Bradford & Airedale tPCT

Sexual Health Needs Assessment

Summary of findings

January 2009

Contents

This document summarises the findings of the Sexual Health Needs Assessment and does not contain detailed data and discussion.

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1. Using the Sexual Health Needs Assessment

Key points

1. This is a *strategic* needs assessment
2. It will generate a programme of work designed to address its findings
3. It is a live toolkit, and will be updated every two months in advance of each meeting of the Sexual Health Network in order to allow for and incorporate changes in:
    - Performance data
    - Activity data
    - Published evidence
    - National guidance and policy
    - Local policy and initiatives

The SHNA and the Sexual Health Network

- The delivery vehicle for the SHNA will be the Sexual Health Network
- There are too many recommendations contained within this needs assessment for them all to be implemented at once, and so members of the Sexual Health Network will prioritise recommendations and agree six priority recommendations that will form the ongoing work programme of the Network
- Once work on one recommendation has been completed, it will be removed from the work programme n another selected to take its place.
- The selection of priority recommendations will reflect the capabilities of the members of the Network in order that work is evenly distributed to teams as much as possible
- At any stage network members can add to recommendations by putting them through the chair of the network who has administrative control of the SHNA. Only network members can do this however as there would otherwise be a risk of loss of control of then work programme

Using data from the SHNA

Commissioners and other staff across organisations and partners will wish to use data from the SHNA to inform their own activity. There is a risk however that some data could be unintentionally misinterpreted or misrepresented by people who are not familiar with its derivation or the methods used in presentation.
To avoid this, it is a requirement that any use of data or tables/graphs/charts from the SHNA should be checked with either the chair of the Network or the Performance representative on the Network prior to its use or publication elsewhere.

2. Background

The Sexual Health National Support Team (NST) visited BAtPCT in 2007 and presented its report in November 2007.

Its final report included the following:
Issues & Recommendations:

- Further work will be required to ensure a **comprehensive needs assessment** is available to inform strategic planning (including an equity audit of access to services).
- The NST advised that this should be informed with reference to the **NST-commissioned sexual health needs assessment tool kit**.

Key Action 1:
The PCT needs to develop a new Strategic Plan that is informed by a **Sexual Health Needs Assessment**

Following these recommendations, it was agreed locally that a Sexual Health Needs Assessment would be undertaken with the following brief:

- Where possible, Sub district level of analysis.

Specific consideration of:

- Deprivation
- Geography
- Ethnicity
- Other demographic/epidemiological variables

It was acknowledged that:

- This would be the first time this has been attempted in the district
- There would be possible difficulties accessing sexual health data at source
- Co-operation of providers would be essential to populate a full dataset

3. Methodology

Health needs assessment is classically defined as:

'A systematic method of identifying unmet health and health care needs of a population and making changes to meet those unmet needs'

Health needs assessment was initially thrown into the spotlight in 1989 by the **National Health Service Review** which, by separating purchasers and providers, identified population health care purchasing, and therefore health care needs assessment, as a distinct task. Specific reasons for the introduction of HNA included:

- Increasing costs of health care
- Constraints on public sector finance
- Doubts about effectiveness
- Health inequalities
- More explicit resource allocation

Practical uses of HNA can include:

- To improve health and other service planning
- Priority setting
- Policy development

Note: HNA is not the same as health status measurement as it involves an assessment of the effectiveness of relevant interventions to supplement the identification of health problems.

Three recognised HNA approaches are used in this HNA:

1. Epidemiologically based HNA.

This approach combines epidemiological approaches with assessment of the effectiveness and possibly the cost-effectiveness of the potential interventions.

2. Comparative HNA

This approach Compares levels of service receipt between different populations.

3. Corporate HNA.

This approach involves canvassing the needs and demands of professionals, patients, politicians and other interested parties.

HNA is now being complemented/superseded by Health Equity Audit which specifically investigates issues around access to health care according to epidemiological and demographic group.
The latest development in this area of analysis is Joint Strategic Needs Assessment where the work is undertaken in partnership and is designed to provide strategic direction based on high level analysis of need.

There is a need to begin viewing HNA as a **process** rather than as a document. This is the cornerstone of JSNA and pragmatically addresses issues around data becoming out of date and the danger that the HNA is viewed as purely a document on a shelf that is brought out every now and then

This piece of work is designed to act as a **live toolkit**, and it is anticipated that data will be updated on an ongoing basis and reviewed as a bimonthly iteration of the toolkit at each meeting of the Sexual Health Network. Close co-operation between the Public Health and Health Informatics departments will be crucial to this.

Equally, evidence and policy updates can be incorporated into the HNA as they are published.

Regularly published data, by its very nature, becomes out of date as soon as its next dataset is published, indeed some of the data contained in this HNA will already be out of date by the time you read it. The toolkit approach and bimonthly iteration will ensure that data should never be more than a few months out of date where possible.

Ultimately, the data and documents that constitute this piece of work will be lodged on the tPCT SharePoint system where they can be accessed by all stakeholders. Ownership of this will be allocated to the Chair of the Sexual Health Network.

Format

This HNA follows a template for SH HNA set out by the DoH, as recommended by the NST.

The DoH suggest that this should be an exercise overseen by an expert panel – in the first instance this will be the Sexual Health Network which has multidisciplinary representation, including clinical, however this may evolve with time.

- **PowerPoint file** with "everything"
- **Spreadsheet file** containing raw data and charts/graphs – protocol for use
- **Narrative summary document** for each section – global doc.
- **Recommendations document** for each section – global doc.
- 16 sections:
    1. Background
    2. Methodology
    3. Introduction
    4. Sexual Health Promotion
    5. Service model
    6. Demographics and populations
    7. Chlamydia
    8. Gonorrhoea
    9. HIV
    10. Teenage Pregnancy
    11. Termination of Pregnancy
    12. Service utilisation
    13. Training
    14. User involvement
    15. Programme Budgeting
    16. Performance

Scope

1. Focus on teenage conceptions (prevention and support) and STIs (prevention and treatment). These areas are particularly important in terms of inequalities and the strategic direction of the tPCT and much of the emphasis on service design and capacity is here
2. Outcome data – teenage conceptions, diagnosed STIs / Service activity data
3. Initial consideration of a range of relatively routinely available data, followed by a more in depth look at specific questions
4. Informed, where possible, by qualitative data obtained from surveys and other studies.
5. The overriding purpose is to inform sensible commissioning decisions rather than an in depth consideration of detailed epidemiology.
6. Can be made more sophisticated through deeper analyses – these will take place as required or mandated and incorporated into the next iteration of the HNA
7. This piece of work should be viewed as a starting point
8. More data will be added over time
9. Recommendations will belong to the whole Sexual Health Network

Questions to be answered

- The first element of this needs assessment is to identify the type and level of need
- As part of this process we can also consider what services our patients expect to be able to access
- A key element of health needs assessment is to assess whether current services are **effective** in addressing need. This can be done by a variety of means, but the most important is to look at the relevant **outcomes**, particularly those that are performance monitored, in this case that would include incidence of sexually transmitted infections and teenage and unwanted pregnancies.
- A key imperative for the PCT is to address health inequalities, and in order to do this we must consider issues of **equity**. Equity describes a situation where level of **access** is truly related to level of **need**, and bringing about this

distribution of services is a key vehicle for allowing health inequalities to level out.

- Following on from this, there is little point in providing services that are not provided in a time and place that matches the needs and lifestyles of patients. A key challenge is to identify the combination of “where” and “when” that will lead to the maximum number of patients accessing services.
- Finally, health needs assessment must consider the evidence relating to effectiveness, cost-effectiveness and efficiency of services, in order to deliver maximal **outcomes** for unit input. To this end, we must review our current service provision in the light of existing and emerging evidence, and also other models of delivery. **This is a key area of the HNA that will evolve over time**

Once this process is complete, we should have a clearer idea of what our strategic priorities should be over coming years, and how these can be translated into commissioning activity and intention.

4. Introduction

Sexual Health

The World Health Organisation defines Sexual Health as:

- “(being)...the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love."
- “(involving)...a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic."
- “(involving)…freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships."
- “(involving)…freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive function."

The breadth and depth of this definition highlights the fact that

- Sexual health is a complex area of healthcare that extends beyond the provision of genitourinary medicine or contraception services operating in isolation

- Sexual health is a cross-cutting issue and liaison with colleagues across other sectors of healthcare and related services is therefore essential

Recent developments in Bradford & Airedale

1. Contact centre

Appointments and enquiries for both CASH and GUM services are managed by a single, central point, known as *The Contact Centre,* which has a common telephone number used by all services. The Contact Centre has been live since November 2007 and is staffed and managed by the CASH service. Calls which previously went directly to CASH and GUM clinics are directed to this centre and callers could be ringing for any of the following:

- Sexual health screen or treatment only
- Integrated sexual health (screen / treatment and contraceptive / reproductive health services)
- HIV testing
- Contraceptive / reproductive advice
- Information e.g. advice, options, clinic locations and times

The system's intention was to establish the level of care required, the patient's location and their age (in order to determine whether Young People's clinics could be offered). Based on this the most appropriate options were to be displayed to the operator. The Contact Centre could then book into any clinic diary once agreed with the caller.

At present, the system is not being used to its full potential. The Contact Centre's original specification was to act as a triage to identify which patients could be offered appointments in CASH / GP and those who either needed or requested to attend The Trinity Centre. When The Trinity Centre moved to walk-in appointments, patients were often directed there without triage in line with compliance with the 'offered' indicator. It is possible that patients were also being sent to the secondary care service because of the lack of alternatives and the Contact Centre staff not realising they could/should use alternative pathways. Several delays in adding Level 2 GPs onto the system have meant that the first practices only went live at the beginning of August 2008.

A project board, chaired by the Director of Performance, has been set up to oversee phase two of the contact centre database development to ensure it meets the requirements of both providers and commissioners with robust triage and reporting.

2. Progress on 48hr access target

Improving sexual health and reducing teenage pregnancy features as both national and local targets. One performance indicator is:

"The percentage of patients attending GUM clinics who are offered an appointment to be seen within 48 hours of contacting the service"

Performance for 100% offer of an appointment within 48 hours was achieved by the March 2008 milestone and has been maintained. Nonetheless, the 'seen' indicator for access to Level 3 services has been falling over Summer 2008 within the tPCT Provider Arm service. The 'seen' element, with a target of 95%, is considered to have a major impact on making sure that offers of appointments that are made are reasonable. There is evidence that services with the largest gaps between 'offered' and 'seen' also have higher DNA rates. For 2008/9, sustaining the 100% offer target and maintaining the smallest gap possible between offered remains a key Level 3 metric.

3. Termination of Pregnancy pathway

The TOP pathway was refined at the beginning of 2008 following reports that patients were not consistently attending the correct service at the correct stage of gestation. The new pathway is based on common standards and a common SLA to ensure that performance is maximised and consistent. Feedback from practitioners has been positive since the new pathway was introduced.

4. NST recommendations

The full NST report, including recommendations, is attached at Appendix 1

5. Sexual Health Promotion

<u>Sexual Health promotion initiatives in Bradford & Airedale</u>

- Young Person Drop-ins in Primary Care
- Emergency Contraception available free in pharmacies to under 20s
- Work in schools
- Teenage Information & Advice Centres (TicTacs)
- APAUSE – school-based sex and relationship programme for years 9 and 10

- Looked After Young People's Health Assessment Team
- Information Shop for Young People
- District Condom Distribution Team
- Speakeasy - FPA programme aimed at parents that is being piloted in Bradford and Airedale on behalf of the YPSHPB by the tPCT
- Getting Better With Practice - A 2 hr training programme aimed for practices to look at how each practice can be more 'young person' friendly and improve uptake from young people of Primary Care sexual health services.
- Free pregnancy testing kits Distributed to General Practices with funding from the YPSHPB to reduce the time taken between a positive test and possible referral to a TOPS service
- Work has been carried out by Upfront specifically with South Asian communities. This has led to a successful piece of work and relationship with Community Unity and also with the Council of Mosques who were amongst the first to accept the idea of community based Chlamydia screening.
- African communities from sub Saharan Africa have a high prevalence of HIV and work has taken place to establish credibility and acceptability with the various communities that comprise this larger group. Sexual Health conferences held with this group are to be built upon to encourage *prevention work and testing*. In addition Upfront have supported a number of pilots working with young people from sub Saharan Africa on a range of sexual health issues.
- A training programme delivered to equip the Youth Offending Team with skills, confidence and the means to meet the needs of their client group
- 12 counsellors are signed up and trained to provide neutral support to teenagers that have become pregnant, helping them to make their own choice with regard to their pregnancy.
- A "Health Bus" at Bradford University

6. Service model

Model of services in Bradford & Airedale

The current service model is based on three levels of service:

- **Level 1** – testing
- **Level 2** - those services that provide treatments and partner notification and also initiate tests
- **Level 3** - those services that provide Levels 1 and 2, but also provide testing, treatment and partner notification for those with more complex STI conditions and Human Immunodeficiency Virus (HIV).

Level 1 & 2 services

At Levels 1 and 2, the tPCT Provider Arm's Contraception and Sexual Health (CASH) service provides 31 clinical sessions delivered from 12 venues (Appendix A) over 6 days of the week during the daytime and evening. The venues are predominantly Health Centres but include Local Authority and Youth Service venues worked in partnership. More recently, a number of GP practices have signed up via a standardised Practice Based Commissioning template to deliver services to their own patients at Level 2 and at Levels 1 and 2 to patients registered with other practices with a tariff paid for the Level 2 work. In addition, drop in clinics for young people are provided from eight GP practices offering a range of services from advice to fitting implants and Teenage Information and Advice Centres (TicTacs) are provided in three schools offering signposting and condom distribution with three more to be developed in other hotspot schools. Emergency Hormonal Contraception is available free in 20 pharmacies to young people under 20 years old.

Level 3 – Services delivered by Secondary Care only

Level 3 sexual health services are historically described as those services led by a Genito-Urinary Medicine (GUM) consultant and involve specialised infections management, including co-ordination of partner notification. This level of service is delivered locally by Bradford Hospitals' Department of Infectious Diseases and Sexual Health who undertake a comprehensive range of diagnostic and treatment

services, HIV+ care and follow-up appointments. Level 3 services are provided at The Trinity Centre in the city area of Bradford and at Keighley Health Centre in the Airedale locality. The Trinity Centre is open Monday – Friday with three evening clinics. The Keighley service provides one clinic per week on a Friday morning between 9.15 – 11.30am. It is delivered and reported on by the tPCT Provider Arm, with consultant input contracted from Bradford Hospitals by the tPCT Commissioners.

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

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

General Practice - Delivered as part of the existing PMS/nGMS contract

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

7. Demographics & populations

Bradford

Bradford is a metropolitan district with a population of nearly half a million people. It contains within it a large rural area and comprises of a number of discreet towns, including Bingley, Ilkley, Keighley and Shipley as well as many villages each with their own character, needs and differences as well as the large urban city of Bradford itself, with its high levels of poverty, deprivation and health and social needs. Bradford has many positive attributes but also many areas of severe disadvantage and associated health inequalities.

Age

- Age is a significant factor in the epidemiology of STIs
- STI infection rates are higher prevalent in the 15 – 24 age group
- Age is a defining factor in teenage pregnancy.
- Age profile is not equally spread through the district - City area has the largest % of younger people, followed by South & West, and YCPA the lowest

Deprivation

- Deprivation is often given as a proxy overarching indicator of need
- It is closely correlated with many outcomes, including sexual health
- Deprivation is concentrated in a relatively small number of areas of Bradford
- 43% of the B&A population live in the most deprived 20% of areas in England
- Bradford also has some of the most affluent areas in the country - inequalities exist *within* the city as well as compared with the country as a whole
- STIs and teenage conceptions are strongly associated with deprivation

Ethnicity

Bradford District has a diverse population with the majority of the ethnic minority population in the district residing in the inner city areas of Bradford and Keighley. Minority ethnic communities currently make up approximately 22% of the total current population, and this proportion is forecast to increase to 26% by 2011.

Of particular note are:

- Significantly lower white population cf. E&W
- Significantly higher Asian/Asian British population cf. E&W
- Significantly lower Black/Black British/Caribbean population cf. E&W

Priority populations

Locally the groups with perceived (by clinicians other stakeholders) highest need matches national priorities but data to back up perceptions is limited. These are:

- Injecting drug users (IDU)
- Sex workers
- Men who have sex with men (MSM)
- Asylum seekers / refugee communities
- BME communities
- Deprived groups
- Young people

It is difficult to obtain robust evidence of level and nature of need in these groups.

Older adults

STIs in older adults must not be forgotten – there is a need to develop appropriate service access informed by robust information and support.

- In relation to BME communities, BME women's access to information and advice services, (particularly for those women who want to break with cultural expectations and norms) must be considered.

Asylum seekers and refugees

- Highlighted history of investment in services
- Under pressure as the nature of the incoming population shifts.
- Health care - focused through Bevan House principally
- Entitlement to treatment is a key issue within this population.

Gay Lesbian Bisexual population

Yorkshire Counts report suggested that:

- Estimated 3.6% of population as homosexually active
- The average age in 1998 was 32.9 (range 16-65)
- 7.1% of men were under 20 years old, 31.6% in their 20s, 38.0% in their 30s, 14.7% in their 40s and 8.6% of men were 50 or over.
- The average (median) number of male partners was 4. Roughly a quarter of men (26.3%) had one male partner; and a similar proportion had two, three or four (24.8%); five to twelve (23.8%); or thirteen or more (25.1%).

Recommendations

1. The demographic characteristics of injecting drug users in the district should be explored and analysed in order to inform the Sexual Health Needs Assessment
2. Further work needs to be done to understand the particular demography of working girls, and also epidemiological characteristics such as country of origin.

8. Chlamydia

- Rates of incidence of uncomplicated chlamydial infection have risen steadily since 1996
- This reflects the increase in screening programmes across the PCTs in both hospital GUM settings and the wider community
- The incidence rate of uncomplicated chlamydial infection in Bradford has risen steadily since 1996
- This reflects the increase in screening programmes across the PCTs in both hospital GUM settings and the wider community
- The greatest number of new diagnoses is in the 16-24 age group, reflecting the national target for Chlamydia screening
- It is important to note, however, that the 25-34 age group also shows significant numbers of new diagnoses
- There are also notable numbers of diagnoses at the extremes of age, and the number of diagnoses in the under 16s is a cause of concern
- Females show a consistently higher number of infections than males, although the difference is not particularly marked
- Across Yorkshire and the Humber, The number of diagnoses in females has varied considerably over 2005-2007, with a notable dip in December 2006, however this was not sustained and there is no evidence as yet of a true downward trend in numbers. Numbers of diagnoses in males varied in an unremarkable fashion from 2005-2007, remaining markedly below those for females, in contrast to the gender split in Bradford and Airedale.

Screening

Population screening has been operational in Bradford & Airedale since September 2006 as part of the national programme. The target population of sexually active 15 year olds numbers roughly 11,000.

The programme in Bradford is staffed by 1wte Programme Coordinator, 1wte Health Advisor and 1wte Programme Administrator, with 130 registered sites- 130 (75 screening), working in partnership with GUM and CASH Services

Performance of the programme is addressed in section 17 - Performance

Next steps

- Analysis of socioeconomic breakdown of diagnoses is expected to show socio economic split (analysis not yet complete)

Notes – data issues:

- Clinics include The Trinity Centre and the Keighley Health Centre
- One clinic did not return data for quarters 3,4, 2006
- Numbers of diagnoses were not adjusted for missing clinic data
- % in men who have sex with men (MSM) represents the proportion of the total male diagnoses attributed to MSM
- < 16 population figure includes 13 - 15 age group, 0 - 12 yrs are not included
- Source: KC60 returns, CFI Colindale

Recommendations

1. A “sub-PCT” analysis of both epidemiology of Chlamydia but also screening behaviour should be undertaken.
2. Falling out of this a strategic approach to targeting hard to reach groups should be developed
3. The possibility of expanding awareness raising initiatives should be investigated - e.g. stands/events at the university, letters to young people, “pee in a pot” campaigns
4. Close liaison with performance staff should continue and evolve to develop a real time, reactive approach to changes in incidence and screening behaviour
5. Joint working with other districts to share good practice, particularly with those who have achieved a high coverage

9. Gonorrhoea

New Gonorrhoea diagnoses in Bradford & Airedale

- Numbers of infections peaked in 2002-2004 but, possibly due to effective treatment, screening and health promotion, rates appear to be falling since.
- It should be noted however that one clinic did not return data for quarters 3,4, 2006 and numbers of diagnoses were not adjusted for missing clinic data
- The majority of new diagnoses of Gonorrhoea occur in those aged 16 to 34
- The highest numbers are in the 25 to 34 age group
- The majority of cases occur in men gonorrhoea
- The gap between the two sexes has been closing in recent years
- Rate in Bradford is above Y&H and England.

Gonorrhoea in Yorkshire & the Humber

- There has possibly been a downward trend in male cases however a sustained trend is not observed
- Variation in numbers of female cases appears unremarkable
- There has been a notable increase in cases of “unknown” status since June 2006

Data issues

- Data presented is from KC60 returns
- There are issues relating to data quality and missing data
- In analysis by gender absolute number of infections and % gender split is used, rather than a population rate
- Most of the data is Bradford only – limited comparison with other areas – thus internally consistent to use numbers rather than rates
- Sub-PCT level analysis is possible, but may require new data entry.
- The Health Protection Agency provide data to clinic level, but not below.
- Existing GUM KC60 is not computerised in a way that would allow sub PCT analysis.
- Another possibility is lab data. This is currently being within the tPCT and will be added to the HNA when possible
- Clinics include The Trinity Centre and the Keighley Health Centre
- One clinic did not return data for quarters 3,4, 2006
- Numbers of diagnoses were not adjusted for missing clinic data
- < 16 population figure includes 13 - 15 age group, 0 - 12 yrs are not included

Recommendations

1. The collection and analysis of data should be reviewed with a clear mandate to improve data quality and resolve issues around missing data
2. Discussions should take place with hospital laboratories around receiving data in a real time fashion for addition to the SHNA when possible

10. HIV

1) Data issues

Available data are primarily at Yorkshire & Humber level, supplemented by some local data and overarching national data and evidence, including that sourced from the Health Protection Agency

Direct comparison between local and regional/national trends is complicated by differences in numbers and the effect of this on smoothness of trajectories.

2) Epidemiology

The incidence of new cases of HIV in Bradford has been rising steadily over the last 8 years. This is broadly similar to the regional and national pictures, however these are showing some element of tail-off which has yet to be observed in Bradford - it is possible that this is due to the fact that smoother trends can be observed in the much higher numbers regionally and nationally, and that the Bradford figures are not large enough to demonstrate this. Nonetheless, on current epidemiological evidence, Bradford remains on an upward trajectory of new cases with no evidence of slowdown or plateauing.

There are currently an estimated 245 cases of HIV in Bradford. The number of existing cases of HIV rose in every PCT in Yorkshire and the Humber between 2005 and 2006. The mean percentage increase was 17.7%, however Bradford had the 2nd largest increase at 30.8%, with Leeds at 15.8% and Calderdale at 12.9%

The large majority of existing HIV cases in Bradford are among the 25-54 age group, and in particular the 25 to 44s. 95% of cases are caused by sexual contact, with cases acquired through heterosexual sexual activity outnumbering those acquired through sex between men by 3 to 1. The large majority of cases are seen in Black

African and White people with the former outnumbering the latter by 2 to 1. In Yorkshire and the Humber, male cases have tended to dominate although the split between the sexes is almost even

3) Issues

a) Pregnancy and Antenatal screening

One of the major breakthroughs in controlling the spread of HIV has been in reducing the risk of mother to child transmission. Mother-to-child transmission of HIV is largely preventable where universal antenatal HIV screening is undertaken, exclusive artificial formula feeding is feasible and where there is the provision for anti-retroviral therapy and delivery by caesarean section. The principal risks of transmission are related to maternal plasma viral load, obstetric factors and infant feeding

Around 70 per cent of HIV infections in pregnant women remain undiagnosed at the time of delivery in the UK. There is concern that many women are missing out on risk-reducing interventions, and also on opportunities of more effective treatment for themselves. The risk of mother-to-child transmission of HIV varies between 15% and 20% in non-breastfeeding women in Europe and between 25% and 40% in breastfeeding African populations.

The use of antiretroviral treatments can reduce the rate of perinatal HIV transmission by up to 70 per cent; the risk may be further reduced by certain labour management techniques, and by avoiding breastfeeding (breastfeeding is associated with a two-fold increase in the rate of HIV transmission)

The Department of Health recommends that information about the HIV test is offered to all pregnant women, and that testing is available in all antenatal clinics. The Department of Health also recommends that, in areas of high prevalence, HIV testing should be **offered to all pregnant women** as early as possible in pregnancy - uptake in Bradford and Airedale Hospitals has been high, at **98-99%** over 2006 – 2007, comparing favourably with other hospitals in the Region.

b) Late diagnosis

Late diagnosis has a significant detrimental effect on outcome and survival

- Late diagnosis limits treatment options.
- 35% of diagnoses are too late for effective treatment
- Late diagnosis accounts for 35% of HIV deaths

Local figures are not currently available, however national figures indicate that the proportion of cases diagnosed late has been falling slowly but steadily over the last 10 years.

c) Awareness of diagnosis

1 in 3 people infected with HIV are not aware of their diagnosis. This has significant implications both in terms of being able to treat these people effectively and avoid the complications of late diagnosis, but also in respect of the sexual activity of these people and their potential to unknowingly spread the disease to sexual partners and loved ones.

4) Particular issues for Bradford

a) Working with immigrants

- Awareness of serostatus – imported cases may be unaware of seropositivity
- Prevention/education – promoting and facilitating safe sex
- Helping newly arrived people to access testing and treatment services
- Cultural sensitivity

Recommendations

1. A more developed analysis of incident cases, specifically by route of infection and epidemiological/demographic group gives a potential steer to strategic approaches to tackling the rising incidence of HIV
2. Local analysis should be undertaken to determine the extent of late diagnoses, and in particular the epidemiological characteristics of those in whom late diagnosis is made
3. A bespoke approach to individual high-risk groups such as MSMs should be considered, building on existing work to prevent infection, promote prevention and maximise therapeutic options
4. Access to testing should be widened and directed innovatively to attract those who are at high risk of seropositivity

5. HIV infection is associated with high morbidity and mortality and effective treatment with combination anti-retroviral chemotherapy has the capacity to prolong greatly the quality and length of life. An audit of current treatment interventions should be undertaken in partnership with local clinicians. This will help provide a picture of local prescribing, costs and outcomes, and will help to identify any groups in which compliance with treatment may be an issue
6. Consultation should take place with existing asylum seeker and refugee services to explore issues around awareness, testing and interventions in this group of people.

11. Teenage pregnancy

Strategy

The district has a strategy focusing on young people's sexual health and teenage pregnancy which has targets which sit across services in the district - a 50% reduction in teenage conception rates by 2010, 60% of teenage parents into EET, establish a downward trend in conception rates amongst under16 year olds, to address health inequalities including reducing inequality in rates between the 20% of wards with the highest rate of teenage conception and the average wards by at least 25%. The strategy is a shared responsibility requiring tPCT engagement as one of the key partners in working towards achieving the district's goal.

Data

There are two data sources:

1. Maternity data
2. Terminations data

The tPCT does not receive monthly ONS birth figures which provide mothers age and therefore is reliant on local providers to provide maternity data containing this data

The tPCT is currently not in receipt of complete datasets from all providers and the local picture is based on our two main providers ANHST and BTFTH

Work is ongoing to address this through contracting arrangements with other providers and PCTs

The tPCT does not currently have access to private termination figures from local providers, but this will be raised as an issue through the TOPs Subgroup of the Sexual Health Network

Rates of teenage pregnancy

- In comparison to other spearhead PCTs, the under 18 conception rate in Bradford is one of the lowest, and comparable to Yorkshire & the Humber as a whole
- The Bradford rate has been running at roughly 4-10/1,000 greater than the rate for England & Wales
- For all but one year (2005) the U18 conception rate in Bradford has been falling (a 22% fall over the period) – when compared to other spearhead areas (i.e. those with comparable demographics and socioeconomic characteristics).

Nonetheless, even though rates have gone down there still over 300 teenage pregnancies a year - 456 in 2006.

A degree of caution must be exercised in interpreting falling rates as apparently low rates may mask intra-population differences within the district

There may be cultural influences, for example relating to ethnicity and religious belief, that impact upon the distribution of rates across the district

In comparison to other Yorkshire & Humber Local Authorities, Bradford is achieving well.

Terminations of teenage pregnancy

Currently in Bradford 41% of under 18 conceptions end in termination. This compares to 44% in Yorkshire & the Humber and 48% in England and Wales.

There has been a significant increase in the number of young women choosing to terminate from 1998 to 2006, with a notable upward swing from 2004 to 2006.

The trajectory of the observed trend is similar to other spearhead areas in Yorkshire & the Humber, however the proportion of Bradford/Airedale under 18 conceptions leading to termination is lower than in many other YH spearheads.

Geographical distribution of teenage pregnancy

There are a number of wards where conception rates are notably higher than in other wards. These require targeting, not only to affect the overall figure but also to address health inequalities.

The most up to date ward data is awaited and will identify key areas to focus and extend existing work. In the interim, and until the conception figures are available, the areas with higher teenage conceptions have been estimated by using the proxy measure of births to teenage mothers conceived under the age of 18 years during 2004-6.

Based on currently available information, hotspot wards for Bradford are:

- Tong
- Windhill & Wrose
- Little Horton
- Eccleshill
- Wyke

Areas with *low* rates of teenage births (and therefore estimated conceptions) are:

- Wharfedale
- Ilkley
- Worth Valley
- Craven
- Bingley Rural.

<u>Ward based analysis</u>

- Work is ongoing to develop the use of ward-based data from the Office for National Statistics on under-18 conceptions data for 2003-05.
- ONS plan to release under-16 LA conception statistics for 2006 at the end of 2008 when conception data for 2006 are finalised.

Teenage pregnancy and deprivation

- 38% of all teenage pregnancies are in the most deprived quintile (quintile 1)
- 72% of all teenage pregnancies are in the two most deprived quintiles (quintiles 1 and 2)

In order to understand this distribution and how it relates to strategic approaches to tackling teenage pregnancy, it will be necessary to further explore cultural, religious and ethnic issues in sexual health

Deprivation quintiles are not controlled for ethnicity and given Bradford's large minority ethnic population, it may be misleading to conclude that there is necessarily a simple or robust causal relationship between teenage pregnancy and deprivation
Higher rates of teenage pregnancy are largely (though not completely) concentrated in urban areas where the population is:

- Younger
- More deprived

The City Centre of Bradford and Keighley Centre show particularly high rates
Rates are strikingly lower in the Northern part of the district and the Aire Valley (with the exception of the Keighley area)
In order to understand this distribution and how it relates to strategic approaches to tackling teenage pregnancy, it will be necessary to further explore cultural, religious and ethnic issues in sexual health
Deprivation quintiles are not controlled for ethnicity and given Bradford's large minority ethnic population, it may be misleading to conclude that there is necessarily a simple or robust causal relationship between teenage pregnancy and deprivation

Recommendations

1. Further sub PCT level analysis of the epidemiology of teenage conceptions should be undertaken, specifically considering:
    a) % of teenage conceptions leading to TOP by socio economic classification
    b) Teenage pregnancy rates by ethnicity
2. Complete datasets should be made available from all providers including those in the independent sector
3. A comprehensive, tiered, accredited **model for training** should be developed across the District.
4. Training should be audited for quality, developing into audit of the work of the professionals that have undertaken training
5. The broader workforce around teenage pregnancy should be developed to provide a workforce that has the basic core skills, knowledge and confidence to work with young people to have open and honest dialogue around sex that is embedded into their normal working structures, with:
    a) **Consistent messages**
    b) An understanding of broad, holistic approach to SRE

6. A work programme to understand the views and opinions of service users should be developed
7. Clear referral pathways should be developed, embedded and effectively disseminated so that all professionals are aware of, and use, a **consistent approach to referral**
8. Every young person should receive comprehensive, high quality, consistent SRE that is embedded into key services such schools, youth services, social care services and services that work with vulnerable groups and young offenders regardless of age, race, disability etc
9. A district wide, coordinated and consistent approach to media and marketing should be developed and implemented. This should include leaflets, electronic resources and websites, and should that ensure wide and systematic dissemination of information to:
    a) Young people
    b) Parents and guardians
    c) Communities
    d) Professionals
10. Every parent and guardian should receive information about talking to their children about sex and relationships education, and have the opportunity to take part in a programme that develops their skills and knowledge around talking to their children about SRE

12. Termination of Pregnancy

Despite a well regarded TOPS pathway and improvements in service and access, terminations in Bradford are lower than England & Wales, West Yorkshire and many other Local Authorities. Socio-economic factors and aspirations can play a large role in sexual health, particularly teenage conceptions, and many Bradford residents have lower levels of both. Bradford has a disproportionately low take up of TOP services which may indicate a higher proportion of communities for whom early parenthood is regarded as normal.

Data issues

Local monitoring still remains inconsistent. There is a need for clarity in relation to the number of terminations being carried out in the independent sector

Until we can be assured that we have accurate and timely data to support local monitoring the figures presented must be used with caution.

TOPs in Bradford & Airedale

Numbers have increased over the last 5 years, however the rise has not been sustained year on year and may represent a common cause/unremarkable variation

Current performance shows an increase in terminations on the 2006 position of 5.3%. B&AtPCT performance may be inconsistent with regional and national trends although small numbers make it difficult to draw robust conclusions in this respect

TOPs under 10 weeks

Current DoH performance data shows a 2007 (Calendar year) position against the **70%** target of TOPs procedures at under 10 weeks as **53.6%** compared to an SHA average of **61.4%** and an England average of **68.3%**

Currently we are unable to monitor this target locally due to gaps in the provision of data from our local NHS Trust. Discussions are ongoing to resolve this

Medical terminations

Medical terminations are currently at ~50% of national rates

The opportunity to choose a medical rather than surgical termination is being monitored locally.

Terminations by age group

Most terminations occur in the 20-29 age group, and all age groups show a rise over the period 2003-07

Terminations by Ethnic Group

The majority take place in white British women

The largest minority ethnic group is Pakistani

Ethnicity is unknown in a large proportion

Termination of Pregnancy in Under 18s

Currently in Bradford 41% of under 18 conceptions end in termination. This compares to 44% in Yorkshire & the Humber and 48% in England and Wales.

There has been a significant increase in the number of young women choosing to terminate from 1998 to 2006.

A notable upward swing from 2004 to 2006 has brought Bradford broadly into line with the Y&H average.

This increase in termination rates should be considered alongside the reduction in under 18 conceptions that has occurred over the same time period. The trajectory of the observed trend is similar to other spearhead areas in Yorkshire & the Humber, however the proportion of Bradford/Airedale under 18 conceptions leading to termination is lower than in many other YH spearheads.

Repeat TOPs in under 19 yr olds

Bradford & Airedale shows the 3rd highest rate of all recorded PCTs in Y&H and is notably higher than England level

Note: Up to 70% of young people leaving TOP do so with LARC in place

Recommendations

1. Continued monitoring of the observed trend is required, as a continued upward trajectory may suggest a shift in social /cultural norms and/or might be an indication of better services and a better functioning TOPS pathway.
2. A more detailed analysis of numbers of terminations is required- particularly for under 18s - from all providers in the district compared with live birth rates over the past few years, with subgroup analyses including age bands and ethnicity. This analysis may both direct future work, e.g. social marketing approaches, or present conclusions as to whether recent service changes to improve access to termination have been successful
3. Potential influences of population and demographic characteristics within the district also need to be explored further.
4. Further work should be undertaken to ensure that data on medical terminations reflect local practice and all local providers
5. Work relating to terminations in under 18s should be closely co-ordinated with teenage pregnancy workstreams and the BeHealthy partnership
6. Efforts should be made to increase the recording of ethnicity in women undergoing termination f pregnancy

13. Service utilisation

Contraceptive and Sexual Health (CASH) services

- The Bradford and Airedale CASH has been developed by Bradford and Airedale Teaching PCT in partnership with Bradford Teaching Hospitals Foundation Trust
- A significant amount of new funding was invested in developing the new service.
- It brings together all the services provided by the tPCT – such as contraception, cervical smear teats, pregnancy testing and sexual health screening - and more specialised services provided by Bradford hospitals' genitourinary medicine (GUM) clinic
- Under the new service, people have the guarantee of being offered an appointment with a health professional within 48 hours, if they need to see one
- A team of NHS staff takes calls from 8am to 6pm, Monday to Friday, so that people don't have to leave a message or phone back at a later stage.
- Callers are asked some questions to help the team decide what type of help they need – this is to make sure they get the right treatment as quickly as possible. If an appointment is needed this may be at one of several CASH clinics around the district, which are closer to people's homes, or at the hospitals' GUM clinic at Trinity Road, Bradford
- The service is open to everyone, regardless of age, marital status or sexuality and GP referrals are not needed. All aspects of the service are free, straightforward and strictly confidential, and the staff are supportive and understanding.
- The tPCT worked closely with a genitourinary medicine consultant from Bradford hospitals, to help train call operators and develop a system for carrying out assessments over the phone. This partnership approach means better, joined up services that are tailored to people's individual needs
- Extra funding for local sexual health services also means more nurses will be available in CASH clinics throughout the district. In turn, they will be able to see more people and help make access even quicker and easier.

CASH activity

- CASH contacts show a largely unremarkable pattern of variation over the period April 2007 to February 2008. There was a notable dip in December which was not sustained and suggests a transitional/seasonal effect
- CASH contacts analysed by level, for both levels, show a largely unremarkable pattern of variation over the period April 2007 to February 2008
- Horton Park is the busiest of the CASH clinics, attracting over a third of total activity. Barkerend, Eccleshill, Kensington St Westbourne Green and the Young People Information Centre also attract a large % of overall activity
- Overall, 40% of contacts are in the 25-35 age group
- A third of contacts are in the 15 – 24 group
- One in five contacts are with those in the 35 to 44 age group
- The Young Person facilities receive a majority of under 25s as expected
- Eccleshill and Holmewood have notably higher proportions of 16-24 year olds
- Hillside Bridge and Kensington Bridge see a largest % of 25-35 year olds
- The vast majority of contacts are in females
- The most common interventions are:
    1. Latex condoms
    2. Health surveillance
    3. Contraceptive advice
    4. Pregnancy tests
    5. Oral contraceptive
- Level 1 activities are roughly 7 times more common than level 2 activities among females, whereas they are 11.5 times more common in males
- The dominance of Level 1 activity is significantly greater at Western European Clinic, Holmewood and both Young Persons' clinics
- The dominance of Level 1 activity is significantly greater at ages 0-15, with higher ratios also seen in 16-24 and 55-64 age bands.
- Level 1 interventions outweigh level 2 interventions by over seven to one
- For level 2 services, Intrauterine contraception methods account for over 40% of activity
- Control chart analysis of these data suggest that variation in family planning attendances up to 2004/05 has been unremarkable and within normal expectation, however the jump to 26,606 in 2005/06 was statistically significant and suggests a "special" underlying cause.

Contraception in primary care

- The rate of prescribing of emergency contraception is highest in the Bradford City area
- Oral contraception is the most commonly used form of contraception in Primary Care throughout the district
- Long-acting reversible contraception (LARC) constitutes roughly 10 to 25% of prescribing depending on area, appearing to be highest in the Yorkshire Alliance/North of Bradford City area.
- Rates of prescribing of oral contraceptives are concentrated in urban areas, particularly Keighley, Yorkshire Alliance/North Bradford area and Southwest Bradford.
- The rate of prescribing of the oral contraceptive appears relatively small in the Bradford City Centre
- Rates of prescribing of emergency contraception are concentrated in urban areas, particularly Keighley, Yorkshire Alliance/North Bradford area and Southwest Bradford.
- There is a notable clustering of high emergency contraception prescribing rates in Bradford City Centre (Note: This information does not include over the counter emergency hormonal contraception)
- Rates of prescribing of LARC are concentrated in urban areas, particularly Keighley, Yorkshire Alliance/North Bradford area and Southwest Bradford.
- The rate of prescribing of LARC appears relatively small in Bradford City Centre
- CityCare clearly has a far lower rate of prescription of LARC than the other three alliances
- Yorkshire alliance has the highest rate of prescription of LARC
- A relationship between deprivation profile of practice and the rate of LARC prescription at practice level is observed in Bradford & Airedale, however the nature of this relationship is unclear and it should be treated with caution until further analysis has taken place.

GUM activity

- GUM activity has risen steadily since 1996, with a notable upswing from 2002
- Male and female GUM activity show broadly comparable trends, although male activity has been higher than female since 2003
- There are between 3,000 and 4,000 new GUM patients every year
- There are between 3,500 and 4,000 new GUM diagnoses made every year

Recommendations

A number of sub-PCT level analyses need to be developed for addition to the SHNA

1. Are access and utilisation broad enough to include the socio-economic groups most likely to need these services?
2. Are services in the right place at the right times delivered to the patient groups, as they require, so that they are more likely to use them
3. Are contraception clinics are being overwhelmed by people wanting STI treatment - if so do we need more and where?
4. Age group attendance by clinic
5. Further data from contact centre database
6. Utilisation of level 1 2 3 by ethnicity (if coded), deprivation / geography
7. Utilisation of CASH by geography / deprivation / ethnicity / age

14. Training

- Over 200 practitioners have attended the Sexually Transmitted Infection Foundation (STIF) course, which provides multidisciplinary training in the attitudes, skills, and knowledge required for the prevention and management of STIs.
- Additional training in coil and implant fitting is undertaken on an 'as and when needed' basis by GPs with Faculty of Sexual and Reproductive Healthcare qualification, including the tPCT's Clinical Lead for Women's and Sexual Health. This has resulted in a wealth of well-trained clinicians in our community as recommended by the NICE Clinical Guideline on the increase use of Long Acting Reversible Contraception by improved provision by training of providers and improving signposting.
- A PBC business case for GP practice delivery of L1 and L2 services was launched in September 2007 and included stringent accreditation measures.

- Training and governance for accreditation at Level 2 was contracted for with Bradford Hospitals in 2007/08 on a recurrent contract
- Due to the maternity leave of two GUM consultants, accessing education and training at Level 2 has becomes increasingly difficult.
- 15 practitioners have completed their accreditation and 52 remain on the waiting list. To address this the tPCT's clinical lead and commissioner have been re-thinking accreditation for community sexual health service provision in general practice and CASH services.

Training and accreditation development for sexual health provision is proposed as:
Level 1 – already a core service for primary care and a level at which CASH staff are capable of providing now with minimal training
Level 1plus – additional training and qualification to a standard which allows screening of asymptomatic men, facilitated by the tPCT
Level 2 – training and accreditation by the GUM service to test symptomatic men and test and treat positive results in both men and women

Level 1+
Screening of men is currently seen as a Level 2 service but, as testing can now be done by a urine sample for Chlamydia and Gonorrhoea and a blood test for HIV and Syphilis, it could be done within a Level 1 service with patients subsequently requiring treatment and contact tracing being referred to Health Advisors based in The Trinity Centre and CASH service. This has been implemented successfully in Salford and in Hull where screening is undertaken by Health Care Assistants. This modification would allow maximisation of screening in the community directing demand away from Level 3 settings.

For those wishing to continue on to Level 2 accreditation, implementing Level 1plus will mean they can open a service almost immediately (accreditation is based on completion of a STIF course and a series of best practice reading materials). Practices could then be listed with the Contact Centre for asymptomatic men and women prior to attending further training, which will continue for those practices who want to offer a complete service. This remains subject to agreement by the medical and contracting directorates who have been working closely with commissioners.

This revised accreditation programme has the added advantage of keeping practices engaged while waiting for training, offering more choice for patients by increasing capacity in the community, reducing costs of services but still enables certain practices to offer level 2. Most GPs and primary care and CASH nurses could adopt this standard very quickly with additional training sessions delivered for those who feel they need more educational input.

Recommendations

1. Training and accreditation development for sexual health provision is proposed as:
    a. Level 1 – already a core service for primary care and a level at which CASH staff are capable of providing now with minimal training
    b. Level 1plus – additional training and qualification to a standard which allows screening of asymptomatic men, facilitated by the tPCT
    c. Level 2 – training and accreditation by the GUM service to test symptomatic men and test and treat positive results in both men and women
2. Teenage pregnancy
    a. A comprehensive, tiered, accredited model for training should be developed across the District.
    b. Training should be audited for quality, developing into audit of the work of the professionals that have undertaken training
    c. The broader workforce around teenage pregnancy should be developed to provide a workforce that has the basic core skills, knowledge and confidence to work with young people to have open and honest dialogue around sex that is embedded into their normal working structures, with:
        i. Consistent messages
        ii. An understanding of broad, holistic approach to SRE

15. User involvement and perspective

The recent Joint Area Review highlighted a number of key developments in sexual health services resulting from young peoples' perspectives in Bradford & Airedale, including:

- Young people's reluctance to attend GUM clinic appointments has led to GUM services being delivered in one place at the Information Shop for Young People via CASH
- Young people have also influenced changes to provision of counselling re TOP for undecided young people.
- A young persons' conference of YP led to increased provision of drop-ins at GPs, the development of confidentiality posters and an increase in media use for services and prevention messages.
- Information produced is updated based on evaluations or inputs by young people.

In addition:

- Research has shown considerable impact of media activity on young people, with 72% asked having seen or heard adverts from local safe sex campaigns on radio and bus. Most of the young people described the campaign as `helpful' or `interesting'.
- A local survey shows young people's reasons for first sex includes 'being ready for it' and 'love and commitment' but 'peer pressure' is an important third component with 'opportunity' and 'alcohol' also important.
- Young people have expressed a desire for more school nurses and for sex education to be made more relevant. This has been factored into future planning

Elsewhere, Use of surveys, meta-planning and focus groups is helping to shape services, research includes:

- The sexual health education needs of Asian young people attending school
- South Asians' Sexual Health
- Service needs of Asian young women,
- HIV related needs of people from sub-Saharan countries
-

Recommendations

1. User involvement should be expanded and developed with particular attention to BME groups where culture-specific issues should be considered pro-actively and sensitively.
2. Structures to facilitate user involvement should be incorporated into existing and developing service provision.
3. Commissioners and frontline staff should be responsive to patients
4. Provision of services to facilitate user involvement must be within allowed resources
5. Some services have achieved a great deal – processes to share good practice should be developed

16. Programme budgeting

Programme budgeting

Programme budgeting provides a retrospective appraisal of the allocation of resources broken down into "programmes" (e.g. sexual health, cardiovascular disease, musculoskeletal disease etc.) with a view to influencing and tracking future expenditure to maximise health outcomes.

Programme budgeting helps us understand where the money is going (which can then be compared to population characteristics and need) and relating this to the outcomes that result from investment.

Programme budgeting is potentially powerful tool in identifying and characterising inequitable allocation of resources, and thereby can help to tackle inequalities

Bradford & Airedale

Analysis of FHS prescription expenditure for genital tract diagnoses as thousand pounds per 100,000 population, used as a proxy measure for overall Sexual Health spend, shows that:

- The Airedale and Bradford North areas fall into a high spend group at £108,500-£115,400 per 100,000 population
- The Bradford South and West area shows a relatively high spend at £100,300 – £108,400 per 100,000 population
- The Bradford City area shows a lower spend of £90,600 – £98,000, roughly in line with the national average

The most striking observation is that Bradford City has the lowest spend, where it has both the most deprived and the youngest population of all the areas within the district. This is likely to be a manifestation of the Inverse Care Law (Tudor-Hart) a ubiquitous phenomenon in health service allocation and access behaviour, whereby those in greatest need receive least treatment and vice versa.

Programme Budget Bradford & Airedale 2005/6 = £5.3million

- Secondary Care GUM Outpatient Services (£3.23m)
  - Inc HIV block contract and drugs
- Community Provider Services (£1.22m)
  - CASH, Family Planning, Chlamydia, SEHAT
- Health Inequalities (£840k)
  - Choosing Health, APAUSE, Condoms, Bus etc.
- Prescribing - Antibiotics, LARC

Recommendations

1. Programme budgeting should be developed to be the prime strategic lever for addressing inequalities elements of the SHNA
2. A bespoke analysis should be undertaken to break down spend by PCT in more detail. This should include:
   a. Levels of expenditure.
   b. Outcomes achieved
   c. PCT level
   d. Alliance level
   e. Practice level

17. Performance

1. GUM access - offered
    - The Contact Centre Appointment System continues to deliver the 100% target for Aug 2008 for all locally ***delivered*** GUM Level 3 services
    - B&AtPCT Commissioner performance also demonstrates 99.2% for July 2008 success a small dip in performance on the May 2008 position of 100%. This is equal to the Y&H average 99.2% and above the England average 99%
    - Despite a slight recovery against the 95% seen target there is still a circa 10% shortfall for Bradford & Airedale as a commissioner 86.1% and a district provider 87.40% for July 08. This performance is above England 85.8% but slightly below the Y&H average 86.9% for July 08

2. GUM access - seen
    - A proposed 80% seen target for GUM is to be set as a minimum standard for those PCTs not yet reaching 80%. Bradford & Airedale are performing above this between 85-95% and therefore there is an expectation of sustained performance at this level
    - Currently, the Trinity Centre is achieving 91% and Craven GUM clinic 36%
    - Performance at Keighley Health Centre continues to fall - August 2008 reported performance against the Seen target was just 13.6%

3. Chlamydia screening
- Performance is currently running at 3.13% vs. a target to date of 7%
- 73% of screens are in females, 27% males
- Positive screens are currently 9.3% of total screens
- Q1 performance was 1.83% vs. a national average of 1.80% and a Y&H average of 2.00%

4. Teenage pregnancy

An amended trajectory has been submitted to the DoH. The PCT is waiting confirmation that this lower trajectory is acceptable. In the interim, performance against a 50% reduction on the 1998 baseline continues to be monitored.

5. Termination of Pregnancy

- The current target is that 70% of NHS funded terminations should take place before 10 weeks gestation
- Current DoH performance data shows a 2007 (Calendar year) position against the 70% target of TOPs procedures at under 10 weeks as **53.6%** compared to an SHA average of **61.4%** and an England average of **68.3%**
- Currently we are unable to monitor this target locally due to gaps in the provision of data from our local NHS Trust. Discussions are ongoing to resolve this
- Local monitoring still remains inconsistent. There is a need for clarity in relation to the number of terminations being carried out in the independent sector
- Until we can be assured that we have accurate and timely data to support local monitoring the figures presented must be used with caution.

6. Medical terminations

    - Medical terminations are currently at ~50% of national rates
    - The opportunity to choose a medical rather than surgical termination is being monitored locally.

18. Agreed programmes of work under Bradford & Airedale Sexual Health Network, January 2009

1. Chlamydia: A "sub-PCT" analysis of both epidemiology of Chlamydia but also screening behaviour.
2. Gonorrhoea: Review of the collection and analysis of data to improve data quality and resolve issues around missing data, with discussions taking place with hospital laboratories around receiving data in a real time fashion for addition to the SHNA.
3. HIV: Widening of access to testing, directed innovatively to attract those who are at high risk of seropositivity
4. Teenage Pregnancy: Further sub-PCT level analysis of the epidemiology of teenage conceptions, specifically considering:
    i. % of teenage conceptions leading to TOP by socio economic classification
    ii. Teenage pregnancy rates by ethnicity
5. Training: Training and accreditation development for sexual health provision structured as:
    i. Level 1 – already a core service for primary care and a level at which CASH staff are capable of providing now with minimal training
    ii. Level 1plus – additional training and qualification to a standard which allows screening of asymptomatic men, facilitated by the tPCT
    iii. Level 2 – training and accreditation by the GUM service to test symptomatic men and test and treat positive results in both men and women
6. User involvement: Expansion and development with particular attention to BME groups where culture-specific issues should be considered pro-actively and sensitively.