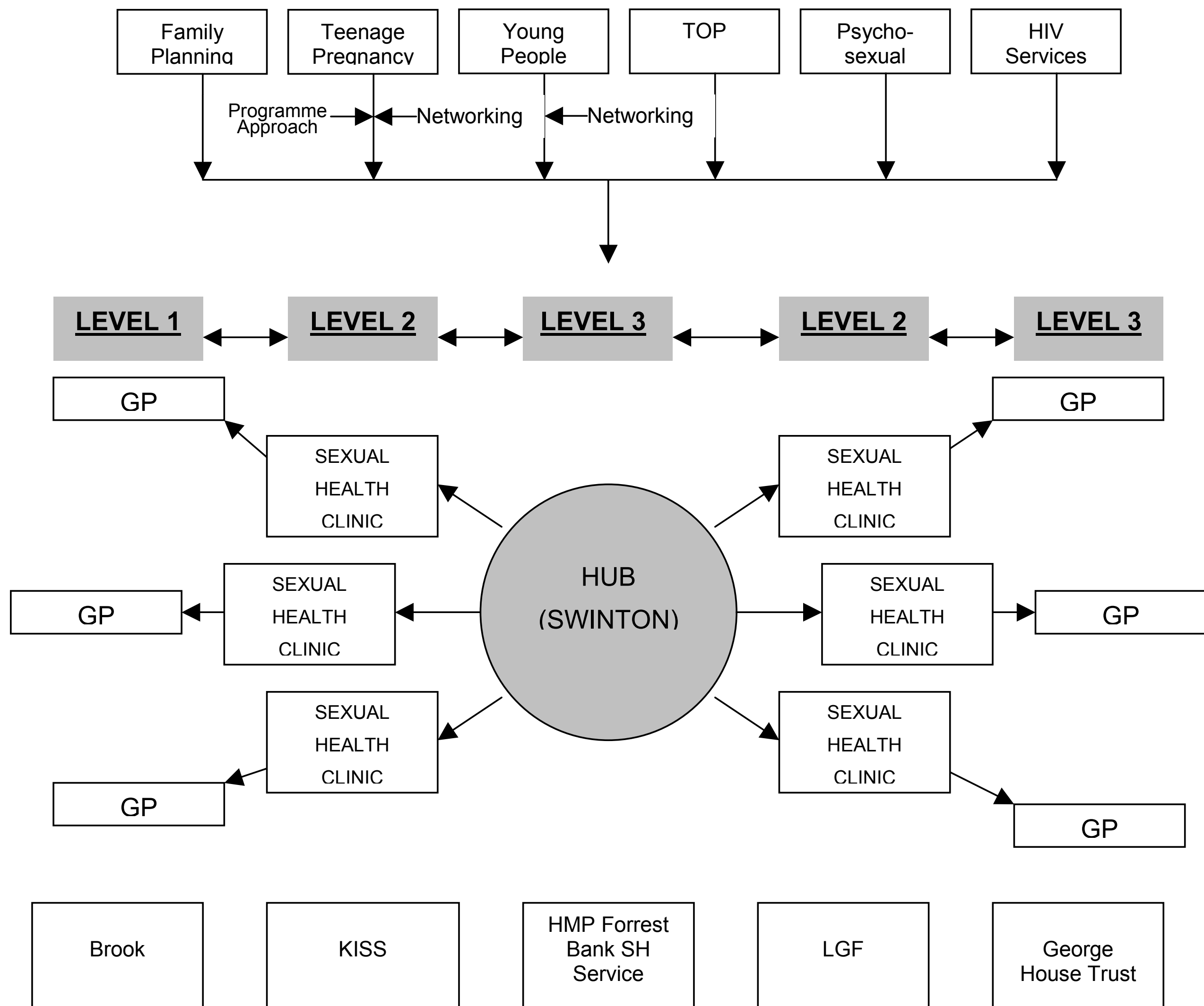
6.3.5 We propose to create a number of full-time and part-time posts to replace the numerous single session posts currently staffing the service. This will mean additional staff within each of the eight current Family Planning clinics, dealing with a larger number of people and a wider range of sexual health issue; including STI screening, treatment and HIV testing. The redesign

process developed the proposed model of integrated service delivery, based on national policy, best practice, health needs and evidence based clinical practice. This new service configuration will support the delivery of access and quality targets, including those laid down by the Government White Paper “Choosing Health” [9]. This sets a 48-hour access target for GUM. The proposed service configuration will allow “Walk-In”/”Open Access” services to be established by April 2006.

6.3.6 The majority of staff have already been part of the process, attending the Sexually Transmitted Infections Foundation (STIF) Course to enable staff to deal with a wider range of issues for clients.

Figure 7 illustrates the vision for integrated sexual health services in Salford, with core services provided through the hub and spoke model.

Figure 7 Schematic representation of Hub and Spoke Service



6.4 Action Plan

The Sexual Health Service Redesign Group operating under the Salford Sexual health Strategy Group is driving the following work forward to develop the vision. Actions include:

- Development of an integrated primary care based sexual health service within Salford.
- Agreement of an action plan and timetable for the proposed integration of primary care based sexual health services.
- Agreement of a management structure to support a primary care based sexual health service.
- Support of staff development, promoting skill mix and flexible working, which will ensure the acquisition and maintenance of 'fit for purpose' skills and competencies. (This also includes the recruitment of new staff).
- Current management of the transition from the current multi-agency model of delivery to full integration.

6.8 Current Progress

- Integration of local specialist services (GUM, Family Planning, Teenage Pregnancy Team, HIV services, young peoples clinics, Erectile dysfunction/psychosexual medicine)
- Developments agreed and implemented via the Sexual Health Service Redesign and Sexual Health Steering Group Ongoing
- Appropriate staffing levels agreed.
- Appropriate training in place to support redesign
- Support services agreed

This service redesign will bring Salford PCT Sexual Health Services to a standard and capacity that will meet the needs of the people of Salford.

6.9 Resources

The original Family Planning Service budget was £225,000 per annum plus the former GUM budget of approximately £500,000. Total cost for the expanded and integrated service will be approximately £1.6 million.

The costs for this service expansion have been met through DoH Grant monies and it is proposed that the indicative "Choosing Health" monies are used.

SECTION 7

TARGETED SEXUAL HEALTH WORK

7.1 Sexual Health for People with Learning Disabilities

(The terms learning disability and learning difficulty are used interchangeably throughout this section)

7.1.1 Needs Assessment/Current Situation

Sexual health services for people with learning disabilities are not optimal, for example there is low uptake of cervical screening that cannot be explained by risk. There are a number of reasons for this:

- assumptions are made about the level of sexual activity ;
- perceived difficulties in obtaining consent;
- lack of communication skills amongst staff in non-specialist services;
- poor liaison between learning disability services and sexual health services;
- pressure of demand from other groups e.g. contraception;
- limited support for learning disabled patients at consultation;
- limited effective advocacy during consultation;
- misunderstanding about consent issues regarding learning disabilities;
- limited appropriate literature in accessible formats;

The issues are complicated and will require multi-agency and multi-disciplinary team working.

7.1.2 Strategic Objectives:

The agenda for specialist learning disabilities services is set by the Valuing People White Paper [22]. Unfortunately, nationally to date, sexual health services have been a neglected area in specialist learning disabilities services.

The PCT and partner organisations are supporting the delivery of the Sexual Health Strategy and Teenage Pregnancy Strategy specifically for people who have a learning disability and have set a two-year time-scale to achieve the following:

- Develop and implement a policy on sexual health, sexuality and personal relationships. This will be an umbrella policy for all agencies within Salford across child and adult services.
- Identification of the need of learning disabled people for life long sex and relationships education programmes.
- Identification of the training needs of:
  - parents and carers of learning disabled children/adults
  - professionals/workers in learning disabilities services

- professionals/workers in sexual health services, leading to the development of a multi-disciplinary training strategy

- Re-designing existing health promotion materials to be accessible for people who have learning disabilities
- Supporting the re-design of sexual health services to meet the needs of learning disabled people.

By identifying and addressing the factors that contribute to poor sexual health as experienced by people who have a learning disability the work aims to:

- Increase uptake of cervical screening
- Increase life opportunities
- Reduce unwanted pregnancies
- Reduce sexually transmitted infections
- Improve poor contraceptive outcomes
- Reduce legally and ethically questionable sterilisation
- Address a fundamental health inequality

People with learning disabilities have the same rights and responsibilities as everyone else, but may need help with various parts of their lives. Some people may need help to understand their rights and responsibilities regarding social and personal relationships.

Based on the four key principals of the 'Valuing People' White Paper [22] all organisations in Salford can contribute to peoples':

- Legal and civil rights: by affirming individual's rights to a range of sexual expression through lifelong sex and relationship education.
- Independence: by providing support that maximises independence and challenges attitudes and practices that create dependence.
- Choice: by enabling individuals to make informed choices through developing skills and knowledge and by learning through experience.
- Inclusion: by designing accessible mainstream sexual services and providing information in accessible formats.

By developing skills to communicate with people who have communication difficulties, the transferable skills developed by Sexual Health Service staff will also benefit communication with: people with mental health problems, some sensory

impairment, people for whom English is not their first language and people with low literacy levels.
This will involve the development and use of: signs and symbols, simplified language, visual representation and accessible/easy to use visual and auditory information.
This policy development and implementation programme focuses on rights, responsibilities and risks in relation to social and personal relationships for people with learning disabilities, their carers/relatives, staff and organisations.
This planned programme supports organisational development for services providing support to the Salford population who have learning disabilities. All organisations providing education, health or social support to adults and children with learning disabilities will work together to ensure that individuals experience a clear and consistent approach as they grow and develop throughout their lives.

To ensure that the sexual health needs of all people who have learning disabilities are addressed as an integral part of planning services, and of assessment and care management, it is necessary:

- To disseminate the values base to address working practice in each service area.
- To enable service providers to meet these needs and to feel supported by the policy and strategy.
- To give full consideration to working in partnership with carers to meet the needs of individuals.

Protection Procedures relating to sexual abuse are a vital dimension of all our work in supporting and protecting people who have learning disabilities.

7.1.3 Current Progress

A subgroup of the Sexual Health Steering Group has been established, progress to date includes:

- Inclusion of a commitment to learning disabilities written into all new job descriptions for PCT Sexual Health Service staff
- Development of a draft policy on sexual health, sexuality and personal relationships
- Completion of an audit of training being delivered to:
    - People who have learning disabilities
    - Their Parents/carers
    - Professionals/Workers

- Identification of the training needs of
    - People who have learning disabilities
    - Their parents/carers
    - Professionals/Worker

7.1.4 Resources

This work is mainly concerned with organisational development, within existing resources. However this does not mean that the work is cost neutral. Buying and developing bespoke training and support packages will be managed within existing training budgets.

7.2 Men Who Have Sex With Men

For the purpose of this strategy men who have sex with men (MSM) are defined as any man who has or has previously had sex with another man. This will include men who self define as gay or bisexual.

7.2.1 Needs Assessment/Current Situation

High-risk sexual behaviour remains the key determinant of HIV and STI transmission, with evidence of ongoing HIV risk behaviours among MSM in the UK. Behavioural surveillance data on MSM have also shown increases over recent years in rates of unprotected anal intercourse, with casual partners, and with partners of a HIV discordant or unknown status. Data from the second National Survey of Sexual Attitudes and Lifestyles (NATSAL) [(5)] also show increases in the prevalence of male homosexual behaviour in general and increase in specific high-risk behaviours among homosexually active men. Both factors would increase the overall 'at risk' population, but reasons for behavioural change remain unclear.

Explanations for the high-risk behaviour among gay men are due to be released in forthcoming outputs from the INSIGHT study [(23)], an investigation into the risk factors for HIV seroconversion in gay men who HIV test, co-ordinated by the HPA in collaboration with clinics in London, Brighton and Manchester. INSIGHT combines qualitative and quantitative methods to explore sexual behaviour, attitudes and lifestyles of men undergoing HIV testing at sexual health clinics. The study focussed on the circumstances and behaviour of respondents during the interval between their most recent HIV test (which would have been negative for controls and positive for cases) and the last negative test up to two years prior to that.

The sexual health needs of these men remain a genuine challenge as we progress into the 21st century. The notion that poor sexual health, particularly HIV is now primarily a heterosexual concern is not only incorrect but potentially dangerous as it negates the sexual health needs of men who have sex with men.

7.2.2 Key Points

- Men who have sex with men remain the group at greatest risk of acquiring HIV
- In the UK the greatest incidence of HIV is amongst gay men
- Rates of acute STI's amongst men who have sex with men are also increasing

The sexual health needs of MSM in Salford are not yesterday's news but a real consideration for sexual health services, programmes and initiatives in the future.

7.2.3 Strategic Objectives

- To improve and promote good sexual health amongst MSM
- To reduce the incidences of new HIV infections and other STI's through sex between MSM
- To ensure that all MSM have access to accurate, appropriate sexual health information
- To improve access to sexual health services for MSM through specialised community based initiatives and programmes
- To increase the uptake of GUM screening

7.2.4 Local Initiatives and Actions

Within the National Sexual Health & HIV Strategy (2001) **[8]**, the Department of Health proposed the Community HIV & AIDS Prevention Strategy (CHAPS) Collaborative Planning Framework should become the model for locally delivered HIV health promotion for gay men. Salford PCT commissions work from the LGF in Manchester. The LGF is the UK's leading lesbian, gay and bisexual voluntary and community sector organisation. Based in Manchester, the LGF provide services and support to people throughout the North West of England. The LGF was founded in April 2000, following the successful merger of Healthy Gay Manchester (a gay men's HIV prevention agency established in 1994) and Manchester Lesbian & Gay Switchboard Services (a community help and support agency established in 1975).

CHAPS was established in 1997 and is an ongoing partnership between agencies across England to reduce the incidence of HIV infection during sex between men.

The CHAPS Collaborative Planning Framework is called 'Making it Count' [24] and states:

'The most ethical and effective approach to reducing HIV incidence among homosexually active men is through raising awareness and empowering men through clear, accessible information and facilitating the development of the skills to carry out their choices'

The LGF is the lead CHAPS partner for Greater Manchester, and has designed its service provision around the strategic aims of Making it Count.

7.2.5 Action Plan/Progress

Examples of the type of work commissioned by Salford PCT from the Lesbian and Gay Foundation include:

Direct Interventions

Media campaigns	Detached & street work
Sex & relationship education	Peer education programmes
Group work	Arts work
121 work (helplines, counselling, etc.)	Printed & electronic information
Condom & lubricant distribution	Screening & testing services
Publicising local sexual health services	Promoting self-care

Indirect Interventions

Training courses	Needs Assessments
Conferences & seminars	Joint work with Commissioners
Newsletters	Inter-agency/multi-sector working
Policy & strategy development	Consultancy, support & advice
Research	Proactive working with the media

7.2.6 Resources

This targeted work commissioned for the registered population of Salford and in line with the redesign and modernisation of Salford sexual health services is currently paid for within the contract with the voluntary sector (LGF and George House Trust) as part of a £100,000 allocation per annum. We believe this to be the most cost effective measure for targeting work at this particular group, for the reasons stated.

7.3 One size fits all – Salford's Black and Minority Ethnic population

For the purpose of this strategy and in order to target finite resources effectively, Black and Minority Ethnic (BME) communities are defined as those groups who have barriers to accessing sexual health services because of their ethnicity and those BME people or communities who have high incidences of STI's and HIV.

7.3.1 Needs Assessment/Current Situation

Acknowledgement must be given to the fact that no group is the same and that the one size fits all approach around sexual health services will not serve Salford's burgeoning and diverse Black and Minority Ethnic population.

There has been a disproportionate increase in diagnosed STI's among BME communities in the UK, with an increase of HIV in both African and Caribbean communities. The incidence of HIV amongst black people in the UK is a reflection of the fact that a large proportion of heterosexual men and women diagnosed in the UK acquired their infection in sub-Saharan Africa.

7.3.2 Key Points

- Over 90% of heterosexually acquired HIV infections diagnosed in the UK during 2004 were probably acquired in high prevalence countries of origin, mainly sub-Saharan Africa, with 38% acquired uptake in Zimbabwe.
- While relatively low, the number of black and minority ethnic (BME) adults acquiring HIV through sexual contact in the UK is rising steadily.
- The prevalence of previously undiagnosed HIV infection was 2.7% among sub-Saharan African-born heterosexuals at sentinel GUM clinics in London during 2004, and 7.1% elsewhere in England, Wales and Northern Ireland.
- Qualitative data has shown that among migrant African communities fears of an HIV diagnosis and HIV-related stigma and discrimination are key factors among those reluctant to uptake voluntary confidential testing for HIV.
- Black Caribbean populations continue to be disproportionately affected by gonorrhoea in 2004 and increasing numbers of black Caribbean's were diagnosed with HIV.
- HIV and STI diagnoses remain low in Asian populations however, this situation needs to be monitored because of steady increases in HIV prevalence across Asia.
- Just as homophobia and sexism have fuelled the HIV epidemic so too has racism.

7.3.3 Vision for Sexual Health Services for the Black and Minority Ethnic Population

The broad ethnic categorisation used for surveillance reports obscures the complexity behind the HIV epidemic in BME groups diagnosed in the UK. There is a tremendous diversity of languages, cultures, and faiths, which pose a challenge to the delivery of sexual health services and sexual health campaigns to BME groups.

HIV may be just one of many issues that individuals are attempting to deal with, particularly those from newly migrant communities who may also be dealing with uncertain immigration status, housing, pregnancy, other infections such as TB, as well as issues of stigma and discrimination.

Qualitative data from the 2004 Mayisha II study among migrant African communities [(25)] indicates that fear of the implications of an HIV diagnosis and HIV related stigma and discrimination continue to deter individuals from taking the Voluntary Confidential HIV Test (VCT). Despite such concerns, the Mayisha II study reported that 43% of male and 51% of female respondents had had a previous voluntary confidential HIV test, the vast majority of whom had done so in the past five years.

Participants in the study made suggestions regarding interventions that would encourage HIV testing and knowledge of status. Respondents requested information about HIV testing in general, for example what happens at a VCT, improved access to rapid or same day testing services, and information about the impact of HIV test results on migration plans. Respondents also wanted to learn more about the effectiveness of treatment and the difference between HIV and AIDS.

The recurring theme of the continued impact of HIV-related stigma and discrimination reported in the Mayisha II study confirms that such issues remain real to African communities in the UK and influence the uptake of services and decisions to HIV test.

7.3.4 Strategic Objectives

- To improve and promote good sexual health amongst BME communities
- To reduce the incidence of new HIV infections and other STI's in BME communities
- To increase uptake of GUM screening
- To develop sexual health partnerships with a range of non-specialist agencies that work with BME communities

7.3.5 Action Plan/Progress

This work is currently under development. A progress report and action plan is expected in early 2006.

7.3.6 Resources

This work is currently not costed, although it is factored into the Sexual Health Service redesign programme. Funding has been secured for the post of Refugee & Asylum Seekers Development Manager for a further two years.

7.4 People That Services Do Not Reach

7.41 Needs Assessment/Current Situation

A vulnerable person is:

- Less likely to access services, experience poverty and deprivation
- Is likely to experience discrimination and prejudice
- Is marginalized or excluded from mainstream society

The links between inequalities, inequities and poor health are well researched and documented. It is also known that particular sectors of society find it hard to access mainstream or indeed any health services. Whilst the focus on acknowledging the need to reach vulnerable groups is present in local and national policy, in practice facilitating this process in a meaningful way is problematic.

It is important to remain aware of the consequences of the Inverse Care law [26], where medical care is least available where it is most needed should be borne in mind. This law is ubiquitous and applies with regard to access, uptake and quality of care and as such is of particular relevance to vulnerable groups.

7.4.2 Strategic Objectives

- To improve and promote good sexual health amongst vulnerable groups
- To improve access to services for hard to reach groups
- To increase uptake of GUM screening
- To increase uptake of hepatitis B vaccinations
- To support interventions to reduce the incidence of STI's amongst vulnerable groups

7.4.3 Action Planning

This area will be addressed in principle by Salford PCT through appropriate processes such as partnership working and Health Equity Audit

SECTION 8

TEENAGE PREGNANCY

This section summarises the broad activities that are happening under the Salford Teenage Pregnancy Strategy.

For the purpose of this local strategy young people are defined as 18 and under.

8.1 National Policy

In 1999 the government's ten-year national teenage pregnancy strategy was launched. The main aims of the strategy are to:

- Reduce the rate of teenage conceptions with the specific aim of halving the rate of conceptions among under-18s and to set a firmly established downward trend in the rate of conceptions among under -16's, by 2010.
- Increase the participation of teenage parents in education, training and employment to 60% by 2010, to reduce their risk of long-term social exclusion.

The Teenage Pregnancy Strategy has 4 key themes:

1. National media and communications campaign.
2. Joined up action, with mechanisms to co-ordinate local and national action.
3. Better prevention of the causes of teenage pregnancy, including better sex and relationship education and better access to sexual health services.
4. Better support for pregnant teenagers and teenage parents.

8.2 National Targets

The national Teenage Pregnancy Strategy targets are to:

- Halve the under 18 conception rate by 2010 and set a firmly established downward trend in under 16 conceptions (compared to 1998 baselines)
- Improve the health and social outcomes for teenage parents and their children, with a target of 60% of teenage parents in education, training or employment by 2010

Each top-tier Local Authority is to have a 10-year strategy to achieve these targets.

8.3 Teenage Pregnancy in Salford

On average 6 young women in a Salford High School year 11 group will be pregnant before they are 18, 4 of them will go on to have babies and 2 opt for termination of pregnancy. Additionally, it should be noted that there has been an increase in HIV and sexually transmitted infections amongst young people, and an average 10% of young people are infected with Chlamydia

8.4 Progress in Salford

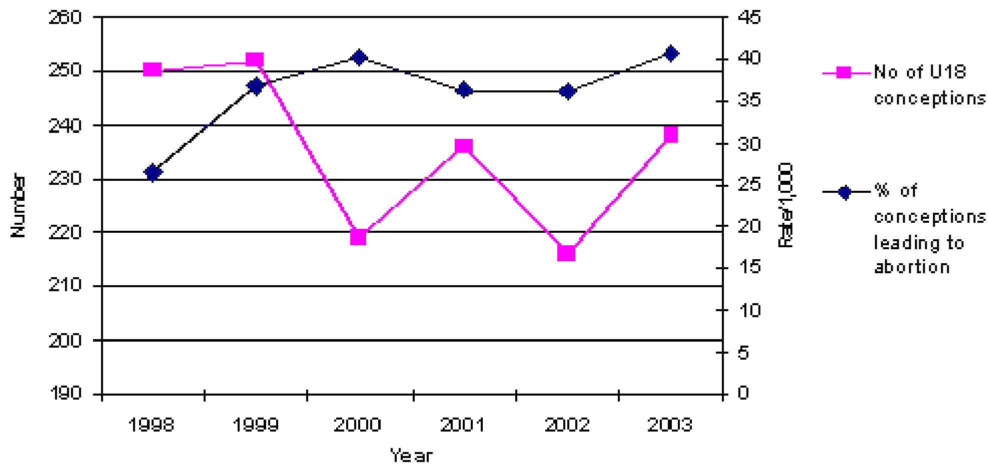
Table 3 and figure 8 illustrate progress in relation to conceptions in women under 18 in Salford from 1998 to 2003. Clearly, the number of conceptions has fallen since 1998 and now appears to be varying around a lower mean value. The number of conceptions shows an opposing pattern, with levels rising since 1998 and now steady around a higher mean value.

Table 3 Progress Towards <18 Targets, Salford MDC 1998-2003

	No of U18 conceptions	% of conceptions leading to abortion	Conception rate per 1,000 women aged 15-17	% increase (+)/decrease (-) in rate since 1998
1998 (baseline)	250	26.4	61.5	N/A
1999	252	36.7	62.1	1
2000	219	40.2	53.5	-12.9
2001	236	36.4	56.7	-7.8
2002	216	36.1	52.6	-14.4
2003	238	40.8	58.2	-5.3

Source: Office for National Statistics

Figure 8 Under 18 Conceptions 7 associated abortions, Salford MDC 1998-2003



Source: Office for National Statistics

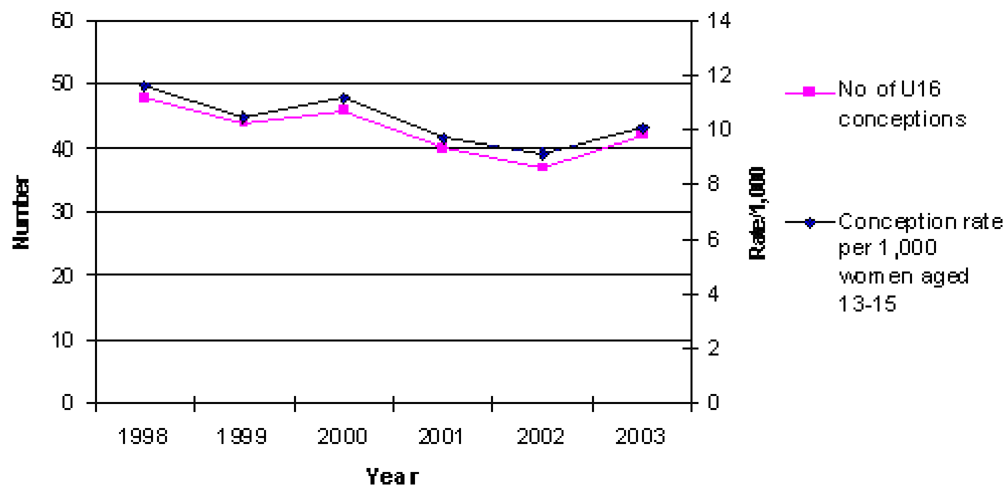
Table 4 and figure 9 illustrate progress in relation to conceptions in women under 16 in Salford from 1998 to 2003. A steady downward trend is suggested, however the rise in 2003, if repeated, may indicate a reverse in this trend.

Table 4 Progress Towards <16 Targets, Salford MDC 1998-2003

	No of U16 conceptions	Conception rate per 1,000 women aged 13-15	% increase (+)/decrease (-) in rate since 1998
1998 (Baseline)	48	11.6	N/A
1999	44	10.5	-9.5
2000	46	11.2	-3.4
2001	40	9.7	-16.3
2002	37	9.1	-21.6
2003	42	10.1	-12.9

Source: Office for National Statistics

Figure 9 Under 16 Conceptions, Salford MDC 1998-2003



Source: Office for National Statistics

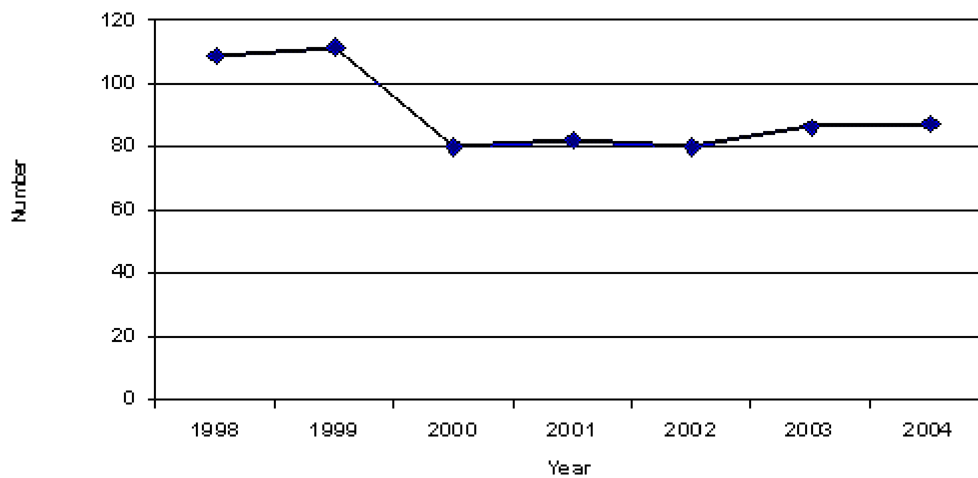
Table 5 and figure 10 show the number of live births in Salford from 1998 to 2004. It can be seen clearly that rates dipped significantly in 1999/2000 and have stayed at a lower level steadily since then, suggesting a downward trend if the 2004 data set rise as 2003 did.

Table 5 Live Births in Under 18s, Salford 1998-2004

	Under 16's live births	16-17 live births	Total under 18 live births
1998	13	96	109
1999	13	99	112
2000	5	75	80
2001	9	73	82
2002	6	74	80
2003	6	80	86
2004	5	82	87

Source: Salford PCT Child Health, 2005

Figure 10 Live Births in Under 18s, Salford 1998-2004



Source: Salford PCT Child Health, 2005

In summary, it appears that progress towards reducing teenage pregnancy in Salford is substantial and suggests that the national targets are well within reach. Salford's under 18-conception rate (2003) has decreased 5.3% from baseline 1998 compared to a 9.8% reduction for England and a 10.7% reduction for the North West and a 4.3% reduction for Greater Manchester. Our most similar comparative local authority (Gateshead) has experienced a 15.4% reduction; however using three year averages from 1998-2000 and 2001-2003 Salford has experienced a 5.4% reduction compared to a 17.7% reduction for Gateshead. Salford had higher conception rates in 1998 and is ranked as more deprived than all our comparative local authorities.

Further analysis of Salford teenage conception rates using three year averages from 1994-2003, indicates a significant decline and suggests that with further accelerated decreases, Salford could meet the target of 50% reduction by 2010. Salford's under 16's conception rate, (2003) has decreased 12.9% from baseline 1998. 2004 under 18 conception data will be made available to us in February 2006.

Births to under 16's for 2004 have reduced from 13 to 5 representing a 61.5% decrease from baseline 1998. Births for 16 & 17 years olds have reduced 14.2% and total births to under 18's have decreased 20.2%. 2005 Live Birth data is available in January 2006.

8.5 Strategic Drivers

Teenage pregnancy rates in Salford have historically been higher than national and regional averages. This is not only a reflection of the sexual behaviour of young people in Salford but also local cultural and socio-economic issues – any strategy thus needs to operate at both the individual and population levels.

As well as representing a significant part of the Sexual Health Strategy, Salford's Teenage Pregnancy Strategy will form part of Salford's Children and Young Person's Plan. Delivery of this plan will fall to the partnership of statutory and voluntary organisations which deliver health, education, social care and other services to children and young people within the city, led by the Children's Directorate of the Local Authority.

8.6 Current Provision in Salford

The Teenage Pregnancy Team is currently mainly located at Hope Hospital. The Making It Real, Making It Happen consultation on the future of paediatric, maternity and neo-natal services across Greater Manchester and the surrounding areas is to include five options for future provision of services. Continued provision of obstetric services at Hope Hospital is included in only one of these options. The outcome of the consultation may thus have a significant impact on the operation of the Teenage Pregnancy Team.

8.7 Evidence Base for Interventions

The national Teenage Pregnancy Team recommends interventions to:

- Raise aspiration and self esteem
- Enhance regeneration and opportunity
- Delay first sex

- Provide accessible, youth friendly, confidential contraceptive / sexual health services
- Offer tailored health, education and social support for teenage parents

In addition, as teenage pregnancy funding is likely to no longer be ring fenced but will come to the city as part of the Local Authority baseline, mainstreaming local strategies is a current area for focus through effective partnership arrangements, joint ownership of the interventions and long term financial commitment to those elements of the strategy that have been shown to be effective.

8.8 Salford's Teenage Pregnancy Strategy Vision

The vision is to deliver a multi-faceted approach to address these issues, with all of the following factors in place and with at risk groups targeted for more intensive intervention: Any sexual health interventions with young people must acknowledge their complex needs and services need to be designed in line with national guidance and evidence based good practice.

Salford's Teenage Pregnancy Strategy is evidence based on the Social Exclusion Unit, Teenage Pregnancy Report [27] that specifies:

- There should be clear messages to young people in their own media
- Sex and Relationships Education (SRE) in schools and out of school settings providing knowledge and skills on delaying first sex, risks of unprotected sex and effective contraceptive/condom use
- There should be open discussion with parents/carers
- There should be easy access to confidential youth friendly contraceptive/sexual health services
- There should be tailored health and social support for teenage parents
- A multi-faceted approach should be taken, with **ALL** factors in place, intensive delivery to at risk groups, combined with additional motivation to delay early pregnancy

8.9 Actions

The Teenage Pregnancy Team's Annual Report and Strategy describes future actions in detail; key areas of current focus include:

- Continued work with schools and other settings to develop SRE in Salford

- The further development of sexual health services for young people, integrated with other sexual health services and thereby offering a fuller range of STI services
- Development of dedicate teenage pregnancy services networking with appropriate sexual health services
- Work to mainstream appropriate aspects of the Teenage Pregnancy Strategy within the Children and Young Person's Plan as it develops
- Contributing to the Making It Better, Making it Real consultation
- Led by an independent advisory group, undertake a review, using Best Value principles, of the PCT's investment in the Eccles Brook Service

8.10 Commissioning Young Persons Sexual Health Services in Salford

8.10.1 Within the broad actions described above, the following services are provided:

- Keep It sorted in Salford (KISS), a PCT provided sexual health service for young people.
- Brook in Eccles – an alternative provider of sexual health advice for young people
- Sure Start Plus Teenage Pregnancy Team – antenatal and postnatal support for young parents

Universal sexual health services are also provided by health visitors, and it is a key role for school nurses. Young people will also be accessing local GPs for contraceptive advice.

In line with the review of adult Sexual Health services, it is timely that the PCT should review those for young people. Much has been done with the KISS service to ally the vision for and activity around young peoples' services with those for adults. As such, commissioners are considering the long-term strategy for young people's sexual health services in Eccles, currently provided by Brook and KISS. An independent advisory group is being formed to make a decision on this. This review will work within the following principles:

- The lead commissioner will lead an independent group, which will take the final decisions. The group will consist of representatives from the Commissioning, Salford Royal Hospitals Trust, City Council Children's Directorate and the voluntary sector (the voluntary sector representative

of the Children and Young Person's Partnership Board).

- Terms of reference of group to be documented - Best Value principles for commissioners of young persons sexual health services in Eccles
- Position paper from commissioners to be prepared laying out current position, issues and options. Background to this papers to include what have already been prepared and need something about KISS plans including possible NRF funding for 2006/07
- Representatives from Brook and KISS have the opportunity to prepare response to these papers
- Papers and Brook and KISS written responses to go to the independent group for final decision.

8.10.2 Costs:

The costs of the Teenage Pregnancy Strategy are currently met by mainstream services with additional costs met by the Teenage Pregnancy Strategy Local Implementation Grant and Sure Start Plus funding. Mainstreaming these costs needs to be discussed. KISS services are funded within the sexual health integrated service. Services commissioned from Brook cost £100,000 per year.

SECTION 9

HIV COMMISSIONING

9.1 Policy Context

1. National Strategy for Sexual Health and HIV [8]

This Strategy has core aims to:

- Reduce HIV transmission
- Reduce the prevalence of undiagnosed HIV
- Improve health and social care for people living with HIV; and
- Reduce the stigma associated with HIV
- Provide clear information so that people can take informed decisions about preventing HIV
- Ensure there is a sound evidence base for effective local HIV prevention;
- Set a target to reduce the number of newly acquired HIV infections;
- Develop managed networks for HIV and sexual health services,
- Increase the offer of testing for HIV
- Set standards for the treatment, support and social care of people living with HIV
- Address training and development needs across the whole range of HIV services.

2. Choosing Health [9]
3. Department of Health Sexual Health Commissioning Toolkit [28]
4. The Wanless Reports [10]

9.2 Guidelines

1. British HIV Association (BHIVA) Guidelines on Highly Active Antiretroviral Therapy (HAART) [29]
2. Medical Foundation For AIDS and Sexual Health (MedFASH) Guidelines 2003 [13]
3. Royal College of Psychiatrists Guideline on Prescribing for Mental Health in HIV [30]

9.3 Prevalence of HIV

Note - Epidemiological Information is only available by Genito-Urinary Medicine (GUM) clinic, and not by PCT. Rates are calculated on a zonal, or county level by collating returns to the Public Health Laboratory Service from individual GUM clinics (KC60 data). As such, the best data available for Salford is that relating to Greater Manchester as this is collected centrally by and published by the Health Protection Agency.

The Health Protection Agency recently published “Mapping The Issues”, a comprehensive review of HIV and STIs in the United Kingdom [1]. This document makes a number of important observations regarding HIV in Manchester. Theses include:

- Outside London, rates of HIV-infected people accessing HIV-related services were highest in Greater Manchester (99/100 000)
- The North West is one of few regions that had more than 500 HIV diagnoses in 2004, with 64% of these diagnoses in Greater Manchester SHA
- Nearly half of the HIV diagnoses made in North West region (272/579) during 2004 were probably acquired through sex between men, the majority (174) in Greater Manchester SHA.
- The three regions with the largest increases in the number of resident individuals seen for HIV care between 2000 and 2004 were the South East (+122%, 2040 to 4534), **North West** (+111%, 1598 to 3368) and East of England (+202%, 814 to 2462). Within these regions, Surrey and Sussex (+998), Thames Valley (+843), **Greater Manchester** (+1154) and Bedfordshire and Hertfordshire (+814) SHAs experienced the largest numerical increases.
- In 2004, the prevalence of diagnosed HIV-infected individuals was highest in the South East (66/100 000), **North West** (59/100 000) and East of England regions (53/100 000), and specifically in **Greater Manchester** (99/100 000),
- Overall, Surrey and Sussex and **Greater Manchester** SHAs provided care for the largest proportions (17% [1219/7011]) and (17% [1175/7011]) of HIV-infected MSM seen for care outside of London in 2004. The majority of MSM seen for care in England outside London during 2004 were of white ethnicity (94% [6585/7011])

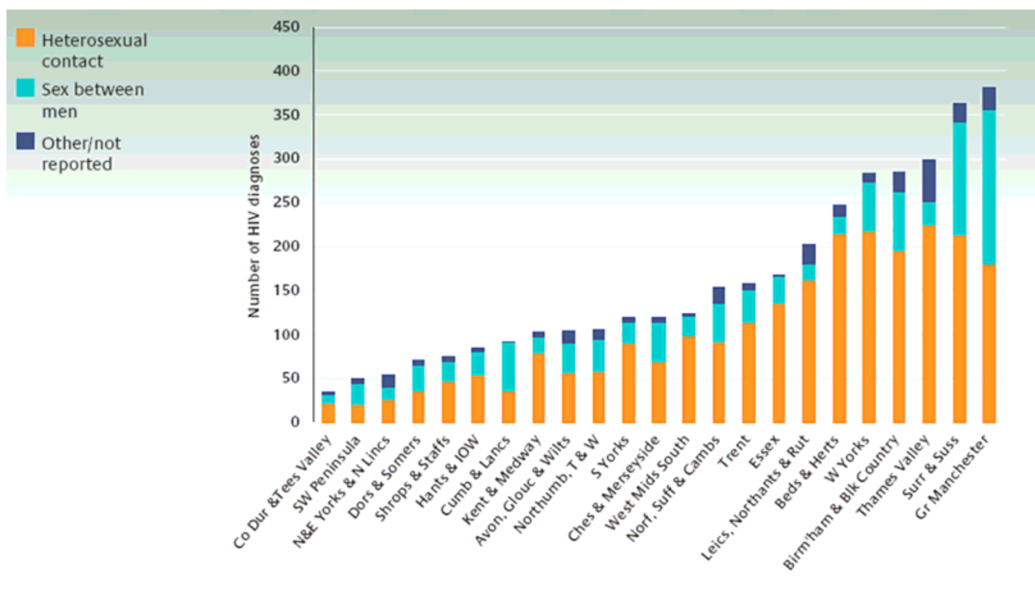
Table 6 illustrates both the current prevalence of HIV in Salford [31], and the fact that this is increased compared with national prevalence. The UK row shows national figures as provided by the HPA [1], whilst the Salford (projected) row shows *expected* figures for Salford if national rates are applied. The Salford (actual) row shows the actual number of HIV cases in Salford for 2004 (282), the theoretical number of undiagnosed cases if national rates are applied and the total number if these are added (in parentheses). Clearly, Salford prevalence is significantly greater than national prevalence, and there are potentially a large number of undiagnosed cases within the PCT.

Table 6 HIV cases in Salford by Comparison with National Data

	Population	HIV Cases	Diagnosed	Undiagnosed
UK	60,000,000	58,300 (1)	38,600	19,700
Salford PCT (projected)	237,000	230	152	78
Salford PCT (actual)	237,000	(523)	346	(177)

Figure 11 below demonstrates the position of Greater Manchester as compared with other SHAs outside London. Although all categories are large by comparison with other SHAs, the number of diagnoses in MSMs is most notable.

Figure 11 HIV Diagnoses by Exposure Category, by SHA, outside London, 2004



Source: Health Protection Agency

9.4 Key Issues

- Salford has a significantly higher incidence and prevalence of HIV than other parts of the country (outside London)
- There is a particularly high prevalence in MSMs
- Social care and support is a key component of any strategic approach

9.5 Principles to inform strategy

- To empower people with HIV to take as much control of their lives as possible.
- To promote the social inclusion of people infected and affected by HIV in mainstream services where possible.
- To ensure client confidentiality is maintained.
- To provide non-stigmatising services from specialist staff where necessary.
- To ensure best value in use of available resources.
- To employ an evidence based and outcome focused commissioning framework.
- To prioritise those clients in highest need.

9.6 Strategic goals

- To enable rehabilitation from illness as far as possible.
- To develop community support services for people with HIV and their carers, reducing the need for institutional care and treatment.
- To enable a high quality involvement of service users in the consultation process
- To promote and facilitate treatment outside tertiary care settings

9.7 Strategic priorities

- To establish a model for commissioning services in light of health and social services structures locally.
- To facilitate the management of patients outside tertiary care settings
- To promote services that target those with higher care needs and their carers.
- To maintain services that support families where children are infected or affected by HIV.
- To continue to exercise stringent financial checks, maintaining budgetary balance in a climate of changing funding arrangements.
- To engage service users in consultation process with regard to services for people with HIV in Salford.

- To set and monitor standards across all service areas

9.8 Best Practice

The MedFASH standards make recommendations in 12 distinct areas [13]:

- HIV Prevention
- Early diagnosis of HIV
- Empowering people with HIV
- Clinical care of people with HIV
- Primary Care
- Social Care Integrated with Healthcare
- Sexual Healthcare
- HIV in Pregnancy
- Care of families with HIV
- Emergency care in people with HIV
- Care of People with HIV during admission to hospital
- Respite, Rehabilitation and Palliative Care

An expanded interpretation of these is provided in Figure 12

9.9 Current Services in Salford

The GMSHN is currently developing a HIV strategy for Greater Manchester. It is anticipated that Salford PCT will subscribe to this strategy. The GMSHN Action Plan for 2006 and onwards in respect of HIV is shown in table 7 below

National/Local Targets	Priority Action Group	Baseline Performance	Action Plan	Date
A reduction in the rate of growth of new cases of HIV by 2008	PAG 5 - To create a clear patient pathway for commissioning HIV prevention, treatment and care services.	We have over 1,700 people living with HIV and over 2,000 treated in GM. New diagnosis rates are increasing at 20% per year.	20 - Develop point of care testing for High Risk Groups	Sep-06
			21 – Ensure all HIV patients receive STI screening	Apr-06
			22 - Develop agreed Care pathway for HIV prevention, treatment and care services.	Apr-06
			23 - Agree and implement Commissioning Strategy and Framework for future services	Sep-06

Table 7 GMSHN Action Plan 2005/6 onwards – HIV Section

Source: GMSHN

9.10 Patient Flows

Of the 346 cases of diagnosed HIV in Salford, 65% (225) are on Highly Active Antiretroviral Therapy (HAART) [31]:

The distribution of patients by Hospital is:

- Hope Hospital: 51
- Regional Infectious Disease Unit: 167
- North Manchester General Hospital : 37
- Manchester Royal Infirmary: 64
- Plus small numbers elsewhere

Note:

- Care is sometimes shared between Trusts
- There is a lag period in collection of HIV figures, and as of 10/01/06, Hope Hospital is treating 71 HIV patients [32]. This reflects the rising prevalence of HIV as patients live longer thanks to more effective chemotherapy.

9.11 The Voluntary Sector

1. The George House Trust:

The George House Trust (GHT) is the HIV Voluntary Organisation for the North West of England. GHT provides high quality services for people living with HIV and for people affected by HIV (including partners, children, carers and family). All services are free and include social care and support. Funding comes from public donations, fund-raising events, payments from NHS trusts and councils, and from minor trading activities. Salford PCT is a contributing NHS Trust.

2. The Lesbian and Gay Foundation:

Between 1994 and 2002 the LGF received HIV prevention funding for work with gay and bisexual men from all 6 Health Authorities across Greater Manchester. All the Health Authorities were contributing to services provided by the LGF in Manchester's Gay Village and at our community centre in the City. Salford PCT continues to provide funding for the LGF.

Table 8 shows Salford PCT's population numbers of gay and bisexual men:

Table 8 Salford PCT Population Numbers – Gay and Bisexual Men

Homosexually Active Men between 17-54 years old (2% - 5% of total population(Sigma Research))	HIV Prevalence Gay & Bisexual Men 2004 (JMU 2005)
4,550 to 11,330 (av. 7,940)	216(2.72%)

Source: LGF

During 2002 the 6 Health Authorities became 14 PCTs, all of which adopted existing contracts with the LGF. However, over the last 3 years, the LGF has received no real increase in funds neither in line with increased demand for services nor in line with the increased demand for modernisation and innovation.

The LGF also continues to receive year on year allocations from PCTs, with the exception of Manchester who have recently moved towards 3 year contracts with the HIV voluntary sector.

Table 9 shows Salford PCT's 2004/05 LGF Activity & Funding Levels for monitoring and HIV Prevention in Gay & Bisexual Men.

3. Others:

Other voluntary organisations that have received funding from Salford PCT include Manchester Action on Street Health (MASH), through which Salford PCT has funded needle exchange, and The Black Health Advisory Forum (BHAF).

Table 9 Salford PCT 2004/05 LGF Activity & Funding Levels

SERVICE / ACTIVITY	Provided to gay & bisexual residents in Salford	Provided in Manchester to Salford gay & bisexual residents	2004/2005 Total	2004/2005 Costs	2004/2005 Paid
Condom & Lube Distribution	1200 packs	45,795 packs (22%)	46,995 packs	32,900	32,900
The Clinic (including outreach)		132 patients	132 patients	28,000	0
The Jarman Clinic		Contribution	Contribution	3,000	0
CHAPS devel./campaigns				0	0
outnorthwest magazine	4550 copies	18,925 (22%)	23,475 copies	17,000	12,000
lgf website		80,000 hits	80,000 hits	12,000	5,000
Helpline/Email support		240 calls	240 calls	5,000	0
121 & relationship counselling		21 clients	21 clients	9,450	0
Therapy groupwork				0	0
Self-help groups (x5)		181 attendees	181 attendees	9,050	7,000
Training & workshops		54 attendees	54 attendees	8,100	7,000
Rampton Hospital				0	0
Alcohol & drugs work		72 participants	72 participants	10,800	0
Information resources	1550 copies	15,466 copies (22%)	17,016 copies	3,450	7,000
Events				0	0
Male sex workers project		Contribution	Contribution	2,000	0
E. M'chstr New Deal project				0	0
Core Salary Costs		Contribution	Contribution	10,000	4,000
Infrastructure Costs		Contribution	Contribution	5,000	1,564
				155,750	**76,464**

Source: LGF

9.12 Support Services

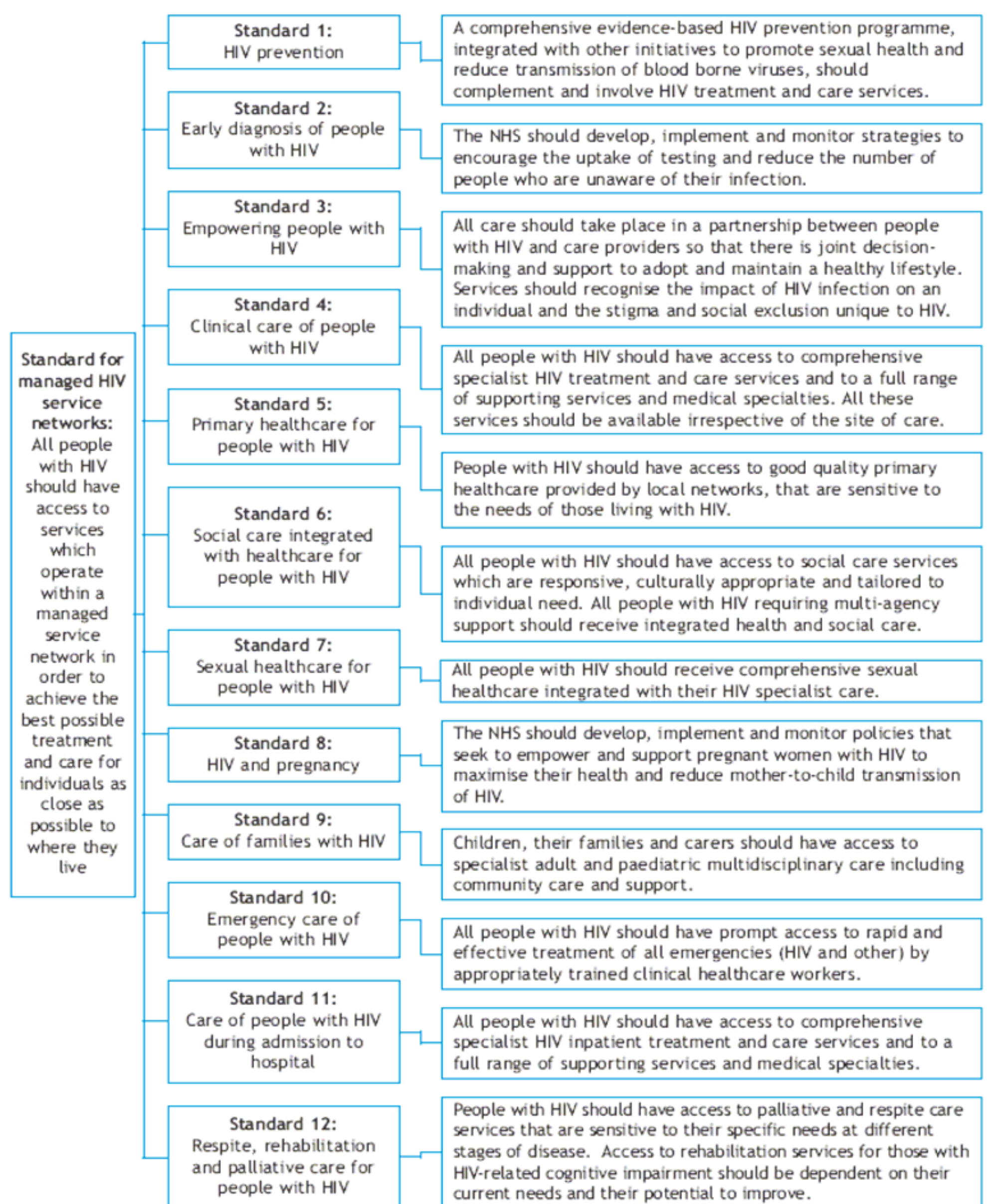
1. Psychology:

   There is a dedicated psychologist in post at Hope hospital

2. Social support

   There is a nominated social worker at the Local Authority for HIV patients

Figure 12 **The MedFASH Standards**



9.13 Clinical Management

Clinical management of HIV is a complex and rapidly evolving area. Drugs are the current mainstay of treatment, particularly Highly Active Antiretroviral Therapy

(HAART), which is generally given as combination chemotherapy. Drug resistance is a growing challenge and can necessitate changes in drug regimens and addition of other agents such as Protease Inhibitors. Newer drugs are likely to be included in the future and this is referred to below.

The PCT should commission clinical care that is in accordance with best practice guidelines. BHIVA guidance [29] is evidence-based and sets clear standards on the management of HIV, covering:

- When to start treatment
- Initial Therapy
- When to change therapy
- Resistance
- Drug monitoring

9.14 Commissioning Arrangements

Commissioning for HIV is done by North Manchester PCT on behalf of all Greater Manchester PCTs for the specialist services at North Manchester Hospital.

9.15 Costs and Financial Flows

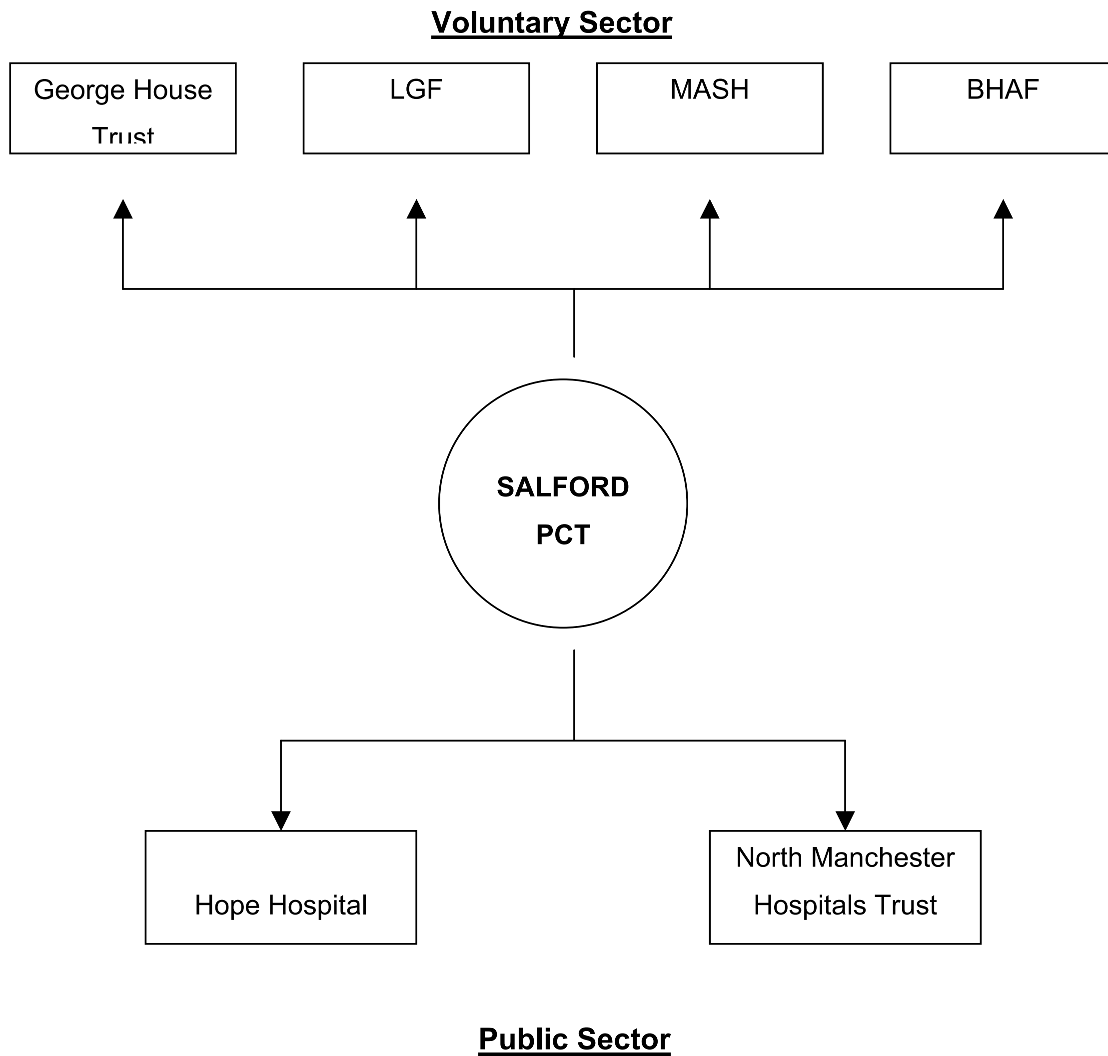
Funding is allocated to the Regional Infectious Diseases Unit at North Manchester Hospitals Trust.

Current spending by Salford PCT on HIV drugs for 2005/06:

- Salford Royal - £202,000
- North Manchester - £1.7,000,000

Funding is also provided to voluntary organisations as outlined above. This is summarised in figure 13 below.

Figure 13 Financial Flows - Salford PCT HIV Services 2005/6



9.16 Horizon Scanning [29]

HIV and its management is a complex and rapidly evolving area of healthcare. The PCT should be aware of potential new interventions that may acquire the evidence base necessary to make them legitimate treatment options.

For example:

New drugs likely to be used in the near future

1. Atazanavir

The main interests in this drug lie in its once-daily dosing, its lack of effect on lipid metabolism and, by implication, low probability of an association with lipodystrophy. Present studies indicate similar potency to an NNRTI or unboosted Protease

Inhibitors (PIs) in treatment-naive patients. If these early results are confirmed, many clinicians may find this drug an important option when choosing a first PI.

2. Enfuvirtide (T20)

This drug has recently been licensed for patients with treatment failure. It is the first of a new class of compounds interfering with HIV cell entry. Its main disadvantage will be mode of administration (by injection twice a day). Wherever possible it should be reserved for use after second or subsequent treatment failure, in combination with one or preferably two other new drugs that are expected to be active on the basis of resistance data, to give a realistic prospect of suppressing viral replication completely. This may mean keeping some patients on their current regimen while waiting for other new drugs to become available for use alongside T20. In individuals at imminent risk of clinical disease and death, T20 might have a limited role as additional therapy in a failing regimen where there are no other active drugs available.

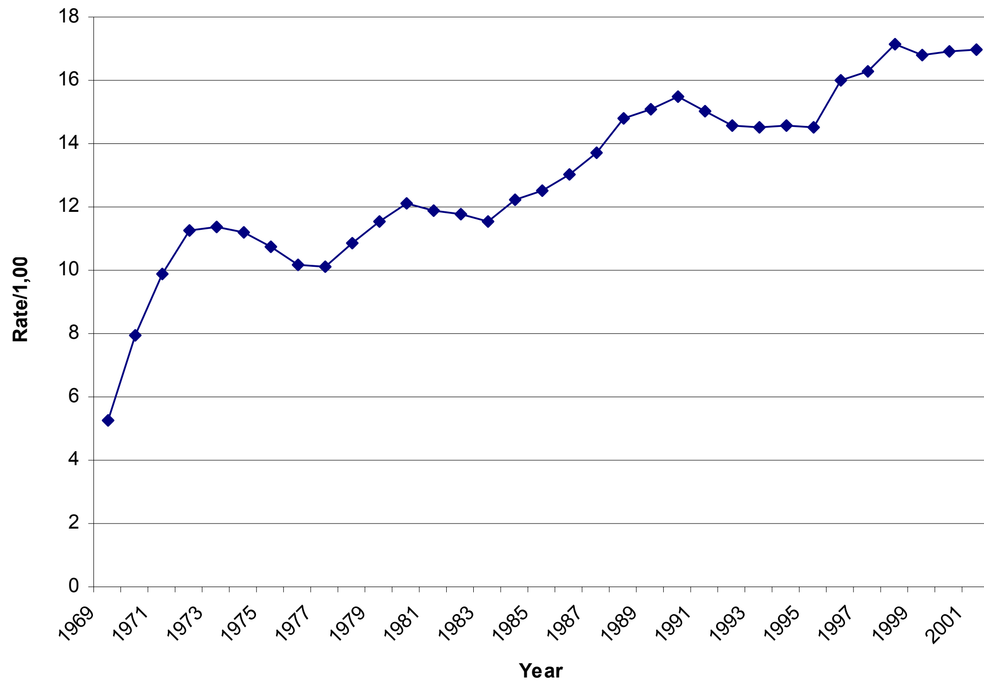
SECTION 10

TERMINATION OF PREGNANCY

10.1 National Figures

The Office for National Statistics has published statistics related to legally induced abortions within England and Wales, with the most recent figures being for 2001. Figure 14 demonstrates the steady increase in the rate (age-adjusted) over the 32 year period 1969-2001.

Figure 14 Incidence of Termination of Pregnancy, England & Wales, 1969-2001



Source: Office for National Statistics

10.2 Legal Issues

These are governed by the Abortion Act 1967, the Human Fertilisation and Embryology Act 1990 and any subsequent amendments to these.

10.3 Data Issues

Data are available on a practice basis for Salford PCT, however the small nature of the numbers involved makes it inappropriate to publish them in this document. These may however be analysed further in a confidential report.

10.4 The Salford Pathway:

A new operational process has been introduced in Salford whereby:

- Up to 12 weeks gestation to Hope Hospital
- Over 12 weeks gestation to South Manchester Clinic
- Medical TOPs are now performed at Hope hospital

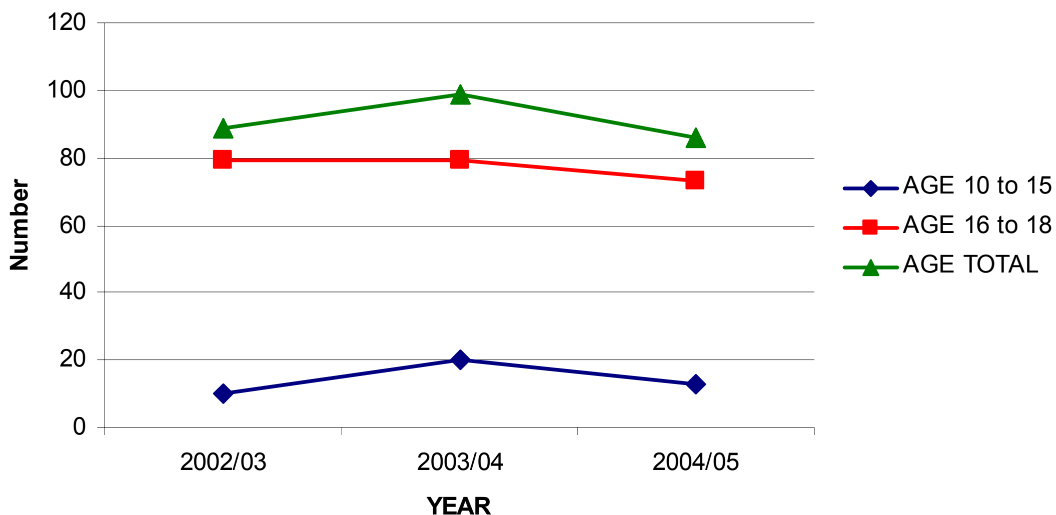
10.5 TOPs in Teenage Pregnancy in Salford

Table 10 and figure 15 illustrate TOPs in Teenage Pregnancy in Salford from 2002 to 2005. Most recent figures show a fall in numbers, however further years' figures will determine if this is sustained. Small numbers restrict the amount of data that can be shown, however other data do show that the large majority of these TOPs are surgical.

Table 10 TOPs in Teenage Pregnancy in Salford 2002 – 2005

		YEAR		
		2002/03	**2003/04**	**2004/05**
AGE	**10 to 15**	10	20	13
	16 to 18	79	79	73
	TOTAL	**89**	**99**	**86**

Figure 15 TOPs in Teenage Pregnancy in Salford 2002 – 2005



Source: Greater Manchester TIS

Prior to this period, TOP figures for 2002 showed a 10% increase from baseline 1998.

Currently, access to TOP services is good and the Teenage Pregnancy Team (TPT) provide pre/post TOP counselling, sexual health advice and contraception to all young women under 20 years attending Hope Hospital for TOP. Investment to increase Brooks capacity, expansion of KISS Young Peoples Sexual Health Services, TOP service re-design and the integration of Sexual Health Services have all contributed to declining conception rates, an increase in the number of TOPs performed and a reduction in births.

The Salford Teenage Pregnancy Partnership Board Action Plan for 2005/06 addresses five key areas:

- Local co-ordination
- Media and Communications
- Sex and Relationship Education
- Sexual Health Services
- Support for Young Parents and Their Children

As less young women become pregnant more are opting for TOP and particularly the under 16's are not continuing with their pregnancy. This is encouraging as they are the most vulnerable and more likely to have their education disrupted as a result of pregnancy. Further preventative work is required to ensure that young people are using contraception at first and subsequent intercourse.

10.6 Key issues

There are three areas in need of consideration currently:

- The effect of delay between GP consultation and attendance at Hope Hospital. This can potentially change the pre-/post-12 week status of the gestation.
- What a GP should do when a woman presents in the 10th / 11th week of pregnancy.
- The degree of matching between GP referral activity and the processes set out in the new referral process

10.7 Actual Current Activity

- <50% of the activity at South Manchester relates to women who are actually >12 weeks
- Overall activity levels at the South Manchester Clinic do not appear to be very much lower than Hope Hospital overall levels.
- There are a number of practices who seem to be referring virtually all their TOPs to South Manchester rather than just those at >12 weeks gestation.
- New referral forms were loaded on to all GP systems in Salford.

10.8 Action Planning

- GP compliance with the new referral process should be monitored and audited
- Consideration should be given to clarifying for GPs the appropriate referral procedures for women on the borderline between pre- and post-12 week gestation.

SECTION 11

RECOMMENDATIONS

Key Recommendations

1. Integration of sexual health services based on a hub and spoke model to support the delivery of access and quality targets.

2. Community-based prevention initiatives to be implemented as a priority, including continued development of work with the Lesbian and Gay Foundation and the Teenage Pregnancy Strategy.

3. High-risk groups to be targeted based on epidemiological evidence as described.

4. Consolidation and enhancement of existing screening programmes.

5. Dedicated teenage pregnancy services, networked into sexual health services appropriate for teenagers following review.

6. Provision of basic, accurate information through clear, unambiguous messages.

7. Support of staff development, promoting skill mix and flexible working, which will ensure the acquisition and maintenance of ‘fit for purpose’ skills and competencies.

8. Provision of equitable access to appropriate services for all population groups.

9. In respect of proposed resource implications, these will be put forward through the Local Delivery Plan, in the main against the indicative allocation for “Choosing Health”. Greater Manchester PCT Chief Executives have recently made a commitment to putting their collective shoulders behind “Choosing Health”.

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