Draft

Sexual Health Strategy for Hertfordshire 2007-08

CONTENT

Appendix 1 – 3.2

Vision for Hertfordshire Sexual Health

'A dynamic and empowering process to access sexual health and services, aiming to improve the sexual health of the population'

supported by the vision for East of England:
'We will be the best Health Service in England'
Under consultation
The EoE will measure this by adding 5 million years of life to the people in the EoE.

Commissioning Intention:

"The purpose of commissioning is to maximise the health of a population and minimise illness by purchasing health services and by influencing other organisations to create conditions which enhance peoples health."
Ouvriet, J. Purchasing for Health – Oxford Unit Press 1995, p.18

We will contribute to this by:

- Providing a commissioning framework that is part of a comprehensive health reform programme to provide better care, better patient experience and better value for money
- Money following patients, rewarding the best and most efficient providers, giving others the incentive to improve.
- More diverse providers and improved services (supply reforms)
- A framework to ensure regulation and decision making to ensure safety, quality, equity, fairness and value from public funds (system management reforms)
- Choice & commissioning (demand reforms)

East of England regional Targets:

1) reduce unfairness in health
2) improve health
3) provide better patient experience

This Sexual Health Strategy for Hertfordshire builds on national policy and national targets and is supported by local needs assessment data including stakeholder involvement. It sets the vision for delivering change and improvement in the sexual health and well-being of people living in Hertfordshire. This strategy has commitment from providers and commissioners and is supported by the CEOs of the PCT and provider trusts, voluntary sector and users.

The purpose of strategy:

To provide service commissioners and service providers with evidence based recommendations and actions to support the design and implementation of a local sexual health service. It is an inclusive approach that reflects service need and demand.

It aims to provide a model illustrating solutions that are sustainable, locally appropriate and deliverable. It identifies gaps in provision and ways forward.

Key areas for planned focus: Local Targets and Deliverables:

The epidemiological needs assessment, service review and visioning day identified several key areas:

Access to appropriate sexual health services including free condom provision**,** signposting, social marketing/advertising.

Empowerment 'Self-service' access to health information through peer teaching and mentoring, condoms for young people – signposted in all health outlets and partner organisation

Equity of access; services provided in areas that facilitate ease of access for specific target groups: **Young People, Vulnerable groups, Men who have Sex with Men, Looked After Children and Sex Worker's**.

HIV and GUM clinical network; agreement was reached at the visioning day to provide a clinical governance framework for the service of Hertfordshire.

HIV / STI provision; Separating out services to identify better service delivery and cost per case.

Community In reach / Outreach service; Developing a broader range of services below stage five, in order that the GUM clinics can concentrate on more complex work.

A co-ordinated, integrated provision of the '5 stage model' enabling improved access facilitated by a centralising of the appointment services, using information technology.

Introduction and Background National Targets

Sexual health is an NHS and public health priority. Rates of diagnosed sexually transmitted infections (STIs) are rising and research suggests that sexual risk taking is also increasing. The first national strategy for Sexual Health and HIV (DH 2001) highlighted the inequalities that exist in sexual health, and the government white paper *Choosing Health* (2004) outlined the importance of modernising services and delivering care in different ways. *Choosing Health* emphasised the need to communicate better with people about risk, and to offer more accessible services with faster and better prevention and treatment. Supporting the white paper, the Medical Foundation for Aids and Sexual Health (MedFASH) developed ten standards with the aim of enabling people to have prompt and convenient access to consistent, equitable and high quality sexual healthcare.

***Choosing Health* set out the following priorities for PCTs:**

- a reduction in the rate of conception by those under 18 by 50% by 2010 (from the 1998 baseline) as part of a broader strategy to improve sexual health (PSA 11a)
- 100% of patients attending genito-urinary medicine clinics to be offered an appointment within 48 hours by 2008 (PSA 11b)
- a decrease in rates of new diagnoses of gonorrhoea by 2008 (PSA 11c)
- an increase in the percentage of people aged between 15 and 24 accepting screening for Chlamydia (deferred to 2007/2008) (PSA 11d)

Evidence:

This strategy is based on national and local evidence, to most effectively integrate the GUM element of service provision within the existing service network and to create a service which is effective and efficient and meets the needs and preferences of users. While the final document must describe a service that is responsive to the needs to all users in Hertfordshire the development of this document focused particularly on priority (high risk) users of sexual health services, including young people, looked after children, men who have sex with men (MSM) and vulnerable groups such as sex workers as described in the visioning summary notes. **Appendix 2**

Visioning & Strategic Planning Day on 5th September attracted 139 delegates plus staff from PCT. Delegates discussed a holistic model of sexual health across five stages of need/access/use. A mini summary can be seen below followed by the holistic model

Summary of Key themes from the visioning day -

1) The importance of consulting with users, especially young people
2) Improved access to an appropriate level of service
3) Communication between all services
4) The need for a Sexual health network across the county
5) Targeted services for young people – from self-management to GUM clinics
6) Clinical networks to provide a clinical governance structure.
7) Equity

***Key resources and further reading**. Particular attention is drawn to the recommendations for core service provision in GUM produced by the British Association for Sexual Health and HIV (BASHH). That document includes notes for commissioners and clinical governance leads and highlights the essential service features of choice of clinical sites, staffing and training needs, along with practical issues for consideration such as storage of notes, chaperones, clinical equipment and on-site laboratory needs*.
http://www.bashh.org/committees/cgc/servicespec/core_services_provision_1205_final_approved.pdf

Holistic Sexual Health Model

STAGE 1	STAGE 2	STAGE 3	STAGE 4	STAGE 5
Client focused information	‘Self Help’ with ‘professional’ input		Diagnose and treat patients (non-complex)	**Sexual Health Service HUB**
		Clinical Level 1	**Clinical Level 2**	**Clinical Level 3**
• Easy information access, variety of settings, physical and virtual • Education and training of those who are delivering – key issues being stigma and branding of services – need to refer to client groups i.e. young people to understand more appropriate terminology • Teaching life skills • Should be integral to school curriculum • Explore new technology - i.e. networking sites • Information needs to be available 24/7 inc. 40+ age group	• Need variety of venues, use of pharmacies Facilities for outreach – i.e. Boots have booths for rent • Advertising toilets / Mac Donald’s • School nurses delivering sexual health	• ‘Drop in’ style centres – i.e. no queuing • Pharmacy / Gyms signposting to services • Voluntary sector should be involved as part of referral pathways • Male nurses • Weekends and evenings availability for STI screening	• Treat patients and contact tracing	• Outreach to sex workers • Separating HIV – long term condition – from acute GUM cases • Confidentiality • Voluntary services to support secondary services • Patient held record • Email text system – that gives direct access to consultants for clinicians • Service delivered needs to support young, not so young eg >40yrs.

Strategy

Strategy	National Targets	Local Targets	Actions/ outputs (the way forward)	Outcomes
***S**pecific*	***M**easurable*	***A**chievable*	***R**ealistic*	***T**imely*
Structure and Contents of the service to reflect current demand, user involvement and new ways of delivering the **Hertfordshire Holistic Sexual Health Model & Integrated Sexual Health Service**	**Sexual health** is an NHS and public health priority. **National strategy for Sexual Health and HIV** (DH 2001) The government white paper *Choosing Health* (2004) modernising services	**The epidemiological needs assessment**, *service review and visioning day identified several key areas:* **Monitoring** activity, regularly inform the needs assessment demand and capacity management, data collection and real time.	**Visioning & Strategic Planning Day** on 5th September attracted 139 delegates plus staff from PCT. **Holistic model of sexual health** agreed. With an ability to be responsive and timely	**Quality and outcome monitoring will be achieved by:** **Data collection** indicates achievement based on access of services at the right time and the right place to achieve the overall objective of reducing STI and HIV in the population of Hertfordshire.

Commissioning Strategy

Enablers ***Outcomes based commissioning***	**World Class Commissioning**	**As part of Practice Based Commissioning (PBC)**	**Commissioning work:** ***Set up a Hertfordshire wide commissioning consortium*** for sexual health, to include local authorities, CSF, voluntary sector, Brook, PCT, police	An approved network supported and monitored by the PCT. arbitrated by outside professional body. Clinical decisions disseminated through the clinical groups, cascade

			(SARC) and PBC ***To maintain/strengthen current capacity at level 3 GUM*** with further investment to enable the level 3 hub to support training and all satellite clinics including enhanced service provision level 1&2 through PBC	down through the sexual health network i.e. E -News letter **Commissioning to directly reflect need** for service based on evidence, needs assessment to provide yearly updates. Needs assessment document to be a joint approach reflecting service provision and use.
A central sexual health HUB will support all service provision with good clinical governance and leadership applicable for a service area covering the county of Hertfordshire.	***Choosing Health*** emphasised the need to communicate better with people about risk, and to offer more accessible services with faster and better prevention and treatment	**Local areas identified** – location of services to match areas of need demonstrated by 'risk taking behaviour' and access/use of local services	**Key themes to develop action plans** from the visioning event:	**Measured by:** • a reduction in the rate of conception by those under 18 by 50% by 2010 (from the 1998 baseline) as part of a broader strategy to improve sexual health (PSA 11a)
HIV / STI provision; Separating out services to identify better service delivery and cost per case.	**National Strategy recommendations**	**HIV / STI provision**; Separating out services to identify better service delivery and cost per case	**PbR (payment by results) (and local tariff)**	
Sexual Health Spokes, • Contraceptive services • Practiced Based Commissioning Groups providing services, • Voluntary agencies and • Other Partners	**Ten standards for sexual health** supporting the white paper, developed by the Medical Foundation for Aids and Sexual Health (MedFASH) with the aim of enabling people to have prompt and convenient access to consistent, equitable and high quality sexual healthcare. Both organisations in Herts	**Access** to appropriate sexual health services including free condom provision**,** signposting, social marketing/advertising	**Targeted services and Equity for hard to reach** groups,ie. *for young people, BME, sex workers, MSM.* **Site location**, actual and virtual. **Communication** to overcome barriers, cultural physical and psychological. **Special services** i.e. for victims of sexual assault.	▪ 100% of patients attending genito-urinary medicine clinics to be offered an appointment within 48 hours by March 2008 (PSA 11b) • a decrease in rates of new diagnoses of gonorrhoea by 2008 (PSA 11c)

	have undergone department of health reviews. The West has also benefited from input form the National Support Team. This plan takes account of all these recommendations they may be used to support local developments. (*Report available to the organisation concerned.)*			• an increase in the percentage of people aged between 15 and 24 accepting screening for Chlamydia (deferred to 2007/2008) (PSA 11d)
Support Systems				
Workforce Development to accommodate the need for developing new sites. To include recruitment, skill mix including nursing and support staff in sexual health hubs, education and training for staff – in reach and outreach.	**National Strategy recommendations**	**Community In reach / Outreach service**; Developing a broader range of services below stage five, in order that the GUM clinics can concentrate on more complex work.	**Prevention work:** Build on current work of strategic groups, working with Health protection agency, Health promotion, teenage pregnancy steering group, local authority, county council and other agents.	**Network meetings to share best practice** and evidence base and identify achievements, with key practitioners including school nurses, health protection, connections, youth agencies, LAC, voluntary sector and other.
Clinical Leadership will operate with support from recognised national bodies	**National Strategy recommendations**	**Robust reporting** and monitoring mechanism to accountable commissioning groups i.e. PCT	**All commissioned and provider groups to report monthly with raw data.**	**Monitor using unify and other data bases**
Information Technology and Management, to facilitate data collection to achieve performance monitoring to improve service provision.	**National Strategy recommendations**	**Co-ordinated integrated provision** for the 5 stages of access with centralisation using information technology	**Develop IT pathway** Managed by the PCT Sexual Health Network Manager	**Web site** Accessible monthly information reporting service changes, protocols for service providers and a user site for information.

Access / user involvement/Equity Services designed to be accessible by consulting with informed/empowered users. This requires a structure of information gathering and implementation.	**National Strategy recommendations**	**Empowerment 'Self-service'** access to health information through, information technology, peer teaching and mentoring, condoms for young people – signposted in all health outlets and partner organisations **Equity** of access; services provided in areas that facilitate ease of access for specific target groups: Young People, Vulnerable groups, Men who have Sex with Men, Looked After Children and Sex Worker's.	**Improved access** to an appropriate level of service, using 5 stage holistic model for delivery enabling monitoring of access and outcomes **Equity for hard to reach groups, improving access,** though site location, communication and identifying cultural, emotional and physical barriers. Provide services for victims of sexual assault. **Specific steps** to ensure easy access of condoms for young people: Set out access sites; with self service facilities. Health promotion to aid in setting up appropriate signs for all outlets Develop peer teaching/mentoring as an ongoing programme, identify key agent to co-ordinate activity as part of role in sexual health.	Monitoring to ensure uptake to be observational during peak times. Notes to be taken of adverse conditions restricting access. No lower age limit for these sites. Access for vulnerable groups to have no age limit. General monitoring of regular customers. No refusal of supplies by staff. Map and report on sites delivering services.

Action Plan - PCT

Specific	Measured	Achievable	Realistic	Timely
Action Plans/Communication To ensure that effective Monitoring/Data collection is able to provide key information to influence the dynamic development of the service	**National Strategy recommendations**	**IT systems across county to provide centralised booking**	**Communication between all services** by consulting with users, delivery. The need for a Sexual health network across the county, achieved in the first instance via the pct *newsletter and intranet*	**Evidence** though qualitative feed back and key stakeholders and advocates. *(DOH suggests using a credit card format that recognises a pin or bar code number which is swiped on access to a service.)*
To monitor the delivery of all action plans to support the strategic plan	**Quarterly reports and attendance at project meetings and established strategic meetings pan Herts and multi agency.**	**Robust methods of sharing reports. Rationalisation of all meetings to maintain workforce.**	**Target Groups;** Specific actions plans need to be developed to show that these groups are accessing services. *especially young people. A robust and regular method to be developed using the provider's and user's information and the users including those who access information though peer teaching and mentoring.*	
To collate all action plans and attach to the strategic plan to ensure targets are clear deliverable and synergic.	**Match national strategic and local measurements**	**All action plans for the delivery of integrated sexual health are currently co-ordinated by the lead commissioner in public health**	**Data collection issue**.	**Acton plans need to fit within the commissioning cycle of the PCT and should be used to identify gaps is provision and joint action**

Key Recommendations to be used to support the action plans:

1. Integration of sexual health services based on the Holistic Model 'a 5 stage approach' supported by the clinical structure of the hub and spoke, to support the delivery of access and quality across the county

2. Practised Based Commissioning to develop current delivery of Level 1 & 2 clinical services as part of the 'spoke' with hub support.

3. Community-based prevention initiatives to be implemented as a priority, including continued development of work with the Teenage Pregnancy Strategy and the strategically aligned Herts aid and the Crescent for STI & HIV screening . High-risk groups to be targeted based on epidemiological evidence as described.

4. Consolidation, integration in to main stream and enhancement of existing STI, HIV and Chlamydia screening programmes.

5. Teenage pregnancy services, networked into sexual health services appropriate for teenagers.

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

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

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

9. In respect of proposed resource implications, these will be put forward through the Local Delivery Plan, under "Choosing Health" developments.

10. Provision will be:: Person centred, non stigmatising, responsive to the needs of the whole community including underserved groups, confidential and non judgemental

Current Situation on information:

Epidemiological needs assessment underpinning service redesign Appendix 3

*An epidemiological needs assessment was carried out that looked at sexual and reproductive health in Hertfordshire (**appendix 1**).*

Key points included:

Teenage pregnancy

Between 1998 and 2004 teenage conceptions decreased from 32/1,000 (588 conceptions) to 27.4/1,000 (568 conceptions).

54% of teenage conceptions in Hertfordshire lead to a termination

HIV/AIDs – awaiting data *from Emma*

Chlamydia

Estimated diagnosis rate for 15-24 yr olds in 2005 was 1,521 per 100,000 females and 1,217 per 100,000 males.

There are estimated to be 3906 undiagnosed Chlamydia infections in the 16-24 year old sexually active population

Gonorrhoea

Diagnosis rates in men aged 15-34 years decreased from 114/100,000 in 2003 to 74/100,000 by 2005. In women diagnosis rates decreased from 67/100,000 to 24/100,000.

Overall Summary of Hertfordshire Sexual Health Services

The GUM clinics in Watford and St Albans offer open-access clinics with appointments for specialised services and GU appointments in the afternoon. Clinic E and Woodlands offer appointment only services. Clinic E in Hertfordshire offers early evening clinics, but otherwise clinics currently open only within office hours with no weekend opening. Watford and SACH both offer young peoples 'awareness' clinics 4pm-6pm once a week.
Mapping of services has shown that GUM clinics are largely positioned in the most densely 'at risk' populated areas. However, more work is needed to properly quantify demand for services.

Family Planning Services & specialist service in Sexual health HUB
There are usually 20 clinics a week operating in the East and over 20,000 attendances were recorded 2005/06. 17 clinics run in the West with an estimated 240 attendances a week (March 2007 estimate). Data is currently handled manually and this limits service mapping.
Emergency contraception can be provided free to women under 21 years by 62 pharmacists in all areas across the county except St. Albans and Harpenden.

GP provision of family Planning
Hertfordshire Condom provision and C card Scheme
Teenage pregnancy
Midwives are available to offer confidential information and support and there is a network of services across the county.

http://www.westhertshospitals.nhs.uk/clinicalservices/sexualhealth/
Terminations
Theses are provided in Hertfordshire by Marie Stopes clinics with contraceptive provision post termination

Chlamydia screening
This is currently being rolled out across Hertfordshire and is initially targeting family planning clinics.

Voluntary Service Provision
Hertsaid and The Crescent run services such as self-help and support groups specifically for people who are infected or affected by HIV, or who have friends or family who are infected. HIV testing and counselling is a key element of service provision working with vulnerable and hard to reach groups

Training & Education Sexually Transmitted Infection Foundation (STIF) course is a multidisciplinary course offered by clinics on both sides of the county to provide training in sexual history taking to facilitate diagnosis and to optimise care pathways through better understanding of local GUM and sexual health services.

Emergency Hormonal Contraception Provided in several settings including Pharmacies

Sexual Health Action Groups in both PCTs are currently working on action plans to address the 10 High impact changes to facilitate 48 hr access –

Next steps :
Action and Implementation plans to be submitted.
Please view Teenage pregnancy action plan via link.
Please add your links.

N:\Public Health\Choosing Health\Sexual Health\teenage pregnancy/Hertfordshire Teenage Pregnancy Action Plan 07-08.pdf

- **Consultation on this strategy will run from Feb. 08….. to……beginning of March 08**
- **Please submit your comments via email and do not enter on this document.**
- **The review National Strategy will be available in April and this Strategy will be amended to reflect and relevant changes.**

- **Following agreement on the strategic direction that forms this consultation more detailed implementation and action plans will be developed and submitted**.

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- **In the interests of supporting the development of the Herts wide sexual health service it is necessary to understand the care pathway for users and develop more accessible user friendly services to sustain provision. Consideration needs to be given to 'Payment by Results for GUM' and understanding that there is scope for local negotiation of tariffs'**.

- **Actions plans should consider how services will work together to deliver the strategy**.
  1) Providers of level 3 GUM. 2) Primary Care 3) Voluntary Sector 4)Local authority 5) other agencies.

Appendix 1 Background information:

Policy Context
The first ever National Strategy for Sexual Health and HIV for England was published in 2001. The 10 year strategy aims to:

- Reduce the transmission of HIV and STIs;
- Reduced 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.

Building upon the national strategy, the Government published its white paper Choosing Health: Making healthy choices easier (2004), in which it gave a commitment to further transform sexual health services by accelerating implementation of the national screening programme for Chlamydia to cover the whole of England and, the introduction of a national target to improve fast access to high quality GUM services – so that by 2008 everyone referred to a GUM clinic should be offered an appointment within 48 hours (including self-referrals). Access to reproductive health services has also been included for the first time in the Healthcare Commission's (HC) annual health check for 2006/07. This is a two-part composite indicator for access to reproductive health services using a process indicator for access to contraceptive services, and an outcome indicator on the number of NHS funded abortions undertaken at, up to, and including nine completed weeks gestation. Together these three areas (the percentage of the population aged 15-24 accepting a test / screen for Chlamydia; access to GUM within 48 hours and access to reproductive health services) link into the Public Service Agreement (PSA) to reduce the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health. PCTs will be assessed against these targets by HC. Priority was given to sexual health in the NHS operating framework for 2006/07, which included access to sexual health services within 48 hours as one of six top priorities for the NHS. The Department of Health recently published the NHS Operating Framework for 2007/08.

While GUM access is no longer a top-priority, it states:

'' While progress has been made to improve access to sexual health services, more needs to be done, in particular to deliver 48-hour access to genito-urinary medicine (GUM) clinics. Quick access to services means fast diagnosis and treatment for individuals who have a sexually transmitted infection (STI). It reduces the risk of STIs being passed to others. The Sexual Health National Support Team is providing intensive support to the areas that are most challenged".

The Department of Health National Support team, along with the Medical Foundation for Sexual Health and HIV (MedFASH) recently published guidance for PCTs, service commissioners and service providers on meeting the 48 hour access target. '10 High Impact Changes for Genitourinary Medicine 48-hour Access (Dec 2006)' is an essential reference document for the PCTs in developing local services. A summary of the 10 high impact changes is available below.
The full document is available at:
http://www.medfash.org.uk/publications/documents/10_High_Impact_Changes_for_GUM_48hour_%20Access.pdf

PSA11b (Revised): Broader Strategy to Improve Sexual Health: Access to GUM Services

Detailed Descriptor:

The percentage of patients attending GUM services who are offered an appointment to be seen within 48 hours of contacting a service

Units:

Number of patients attending GUM services who are offered an appointment to be seen within 48 hours of contacting a service, expressed as:
Line 1: Total number of first attendances at the GUM service
Line 2: Number of people attending a GUM service who were offered an appointment to be seen within 48 hours of contacting a service
Line 3: Number of people who were seen within 48 hours of contacting a GUM service

Basis:

Commissioner

Timeframe:
Baseline:

Quarter three data from the Genito-Urinary Medicine Access Monthly Monitoring collection.

Until

March 2008

Frequency:

Monthly (Financial Year)

Direction:

The percentage of patients attending GUM services who are offered an appointment within 48 hours of contacting a service should increase with time and reach 100% by March 2008.
The percentage of patients attending GUM services who are seen within 48 hours of contacting a service should increase with time.

Rationale:

A new continuous data collection for GUM waiting times was introduced in August 2006 to improve the quality of data and strengthen performance management. PCTs and SHAs should therefore refresh their plans taking into account findings from the new returns.

The White Paper *Choosing Health,* placed significant emphasis on sexual health. Noting the high levels of sexually transmitted infections, particularly Chlamydia, a comprehensive approach to the development of a broader strategy for sexual health is required. As part of this all services for sexual health, including GUM services have a key role.

Improving access to services for sexual health, including GUM services, will lead to improvements in sexual health for those most at risk of infection. Delays in access to services for communicable diseases will result in poorer sexual health through increased risk of undiagnosed and untreated disease. This will result in unnecessarily high levels of sexually transmitted infections within the population and adverse consequences for individuals through delays in access, leading to additional pressure on NHS services.

Data Definition:

Line 1: Total number of people who have attended the GUM service

Line 2: Number of people attending the GUM service who were offered an appointment to be seen within 48 hours of contacting the service

Line 3: Number of people who were seen within 48 hours of contacting the service

Guidance on additional technical details was issued by DH on 28th July 2006.

Contact – everyone who contacts a GUM service requesting to be seen **must be offered an appointment** whether the request is by GP referral, self-referral in person, by letter or by phone. This includes people attending walk-in clinics who cannot be seen that day.

Walk in clinics - Every person attending walk in services who cannot be seen that day should be offered an alternative appointment and counted as a contact. The service should then record when that person attends and whether this was within 48 hours of their original attendance.

'*Within 48 hours*' - within two normal **working** days (i.e. not including Saturday or Sunday or Bank Holidays) following the day when a request by a patient was made. This does not include emergency appointments (i.e. someone with acute STI symptoms) which must always be seen within 48 hours.

'*To see*' - face to face personal contact. Telephone consultations can reduce the overall demand for appointments but they cannot be counted for the purposes of this measure.

'GUM services' are specialised services, where the primary function of the specialist clinical multidisciplinary team is concerned with the provision of screening, diagnosis and management of sexually transmissible infections and related genital medical conditions. In line with the national strategy for sexual health and HIV, GUM services would be represented as level three providers.

Follow up attendances should be excluded for the purposes of this measure.

"Specialist clinics" - All people attending a service for an STI related issue should be counted for the purposes of this measure. Those attending specialist clinics which required scheduled appointments based on clinical need i.e. psycho-sexual dysfunction, HIV treatment and specialist gynaecological services should be excluded.

SHA Envelopes:

No

Criteria for plan sign off:

All SHAs should plan for 100% of patients attending a GUM service to be offered an appointment to be seen within 48 hours of contacting a service, by March 2008. We would expect SHA plans for 07/08 to build on agreed LDPs for 06/07, which are based upon the percentage of patients being seen in 48 hours

Further Information: http://nww.unify.dh.nhs.uk
Monitoring Frequency: Monthly
Data Source: Genito-Urinary Medicine Access Monthly Monitoring

Hertfordshire Sexual Health Summary Report

Visioning & Strategy Planning Day

5th September 2007

Hertfordshire Primary Care Trust's
Public Health Directorate
Summary Authors: Rosie Gagnon & Dr Linda Mercy

Purpose: The purpose of the event was to refocus our strategic direction and to set out how, as a health community, we can begin to progress plans to create holistic integrated sexual health services.

THE EVENT:

139 delegates from across Hertfordshire attended the Sexual Health Visioning Day held at Whipsnade Zoo on 5th September 2007.

Jane Mezzone, delivery manager for the Department of Health's National Support Team for Sexual Health chaired the day and gave a presentation on the holistic approach to improving access to screening, diagnosis and treatment for sexually transmitted infections. Dr Jane Halpin, director of public health for Hertfordshire PCTs, gave the public health view and was followed by Emma Sanford, epidemiologist from Herts PCTs, who outlined a needs assessment for sexual health services in the county. Rima Hawkins-Chowdury, associate delivery manager for the department of health, then looked at how the current delivery model works. The key note speaker, Dr Simon Barton, then took the delegates through some of the clinical issues impacting on service redesign.
During the day several workshops were held. Teams from the four genito-urinary medicine (GUM) clinics met with other delegates from primary care in a group led by Dr Simon Barton to explore the potential for clinical networks in Herts. In the parallel workshops delegates spent the morning 'visioning' sexual health care across the spectrum from self-management to complex sexual and reproductive care. In the afternoon delegates considered specific client groups – with much of the focus on younger people. These discussions will support the strategic planning process.

KEY OUTCOMES OF THE DAY

- A Sexual Health Network for Hertfordshire was set up that will include all delegates who attended – all delegates will receive a network newsletter to which they will be able to contribute
- Networking achieved greater understanding of services available
- A GUM clinical network was set up
- An HIV clinical network was set up
- Inequity was identified around the type of Chlamydia screening tests available in GUM clinics – action taken to make tests available for E&N Herts
- Workshops on the day provided a wealth of information to support the development of a sexual health strategy for Hertfordshire.

Clinical GUM and HIV Network Groups

Delegates from the four GUM clinics in Hertfordshire and representatives from primary care and the third sector met to discuss the development of clinical networks for GUM and HIV in Hertfordshire.

There was agreement to set up clinical network groups on the Visioning Day. NICE guidance, national standards and national templates will support the networks. Reference to outside national professional bodies and support organisations will be made to underpin clinical evidence base

Role of the clinical network groups:

- To support delivery of effective care
- As a Countywide group
- Provide Clinical Governance – supporting levels 1 and 2 – Clarity of responsibility and accountability
- Guideline implementation
- Support training
- Responsibility to communicate
- Implement appropriate service change
- Involvement of all physicians in service planning i.e. GPs

The PCT will support these networks in setting up the initial meetings and providing administrative support.

Outline of Issues Covered by the Clinical Network Group During the Visioning Day

MAIN THEMES

Function of clinical network:

- The clinical network has agreed to standardise and monitor / govern clinical pathways pan Hertfordshire. This would be across all organisations, wherever sexual health screening is carried out, including voluntary sector.
- Provide updated info for website
- Along with strategic direction, need to be up to speed with new technologies.

Training, development and partnership working:

- FP – need for training – current courses available, STIF, mentoring and shadowing
- LARC – training need identified
- Discussion around developing GUM on-call rota for Hertfordshire
- Physicians involved in service planning
- PBC groups involvement
- Importance of having an IT infrastructure that allows for 'real time' data collection to aid planning

Options for network structure-:

need to look at network function and be timely and responsive

- Suggested Option 1 for network– once a year clinical group – core membership to include Jane Halpin, Acute provider, director level
- Suggested Option 2 for network – two groups meet as an when
- Option 3 – virtual network
- Option 4 – 3 monthly meetings – need to be aware of time and funding needed to support attendance/participation
- Possible option of a combination of the above
- Highlighted need for a Network Manager

Information technology:

- Centralised database and IT support – to help describe need - funding
- Common dataset
- Data and Audit
- Monitor access to GUM across Herts
- Promote / advertise service
- Use of mobiles and texts

Pathways:

- Formalising patient pathways
- Support to primary care / clinical governance
- Clarification of any medico-legal issues

Future planning:

Work towards a business proposal for a network manager to facilitate:

- Provision of governance and standards – to support commissioning
- Communication and signposting
- clinical network to link with voluntary, advertising, schools, other, in addition to GUM, GPs and FP

Delegate Suggestion – Level 2/3 in Dacorum in addition to other 4 GUM clinics in Hertfordshire. These GUM hubs would support levels 1 and 2 GPs with special interest across Hertfordshire.

- GUM hub outreach role to include support peer education role in schools and universities
- HIV network in Hertfordshire needs to define clinical links to London centres ?? standardise across Hertfordshire

Parallel Groups Morning Session

During this session delegates were asked to consider different levels of service – from self –management to specialised sexual and reproductive health services. Groups outlined what they would like to see at each of the different stages.

STAGE 1
Client focused information

- Easy information access, variety of settings, physical and virtual
- Education and training of those who are delivering – key issues being stigma and branding of services – need to refer to client groups e.g. young people to understand more appropriate terminology
- Teaching life skills
- Should be integral to school curriculum
- Explore new technology - e.g. networking sites
- Information needs to be available 24/7
- Not enough info for 40+ age group

STAGE 2
'Self Help' with 'professional' input

- Need variety of venues, use of pharmacies Facilities for outreach – e.g. Boots have booths for rent
- Advertising toilets / MacDonald's
- School nurses delivering sexual health

STAGE 3 – clinical level 1

- Drop in' style centres – i.e. no queuing
- Pharmacy / Gyms signposting to services
- Voluntary sector should be involved as part of referral pathways
- Male nurses
- Weekends and evenings availability for STI screening

STAGE 4 –clinical level 2
Diagnose and treat patients (non-complex)

- Treat patients and contact tracing

STAGE 5 – clinical level 3

- Outreach to sex workers
- Separating HIV – long term condition – from acute GUM cases
- Confidentiality
- Voluntary services to support secondary services
- Patient held record
- Email text system – that gives direct access to consultants for clinicians
- Service delivered needs to support young, not so young e.g. >40yrs.

Afternoon Sessions

Groups looked at particular client groups and themes to identify pathways.

The stakeholder groups involved included multi-agency multi-professional and user.

Major themes emerged across all the workshops

- Awareness of access
- Signposting
- Skill mix
- Pathways that cut across all organisations
- Clear policies and protocols – consistency across services
- Ensuring sex education is being delivered to a high standard within the national curriculum

Young People 14–25 age band

Summarised below some of the key issues and suggestions for the client groups discussed.

Main themes identified in Workshops

- Information needs of young people – particularly on transfer to secondary school
- Access to sexual health services and GUM clinics

Suggestions for way forward

Information / Communication

- Newsletter for Sexual Health Network to keep all updated
- Communication about access and services needs to be part of strategic plan
- Education in schools - Information needs to be tailored to this group – particularly around transfer to secondary schools and Key Stages 3 and 4 - Position in faith schools
- Work with extended school programme
- Role of school nurses
- Peer workers
- Distribute contact details of services as part of 'Numbers you need' project
- Information / signposting and services where young people gather – 'café' style
- Teenage pregnancy midwife – e.g. discussion around sexual health and long acting contraception
- Use technology
- Involve young people – survey of what young people want

Access

- Reference document - You're Welcome quality criteria: Making health services young people friendly DH March 2007
- On-line appointments
- Weekend opening
- Open-access clinics - Some young people don't know how to make a doctors appointment – may find it difficult to ring back if not appointments available
- Evening clinics
- Need to look at other locations for services – times and places not always suitable – Some clients just won't attend a GUM clinic, 'Basic screening' should be available at different locations in the community. – e.g. One-stop-shops
- Outreach services
- More sexual health in FP clinics – targeting young women – could offer 'quick check' service
- Enhanced service in primary care
- GPs need to be made aware of what is available
- Extend C-Card scheme across county

Training needs identified

- Training around subject holistically – issues such as drugs, alcohol, broken homes
- Communicating with young people – some staff 'put off by groups of young men'
- Help parents to communicate with their children
- Pharmacies – what can be offered
- Patient group directives (PGDs)

Specific protocols and policies

- Under 16yrs need to consider sexual abuse, competence. CRB checks
- Key PGDs that are needed
- Chlamydia screening / training requirements for this group
- C-Card / condom 'training'
- Family planning training – 6/12 via 2-3 modules ? need all of it?
- Emergency contraception (could link with Chlamydia testing)

Who to involve

- Connexions
- NHS direct
- Sexual health network to produce a newsletter for young people
- Include young people need to be involved from all areas – Where do they want services? – survey
- Peer group education
- Health promotion team at PCT
- One-stop-shops – extending their role
- 'Numbers you need'
- Extended schools and Children's centres– Childrens schools and Families teams
- Midwives/health visitors – discussion around sexual health and long acting contraception for young mums. – more parenting support in general, including peer support.
- teenage parent midwives
- Pharmacies
- HCC run youth clubs
- Youth Counselling services
- Psychosexual counselling services
- Children's Trust
- Drugs and Alcohol services

Gay Men

Main themes identified

- Lack of local resources to support and advise on gay relationships
- Access to services

Suggestions for way forward

Access to services

- More community based services
- Outreach workers
- Preventative teams

Information

- Need local information/leaflets – nothing available locally on gay relationships Health Promotion support and advice
- Need to find out what gay men need
- -Lighthouse etc
- -Information from London services may be useful
- Use of innovative approaches to get message across – e.g. Hollyoaks etc used to bring messages to target groups
- Face-book given as an idea – other specific local/need
- “30% of married men go to Gay Clubs”
- After Care – the crescent given as an example
- 24hr helpline

Joint working

- School education – need to work with governors - ?training of school teachers
- PCT – Children Schools and Families – Schools and Healthy schools
- ‘Free to be ‘youth group - ? no longer functioning
- ‘Broken Rainbow’ – organisation in Hemel
- HertsAid work within Woodlands Clinic

Vulnerable Groups

Main themes identified

- Education services need to be tailored to needs of these groups

ISSUES identified

- Confidentiality, legislation – mental health act,
- Extra time may be needed for this patient group
- Think about literacy ages – e.g. LAs use reading age of 8yrs
- Language use in general – need better terms
- Client – set at their level
- Available support not suitable
- Public transport issues
- Need to be aware – not easy – e.g. making appointments

SUGGESTIONS

- Outreach education in special needs schools
- May need one-to-one support
- Staff equipped to be able to support
- Training needs – need to provide education in a way that is understood, not take away decision making
- Referring to someone trained to communicate
- Need to look for evidence of best practice – literature searches
- Need a Positive attitude
- Care plan
- Dedicated staffing
- Multidisciplinary approach
- Money

Who else to involve?

- Services pulling together
- Social services
- Special needs schools
- Learning disability schools and homes
- PCT – standard of care – provision of contraception etc…

Other Areas Discussed

Issues Identified

BME groups

- Cultural awareness – a guide that tells exactly what is appropriate and not appropriate in different cultures - training
- Good access times – out of hours
- Need for interpreters – incidents where sons attend clinics to interpret for their mothers
- Clinics out in community – not in GUM clinic setting
- Need population data
- Joint working with LA
- Link workers from actual community
- Case meeting with joint work would be helpful e.g. 1/12
- Ethnic minority health advisors employed by PCTs and health trainers.
- Clients paying for Treatment who do not have right to remain in UK- Public Health concern risk-

Homeless people

- Need local GPs covering 'short term' accommodation. Good in Hemel – links with GPs and Health visitors
- Access to information on sexual health difficult for group to get hold of.
- *Services*
- Open access important for this group.
- Outreach - ?nurse, GUM teams
- Transport issues
- Drug and Alcohol Team
- Youth offending
- Resettlement Officer
- CSF – child Protection
- Paula Parkins – Resettlement Officer
- Herts Young Homeless Group – 16 – 17 yrs

Terminations in Under 18years

- Free pregnancy testing – clear local instructions on where to get support,
- Opportunity to discuss what a positive test means – if termination wanted – post termination support
- Standardised access to termination protocol across Hertfordshire. Support package for LARC
- Widespread access to free preg testing should be available– community setting , health settings
- CSF,PCT, Youth Service, voluntary Sector, connexions

Older People

- Hidden
- Need – 'normalising' and awareness
- Balance between drop in and appointment
- Where – GP, FP, GUM and RELATE, self refer
- GUM as hub – with multiple spokes, common policies and protocols
- Clear policies for worried well, without symptoms, need better signposting and sharing of info
- Will need leadership from clinical network
- Will need identified link with GPs, Practice-based commissioning

Action

- Herts Aid go to Woodlands on a weekly basis
- Herts Aid go out to clients
- Social work to be contacted
- Adult Care Services

Appendix 11.1

Health Economics of Sexual Health:
A Guide for Commissioning and Planning.

INTRODUCTION

In essence, this question is simple – have we got the right level of relative investment in sexual health services in this country? How can Primary care Trusts - PCTs (who are responsible for most of the commissioning of these services) be best advised about investment levels and service provision?
If the level of investment is insufficient, how can a PCT Board, and in particular its Director of Finance be provided with clear evidence to show that more investment will deliver cost-effective benefits (or even reduce costs) in the future?
Individual aspects of this question include the following examples:

- Would the costs of reducing waiting times in GUM Clinics be paid for by reduction in transmission of infections and hence in costs of new cases?
- Would costs of greater investment in preventative services be offset by averted reduced costs of care for Sexually Transmitted Infections (STIs)?
- Would costs of screening services be offset by reduced need for treatment for infertility?
- Would investment in contraception services be offset by reduced need for abortions and maternity services?

Scope of report and definitions.

The areas covered by sexual health include sexually transmitted infections, including HIV, contraception, health promotion and sex education. Note that the benefits from prevention of an STI extend beyond the individual because onward transmission to other people is also prevented.
This report is offered to those commissioning and planning services in the hope that it might be useful in making a case for these services, and will also avoid them needing to replicate this sort of review locally.

Cost-Effectiveness

Often used (incorrectly) simply to mean cost-saving, it is generally taken to mean the ratio between the cost incurred and the benefit produced.
The cost-effectiveness of health interventions are often measured in terms of cost per life year gained. Other measures might include cost per STI/

Appendix III

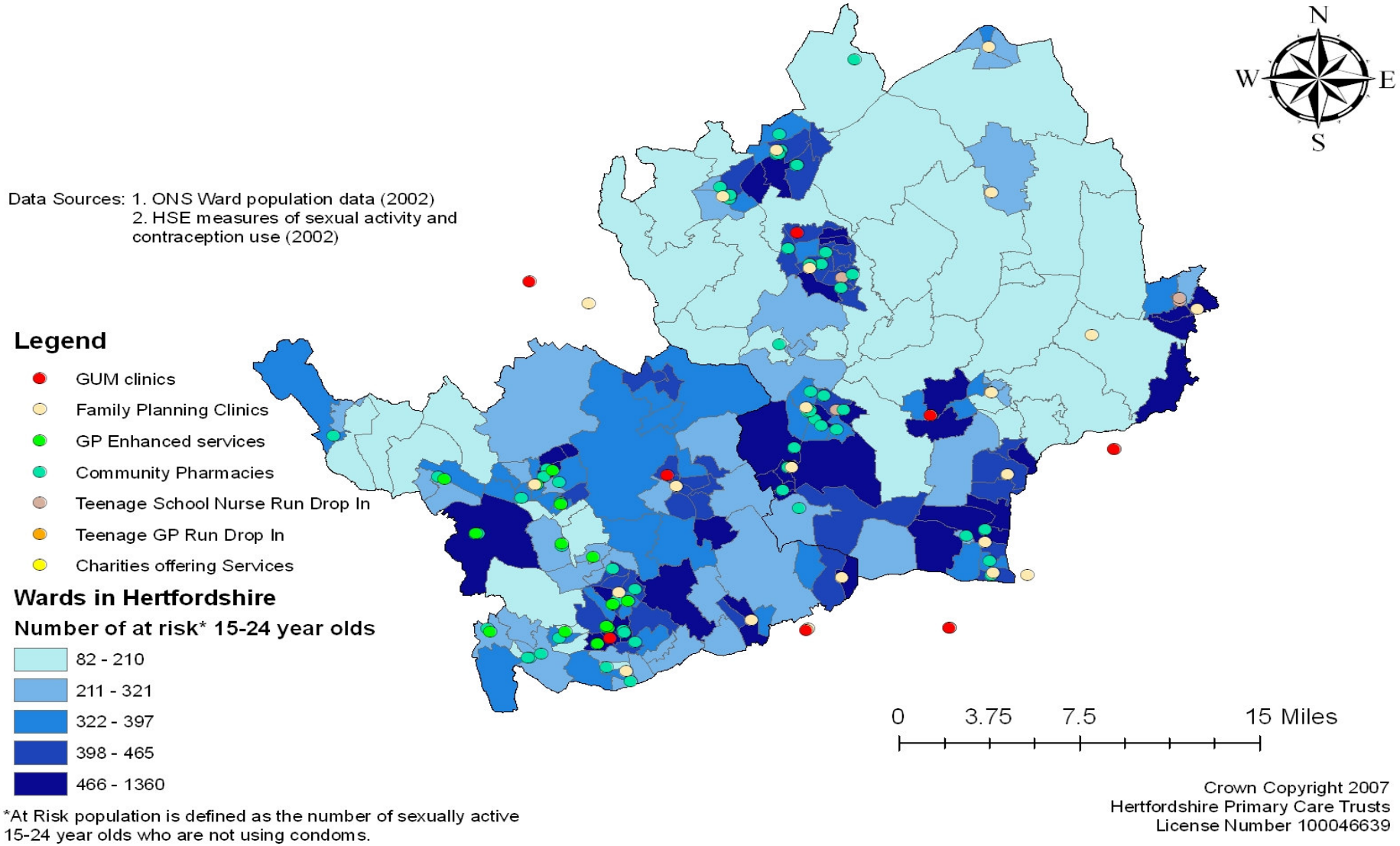
1. Maps used at Visioning Day to help identifying at risk populations aged 15 – 24 years

Map 1	Map 2
Identify Services including pharmacies GUM and family planning etc	Population of sexually active not using condoms, (darkest areas are the most densely populated at risk areas) information based on house hold survey data

2. Needs Assessment for Sexual Health Services in Hertfordshire

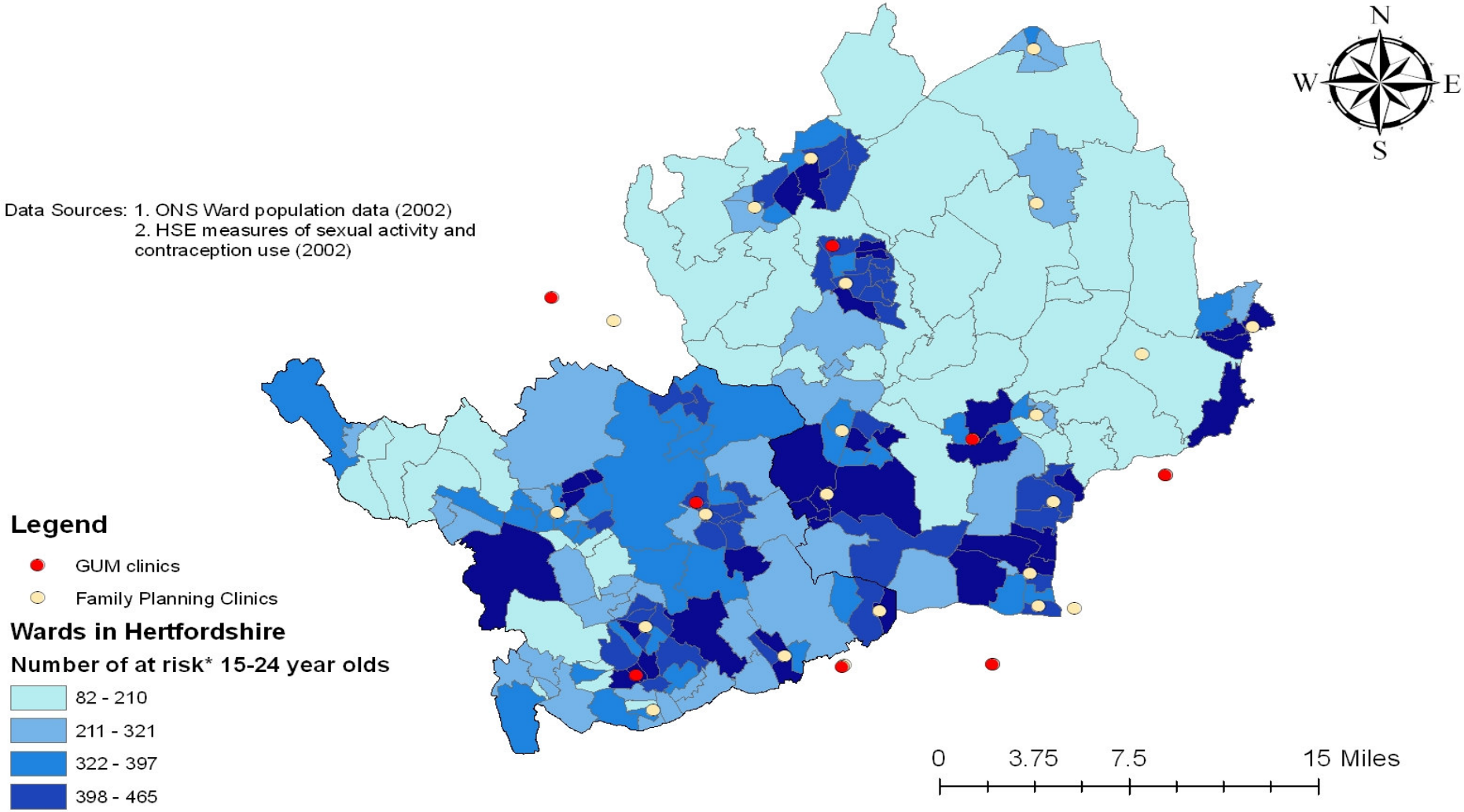
November 2007

At Risk* Populations and Sexual Health Services in Hertfordshire



*At Risk population is defined as the number of sexually active 15-24 year olds who are not using condoms.

At Risk* Populations and Sexual Health Services in Hertfordshire



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West Hertfordshire Primary Care Trust and
East and North Hertfordshire Primary Care Trust

Needs Assessment for Sexual Health Services in Hertfordshire

November 2007

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CONTENTS

INTRODUCTION

This document looks at what is known about the need for sexual health services in Hertfordshire, based on epidemiological data and service use. It is a parallel document to the summary from the county sexual health 'visioning day' on September 5th.

Hertfordshire

Covers an area of 624sq miles

Estimated population of just over 1 Million, with 115,000 young people aged 15-24yrs – a high risk age-group for sexually transmitted infection.

(See Appendix A for full population breakdown by age-group)

This document presents –

- The epidemiological data available for sexually transmitted infections in Hertfordshire, and also looks at teenage conceptions and termination rates.
- Areas in Hertfordshire where the largest numbers of the young (15-24yrs) 'at risk' population are resident.
- The range of services available within Hertfordshire and their activity levels – ranging from family planning clinics, emergency oral contraception to Genito-urinary medicine (GUM) clinics. The location of these services is mapped across the county where possible.
- Data on patients accessing GUM clinics located outside the county.
- The progress towards achieving 48hr access to GUM clinics is also presented.

The document ends with a summary table and map to highlight where there may be a mismatch between need and services.

2.0 Sexually Transmitted Infections (STIs)

The following sections outline some of the available data for STIs diagnosed in Hertfordshire. Patients do not have to attend a clinic in the area they live, so it should be noted that in some cases the data represents diagnoses made in all patients attending Hertfordshire clinics. These patients may not all be resident in Herts, and similarly Herts residents may attend services in other areas. (see section 6.4.2.3)

2.1 Chlamydia

Chlamydia is the most prevalent of all diagnosed STIs in the UK. If left untreated, it can lead to chronic conditions, especially in women – for example pelvic inflammatory disease and ectopic pregnancy. Most prevalent in women, over half of all cases show no symptoms. The majority of cases are diagnosed in the 15-24 age group. Table 1 compares the total number (all ages) of diagnosed cases of Chlamydia in GUM clinics for the years 2003 to 2006.

Table 1 Chlamydia diagnoses (uncomplicated) in Hertfordshire GUM clinics, all age groups, for West Herts and E&N Herts 2003-2006.

PCT	2003	2004	2005	2006
E&N Herts	259	352	285	307
W Herts	945	921	785	720

Data source KC60 reports from GUM clinics analysed at Health Protection Agency Centre for Infections

Only around 60% of all Chlamydia diagnoses are made in GUM clinics, with diagnoses also being made in other settings, such as primary care and hospital inpatient settings. So we can estimate that in total there were **512** Chlamydia cases diagnosed in E&N Herts PCT in 2006 and **1200** in West Herts PCT.

We know from large research projects[1] that many cases of Chlamydia remain undiagnosed. Using information from this research, we can estimate that there are in the region of **4,000** undiagnosed cases of Chlamydia across Hertfordshire in the 16-24 year age group alone.

2.2 Gonorrhoea

Gonorrhoea is the second most prevalent STI diagnosed in the UK, and as with Chlamydia, the majority of cases are diagnosed in the 16-24 year old age group. Complications in women can lead to pelvic inflammatory disease and ectopic pregnancies. Recent reports show that across the whole of the Eastern Region there was an increase in diagnosed cases towards the end of 2006, following the original decrease in 2004/5. National data shows that while cases among the heterosexual population are declining, numbers of cases in the men who have sex with men (MSM) population are increasing. On the whole ddiagnoses' are particularly concentrated in young adults, men who have sex with men and black ethnic minority populations. Table 3 compares the number of cases diagnosed in Hertfordshire GUM clinics for the years 2003 to 2006.

Table 2 Gonorrhoea (uncomplicated) diagnoses for GUM clinics in Hertfordshire years 2003-2006.

PCT	2003	2004	2005	2006
E&N Herts	73	47	29	54
W Herts	145	138	98	74

Data source KC60 reports from GUM clinics analysed at CfI

Data from 2006 suggests that 86% of cases are diagnosed in a GUM clinic setting, so the majority of diagnosed cases are accounted for in table 2. However, the real number of cases was likely to be in excess of 250 cases across Hertfordshire in 2006, as it is estimated that half of all cases of gonorrhoea are undiagnosed[2].

[1] CLASS study Low N, McCarthy A, Macleod J, Salisbury C, Horner PJ, Roberts TE, et al. The Chlamydia screening studies: rationale and design. *Sex Transm Inf* 2004;80:342-8.

[2] CDC

2.13 HIV - New Diagnoses

Table 3 shows the combined number of new HIV diagnoses for the years 2000-June 2006 by PCT area of diagnosing hospital or centre. The greatest burden of disease in the Eastern Region is diagnosed in Bedfordshire, and this area is included for comparison.

Table 3 New HIV diagnoses for the years 2000-June 2006, by location of diagnosis.

Site	2001 and 2002 combined	2003 and 2004 combined	2005 and 2006 (Jan – June only) combined	Total New HIV diagnoses (2001 to June 2006)*
Bedford General Hospital	59	61	52	**172**
Luton and Dunstable	233	271	134	**638**
West Herts PCT	71	118	74	**263**
East and North Herts PCT	40	62	48	**150**
Not known and other (inc GPs, prisons etc)	24	37	27	**88**

* Numbers will rise as further diagnoses received

KEY POINTS

- Estimates suggest up to 4,000 residents of Hertfordshire aged 16-24yrs are infected with Chlamydia and remain undiagnosed
- Following a decrease, the rate of gonorrhoea diagnoses now appears to be increasing.
- The proportion of cases of gonorrhoea has increased for the MSM group

3 Teenage Conceptions

3.1 Overview

The United Kingdom has one of the highest teenage pregnancy rates in Western Europe. Locally some of the action plans to address this include a 50% reduction of teenage conception rates from baseline 1998 by 2010. The chart (Fig 1) shows that Hertfordshire has a lower rate of Teenage Conceptions than the East of England and England, and the declining trend in Hertfordshire is in line with the national decline. In Hertfordshire the rate of Teenage conceptions in Hertfordshire was 32/1,000 (588 conceptions) in 1998; this had dropped to 27.4/1,000 (568) in 2004, this decline corresponds to a 14.5% decrease. The rate in England had declined by 11.1%: dropping from 46.6/1,000 in 1998 to 41.5/1,000 in 2004.

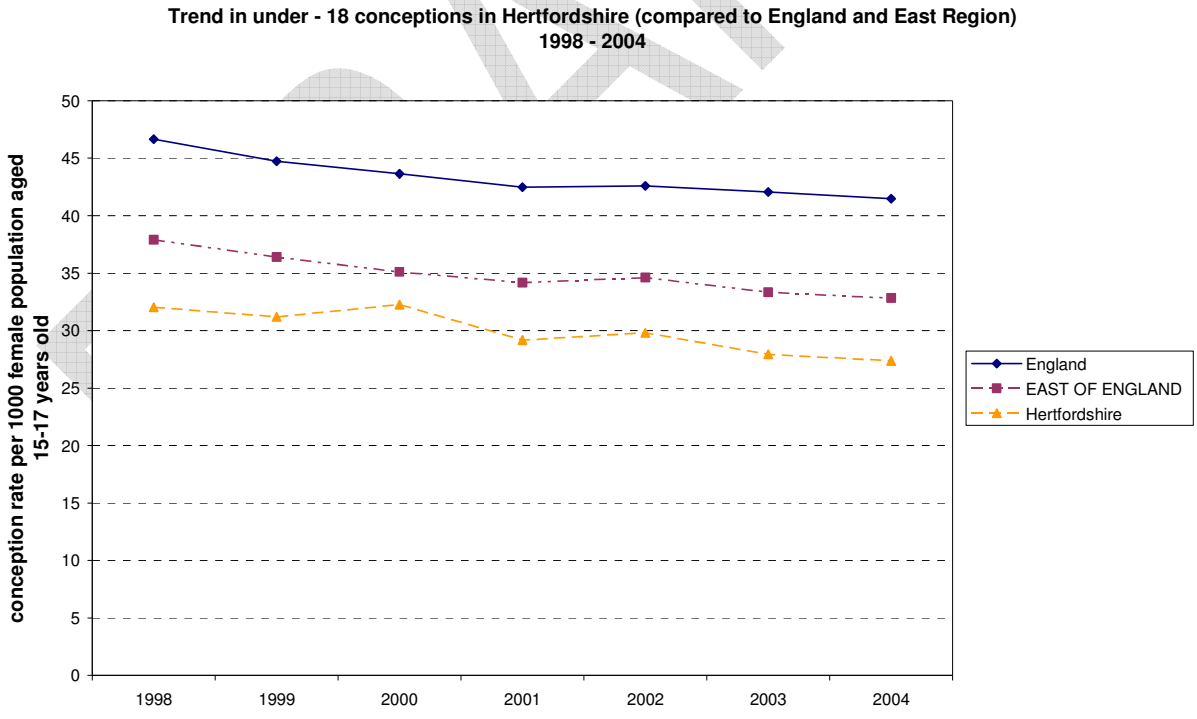


Fig. 1
Source: NCHOD

3.2 "Hotspot" Wards and Deprivation

Teenage pregnancy is associated with poorer education outcomes and future socio-economic deprivation. The map of Hertfordshire (Fig.2) shows that wards with high rates of teenage conceptions also tend to be the wards which are most deprived as determined by IMD 2004. Those identified as having high rates of teenage conceptions compared to Hertfordshire as a whole were St Nicholas, Waltham Cross, Sheppal, Bedwell, Batchwood and Baldock Town. For these wards we can be statistically '90% confident' that the true rate is higher than that of Hertfordshire as a whole. Local knowledge suggests that Northwick Ward should also be included as a hotspot ward, although it does not meet the statistical definition.

Deprivation (IMD2004) and Teenage Conception Hotspot Wards in Hertfordshire County, by Ward

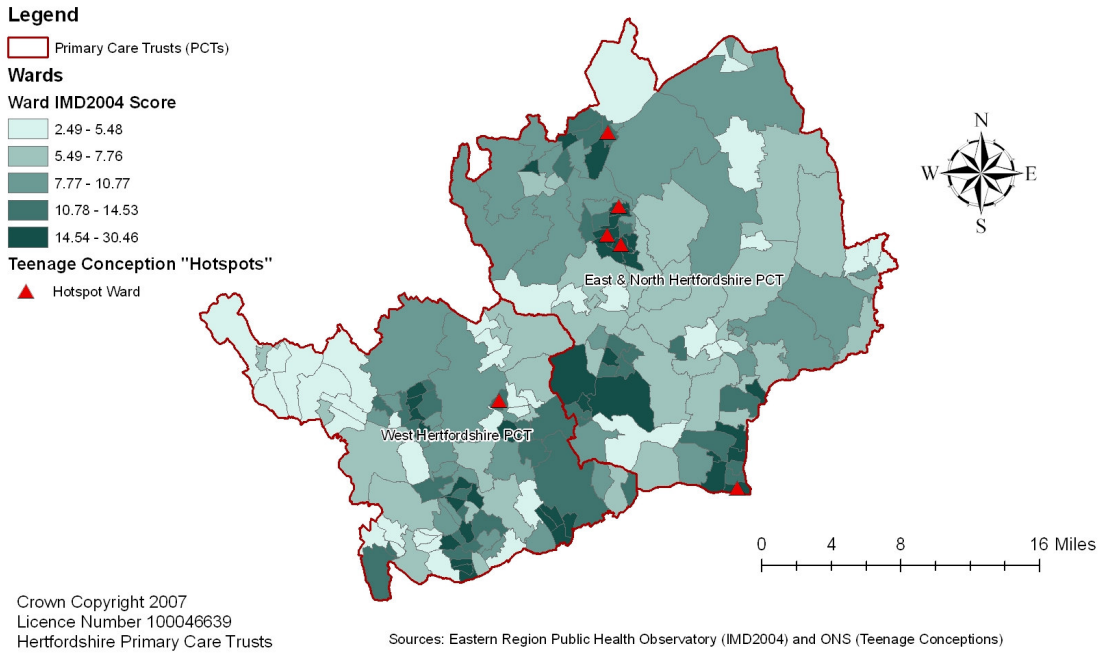
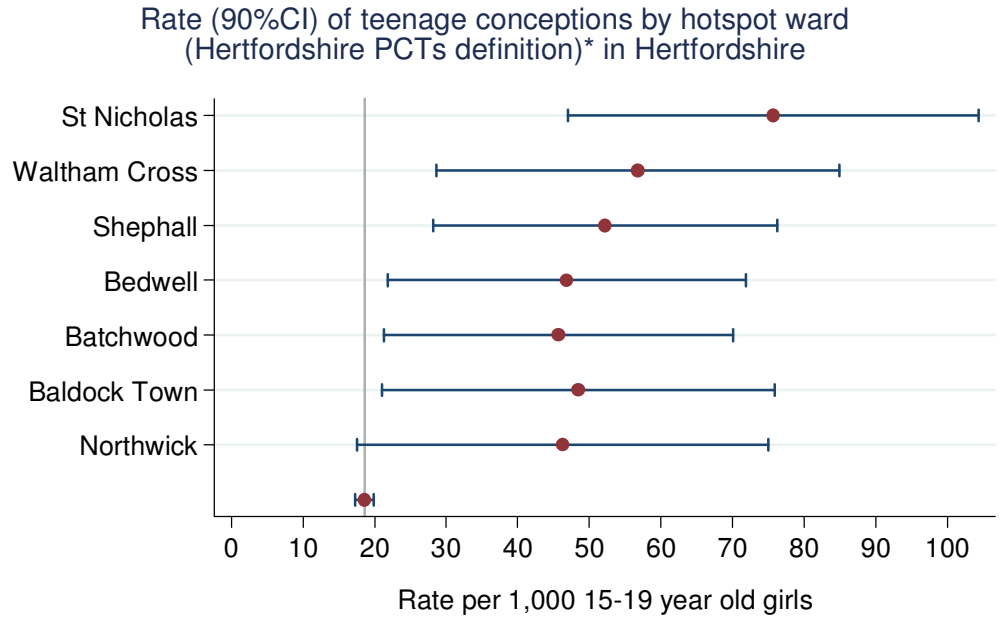


Fig. 2

Fig 3.



Source: Teenage Pregnancy Unit, ward data for 2001/03
*Hotspot ward (PCT) definition: 90% confident that ward has a higher rate than the PCTs average rate.

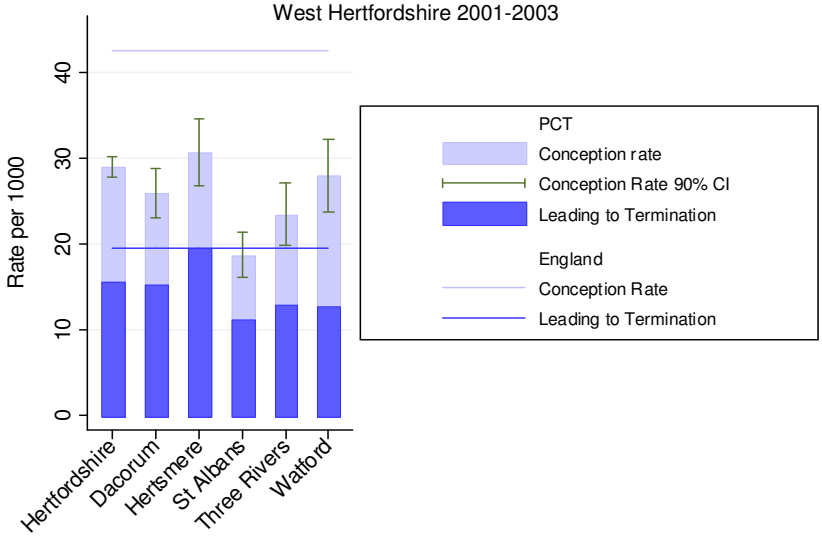
4.0 Termination of pregnancy

4.1 Termination of Teenage pregnancies

Unintended pregnancies often lead to terminations. Over half (54%) of all teenage conceptions in Hertfordshire lead to a termination.

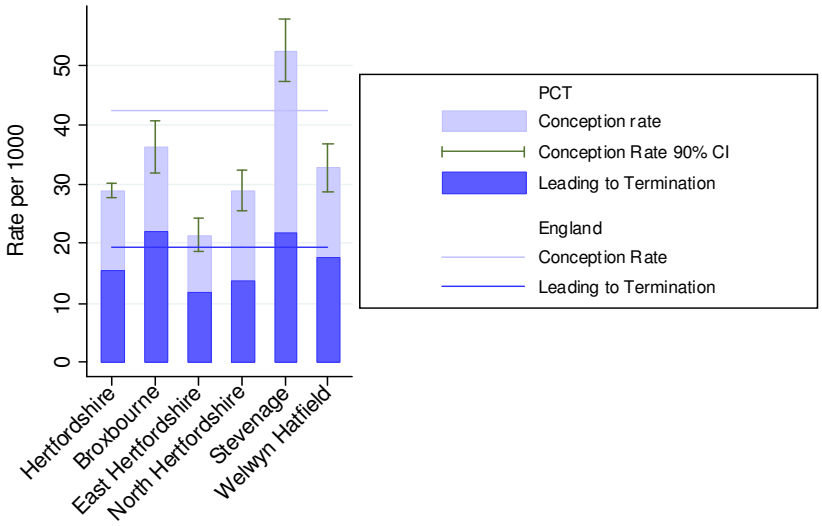
Some of the Local Authorities in Hertfordshire have a lower proportion of conceptions leading to termination compared to other Local Authorities and Hertfordshire as a whole (figures 4 and 5).

Fig. 4 Teenage Conceptions (under 18) and proportion leading to Termination
West Hertfordshire 2001-2003



Source: National Statistics

Fig 5 Teenage Conceptions (under 18) and proportion leading to Termination
East and North Hertfordshire 2001-2003



Source: National Statistics

4.2 Repeat Terminations

Table 4 shows the numbers of legal terminations by age in the Hertfordshire PCTs during 2006. In both East and North Herts and West Herts PCTs approximately 25% of women aged under 25 years having a termination have had a previous termination. From the data in table 4 we can estimate that this was **388** women in 2006. This compares to 23% of women in this age group for the East of England as a whole.

Table 4 Numbers of legal terminations in the Hertfordshire PCTs and East of England as a whole, 2006, by age.

	Under 18yrs	18-19yrs	20-24yrs	25-29yrs	30-34yrs	Over 35 yrs	**Total number**
East of England SHA	1604	1891	4475	3301	2394	2871	**16536**
E&N Herts	145	189	425	311	244	290	**1604**
W. Herts	140	178	475	355	299	342	**1789**

KEY POINTS

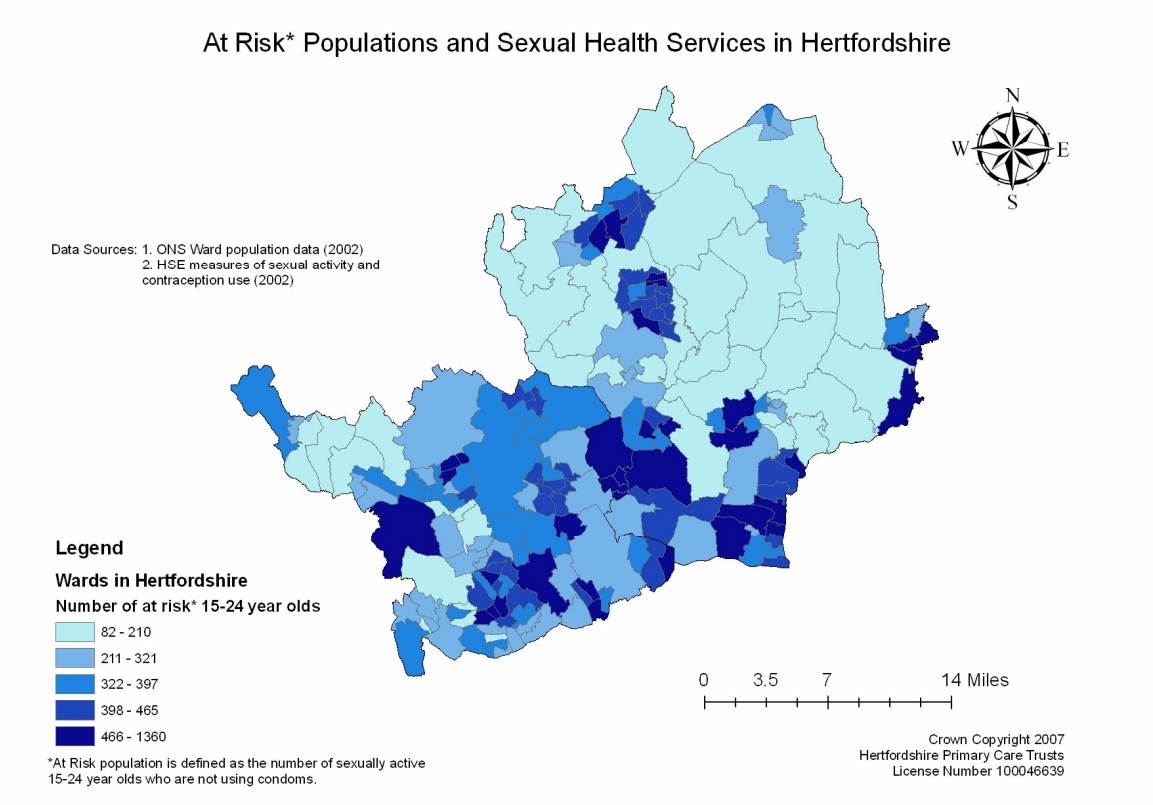
- Hertfordshire has a lower rate of teenage pregnancy than the East of England as a whole, but 'hot spot' wards have been identified, linked to areas of deprivation
- Over half of all teenage pregnancies in Hertfordshire lead to a termination
- 25% of women aged under 25yrs having a termination have had a previous termination.

5.0 Mapping of 'at risk' 16-24 year old population

From Health Survey for England data we know what proportion of the English population are 1) in a sexual relationship and 2) not using condoms as contraception. This information is available by age group. Applying this information to our known population estimates we have calculated the population of 16-24yrs old who are "at risk" of picking up an STI and this has been mapped in figure 6 below.

The areas with the highest number of people at risk are darkest on the map and there appear to be higher numbers of 16-24yrs at risk across West Herts and in the urban areas in East and North Herts.

Fig 6.



The following sections of the report look at the activity and location of the sexual health services covering Hertfordshire and these are then shown mapped to the estimated population at risk in section 7.

6 Health Service Activity

6.1 Contraceptive Services – National Situation

Contraception has been provided free of prescription charges since 1974. It is available from –

- GPs
- Community Family Planning Clinics (FPC)
- Not for profit charitable clinics such as Brook
- Some sexual health and Genito-urinary medicine (GUM) clinics
- NHS walk-in centres
- Pharmacists providing emergency hormonal contraception free through local protocols

The National Institute for Clinical Excellence published a report on long acting reversible contraception (2005). This reported that most (**81%**) of women seeking contraceptive advise had, at some point, visited their GP surgery, and 32% had visited a family planning clinic (FPC). Not all services are able to provide the full range of contraceptives, and women attending FPCs are more

likely to use a long-acting method of contraception, particularly implants and IUD/IUS, than those seeing their GP.

The NICE guidance recommends that women requiring contraception should be given information about and offered a choice of all methods including long-acting reversible methods (LARC).

Table 5 shows that 'user dependent' methods of contraception, such as the oral contraceptive pill, are by far the most widely used, with long acting contraception being used by roughly 8% of women.

Table 5 Use (percentage) of contraception by Age for the year 2003/4[3]

Contraceptive	16-17yrs	18-19yrs	20-24yrs	25-29yrs	30-34yrs	35-39yrs	40-44yrs	45-49yrs
'Pills' – all types	26	58	49	40	31	15	12	5
Minipill	*1*	*14*	*9*	*6*	*4*	*4*	*5*	*2*
Combined pill	*20*	*29*	*31*	*31*	*24*	*10*	*6*	*2*
Male condom	33	36	37	24	24	22	15	14
Withdrawal	3	-	1	3	5	5	1	1
IUD	2	-	1	3	5	5	5	4
Injection/implant	3	2	6	5	4	3	1	1
Rhythm method/persona	-	-	1	1	2	1	1	0
Cap/diaphragm	-	1	0	0	1	1	1	2
Foam/gels	-	-	-	-	0	0	-	1
Hormonal IUS	-	-	0	1	1	1	1	1
Female condom	-	-	-	-	0	0	-	-
Emergency contraception	5	4	2	0	0	0	-	-
Sterilised/partner sterilised	-	1	3	7	14	32	42	45
Total using at least one method	50	71	78	73	77	80	77	73
Total not using any method	50	29	22	27	23	20	23	27

[3] From Long-acting Reversible Contraception, by the NCC for Women's and Child health 2005, data from ONS

6.2 Hertfordshire - Contraceptive services in primary care

Contraceptive services are part of the additional services that practices are expected to provide –

Contraceptive Services: A practice shall make available:

- Advice about contraceptive methods and the medical examination of patients seeking such advice.
- Treatment of patients for contraceptive purposes and the prescribing of contraceptive substances and appliances.
- Advice about emergency contraception and, where appropriate, the supplying or prescribing of emergency hormonal contraception.
- Advice and referral in cases of unplanned or unwanted pregnancy.
- Advice about sexual health promotion and sexually transmitted infections (STIs).
- Referral for specialist sexual health services, including tests for STIs.

Oral contraceptive pills make up the majority of contraceptives prescribed in primary care, but in addition to the services in the box above, a number of surgeries in Hertfordshire are also able to fit intrauterine devices as part of an enhanced service available only to patients registered with each practice (see table 6). Certain other types of contraceptive, such as hormonal implants, are currently available only at family planning clinics in East and North and at a few practices (data awaited) in West Herts.

Table 6

Old PCT area	Proportion of surgeries offering IUDs
RBBS	7/9 i.e. seven out of nine practices
S.E. Herts	20/24 2/24 do checks or removal only
Welhat	8/8
N.H and Stevenage	19 /21
St Albans and Harpenden	13/13
Watford	20 /27
Dacorum	17 /19
Hertsmere	8/9

Work is required to fully understand the accessibility of the long acting contraceptive services that GPs offer, and whether there is potential for further development. In East and North Hertfordshire long waiting lists for IUD fitting at GP surgeries have been reported.[4]

6.3 Family Planning Clinics

6.3.1 Data Collection

Family Planning clinics are run separately within each of the Hertfordshire PCTs. Neither area has computerized records and data is aggregated by hand. The department of health has proposed a common dataset for Sexual Health and at present the family planning clinics in Hertfordshire routinely collect 8 out of the 27 suggested items.

6.3.2 Clinics in East and North Hertfordshire

Within E&N Herts PCT area there are 20 clinics running and these are outlined in table 7. The locations of the clinics are shown on the map in section 7. Aggregated data for the year 2005/6 showing FPC attendances across E&N Herts during this period is presented in table 8. Table 9 summarises the main method of contraception, by age, chosen by women who had their first attendance at one of the FPCs during 2005/6. User dependent methods such as oral contraceptive pills and condoms were the most frequent choice.

[4] Family Planning Services in East and North Herts, 17th Annual Report, Oct 2006

Table 7 Location and attendances at Family Planning Clinics in E&N Herts for the period 2005/06

Family Planning Clinic	Attendances 2005/06	Sessions
YOUTH CLINICS		
Bishops Stortford Youth Clinic	181	Term time. Weekday lunchtimes, Mondays 3.15-5.25
Face 2 Face (Stevenage)	64	Mondays 4-6pm
Bishop's Stortford Youth	181	Term time. Weekdays 1.30-2.30 and Mondays 3.25-5.15
Oakland's College St Albans campus	95	Term time Mon lunchtime.
Oakland's College Smallford campus	132	Term time, Tues lunchtime
Oakland College Welwyn Garden Campus	234	Term time, Weds lunchtime
Hertford Regional College - Broxbourne	334	Term time, Monday lunchtime. Funded by college
Hertford Regional College – Ware	321	Term time, Monday lunchtime. Funded by college
REGULAR CLINICS		
Hatfield	1335	Monday evening 7-9pm, Friday am (monthly)
Hertford	732	Tuesday evening (6.30-8.30)
Buntingford	Dr+ Nurse = 295, Nurse= 290	Wednesday evening
Bishops Stortford	938	Monday evening (weekly)
Ware centre	321	Monday lunchtime. Funded by college
Hitchin	2625	Monday afternoon, Tues + Weds evening (6.30-8.30)
Hoddesdon	1046	Tuesday evening (7-9pm)
Letchworth	1446	Monday evening (6.30-8.30), Weds morning
Royston (Nurse only)	414	Thursday evening (6.30-8.30)
Stevenage	6640	Tues & Thurs evening (6.30-8.30), Thurs and Fri am
Waltham Cross	804	Monday evening (6.30-8.30)
Ware	Dr +Nurse= 374, Nurse= 476	Monday evening (6.30-8.30)
Welwyn Garden City (Parkway)	1738	Thursday evening (6.30-8.30)

Table 8 Reason for **attendance** at family planning clinics in E&N Herts, aggregated data for all clinics 2005/06

April 2005 to March 2006	Total number of patients
Female	18862
Male	1419
Under 16 years	995
16-19 years	5595
Contraceptive advice inc OC	15330
IUD fitted	312
Implanon fitted	214
Implanon removed	61
Post coital OC	872
Post coital IUD	25
Injectables	2130
Femidom	60
Pregnancy Test	1243
Infertility advice	7
Pre-conceptual care	41
Menopause	48
Psychosexual	3
Gynae/Breast	36
HVS/Chlamydia	382
Smear	843
Referred GUM	140
Referred TOP	186

Data: E&N Herts FPS 17th annual report 2006

Table 9 Main method of contraception chosen by women making first contact with the service in the year 2005/2006, by age

Method of contraception chosen	<15yrs	15yrs	16-17yrs	18-19yrs	20-24yrs	25-34yrs	35+
Oral contraceptive	56	157	631	686	1139	1166	498
IUD	1	-	2	3	36	113	181
Cap/diaphragm	-	-	-	-	3	28	50
Injectable	3	7	59	91	184	215	149
Other chemical e.g. sponge	-	-	-	1	2	3	6
Condom	88	156	417	224	333	389	436
Rhythm/persona	-	-	-	-	-	-	1
Female sterilization	-	-	-	-	-	2	-
Implant	2	2	9	20	36	51	28
IUS inc Mirena	-	-	2	2	25	106	245
Contraceptive patch	-	1	-	-	1	1	4
Other methods	13	29	81	42	36	16	12

Data: E&N Herts FPS 17th annual report 2006

6.3.3 Clinics in West Hertfordshire

There are currently 17 sessions per week operating in West Herts, however, there has not been the administrative capacity to aggregate the clinic data for the year 2005/6. Tables 10 and 11 present data from one week's observation of the service beginning 5th March 2007.

Table 10 Location and attendances at Family Planning Clinics in West Herts for the week beginning 5th March 2007

Family Planning Clinic	Date of session	Number of attendances
Marlowes Health Centre, Hemel Hempstead		
Sessions – Monday 6-8pm	5/3/7	17
Tuesday 2.45-4.45 Walk-in	6/3/7	21
Wednesday 6-8pm appts and emergencies	7/3/7	19
Thursdays 6-8pm	8/3/7	22
Friday 6-8pm and emergencies	9/3/7	9
Elstree Way, Borehamwood		
Sessions – Tues 6.30-8.30 walk-in	6/3/7	27
Saturday 10-12noon walk-in	10/3/7	11
Principal Health Centre St Albans		
Sessions – Mon 7-9pm walk-in	5/3/7	11
Wed 7-9pm walk-in	7/3/7	15
Thurs 7-9pm walk-in	8/3/7	16
Sat 11-1pm walk-in	10/3/7	11
Garston Clinic Watford		
Sessions – Mon 6-8pm walk-in	5/3/07	18
Wed 6-8pm walk-in	7/3/7	18
South Oxhey, Watford		
Sessions – Thurs 6.30-8.30 walk-in	6/3/7	20
Watford Sexual Health Centre		
Sessions – Thurs 5-7pm walk-in	8/3/7	9
Friday 5-7pm walk-in	9/3/7	2
Potters Bar Community Hosp		
Sessions 7-9pm walk-in	6/3/7	16
Total		**262**

Table 11 Reason for attendance at Family Planning Clinics in West Herts week commencing 5th March 2007

Service	Number of patients
Combined Pill	94
Pregnancy Test	13
No method provided	12
Preliminary Interview	23
Injectable Hormone	42
General Enquiry	32
Progestogen only PCC	23
Sheaths	20
Cervical Smear	19
Progestogen only Pill	16
Referral to Other service	5
Intra-uterine system	5
IUD check	4
Implanon removal	4
IUD removal	3
Intra-uterine system check	2
Intra-uterine device	8
Intra-uterine system removal	3
Chemicals only	1
Implanon	9
Infection screening	2
Diaphragm	1
Pelvic examination	1
Telephone contact	1

6.3.4 Age ranges of patients seen in FPCs

From the data available we can see that the vast majority of patients accessing the community family planning clinics are aged over 20 years.

Table 12 Age range of patients seen at FPCs

	D.O.B Unknown	Under 16 yrs	Under 20yrs	20+ yrs
E&N Herts		5%	32%	68%*
West Herts – one weeks data	1%	-	27%	72%

*estimated from available data

6.3.5 Chlamydia Testing in FPCs

15 family planning clinics are currently offering Chlamydia screening as part of the National Screening Programme to implement and monitor opportunistic screening for young people under 25yrs.

Table 13 Family Planning Clinics offering Chlamydia screening

Dacorum	0 in community (1 imminent)
Hertsmere	1 in community
North Herts and Stevenage	3 in community (1 imminent)
RBBS	2 in community
South East Herts	4 in community (4 imminent)
St Albans and Harpenden	2 in community
Watford and 3 Rivers	1 in community
Welwyn Hatfield	2 in community

Chlamydia screening is also available in the Mount Prison.

6.3.6 GP Training in Family Planning

The service in E&N runs a course for GPs wanting to take the Diploma of Faculty of Family Planning. There is a 10mth waiting list for this course. There is no system in place in E&N to train GPs to fit long acting reversible contraception (LARC) such as coils and implants. Dr Agrawali (lead clinician in family planning) has been providing some training for GPs in their own surgeries with pharmaceutical sponsorship.

Dr Elizabeth Broadwith provides family planning training and support to professionals including GP's within the West Herts PCT.

6.3.7 Emergency Hormonal Contraception

Emergency contraceptive pills are available from GPs, family planning clinics and the Accident and Emergency Departments of local hospitals including QEII hospital Welwyn Garden City and Watford General Hospital. Some community

pharmacies are also able to provide free emergency hormonal contraception to women aged under 21 years and Table 13 lists the locations of these

pharmacies. Notably there are no pharmacies providing this service in the St Albans and Harpenden area.

Table 13 Location of pharmacies providing free emergency hormonal contraception to women under 21 years in Herts

AREA	Number of Pharmacies
Broxbourne	4
North Herts area – Ashwell, Codicote, Hitchin and Letchworth	12
Stevenage	8
Dacorum	9
Watford and Three Rivers	16
Welwyn Hatfield	13

The data on uptake of emergency hormonal contraception from pharmacies is currently being collated, and this will provide useful information on whether the service is accessible for young people.

6.3.8 Contraceptive Services offered by Marie Stopes

Terminations are carried out by Marie Stopes clinics. In response to concerns around repeat terminations (see section 4.2) the PCT have worked with the clinics to introduce a LARC service for young women.

6.3.9 Condom Distribution Schemes

Improving access to condoms is a nationwide issue. In Hertfordshire we have two PCT funded systems and support other outlets as part of a wider approach. In the West there is a free condom scheme targeted at under 25yrs and vulnerable groups that operates from a variety of health outlets. In the East and North a scheme known as 'C-Card' is now being rolled out following a pilot project. This scheme enables young people to access condoms following a confidential consultation with a person trained in the delivery of sexual health information and advice.

KEY POINTS

- Most contraception is prescribed in primary care, however, patients in Herts may need to attend a FPC in order to access the full range of long-acting contraceptives.
- Family planning clinics are sited in a variety of setting across the county, however there are only a small number of youth oriented clinics that are not located within a college. The college locations cannot be considered accessible to all young people.
- Most clients seen in the FPCs are aged over 20 years and this age group are more likely to attend for LARC. There may be an opportunity for improved links with primary care, and consideration of a system to train GPs to provide full range of contraceptive care.
- User dependent forms of contraception are currently the most commonly prescribed to clients aged under 20 years.
- The family planning clinics are not computerised and there are problems, particularly in West Herts with admin and data collection.
- LARC is now available at Marie Stopes for clients having a termination
- A number of pharmacies are providing EHC targeted at younger people – evaluation of this service is awaited

6.4 Health Services available for management of STIs.

The national strategy for sexual health and HIV (2001) described three levels of service required for comprehensive provision of sexual health care. Services at level one provide care including sexual history taking, STI testing in women and assessment and referral of men, those providing level two services would also provide STI testing and treatment for both sexes and partner notification, while level three GUM clinics would manage more complex clinical cases and clinical governance leadership role. See appendix B for full description of levels of care.

6.4.1 Sexual Health Services in Primary Care

Level 1 services would be expected to be available at all general practices in Hertfordshire, however, some of the more advanced level 2 services are currently only available at surgeries that have opted to provide more specialised sexual health services as part of a nationally enhanced service. GPs at these surgeries need to have undertaken the Sexually Transmitted Infection (STIF) Course or equivalent, together with a recognised accredited family planning training course including intra-uterine device fitting.

The surgeries offering this service provide it only for patients currently registered with them, and the 14 surgeries signed up to provide this service are all located in the Watford and Dacorum areas. See Table 15 and map in section 7. Available data for 2006/7 suggests that these level 2 providers saw **52 patients with HIV and 237 other patients** between them. (The service specification for the nationally enhanced service is included in Appendix C)

Table 15 Surgeries providing more specialised sexual health services under the nationally enhanced services specification

Watford Surgeries	Dacorum Surgeries
Baldwins Lane	Archway
Callowland	Bennetts End
Chorleywood HC	Fernville
Coach House	Highfield Surgery
Holywell	Gossoms End
Rickmansworth Road	The Nap
Tudor	
Vine House	

The Watford and Dacorum areas have a high density of young people likely to be in need of these level 2 services (eg STI testing, treatment and contact notification), so these services appear to well placed, however, there has been no formal evaluation of the services and this would provide useful information

around access to services, and also how data collection and clinical governance fit into the wider sexual health clinical networks.

6.4.2 Genitourinary Medicine Clinics (GUM clinics)

6.4.2.1 Workload

There are four GUM clinics in Hertfordshire, Woodlands Clinic, Stevenage, Clinic E, Hertford, St Albans City Hospital clinic and Watford General Hospital Clinic. As shown in figure 7, the number of patients attending GUM clinics in Herts has substantially increased since 2000**.** The workload is greater in females. (Fig. 7)

GUM workload trend: Gender specific rate per 100000 population in Hertfordshire 2000 - 2005

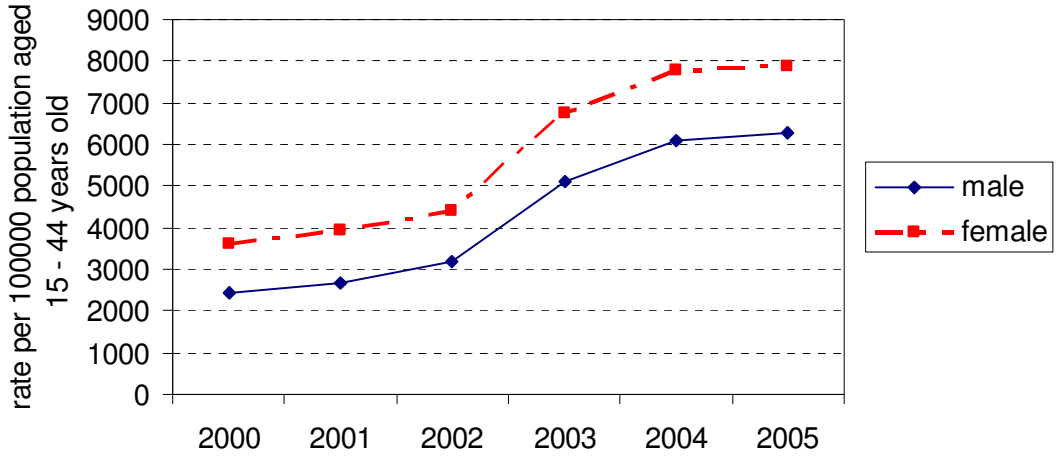


Fig. 7
Source: GUM Clinics in Hertfordshire

The clinics across Hertfordshire are now using the same computer software to analyse their activity, and table 16 shows activity for the months since May 2007 when complete data has been available for all four clinics.

Table 16 Total number of patients seen at each GUM clinic, May to August 2007

CLINIC	May	June	July	Aug	TOTAL
Woodlands	423	420	459	309	1611
Hertford	202	228	228	150	808
SACH	558	552	527	625	2262
Watford	950	903	740	1025	3618

6.4.2.2 Access

Target

- 100% of patients attending GUM clinics to be offered an appointment within 48hrs by 2008.

There are four GUM clinics in Hertfordshire, Woodlands Clinic, Stevenage, Clinic E, Hertford, St Albans City Hospital clinic and Watford General Hospital Clinic. Table 17 below outlines the current timetable arrangements at the four clinics, but it should be noted that steering groups in both West and E&N Herts are currently reworking the clinic timetables in order to meet the 48hr access target and also to increase patient choice. For example, additional nurse-led clinics and more evening clinics are being developed. The limited opening of clinics in East and North Hertfordshire on Fridays is also being reviewed.

Table 17 Clinic Timetables

	Clinic E	Woodlands	St. Albans	Watford
Monday	Dr M & CA & N AM – **20appts +6 Follow Up** (FU) max PM – no clinic	Dr K AM – **15 appts** (HIV 8, GUM 7) **+ 7 FU max** Dr M PM – **10 appts + 7 FU** (all GUM)	AM – Walk-in	AM – Walk-in PM – 3.30-6.30
Tuesday	AM – no clinic Dr M & CA & N PM – **19 appts + 6 FU max**	Dr K AM – **14 appts (HIV 6, GUM 8) + 14 FU max** Dr K PM – **10** – all GUM finishes 2.50pm	AM – Walk-in PM – Young people	AM-Walk-in PM – 1-4.30
Wednesday	Nurse-led AM – **10 appts** PM – no clinic	Dr M + CA AM – **22 appts + 7 FU max** (HIV 5, GUM 17) PM – No clinic		AM-Walk-in PM – 1-3.30
Thursday	AM – no clinic Dr M & N* PM – **16 appts + 8 FU**	Dr K + CA AM – **22 appts + 8 FU max** (HIV 6, GUM 16) Dr K + CA PM – **10 appts + 7FU max** (all GUM)	AM – Walk-in	AM- Walk-in PM – 3.30-6.30
Friday	CLOSED	Dr K AM – **12 appts + 2 FU** (all GUM) PM – no clinic	AM – Walk-in	AM-Walk-in
TOTAL appointments available each week	**65 appts for new patients 20 follow-up appts max**	**90 appts for new patients 25 for patient with HIV 52 follow-up appts maximum**	**Up to 156 appts per week (estimate from Unify2 returns)**	**240-250 appts per week (estimate from Unify2 returns)**

CA = Clinical assistant
N = Nurse-led clinic
Dr M = Dr Maiti
Dr K = Dr Kumar

The following four tables (18,19,20,21) show the recent progress that the clinics are making towards 48hr access for patients. They show the percentage of patients who are currently offered an appointment within 48hrs and also the percentage of patients who are actually seen within 48hrs.

Table 18 Woodlands Clinic progress towards 48hr access – May to Sept 2007

CLINIC	May	June	July	August	Sept
Woodlands					
TOTAL patients seen	423	420	459	309	390
FIRST appointments	*287*	*301*	*324*	*193*	*288*
First appointments offered within 48hrs (%)	*273* ***(95%)***	*280* ***(93%)***	*299* ***(92%)***	*157* ***(81%)***	*257* ***(89%)***
First appointments seen within 48hrs (%)	*273* ***(95%)***	*280* ***(93%)***	*299* ***(92%)***	*157* ***(81%)***	*257* ***(89%)***

Table 19 Hertford Clinic E, progress towards 48hr access – May to Sept 2007

CLINIC	May	June	July	August	Sept
Hertford					
TOTAL patients seen	202	228	_	150	230
FIRST appointments	*114*	*160*	*179*	*100*	*174*
First appointments offered within 48hrs (%)	*78* ***(68%)***	*99* ***(62%)***	*114* ***(64%)***	*64* ***(64%)***	*109* ***(63%)***
First appointments seen within 48hrs (%)	*78* ***(68%)***	*97* ***(61%)***	*114* ***(64%)***	*64* ***(64%)***	*109* ***(63%)***

Table 20 St Albans City Hospital GUM clinic, progress towards 48hr access May to August 2007

CLINIC	May	June	July	August	Sept
St Albans					
TOTAL patients seen	558	552	527	625	
FIRST appointments	*465*	*446*	*428*	*502*	
First appointments offered within 48hrs (%)	*369* ***(79%)***	*441* ***(99%)***	*412* ***(96%)***	*470* ***(94%)***	
First appointments seen within 48hrs (%)	*369* ***(79%)***	*412* ***(99%)***	*403* ***(94%)***	*420* ***(84%)***	

Table 21 Watford GUM clinic, progress towards 48hr access May to August 2007

CLINIC	May	June	July	August	Sept
Watford					
TOTAL patients seen	950	903	740	1025	
FIRST appointments	*705*	*661*	*516*	*675*	
First appointments offered within 48hrs (%)	*680* ***(96%)***	*627* ***(95%)***	*495* ***(96%)***	*639* ***(95%)***	
First appointments seen within 48hrs (%)	*585* ***(83%)***	*551* ***(83%)***	*457* ***(89%)***	*549* ***(81%)***	

The best progress towards offering appointments within 48hrs is seen at clinics in West Hertfordshire, however, a lower percentage of patients are actually able to be seen within 48hrs, indicating some difficulties with access. The data from East and North Hertfordshire shows the need for a review of the clinic timetables and the importance of increasing access through the planned nurse-led clinics and increased opening hours.

6.4.2.3 Where else do Hertfordshire residents attend GUM clinics?

As outlined before, not all residents in Hertfordshire attend GUM clinics within the county. The new data collection system for GUM clinics has begun to allow analysis of place of residence of patients accessing different clinics. Table H below shows the different clinics that patients resident in West Herts attended during the four months May –August 2007. The majority of patients attended clinics within the county, with the next most common clinic being at Barnet General Hospital, where 5.5% of attendances occurred. In contrast, Table I shows that while the majority of residents in E&N Herts attended a clinic within the county, 25% of attendances occurred at the Princess Alexandra Hospital in Harlow, Essex.

Table 22 Number of patients resident in West Herts PCT attending GUM clinics May – Aug 2007

NB. There may be some double counting in this table as patients who are seen at more than one clinic during this time period would be counted at both clinics.

CLINIC	Number of patients	Percentage of total
Barnet General	288	5.5%
Brookside, Aylesbury	105	2.0%
Hertford Clinic E	7	0.1%
Luton and Dunstable	66	1.3%
Northwick Park	99	1.9%
St. Bartholomew's	25	0.5%
Waverley Wing, St Albans	1626	31.0%
Watford Clinic	2768	53.0%
Woodlands, Stevenage	20	0.4%
65 other identified GUM clinics	224	4.3%
TOTAL	5228	100%

Table 23 Number of patients resident in East and North Herts PCT attending GUM clinics May - Aug 2007

CLINIC	Number of patients	Percentage of total
Barnet General	100	2.3%
Bedford	27	0.6%
Clinic 1A Addenbrookes	245	5.3%
Enfield Town Clinic	117	2.5%
Hertford Clinic E	741	16.0%
Luton and Dunstable	62	1.3%
Princess Alex Harlow	1162	25.0%
St Ann's London	51	1.1%
St Bartholomew's	35	0.75%
Waverley Wing, St Albans	449	9.7%
Watford GUM	55	1.2%
Woodlands, Stevenage	1364	29.5%
56 other identified GUM clinics	230	5.0%
TOTAL	4638	100%

NB. There may be some double counting in this table as patients who are seen at more than one clinic during this time period would be counted at both clinics.

The current data we have on GUM clinic activity does not allow us to map where the residents accessing clinics outside Hertfordshire live, however, some work done by the Health Protection Agency (HPA) in 2005 using old PCT boundaries did look at this. The results indicate that residents in South East Hertfordshire, Hertsmere and particularly RBBS are more likely to access clinics outside the county. In RBBS 90% of patients attended a non-Hertfordshire clinic.

Table 24 GUM attendees seen in non-Hertfordshire clinics

	% of Hertfordshire GUM attendees Seen by Non-Hertfordshire GUM Clinics
Dacorum	16%
Hertsmere	30%
North Hertfordshire and Stevenage	14%
RBBS	90%
South East Hertfordshire	40%
St Albans & Harpenden	13%
Watford & Three Rivers	3%
Welwyn Hatfield	13%

Source: HPA GUM waiting times audit August 2005

6.4.2.4 Number of people with HIV resident in Hertfordshire

In 2006 there were **305** HIV-infected patients resident in East and North Herts PCT. Of these approximately 40% were treated within the PCT, with a similar percentage receiving treatment at one of the London hospitals. 6% were treated at Watford and 4% attended Princess Alexandra and 4% Addenbrookes in Cambridge.

In 2006 there were 347 HIV-infected patients resident in West Herts PCT, 97 of whom were treated through the London Consortium.

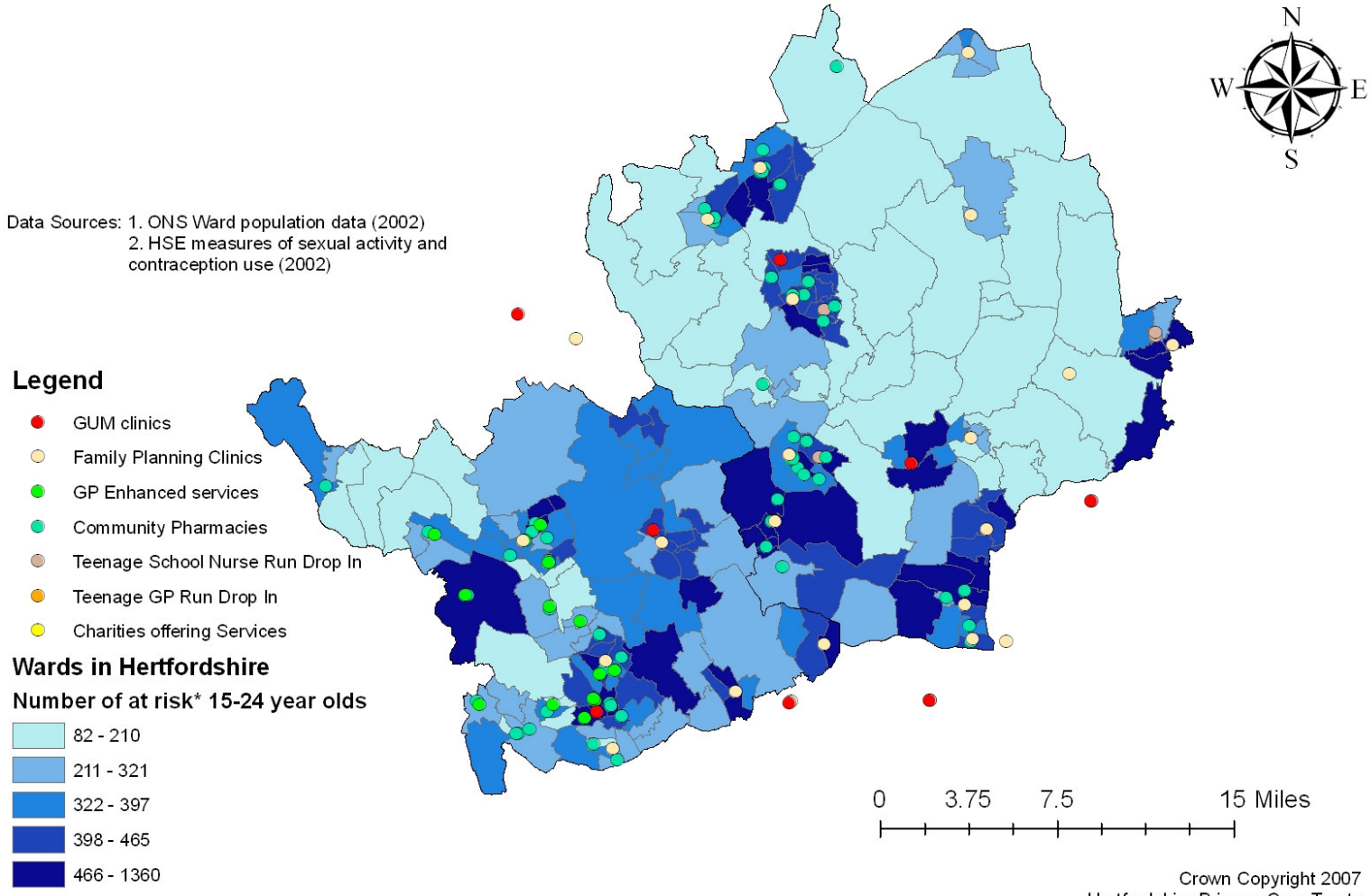
Key Points

- The number of people accessing sexual health services in Hertfordshire is increasing
- 14 General practices in Dacorum and Watford are offering level 2 services
- The majority of residents in West Hertfordshire attending a GUM clinic attend within the West Hertfordshire area.
- More than half the residents of E&N Herts attending a GUM clinic attend outside the PCT area – with 25% going to Princess Alexandra Hospital in Harlow
- More work is needed to achieve the 48hr access target

7 Summary Table

Old PCT area	Total Population (number of 15-24yr olds)	Location of GUM clinics accessed by population (all ages)	GUM service provision		GP locally enhanced service for more specialised sexual health	GP locally enhanced service for IUDs	Chlamydia screening sites	Family Planning Clinics
			In Herts	nearest out Herts				
Dacorum	137,800 (14,900)	84% seen in Herts 16% out of Herts	*None in area* Nearest - Watford St Albans	L&D Aylesbury	6 practices	17/19	0 (1 imminent) 1 in Mount Prison	Marlowes 5 sessions
Hertsmere	94,500 (10,400)	70% seen in Herts 30% out of Herts	*None in area* Nearest – Watford SACH	Barnet		8/9	1	Elstree Way Clinic, 2 sessions Potters Bar Hosp 1 session
North Herts and Stevenage	179,900 (19,800)	86% seen in Herts 14% out of Herts	Woodlands	L&D		19/21	3 (1 imminent)	Danestrete Clinic 2 sessions Face2face 1 session Hitchin 3 sessions Letchworth 2 sessions
RBBS	70,400 (7,400)	10% seen in Herts 90% out of Herts	*None in area* Nearest – Hertford Woodlands	Addenbrookes Cambs		7/9	2	Bishops St Youth term time 5 sessions Buntingford 1 session Bishops Stort 1 session Royston 1 session
South East Herts	162,800 (18,000)	60% seen in Herts 40% out of Herts	Hertford	PAH Enfield		20/24 2/24 removal or check only	4 (4 imminent)	Hertford Colleges Term time 2 sessions Hertford evening 1 session Ware term time 1 Hoddesdon 1 session Waltham Cross 1 session Ware evening 1 session
St Albans and Harpenden	129,200 (13,100)	87% seen in Herts 13% out of Herts	SACH	L&D		13/13	2	Oaklands college term time 2 sessions Principal HC 4 sessions
Watford and 3 Rivers	163,300 (17,900)	97% seen in Herts 3% out of Herts	Watford St Albans	London	8 practices	20/27	1	Garston 2 sessions Watford SHC 2 sessions South Oxhey 1 session
Welwyn Hatfield	97,600 (13,600)	87% seen in Herts 13% out of Herts	*None in area* *Nearest* - Woodlands Hertford SACH	London		8/8	2	Oaklands term time 1 session Hatfield 1 weekly+1montly WGC 1 session

At Risk* Populations and Sexual Health Services in Hertfordshire



*At Risk population is defined as the number of sexually active 15-24 year olds who are not using condoms.

Appendix A

Population of Hertfordshire

Age Range	Total	Males	Females
0 - 4	64979	33140	31839
5 - 9	68669	34624	34045
10 - 14	68232	34767	33465
15 - 19	59716	30306	29410
20 - 24	55160	27501	27659
25 - 29	68075	33117	34958
30 - 34	82209	40301	41908
35 - 39	88236	43607	44629
40 - 44	78354	39736	38618
45 - 49	68300	34622	33678
50 - 54	71820	35634	36186
55 - 59	56789	28302	28487
60 - 64	46991	23000	23991
65 - 69	43900	21187	22713
70 - 74	39199	17864	21335
75 - 79	32704	13843	18861
80 - 84	21687	8138	13549
85 - 89	12702	3964	8738
90 and over	6255	1406	4849
Totals	1033977	505059	528918

Source: ONS 2001 Census data

Appendix B

Levels of Service Provision - National Strategy for Sexual Health

The National Strategy for sexual health and HIV (2001) outlined three levels of service provision recommended within any model for developing a comprehensive local service.

LEVEL 1

- Sexual history and risk assessment
- STI testing for women
- HIV testing and counselling
- Pregnancy testing and referral
- Contraceptive information and services
- Assessment and referral of men with STI symptoms
- Cervical cytology screening and referral
- Hepatitis B immunisation

LEVEL 2

- Intrauterine device insertion (IUD)
- Testing and treating sexually transmitted infections
- Vasectomy
- Contraceptive implant insertion
- Partner notification
- Invasive transmitted infection testing for men (until non-invasive tests are available)

LEVEL 3

Level three clinician teams will take responsibility for sexual health services needs assessment, for supporting provider quality, for clinical governance requirements at all levels, and for providing specialist services. Services could include:

- Outreach for sexually transmitted infection prevention
- Outreach contraception services
- Specialised infections management, including co-ordination of partner notification
- Highly specialised contraception
- Specialised HIV treatment and care

Appendix C

National Enhanced Service - more specialised sexual health services

Source: BMA

Introduction

1. All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

Background

2. The past decade has seen substantial increases in high-risk sexual behaviours in the UK population. During the 1980s and early 1990s, new diagnoses of sexually transmitted infections (STIs) declined, but since 1995 STIs including HIV have risen and diagnoses of Chlamydia, gonorrhoea and syphilis have doubled in the past five years. Teenage pregnancy rates in the UK are the highest in Western Europe.

3. Data are also available from the National Survey of Sexual Attitudes and Lifestyles (Natsal 2000)** which can be compared with information from a similar survey undertaken in 1990. This shows that between the two surveys there had been an increase in behaviours associated with increased risk of HIV and STI transmission, including increases in numbers of partners and concurrent partnerships. In particular, there were considerably higher rates of new partner acquisition among those younger than 25 years and this is reflected in the substantially higher incidence of STIs in this age group.

4. Sexual ill health has great human and economic costs. The Department of Health document 'Effective commissioning of sexual health and HIV services' (January 2003) provides the following data:

(i) Chlamydia causes pelvic inflammatory disease, infertility and ectopic pregnancies
(ii) HIV is a chronic, life-threatening condition costing an average of between £135,000 and £181,000 to treat over a lifetime
(iii) Teenage pregnancy can compound social inequalities faced by the mothers and their children
(iv) Open access contraceptive and GUM services are in place, but are greatly overstretched and much need is currently unmet.

5. The importance of primary care in an enhanced sexual health strategy is demonstrated by the facts that:

(i) about 75-80 per cent of contraception is provided in primary care
(ii) more than a third of women found to have Chlamydia (the most common bacterial STI in the UK) were diagnosed in primary care
(iii) 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.

Service Outline

6. Service delivery should be informed by relevant national strategies, such as (in England) the Social Exclusion Unit Teenage Pregnancy Report (June 1999), the Best Practice Guidance on the Provision of Effective Contraception and Advice Services for Young People, published as part of the Teenage Pregnancy Strategy in 2000, and the National Strategy for Sexual Health and HIV (July 2001) and the Strategy Implementation Action Plan (June 2002).

7. Each Primary Care Organisation should consult with all relevant stakeholders, to determine the service models and standards of care appropriate to its local population with respect to minimum standards of prescribing (formulation, dose, drugs of limited value etc), attendance and follow-up rates, hepatitis B testing and immunisation rates, partner notification etc. Care pathways should be agreed with stakeholders, and all should be made aware of these pathways. The pathways should include guidance with respect to other relevant services. These should be used as part of the audit and monitoring criteria for the national enhanced service.

8. This National Enhanced Service will fund:

(i) A service for HIV testing, including pre and post test counselling
(ii) STI screening and treatment using the most reliable testing methods available
(iii) The practice to act as a resource to colleagues in sexual health care in primary care
(iv) The training of GPs and GP registrars, practice nurses and other relevant staff (such as health advisors)
(v) Effective liaison with local sexual health services and cytology and microbiology laboratory support and other statutory or non-statutory services where relevant (such as young people's services)
(vi) Additional training and continuing professional development for clinicians commensurate with the level of service provision expected of a clinician in line with any national or local guidance to meet the requirements of revalidation
(vii) Records kept on the advice, counselling and treatment received by patients. It is the clinician's responsibility in conjunction with the patient to agree what to enter in the lifelong patient notes
(viii) A register of all patients being treated under the enhanced service

(ix) Appropriate arrangements for review
(x) Costs of condoms, pregnancy testing kits and other additional resources or referral costs
(xi) Treatment of STIs without prescription charge
(xii) Effective communication with all young people including young men, gay and lesbian people, and ethnic minorities
(xiii) A holistic approach to assessment of risk of STI, HIV and/or unplanned pregnancy, including consideration of other relevant health problems such as drug misuse or mental health problems
(xiv) The provision of information on, testing and treatment for all STIs (excluding in the case of testing and treatment HIV infection, syphilis, Hepatitis B and C or treatment-resistant infections)
(xv) The assurance of partner notification of relevant infections by adherence to agreed guidance
(xvi) A sound understanding of the role of different professional groups in the shared care of HIV positive patients, and those at risk of HIV
(xvii) Suitable training for all staff involved with patients seen for sexual health and HIV-related conditions
(xviii) Review. All practices undertaking this service will be subject to an annual review which could include an audit of:

(a) The number of patients seen for specific interventions
(b) The number of people screened and treated effectively
(c) Attendance rates for each service offered
(d) Gestation at abortion and follow-up contraception rates
(e) The number of at-risk individuals tested and immunised according to local guidance for blood-borne viruses
(f) Age, gender, sexuality and ethnicity of patients to ensure that those most at risk from unplanned pregnancy and poor sexual health are accessing the practice.

Accreditation

9. Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

Costs

10. In 2003/04 each practice contracted to provide this service will receive an annual retainer of £2,000 plus an annual payment of £200 per HIV positive patient (paid quarterly in arrears) and £100 per other patient (paid quarterly in arrears.) These prices will be uprated by 3.225 per cent in 2004/05 and again in 2005/06.

**** Johnson A, et al. Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. Lancet 2001; 358: 1835-42**

Appendix 3.2

Useful Links and Support References

- A Common Data Set for sexual health services has been developed which meets the information standards required for the national IT programme, is agreed by clinicians and is applicable to all service providers. The common data set can be found at www.cdssexualhealth.org.uk. The common data set will generate all the key information requirements for complete patient information – demographics, treatment, referral and data gathered from behavioural questions. Providers should be aware of the Department of Health policy around handling and disclosing patient information. 'Confidentiality – NHS Code of Practice' can be found at www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf. There is also a specific confidentiality code of practice for GMS, PMS and APMS providers at www.dh.gov.uk/assetRoot/04/10/73/04/04107304.pdf.

- *You're Welcome* quality criteria for young people's services (2005) www.dh.gov.uk/assetRoot/04/12/15/64/04121564.pdf and the Medical Foundation for AIDS and Sexual Health (MedFASH) www.medfash.org.uk recommended standards for sexual health services and NHS HIV services should be used as a basis for measuring overall service quality, effectiveness and performance.

- A local basket of indicators also exists for Health Inequalities and can be found at the London Health Observatory www.lho.org.uk

- http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=Sexual+Health