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Manchester Sexual Health Commissioning Strategy

2010 - 2013

Foreword

As Chief Executive for **NHS Manchester** I'm proud to be able to say that local sexual health services have been transformed over the last few years.

We have reconfigured community contraception and sexual health clinics, achieved 48 hour access to GUM clinics, reduced waiting times for abortion services, and worked closely with GPs and pharmacists so they now provide more services than ever before. Across the city it is now much easier for people to access contraception, sexual health and abortion services.

However we still have much to do in order to improve sexual health and to reduce teenage pregnancies in the city. This document sets out how NHS Manchester will do that over the coming years.

The Sexual Health Commissioning Strategy has been produced to inform our approach to improving the sexual health of the local population, and to reduce sexual health inequalities between the general population and defined vulnerable groups.

NHS Manchester will continue to work to help reduce teenage conceptions, increase the number of young people being screened for chlamydia as well as encouraging the uptake of long-acting reversible contraception, reducing the number of repeat abortions, and working with our partners to ensure those living with HIV receive excellent health and social care.

We will need to address our priorities, improve productivity and performance, drive up quality, and meet defined targets, all within the increasing restraint that will be placed on public sector funding. This commissioning strategy will inform our approach to these challenges.

Finally, I would like to thank all of the contributors to this important strategy and look forward to seeing the policy being implemented.

Laura Roberts
Chief Executive, NHS Manchester



As Chair of the **Manchester Sexual Health Forum** I am very pleased that we continue to place sexual health and its associated health and risk issues as a major public health priority in Manchester.

The approval of this Commissioning Strategy by the PCT Board is testament to the ongoing commitment locally to build on previous good work and continue to address local priorities for sexual health.

The Sexual Health Forum has a history of partnership working and a long standing spirit of cooperation in order to ensure we use resources to best effect to support priority needs within the City. At a time of increasing pressure on public sector finances, this partnership working is more crucial than ever. As a Forum we are committed to continuing to work together with a shared vision to shape cohesive, effective and efficient sexual health activity, resources and service provision within the City.

I should like to thank the authors of the Strategy for their hard work in pulling together a complex piece of work into an accessible document and the dedicated members of the Forum for their input into the development of the priorities for the Strategy.

I look forward to the implementation of the Strategy during the next 3 years acknowledging the challenges we face as providers and commissioners of services. I feel confident that as a Forum we have the professionalism, experience, skills and enthusiasm for taking the work forward to continuing to improve the sexual health of the population of Manchester.

Bridget Hughes
Chair of the Sexual Health Forum

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Setting the scene

1.1 Introduction

Sexual health is a major public health issue both nationally and locally. We are faced with several challenges to overcome.

Sexually transmitted infection (STIs) rates have been rising steadily over the past few years with more than 1.5 million episodes of STIs seen in UK clinics each year.

The North West has the highest incidences of HIV, HIV related illness and STIs outside of London and the South East, with the majority of these occurring in Manchester. We have also seen increases in Manchester in new incidences of some sexually transmitted infections including chlamydia, genital warts and herpes. Several outbreaks of syphilis occurred in Manchester in the middle of the last decade.

There are continuing high rates of unintended pregnancy and abortion. Manchester's teenage conception rate remains higher than most other areas in the country. The number of repeat abortions is also higher than in other areas.

Nationally, there are variations in access to, and quality of, sexual health services. In Manchester there have been great improvements to sexual health services in the past five years, with investment made to modernise buildings and redesign services. However, this process is still ongoing and further work is needed to ensure better access to the sexual health services in the city.

Manchester is one of the most dynamic and diverse cities in the UK, bringing economic growth and prosperity for the region. It is an international, sophisticated tourist destination, and a centre for culture, music and sport. However, it continues to face considerable health inequalities and major social, economic and environmental challenges.

Manchester has a growing population. The resident population stood at 461,000 in mid-2008. Based on current trends the local population is projected to reach 538,400 by 2018 (an increase of 19.1% compared to 2006). The male population is growing at a faster rate than that of females.

There is a clear relationship between sexual ill health, poverty and social exclusion. Groups who are at most risk of poor sexual health and may experience barriers to accessing services include young people, asylum seekers and refugees, black and minority ethnic groups, single homeless people, gay and bisexual men, sex workers, looked after young people, injecting drug users, people with learning difficulties, people in prisons and youth offending institutions, young people not in education, training or employment.

The impact of poor sexual health in Manchester is exacerbated by Manchester's role as a centre for nightlife, and we have evidence of a number of recent national outbreaks of sexually transmitted infections having originated in Manchester. The role of alcohol in the spread of sexually transmitted infections and unplanned teenage conceptions must not be underestimated.

Given the sexual health inequalities of people living in Manchester, statutory and third sector providers of sexual health services, sexual health promoters and sexual health commissioners are faced with great challenges when working towards improving the sexual health of the population.



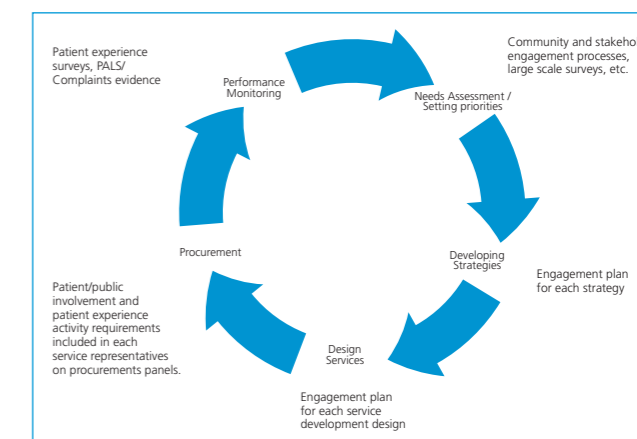
1.2 Purpose

The sexual health strategy sets out NHS Manchester's commissioning priorities for 2010-2013, to meet national and local targets and to address local priorities for sexual health.

This strategy builds upon The Manchester Sexual Health Strategy 2006-2009 and includes priorities raised by providers and commissioners through the Sexual Health Forum discussions and stakeholder event. We seek to engage with local communities, partners and key stakeholders including service users at every point in the commissioning cycle (See Fig 1).

This commissioning strategy has been written with reference to national and regional strategies and guidance and the findings from National Support Team visits to Manchester. The NST for Sexual Health visited Manchester in 2006 and we welcomed the NST for Teenage Pregnancy in 2007.

Fig 1: NHS Manchester's approach to embedding engagement throughout the commissioning cycle



Since The Manchester Sexual Health Strategy 2006-2009 was written, public sector finances are now under great pressure. It is imperative that we address this fact within this strategy and that we review our services and priorities in order to maximise value for money across the city.



This strategy builds on the previous sexual health strategy and has been written with reference to other relevant strategies and programmes.

- **The Manchester Community Strategy (2006-2015)** which sets out the vision and priorities for the city for Manchester people to be wealthier, live longer, be healthier and enjoy happier lives
- **Local Area Agreement (2008)** which is the delivery plan for the community strategy and sets out shared priorities, targets and a framework for monitoring progress for organisations across the city
- **Joint Strategic Needs Assessment (2008)** which is a joint-publication between the council and NHS Manchester and describes the future health and social care needs of the local population and the strategic direction for services to meet these needs. The JSNA is expected to influence the commissioning process across both health and social care and underpin the development of the Local Area Agreement
- **NHS Manchester Commissioning Strategic Plan (2009-2014)** which describes how NHS Manchester will realise its vision to address health inequalities and improve health in Manchester. This is informed by World Class Commissioning. Reducing the number of teenage conceptions has been included as a commissioning strategic priority

- **World Class Commissioning (2007)** which places Primary Care Trusts and their commissioning partners at the forefront of leading the future NHS at a local level. Great emphasis is placed on quality interventions that meet the local demand, provide value for money, and are measured by their outcome rather than service activity
- **Manchester Teenage Pregnancy Strategy (2008-2010)** that sets out a broad framework for the commissioning and provision of interventions to reduce the number of under-18 conceptions and to improve support for teenage mothers and their children
- **Transforming Community Services (2009)** which is a programme that sets out the vision for the NHS with quality at the heart of commissioning. The local strategy identifies NHS Manchester's commissioning intentions for community services.
- **Manchester Alcohol Strategy (2008-2011)** which aims to provide information to low, increasing and higher risk drinkers about safer, healthier and lawful consumption of alcohol in a way that will facilitate behaviour change. The strategy intends to ensure the alcohol treatment system is responsive to the needs of higher risk drinkers and higher risk with dependence drinkers, their families and carers.

Through the strategy it is hoped that improvements will be made in the outcomes for children and young people where either their own or their families' alcohol misuse means they are less likely to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well being. The strategy also hopes to reduce alcohol related offending and re-offending.

1.3 Vision

Sexual health services in Manchester will be built upon the belief that all people have the right to good sexual health.

Sexual health is not only concerned with disease or infection but with promoting good sexual health in a wider context in line with the following WHO definition.

“Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.”



1.4 Aims

The overall aims of the sexual health commissioning strategy are:

- To improve the sexual health of the population of Manchester
- To reduce sexual health inequalities between the general population and vulnerable and socially disadvantaged groups who are most at risk of poor sexual health in Manchester

We will achieve our overall aims by:

- Improving sexual health promotion and disease prevention interventions
- Reducing the number of under-18 conceptions
- Reducing the number of unintended conceptions (all ages)
- Providing accessible and equitable abortion services
- Reducing the transmission of HIV and sexually transmitted infections
- Reducing the prevalence (total number of infections) of undiagnosed HIV and sexually transmitted infections
- Improving diagnosis, treatment and social care for people living with HIV
- Reducing the stigma associated with HIV and sexually transmitted infections
- Ensuring that the workforce can deliver modern, integrated sexual health services
- Improving links to other relevant strategies, for example, the alcohol strategy.



1.5 Principles

Sexual health services in Manchester will:

- meet the current and projected needs of the local population
- be positioned where they are needed the most to reduce health inequalities
- involve service users in service development and evaluation
- be free and confidential
- be delivered in a variety of clinical and community settings so that people can use the service of their choice
- be easy to access
- have low, or no, waiting times and no unnecessary waiting
- be developed in line with patient need, including locations and timings of services
- encourage and empower service users to take responsibility for their own sexual health and support them to make healthy choices
- treat all service users with dignity and respect
- offer prevention and treatment that is evidence based and consistent across services
- be cost effective
- provide services in accordance with the Department of Health's "You're Welcome" criteria.

1.6 Scope

This strategy covers sexual health and wellbeing needs of Manchester's whole population.

The strategy covers the next three years (2010 – 2013) and will be regularly reviewed by the commissioning partners through robust engagement and performance management to ensure that it remains appropriate and is delivered upon. The scope and focus of the strategy may require revision in response to changing national policy.

This strategy covers the following areas:

- Community contraception and sexual health services
- Genitourinary Medicine clinics
- Primary Care (including General Practice and Pharmacies)
- Abortion services
- Chlamydia screening
- HIV testing, treatment and care
- Sexual health promotion including HIV prevention and support services
- Teenage pregnancy prevention.

NHS Manchester is not the commissioner of sexual assault services. We will, however, link with relevant strategies and strengthen our partnerships to ensure that men and women who have experienced sexual assault receive appropriate support and counselling.

We will ensure that the Sexual Assault Referral Centre (SARC) at St Mary's Hospital is linked into local contraception and sexual health services.

1.7 Priority groups

The Manchester Sexual Health Forum has prioritised work with particular social groups to reduce sexual health inequalities.

These groups have been chosen because of high rates of sexually transmitted infections within these populations, and the perceived lack of services to meet their needs.

The priority groups are:

- Young people
- Gay / Bisexual men and men who have sex with men (but who may not self-classify as gay or bisexual)
- People from Black and Minority Ethnic Groups (in particular, Sub-Saharan African groups)
- Other vulnerable groups (see 1.7d).

a) Young people

Sexually transmitted infections, including HIV, remain one of the most important causes of illness due to infectious disease among young people (aged 16 – 24). In 2007, young people accounted for 65% of new diagnoses of chlamydia, 50% of gonorrhoea and 50% of genital herpes made at GUM clinics in the UK.

If left untreated, chlamydia and gonorrhoea can lead to long-term fertility problems. Infection with HIV or the strains of human papillomavirus that can cause cervical cancer can lead to long-term illness and possible death.

Despite a reduction in the under-18 conception rate in England over the last decade, the numbers of under-18 conceptions remain high. Having a child at an early age can damage young women's health and well-being, and limit their education and economic prospects.

Mid-2008 population estimates suggest that there are around 93,589 young people aged 16 – 24 living in Manchester. Around two-thirds of our wards are classified as teenage conception hotspots (wards with rates in excess of 60 per 1,000), with a small number of wards having rates in excess of 100 per 1,000. Most of our under-18 conceptions occur to 16 and 17 year olds.

Manchester also has a high number of Looked After Children. As at 31st March 2007, a total of 1482 children and young people in Manchester were being looked after by the local authority (including 134 unaccompanied asylum seeker children) .

It should also be noted that Manchester and Salford have the largest concentration of higher education students in Europe. It is estimated that there are 50,000 students in Manchester including around 5,000 students from overseas. We need to ensure that the sexual health needs of students, particularly in relation to access to contraception, are addressed.

b) Gay / Bisexual men and men who have sex with men

There remains a high prevalence (total number of infections) and a high incidence (new infections) of HIV and other sexually transmitted infections acquired sexually between men.

The North West Development Agency suggests that the size of the Lesbian, Gay, Bisexual and Transgender communities is between 5-7% of the population with an estimated 400,000 LGBT people in the North West of England, the majority of these residing in Greater Manchester . Manchester has the United Kingdom's largest LGBT community outside London and is renowned for its Gay Village, on and around Canal Street.

Manchester is the Local Authority in the North West with the largest number of HIV positive residents infected through sex between men, with 765 cases (50%) of cases in 2007. Greater Manchester accounted for the highest number of HIV positive injecting drug users (72 individuals) .

c) People from Black and Minority Ethnic Groups (in particular, Sub-Saharan African groups)

Research has shown that, compared with the population as a whole, people from black and minority ethnic (BME) groups tend to suffer from poorer health and greater levels of socio-economic deprivation. Certain BME groups have been identified as bearing a disproportionate burden of sexual ill-health.

The rates of gonorrhoea in some inner city BME groups are ten times higher than in the white population. Britain's African communities have been particularly badly affected by HIV/AIDS, with high rates among both adults and children.

Manchester is a cultural city, with diverse communities made up of people from around 70 different countries. The proportion of the population from a non-white ethnic group is projected to increase to 26.9% by 2011. More recently, the black and minority ethnic population in Manchester is estimated to have grown from 19.1% of the population in 2001 to 24.3% in 2007.

The ethnic groups that experienced the largest increases in numbers during this period were Black African, Chinese and Other White groups. These changes reflect the growth in migration to Manchester from European Union Accession States and certain African countries.

In 2007 in Greater Manchester 41% of individuals with HIV were from BME communities .

d) Vulnerable groups

The Sexual Health Forum recognises that some groups within the population have additional vulnerability.

This may be because of the setting or circumstances they live in, e.g. prisoners and asylum seekers, or because of risks related to behaviour, e.g. sex workers and injecting drug users.

Additionally, some groups find accessing services more difficult because of concerns regarding stigma or other service limitations, e.g. lesbian, gay, bi-sexual and transgender groups, over 50s, and homeless people.

Finally, other people may be at additional risk of exploitation because of life circumstances, e.g. people with mental health difficulties or learning difficulties, victims of sexual assault or domestic violence.

1.8 Structures

NHS Manchester and Manchester City Council both have roles in commissioning aspects of contraception, sexual health and abortion services, and HIV treatment and care, to meet the needs of the local population. A broad range of public, private and third sector organisations are engaged in the provision of services.

The sexual health commissioning lead for NHS Manchester sits within the Public Health Team. The coordination of the teenage pregnancy prevention and support programme is led by the Joint Health Unit.

The Commissioning and Public Health teams work very closely together to ensure that the commissioning process is informed by public health knowledge and identified public health priorities.

Manchester has a well established Sexual Health Forum, made up of both commissioners and providers of sexual health services. Sexual Health Forum members come from specialist sexual health services, statutory agencies and third sector agencies. The inclusive nature of the Forum, and the joint work that it allows between commissioners and providers, gives members the opportunity to share information and makes it invaluable in identifying areas where further service development is required.

The Teenage Pregnancy Partnership Board (TPPB) directs and performance manages local efforts to reduce the number of teenage conceptions. The Chair of the Board is the Chief Executive of NHS Manchester. The Better Contraception and Sexual Health Services sub-group is responsible for ensuring that services meet the sexual health needs of local young people. Most decisions that relate to the provision of contraception and sexual health services are referred to this Board.

There are other groups within Manchester that are focusing on particular areas of sexual health, such as the Manchester Chlamydia Screening Implementation Group and the Termination of Pregnancy Provider Group.

Manchester benefits from being part of the Greater Manchester Sexual Health Network. The network supports commissioners and providers across Greater Manchester to work together to improve sexual health.

There are numerous priority action groups within the network as well as a Greater Manchester Sexual Health Commissioners meeting. The network enables ideas to be shared across PCT areas and encourages joint working across PCTs in tackling particularly difficult issues, for example meeting the GUM access targets.



National Strategies and Targets

2.1 National Strategies

There has been a demonstrable improvement to contraception, sexual health and abortion services over the last decade.

Service modernisation and development has been informed by a number of national strategies, including:

- 'Better Prevention, Better Services, Better Sexual Health' (2001)
- 'National Teenage Pregnancy Strategy' (1999)
- 'Choosing Health: Making Healthier Choices Easier' (2004).

a) 'Better Prevention, Better Services, Better Sexual Health'

The Government launched the 'Better Prevention, Better Services, Better Sexual Health: the national strategy for sexual health and HIV' (2001) in response to increasing diagnoses of HIV and sexually transmitted infections and the identified need to modernise sexual health services.

It detailed five main aims:

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

The Implementation Action Plan, published in 2002, provided a framework for service improvement, and set a number of goals and standards to enable progress at national and local levels to be monitored (Table 1).

Table 1: Sexual Health goals and standards, 2001 – 2007

Goals

Goal: 25% reduction in the number of newly acquired gonorrhoea infections, by the end of 2007.

Outcome: There was an overall reduction of 27% of new diagnoses of gonorrhoea between 2002 and 2007. Most of this reduction has been attributed to lower levels of heterosexual transmission.

Goals

Goal: 25% reduction in the number of newly acquired HIV infections, by the end of 2007.

Outcome: There was an increase in the number of HIV diagnoses between 2002 and 2007.

Standards

Standard: GUM clinics to offer an HIV test to all clinic attendees on their first screening for STIs (and then according to need).

Outcome: 73% of first time clinic attendees were tested for HIV in 2006, exceeding the target of 60%.

Standard: GUM clinics to increase the uptake of Hepatitis B immunisation in homosexual and bisexual men.

Outcome: 92% of men who have sex with men attending GUM clinics for the first time in 2006 accepted the first dose of the Hepatitis B vaccination. 38% completed the full course (three doses).

b) National Teenage Pregnancy Strategy

The national Teenage Pregnancy Strategy was launched in 1999 with the dual aims of reducing the number of teenage conceptions and improving support for teenage parents and their children.

Two targets were set: to achieve a 50% reduction in the under-18 conception in England, and to increase the proportion of teenage mothers in education, employment or training (EET) to 60%, both by 2010.

The national teenage pregnancy strategy is due to be updated and re-released in February 2010.

c) Choosing Health

Choosing Health (2004) set out the principles for supporting the public to make healthier and more informed choices regarding their health, including their sexual health.

The paper made a number of commitments with regard to sexual health, including:

- Extending the range of sexual health services to be delivered in community settings, including contraception and screening for sexually transmitted infections
- Enhanced sexual health services to be delivered in primary care
- Better targeting of hard to reach and vulnerable groups
- Faster access to GUM clinics
- Implementation of the national chlamydia screening programme for England.



2.2 Reforms

The period since the publication of Manchester Sexual Health Strategy 2006-09 has seen unprecedented organisational and structural changes, policy developments, commissioning and financial reforms, in both local government and health services, all of which need to be taken into account when planning sexual health services for the start of the new decade.

Policy developments include:

- The devolution of decision-making power to local organisations, as first set out in the NHS Plan (2000) and further developed in subsequent policies including 'Our Health, Our Care, Our Say' (2005)

- New opportunities for local priority setting – as evidenced by the introduction of Vital Signs and the National Indicator Set, both of which contain sexual health indicators

- The introduction of the Joint Strategic Needs Assessment (JSNA) – requiring local authorities and PCTs to work together to assess the well-being and healthcare needs of their local population.

Commissioning reforms include:

- The introduction of Practice Based Commissioning in 2005 – this has created new opportunities for general practice to commission care from a range of providers

- The publication of 'Commissioning a Patient-Led NHS' (2005) – this strengthened the commissioning role of PCTs and placed more emphasis on commissioning for outcomes: healthier, longer lives, and reduced inequalities

- 'Commissioning a Framework for Health and Wellbeing' (2007) – set out the steps needed for the joint commissioning of health and social care

- The introduction of World Class Commissioning (2008) is delivering a more strategic and long-term approach to commissioning health services.

Market and service development reforms include:

- Market reform has created new opportunities for the independent and third sectors, and social enterprise organisations to enter the market, further extending patient choice.

Financial reforms include:

- The introduction of the General Medical Services (GMS) contract and other contracting routes for GPs – creating new opportunities for contraception and sexual health provision to be delivered in primary care settings

- The introduction of Payment by Results (PbR) – tariffs to finance procedures or treatments in some consultant-led services, including HIV inpatient and GUM outpatient services.

2.3 National and Local Targets

Sexual health remains on the agenda at the national, regional and local levels.

The continuing focus on improving sexual health is reflected in the national target setting framework, with local areas being asked to respond to a number of priorities. The current targets (as of September 2009) are outlined in Table 2.

Table 2: Current national sexual health targets

Under 18 conception rate	PSA 14 National Indicator Set 112 Vital Signs
Prevalence of chlamydia in under 25s	National Indicator Set 113 Vital Signs
48 hour access to GUM clinics	Vital Signs

Good progress has been made to improve sexual health services at the national and local levels in the period since the publication of 'Better Prevention, Better Services and Better Sexual Health' (2001) and most of the recommended actions detailed in the associated Implementation Action Plan (2002) have been delivered.

There have been some real improvements in the sexual health of the population of England, including reduced rates of gonorrhoea, falling under-18 conception rates, and better access to GUM and abortion services.



a) Under-18 conception rate

Manchester is required to reduce the under-18 conception rate by 55%, from 67.1 per 1000 in 1998 (baseline) to 27.6 per 1000 in 2010.

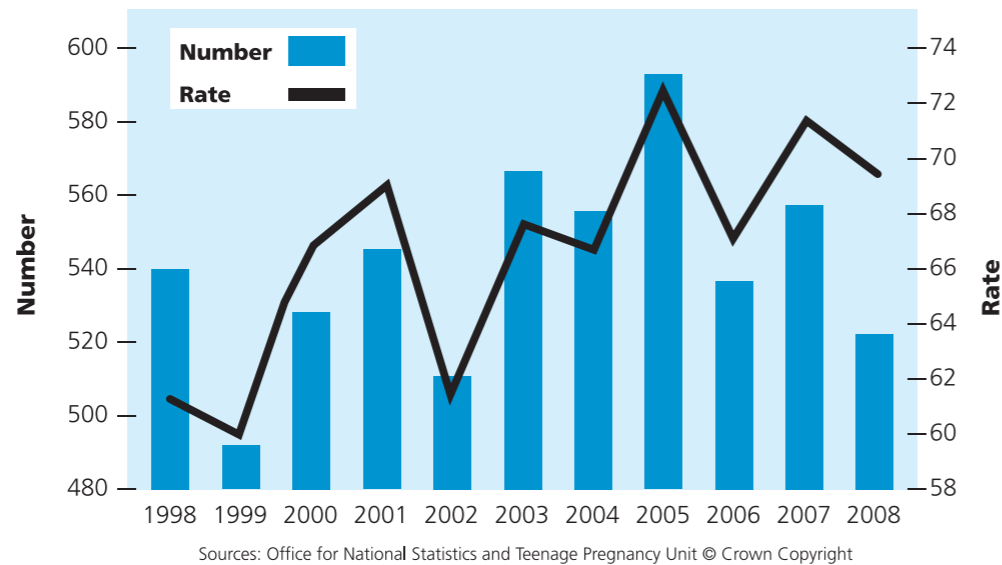
Manchester has experienced difficulties in reducing the under-18 conception rate. The rate has remained high and has fluctuated in the period between 1998 and 2007. The under-18 conception rate in Manchester in 2007 was 71.1 per 1000, up from 67.0 per 1000 in 2006 – an increase of 6.1%.

The rate had fallen between 2005 and 2006, down from 71.9 per 1000 to 67.0 per 1000. In parts of our city, one in ten young women conceive before reaching the age of 18 (Map 1).

There were 558 conceptions in 2007, a small increase on the 537 recorded in 2006. This is much less than the 591 conceptions recorded in 2005.

Table 3: Under 18 conception numbers and rates, Manchester, 1998 – 2008

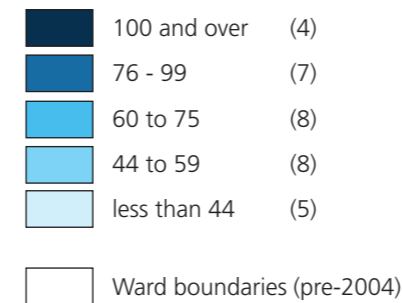
	No	Rate
1998	540	61.3
1999	492	59.9
2000	525	66.0
2001	541	69.0
2002	508	61.1
2003	565	67.3
2004	557	66.7
2005	591	71.9
2006	537	67.0
2007	558	71.1
2008	523	69.8



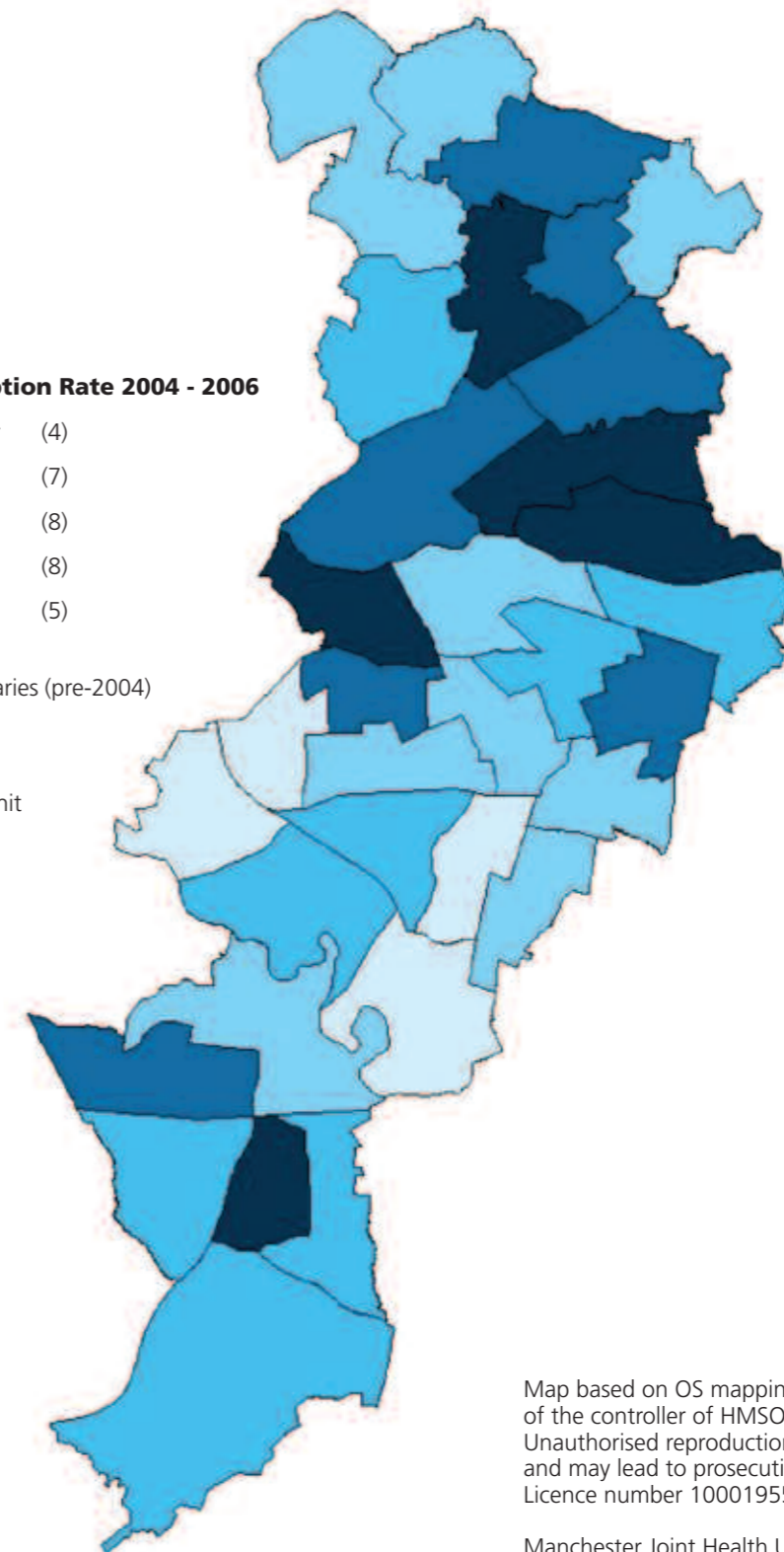
The reduction in the number of females aged 15-17 living in the city, from 8,802 in 1998 to 7,848 in 2007 (10.8% reduction) has meant that the rate has increased despite the numbers of conceptions remaining at a more consistent level. If the population had remained stable, the conception rate would now be 63.3 per 1000.

Map 1: Under-18 conception rates, Manchester wards, 2004-06

Under - 18 Conception Rate 2004 - 2006



Source: ONS and Teenage Pregnancy Unit



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Manchester Joint Health Unit (March 2009)



b) Prevalence of chlamydia in under 25 year olds

The national chlamydia screening programme has had full coverage across England since April 2008. The new indicator relating to prevalence (the total number of infections) of chlamydia in under 25 year olds was introduced at the same time to monitor the performance and impact of the programme in each area. A reduction in prevalence will indicate young people's improved management of their sexual health and reflect an increase in self-efficacy and resilience.

The chlamydia screening indicator monitors screening volumes and prevalence of the infection among the target population, and requires the reporting of the following:

a) Proportion of the resident population aged 15 – 24 accepting chlamydia screening (Years 1 to 3)

b) Number of positive diagnoses for chlamydia in the resident population aged 15 - 24 (Years 2 and 3)

NHS Manchester was tasked to screen 17% of the target population in 2008/09, and succeeded in screening 18.8%. The targets become more challenging in 2009/10 and 2010/11 and will require a marked increase in the proportion of young people being screened or tested. From 2009/10, prevalence (number of infections) will be measured as well as screening volumes using 2008/09 baseline data.

Table 2: Chlamydia screening target

	2008 / 09	2009 / 10	2010 / 11
Required screening volume	17% 15,861 tests	25% 24,225 tests	35% 33,775 tests
Actual screening volume	18.8% 17,503 tests	-	-

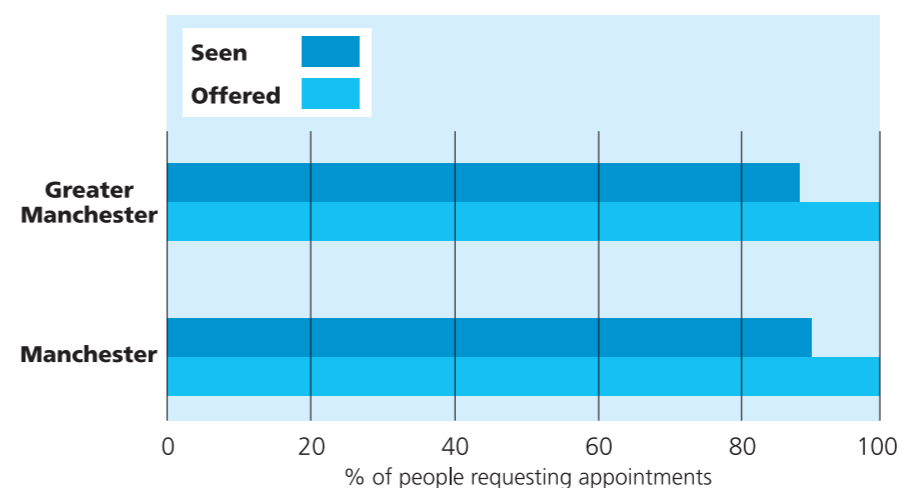
c) 48 hour access to GUM clinics

The GUM 48 hour access target was one of the top NHS priorities for 2006/07 and 2007/08; and from 2008/09 it has become a national standard that has to be maintained. The standard is that all patients should have guaranteed access to a GUM clinic within 48 hours of contacting a service. The target was introduced to address the problems of long waiting times and high levels of unmet demand, and to facilitate earlier testing and treatment.

The national standard is now that 100% of patients should be offered an appointment and 85% of patients should be seen within 48 hours of contacting a GUM clinic.

Excellent progress has been made to improve access to GUM clinics across Greater Manchester. In 2008/09, 100% of patients who contacted the GUM clinics in Manchester were offered an appointment and 90% were seen within 48 hours.

Fig 2: 48 hour access to GUM clinics in Manchester



d) Improving access to long-acting reversible contraception

There is a national consensus to increase the proportion of women being offered and accepting long-acting reversible contraception (LARC) methods. This will contribute to reducing the number of unintended conceptions and repeat abortions. NICE Guidance states that women requesting contraception should be given information about and offered a choice of all methods, including LARC methods .

LARC methods include intrauterine devices (IUD), the intrauterine system (IUS), injectable contraceptives and implants. Increasing the use of LARCs has been identified as clinical and cost effective intervention by NICE and this has been reinforced by the introduction of LARCs into the latest GP contract (QOF).

Business Services Authority data shows 8046 issues of LARC were prescribed to patients within the NHS Manchester area between April 2007 and March 2008.

e) Improving access to abortion services National standards have been set to further improve access to abortion services.

These include:

- At least 60% of abortions to be carried out before the patient reaches 10 weeks gestation
- Women should have access to an abortion within 3 weeks of being referred
- All abortion services must provide the full range of contraception advice and treatment services (National Contract 2008).

NHS Manchester has exceeded the PSA target of 60% of NHS funded abortions being carried out under 10 weeks gestation, achieving 78% in 2008 (compared with 71.9% in England and Wales).

The Central Booking Service was introduced in Manchester in 2005 to organise consultation appointments at abortion services and this has helped to reduce waiting times greatly. Between 1st April 2008 and 31st March 2009, the average wait from referral to consultation appointment was 4.5 days.

Since April 2009, our abortion providers have been contracted to offer contraception advice and supplies, including long-acting reversible methods. It is hoped that this will make it easier for women to obtain and use contraception, and that this will contribute to reducing the number of second or repeat abortions.



Local Statistics

The numbers of new diagnoses of HIV and most other sexually transmitted infections in Manchester has been increasing over the last decade. This is thought to be a result of a combination of factors including more testing, better diagnostic methods, and an increase in unsafe sexual behaviour.



This increase in unsafe sexual health behaviour may be linked to patients' awareness of the improvements around access to services and the treatments that are available to them.

3.1 HIV

The number of people living with HIV in the UK is small in comparison with some other parts of the world. However, the annual rate of new diagnoses of HIV is increasing, more than doubling between 1999 and 2003. In 2007, 7734 new diagnoses of HIV were made in the UK, bringing the estimated total number of people living with the infection to 77,400 .

In 2007, 47% of people diagnosed in the UK were infected through heterosexual sex, making this the single biggest exposure category. Of these people, 77% are thought to have acquired the infection outside the UK.

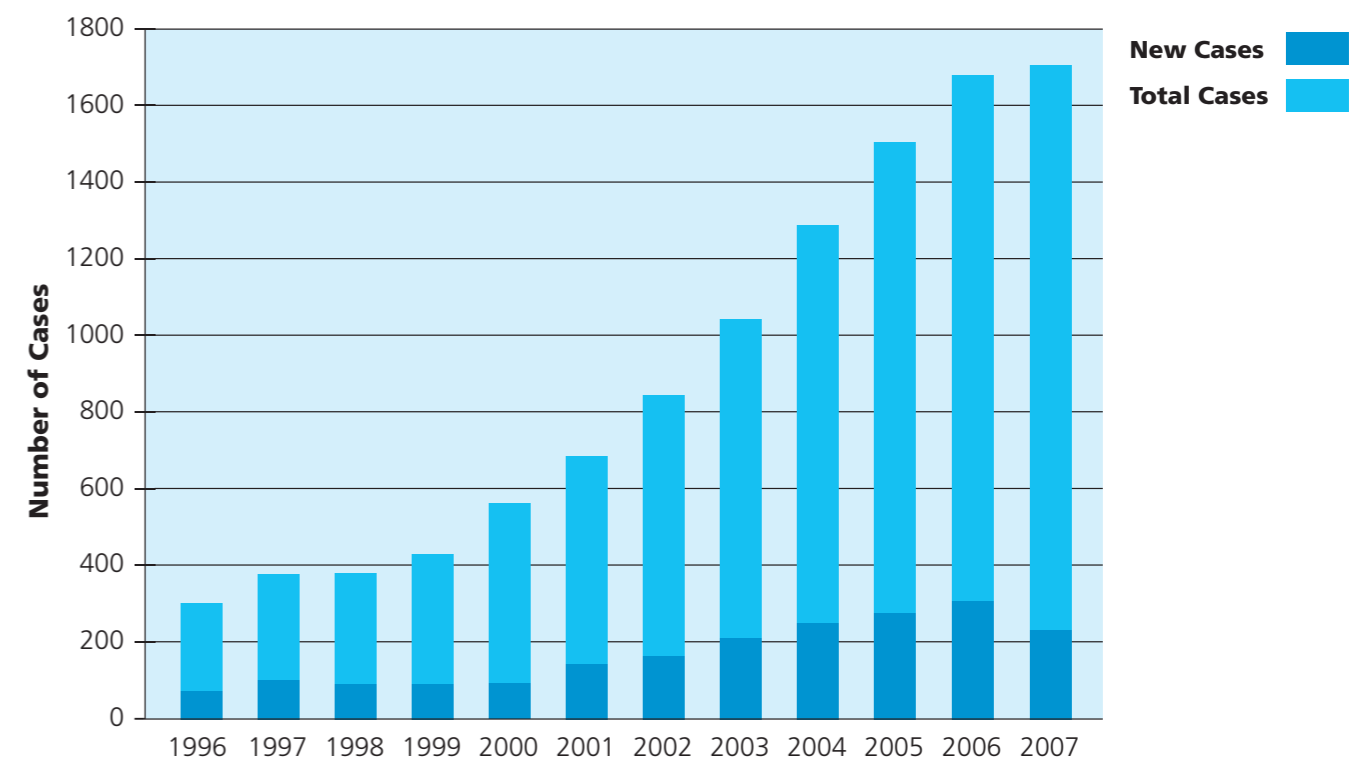
The proportion of people acquiring the infection through heterosexual sex within the UK as opposed to abroad is increasing.

In 2007, the number of new diagnoses of HIV among men who have sex with men increased for the third successive year, reaching an all time high. 2,679 gay men were diagnosed with HIV in the UK in 2007, representing around one third of all new HIV infections that year. Of those who acquired their infection in the UK, men who have sex with men accounted for 63% of all new diagnoses.

Manchester has the highest incidence (48 per 100,000) of HIV and HIV related illness outside of London and the South East. In 2007, there were at least 1,505 reported cases of HIV/AIDS in Manchester, of which at least 209 (13.9%) were new cases of the illness.

There has also been a small but concerning increase in rates among injecting drug users.

Fig 3: Total number of cases of HIV in Manchester, 1996 - 2007



Source: KC30 data compiled by the Health Protection Agency

3.2 Chlamydia

Genital chlamydial infection is the most common bacterial sexually transmitted infection in the UK. If left untreated, it can lead to pelvic inflammatory disease, chronic pelvic pain, ectopic pregnancy, and tubal infertility in women.

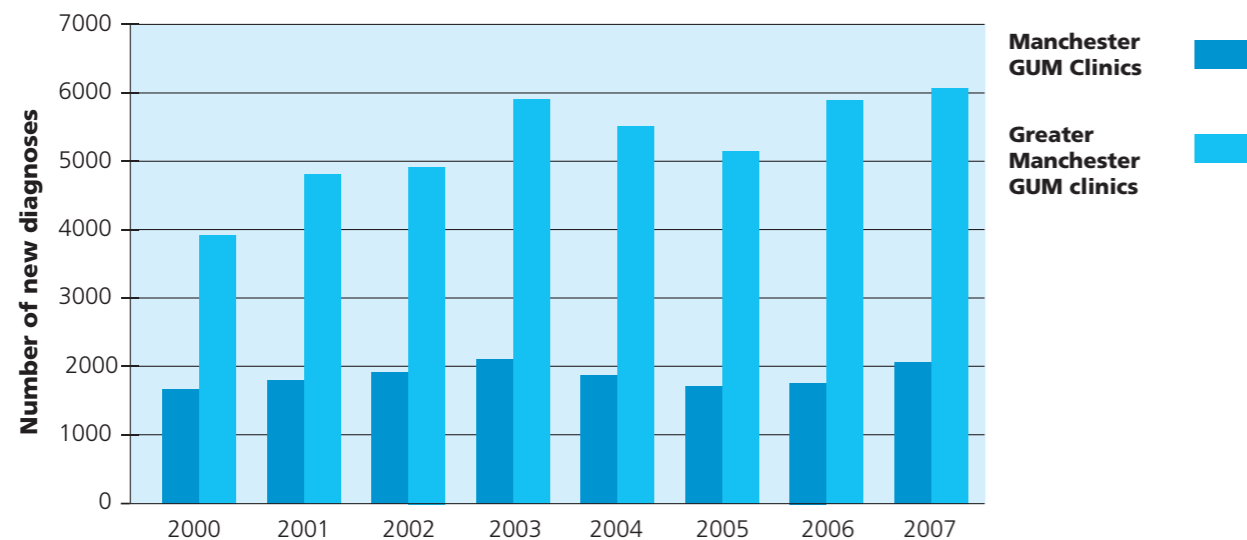
There has been a dramatic increase in diagnoses of genital chlamydial infection over the last decade (increase of 150% since 1998). This is due, in part, to increased uptake of screening and the use of more accurate diagnostic tests.

GUM clinics diagnosed 121,986 cases of uncomplicated genital chlamydia infection in the UK in 2007, 60,798 (49%) cases in men and 61,188 (51%) cases in women. Nationally, rates are highest among women aged 16 – 19 and men aged 20 – 24.

In 2007, GUM clinics in Manchester made 2,230 new diagnoses of uncomplicated chlamydial infection. It is important to note, however, that significant numbers of diagnoses are now being in non-GUM settings, particularly among women attending general practice, and young women and men being tested as part of the national chlamydia screening programme.

Locally, RUclear carried out 17,503 chlamydia and gonorrhoea tests to young people under the age of 25 in 2008/09 (18.8% of under 25s). Data for 2007 shows that positivity rates were 13.60% for males and 9.39% for females (average 10.07% positivity).

Fig 4: GUM clinics in Greater Manchester
New diagnoses of uncomplicated chlamydial infection in Manchester, 2000 - 2007



Source: KC30 data compiled by the Health Protection Agency

3.3 Gonorrhoea

Gonorrhoea is the second most common bacterial sexually transmitted infection in the UK which, if left untreated, can lead to health complications including chronic pelvic pain, ectopic pregnancy, and reduction of fertility for both women and men.

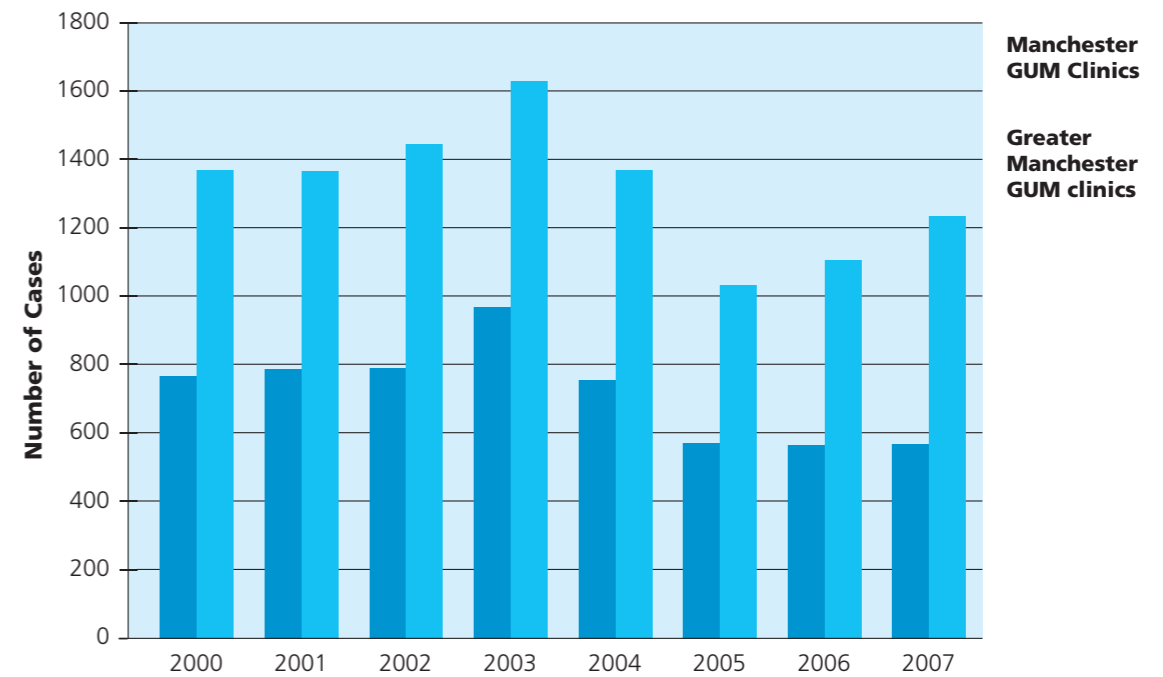
Nationally, there is evidence that transmission of gonorrhoea among heterosexual men and women is in decline following a substantial increase in diagnoses from the mid-1990s. GUM clinics in the UK diagnosed 18,710 cases of uncomplicated gonorrhoea in 2007 (12,933 cases among men and 5,777 among women), down from 25,591 in 2002.

The Health Protection Agency believes that an increase in numbers of people being tested for gonorrhoea and better management of patients and their sexual partners has helped to interrupt transmission.

In 2007, around 20% of people diagnosed with gonorrhoea were men who have sex with men, and 17% were Black Caribbean women and men. Annual rates of infection are highest in 20 – 24 year old males and 16 – 19 year old females.

Locally, there has been a recent reduction in the number of new diagnoses of uncomplicated gonorrhoea made at GUM clinics. Manchester clinics diagnosed 566 cases in 2007, down from 571 in 2006, lower than 952 cases recorded in 2003.

Fig 5: GUM clinics in Greater Manchester
New diagnoses of uncomplicated gonorrhoea infection, 2000 - 2007



Source: KC30 data compiled by the Health Protection Agency



3.4 Genital Herpes

Genital herpes is the most common ulcerative sexually transmitted infection in the UK and is associated with considerable physical and psychological morbidity.

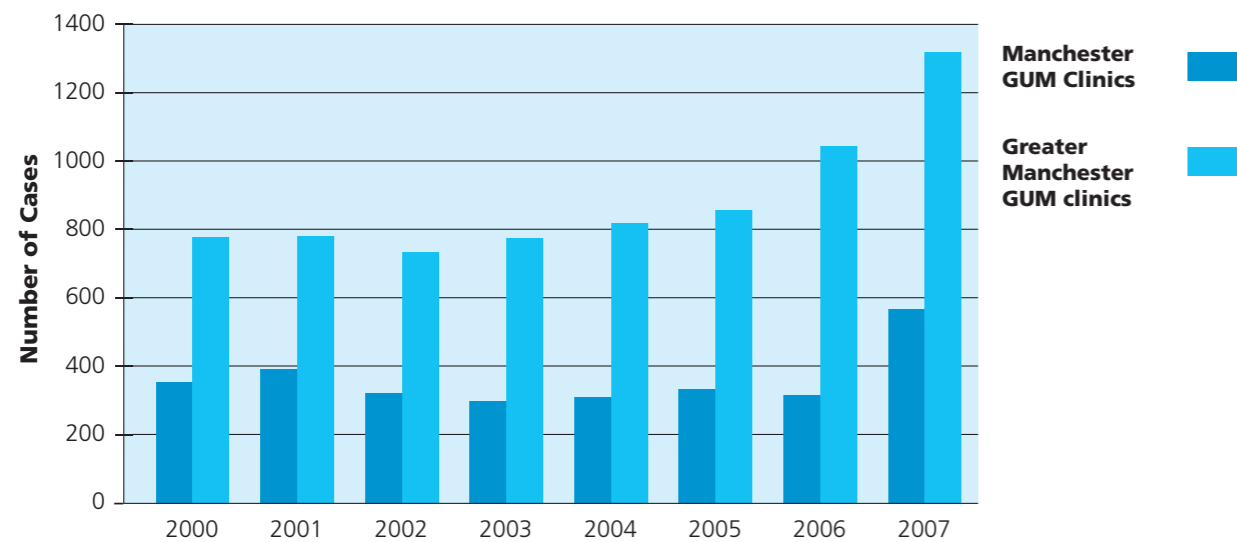
Herpes is a life-long infection and people can experience frequent recurrent attacks.

Rates of genital herpes diagnoses have been increasing since the 1970s. In 2007, GUM clinics in the UK made 26,062 diagnoses of first attack genital herpes, 10,031 in men and 16,031 in women. 44% of all episodes in men and 39% of those in women were recurrent episodes.

A substantial number of new diagnoses were also made in general practice in 2007. The highest rates of diagnoses are among younger adults and most cases are acquired through heterosexual sex.

There has been a gradual increase in the number of new cases of ano-genital herpes simplex diagnosed in GUM clinics in Greater Manchester since 2002. New cases increased from 763 in 2002 to 1327 in 2007.

Fig 6: GUM clinics in Greater Manchester
New diagnoses of Ano-genital Herpes Simplex (first attack), 2000 - 2007



Source: KC30 data compiled by the Health Protection Agency

3.5 Genital Warts

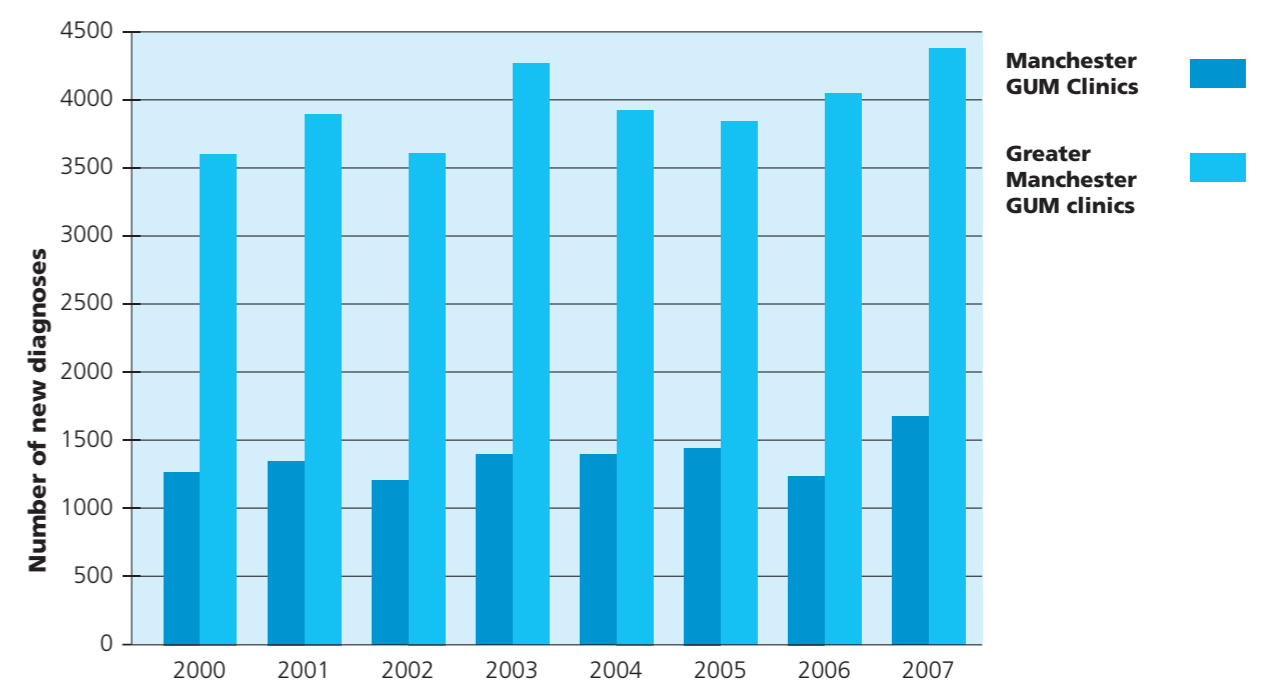
Genital warts are the most common viral sexually transmitted infection in the UK. Some of the wart viruses are associated with cancers, in particular cervical cancer. There are around 1,000 deaths from cervical cancer each year in the UK.

Diagnoses of genital warts have increased over the last decade. GUM clinics in the UK made 89,838 diagnoses of first attack ano-genital warts in 2007, 47,239 cases in men and 42,599 in women. In the same year, 30,681 cases of recurrent ano-genital warts were diagnosed in men, 19,106 cases in women.

Ano-genital wart infections are concentrated in young adults; rates of new cases are highest in men aged 20 – 24 and women aged 16 – 19. Nationally, most infections are thought to be acquired through heterosexual sex though a small increase in the number of men who have sex with men being diagnosed with the infection was observed at the end of the last decade.

GUM clinics in Manchester made 1,782 diagnoses of ano-genital warts (first attack) in 2007, up from 1,201 cases in 2006. This is in line with the national trend that saw the number of reported cases increase by 7% between 2006 and 2007.

Fig 7: GUM clinics in Greater Manchester
New diagnoses of Ano-genital warts (first attack), 2000 - 2007



Source: KC30 data compiled by the Health Protection Agency



3.6 Syphilis

Syphilis is a bacterial infection that can lead to serious complications, even death, if left undiagnosed and untreated.

There has been a substantial increase in the number of new diagnoses of primary and secondary infectious syphilis in the UK, from 288 cases in 1998 to 3,749 cases in 2007. Of the 3,301 men diagnosed in 2007, 64% (2,005 cases) of diagnoses were among men who have sex with men.

Patients diagnosed with syphilis tend to be older than those with other sexually transmitted infections: the highest rates of primary and secondary infectious syphilis were reported in 35 – 44 year old men and 20 – 24 year old women in 2007 .

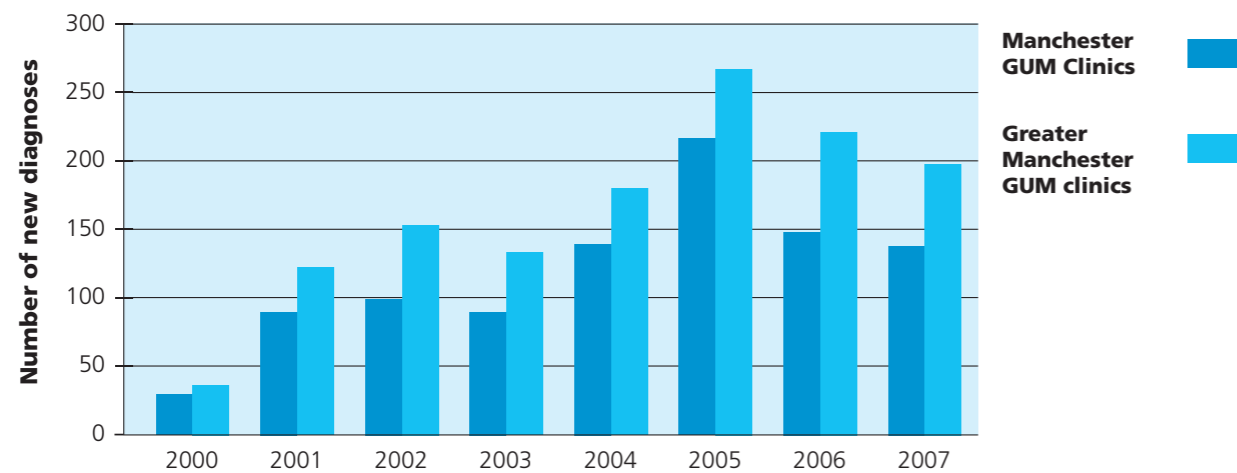
Although less common than most sexually transmitted infections, syphilis is of public health importance as it is often associated with outbreaks in vulnerable groups and with an increased risk of HIV infection.

Manchester, London and Brighton experienced outbreaks of syphilis towards the end of the 1990s and again in the last decade. In 1995, 3 cases of primary or secondary infectious syphilis were diagnosed at local GUM clinics. In 1999, at the start of the first local outbreak, this number rose to 27. 223 cases were diagnosed at local GUM clinics in 2005, falling to 143 in 2007.

Casual factors included rapid partner change and poor adherence of safer sex procedures among cohorts of men who have sex with men.

Fig 8: GUM clinics in Greater Manchester

New diagnoses of primary and secondary infectious syphilis, 2000 - 2007



Source: KC30 data compiled by the Health Protection Agency

3.7 Births and Abortions

The number of live births to women resident in Manchester has risen over the last decade. At the same time, the number of abortions has also increased, as has the number of repeat abortions.

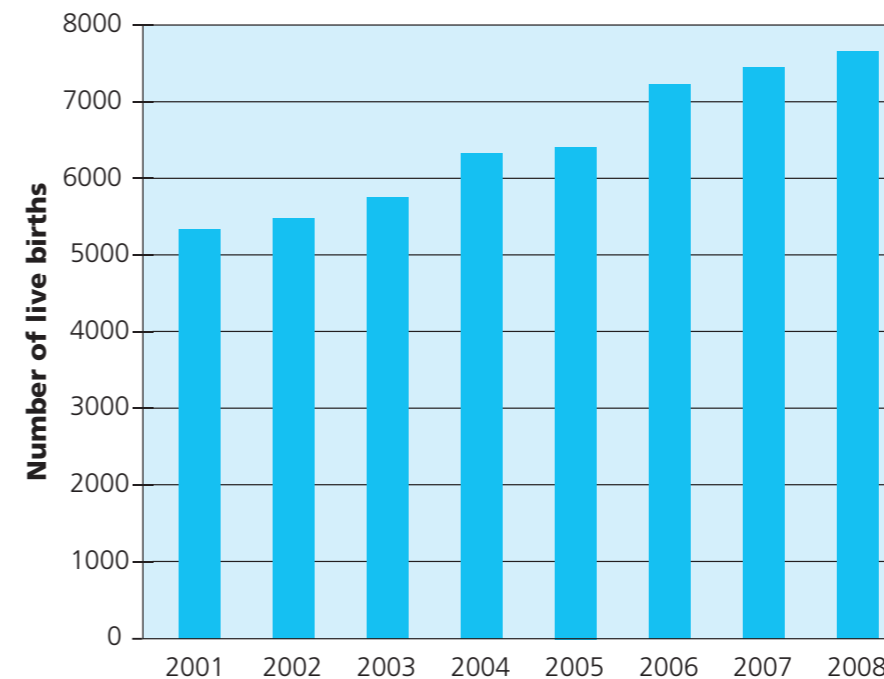
a) Births

An increasing number of babies are being born in England and Wales. There has been an annual increase in the number of live births since 2001, reaching 708,708 live births in 2008 - the highest level since 1972. An increasing number of women aged 40 and over are having babies, almost doubling from 13,555 births in 1998 to 26,419 births in 2008.

There has also been a rise in the proportion of births to mothers born outside the UK: from 14% of births in 1998 to 24% in 2008. The provisional standardised average (mean) age of women giving birth is now 29.3 .

The number of live births to women resident in Manchester has also been rising (see Fig 9). The number of live births increased from 7,552 in 2007 to 7,749 in 2008 – up 3%. The rate of increase is above the rate for England and Wales as a whole (2.7% increase).

Fig 9: Live births to women resident in Manchester, 2001 - 2008

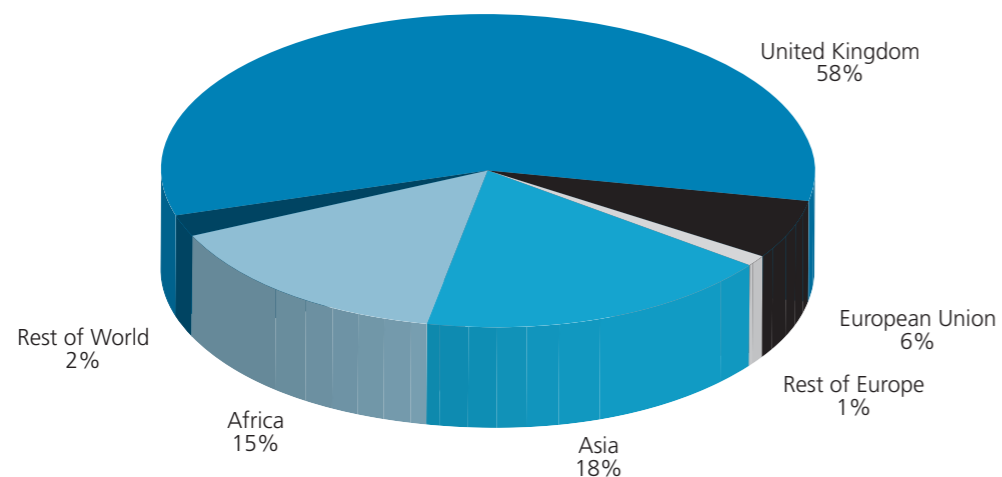


The provisional total fertility rate for 2008 gives an average number of 1.91 children per woman in Manchester – up from 1.87 in 2007, and a significant increase from a low point of 1.64 in 2001. The 2008 figure is lower than the figure for England and Wales as a whole (1.95).

The proportion of live births to mothers resident in Manchester but born outside the UK has also been rising. In 2008, 41% of all live births (3,059 births) that took place in the city were to mothers who were born outside the UK, up from 25% of all live births (1,383 births) in 2001.



Fig 10: Live births to women resident in Manchester, 2001 - 2008: Origin of mothers



b) Abortions

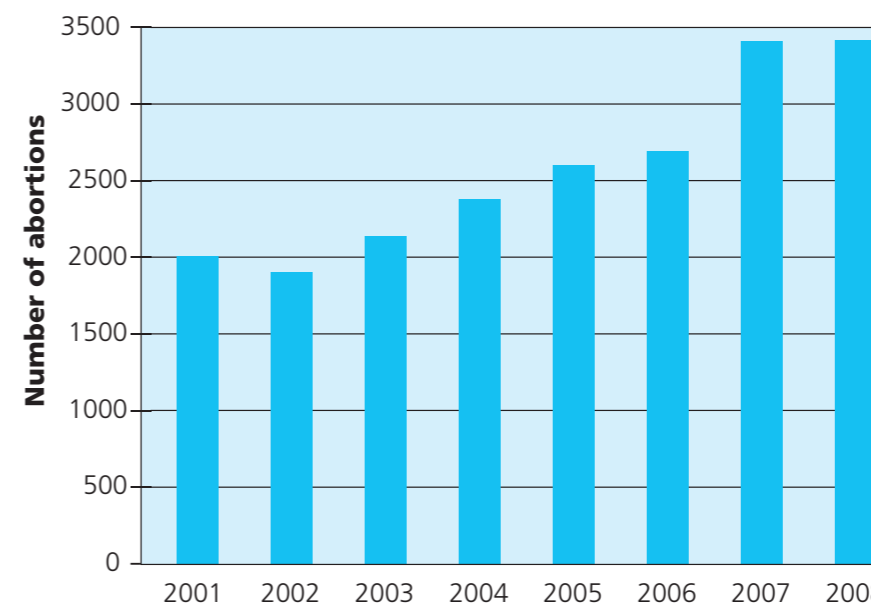
There were 195,296 legal abortions carried for women resident in England and Wales in 2008, a 1.6% reduction from 2007. However, the number of procedures has been rising over the last decade, increasing from 177,871 carried out in 1998.

In 2008, 64% of all legal abortions were carried out to women aged 20 – 34, 22% to women aged under 20, and 14% to women aged 35 and over.

There was a small increase in the number of abortions performed to women resident in Manchester in 2008 – up three from 2007 to 3,006. Compared to the average for England and Wales, a smaller proportion of abortions were carried out to women aged under 20 (19% compared to 22%) and women aged 20 – 34 (57%), with a greater proportion being carried out to women aged over 35 (24%).

In 2008, the age standardised abortion rate was 18.2 per 1000 resident women aged 15-44 in England and Wales compared with a rate of 25 per 1000 women in Manchester.

Fig 11: Abortions to women resident in Manchester, 2001 - 2008



c) Repeat Abortions

Of women aged 25 and under having an abortion in Manchester in 2008, 27% of these were repeat procedures, this compares with 24.2% for England and Wales .

The number of repeat abortions is also having a negative impact on local efforts to reduce the under-18 conception rate: nationally 11% of abortions to under 19s are repeat abortions, and in Manchester this proportion is higher at 13.7%.

Table 5: % repeat abortion to women aged under 19, 2008

	2006	2007	2008
England	10.7	10.4	11.0
Manchester	12.3	14.9	13.7



Service Modernisation and Integration

NHS Manchester intends to continue to commission sexual health services in line with the three-tiered model set out in 'Better Prevention, Better Services and Better Sexual Health' (2001).

This model proposes modern, integrated sexual health services, responsive to the needs of the local population, providing a broad range of provision in a number of different settings.

'Choosing Health' (2004) is clear that services need to be more accessible, offer faster and better prevention and treatment, and that the boundaries between primary and specialist services need to be broken down.

The three-tiered model (Fig 12) allows for the holistic commissioning of contraception and sexual health services in an integrated manner along the care pathway. Commissioning services at the most appropriate level will lead to fair, effective and best value provision.

In Manchester there is a 'hub and spoke' model used to structure the Palatine Contraception and Sexual Health Service. Palatine clinics are described as hubs, with other services, such as GP Practices and pharmacies, described as the spokes in the model.

The proposed direction of travel is that the current 'hub and spoke' model will be further developed to increase the proportion of Level 1 and Level 2 services provided in primary care and community settings. This will allow specialist providers to focus on providing Level 3 services. This approach will maximise the potential of available resources and ensure that the right provision is provided to the right people in the right place at the right time.

This model allows for both the development of nurse-led services with appropriate medical support, and for the maximisation of specialist skills. This skill mix is especially important at levels 1 and 2.

a) Level 1 provision

Level 1 refers to contraception and sexual health services that can be offered in primary care and community settings. Level 1 services include the provision of oral and emergency contraception, screening for common sexually transmitted infections, pregnancy testing, and referral to specialist services. Level 1 also includes sexual health promotion and disease prevention work.

NHS Manchester has started to broaden the range of contraception and sexual health services available in primary care and community settings. An increasing number of general practices and pharmacies are providing elements of Level 1 / 2 services and our intention is to increase this number over the duration of this strategy. Third sector organisations also have an important role in delivering sexual health promotion and disease prevention campaigns and interventions and this is acknowledged.

b) Level 2 provision

Level 2 refers to enhanced contraception and sexual health services. Level 2 services include the provision of long-acting reversible contraception (e.g. implants and IUDs) and the testing and treatment of uncomplicated sexually transmitted infections.

Level 2 services tend to be delivered in community contraception and sexual health clinics and our intention is that this position should be maintained. Community clinics will be expected to further extend their role in STI screening and the management of uncomplicated STIs, freeing up GUM clinics to concentrate on delivering relevant Level 3 provision.

c) Level 3 provision

Level 3 refers to specialist contraception and sexual health services. Level 3 services include treating complicated sexually transmitted infections, complex contraception, and abortion.

Our intention is that specialist clinical teams located at GUM clinics (bar provision for abortion and complex contraception) will provide most Level 3 services. GUM clinics will focus on patients with complex, chronic or intensive needs, particularly in relation to treating clients with HIV and complex STIs. Community contraception and sexual health clinics also have a role in providing Level 3 services, and will continue to provide specialised contraception and the coordination, teaching and training of Level 2 providers.

d) Direction of Travel

There is evidence that integration can improve efficiency and cost effectiveness by reducing duplication of services and providing more services by client contact. Failure to provide services in this way will result in an increase in health inequalities, a decline in sexual health, increases in STIs and unplanned pregnancies, and a failure to meet national targets.

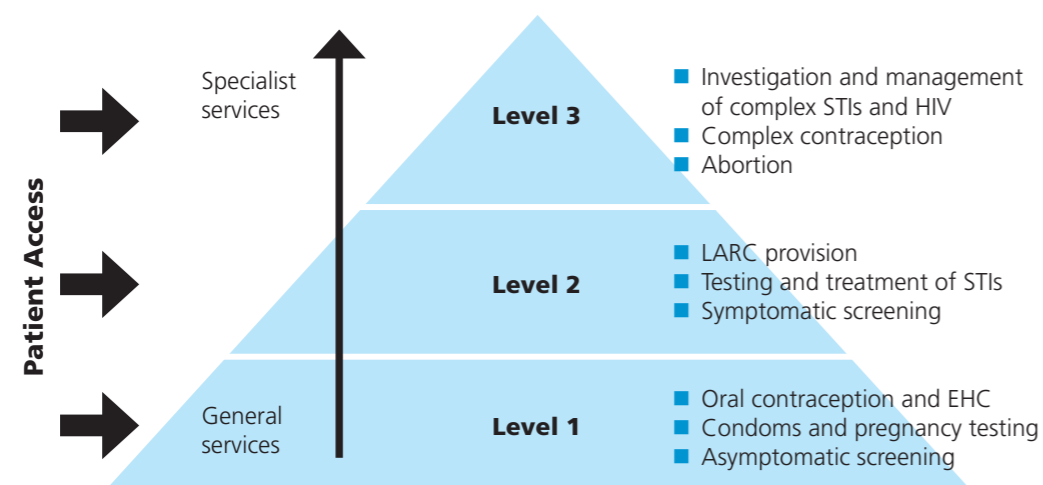
NHS Manchester recognises that there are disincentives for integrated sexual health provision. New funding mechanisms – in particular, Payment by Results (PbR) – could lead to disjunction between community and acute services, hindering efforts to commission along the care pathway. This is recognised at the national level and is being addressed .

Increasing contraception and sexual health provision in primary and community settings, making it easier for people with uncomplicated needs to access services closer to their home or work, will have an impact on specialist providers in the medium and longer terms. We expect that overall referrals to specialist providers will decrease and the ratio of complicated cases to uncomplicated cases will increase. The attention of providers is therefore drawn to the possible changes to patient and financial flows implicit in the service re-design programme and the impact on the relevance of the current (and future) PbR tariffs.

The Department of Health is working to develop a new sexual health commissioning framework. The framework will adopt the 11 world class commissioning competencies to inform local commissioning of sexual health services, offering a pragmatic approach to needs assessment; procurement and contestability of services; and evaluation and performance management.

It will also incorporate guidance on sexual health promotion and prevention and will also include service specifications for the three levels of sexual health services as described in this document. The commissioning framework was due to be published in late 2009 .

Fig 12: Model of integrated sexual health provision



Financial Context and Cost Effectiveness

Given the present economic climate and current and potential pressures on public service finances, it is imperative that contraception, abortion and sexual health services, including sexual health promotion and disease prevention programmes, are cost effective and deliver measurable outcomes.

NHS Manchester will review priorities and service provision in order to maximise value for money.

NHS Manchester will be taking a health economics approach across the pathway from prevention to outcomes. We intend to work with partners to find the right footprints for commissioning and delivering sexual health services, to avoid duplication, to better meet client needs, and to achieve value for money. We will seek to ensure that interventions are at least cost effective and based on evidence of effectiveness.

It is recognised that investing in sexual health services can deliver cost savings for the NHS through preventing unintended conceptions (and the costs associated with maternity and abortion services) and reducing the prevalence of sexually transmitted infections.

HIV and other sexually transmitted infections put a significant burden on NHS resources. In 2003 it was calculated that the average lifetime treatment cost for an HIV positive individual was in the region of £135,000 - £185,000, though this figure is now higher due to increased drug costs and longer life expectancy and is probably closer to £276,000.

Preventing each onward transmission of HIV could save up to £1million in terms of health benefits and treatment costs. The direct cost to the NHS of treating other STIs is at least £170million per annum (not including the costs of managing complications).

The average cost of contraceptive failure is at least £1800 including costs of maternity (live births and miscarriages) and abortion. Contraception services save the NHS at least £2.5 billion per annum.



a) Contraception and abortion services

Contraception services, in themselves, result in reduced costs. It is estimated that for every £1 invested in contraception services, the NHS saves £11. Further cost-saving can be achieved through making it easier for women to obtain long-acting reversible contraception (LARCs) and ensuring prompt access to emergency contraception. Medical abortions are simpler and cheaper than surgical abortions therefore by reducing waiting times more women have the option to have a medical abortion.

LARC methods (intrauterine devices, injectable contraceptives and implants) have been proven to be more cost effective than oral contraceptive pills even at one year of use

Table 6: Contraception and abortion services

Cost saving and cost effective interventions	<ul style="list-style-type: none"> ■ Contraceptive services, in themselves, result in reduced cost and increased benefit (cost saving) ■ Provision of an 'ideal' profile of contraceptive methods – including long-acting reversible contraception (saving) ■ Short waiting times for abortion services (saving) ■ Access to over the counter oral contraception (saving) ■ Access to emergency hormonal contraception (saving) and intrauterine devices (cost effective).
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b) Screening

Screening strategies targeting high risk populations, such as pregnant women for HIV, and young women for chlamydia, that lead to early identification and treatment are often cost-saving, averting the costs associated with managing complications and onward transmission.

Table 7: Screening

Cost saving and cost-effective interventions	<ul style="list-style-type: none"> ■ Antenatal screening for HIV in high risk women (cost saving) / all women (cost effective) ■ Screening for syphilis in high risk prison populations ■ Screening for chlamydia in young women (cost saving) and young men (cost effective).
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c) Sexual health promotion and disease prevention

The overall cost of sexual health promotion and disease prevention is small compared to the costs associated with unintended conceptions and treating HIV and other sexually transmitted infections.

Interventions that are evidence-based and result in behaviour change, such as encouraging individuals from high-risk populations to adopt safer-sex practices tend to be the most cost-effective.

Table 8: Sexual health promotion and disease prevention

- | | |
|---|---|
| <p>Cost saving and cost effective interventions</p> | <ul style="list-style-type: none"> ■ Free condom provision for medium and high risk groups (cost saving) ■ Assertive health promotion outreach for high risk groups (saving) ■ Safer sex skills training / cognitive behaviour interventions for men who have sex with men (saving) ■ HIV risk reduction messages in gay bars (saving) ■ Peer led interventions for MSMs (saving) ■ Needle exchange provision for injecting drug users (saving) ■ Sex and Relationships Education in schools (saving) ■ Behaviour HIV risk-reduction for high risk women (cost effective) ■ Interventions based on individualised risk assessment and counselling (effective). |
|---|---|

d) Treatment interventions

Comprehensive and accessible services for detecting and treating sexually transmitted infections are cost-effective.

Untreated infections lead to onward transmission and further increase the demand on GUM services. The prompt treatment of sexually transmitted infections, and effective partner notification, are cost-effective interventions.

Table 9: Treatment interventions for sexually transmitted infections

- | | |
|---|--|
| <p>Cost saving and cost effective interventions</p> | <ul style="list-style-type: none"> ■ Comprehensive and accessible (including extended outreach) sexually transmitted infection treatment services in groups at high risks of HIV (cost saving) ■ Comprehensive treatment of bacterial sexually transmitted infections for the general population (cost effective) ■ Antiretroviral treatment for HIV (effective) ■ Routine HIV testing for GUM clinic attendees (effective). |
|---|--|



Service Provision in Manchester

NHS Manchester commissions a broad range of providers to deliver contraception, sexual health and abortion clinical services, and to undertake HIV prevention and sexual health promotion work. This chapter describes current provision and details our commissioning intentions for 2010-2013.

It is important to note that the Department of Health is developing a new national sexual health commissioning framework.

The framework will adopt the 11 world class commissioning competencies and is designed to inform local commissioning of sexual health services; to offer a pragmatic approach to needs assessment; procurement and contestability of services; and evaluation and performance management. It will also incorporate guidance on sexual health promotion and prevention and will include service specifications for the three levels of sexual health services as described in this document. It is due to be published in late 2009. NHS Manchester will work with our providers to review the sexual health commissioning framework and to establish and agree next steps.

6.1 Community Contraception and Sexual Health Services

NHS Manchester contracts two providers to deliver community contraception and sexual health services.

For the purpose of this strategy, Palatine refers to the Manchester Community Health contraception and sexual health service. Brook is a third sector organisation and is commissioned to deliver a specialist clinic for young people aged under 19. See Maps 2a and 2b.

NHS Manchester inherited two separate contraceptive and sexual health services from the predecessor PCTs. The former North PCT

provided contraceptive services in the north of the city and Central and South PCTs worked in partnership to provide services in the rest of the city. The service is now part of Manchester Community Health and has a single management structure.

The reconfiguration of contraception and sexual health services in central and south Manchester occurred during 2008. The process had started in 2006 under the direction of the former Central Manchester PCT. Following consultation with patients and staff, a number of part-time clinics were closed in favour of establishing a hub and spoke model with four new hubs. Each hub has extended opening hours and offers a comprehensive range of services including the provision of contraception and the testing and treatment of uncomplicated sexually transmitted infections. The spokes include outreach services, General Practices, and pharmacies.

The Palatine clinics in the North Manchester are currently being reviewed with a plan to consolidate existing services in the North into hubs and rolling out the outreach services into North.

NHS Manchester also commissions dedicated contraception and sexual health services for young people. Palatine operates FRESH clinics for young people aged under 25 and provides clinical and education outreach activities. Brook operates from their clinic on Lever Street in the city centre, provides education outreach and the clinical outreach service for further education students. Brook is contracted to work with young women and men aged 19 and under.

a) Clinic Attendances

Community contraception services are required to collect attendance data and to submit annual monitoring data – the KT31 return. The most recent published data is for the period April 2008 – March 2009.

Manchester community contraception and sexual health clinics (Palatine clinics and Brook) reported over 63,000 clinic attendances during the period 2007/08. KT31 data indicates that the total number of clinic attendances rose in 2008/09, up to 63,808 (Table 10). Palatine saw a small reduction in the total number of clinic attendances (down from 48,400 to 47,765) but Brook saw an increase of 1,343.

Table 10: Total Clinic Attendances

	2005-06	2006-07	2007-08	2008-09
Palatine clinics	54,300	51,000	48,400	47,765
Brook clinic	20,100	13,300	14,700	16,043
Total	74,400	64,300	63,100	63,808

KT31 data indicates that local clinics saw 30,892 new clients in 2008/09 (Table 11). This is down from 2007/08 but is comparable to the level in 2006/07. The predecessor contraception and sexual health services (former North PCT and Central / South PCT services) had different and incompatible data collection and reporting methods; the new service submitted an estimate in 2007/08 and it now seems that numbers were over reported.

Brook saw 4,524 new clients (male and female) in 2008/09. This is up from the 4,300 new clients reported in 2007/08.

Table 11: First Contacts (All Ages), Manchester clinics

	2005 / 06		2006 / 07		2007 / 08		2008 / 09	
	Female	Male	Female	Male	Female	Male	Female	Male
Palatine Clinics	24,900	900	23,700	1,200	32,100	1,400	23,801	2,567
Brook Clinic	9,400	1,200	3,100	1,200	3,000	1,300	2,996	1,528
Totals	34,300	2,100	26,800	2,400	35,100	2,700	26,797	4,095



In terms of new female clients aged 19 and under, provisional data suggests that Palatine clinics saw 3,870 clients (Table 12) and Brook saw 2,993 clients (Table 13) in 2008-09. The increase in the numbers of young women attending Palatine services could be due to the additional FRESH sessions introduced at the new hubs.



Brook saw a small reduction (7 contacts) in the number of first contacts with females aged 19 and under in 2008/09 compared with the previous period.

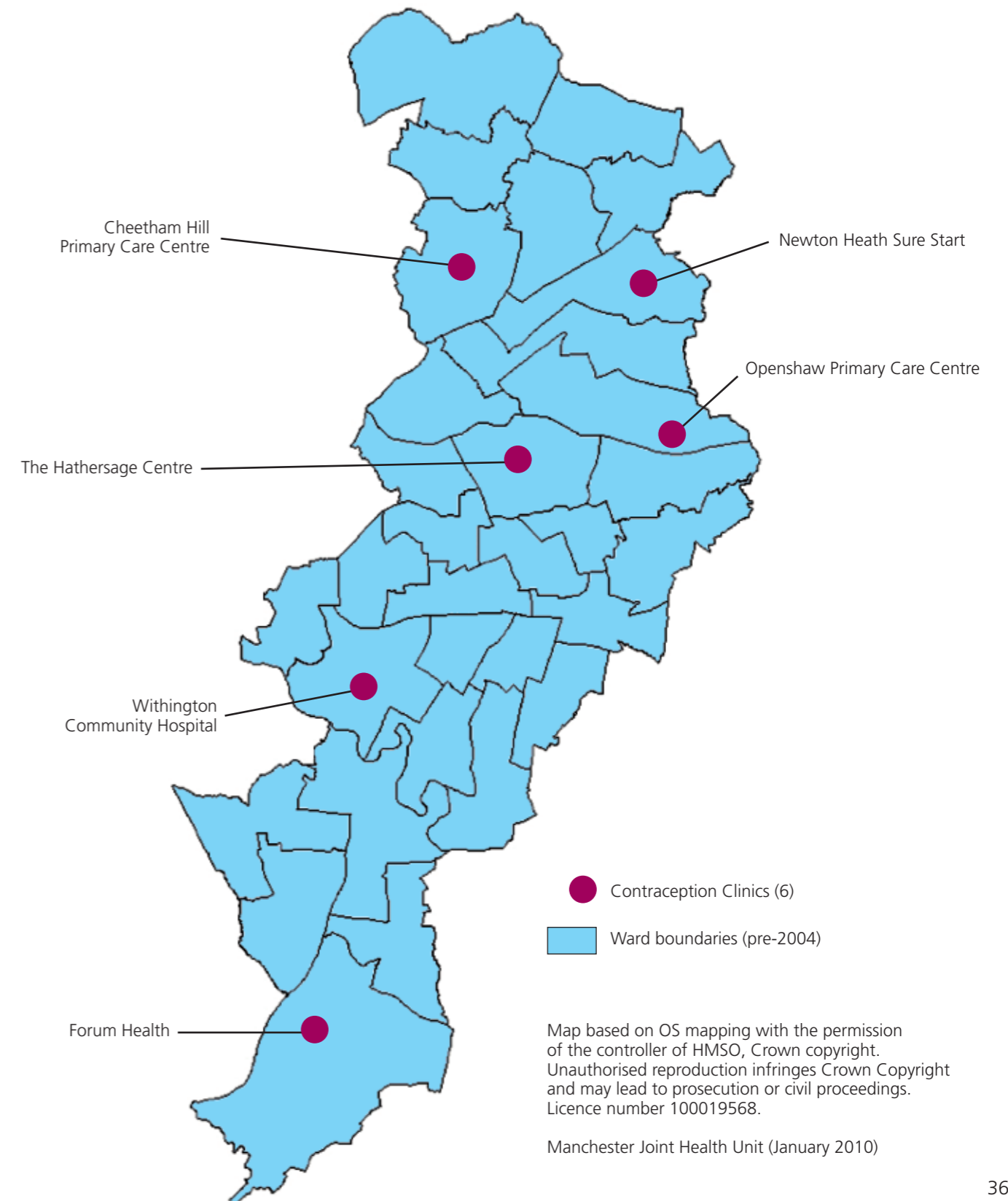
Table 12: First Contacts with Females, Palatine clinics

	2006 / 07			2007 / 08			2008 / 09		
	19 & under	20 - 34	35 & over	19 & under	20 - 34	35 & over	19 & under	20 - 34	35 & over
Number	2,844	15,879	4,977	3,531	21,507	6,741	3,870	14,603	5,328
% of total	12%	67%	21%	11%	67%	21%	16%	61%	23%

Table 13: First Contacts with Females, Brook clinic

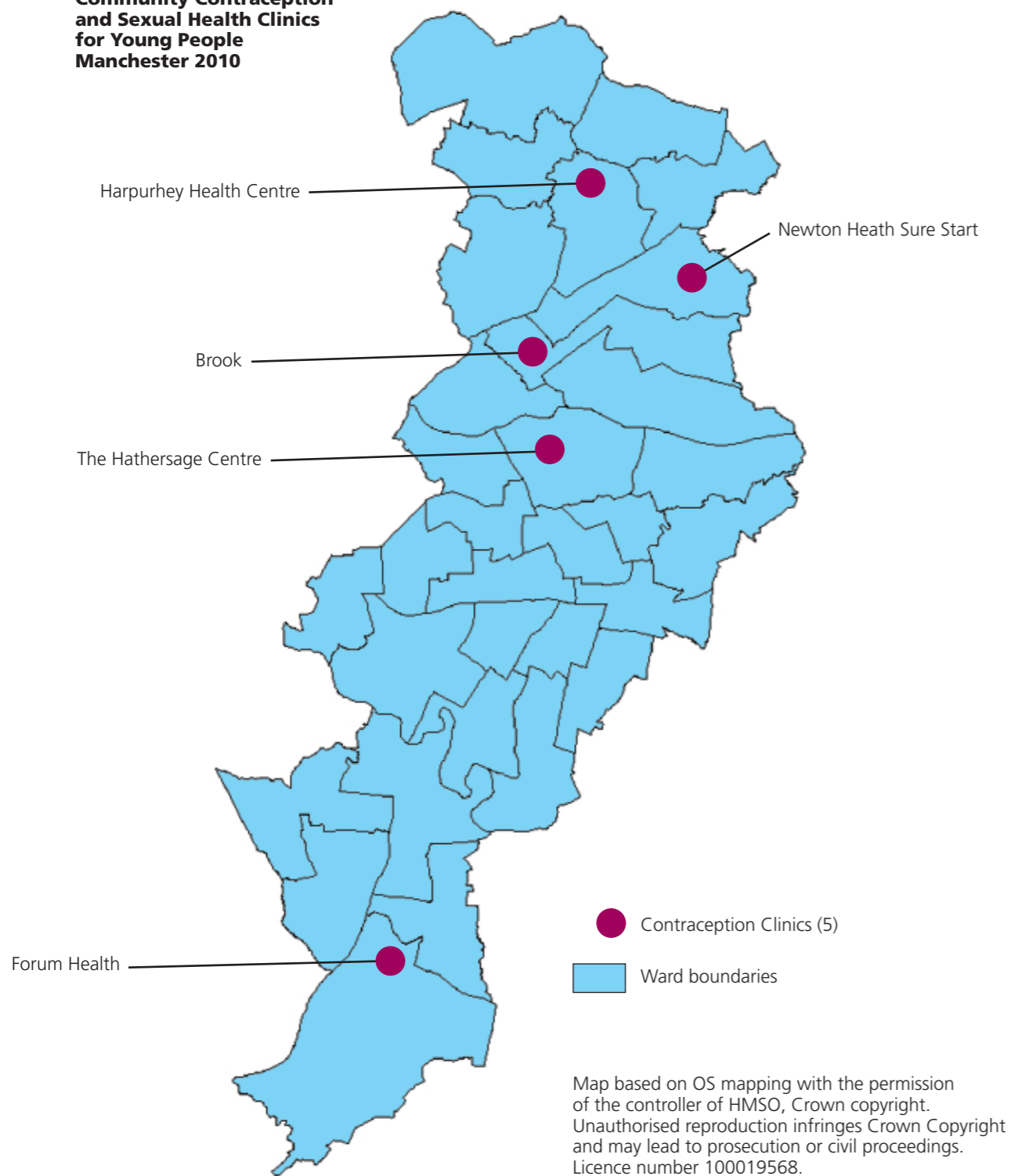
	2006 / 07			2007 / 08			2008 / 09		
	19 & under	20 - 34	35 & over	19 & under	20 - 34	35 & over	19 & under	20 - 34	35 & over
Number	3,038	62	-	2,940	60	-	2,933	63	-
% of total	98%	2%	-	98%	2%	-	98%	2%	-

Map 2a: Locations of community contraception and sexual health clinics (all ages)



Map 2b: Locations of young people's contraception and sexual health clinics

Community Contraception and Sexual Health Clinics for Young People Manchester 2010



It is important to note that Palatine and Brook are specialist contraception and sexual health services. Around 80% of women who use contraception choose to obtain their supplies from their GP. All GP practices in Manchester offer Level 1 contraception services – in particular, the provision of oral contraception, which remains the most popular (though not the most effective) contraception method.

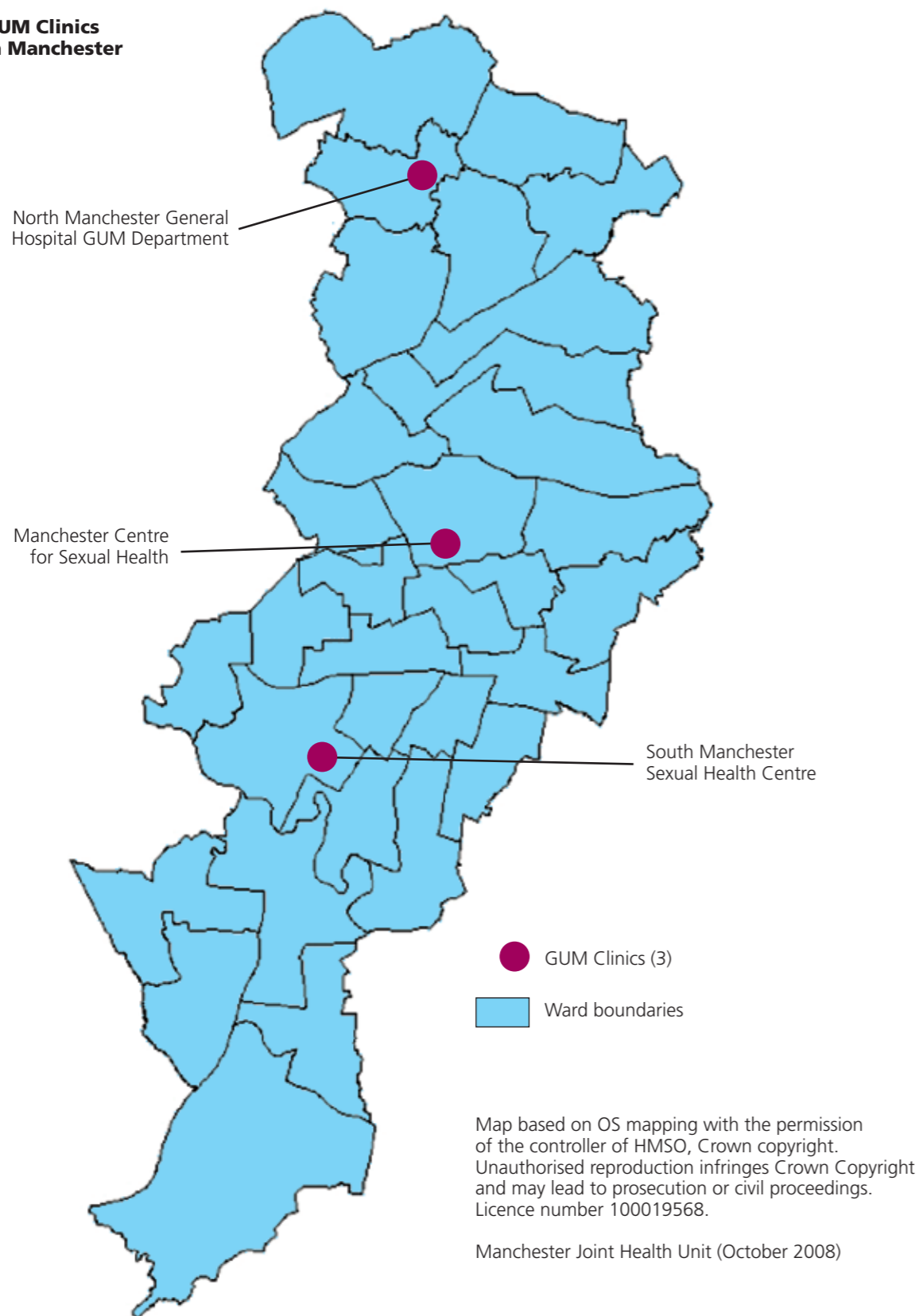
Commissioning intentions:

- To ensure that community contraception and sexual health services collect and report accurate attendance and activity data for the purposes of designing and delivering services and for performance monitoring
- To consider further opportunities for the modernisation and integration of sexual health services
- To further develop care pathways to ensure that patients are directed to the most appropriate services to meet their needs
- To provide opportunities for public and patient involvement in the commissioning and provision of community contraception and sexual health services
- To ensure that community contraception and sexual health services concentrate on the provision of Level 2 and 3 services, and to consider opportunities for directing patients seeking Level 1 services to primary care providers
- To make long-acting reversible contraception more available in order to make it easier for women to obtain these methods
- To set minimum standards and waiting times for accessing appointments at community contraception and sexual health services
- To consider reducing the upper age limit for FRESH clinics to 19 years
- To ensure that contraception and sexual health services meet their contractual obligation to achieve You're Welcome accreditation no later than March 2011
- To consider areas for sexual health staff to deliver other messages, for example, identification and brief advice around alcohol and drugs.



Map 3: Location of GUM clinics in Manchester

GUM Clinics in Manchester



6.2 Genitourinary Medicine (GUM) Services

GUM services in Manchester are provided from North Manchester General Hospital in North Manchester, The Manchester Centre for Sexual Health at the new build Hathersage Centre in Central Manchester, and from Withington Community Hospital in South Manchester.

The locations of the GUM clinics are plotted on Map 3. Each clinic provides a consultant-led service, supported by medical, nursing and health advising staff.

All GUM clinics offer full sexual health screens, testing and treatment of sexually transmitted infections, nurse-led screening or worried well sessions, HIV testing, treatment and advice. Home treatment for warts, prevention and referral activities are offered at all GUM clinics. Hepatitis B screening and vaccine for risk groups, PEP, Hepatitis A vaccines and emergency hormonal contraception are offered at some of the clinics.

The three GUM clinics in Manchester have successfully met the 48 hour access target by working together with clinics across Greater Manchester, with the support of the Sexual Health Network. The GUM service at North Manchester General can be accessed via a central booking service. At the Hathersage Centre and Withington Community Hospital there are walk-in open access services and appointments are also offered. There is also a specialist GUM clinic for young people at the Hathersage Centre.

Manchester GUM clinics have achieved the 48 hour access target through examining demand and capacity, patient flows and possible areas for service redesign, reviewing opening hours and appointment systems as suggested by the Department of Health's 10 High Impact Changes for Genitourinary Medicine document (2006).

The national standard is now that 100% of patients should be offered an appointment, and at least 85% of patients should be seen within 48 hours of contacting a GUM clinic. (The average figure for 2008/9), GUM clinics in Manchester saw 89% of patients within 48 hours meeting the target. Appointments were offered to all patients.

Increasing numbers of HIV positive patients accessing HIV care through GUM services has led to pressures within these services. A review of the funding arrangements for HIV is underway and is likely to increase HIV related funding to GUM services. We are confident that this will lead to a reduction in pressure on access targets.

Commissioning intentions:

- To ensure that GUM services continue to meet the 48 hour access targets on appointments offered and patients seen
- To move towards equitable HIV funding across Greater Manchester
- To ensure that GUM services collect and report accurate attendance and activity data to inform the commissioning process and for performance monitoring
- To consider further opportunities for the modernisation and integration of sexual health services
- To work with Pennine Acute Trust and the Greater Manchester Sexual Health Network to understand and address accommodation issues at the GUM service at North Manchester General Hospital
- To further develop care pathways to ensure that patients are directed to the most appropriate services to meet their needs
- To provide opportunities for public and patient involvement in the commissioning and provision of GUM services
- To review cost effectiveness of providing more level 2 services, particularly screening asymptomatic women and men for sexually transmitted infections, in primary care or community settings
- To review the case mix of staff working at the GUM clinic
- To ensure that GUM services achieve You're Welcome accreditation no later than March 2011
- To consider areas for sexual health staff to deliver other messages, for example, identification and brief advice around alcohol and drugs
- To recognise the role that GUM clinics have in training other health professionals.



6.3 Primary Care

a) GENERAL PRACTICE

General practice has an important role in determining and responding to sexual health needs. Research has shown that more people have, or would, consult their GP about contraception or sexual health in preference to other healthcare providers. General practitioners are, for around 80% of women, the preferred suppliers of contraception.

The GMS contact allows GPs to provide contraception as an 'additional service'.

All practices in Manchester provide this additional service, offering the following Tier 1 services:

- Contraception and sexual health information and advice
- Prescribing of contraception supplies and devices
- Prescribing of emergency hormonal contraception*
- Providing advice in the cases of planned or unplanned conception*
- Referral for specialist sexual health services.

NHS Manchester has developed a Local Enhanced Service for Sexual Health.

At present, 15 practices are providing one or more of the following Level 2 components:

- Fitting and removal of contraceptive implants and IUDs
- Screening and treatment of common sexually transmitted infections.

General practice is being encouraged to promote LARC methods. The revised framework for the GMS Contract 2009-10 reallocates a number of QOF points to support a number of clinical priorities, including contraception. 10 points are available for practices that can demonstrate discussing LARCs with women attending to obtain other forms of contraception.

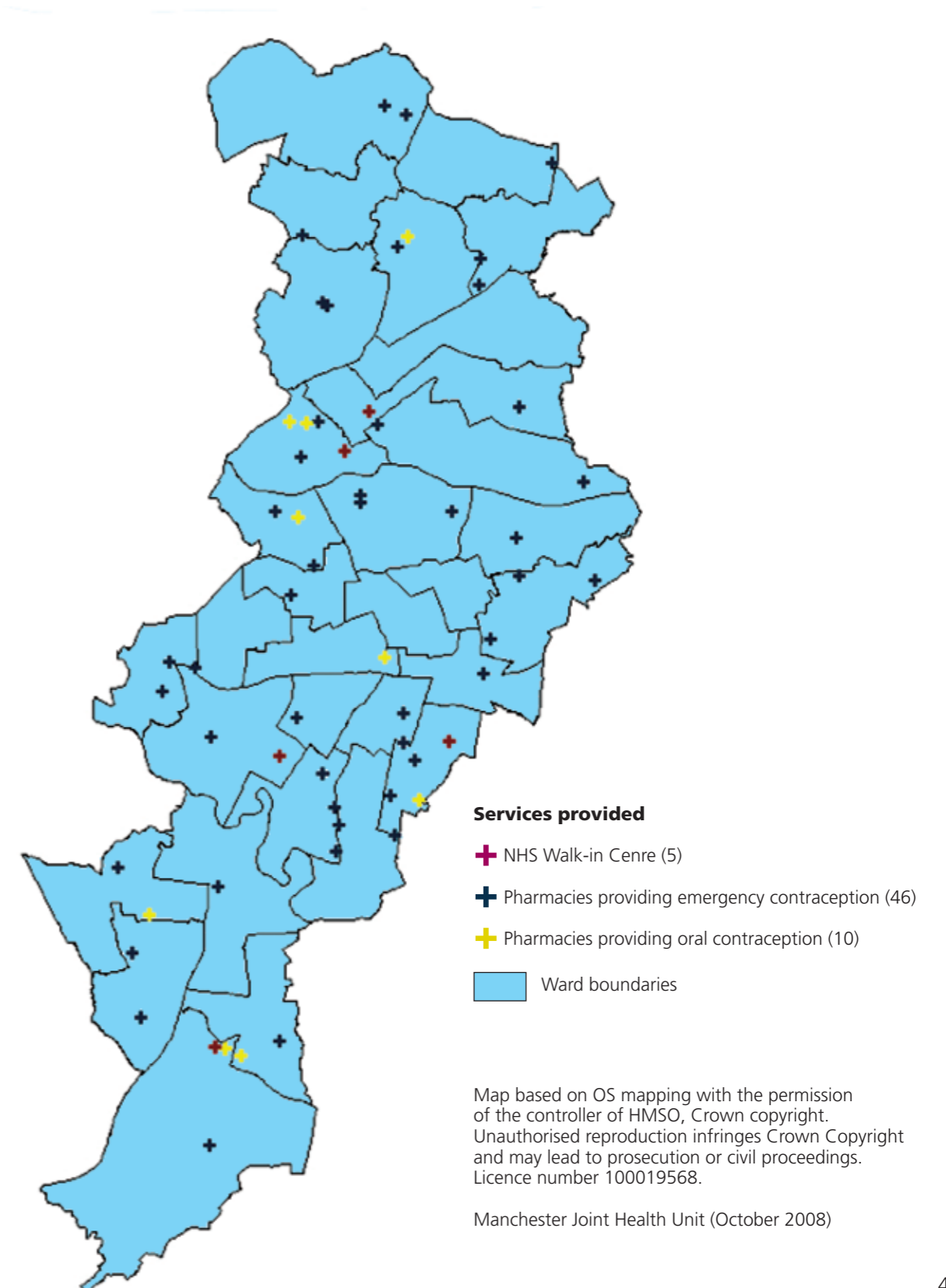
Commissioning intentions:

- To review levels of sexual health service provision in primary care
- To make recommendations as to minimum standards expected within core services and within enhanced services
- To review enhanced service provision and to recommend areas for further development
- To ensure that links between GPs and community contraception and sexual health clinics, GUM clinics and the RUclear programme are robust and clear
- To increase the numbers of GP practices engaged with the RUclear and teenage pregnancy prevention programmes to increase the number of young people being screened for chlamydia via their GP
- To ensure that GPs providing enhanced contraception and sexual health services work towards achieving You're Welcome accreditation.

* Where the GMS contractor has a conscientious objection to either emergency contraception or abortion it must offer prompt referral to a contractor which has no such objection.



Map 4: Location of pharmacies and walk-in centres providing contraception services



b) Pharmacies

The role of pharmacists as providers of contraception and sexual health advice and services has broadened over the last decade. An increasing number of pharmacies have been commissioned to prescribe emergency hormonal contraception (EHC) and to provide chlamydia screening.

The proportion of women choosing to obtain EHC from pharmacies increased from 20% to 55% between 2002 and 2008 in England. The further development of the role of pharmacists in the provision of sexual health services has been recommended in recent national policies and guidelines .

Pharmacies provide a convenient and less formal environment for people to access health services. The provision of commissioned sexual health services, and the retailing of condoms and pregnancy testing kits, present opportunities for pharmacists and their colleagues to deliver sexual health promotion work.

NHS Manchester (as of Sept 2009) commissions around 50 pharmacies to provide free emergency hormonal contraception. Of these, 10 also offer first and repeat prescribing of oral contraception and 10 are participating in the RUclear chlamydia screening programme (see Map 4).

Commissioning intentions:

- To review level of sexual health service provision in pharmacies
- To further develop sexual health service provision in pharmacies located in the geographical areas of greatest need
- To maintain or improve levels of access to emergency hormonal contraception from pharmacies
- To evaluate the oral contraception pilot and rollout to additional pharmacies as appropriate
- To increase the numbers of pharmacies engaged with the RUclear and teenage pregnancy prevention programmes
- To further promote the provision of sexual health services from pharmacies
- To ensure that pharmacies providing sexual health services work towards achieving You're Welcome accreditation



6.4 Abortion services

The main abortion providers commissioned by NHS Manchester are The Whitworth Clinic at St Mary's Hospital, Marie Stopes International, South Manchester Private Clinic, North Manchester General Hospital and bpas.

All consultation appointments are made through the centralised telephone booking service, which will offer the first available appointment, and the appointment at the clinic closest to the woman's home. Providers now hand over a proportion of appointments to the call centre to give out. Each provider has allocated a front-line contact with the central booking service to enable good communication. The system has been widely publicised with the public, referrers and providers. Women can self-refer or appointments can be made on their behalf by their GP or other health professional.

Between 1st April 2008 and 31st March 2009 there were 3056 consultation appointments for abortion booked for Manchester women through the Central Booking Service. Of these:

- 46.6% of appointments were made at Marie Stopes International, 33.2% at NHS providers, 19.7% at South Manchester Private Clinic and 0.5% at bpas
- Just over half of clients were aged under 25 at the time of appointment booking (7.6% under 18, 45.3% aged 18-24 and 47% aged over 24)
- For 87% of clients their gestation at time of appointment booking was under 10 weeks
- There was an average wait of 4.5 days from referral to consultation
- Referrals were made by the women themselves (41.1%), GPs (38.3%), Contraception and Sexual Health clinics (9%) and other organisations (11.6%).

NHS Manchester has contracted all of our abortion providers to offer contraception and is supporting them to be able to provide the full range of contraceptives at their clinics. The majority of providers are able to provide these but some training needs have been identified around implant fitting.

Commissioning intentions:

- To ensure that access and waiting time targets are maintained
- To increase the proportion of medical terminations
- To increase uptake of contraception at abortion clinics
- To reduce the repeat abortion rate
- To ensure that abortion providers meet their contractual obligation to achieve You're Welcome accreditation no later than March 2011.



6.5 Chlamydia screening

The National Chlamydia Screening Programme was established in 2003.

It offers free, opportunistic screening, treatment, partner management and prevention to sexually active young men and women under the age of 25.

The programme includes under 16s, partners of any age and asymptomatic individuals who are not requesting investigation of a sexually transmitted infection.

The goal of the programme is to:

- Prevent and control chlamydia through early detection and treatment of asymptomatic infection
- Reduce onward transmission to sexual partners
- Prevent the consequences of untreated infection

The chlamydial infection often has no symptoms but it is easy to diagnose and treat. If left untreated it can lead to long-term health problems, including infertility, ectopic pregnancy and pelvic inflammatory disease.

Treatment and partner notification can reduce complications that are estimated to cost the NHS at least £100 million per year.

Manchester is part of the Phase 3 rollout of the National Chlamydia Screening Programme. The Chlamydia and Gonorrhoea Screening Programme "RUclear" is co-ordinated across all the 10 Primary Care Trusts in Greater Manchester and is overseen by the Sexual Health Network.

Manchester has a broad range of sites that are actively screening. 60% of screens are carried out through the Palatine Contraception and Sexual Health Services. Other high volume screening sites include Brook and Marie Stopes International.

Commissioning intentions:

- To increase the number and range of access points to make it easier for young people to obtain chlamydia screening and treatment
- To increase the numbers of GPs and pharmacists offering chlamydia screening and treatment
- To set and monitor targets with providers to increase screening volumes
- To ensure better engagement between chlamydia screening and safer sex programmes and interventions
- To work with providers to increase the number of young men accepting chlamydia screening
- To ensure that there is equity of services across the city and that hard to reach groups are being effectively targeted.



6.6 HIV Testing, Treatment and Care

The numbers of people infected with HIV continue to rise both in Manchester and across Greater Manchester, but we are seeing some changes in transmission routes.

In 2008, the number of new cases attributed to heterosexual transmission overtook the number of cases diagnosed among men who have sex with men.

Additionally, the rate of heterosexual transmission acquired outside Africa was higher than from within Africa for the first time in 2008.

Late diagnosis of HIV remains a problem in Manchester with an estimated 38% of HIV positive people being diagnosed late, compared with a national average of 31%. Consideration needs to be given to how to ensure early diagnosis in all cases. This could include setting a late diagnosis target.

Outcomes for HIV positive individuals who are receiving treatment continue to improve, particularly among individuals who received an early diagnosis. There is some evidence that non-UK nationals are no more likely to be diagnosed at a later stage, and are equally likely to be asymptomatic at diagnosis, but there is evidence of a greater need for social care and support. Across all populations, higher levels of deprivation are associated with higher levels of use of voluntary sector services.

The excellent work of our maternity hospitals and the specialist midwifery service has delivered a good level of uptake of antenatal HIV testing and are proving extremely effective at reducing mother to child transmission. We are aiming to introduce a consistent process for funding sperm washing for HIV discordant couples in 2010, in order to reduce the risk of transmission of HIV to mother or baby.

NHS Manchester is keen to reduce the rate of undiagnosed HIV among the local population. We will achieve this through improving access to HIV testing (including via GPs and other primary care / community settings), and better communicating the benefits of testing.

NHS Manchester and partners have been working over the last few years to develop consistent care pathways for HIV treatment and care, with the aim of both ensuring care quality standards and of setting a local tariff for HIV care. HIV-related drug costs are excluded from this work but continue to be a pressure for services. This work is now entering the implementation phase and we are hoping to use a shadow tariff in 2010/11.

We have also moved primary care prescribing out of secondary care and back to primary care with GPs managing the primary care needs of their HIV positive patients. We will be doing some further work to evaluate the impact (positive or negative) that this change has had on patient experience and quality of treatment.

Numbers of patients with co-infections such as Hepatitis C, syphilis and gonorrhoea continue to rise and services are working to ensure that individuals are aware of risks and that we have effective secondary prevention measures.

NHS Manchester will seek to ensure that, where non-Manchester residents are using local HIV and sexual health services, that their respective health and social care commissioners are making a proportional financial contribution towards these services.

NHS Manchester and Adult Social Care, Manchester City Council, intend to collaborate to develop a joint commissioning strategy for HIV/AIDS prevention and social care during 2010/11. Through this Transforming Community Services work the potential benefits of both partners moving towards holding joint contracts with provider organisations will also be explored.

Manchester has a strong and responsive third sector that complements statutory service provision. Work continues on developing stronger commissioning arrangements from both health and social care, in order to allow third sector organisations to operate on a more secure financial footing.

Commissioning intentions:

- To move to the introduction of a tariff for HIV treatment and care
- To work with Manchester City Council to develop a joint commissioning strategy for HIV prevention, treatment and care
- To increase screening and to set a local target for reducing the numbers of late diagnoses
- To further develop care pathways to ensure that patients are directed to the most appropriate service to meet their needs
- To improve awareness and knowledge of HIV in primary / community services
- To ensure robust antenatal and maternity provision for HIV positive patients and to ensure that children at higher risk of HIV are offered testing
- To develop protocols for sperm washing for approval and adoption across Greater Manchester
- To introduce partner testing within antenatal settings
- To improve commissioning arrangements for third sector organisations
- To provide opportunities for public and patient involvement in the commissioning and provision of HIV prevention, treatment and care services.



6.7 Sexual Health Promotion and HIV Prevention

a) Sexual health promotion and HIV prevention and services

NHS Manchester commissions a number of provider organisations to deliver sexual health promotion and HIV prevention services. These include Manchester Public Health Development Service, the Lesbian and Gay Foundation (LGF), the Black Health Agency (BHA), George House Trust (GHT) and Manchester Action on Street Health (MASH).

HIV prevention and sexual health promotion work tends to focus on the following groups:

- Gay and bisexual men / men who have sex with men
- Black and minority ethnic (BME) women and men
- HIV positive individuals, particularly in terms of reducing onward transmission.
- Street-based female sex workers.

Local providers have developed a broad range of HIV prevention and sexual health promotion interventions, at the structural and individual levels, to address the needs of each population group.

In broad terms, most interventions are based on the following principles:

- for behaviour to change, individuals must recognise the problem, be motivated to act, and have the knowledge and skills to perform and sustain the action
- to increase the likelihood of action, barriers in the social environment must be removed or overcome and support or reinforcement provided wherever possible.

NHS Manchester commissions HIV prevention and sexual health promotion activities to reduce new incidences of HIV and other sexually transmitted infections, particularly among high risk population groups, and to promote good sexual health and well-being. Providers are working to increase awareness of HIV and risk of sexually transmitted infections, to address risk-taking behaviours, to encourage HIV testing, and to promote access to mainstream and specialist sexual health and social care services.

The Department of Health is developing a prevention framework to promote better synergy across national programmes and to inform sexual health promotion and prevention at the local level. It will be aligned to world class commissioning through the sexual health commissioning framework; this is seen as crucial to the effectiveness of the framework and its contribution to positive sexual health outcomes for all. Linked to the framework will be relevant research and evidence about the impact of sexual health promotion and prevention activities, including information about cost effectiveness, to support the further development of effective interventions that achieve the desired sexual health outcomes. NHS Manchester will work with provider organisations to review the new prevention framework and to establish and agree next steps, including reviewing the effectiveness of current programmes .

NHS Manchester will also seek to ensure that, where non-Manchester residents are using local HIV prevention and sexual health promotion services, that their respective health and social care commissioners are making a proportional financial contribution towards these services.

The Department of Health recommends that, to be effective, all those who work in the sexual health field should be encouraged and empowered to collaborate with each other, to devise the best response to meet local needs and to make the best use of finite resources. NHS Manchester contracts different providers to work with different population groups. It is therefore important that we work with all providers to ensure a coordinated and coherent approach to sexual health promotion and HIV prevention work to benefit all local residents .



Commissioning intentions:

- To ensure that sexual health promotion work contributes to work to improve the sexual health of the population of Manchester and to reduce inequalities
- To work with Manchester City Council to develop a joint commissioning strategy for HIV / AIDS prevention and social care
- To review and ensure that the national prevention framework informs sexual health promotion and prevention at the local level
- To work with other commissioners and provider organisations to ensure that, where non Manchester residents use local prevention services, their health commissioners are making a financial contribution
- To work with providers to ensure that there is a co-ordinated approach to sexual health promotion interventions across the city
- To work with provider organisations to ensure that sexual health promotion and HIV prevention interventions are evidence based, cost effective and designed to meet local needs
- To review HIV and STI data and ensure that resources are targeted at those groups most likely to contract HIV or sexually transmitted infections
- To consider areas for sexual health staff to deliver other messages, for example, identification and brief advice around alcohol and drugs.

b) Sex and Relationships Education

Sex and Relationships Education (SRE), delivered as part of Personal, Social and Health Education (PSHE), can allow young people to develop knowledge and understanding about sex and relationships and the skills and confidence to make positive choices in relation to their sexual health. NHS Manchester will continue to work with the council to challenge and support local schools to improve their SRE provision. We will continue to support the work of the Healthy Schools Partnership and the school nursing service. This work will be particularly important as schools prepare for PSHE becoming statutory in 2011, and as efforts continue to improve the provision of contraception and sexual health services delivered from schools.

Commissioning intentions:

- To continue to support the Health Schools Partnership to work with schools to improve SRE
- To contribute to the review of the School Nursing Service to ensure that SRE work and sexual health services in schools continue to be prioritised.

c) Condom distribution

Condoms have a dual purpose: to prevent unintended conceptions; and to reduce the risk of contracting or transmitting sexually transmitted infections. The provision of free condoms for medium and high risk groups has been evaluated as a cost saving intervention for disease prevention.

There is also evidence that free condoms distribution schemes for teenagers can contribute to reducing under-18 conception rates. Manchester has three condom distribution schemes:

i) The Manchester Condom Distribution Scheme

The Manchester condom distribution scheme was set up in the 1990s to help reduce the incidence of sexually transmitted infections and HIV. This scheme promotes access to condoms via organisations working with vulnerable people and those in at risk groups. The scheme is operated by the Public Health Development Service in partnership with Manchester City Council. The scheme is funded by NHS Manchester.

ii) Free condom scheme for gay and bisexual men

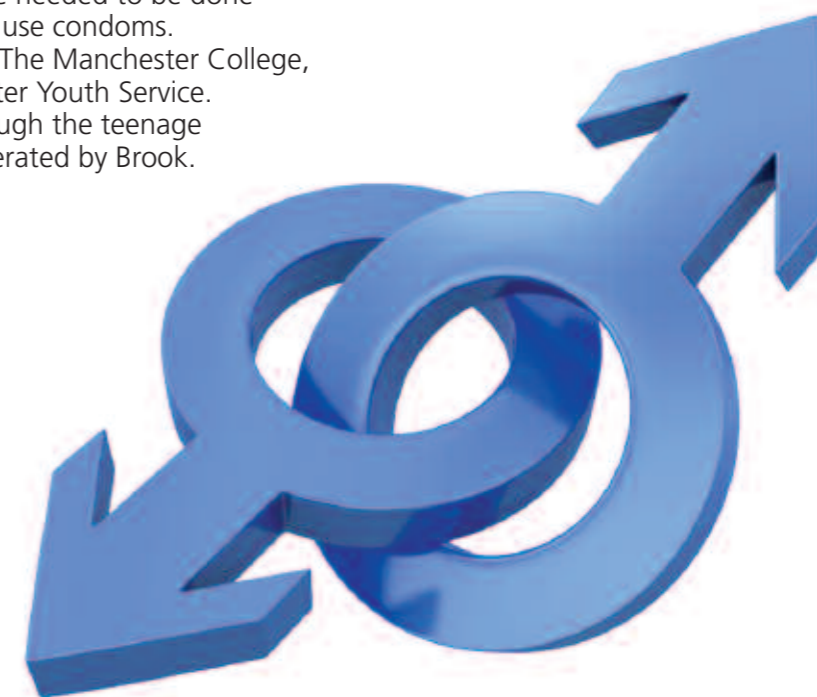
The Gay Men’s Safer Sex scheme was launched in 1994 and now distributes around half a million condoms throughout Greater Manchester each year. The condoms and lubricants are distributed within safer sex kits which include information on safer and proper condom use and HIV and sexually transmitted infection prevention information. The scheme is operated by the LGF and receives funding from NHS Manchester and other sources.

iii) C-Card scheme

The C-Card scheme was launched in 2008 to respond to the National Support Team recommendation that more needed to be done to encourage teenagers to use condoms. Distribution points include The Manchester College, Connexions, and Manchester Youth Service. The scheme is funded through the teenage pregnancy grant and is operated by Brook.

Commissioning intentions:

- To work with providers to develop a clear overarching strategy to inform condom distribution in Manchester, taking account of the different needs of different populations in the city
- To undertake equity audits of access to condoms and make recommendations about the best outlet points including the role of social, primary and community providers
- To provide opportunities for public and patient involvement in the commissioning, review and provision of the free condom distribution schemes.



6.8 Teenage Pregnancy Prevention

Reducing the number of teenage conceptions and improving support for pregnant teenagers and teenage parents are important local priorities; the conception rate reduction target has been included in the current Local Area Agreement.

The Teenage Pregnancy Partnership Board, with support from national and regional colleagues, continues to oversee the strengthening of local prevention and support activities. The Board, which is chaired by the Chief Executive of NHS Manchester, sets the strategic direction; performance manages the annual action plans; monitors outcomes; and makes investment decisions leading into commissioning.

It is difficult for public services to influence young people's decision making in relation to their sexual behaviour. However, local partners are acting to establish an environment that better supports young people to make positive choices in relation to their sexual health.

The agreed approach is to make sure that young people have both the 'means' and the 'motivation' to avoid unwanted sexual experiences, to practice safer sex, and to make the conscious choice to put off parenthood until later in life.

The Teenage Pregnancy Partnership is addressing the following issues:

- Improving knowledge and understanding in relation to sex and relationships and supporting young people to develop the skills and the confidence to make positive choices about their sexual health
- Improving access to dedicated contraceptive and sexual health services and ensuring that young people understand the importance of condom use
- Ensuring that parents and professionals feel confident to discuss sex and relationships with young people
- Improving support for pregnant teenagers and teenage parents.

Commissioning intentions:

- To maintain a strategic approach to teenage pregnancy prevention and support, and to continue to participate in the Teenage Pregnancy Partnership
- To support the Teenage Pregnancy Partnership to review the impact of teenage pregnancy prevention interventions
- To support the Teenage Pregnancy Partnership to explore options for continuing to fund successful interventions following the end of the national strategy
- To continue to invest in dedicated and responsive contraception and sexual health services for young people
- To review the C-Card scheme as part of broader work to evaluate the impact of the various condom distribution schemes
- To continue to support schools to develop and deliver Sex and Relationships Education – maintaining close links with the Healthy Schools Partnership
- To ensure that the workforce feels confident to discuss sex, relationships and sexual health with young people.

6.9 Cross-Cutting Issues

a) Workforce planning and development

i) Health professionals

There has been a considerable expansion of the local sexual health workforce over the last decade. This has seen the broadening of existing roles to take on new aspects of sexual healthcare, and the development of new roles outside of specialist settings. This has been in line with the vision for modern, integrated contraception and sexual health provision set out in 'Better Prevention, Better Services, Better Sexual Health' (2001) and 'Choosing Health' (2004).

The Department of Health recommends that education and training of the workforce is considered across entire pathways rather than focusing on individual staff groups. This will help to ensure that the NHS has the right workforce with the right skills in the right places to deliver high quality care for all patients.

Local contraception and sexual health services have developed multi-disciplinary teams, to make full and effective use of the skills of all team members. Notable developments include the further development of nurse-led clinics, and an increasing proportion of dual-trained contraception and sexual health nurses. This has allowed contraception services to offer sexual health screening, and has supported GUM clinics to meet the 48 hour access targets.

The increasing use of Patient Group Directives (PGDs) has allowed healthcare professionals from a broad range of disciplines to offer some contraception and sexual health services, including:

- Pharmacists prescribing oral and emergency hormonal contraception, and treating chlamydia and gonorrhoea as part of the RUClear programme
- School nurses prescribing emergency hormonal contraception.

The ongoing development of contraception and sexual health service provision in a broader range of settings has necessitated additional clinical training for non-sexual health specialists.

Additional training is being provided to allow GPs to develop the clinical competencies to provide the services set out in the Local Enhanced Service (LES) for Sexual Health. GUM clinics have responsibility for training other health professionals around screening and treatment of sexually transmitted infections and to help GPs manage HIV positive patients.

Additional training has also been arranged to increase the number of health professionals across Greater Manchester who are trained to fit and remove the contraceptive implant and the coil. 100 places on the theoretical course and practical placements have been arranged for 2009/10 and 2010/11. Further training will be required, both clinical and to ensure that staff are skilled to provide accurate, realistic advice for women about the advantages and disadvantages of LARC methods, to further promote contraceptive choice.

ii) Non-health professionals

Non-health professionals have an important role in improving the sexual health of the local population.

NHS Manchester and Manchester City Council commission a broad range of sexual health, harm reduction, and teenage pregnancy prevention training courses from a number of different sources. Our intention is to review current training programmes to ensure that there are clear and agreed pathways for different staff groups, and that the training offer is aligned to local priorities.

Commissioning intentions:

- To increase training provided to services to develop clinical competencies to provide sexual health services, for example, training for fitting and removing long acting reversible contraception
- To increase training on sexual health for non clinical staff
- To review training opportunities for non health professionals and to develop a comprehensive and integrated training pathway
- To improve the skill mix of staff working in contraception and sexual health services, including GUM services to facilitate the further modernisation and integration of local services.

b) Communications and campaigns

The Department of Health (DH) and the Department of Children, Schools and Families (DCSF) have launched a new integrated sexual health communications campaign. The campaign has four main strands: promoting contraceptive choice, relationships and communication skills, promoting the use of condoms; and encouraging testing for sexually transmitted infections. It replaces existing national campaigns.

NHS Manchester recognises that contraception, sexual health and abortion providers working in Manchester have their own media and communication strategies, and publish print and electronic resources to promote their services and to communicate sexual health promotion and disease prevention messages.

In Manchester there appears to be little or no coordination between partners, both commissioners and service providers, and as such there is potential for duplication, communicating mixed messages, and not reaching all target populations.

Commissioning intentions:

- To work with local providers to support the implementation of the new integrated sexual health communications campaign
- To work with service providers to improve co-ordination of local sexual health and HIV prevention campaigns, to make the best use of resources and avoid duplication
- Further develop **www.anyplanstonight.co.uk** as the main portal for members of the public seeking information about local contraception, sexual health and abortion services.

c) You're Welcome

The Department of Health is leading the rollout of the You're Welcome quality mark across England. This scheme aims to ensure that all health providers are delivering young person friendly services. The intention is that all young people, wherever they live, will be able to access services that are best suited to their needs.

NHS Manchester is using the commissioning and contracting processes to require local health providers to work towards achieving You're Welcome accreditation. NHS North West is responsible for moderating regional submissions and for awarding the quality mark to successful providers. Services that meet the required standard are entitled to use the national quality mark (YW 11-19 logo).

Commissioning intentions:

- NHS Manchester will require all contraception, sexual health and abortion services to obtain You're Welcome accreditation. This will be specified in all contracts.



Next steps

This strategy has set out NHS Manchester's commissioning intentions around sexual health for 2010 – 2013.

To deliver this strategy we must build on the knowledge and examples of best practice that exist within organisations working in Manchester. We must also encourage new ways of working and innovative ideas to tackle some of our greatest challenges.

Given the present economic climate and current and potential pressures on public service finances, it is imperative that contraception, abortion and sexual health services, including sexual health promotion and disease prevention programmes, are cost effective and deliver measurable outcomes.

NHS Manchester will review priorities and service provision in order to maximise value for money. These issues will be addressed through the commissioning processes.

The Sexual Health Forum in Manchester demonstrates that there is already a strong commitment from organisations within the city to work together to improve the sexual health of our population.

NHS Manchester will work in partnership with the organisations that are part of the Sexual Health Forum, along with others, to develop an action plan based on the priority areas within the strategy.

Implementation of the action plan will be overseen by NHS Manchester sexual health commissioning leads.



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Notes

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