

Promoting, Improving and Sustaining the Sexual Health of Bolton

*Strategy and Implementation Action Plan for 2004 -
2005*

February 2004

Sexual Health Strategy and Action Plan

Contents

1	Executive Summary	3
2	Introduction	4
3	Setting the scene	4
3.1	What is sexual health?	4
3.2	Inequalities in sexual health	4
3.3	National policy context	5
4	The Local Picture	8
4.1	Demographic Profile	8
4.2	Epidemiology	9
4.2.1	Chlamydia	10
4.2.2	Syphilis	11
4.2.3	Gonorrhoea	11
4.2.4	Genital Herpes	12
4.2.5	Anogenital Warts	13
4.2.6	HIV/AIDS	13
4.2.7	Teenage Pregnancy	15
4.3	What underlies current trends?	16
5	Service Provision	17
5.1	GUM	17
5.2	HIV/AIDS	20
5.3	Family Planning	22
5.4	Primary Care	24
5.5	The Parallel Young People's Health Service	25
5.6	School Nursing Service	25
5.7	Sex and Relationship Education in Schools	26
5.8	Project 360 U19 Substance Misuse Service	27
5.9	Termination of Pregnancy Service	27
5.10	Teenage Pregnancy Services	28
5.11	Emergency Hormonal Contraception	29
5.12	HIV Prevention & Promoting Good Sexual Health	29
5.13	Chlamydia Screening	31
5.14	Services for Ethnic Minority Groups	31
5.15	Services for Marginalised Groups	32
5.16	Area Based Regeneration Initiatives	32
6	Commissioning Services for Sexual Health	33
6.1	Funding Profile	33
6.2	Specialist Commissioning Arrangements	34
6.3	Voluntary Agency Commissioning Arrangements	34

7	Tackling Sexual Health in Bolton	36
7.1	Sexual Health Strategy Group	36
7.2	Core purpose	36
7.3	Terms of Reference	36
7.4	Public and user involvement	37
8	Development of an Integrated Sexual Health Service	38
8.1	Bolton Sexual Health Network	38
8.2	The Network Model	38
8.3	Scope of the Integrated Sexual Health Service Network	39
8.4	Network Components	40
8.5	Network management and leadership	41
8.6	Network structure and accountability	41
9	Translating the vision into action	42
10	Priorities and recommendations	42

Appendices:

- A Sexual Health Strategy Group Membership
- B Sexual Health Strategy – Implementation Action Plan

1. Executive Summary

The rising tide of sexually transmitted infections (STIs) and HIV evidenced nationally is mirrored at a local level and like many neighbouring areas, Bolton too is experiencing a rise in the number of STIs together with a rise in the number of newly diagnosed HIV infections and an increase in the number of visits to Departments of genito-urinary medicine and subsequent demands on service provision.

This Sexual Health Strategy and Action Plan sets the direction of travel for delivering change and improvement in the sexual health well-being of people living in the metropolitan borough of Bolton. It details the range of sexual health services already being provided throughout the Borough; recognises gaps in current service provision and identifies key issues for action that must be tackled if the increasing trend in sexually transmitted infections is to be reversed.

A central feature underpinning the delivery of the strategy is the vision for the development of an integrated sexual health network. The network will be the key driver for delivering change and improvement over the coming months and years. Drawing on existing good practice, expertise and knowledge, the network will be fundamental in drawing services together to work as a co-ordinated whole towards:

- Reversing the increasing trend in sexually transmitted infections through better services and prevention.
- Promoting safer sex.
- Reducing stigma and prejudice.
- Improving the sexual health and well-being of the population.
- Facilitating meaningful user involvement in the development of sexual health and HIV services.
- Improving commissioning of sexual health and HIV services.
- Improving access to quality services for treatment, care, support and health promotion.
- Developing and delivering new models of service provision.
- Developing and implementing comprehensive service standards, protocols and policies.
- Delivering a systematic approach to performance monitoring and review.

Establishing the necessary structure and processes to support the emergence of the integrated service network is an important first priority. There is a real commitment across statutory and voluntary agencies to develop the network model of working. It will take time. However, it is important to emphasise that progress in network development will not be at the expense of other service improvements. Existing work streams for example, in relation to family planning and termination of pregnancy services, the independent review of GUM services will come to fruition in the short term and recommendations for action translated into action and investment plans.

The action plan represents immediate priorities for development over the next 12 months. Outcomes, priorities and actions from development work carried out in this time will help to shape the annual business plan for the network. This will make explicit future investment and service development priorities.

Moving forward in an integrated way is an important first step to delivering change and improvement and will lead the way in laying robust foundations to deliver sustained change and improvement that promotes the sexual health well-being in the short, medium and long term.

1. Introduction

This Sexual Health Strategy and Action Plan provides for the first time a comprehensive service model and direction of travel to improve the sexual health and well-being of the residents of Bolton. It describes an overarching vision for a network of sexual health services and clarifies the important first steps required to make progress towards delivering change and improvement.

The action plan details tasks that will be delivered over the course of the next few months. Implementation of the plan will result in more detailed plans being developed and investment priorities identified. These will translate into a long-term programme of action that will deliver the overall vision of the strategy.

There is an enormous amount of work to be facilitated and achieved. Equally, there is an enormous amount of willingness, commitment and energy available to deliver it.

2. Setting the Scene

3.1 What is sexual health?

Sexual health goes well beyond the medical model of the treatment of disease. The World Health Organisation definition of sexual health captures this point:

Sexual Health is a state of physical, emotional, mental and social well-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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.¹

This definition is central to the delivery of the sexual health strategy and action plan and provides an important focus for the future development of services.

3.2 Inequalities in sexual health

The NHS Plan signalled the Government's intention to tackle unjustified variations and raise standards permanently, this applies to sexual health and HIV services as much as any other.

Sexual ill health is not equally distributed among the population. The highest burden is borne by women, gay men, teenagers, young adults and black and minority ethnic groups.^{2,3}

The rates of gonorrhoea in some inner city black and minority ethnic groups are ten or eleven times higher than in whites.⁴

¹ See www.who.int

² Lacey CJN, Merrick DW, Bersley et al. Analysis of the socio-demography of gonorrhoea in Leeds, 1989-93: BMJ June 14 1997: 314: 1718-9

³ HughesG, Catchpole M, Rogers PA et al, Comparison of risk factors for sexually transmitted infections: results from a study of attenders at three genito-urinary medicine clinics in England. Sex. Trans. Inf. 2000; 76: 262-267.

⁴ Low N, Daker-White G, Barlow D, Pozniak AL. Gonorrhoea in Inner City London: results of a cross sectional study: BMJ 1997 June 14; 314 (7097): 1719-23

HIV infection also has an unequal impact on some ethnic and other minority groups. Britain's African communities have been particularly badly affected by HIV/AIDS, with high rates among both adults and children.⁵

Research using the Office for National Statistics Longitudinal Study has shown that the risk of unintentionally becoming a teenage mother is ten times higher among girls in social class V (manual skilled) than in social class I (professional). Children in care and children of teenage mothers are also more likely to become teenage mothers, as are girls of Bangladeshi, Pakistani and Afro-Caribbean origin. Data also suggests that those girls who have higher educational aspirations are more likely to opt for an abortion.⁶

The Government is committed to improving sexual health and reducing health inequalities, and recognises the direct links between sexual ill health, poverty, poor housing, unemployment, discrimination and other forms of social exclusion.

In addition to inequalities in sexual health, there are significant variations nationally in the way sexual health services are provided, including health promotion and HIV prevention. This affects the quality and range of services as well as access to them.

3.3 National Policy Context

The national strategy for sexual health and HIV⁷ was published in December 2001. The aims of the strategy are to:

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

The national strategy sets out a model of service that is characterised by better integration across all services and a greater emphasis on the role of primary care. As such the challenges for primary care, which is already facing additional demands, are considerable.

The need to take a multi-agency approach is also clear, as is the need for a more holistic approach to sexual health promotion.

The model of service delivery proposed by the strategy is a 3 tier model which encompasses both primary care and more specialised services provided by GUM and Family Planning Services.

Level 1: Services are to be provided by primary care teams. It is acknowledged that service provision is currently variable and services will need to be developed to deliver the following:

- Sexual history & risk assessment
- STI testing for women
- Contraception information and services
- Assessment and referral

⁵ Communicable Disease Report, AIDS & HIV infection in the UK: monthly report; 26 April 2001: Vol. 11, No.17

⁶ Sexual Health. Third Report of Session 2002-03. Volume 1. House of Commons Health Committee. June 2003

⁷ DOH (2001). The national strategy for sexual health and HIV.

- HIV testing & counselling
- Pregnancy testing & referral
- of men with STI symptoms
- Cervical cytology screening & referral
- Hepatitis B immunisation

Level 2: To be provided by primary care teams with a special interest in sexual health. Alternative models include Family Planning and GUM clinics working in conjunction with primary care. Services to include:

- Intrauterine device insertion
- Testing & treating STIs
- Vasectomy
- Contraceptive implant insertion
- Partner notification
- Invasive STI testing for men (until non invasive tests available).

Level 3: Specialist service with the focus and expertise to provide care for those with more complex, chronic or intensive needs. They will take responsibility for sexual health services needs assessment, supporting provider quality and clinical governance at all levels. They will ensure that local guidelines are in place and that there is a framework for monitoring and improving practice. They will support the planning and delivery of sexual health education in schools, colleges and prisons, devolving them to level 2 services as these evolve. An expanded role for nurses as specialist and consultants is envisaged. Services will include those aimed at individual patients and those aimed at improving public health. Where possible they will be open access.

They will include:

- Specialist GUM services
- Specialised HIV services
- Terminations of pregnancy services
- Specialised contraception for those with complex medical conditions
- Co-ordination of services for sexual assault
- Services for those with psychological and sexual problems

In addition services could include

- Outreach services for prevention of STIs
- Specialised infection management – including co-ordination of partner notification
- Outreach contraception services

Underpinning the 3 tier model is a focus on delivering better prevention and services that will lead to better sexual health of the population.

The strategy applies the principles of the NHS Plan to sexual health. It sets out to re-design services around the people who use them. It has four broad themes:

- Better prevention, including public information campaigns, targeted sexual health information, helplines and information and support for professionals.
- Better services, based around a new model setting out three different levels of service provision that should be available within each PCT area, with specific targets for improvements in several areas of service provision.
- Better commissioning, including the establishment of local multi-agency commissioning panels;
- Supporting change, including measures to improve information, research and training in the field of sexual health.

The national strategy includes four targets:

- To reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by 2007.
- By the end of 2004, all GUM clinic attendees should be offered an HIV test on their first screening for sexually transmitted infections.
- By the end of 2003, all homosexual and bisexual men attending GUM clinics should be offered hepatitis B immunisation at their first visit.
- From 2005, commissioners should ensure that women who meet the legal requirements have access to abortion within 3 weeks of the first appointment with the GP or other referring doctor.

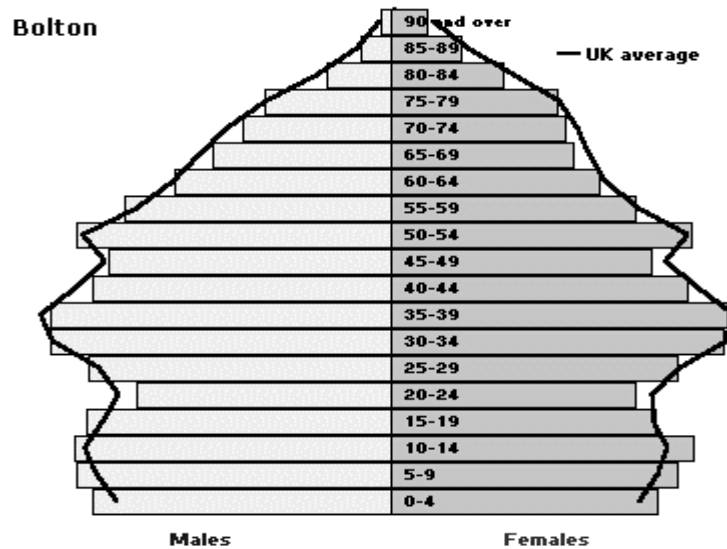
The national strategy identifies gay men and African communities as the priority groups for HIV prevention. This concurs with current HIV epidemiology in Bolton which show the numbers of people newly testing HIV positive in 2002 were largely from African communities with 3 new cases amongst gay men.

4 The Local Picture

4.1 Demographic Profile

Population estimates for Bolton by age and sex are shown as in figure 1.

Figure 1: Population estimates by age and sex for Bolton as per the 2001 census.



Source: Office of National Statistics, 2001 Census

Population estimates from the 2001 census indicate that the population of Bolton is 261,035. The number of young people in the 15-19 age group is 16,863 with slightly more males (8,793) than females (8,070). By contrast in the 20-24 age group there are slightly more females (7,501) than males (7,302), the total number being 14,821. Overall there are a total of 31,684 young people in Bolton in the 15-24 age group (approx 12% of the population) of which 53% are in the 15-19 age group. Within the 15-24 age group 51% are male and 49% female.

Data from the 2001 census indicates that while the population of England and Wales has increased by 1.8% in comparison to the 1991 mid year estimates, the population of the North West, Greater Manchester and Bolton has declined. The North West has declined by 2.3%, Greater Manchester by 3.4% and Bolton by 0.7%. Overall in comparison to the 1991 mid year estimates, the 2001 census data indicates that the population of Bolton has fallen by approximately 2000 people⁷.

Table 1 provides an analysis of the population of Bolton by Ethnicity.

Table 1: Analysis of the population of Bolton by Ethnicity.

Ethnic Group	% of Population
White	89.0
Mixed Race	1.0
Asian/Asian British	9.1
Indian	6.1
Pakistani	2.5

Bangladeshi	0.1
Other Asian	0.4
Black	0.6
Chinese or other ethnic group	0.3

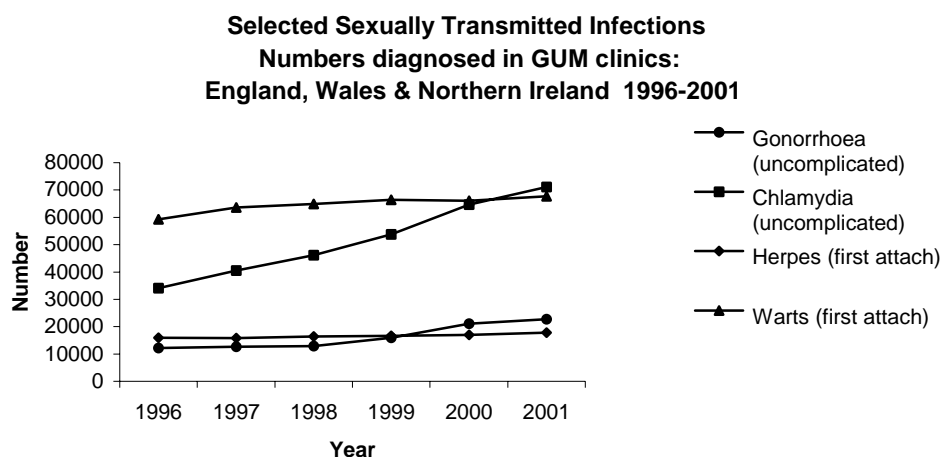
Source: ONS 2001 Census.

The Bolton Health Survey 2001 demonstrates that Bolton is a multi racial community. The vast majority of the Bolton population is white (89.7%). The total minority ethnic population (10.3%) is heavily concentrated in a small number of wards. In 15 of the 20 wards, the white population accounts for over 90% of the total population. The highest ethnic minority populations are seen in the wards of Derby (57.2%) Central (43.5%) Burden (23.1%) Halliwell (21.9%) and Daubhill (14.4%)⁸. According to the Index of Multiple Deprivation Derby ward is ranked 137th out of a total of 8414 English wards. It is the 2nd most deprived ward in Bolton. Central ward is ranked 51st and is the most deprived ward within the Borough⁹.

4.2 Epidemiology

The national strategy for sexual health and HIV is set against a national background of an increased prevalence in STIs (Figure 2), a rise in the number of newly diagnosed HIV infections and an increase in the number of visits to Departments of genito-urinary medicine (GUM). Between 1991 and 2001 there has been an increase in workload in GUM clinics of 155%. In addition, England has the highest teenage pregnancy rates in Western Europe.

Figure 2: Selected Sexually Transmitted Infections: Numbers diagnosed in GUM clinics in England, Wales and Northern Ireland 1996-2001. Source: Health Protection Agency



The burden of sexually transmitted infections falls unequally in the population, young heterosexuals, men who have sex with men and minority ethnic groups are at an increased risk. Data from the Health Protection Agency (HPA) indicates that in England, Wales and Northern Ireland between 1996 and 2001, the number of newly diagnosed cases of uncomplicated Gonorrhoea rose by 87% (12,140 - 22,685), uncomplicated Chlamydia by 108% (34,136 - 71,055), Herpes (first attach) by 12% (15,915 - 17,853) and warts (first attach) by 14% (59,216 - 67,693). Syphilis also increased although the actual numbers of syphilis cases both primary and secondary are relatively low with 122 cases in 1996 and 716 cases in 2001. This increase is primarily due to a number of syphilis outbreaks in several

cities including Manchester. With the exception of Herpes (first attach) and Syphilis, this rise in newly diagnosed cases of STIs has been reflected locally at GUM services at Bolton Hospitals Trust as shown in table 2.

Table 2: Number of selected STIs seen at Bolton Centre for Sexual Health January to March 1997 and July to September 2002.

Condition	Jan – March 1997 (Number)	July – Sept 2002 (Number)	Change (%)
Uncomplicated Gonorrhoea	19	44	132
Uncomplicated Chlamydia	46	128	178
Syphilis	4	4	0
Herpes (first attach)	30	26	-20
Warts (first attach)	102	114	12

Source: KC60 returns Bolton Centre for Sexual Health.
NB: Figures refer to both male and female diagnoses.

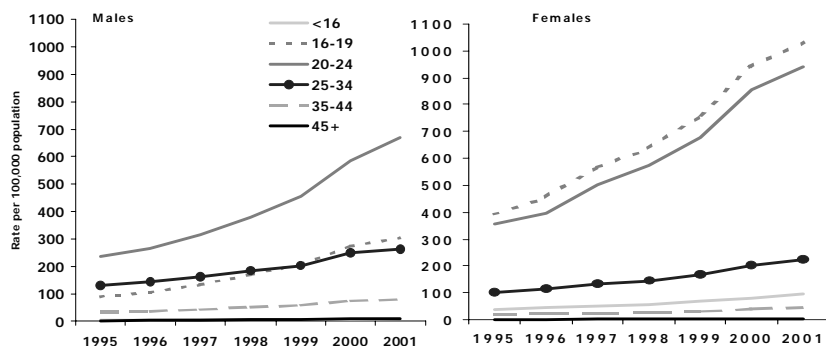
It should be noted that the data from the HPA is derived from the KC60 returns supplied by GUM clinics. It is therefore likely to underestimate the true prevalence of STIs, as unknown numbers of people are diagnosed and treated in other settings, especially primary care. This particularly relates to chlamydia.

4.2.1 Chlamydia

Chlamydia is the most commonly diagnosed bacterial STI in the UK (see figure 3). Within the North West in 1999 the incidence rates were 94 per 100,000 total population in men and 126 per 100,000 total population in women. Between 1996 and 2000 the number of new diagnoses seen in GUM clinics within Greater Manchester rose by 138%. In the UK IN 2001 the highest rates were among 16-19 year old females (1035/100,000) and 20-24 year old men (670/100,000). The report by the Chief Medical Officer's Expert Advisory Group on *Chlamydia Tracomatis*⁸ indicates that up to 70% of women and 50% of men are asymptomatic. Overall, chlamydia is an infection that primarily affects young people, particularly young women, many of whom will be asymptomatic. The long term affects of untreated Chlamydia include pelvic inflammatory disease, ectopic pregnancy and infertility.

Figure 3:

Diagnoses of uncomplicated genital chlamydial infection in GUM clinics by sex and age group, UK: 1995-2001*



*Data are currently unavailable from Scotland for 2000 and 2001

PHLS (England, Wales & Northern Ireland), DHSS&PS (Northern Ireland) and Scottish ISD(D)'s Collaborative Group (ISD, SCIEH & MSSVD)

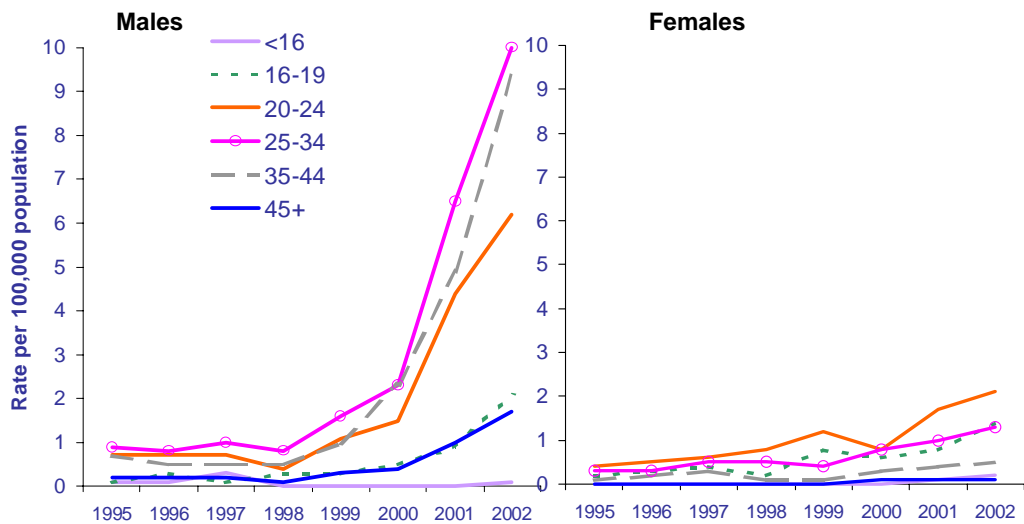
⁸ Summary & Conclusions of CMO's Expert Advisory Group on Chlamydia trachomatis. www.doh.gov.uk/chlamyd.htm

4.2.2 Syphilis

In the UK syphilis infection is relatively uncommon. Though numbers are relatively low, in England, figure 4 shows that rates of infectious syphilis diagnoses in males have increased sharply (0.4 to 4.3/100,000) since 1998. Though not as marked, over this same time period rates have also increased in females in England (0.2 to 0.5/100,000). The increase in rates of infectious syphilis in males and females is likely to be largely attributable to a number of localised outbreaks that have occurred over recent years in Bristol, Manchester, Brighton, Cambridgeshire and London, predominantly among men who have sex with men.

Figure 4:

Diagnoses of infectious syphilis (primary and secondary) in GUM clinics by sex and age group, UK: 1995-2002*



*Data are currently unavailable from Scotland for 2000, 2001 and 2002

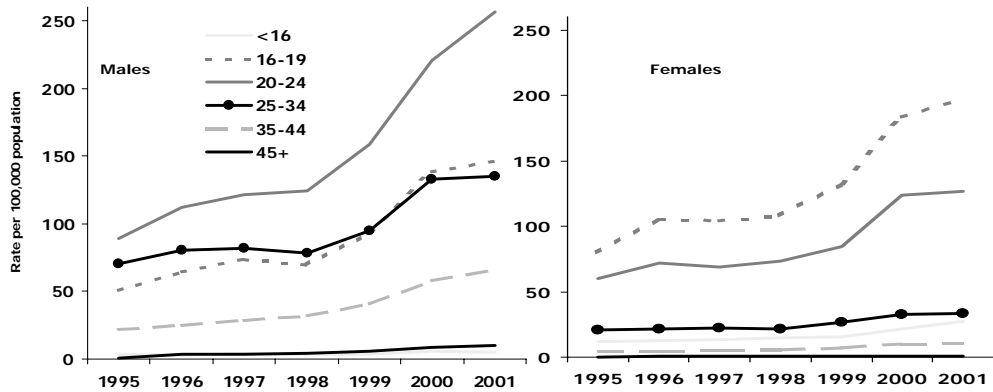
Source: PHLS

4.2.3 Gonorrhoea

Gonorrhoea is the second most common bacterial STI in the UK. During 2001, diagnostic rates in England, Wales and Northern Ireland were highest in 20-24 year old males (256/100,000) and 16-19 year old females (196/100,000) (figure 5). Rates among males and females have increased in all age groups since 1995, with the sharpest increases seen in males aged 20 to 24 years and females aged 16 to 19 years. Of all diagnoses of gonorrhoea in females 42% were in those under 20 years of age. Infection rates in the North West are second only to the London region. In 2001 there was a total of 2708 cases within the North West (males 1963, females 745). Within the North West the highest rates are seen in the Greater Manchester Strategic Health Authority area. Between 1996 and 2000 the number of new diagnoses seen in GUM clinics within Greater Manchester rose by 115%. Those who are at an increased risk are young people and men who have sex with men.

Figure 5:

Diagnoses of uncomplicated gonorrhoea in GUM clinics by sex and age group, UK: 1995-2001*



*Data are currently unavailable from Scotland for 2000 and 2001

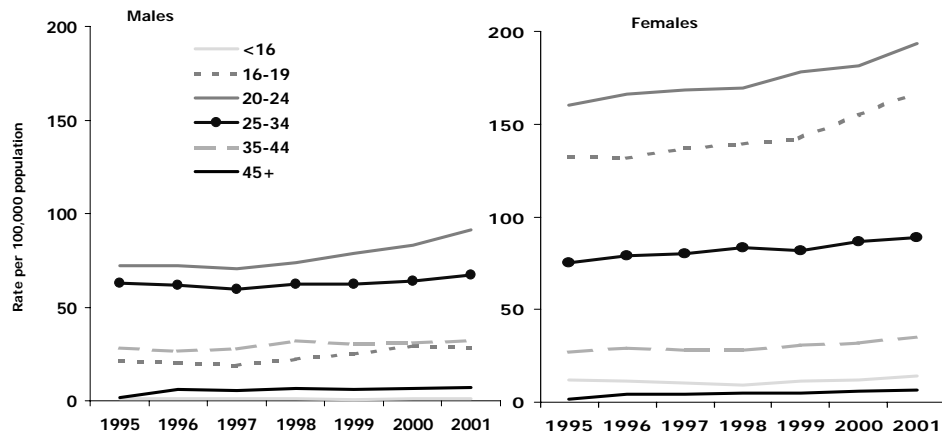
PHLS (England, Wales & Northern Ireland), DHSS&PS (Northern Ireland) and Scottish ISD(D)5 Collaborative Group (ISD, SCIEH & MSSVD)

4.2.4 Genital Herpes (*Herpes simplex virus*)

Genital herpes simplex virus (HSV) infection is the most common ulcerative sexually transmitted STI in the UK (figure 6). It is associated with considerable physical and psychological morbidity and may frequently recur. In 2001, 17,850 new cases were seen in England, Wales and Northern Ireland. 6% of males and 22% of females were under 20 years of age. For females and males highest rates were seen in the 20-24 year olds (193 per 100,000 population and 92 per 100,000 respectively). Between 1996 and 2001 there was a 12% increase in both males and females.

Figure 6:

Diagnoses of genital herpes simplex virus (first attack) in GUM clinics by sex and age group, UK: 1995-2001*



*Data are currently unavailable from Scotland for 2000 and 2001

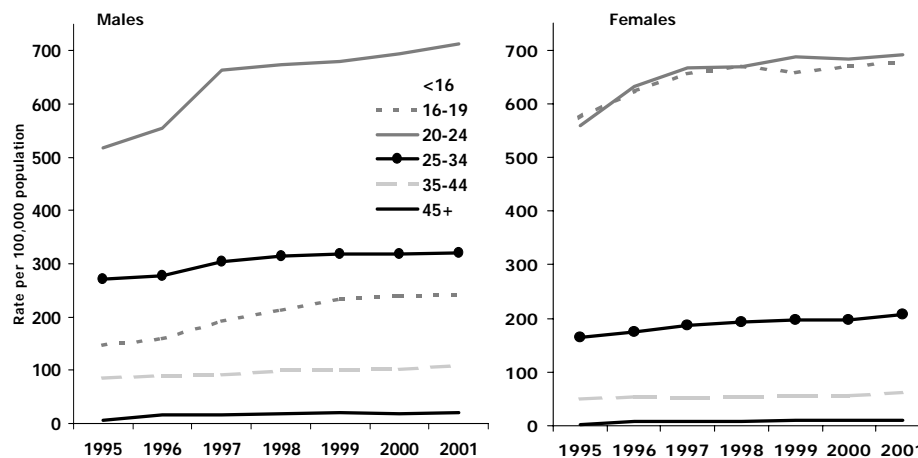
PHLS (England, Wales & Northern Ireland), DHSS&PS (Northern Ireland) and Scottish ISD(D)5 Collaborative Group (ISD, SCIEH & MSSVD)

4.2.5 Anogenital Warts

Anogenital warts (including new, recurrent and re-registered cases) are the most common viral STI diagnosed at GUM clinics comprising 11% of all diagnoses. In 2001, 67,672 new diagnoses were made in England, Wales and Northern Ireland. 9% of males and 29% of females were under the age of 20 years of age (figure 7). For both males and females the highest rates of new cases are found in the 20-24 year old (712/100,000 and 691/100,000 respectively).

Figure 7:

Diagnoses of genital warts (first attack) in GUM clinics by sex and age group, UK: 1995-2001*



*Data are currently unavailable from Scotland for 2000 and 2001

PHLS (England, Wales & Northern Ireland), DHSS&PS (Northern Ireland) and Scottish ISD(D)S Collaborative Group (ISD, SCIEH & MSSVD)

4.2.6 HIV/AIDS

HIV continues to be the most important communicable disease in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and, since it affects mainly younger adults, high number of potential years lost.

There are an estimated 33,500 HIV infected adults living in the UK of whom 28% are undiagnosed. There are an estimated 4,000 new cases per year. Prevalence is rising due to better survival rates (as a result of combination therapy) and increased incidence rates. Although sex between men remains the major route of transmission in the UK there are increasing numbers of new infections acquired through heterosexual sex, three quarters of which were probably acquired abroad. Recently released data for 2001 indicates that, in the UK as a whole, the main route of transmission is now heterosexual sex, but that the majority of people currently living with AIDS acquired the infection by homosexual sex.

In Bolton, the total HIV and AIDS cases between January and December 2002 was 94.⁹ This was a 94% increase from the 51 cases recorded in 2000 and significantly more than the 68 recorded in 2001.

⁹ HIV and AIDS in the North West of England 2002. Liverpool John Moores University. July 2003

Over 89% of the new cases resident in Bolton acquired HIV heterosexually. This is the highest proportion of heterosexually acquired new cases in Greater Manchester. Of the 94 cases recorded in 2002, 37 were asymptomatic, 31 symptomatic, 23 had AIDS and there were 3 AIDS related deaths.

Table 3 provides a breakdown of the 94 HIV and AIDS cases between January and December 2002.

Table 3: The infection route of the 94 people is as follows:

	Number	Percentage (%)
Hetero Sexual	47	50%
Homo/Bisexual	39	41.5%
Injecting Drug Use	3	3.2%
Mother to Child	3	3.2%
Blood/Tissue	2	2.1%

Ethnicity (Total cases):

	Number	Percentage (%)
White	53	56.4%
Black Caribbean	0	0%
Black African	27	28.7%
Black (Other)	1	1.1%
Indian/Pakistani/Bangladeshi	5	5.3%
Other Asian/Oriental	1	1.1%
Other Mixed	4	4.3%
Not Known	3	3.2%
Total:	94	100%

New HIV and AIDS cases by ethnic group January – December 2002:

	Number	Percentage (%)
White	5	17.9%
Black Caribbean	0	0%
Black African	17	60.7%
Black (Other)	1	3.6%
Indian/Pakistani/Bangladeshi	3	10.7%
Other Asian/Oriental	0	0%
Other Mixed	0	0%
Not Known	2	7.1%
Total:	28	100%

Age Category (Total cases):

	Number	Percentage (%)
00-14	3	3.2%
15-19	0	0%
20-24	5	5.3%
25-29	14	14.9%
30-34	14	14.9%
35-39	16	17%
40-44	18	19.1%
45-49	14	14.9%
50-54	6	6.4%
55-69	2	2.1%
60+	2	2.1%
Total:	94	100%

Gender (Total cases):

	Number	Percentage (%)
Male	69	73.4%
Female	25	26.6%
Total:	94	100%

Source: HIV and AIDS in the North West of England, 2002

4.2 Teenage Pregnancy

The Teenage Pregnancy Strategy is inextricably linked to the Sexual Health Strategy and Action Plan for Bolton and shares some of its tasks. Much of the teenage pregnancy prevention work links to the general health promotion agenda for Sexual health. Shared tasks include better access to services, better provision for contraceptive services, pilot of Emergency Contraception through pharmacies, review of termination services, building on the capacity of organisations.

In 1999 at the time of the publication of the Social Exclusion Unit's Teenage Pregnancy Report, the UK had the highest teenage pregnancy rate in Europe. The teenage birth rate at the time was twice that of Germany, three times that of France and 6 times the Dutch rate.

The Social Exclusion Unit's Report on Teenage Pregnancy set out two national targets:

- 1) To reduce by 50% the 1998 England under 18 conception rate by 2010, with an interim target of a 15% reduction by 2004.
- 2) To increase to 60% the participation of teenage parents in education, training or employment to reduce their risk of long-term social exclusion by 2010.

It also set a target that all under 18 teenage lone parents who cannot live with family or their partner should be placed in suitable supported accommodation by the end of 2003.

The targets are joint Department of Health and Department for Education and Skills ones. They are included in PCT Local Delivery Plans and Local Government Public Service Agreements. They are also performance indicators for PCT's and for Local Government Best Value.

Under 18 conceptions

Between 1998 and 2001 the under 18 conception rate (per 1000 women aged 15 to 17) in England and Wales fell from 47.6 to 42.5 per 1000, a fall of approximately 10% (the proportion of conceptions leading to abortion rose from 42.2 to 46.0 in the same period).

Bolton's under 18-conception rate has been higher than both the National and Regional rates throughout this period. The trend in Bolton has also been down albeit the fall in rates has been less: from 51.8 to 48.6 (per 1,000 women aged 15 to 17), a fall of just 6% (the percentage leading to abortion fell from 36.9 to 35.3). Numerically there were 249 conceptions to under 18 year olds in 1998 compared to 252 in 2001. If the downward trend continues at the same rate then Bolton will be on track to achieve a 15% fall by 2004. Unfortunately the official statistics are three years old when they are disseminated; consequently it will be some time before we can measure our success or failure.

Under 16 conceptions

The under 16 conception rate (per 1000 women aged 13 to 15) in Bolton is lower than both the National and Regional rates. The rate in England and Wales has fallen from 9.0 to 8.0 between 1998 and 2001. The rate in the North West has risen from 9.0 to 9.9. The rate in Bolton has fallen from 8.7 to 6.6. (a note of caution in interpreting the under

16 rates: the rates can fluctuate unaccountably; the under 16 rate in Bolton rose to 13.7 in 1999 before falling to 8.00 in 2000).

4.3 What underlies current trends

The national Survey of Sexual Health Attitudes and Lifestyle¹⁰ (NATSAL) survey interviewed 11,161 respondents (4,762 men, 6,399 women) and revealed the following key behavioural trends:

- For men and women the number of sexual partners has increased.
- The proportion of men and women having more than one partner at the same time, which increases the probability of an infection being passed on to more than one person, has also increased.
- Average age at first intercourse has fallen for women and men from 17 years to 16 years.
- The proportion of men in Britain who had ever had a homosexual partner increased from 3.6% in 1990 to 5.4% in 2000.
- The number of men paying for heterosexual or homosexual sex has more than doubled, from 2.1% in 1990 to 4.3% in 2000.
- The number of men and women participating in anal sex in the past year increased from 7% and 6.5% respectively in 1990, to 12.3% and 11.3% respectively in 2000.
- Although the overall use of condoms is up, the overall figures for high risk behaviour, which is defined as “Two or more heterosexual and homosexual partners in the past year and inconsistent condom use in the past 4 weeks” show rises of 13.6% to 15.4% in men and 7.1% to 10.1% in women between 1990 and 2000.

Changing attitudes and sexual habits are, however, only one part of a far more complex picture. The risks posed by frequent intercourse and frequent partner change can be reduced by the use of condoms and other contraceptives to prevent STIs and unwanted conceptions, but people need appropriate education and information to promote safer sexual practices.

In addition to information people also need confidence and good social, communication and negotiating as well as technical skills to put safer sex messages into practice. On top of this people need quick and easy access to high quality healthcare services to provide them with information, preventatives, and diagnosis and treatment of STIs.

Of particular concern is the lack of representation of STIs as a significant health problem in the media.

The national strategy presents a strong case for prioritising sexual health on the grounds of public health.

¹⁰ The National Survey of Sexual Attitudes and Lifestyle. December 2001.

5 Service Provision

The NHS provides a comprehensive range of sexual health services – including GUM clinics, community family planning clinics and services in primary care. The national strategy recognises that too often sexual health services are fragmented, poorly advertised and too narrowly focused. Access is a problem. Long journeys and patchy provision often restrict access to services. Information on sexual health is often out of date or simply not available.

This section provides an overview of current sexual health service provision available in Bolton. For each aspect of service provision key issues are highlighted to be carried forward in the context of the broad strategic approach (described in Section 8) to developing and delivering an integrated sexual health service in Bolton. Central to the model is the need to focus on delivering targeted evidence based service provision that is responsive to the sexual health needs of the population; maximises available resources; avoids unnecessary duplication; and, promotes effective integrated working across all aspects of service provision. Development of the integrated network will facilitate the vision for a 3 tier service model described in the National Sexual Health Strategy (see section 3).

5.1 GUM Services

The Bolton Centre for Sexual Health provides GUM services for a population of approximately 310,000. The Centre for Sexual Health operates 8 clinic sessions per week. There are no clinics on Wednesday and Friday afternoons or weekends. Clinics finish at 5.30pm on Tuesday and 6.30pm on Monday and Thursday. Service provision includes:

- Diagnosis and treatment of sexually transmitted infections
- HIV counselling, testing and monitoring
- HIV inpatient care with input from other interested multidisciplines
- Colposcopy clinic
- Cytology clinic
- Consultant led HIV clinic
- Vulval clinic
- Family planning and contraceptive sessions
- Psychosexual clinic
- Sexual dysfunction
- Nurse Clinics for follow-up appointments
- Nurse led compliance clinics/HIV

The Centre's establishment comprises 2 Consultants (1 vacant post), 4 Doctors (plus 2 GP sessions) 11 nurses, a part-time chartered Clinical Psychologist and 9 Administrative and Clerical Staff. The Centre has a budget of £1,067,002 of which 69% is spent on pay and 31% on non-pay.

The Centre deals with 5,500 new attendances and 4,200 follow-up attendances per annum. The Centre offers open access services for GUM, HIV testing and counselling. It also offers Combination Therapy for an increasing HIV cohort, Viral Load monitoring/CD4 monitoring, resistance testing, TDM (therapeutic drug monitoring), drug adherence support, and sexual health screening.

Along with a requirement to deliver 5,996 new attendances and 4,565 follow-ups by 2005/06, the Centre also has to ensure that all GUM attenders are offered HIV

testing at first STI screening; to reduce the number of undiagnosed HIV cases who remain unaware of infection after visit; and to ensure that all homosexual men attending GUM for a first visit are offered Hepatitis B vaccination.

All nurses are trained to provide family planning services within the sexual health clinic, with one nurse qualified to provide the service in other settings. All nurses are also trained as health advisors.

The GUM service provides training, not only for junior doctors, but also for local health professionals within the Bolton and Greater Manchester area. Due to service pressures it is becoming increasingly difficult to maintain its training commitment.

The GUM service operates an appointment system. All GUM services are available to non-residents. Currently the average waiting time for non urgent appointments is 4 weeks. Referral is either via the GP or self referral. The delay in access time to curative services is important in STI transmission as this increases the duration of infectiousness (since the individual remains untreated for longer) and increases the probability of disease transmission. Many clinics are reporting increases in the number and proportion of complicated cases consistent with deteriorating access.

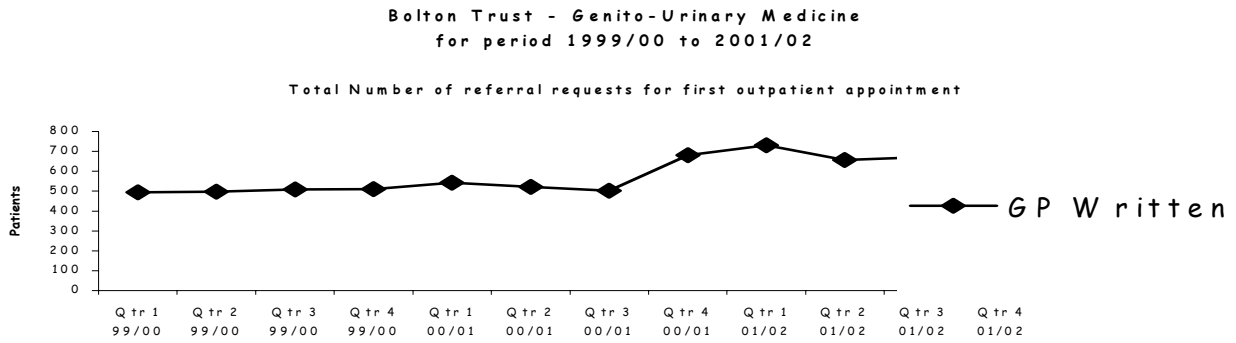
Delays in access:

- present a public health imperative on the basis that patients who have an infectious disease could pass it on to others.
- may have long term health consequences.
- are likely to compound health inequalities.
- tend to adversely affect those who are in greatest need, particularly young people, those from ethnic minorities and those from deprived backgrounds

Acknowledging access issues, in particular for young people, has resulted in the planned provision of a Consultant led GUM clinic at The Parallel Young People's Centre in the centre of Bolton. This outreach services will be carefully monitored and evaluated to inform continued service development.

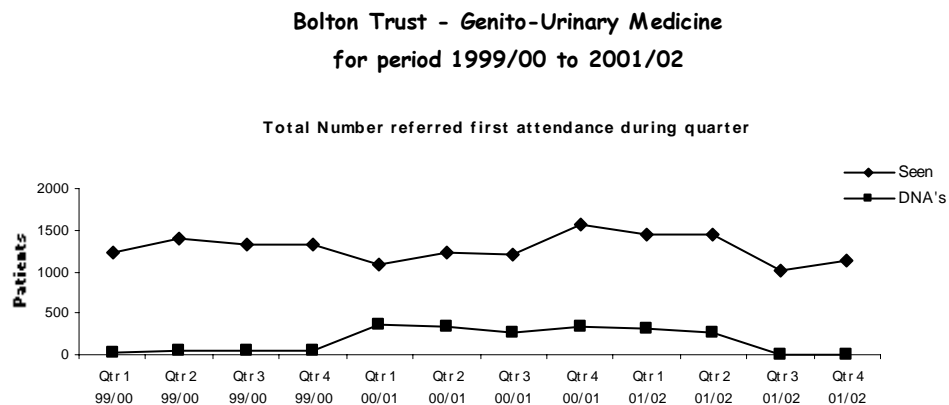
The Centre for Sexual Health also operates a nurse led telephone triage system to differentiate between acute and non acute patients. In practice, during clinic times the reception staff answer the calls and refer to the appropriate nurse. During the quarter July to September 2002 the figures for telephone advice (nurse) were 3,444. Urgent referrals eg symptomatic patients and patient contacts are usually seen as "extras" at the end of clinic either on the same day or the next day. The perceptions of the nursing staff is that most of the "extras" result from partner notifications. The service has seen an increase in service utilisation, as shown in figure 8.

Figure 8: Total number of GP written referrals for first outpatient appointment at Department of Genito-Urinary Medicine for period 1999/00 to 2001/02. Source: Information Services Department Bolton PCT.



During the 1st quarter of 1999/2000 the service received 494 written referral requests from GPs for first outpatient appointments. By the last quarter of 2001/2002 this had increased to 711, an increase of 44%. However the total number of 1st appointment referred also varied during this time period (range 1011-1563), as did the number of patients who did not attend (DNA) range 9-372. The latest figures indicate that the total number of new patients seen between July and September 2002 is 1364 (figure 9).

Figure 9: Total number of referred first attendance and DNAs at Department of Genito-Urinary Medicine for period 1999/00 to 2001/02. Source: Information Services Department Bolton PCT.



There is a clear need to reduce the waiting time for non urgent appointments from the current average of 3.5 weeks. Best practice recommended by the Royal College of Physicians is that patients suspecting an acute STI should be seen on the day they present to a clinic, or on the next occasion the clinic is open.¹¹

Accessibility to the service is seen as problematic due to high demand. Discussions with the nursing staff suggest that the current system of dealing with the urgent cases, the “extras,” also contribute to the pressures on the non urgent appointments.

¹¹ Sexual Health. Third Report of Session 2002-03. Volume 1. House of Commons Health Committee. June 2003

The Sexual Health Centre is provided from good quality premises. However, the stigma associated with accessing such services may mean that people do not attend. Opportunities to provide outreach services that respond to the needs of hard to reach groups needs to be fully explored and appropriate services developed.

A comprehensive external review of GUM services provided by the Centre for Sexual Health has recently been commissioned. Outcomes from the review process will be translated into the plan for action that underpins this strategy.

ISSUES FOR ACTION:

- **Integrated Sexual Health Service Network:**
 - Support the development and delivery of the service network
- **Access:**
 - Address and reduce unacceptable waiting times
 - Development of a systematic approach for urgent cases (the extras) in GUM
 - Development of a fully operational nurse-led triage system in GUM
 - Increase the level of service provision for GUM to include evening, weekend and sessions targeted at young people
 - Additional session times during the evenings and at weekends
 - Specific targeted sessions
 - Provision of information to clients in advance of appointments to reduce risk of further infection
 - Any increase in throughput will invariably impact on other support services – need to consider the resource implications of both.
- **Service Location:**
 - Development of outreach services to facilitate easier access; target hard to reach groups and to reduce stigma
- **Information:**
 - Raise awareness of service availability especially in hard to reach groups
 - Develop a systematic approach to providing people with advice prior to their appointment with the aim of changing sexual practice
 - Tackle stigma and discrimination
- **Service Review:**
 - Translate outcomes from comprehensive service review in to sexual health action plan

5.2. HIV/AIDS

Assessment, diagnosis treatment and care services for individuals living with HIV and AIDS are provided by the GUM service at the Centre for Sexual Health.

5.2.1 Treatment and Care

The existing consultant at Bolton Centre for Sexual Health has a particular expertise in the treatment and care of people with HIV/AIDS. The service is the largest provider of services for people with HIV/AIDS in the North West, after North Manchester General Hospital. The view of both the consultant and the specialist nurse is that this number is likely to increase. The nature of the condition means that the relationship between the patient and clinical staff is particularly sensitive, with patients willing to travel to see the consultant of their choice. Additionally, treatment received outside the area of residence increases anonymity.

Inpatient services are provided locally, with patients being admitted under the care of the physicians. There is a close working relationship between the physicians and the GUM consultant. Patients from out of area are referred to their local hospital for inpatient treatment.

The success of combination therapies in delaying the progress of HIV, and the increasing numbers of women and children from black and minority ethnic groups requiring help and support have led to changes in the package of social care provided by social work departments and others. Dispersal of asylum seekers to areas outside London is beginning to have an impact on the planning and provision of care and support in areas where formerly few required care.¹²

HIV care comprises more than just drugs. If people are given drugs without the support they need to adhere to treatment, and are unable to get the social support which enables them to manage what can be a very difficult life on these drug regimes, the treatments themselves will not be so effective.¹³

Discharging patients with an AIDS diagnosis without the right support structures in place defeats the objective of responding to the crisis in waiting lists in the NHS, and of good patient care.¹⁴

Health visitors and social workers who provide support structures for people who have been diagnosed with HIV/AIDS are integral to the success and cost effectiveness of HIV treatment. In addition, specialist social workers have an important role in developing and maintaining HIV service networks in high and low prevalence areas.

5.2.2 Social Care

Both Bolton Social Services Department and the PCT commission specialist social care services from the voluntary organisations in Greater Manchester. Current services are commissioned from Body Positive North West, Birchgrove North, Barnardo's Health Through Action, and the Black Health Agency.

An independent consultation carried out in 2002 found among other recommendations that local people favoured local services. It is also noted with concern that there is an under use of commissioned voluntary sector social care by Bolton residents despite the year on year increase in those affected by HIV. A task group has been established by the Sexual Health Strategy Group to review current arrangements and make recommendations for future service delivery in relation to HIV prevention and Social Care. The aim of this review is to ensure that services commissioned respond to the need of users and are accessible to Bolton residents.

5.2.3 Prevention

Currently secondary HIV prevention work is commissioned from a number of voluntary agencies providers. As mentioned above, a review of commissioning arrangements with these agencies is underway with a view to commissioning services that respond to the needs of patients locally within Bolton. This will provide

¹² Sexual Health. Third Report of Session 2002-03. Volume 1. House of Commons Health Committee. June 2003

¹³ Sexual Health. Third Report of Session 2002-03. Volume 1. House of Commons Health Committee. June 2003

¹⁴ Sexual Health. Third Report of Session 2002-03. Volume 1. House of Commons Health Committee. June 2003

an opportunity to respond to local needs in relation to primary and secondary HIV prevention and sexual health promotion work with people who have HIV/AIDS.

ISSUES FOR ACTION:

- **Integrated Sexual Health Service Network:**
 - Support the development and delivery of the service network
- **Services for prevention and social care:**
 - To respond to local needs assessment
- **Integrated care pathways:**
 - To ensure access to key members of the clinical team including pharmacist, dietician, clinical psychologist
 - To support and facilitate the management of patients in primary care setting where this is desired
 - Underpinned by comprehensive programmes of training and education and clinical audit and review
- **Social Support:**
 - Effective links and social care support should be in place between services in the hospital and in the community

5.3. Family Planning Services

Family planning services are currently managed and provided by the Maternity & Women’s Health Care Department of Bolton Hospitals Trust. The service is consultant led and supported by 13 doctors working on a sessional basis in 9 community clinic sessions per week. The service has 2 full time family planning nurses and 7 who have regular sessional contracts, equivalent to 1.57 wte. The service is supported by .88 wte clerical staff.

In addition, 2 clinical assistants and a consultant work in the referral hospital clinic. On occasions when there is no doctor available to cover a community clinic, a senior nurse leads the service.

Services are provided in 4 community clinics namely, Lever Chambers Centre for Health, Farnworth Health Centre, Pikes Lane Health Centre and Halliwell Health Centre and at The Parallel Young People’s Centre. Sessions are currently available as follows:

Venue	No. of Sessions per week	Time available
Lever Chambers	3	Mon, 6.30 – 8.30 pm Tue, 6.30 – 8.30 pm Thur, 6.30 – 8.30pm
Farnworth Health Centre	1	Wed, 6.30 – 8.30 pm
Pikes Lane Health Centre	1	Wed, 1.30 – 3.30 pm
Halliwell Health Centre	1	Thur, 2.00 – 4.00 pm
The Parallel Young People’s Health Centre	3	Mon, 3.30 – 6.30 pm Fri, 3.30 – 6.30 pm Sat, 12.30 – 3.30

Activity data shows an increase in attendances between 1999 and 2002. There were 11,886 attendances in 1999 and 13,365 in 2002, an increase of approximately 12.4%. The number of IUCDs fitted has also increased from 446 in 2000 to 525 in 2001, an increase of 31%. The majority of Family Planning patients receive pharmacy items, eg oral contraceptives, IUCDs and condoms. Any increase in attendances has cost implications for both the pharmacy and laboratory services.

The family planning service also provides a domicillary service with 444 visits being made in 2002. Many women who struggle to maintain adequate contraception fail to keep repeat appointments with their GP or Family Planning Clinic. The increased use of Implanon (3 year implant contraception) has however reduced the overall number of repeat visits.

The service also visits several young girls with learning disabilities who have hygiene and medical problems associated with menstruation. The administration of DepoProvera 3-monthly injections to affect amenorrhoea has proved efficient. However, community staff are often unwilling to administer repeat doses and these are therefore given at home or school by family planning nurses.

Insertion of intrauterine contraceptive devices (IUCD) in community clinics have also increased from 446 insertions in 2000 to 525 in 2001. Difficulties in maintaining the Letter of Competence in Intrauterine techniques and Health and Safety aspects in maintaining sterilising equipment in general practice has led to fewer GP practices providing a coil services. Women are also referred to community clinics for Mirena IUS.

Both nursing and medical posts are sessional, which can lead to recruitment difficulties.

The family planning service places a high priority on the training of doctors, including GPs, in order to improve the level of knowledge and skills in some GP practices. Instructing sessions for doctors for the Diploma in Family Planning have been discontinued following the recommendation from the Regional Training Department that Instruction sessions should have 2 doctors. In addition, nurses within the service are involved with training for practice and school nurses which is becoming more difficult to provide due to service pressures.

Horwich and Blackrod Citizens health group has identified local services for young people as a particular need in the area. The development of a strategic plan for Bolton would assist in the development of services, preventing duplication.

The national strategy places a greater emphasis on the role of primary care in delivering sexual health services. A comprehensive programme of service development needs to be put in place. Central to this work will be an appraisal of potential options for future service configuration and delivery. Recommendations flowing from the process will be developed in the context of the integrated sexual health service network outlined in section 8 of this strategy.

Opportunities to broaden the scope of the service to include wider preventative health initiatives for service users rather than a narrow focus on contraception and sexual health will also be fully explored in the context of the 3 levels of service provision described in the national strategy. Central to this service development work will be the need to review training for all staff to build additional capacity to support the future network model of service provision.

ISSUES FOR ACTION:

- Support the development and delivery of a sexual health service network for Bolton.
- Undertake an option appraisal exercise of potential models for future service delivery.
- Identify opportunities to increase clinical capacity to deliver training sessions for the Diploma in Family Planning.
- Develop a model for contraceptive and sexual health services that responds to needs and improves access for all groups.
- Explore opportunities to develop a multi-agency condom promotion scheme.

5.4 Primary Care

The national strategy places a greater emphasis on the role of primary care. About 75-80% of contraception is provided in primary care. More than a third of women found to have chlamydia were diagnosed in primary care and primary care is highly accessible to all people including young women, and primary care is well accessed by many who may be at risk of HIV.

From a primary care perspective there appears to be little integration between primary and secondary care, which may lead to overlapping and duplication of services. Improved communication, collaboration and team working between all service providers in both primary and secondary care could help improve service delivery. Standardised literature and patient information sheets across Bolton could also be helpful.

The new GMS contract offers an opportunity to work with primary care to develop a model for sexual health service provision and to ensure that GPs offer the same high standards of care found in traditional family planning clinics and GUM.

KEY ISSUES:

- Work in partnership to support the continuing development of an integrated sexual health service network for Bolton.
- Work with primary care to develop a model for sexual health service provision in the context of the new GMS contract arrangements.
- Undertake a sexual health training needs analysis of primary health care teams.

5.5 The Parallel Young People's Health Centre

The aim of the centre is to provide general health, contraception and sexual health services to young people aged 11-20 years (20-25 years for those individuals with special needs). Services at the centre will become operational in October 2003.

The Parallel provides an innovative way of delivering services to young people and responds to the needs of this vulnerable group.

KEY ISSUES:

- Support the development and delivery of a sexual health service network for Bolton.
- Ensure work of the Parallel is complimentary to and integrated with the work of the Sexual Health Service Network for Bolton.

5.6 School Nursing Service

The school Nursing service is committed to the health improvement of children and young people of school age. The service is managed within the local health groups, although professional lead is given by the Assistant Director of Nursing. Currently the school nursing workforce consists of 17.78 WTE.

At present 14 out of 28 school nurses are family planning trained, 7 also have been trained in the administration of emergency contraception.

School nurses offer expert advice and support to young people on a range of health issues including sexual health. Many school nurses offer 'drop in' services within schools where pupils may just call in or make an appointment to see the school nurse with a specific issue.

Where appropriate school nurses will issue condoms, and offer pregnancy-testing facilities. This service is currently being provided at the Westhoughton Youth Drop In Centre, where an 'after school' session has been established.

Issues discussed are varied, but frequently address sexual health.

There are two nurses working within the Youth Offending Team. These nurses are both family planning trained and use their knowledge and expertise to support young people at risk of social exclusion on a range of health issues including sexual health. They also support young people in accessing sexual health services.

KEY ISSUES:

- Support the development and delivery of a sexual health service network for Bolton.

5.7 Sex and Relationship Education (SRE) in Schools

The National Healthy Schools Standard (NHSS) is a government initiative to improve schools that is based on evidence that healthier children perform better academically and that education plays an important role in promoting better health and emotional well being. Schools work using a whole school approach to deliver a health theme one of which is Sex and Relationships Education (SRE).

In addition, all schools involved must evidence delivery of national curriculum requirements in relation to SRE in line with statutory requirements, non-statutory guidance and the NHSS criteria.

Currently, of the 130 schools in Bolton 69 are 'signed up' to the local Healthy Schools programme with another 29 about to become involved. The government has targeted schools with 20%+ Free School Meals Entitlement (FSME) to be at level 3 of the Standard by 2006, this translates to 58 schools and units in Bolton.

The local Healthy Schools team works closely with the local SRE co-ordinator to support schools to deliver SRE as a theme, to provide minimum statutory requirements and non-statutory guidance, and to target support to those schools with 20% + FSME.

In addition the local SRE adviser supports other schools not yet within the Healthy Schools programme to develop SRE curriculum and policy and promotion of sexual health services.

Action plans for the Bolton Healthy Schools programme and the Teenage Pregnancy Strategy outline targets for work in all schools.

KEY ISSUES:

- Support the development and delivery of a sexual health service network for Bolton.
- Develop a co-ordinated standardised approach to delivering services in school settings
- Work with LA Education and head teachers to develop a strategic approach to SRE programme in schools

5.8 Project 360 U19 Substance Misuse Service

This service provides holistic specialist health care provision to vulnerable young people aged 13-19 years involved in chaotic substance misuse. Services are provided in a flexible way to meet an individual client's needs, usually from Project 360, (The Base, Marsden Road). At times, other venues are used such as the client's home, Health Centre or The Parallel, as appropriate. Outreach services are being developed.

The service is delivered by 2 WTE nurses, both family planning and sexual health trained, supported by a Community Paediatrician for 1 session per week. Contraceptive services, which include emergency contraception, DepoProvera and oral contraceptive pill prescribing, are provided alongside sexual health advice. This is seen to be part of a one stop holistic health provision that would also include the provision of condoms, screening for STIs, in particular chlamydia, Hep A and B screening and immunisation.

KEY ISSUES:

- Support the development and delivery of a sexual health service network for Bolton.

5.9 Termination of Pregnancy Services

The Royal Bolton Hospital provides 10 appointments per week for termination of pregnancy. These are available on a first come, first served basis without reference to clinical need for women under 12 weeks gestation. The service carries out terminations of pregnancy using medical procedures up to 83 days gestation. Referrals are only accepted up to 14 days ahead to ensure that gestations are not too advanced when seen. Ideally patients should be seen within 7 days. Direct referrals are accepted from the Family Planning Service for women under 17, and one GP practice.

There are a considerable number of terminations funded in the private sector. During 1999 there were a total of 767 terminations of which 241 were funded in the private sector. In 2000, out of 737 terminations 222 were performed in the private sector. Figures for 2001/2 show that a total of 235 terminations were funded via the private sector at a cost of £69,251.00.

A review of current service provision highlighted a number of key issues:

- Inconsistent information available to GPs with regard to options available for the provision of termination of pregnancy services
- Inconsistent approaches by GPs to referral for termination of pregnancy services
- Lack of information available to women to support informed decision making in relation to termination of pregnancy services
- Lack of social support available to women who may require additional help to make informed decisions
- Inconsistencies in service provision between different service providers
- No service quality agreements in place between the PCT and service providers
- Variations in service availability and cost between different providers

The review recognised the need to establish a robust care pathway that delivers access to safe early abortions on the NHS. This should include the provision of comprehensive support throughout the patient journey and provide a non judgemental service underpinned by high quality counselling, assessment, treatment and after care. Clear guidelines and referral procedures will be put in place and supported by appropriate education and awareness raising so that women in Bolton and their GPs are clear of the available options, referral process and can make informed decisions.

Within the current legal framework, practical steps will be taken to improve access to safe, early abortions on the NHS for those who meet the legal criteria. Choice in the availability of service providers is of paramount importance and an appropriate balance between local and out of area provision should be achieved.

The Royal Bolton Hospital is currently preparing a business case to expand its capacity to provide termination of pregnancy services.

ISSUES FOR ACTION:

- Support the development and delivery of a sexual health service network for Bolton.
- Develop guidelines and referral protocols for termination services
- Development of patient awareness campaigns
- Improve local access
- Ensure the needs of young people are considered when services are planned/changed.
- Develop and implement service levels agreements for the provision of termination services that provide for a holistic model of care

5.10 Teenage Pregnancy Services.

A number of activities and initiatives are in place to help make progress towards a reduction in the teenage conception rate, these are detailed in the teenage pregnancy strategy and action plan but there are clear links to the development of a local sexual health strategy. Many actions for Teenage Pregnancy services are reflected in the Strategy for Sexual health. The development of 'Young Person' friendly services are of key importance.

ISSUES FOR ACTION:

- Support the development and delivery of a sexual health service network for Bolton.
- Ensure Teenage Pregnancy Strategy and Action Plan is integrated into the Sexual Health Strategy for Bolton and that actions are complimentary to the sexual health service network development.

5.11 Emergency Hormonal Contraception provided through Community Pharmacies

Emergency hormonal contraception (EHC) is provided by the family planning services, A&E services and GPs. Some nurse practitioners can prescribe EHC as part of their extended roles and some school nurses and health visitors can also prescribe it under a patient group directive (PGD). In addition EHC can be bought over the counter from community pharmacists. EHC is most effective if taken within 24 hours, but can be taken with 72 hours though efficacy is reduced. At the present time EHC cannot be prescribed on school premises.

In December 2000 Wigan and Bolton Health Authority introduced free EHC from community pharmacies. The scheme ran until September 2001. A similar scheme in the Manchester, Salford and Trafford Health Action Zone has been evaluated. Data from the evaluation shows that the number of requests stabilised at approximately 1400 per month in early 2001. The most recent figures indicate that the number of requests has now risen to approximately 1800 per month in a population of approximately 1,000,000. Using this data it is estimated that there would be approximately 500 requests per month in Bolton.

There is currently a non recurrent budget of £33,300 for the provision of EHC via community pharmacies.

ISSUES FOR ACTION:

- Support the development and delivery of a sexual health service network for Bolton.
- Develop a pilot project for targeting the provision of EHC in areas of greatest need.

5.12 HIV Prevention and Promoting Good Sexual Health

Current HIV prevention work in Bolton targets gay male communities and is coordinated at a local level by a PCT based Health Promotion Specialist. A review is currently being undertaken of voluntary agency commissioning arrangements across Greater Manchester in relation to primary and secondary HIV prevention along with HIV social care. HIV prevention is currently commissioned at a Greater Manchester level from a number of voluntary agencies including the Lesbian and Gay Foundation.

A recent consultation with gay and bisexual men in Bolton carried out by John Moores University found that there is a need to develop a range of community based social and support interventions in gay and non-gay scene settings. To address this need a community development worker has been recruited to work with gay and bisexual men in Bolton, initially over a six month period from November 2003. Community development work involves a range of interventions outlined in the planning framework *Making it Count* which the National sexual health strategy recommends as the model for gay men's HIV prevention.

These interventions include:

- Direct contact health promotion

- Community health promotion, including building community infrastructures, community involvement and social diffusion.
- Organisational health promotion
- Equality interventions

There is evidence to demonstrate the effectiveness of community-level interventions in influencing the sexual risk behaviours for men who have sex with men identified in a review of reviews commissioned by the DOH and carried out by the Health Development Agency.

The growth in new HIV diagnoses amongst African communities in Bolton presents another principal area of HIV prevention need which is currently unmet. A range of needs exist, including:

- Provision of culturally appropriate HIV prevention information and support
- Targeted work with recent migrants/asylum seekers
- Promotion of health benefits of early HIV testing
- Integration and delivery of HIV and sexual health promotion work

A range of agencies in Bolton are currently involved in sexual health promotion work as part of their service delivery including schools, youth service, social work, GUM, Primary Care Teams, voluntary agencies etc. The National Sexual Health strategy sets out the importance of local co-ordination in both the planning and provision of sexual health promotion. The DOH toolkit 'Effective Sexual Health Promotion' - builds on the strategy and includes ways to help establish links with other agencies and successfully co-ordinate group activities. The national strategy also identifies the need for local strategies to respond to the specific sexual health promotion needs of local population groups that may need more specific interventions because they are at a higher risk, are particularly vulnerable or have particular access requirements. The needs of the following groups in Bolton should be assessed:

- Young people, especially those in, or leaving, care
- Black and minority ethnic groups
- Gay and Bisexual men
- Injecting drug users
- Adults and children living with HIV
- Sex workers
- Young people in Youth Offending establishments and residential care

It has been decided to develop local sexual health promotion work by linking in, wherever possible, to other local initiatives. An example of this is the Local Teenage Pregnancy Action Plan, where it has been agreed that the Teenage Pregnancy, Sexual Health Operations sub-group will develop a strategy to support and increase the capacity of agencies working with young people to promote their sexual health. This will focus on developing policies and training front line staff. Similar work needs to be carried out with agencies working with the other 'high risk' groups listed above.

ISSUES FOR ACTION:

- Identify lead individuals to take forward needs assessment work in relation to identified high risk groups.
- Ensure that work is developed in the context of the sexual health service network.

5.13 Chlamydia Screening

The results of 2 pilot studies on opportunistic screening using a non invasive urine testing for Chlamydia have recently been reported. The national strategy briefly outlined the proposal to roll out a national screening programme for Chlamydia in 2002. The programme is about to start in ten pilot sites with funding of £1.5million during 2002-03. It is an opportunistic programme primarily targeting young women who access services in the 16-24 age group. This includes young women who attend GUM clinics, seek termination of pregnancy and those having their first cervical smear. The programme will also promote greater uptake of testing among men. Following evaluation, the programme will be rolled out to other sites. However information regarding future funding or timescales is not yet available.

Chlamydia screening within Bolton is fragmented, with services being provided within the GUM and Family Planning Services and in some GP practices. There is a need to develop clear referral protocols protocols for symptomatic and asymptomatic young people and provide training and support for nurses and GPs. In addition, support services, particularly IT and laboratory services may need additional resources.

ISSUES FOR ACTION:

- Need to review current capacity in relation to chlamydia screening and develop a protocol for accessing existing service provision.
- Need to develop appropriate information to support the provision of chlamydia services.
- Need to ensure that partner notification guidelines are developed and implemented.

5.14 Services for Minority Ethnic Groups

Bolton is a multi racial community and services should reflect the needs of the communities they serve and be culturally sensitive. The 2001 Annual Report compiled by the Minority Ethnic Service Development Officers has highlighted the need for Family Planning services in the Great Lever area. This area has a large number of people from minority ethnic groups, who are mainly Urdu/Punjabi speakers. Currently there are no family planning services in this area.

The national strategy recognises that in some cultures female genital mutilation (FGM) is traditional and acceptable. Within the UK FGM is illegal and unacceptable and is considered a violation of the human rights of the young girls (usually aged between 4 and 10) who undergo this procedure. We currently have no information as to whether this practice is undertaken in Bolton.

Language barriers and cultural differences can make counselling and treatment difficult. Given the massive benefits to health and lifestyle of early diagnosis and treatment, it can be demoralising and distressing for service providers to see patients presenting in the advanced stages of disease. The growing number of asylum seekers; a marked rise in the number of infections found in people arriving from abroad; and, the consequential impact on access to services is a major cause for concern.

Early diagnosis of HIV not only reduces the chances of it spreading within the community but it also greatly improves outcomes for those infected.

ISSUES FOR ACTION:

- Establish effective links with ethnic minority communities with a view to identifying local sexual health needs.
- Influence future service development and ensure service provision is culturally sensitive and embraces the needs of ethnic minority groups.

5.15 Services for Marginalised Groups

The national strategy recognises that services should be developed that will encourage the population groups most at risk to access services. Although GUM service currently provides an outreach service to off street sex workers there is a need to ensure that services reflect the needs of marginalised groups, including sex workers, drug misusers, people with learning disabilities, mental health problems, Gay and bi-sexual men.

It is still very much the case that HIV follows the fault lines of society. Marginalised groups are affected by HIV. We mainstream the way we provide services around HIV and HIV prevention but it is still an infection that fundamentally occurs amongst groups that are marginalized from society or otherwise socially excluded.¹⁵

ISSUES FOR ACTION:

- Key service providers to support the development and delivery of a sexual health service network for Bolton.
- Service providers to develop a clear understanding of the sexual health needs and barriers to access in relation to marginalized groups.
- Service development plans to address identified needs and access issues to be developed.

5.16 Area Based Regeneration Initiatives

Area-based regeneration initiatives provide opportunities to develop locally sensitive services in response to the needs and concerns of local people. One example is the Great Lever Neighbourhood Management Pathfinder that aims to bring together local people and public services with a view to improving quality of life. The programme includes a health theme with a number of specific objectives. These include developing sexual health services targeted at young people and ethnic minority groups in the area.

ISSUES FOR ACTION:

- Identify opportunities to promote and develop sexual health services within community based regeneration initiatives.

¹⁵ Sexual Health. Third Report of Session 2002-03. Volume 1. House of Commons Health Committee. June 2003

6 Commissioning Services for Sexual Health

The main provider of treatment and care services for people with HIV/AIDS in the North West is North Manchester General Hospital. This service is currently covered by lead commissioning arrangements with North Manchester PCT in that role and supported by the Greater Manchester Collaborative Commissioning Team. Bolton PCT, however, also commissions treatment and care services from other NHS providers such as Bolton Hospitals NHS Trust and Manchester Royal Infirmary and these currently lie outside the lead arrangements. A network is in the process of being established so that all treatment and care commissioning could be co-ordinated in future years. Whilst this will generate efficiencies, there is little doubt that it will also increase overall financial pressures.

The Greater Manchester HIV Investment Strategy Project began in 1999 with the aim of developing a Greater Manchester-wide HIV investment strategy. The project appears to have been affected by the organisational turbulence following the abolition of the Health Authorities and the formation of the PCTs. There is a need for clarity concerning the progress of the project and how it fits into the extension of the lead commissioning arrangements in Greater Manchester.

Poor sexual health costs the country a lot of money. Preventing poor sexual health has significant potential not just for better health, but for the better use of finite resources. The prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year. The average lifetime treatment costs for an HIV positive individual is calculated to be between £135,000 and £181,000¹⁶, and the monetary value of preventing a single onward transmission is estimated to be somewhere between £1/2 and 1 million in terms of individual health benefits and treatment costs. The costs associated with preventable infertility can also be reduced dramatically.

6.1 Funding Profile

Tables 4 and 5 summarise how existing funding is applied in relation to the provision of sexual health services for Bolton residents:

Table 4: MAINSTREAM FUNDING 2003/04

Service	03/04 £
Genito Urinary Medicine (direct costs only)	995,700
Family Planning Service (direct costs only)	215,000
Grand total	1,210,700

¹⁶ Beck EJ et al. for the NPMS-HHC Steering Group. "Reduced HIV disease progression and mortality due to CART in English NPMS-HCC clinics". 13th International AIDS Conference, Durban, South Africa, 9-14 July 2000: Poster TuPeC3331

Table 5:**HIV/AIDS Budget 2003/04**

Service	03/04 £
Prevention	
Schools resource pack	9,500
Sexual Health strategy	24,452
Off street sex workers	10,000
MASH	14,997
Services for younger gay men	6,912
Ante-natal testing	25,233
Lesbian and Gay Foundation	21,478
Sharps collection service	17,625
Total	130,197
GUM Services	
Bolton Hospital Trust	145,848
Treatment & Care	
Bolton Hospitals Trust	327,540
Body Positive North West	17,003
Regional Infectious Diseases Unit	350,369
MRI	27,560
Viral Load Testing	12,720
Total	735,192
Grand total	1,011,237

ISSUES FOR ACTION:

- Review mainstream funding allocation with a view to clarifying comprehensive budget profile.

6.2 Specialist Commissioning Arrangements

As noted above, current specialist commissioning arrangements only extend to the Treatment and Care services provided by Pennine Acute NHS Trust at North Manchester General Hospital. These are lead-commissioned for Greater Manchester by North Manchester PCT with support from the Collaborative Commissioning Team. At the time of compiling this Strategy, the lead commissioners were involved in a scoping exercise in order to support the establishment of a Treatment & Care commissioning network. This would draw into the lead arrangement all other providers of these services in Greater Manchester and allow for better co-ordination and delivery. The scoping exercise may, however, identify service gaps or areas of unmet need that may require an additional investment by partner agencies in the lead arrangements. Note that at the current time, the commissioning of HIV Prevention services remains at a district-only basis.

6.3 Voluntary Agency Commissioning Arrangements

Both Bolton Social Services Department and the PCT commission specialist social care services from voluntary organisations in Greater Manchester. Current services

commissioned are Body Positive North West, Birchgrove North, Barnardo's Health Through Action, and the Black Health Agency, Lesbian and Gay Foundation.

A task group from the Sexual Health Strategy Group is reviewing HIV prevention & social care and is due to report with recommendations to the Strategy Group. Possible recommendations may include redesigning commissioning arrangements in Bolton by the use of a single pooled budget and contract management arrangements for PCT and SSD resources to purchase appropriate HIV Social Care.

Greater Manchester Sexual Health Leads Group is also developing a single monitoring schedule for all HIV voluntary agency social care and prevention. This new monitoring schedule will aid voluntary agencies by providing a consistent approach across Greater Manchester saving time and money whilst providing the required monitoring information to commissioners. It is hoped that this new monitoring schedule will be adopted by all Greater Manchester PCT's and Local Authorities by April 2004.

7. Tackling Sexual Health in Bolton

7.1 Sexual Health Strategy Group

To date the sexual health strategy group has had a leadership role in developing the sexual health strategy for Bolton. The group is multi-agency / disciplinary and was established in April 2003. Membership of the group is detailed at Appendix A. The group is accountable to the Adult Partnership Board of the Local Strategic Partnership.

7.2 Core Purpose

To work in partnership to improve sexual health across Bolton by reducing the transmission of HIV and sexually transmitted infections (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.

7.3 Terms of Reference

- Lead the strategic development of sexual health services across the local health economy in accordance with the National Strategy for Sexual Health and HIV and the Implementation Action Plan.
- Ensure that appropriate accountability arrangements are in place across the health economy, and in particular with the Health & Well-being Partnership, to report on progress and outcomes.
- Develop a model framework and comprehensive action and implementation plan to support sexual health service improvement and re-design, building on the review of services undertaken in 2002.
- Ensure that action to address inequalities in sexual health and access to sexual health care are fully integrated into service delivery plans and initiatives.
- Ensure that work in relation to sexual health services is translated into the Local Delivery Plan and other financial planning processes.
- Provide a strategic lead on commissioning for sexual health services and prevention.
- Ensure that all aspects of clinical governance are central to service development and re-design, and firmly underpin service delivery.
- Ensure that a co-ordinated and integrated approach to service delivery is developed and maintained across the health economy, including the voluntary sector, to reinforce partnership working and maximise activities and outcomes achieved.
- Ensure that public/patient and user involvement and views are fully integrated into the work of the SHSG.
- Participate in and contribute to the Greater Manchester Sexual Health and HIV Network.
- Develop a comprehensive communication strategy that promotes openness and enables effective communication that is responsive to the needs of patients; compliments national information campaigns; and, fully supports service re-design.
- Ensure that essential structures are in place to facilitate monitoring and review of progress and to support national and local performance management requirements.

7.4 Public and User Involvement

The PCT will have Patient and Public Involvement (PPI) forums in place by December 2003 as required by the Commission for Patient and Public Involvement in Health (CPPIH). These forums will provide an access point to involve patients and users in the ongoing development of the strategy.

Other opportunities to facilitate meaningful public involvement in the development of the strategy include tapping into existing service user networks/forums such as the Young Persons Steering Group at The Parallel will be maximised. The use of tools including anonymous questionnaires can be used to involve service users accessing GUM clinics and other confidential services. E mail, websites and mobile phones (text messaging) provide other options for participation.

8. Development of an Integrated Sexual Health Service

It is recognised that to make progress towards delivering the national strategy, service providers will need to work towards common goals and standards. To this end, the intention is to develop an integrated patient centred sexual health network of services across Bolton. This will be far reaching in terms of the range of services involved and will focus in the short term on addressing some of the key issues identified in section 5 Current Service Provision. The network will have a fundamental role in shaping services for the future and developing the three levels of service provision described in the national strategy (see section 3.3).

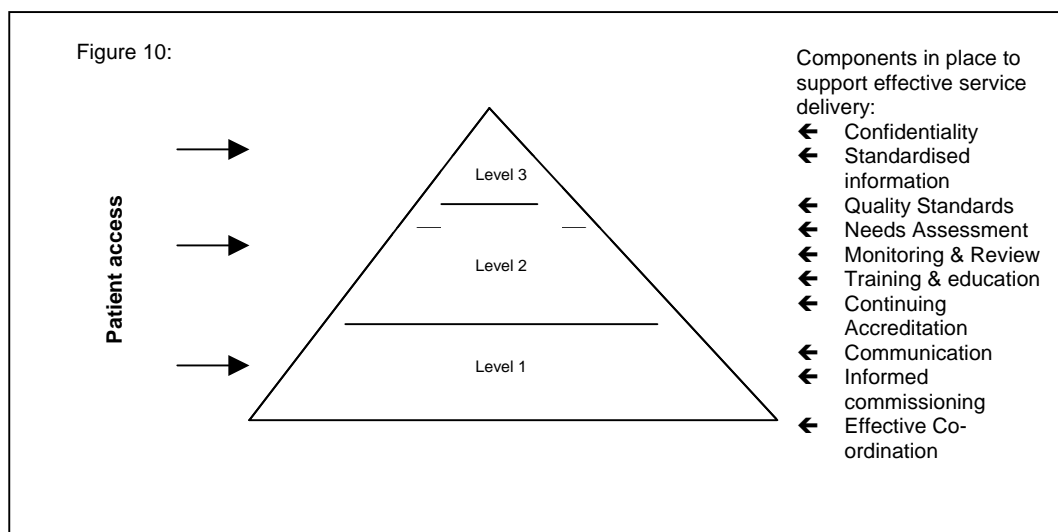
8.1 Bolton Sexual Health Service Network

The Sexual Health Strategy Group has developed a vision to improve the sexual health of the population through the delivery of a comprehensive network of services. Key stakeholders participating in the network will be fully committed and signed up to delivering high quality sexual health services in accordance with locally agreed protocols and guidelines that are underpinned by evidence of what works best and represent value for money.

The network model recognises that working across traditional service boundaries is essential to maximise outcomes from resource investment and efforts targeted at delivering improvements to the sexual health of the population. Locally there is a shared willingness to work in partnership as a network to deliver a comprehensive sexual health service that responds to the diverse needs of the population.

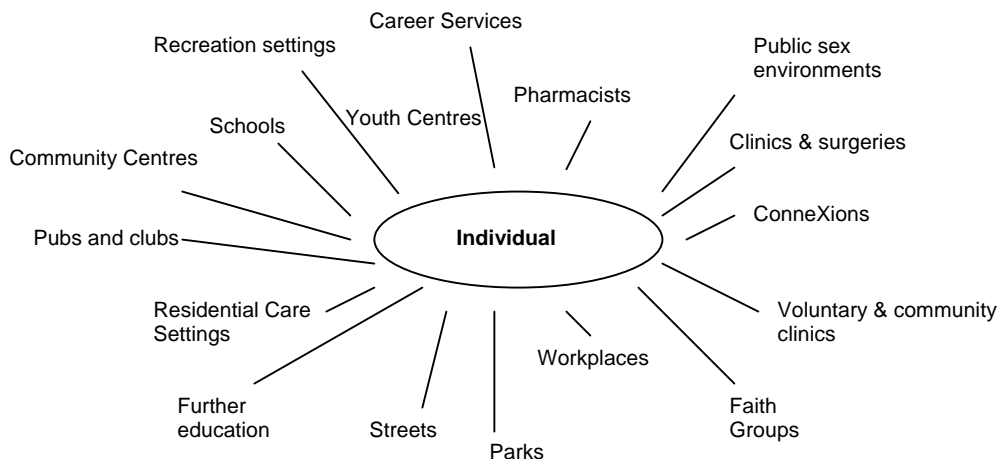
8.2 The Network Model

The network model firmly places the individual at the centre of service provision. It recognises that access to sexual health services needs to be available in a variety of different settings and times, and that the providers of services, regardless of the setting should be fully supported and work towards guidelines and protocols that are underpinned by a network wide quality framework. Figure 10 illustrates the proposed model of service provision. This model builds on the national model described in section 3.3.



- Level 1 service provision will be available in a variety of different settings as illustrated in figure 11:

Figure 11: Potential settings for delivering sexual health services



Integrated care pathways will underpin service delivery and will define the scope of provision available in different settings. Opportunities to provide services in less traditional settings will need to be fully explored and service models carefully developed and comprehensively evaluated before broad implementation.

- Level 2 will be provided by primary health care teams with a specialist interest in sexual health.
- Level 3 services are specialist services with the focus and expertise to provide care for those with more complex, chronic or intensive needs.

Working within the parameters of national guidance and local capacity, early work of the network will be to define and agree the core components of each service level and develop a phased approach to service development in relation to each of these.

Placed firmly at the centre of the integrated network service model will be the needs of the population. Services will be underpinned by evidence of what is known to work well. Network wide standards of treatment and care will ensure consistency in service provision. Integrated programmes of training and education will be developed to support and continue the development of knowledge and expertise of service providers. Monitoring and evaluation will be an integral feature of service delivery and will help to inform continuing service provision and development.

8.3 Scope of the Integrated Sexual Health Service Network Model

The vision is to consolidate all aspects of existing sexual health service provision into a comprehensive network of services that will:

- Provide a continuum of service provision from prevention through to assessment, treatment and care.
- Have a clear focus on users and patients.
- Provide services in environments where users feel safe.
- Enable people to be in control of their sex life.
- Tackle stigma and prejudice.
- Provide choice.
- Provide seamless support and care and recognises that everyone has a role to play in service delivery.
- Work to network-wide agreed standards and protocols for both the delivery of services, professional skills and competency development.
- Recognise and responds to diverse population needs.
- Be underpinned by the clinical governance of service delivery, including continuing education, professional development, clinical effectiveness, audit & evaluation and continuing service development.
- Be supported by an effective communication strategy including public awareness.
- Produce an annual report on progress.
- Produce an annual business and investment plan.

Core principles underpinning the sexual health network will be:

- Accessibility and choice – must be maximised for all clients.
- Confidentiality – must be an essential component of all network services.
- Information - must be appropriate and targeted.
- Flexibility – must be a shared approach to user and patient care and joint working.

There are already many excellent examples of joint working between services. A central focus for the work of the network will be to consolidate and build on current best practice.

The network will provide an overarching framework to support the delivery of:

- Sexual health promotion;
- Better prevention and social care; and,
- Better services.

8.4 Network Components

The sexual health network will include:

- GUM Services
- Family Planning Service
- Maternity Services
- School Nursing Service
- Clinical Psychology
- Health Visitors
- District Nursing
- Voluntary Agency
- Service Users
- Services for people with HIV/AIDs
- The Parallel
- Terminations of Pregnancy services
- Drug and Alcohol services
- Primary Care
- Education Service
- Social Services
- Pharmacists

- GP
- Health Protection Agency
- Dentist

8.5 Network Management & Leadership

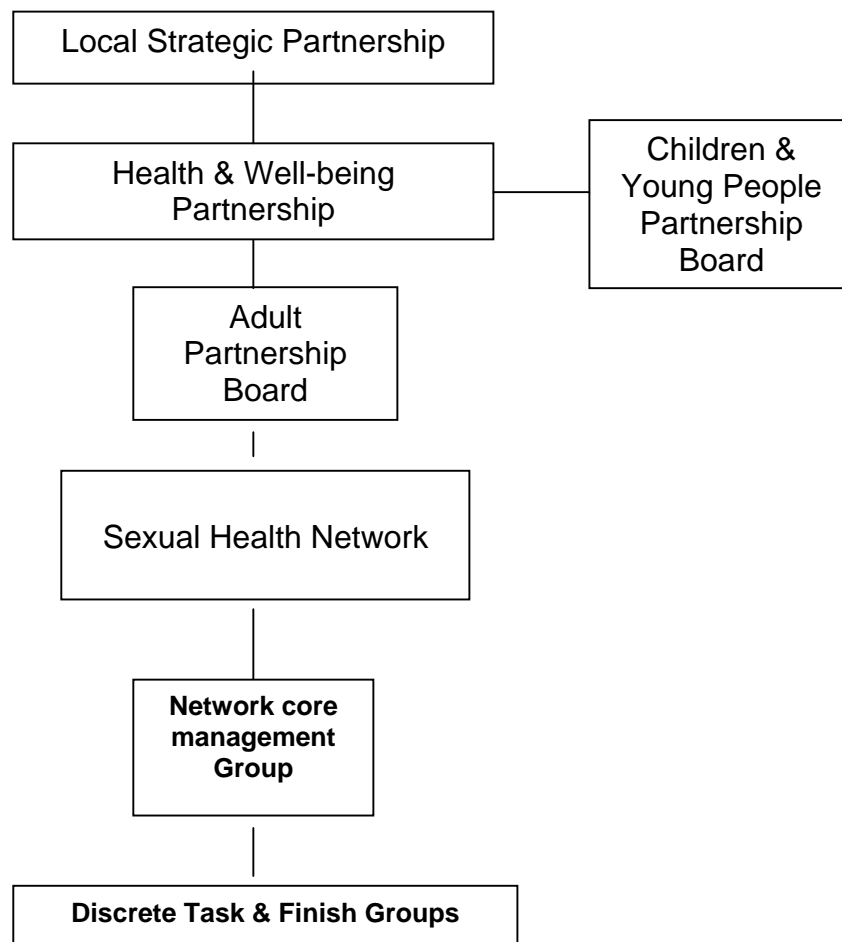
The PCT will take a managerial lead and will facilitate the establishment of the sexual health network, ensuring all stakeholders are fully engaged in the service development process.

Clinical leadership, complemented by effective network management, is seen as essential to support the effective functioning of the sexual health network. A model for clinical leadership and support will need to be developed and agreed as an early priority.

8.6 Network Structure and Accountability

Figure 12 below illustrates the proposed organisational structure and accountability of the network:

Figure 12:



The core management group will include service manager leads and will have a responsibility to translate the sexual health strategy into operational plans and for facilitating implementation. Discrete task and finish groups will be established to develop clearly defined pieces of work in relation to the sexual health strategy action plan. The core management group is accountable to the Sexual Health Network for delivering the implementation action plan and reporting on progress.

Overall the Network is directly accountable to the Adult Partnership Board and on to the Health & Well-being Partnership and Local Strategic Partnership.

9. Translating the vision into Action

The sexual health strategy and action plan is an important first step and provides an early focus to the service development process. It is acknowledged that the service development agenda for the network is ambitious. The national strategy is a ten year plan for action. At a local level, the transition from current service configuration to a more integrated model of delivery will take time. The action plan focuses on laying the foundations for the integrated service model. As work in the plan evolves the action plan will be further developed to reflect the long term implementation programme to support the development of a sexual health network for Bolton.

Strategic commitment across the network will be essential to facilitate and sustain the implementation of the plan for action. This will be particularly important in the early stages of development to support organisational change in the short term and enable long term sustainable service development.

Building on key issues identified from current service provision (Section 5) and the requirements of the national action plan, Appendix B provides a detailed work programme that will facilitate progress towards improving the sexual health of the population of Bolton.

The action plan will be reviewed and updated annually to reflect the evolving work programme and service development requirements of the integrated service network.

10. Priorities for Action

- Establish integrated Sexual Health Network.
- Develop model for network clinical leadership and management.
- Develop model and action plan to facilitate transition to the integrated model of service provision.
- Implement outcomes from the review of family planning services.
- Implement outcomes from the review of termination of pregnancy service.
- Implement outcomes from the review of HIV/AIDS voluntary agency commissioning arrangements.
- Implement the sexual health strategy action plan.

Sexual Health Strategy Development Group

Sexual Health & HIV Strategy Group Membership @ October 2003

Ruth Broadhead	Clinical Lead, The Parallel,
Phil Chia	Consultant Obstetrician & Gynaecologist, Bolton Hospital Trusts
Jacqui Cross	Greater Manchester HIV Voluntary Agency Partnership
Rachel Fricker	Service Re-design, Bolton PCT
Peter Gray	Service Development Manager, Maternity & Womens Health Directorate, Royal Bolton Hospital
Lesley Greenhalgh	Centre for Sexual Health, Royal Bolton Hospital
Paul Hand-Griffiths	Resource Allocation (Finance), Bolton PCT
Angela Hardman (Chair)	Public Health Specialist, Bolton PCT
Patricia Holmes	Non-Executive Director, Bolton PCT
Kirsten Jack	Senior Lecturer, Bolton Institute
Greg Kent	Service Development Manager, Medical/Elderly Directorate, Royal Bolton Hospital
Ann Lees	Clinical Governance, Bolton PCT
Colin Mercer	GP Member, Professional Executive Committee, Bolton PCT
Emile Morgan	Consultant Physician in GU & HIV Medicine, Bolton Hospitals Trust
Andrew Mulholland	Senior Health Promotion Specialist, Bolton PCT
Gail Naylor	Royal Bolton Hospital
Sandie Nesbitt	Drug Action Team Co-ordinator, Bolton MBC
Phil Ramsell	Teenage Pregnancy Co-ordinator, Bolton PCT
Jean Rollinson	Nurse Member, Profession Executive Committee, Bolton PCT
Sandra Smethurst	Manager, The Parallel, Bolton PCT
Andrew Walton	Planning Officer, Social Services Department, Bolton MBC