



## **Review of sexual health services in the North West**

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## List of abbreviations used in the report

AIDS	Acquired immune deficiency syndrome
C&L	Cumbria & Lancashire
C&M	Cheshire & Merseyside
CDSC	Communicable Disease Surveillance Centre
CPH	Centre for Public Health
DoH	Department of Health
GHT	George House Trust
GM	Greater Manchester
GP	General practitioner
GUM	Genitourinary medicine
HA	Health authority
HIV	Human immunodeficiency virus
LGF	Lesbian and Gay Foundation
NHS	National Health Service
NWPHO	North West Public Health Observatory
PCT	Primary care trust
PGD	Patient group directions
RCP	Royal College of Physicians
SHA	Strategic health authority
STI	Sexually transmitted infection
TOP	Termination of pregnancy
TP	Teenage pregnancy
WTE	Whole-time equivalent

## 1 Introduction

This review of sexual health services in the North West has been undertaken to provide a baseline of service provision for 2002. The information will assist primary care trusts (PCTs) and strategic health authorities (SHAs) in the implementation of the National Sexual Health/HIV Strategy and the Teenage Pregnancy Strategy. The review has also been used to produce a Regional Framework for Sexual Health/HIV, which identifies the priority areas for consideration by primary care trusts, strategic health authorities and those for implementation by the Regional Sexual Health Task Group.

Within the PCT local delivery plans, reduction in conceptions in those aged under 18 is an identified inequalities indicator. PCTs are required to show how they will contribute towards achieving the 15% reduction in the number of conceptions in those aged less than 18 years by 2004<sup>1</sup> and what the trajectory is towards the national target of a 50% reduction by 2010. This review integrates outcomes from teenage pregnancy national audits on contraceptive services in primary care, general practice and community contraceptive services with data collected specifically for the review, in order to provide an indication of the position of services to implement both strategies.

PCTs also need to demonstrate how they will modernise and improve access to sexual health services, working towards the national goals of reducing newly acquired HIV infections and gonorrhoea infections by 25% by 2007. In addition, PCTs should ensure that women who meet the legal requirement have access to an abortion within three weeks of the first appointment with the GP or other referring doctor by 2005.

SHAs and the Health Protection Agency will contribute towards the implementation of both national strategies through performance improvement and management, advice and support on surveillance and health protection.

To achieve the necessary changes in access to and provision of sexual health services the emphasis will need to be on effective commissioning arrangements, reviewing and realigning systems to achieve necessary outputs, development and auditing of both service and clinical standards and establishment of managed clinical networks. The focus needs to be clearly on the population and patient needs and where appropriate, the development of integrated services. Strengthening the role of primary care in sexual health is crucial and having clear patient pathways across both primary and secondary care, inclusive of the voluntary sector, will provide more cohesive services.

The national sexual health/HIV strategy highlights that sexual ill health falls unequally across the population, with women, gay men, teenagers, young adults and ethnic minorities groups disproportionately vulnerable. The North West has the highest incidence of sexually transmitted infections outside London, the

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<sup>1</sup> Department of Health (2000) The NHS plan: a plan for investment; a plan for reform. HMSO, July 2000. Available online: <http://www.doh.gov.uk/nhsplan/nhsplan.pdf>

increase in new diagnoses of HIV infection is a concern and the outbreaks of syphilis are clear indications that systems need to change. Whilst, overall the rates of conceptions in those aged less than 18 years are falling in the North West, they are still higher than the national average and there are authorities where rates are significantly higher.

The Department of Health required a baseline review and data collection on sexual health and HIV for implementation of the sexual health and HIV strategy in 2001. This regional review should be used to compliment and verify the baseline reviews.

### **1.1 National Strategy for Sexual Health and HIV**

The National Strategy for Sexual Health and HIV was published in July 2001 and aims to:

- Reduce the transmission of HIV and STIs, with a national goal of achieving a 25% reduction in the number of newly acquired HIV infections and gonorrhoea infections by 2007
- Reduce the prevalence of undiagnosed HIV and STIs – in particular, by setting a national standard that all GUM services should offer an HIV test on clients' first screening, and working towards shorter waiting times in GUM
- Reduce unintended pregnancy rates – including setting a national standard that women meeting the legal requirements have access to an abortion within three weeks of their appointment with the referring doctor
- Improve health and social care for people living with HIV
- Reduce the stigma associated with HIV and STIs

These targets will be achieved by proposals to improve people's access to sexual health services and access to information on sexual health. The national strategy document also highlights that:

- The distribution of sexual ill health falls unequally across the population, with women, gay men, teenagers, young adults and black and ethnic minority groups disproportionately vulnerable.
- Poverty and social exclusion are strongly linked to sexually transmitted infections, abortions and teenage conceptions.
- There are significant inequities in service provision, as with access to genitourinary medicine clinics where delays for urgent appointments have been unacceptably high in regions like the North West.

Local implementation of the strategy is the responsibility of PCTs, each of which has been required to appoint a sexual health lead. Strategic health authorities are given the task of performance managing PCTs. Performance indicator sets are being developed for PCTs. These were initially conceived to include measures of undiagnosed HIV, newly acquired HIV, gonorrhoea infections and offer and uptake of hepatitis B vaccine. However, not all these data are available at PCT level (see section 2, Epidemiological trends and service utilisation).

In order to achieve the aims of the strategy, improvements in services are planned. These include a national audit of genitourinary medicine (GUM) waiting times and the development of a waiting times performance indicator and rolling out the chlamydia screening programme. A key component of the changes in services is that sexual health services are to be divided into three levels, with increasing involvement of general practice at level one.

Level one services are basic services provided within general practice, level two comprises intermediate services provided by primary care services with specific extra training and support. Level three care is specialist services. The details of levels of service elements can be found in the Commissioning Toolkit for sexual health<sup>2</sup>.

- Level one is a general service level (e.g. sexually transmitted infection testing for women, contraceptive services), which will be provided by primary health care teams.
- Level two is an intermediate level service (e.g. testing and treating sexually transmitted infections), which may be provided by community based primary care teams with a special interest in sexual health and by genitourinary medicine clinics.
- Level three service is for the more specialist aspects of care (e.g. specialist infections management, including co-ordination of partner notification), which need to be provided by specialist clinical teams across more than one primary care trust or group.

## **1.2 Organisation of report**

In the main body of this Summary document, survey data, along with primary and secondary data from other sources are presented sub regionally by strategic health authority (SHA).

- Section 2 concerns epidemiological trends and service workload in sexual health services across the North West and includes examination of HIV/AIDS, STI, and reproductive health data.
- Section 3 provides an overview of the characteristics of services, which includes accommodation and funding issues.
- Section 4 focuses on access, with particular emphasis on spatial and temporal issues.
- Section 5 highlights staffing and training, with particular emphasis on service capacity issues.
- Section 6 looks at data collection undertaken by sexual health services.
- Section 7 pulls the findings from the review into a general summary and presents interim conclusions.

The remainder of this introduction to the summary document briefly sets out the methods used to generate the review data.

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<sup>2</sup> Department of Health (2003) Effective commissioning of sexual health and HIV services: a sexual health and HIV commissioning toolkit for primary care trusts and local authorities. Available online: [http://www.doh.gov.uk/sexualhealthandhiv/pdfs/commissioning\\_toolkit.pdf](http://www.doh.gov.uk/sexualhealthandhiv/pdfs/commissioning_toolkit.pdf)

## 1.3 Methods

### 1.3.1 Epidemiology and service use data

Reviews of the epidemiology draw upon data from CDSC North West, the Centre for Public Health HIV Monitoring Unit and the Office for National Statistics. The results are presented by strategic health authority.

### 1.3.2 HIV/AIDS services

The North West HIV/AIDS Monitoring Unit collects, collates and disseminates data on the treatment and care of HIV positive individuals in the North West. The data collected form part of the national dataset - Survey of Prevalent Diagnosed HIV Infections (SOPHID). Data are collected from statutory treatment centres, HIV/AIDS voluntary organisations across the region and relevant drug specialist services. In 2001, data collection included North Cumbria (as part of the revised regional structure) and information concerning home visits. Data on HIV are drawn from the annual report of the HIV/AIDS Monitoring Unit<sup>3</sup>.

### 1.3.3 Genitourinary medicine services

Data on genitourinary medicine services (GUM) were gathered through an administered questionnaire survey of all 34 GUM services in the North West, devised and agreed by the GUM Services Working Group. The questionnaire consisted of both open and closed questions and was piloted at two services to ensure reliability and validity of the questions. The survey began in September 2001 and was conducted over a ten-week period. Findings were collated then returned to individual GUM services in March 2002 for validation. A full report and an executive summary were published in 2002<sup>4</sup>.

### 1.3.4 General practice services

Data on general practice services were derived from three sources. Firstly, a random sample of 245 of the 1512 GPs in the North West Region were surveyed using a self-administered questionnaire designed specifically for this review, which covered current sexual health services and opinions regarding greater GP involvement in the future. The questionnaire was piloted in two general practices to ensure validity and reliability. Clinical Governance Leads from each PCT were asked to assist with follow up of the selected GPs within their PCT. General practices that had not returned the questionnaire within two weeks were contacted by telephone and a copy of the questionnaire sent again on request. In total, 73 questionnaires were returned, yielding an overall return rate of 30%.

The second source of data was a survey carried out as part of the Teenage Pregnancy Audit. Every GP in England was sent a questionnaire on contraceptive services for young people. Clinical governance leads in each primary care trust assisted in encouraging GPs to return questionnaires. This strategy led to a

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<sup>3</sup> Cook PA, Towle A, Rimmer P, Mitchell S, Syed Q, Bellis M (2002) HIV and AIDS in the North West of England 2001, Liverpool John Moores University, Centre for Public Health. ISBN 1-902051-39-4

<sup>4</sup> Cosgrove P, Robin A, Syed S (2002) Review of genitourinary medicine services in the North West of England. Centre for Public Health, Liverpool John Moores University

relatively high return rate of 41% (615 out of the 1512 North West GP practices). There were 209 returns from Cheshire & Merseyside, 102 from Cumbria & Lancashire and 304 from Greater Manchester. The data were analysed by the Centre for Public Health for the purposes of this review. National data were analysed by the National Evaluation Team of Teenage Pregnancy Strategy.

The final source of data was a survey carried out by George House Trust (GHT), who sent out a questionnaire to every GP in the UK<sup>5</sup>. GHT supplied the Centre for Public Health with the raw data for the North West for analysis for this report. Of the total 1330 North West GP practices identified by GHT, 192 were returned, yielding a return rate of 14%.

### 1.3.5 Voluntary agencies

Questionnaires were disseminated on the 18<sup>th</sup> October 2002 at a meeting with sexual health/HIV voluntary services and posted to those agencies that did not attend. Of the 18 questionnaires given out 13 were returned. Five of these were Cheshire & Merseyside agencies, two were Cumbria & Lancashire agencies and six were Greater Manchester agencies.

### 1.3.6 Reproductive health services

#### 1.3.6.1 Contraceptive services

A survey of contraception and advice services for young people was carried out as part of the Teenage Pregnancy Strategy. Each provider in the country was sent a self-administered questionnaire on services for young people. The 171 returns for the North West are analysed for this review, with findings split into specialist young people's contraceptive services (62 services) and community contraceptive services (109 services). The national data will be reported on by the National Evaluation Team of the Teenage Pregnancy Strategy

#### 1.3.6.2 Condom distribution schemes

As part of the North West Review of sexual health services, all 42 primary care trusts were asked to complete by email a questionnaire on condom distribution schemes. The analysis here is based on the 21 questionnaires that were returned, a response rate of 50%.

#### 1.3.6.3 Emergency contraception services

Regional data on emergency hormonal contraception provided by community contraceptive services are taken from KT31 returns. These are supplemented by data from operational Community Pharmacy schemes. The data do not include prescribing of emergency hormonal contraception by general practice or IUD provision.

#### 1.3.6.4 Termination of pregnancy services

Data are taken from a survey, undertaken specifically for this review by the Centre for Public Health, using a self-administered questionnaire sent out to all 32 licensed termination of pregnancy services in the North West. The questionnaire

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<sup>5</sup> George House Trust (2002) HIV: what role for the GP? Insight Briefing 01

was piloted in one statutory and one non-statutory service to ensure validity and reliability. Services that had not returned the questionnaire within two weeks were contacted by telephone and a copy of the questionnaire sent again on request. Of the 32 services, 20 statutory (out of 25) and five non-statutory (out of 7) responded (a response rate of 78%).

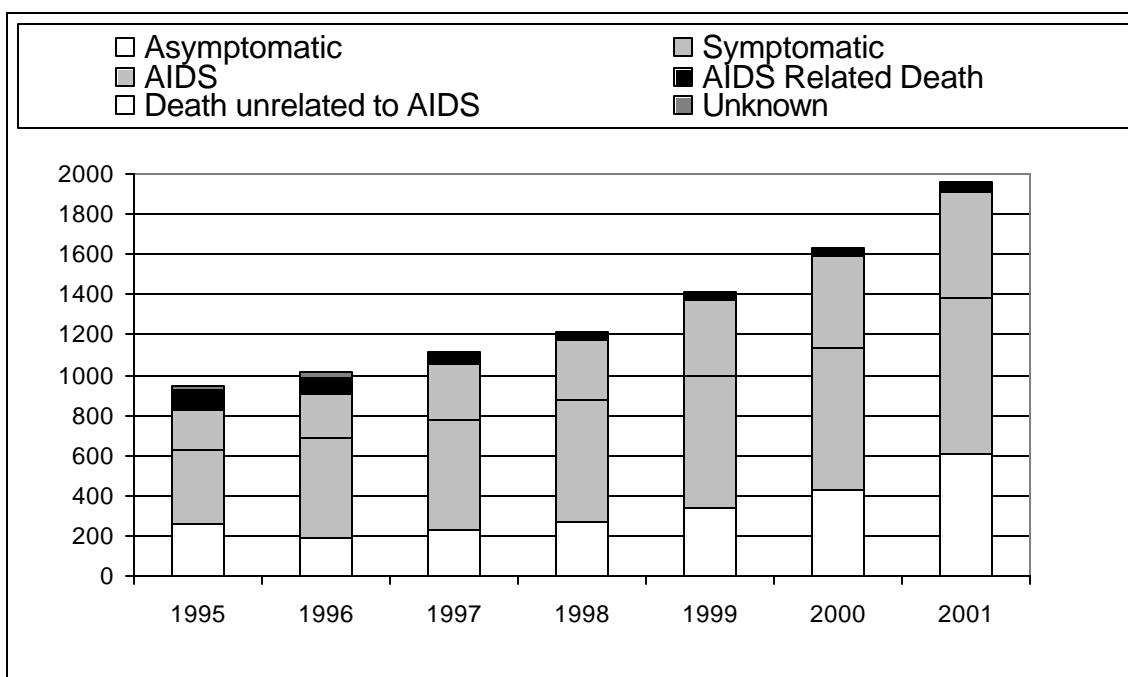
## 2 Epidemiological trends and service utilisation

### 2.1 HIV epidemiology

In the North West, by the end of 2001, a cumulative total of 3,119 HIV infections had been reported to the Communicable Diseases Surveillance Centre at PHLS, including 394 new cases during 2001. There were 16 newly diagnosed AIDS cases in the North West in 2001, bringing the cumulative total to 1,053, 6% of the total number of AIDS cases reported in the UK<sup>6</sup>.

The pattern of exposure to HIV among people with AIDS in the North West is broadly similar to that of the UK, with the majority of people living with AIDS having been infected by homosexual sex. However, the North West has a lower proportion of people infected with HIV via heterosexual sex. The proportion of individuals exposed through the receipt of contaminated blood or blood product is approximately twice the national average for both HIV and AIDS cases. This is partly due to patients from other areas attending specialist haematology units in the North West.

**Figure 2.1: All cases of HIV positive individuals in treatment in the North West by stage of disease, 1995 to 2001**



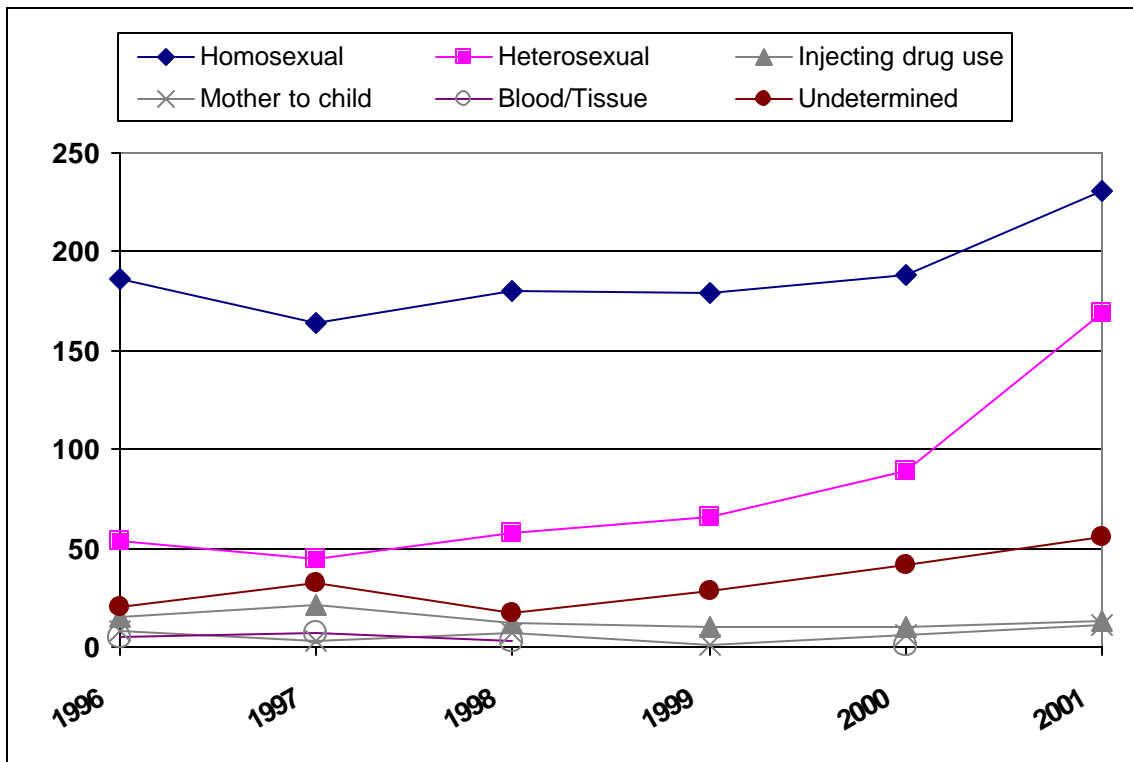
Source: North West HIV/AIDS Monitoring Unit

Figure 2.1 shows the total number of people with HIV accessing treatment in each year from 1995 to 2001, broken down by stage of disease. The size of the HIV positive population accessing treatment in the North West has more than doubled

<sup>6</sup> Public Health Laboratory Service (2003) AIDS and HIV quarterly surveillance tables: cumulative UK data to end December 2002. Number 57 02/4, February 2003. Available online: [http://www.phls.co.uk/topics\\_az/hiv\\_and\\_sti/hiv/epidemiology/files/quarterly.pdf](http://www.phls.co.uk/topics_az/hiv_and_sti/hiv/epidemiology/files/quarterly.pdf)

from 941 to 1964 individuals. This is in part due to effective therapies keeping HIV positive people alive, and partly due to the increasing number of new cases joining the population.

**Figure 2.2: New cases of HIV (defined as individuals not previously seen in the North West) by infection route**



Source: North West HIV/AIDS Monitoring Unit

Figure 2.2 shows the number of new cases of HIV by infection route. These data on cases new to treatment services in the North West assist in identification of trends in incidence and are the most reliable and up to date source of information on HIV epidemiology<sup>7</sup>. Since 1996, the number of individuals newly infected through homosexual sex has risen by 25%, while the number infected through heterosexual sex has increased by 213%, reflecting the national trend for increasing numbers of individuals infected through heterosexual sex. However, unlike the situation nationally, in the North West, the highest number of new infections continues to be among men who have sex with men (51% of new cases).

The level of HIV infection in pregnant women is derived from the anonymous seroprevalence survey conducted by PHLS. The data for 2001 show a slight increase in the prevalence of HIV from 1.7 per 10,000 in 2000 to 2.2 per 10,000 pregnant women<sup>8</sup>. Table 2.1 shows the prevalence in the three SHAs for 2000

<sup>7</sup> Cook PA, Towle A, Rimmer P, Mitchell S, Syed Q, Bellis M (2002) HIV and AIDS in the North West of England 2001, Liverpool John Moores University, Centre for Public Health. ISBN 1-902051-39-4

<sup>8</sup>Department of Health (2002) Prevalence of HIV and hepatitis infections in the United Kingdom 2001: annual report of the unlinked anonymous prevalence monitoring programme. Supplementary

and 2001 combined compared to 1998 and 1999 combined. The prevalence of HIV is over three times higher in Greater Manchester compared to the other two SHAs, at 3.7 per 10,000 in 2000/2001. During 2000 and 2001 a total of 134,297 anonymous samples were tested, 26 of which were found to be positive. The PHLS estimate that half of these were diagnosed during pregnancy.

**Table 2.1 Prevalence of maternal HIV infection**

		C&M	C&L*	GM	NW
1998 and 1999 combined	No. HIV infected	8	5	10	23
	No. of samples tested	55206	32499	57971	145676
	Prev. per 10,000 (No. infected/No. tested)	1.45	1.54	1.73	1.58
	No. diagnosed	3	1	2	6
	No. HIV infected	8	5	10	23
	% diagnosed (No. diagnosed/ No. infected)	37.5	20.0	20.0	26.1
2000 and 2001 combined	No. HIV infected	4	3	19	26
	No. of samples tested	53441	29111	51745	134297
	Prev. per 10,000 (No. infected/No. tested)	0.75	1.03	3.67	1.94
	No. diagnosed	2	5	6	13
	No. HIV infected	4	3	19	26
	% diagnosed (No. diagnosed/ No. infected)	50.0	166.7	31.6	50.0

\*Not including North Cumbria

Source: PHLS Unlinked Anonymous Monitoring Programme 2001, supplementary dataset.

There has been a national objective to increase the uptake of antenatal HIV testing to 90% and the proportion of HIV infections diagnosed prior to delivery to 80% by the end of 2002. Meeting these should result in an 80% reduction in the number of children with HIV acquired from their mothers during pregnancy, birth or through breast-feeding<sup>9,10</sup>. It is unclear how the uptake of tests is being monitored. Early indications are that some antenatal departments are measuring uptake of HIV testing at antenatal and others are measuring offers of HIV testing at antenatal clinics.

Figure 2.3 shows the number of new cases of HIV by SHA. While the number of new cases resident in Greater Manchester almost doubled over the period from 1996 to 2001, increases in Cheshire & Merseyside and Cumbria & Lancashire have been smaller (35% and 38% respectively).

Figure 2.4 shows the total number of HIV positive North West residents in treatment, broken down by strategic health authority. Both Cumbria & Lancashire and Greater Manchester have seen large increases in the size of their HIV positive populations since 1996 (113% and 96% respectively), with Cheshire & Merseyside slightly less so (72%). Greater Manchester has the largest number of HIV positive residents and the highest prevalence of HIV (42 per 100,000

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dataset: data to the end of 2001. Available online:

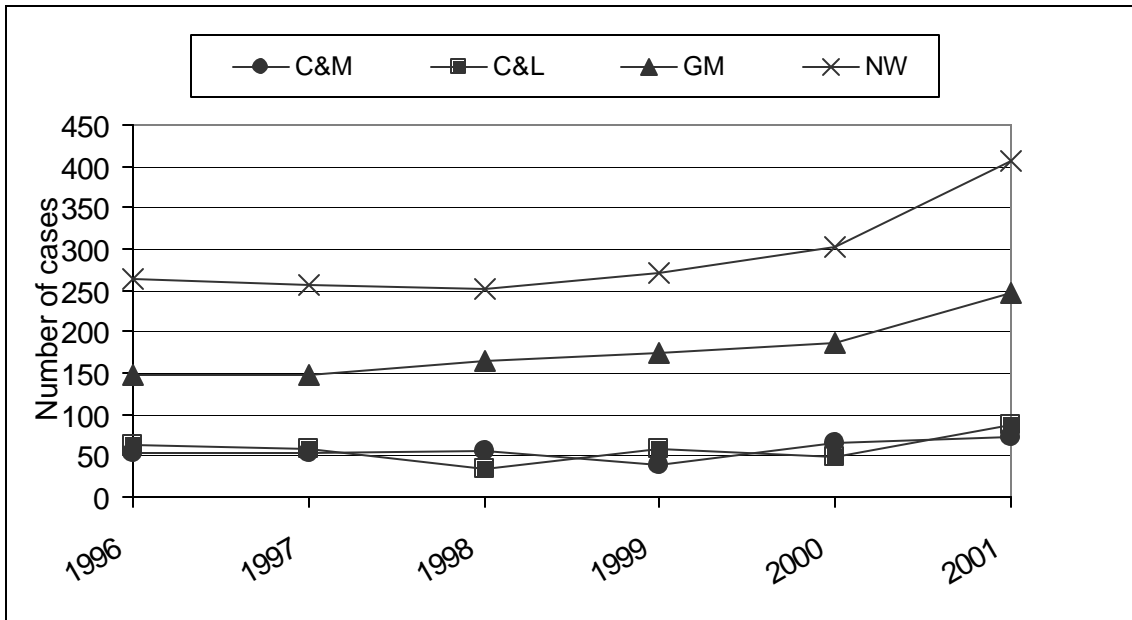
[http://www.phls.co.uk/topics\\_az/hiv\\_and\\_sti/hiv/epidemiology/ua.htm](http://www.phls.co.uk/topics_az/hiv_and_sti/hiv/epidemiology/ua.htm)

<sup>9</sup> NHS Executive (1999) Reducing mother to baby transmission of HIV. Health Service Circular 1999/183. London, August 1999

<sup>10</sup> Department of Health (1999) Targets aimed at reducing the number of children born with HIV: report from an expert group. London, July 1999

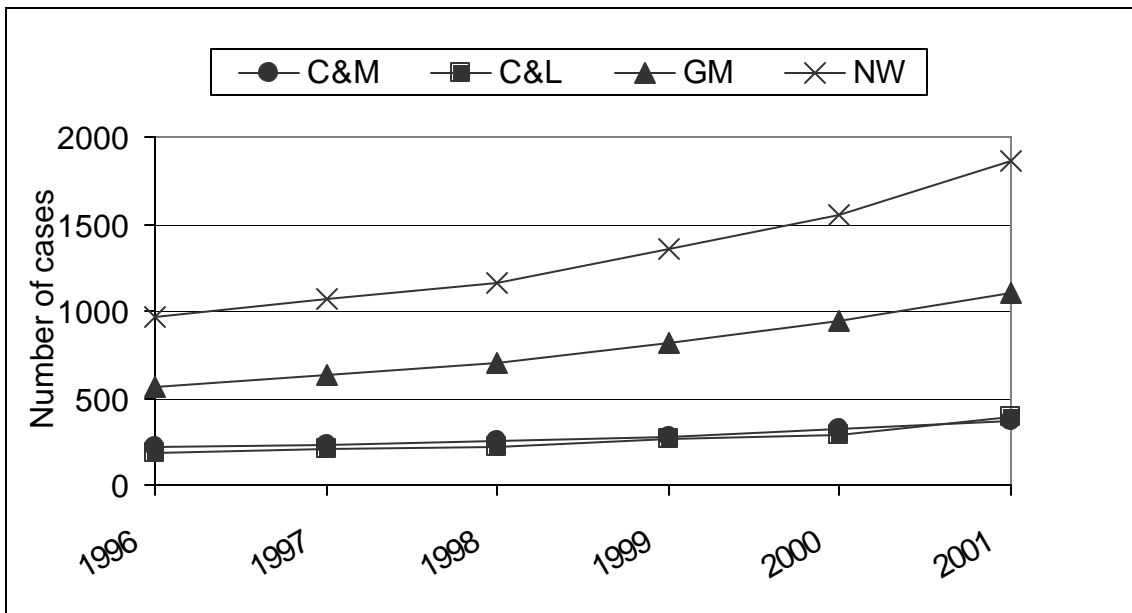
population) compared to Cumbria & Lancashire (21 per 100,000) and Cheshire & Merseyside (15 per 100,000).

**Figure 2.3: New cases of HIV (defined as individuals not previously seen in the North West) by strategic health authority**



Source: North West HIV/AIDS Monitoring Unit

**Figure 2.4: All cases of HIV by strategic health authority**



Source: North West HIV/AIDS Monitoring Unit

Following significant national and local concern over the issue of HIV in asylum seekers, in 2001 the HIV/AIDS Monitoring Unit attempted to measure the number of such individuals accessing HIV treatment and care. Of the 1964 individuals with HIV in treatment during 2001 in the North West, 3% (64) were known to be asylum

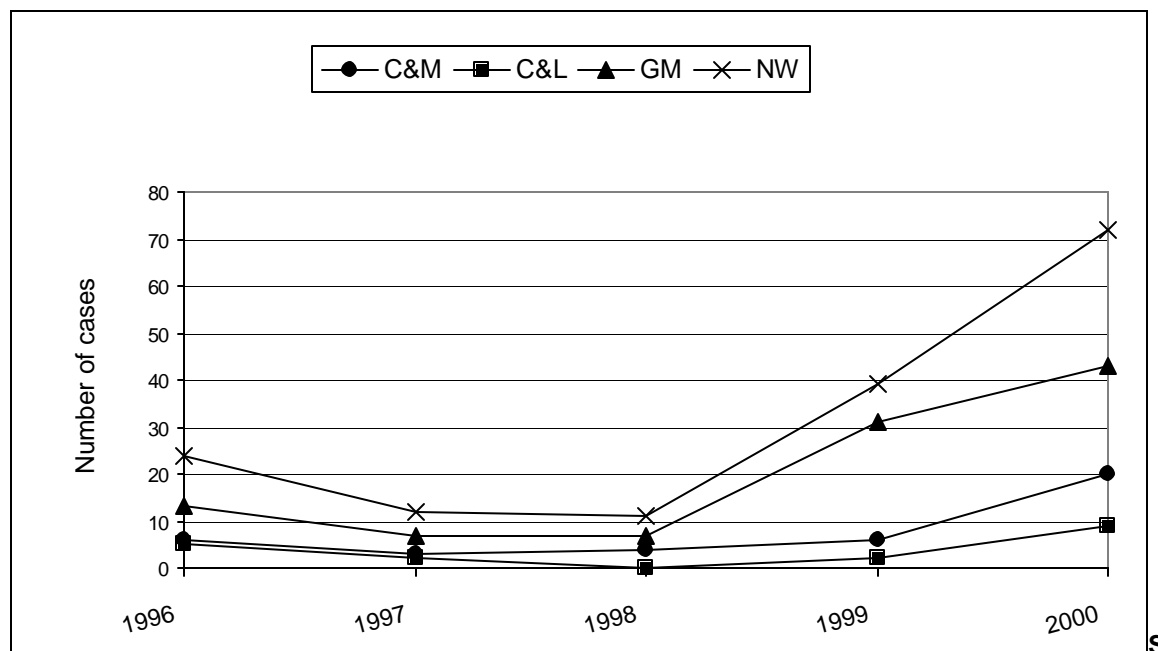
seekers; the status of a further 6% was unknown. Asylum seekers were most likely to reside in Greater Manchester (63%) or Cheshire & Merseyside (30%). Most were black African (94%) and there were more women (60%) than men (40%). The majority were infected through heterosexual sex (90%) and 6% were infected through mother to child transmission.

## 2.2 Epidemiology of sexually transmitted infections

The rates of sexually transmitted infections in the North West are the highest in England outside London. This level is an indicator of sexual risk taking behaviour and also increases susceptibility to HIV transmission.

The recent outbreak of syphilis, centred in Manchester, is one of the largest in England. The majority of cases are in gay men, with a total of over 400 cases between January 1999 and January 2003. However there is a significant number of cases being acquired heterosexually (58). Surveillance also indicates that the numbers of infections is increasing in areas outside Manchester, such as Blackpool.

**Figure 2.5 Number of cases of primary and secondary infectious syphilis by SHA**



Source: North West Communicable Disease Surveillance Centre (CDSC).

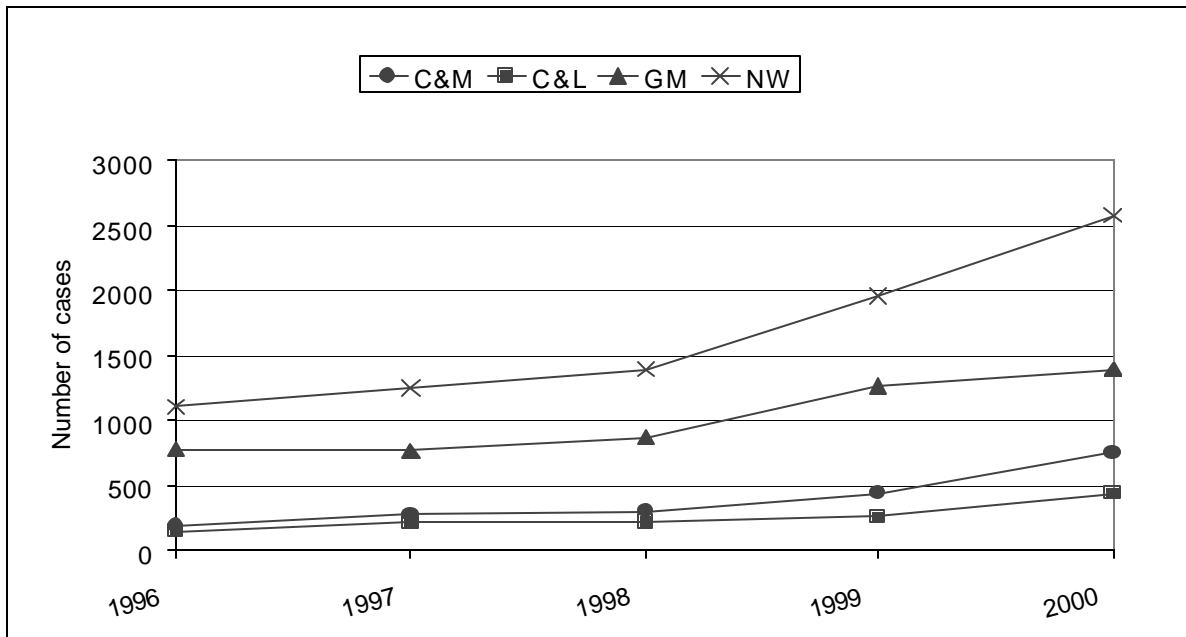
Figure 2.5 shows a steep rise in new diagnoses of infectious syphilis (primary and secondary) in GUM clinics in the North West – a 200% increase in cases over this five-year period. At the SHA level, Greater Manchester exhibits the sharpest increase with a 233% increase in cases, reflecting a localised outbreak<sup>11,12</sup>,

<sup>11</sup> Bellis MA, Cook PA, Clark P, Syed Q, Hoskins A. Re-emerging Syphilis in the UK: a behavioural analysis of infected individuals. *Communicable Disease and Public Health* 2001; 4: 253-258

<sup>12</sup> Bellis MA, Cook PA, Clark P, Syed Q, Hoskins A. Re-emerging Syphilis: a case-control study of behavioural risk factors and HIV status. *Journal of Epidemiology and Community Health* 2002; 56: 235-236.

closely followed by Cheshire & Merseyside with 231% and Cumbria & Lancashire with 80%.

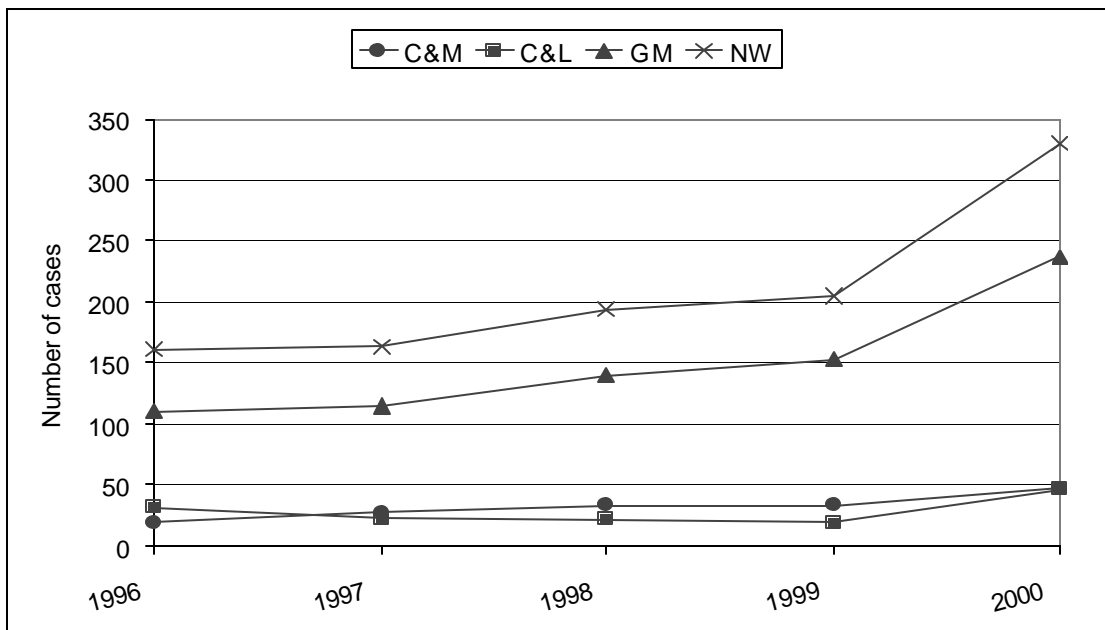
**Figure 2.6: Uncomplicated gonorrhoea**



Source: North West CDSC

Figure 2.6 shows a steep rise in new diagnoses of uncomplicated gonorrhoea in GUM clinics in the North West. Over this five-year period there has been a 133% increase in cases. At the SHA level, Cheshire & Merseyside exhibits the sharpest increase, with a 297% increase in cases followed by Cumbria & Lancashire with 195% and Greater Manchester with 81%.

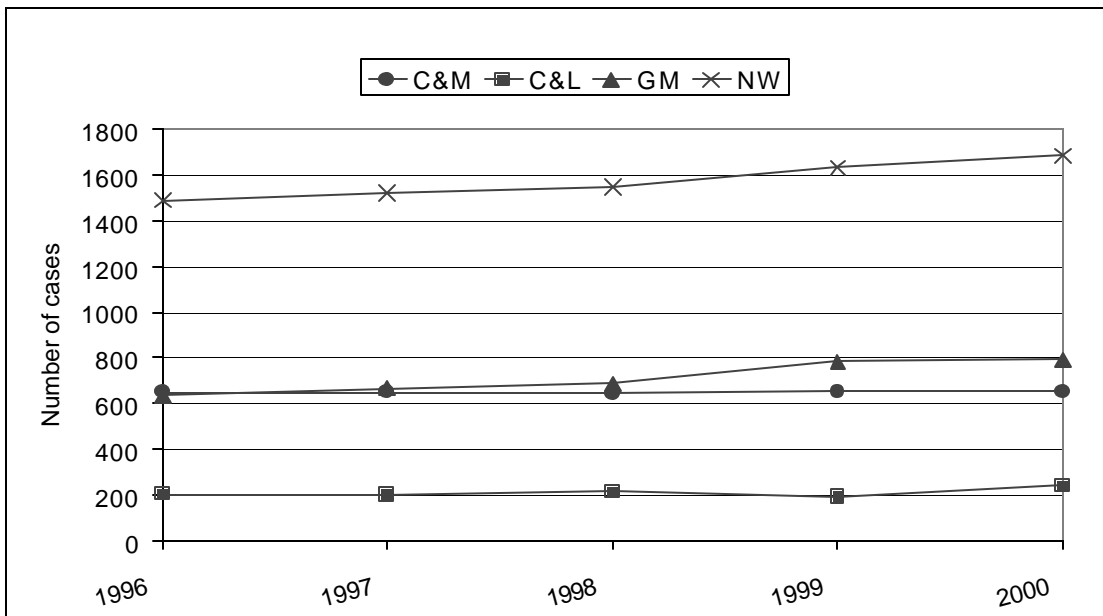
**Figure 2.7: Uncomplicated gonorrhoea - homosexually acquired**



Source: North West CDSC

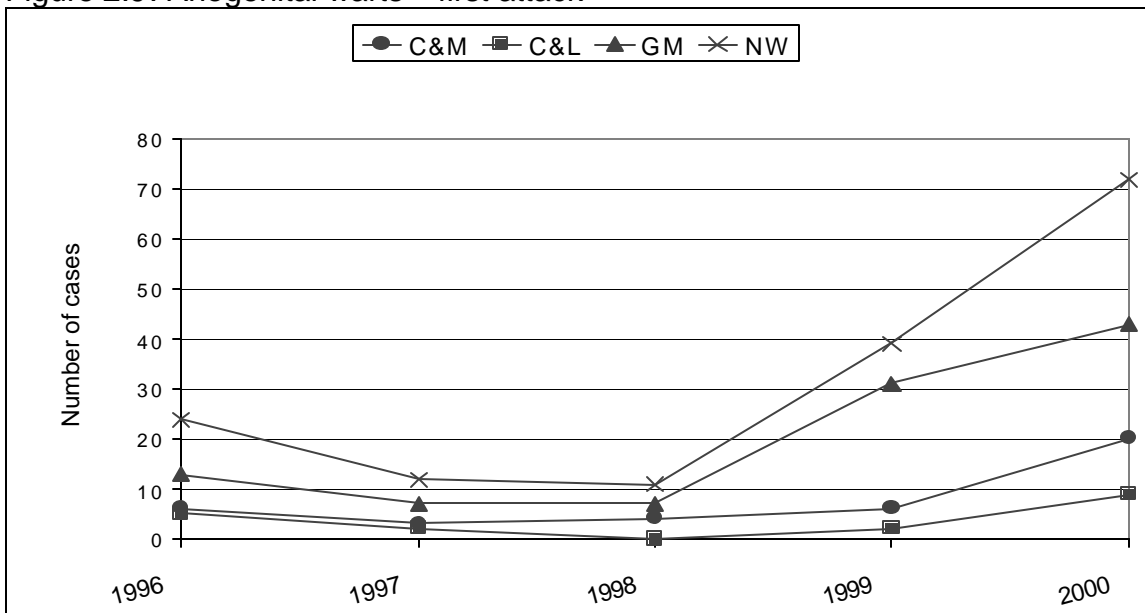
Figure 2.7 shows a steep rise in new diagnoses of uncomplicated gonorrhoea (homosexually acquired) in GUM clinics in the North West. There was a 105% increase in cases over this five-year period. At the SHA level, Cheshire & Merseyside exhibits the sharpest increase, with a 147% increase in cases followed by Greater Manchester with 115% and Cumbria & Lancashire with 44%.

**Figure 2.8:** Anogenital herpes simplex – first attack



Source: North West CDSC

**Figure 2.9:** Anogenital warts – first attack



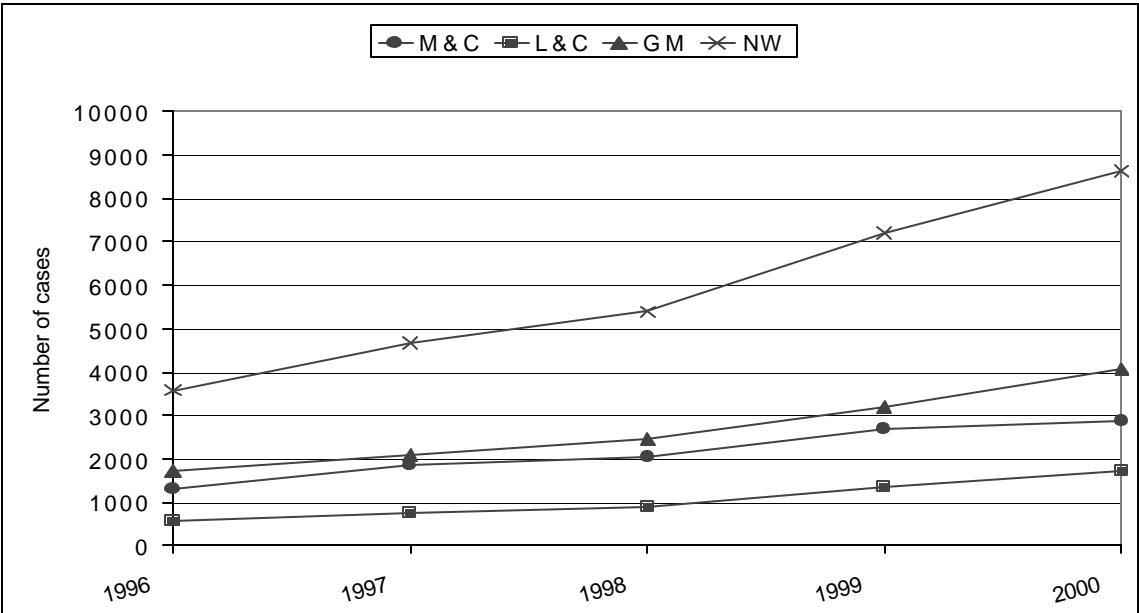
Source: North West CDSC

Figure 2.8 shows a rise in new diagnoses of anogenital herpes simplex (first attack) in GUM clinics in the North West, a 13% increase in cases over this five-year period. At the SHA level, Greater Manchester exhibits the sharpest increase, with a 25% increase in cases followed by Cumbria & Lancashire with 17% and no change in Cheshire & Merseyside.

Figure 2.9 shows a rise in new diagnoses of anogenital warts in GUM clinics in the North West, a 16% increase in cases over this five-year period. At the SHA level, Cumbria & Lancashire exhibits the sharpest increase, with a 30% increase in cases followed by 22% in Greater Manchester and 5% in Cheshire & Merseyside.

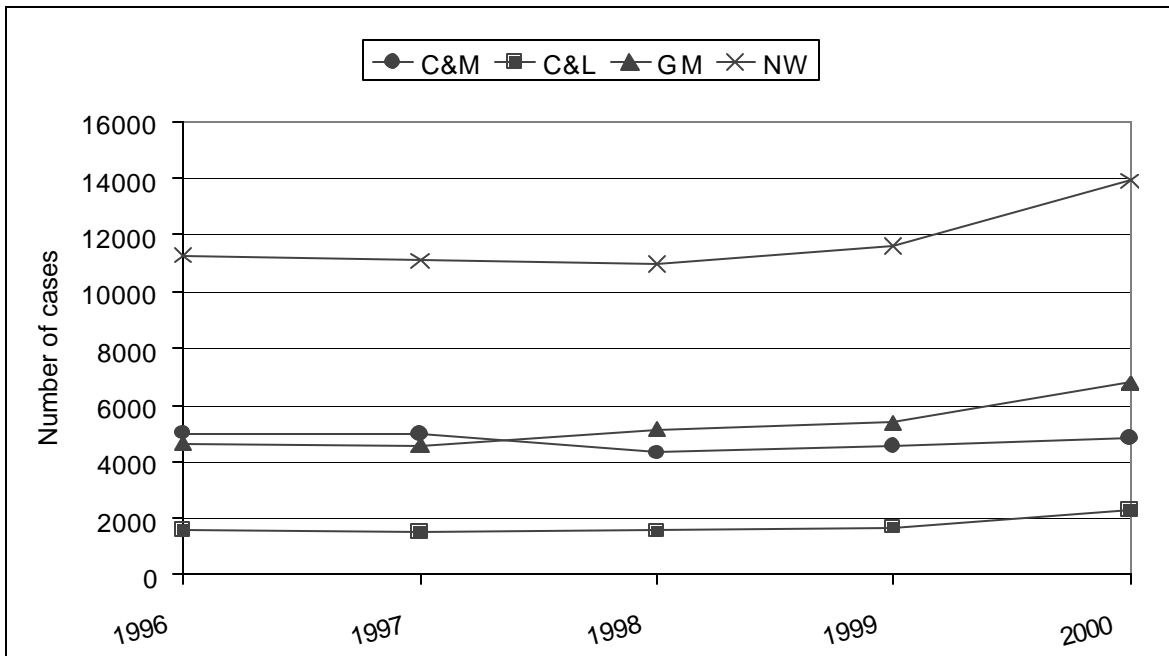
Figure 2.10 shows a rise in new diagnoses of uncomplicated genital chlamydial infection in GUM clinics in the North West. A 141% increase in cases over this five-year period. At the SHA level, Cumbria & Lancashire exhibits the sharpest increase, with a 202% increase in cases followed by 138% in Greater Manchester and 119% in Cheshire & Merseyside.

**Figure 2.10: Uncomplicated genital chlamydial infection**



Source: North West CDSC

**Figure 2.11: HIV antibody counselling with testing**



Source: North West CDSC

Figure 2.11 shows a rise in the number of human immunodeficiency virus (HIV) antibody counselling with testing in GUM clinics in the North West - a 24% increase over this five-year period. At the SHA level, Greater Manchester and Cumbria & Lancashire exhibit the sharpest increases with 46% and 42% respectively.

**Table 2.2: Change in selected STIs and HIV testing with counselling by age (2000 on 1995)**

Condition	Age (years)							
	<15	15	16-19	20-24	25-34	35-44	45-64	65+
Primary and secondary infectious syphilis	- (0)	- (0)	- (0)	- (8)	300% (32)	2300% (24)	500% (6)	- (1)
Uncomplicated gonorrhoea	0% (5)	62% (21)	247% (552)	203% (742)	115% (775)	397% (318)	337% (131)	100% (4)
Anogenital Herpes simplex - first attack	50% (6)	-30% (7)	28% (264)	0% (433)	7% (560)	32% (275)	41% (127)	-15% (11)
Anogenital warts - first attack	-21% (22)	3% (40)	47% (1662)	23% (2921)	15% (2570)	34% (834)	23% (375)	-14% (30)
HIV antibody counselling - with testing	40% (66)	27% (76)	58% (1571)	33% (3717)	33% (4989)	66% (2366)	39% (1051)	-19% (83)
Uncomplicated chlamydial infection	62% (21)	129% (78)	208% (2234)	152% (3231)	105% (2355)	108% (565)	241% (140)	86% (13)

Source: North West CDSC (The number of cases for 2000 is given in brackets).

Table 2.2 presents the proportionate changes in selected STIs by different age groups seen at GUM clinics in the North West. Changes in the burden of STIs are nearly all positive (i.e. increasing) but are unevenly distributed across the different age groups. People in the 16-44 age range account for the bulk of STIs and HIV antibody testing with counselling (see numbers in brackets). For gonorrhoea and chlamydial infection there are increases in excess of 200% for the 16-19 age groups.

### 2.3 Reproductive health data

Data on reproductive health come from conceptions, uptake of contraceptive services and emergency contraception and terminations of pregnancy.

**Table 2.3: Conception rates per 1,000 women by age in England and the North West, 1998-2001**

	Age (years)								
	1998			1999			2000		
	15-44	15-17	13-15	15-44	15-17	13-15	15-44	15-17	13-15
England	74.2	46.5	8.8	71.9	44.7	8.2	70.9	43.6	8.3
North West	71.3	50.1	8.9	69.2	48.6	8.8	68.0	47.4	8.6

Source: Office for National Statistics.

With just one exception, conception rates (per 1000 women) by all ages in England and the North West have gone down over the period 1998-2000 (Table 2.3). However, while for the 15-44 age range conception rates are higher for England, for the 15-17 and 13-15 age ranges the rates are higher in the North West.

**Table 2.4: Conception rates in those aged less than 18 years by strategic health authority, 1998-2001**

Strategic Health Authority	No. of conceptions				Conception rates			
	1998	1999	2000	2001	1998	1999	2000	2001
C&M	2100	2093	2028	1938	47.8	47.1	44.1	40.8
C&L	1715	1621	1700	1533	48.8	46.0	47.2	41.6
GM	2642	2569	2480	2549	56.9	55.4	52.2	51.9
<b>England</b>	<b>41089</b>	<b>39247</b>	<b>38690</b>	<b>38439</b>	<b>47.0</b>	<b>45.3</b>	<b>43.8</b>	<b>42.3</b>

Note: Rebased rates using 2001 Census population estimates for 1998-2001

Source: Office for National Statistics.

Table 2.4 shows conception rates in those aged less than 18 years old for each of the SHAs in the North West, compared to rates for England, calculated on recent Census population estimates. Whilst all three SHAs exhibit a general downward trend in conceptions, Greater Manchester has a rate considerably higher than that in the other two SHAs and in England as a whole.

**Table 2.5: Conception rates in those aged less than 18 years for top-tier local authorities, 1998-2001**

	Year			
	1998	1999	2000	2001
Blackburn with Darwen UA	58.2	56.9	55.0	45.8
Blackpool UA	68.8	79.3	70.5	62.4
Cumbria	41.3	40.0	41.3	35.5
Lancashire County	48.5	43.3	46.0	41.1
Halton UA	50.1	57.0	54.8	46.7
Warrington UA	48.5	48.1	45.2	42.6
Cheshire County	38.4	38.1	33.7	30.8
Knowsley MCD	58.5	49.3	49.7	46.9
Liverpool MCD	57.2	54.3	49.3	44.8
Sefton MCD	34.5	38.2	39.9	33.1
St Helens MCD	55.8	64.6	51.2	51.4
Wirral	53.2	46.4	48.3	48.4
Bolton MCD	51.8	56.8	55.0	48.6
Bury MCD	55.9	46.2	43.0	44.2
Manchester MCD	67.8	65.5	70.3	72.4
Oldham MCD	65.6	58.2	53.6	59.7
Rochdale MCD	64.3	56.5	57.6	51.3
Salford MCD	62.3	62.0	52.9	56.3
Stockport MCD	45.4	44.9	32.7	36.1
Tameside MCD	55.2	51.6	54.1	51.9
Trafford MCD	35.6	40.8	33.5	35.4
Wigan MCD	54.9	61.0	55.6	51.3
North West	50.1	48.6	47.4	45.1

Source: Office for National Statistics.

At the regional level under 18 conception rates exhibit a downward trend over the period 1998-2001. However, within the North West there is significant variation, with no obvious trend in conception rates for many top tier local authorities (Table 2.5). For example, a year on year reduction in conception rates is reported in just two authorities (Cheshire County and Liverpool MDC). Moreover, there are three local authorities where rates have increased from the 1998 baseline (Halton UA, Manchester MCD, and Trafford MCD).

**Table 2.6: First contact by sex at contraceptive services in the North West, 1997/98-2001/02**

	Year					Change on 97-98
	1997-98	1998-99	1999-00	2000-01	2001-02	
First contacts female	190,875	188,278	188,626	195,353	207,456	9%
First contacts male	16,399	16,843	15,877	15,804	17,650	8%

Source: NHS Contraceptive Services, England, Department of Health.

Table 2.6 shows the trend in first contact by sex at contraceptive services (family planning) in the North West from 1997/98 to 2001/02. During this period utilisation

by both males and females has increased. First contacts by females have increased by 9% and first contacts by males have increased by 8%.

### 2.3.1 Emergency contraception data

Data on provision of emergency hormonal contraception is from a number of sources (see section 4.4.4) making the quantification of total provision problematic. Take up of emergency contraception through the IUD method is low across England, at only 2 to 4% of all emergency contraception<sup>13</sup>.

Emergency hormonal contraception is available through prescription from general practice, some accident & emergency departments and community contraceptive services (family planning services). It is also available to purchase from community pharmacists (following reclassification in January 2001 from prescription only to pharmacy only for women over 16 years). In addition trained community pharmacists and trained nurses in walk in centres, young people's services and Brook Advisory Centres can issue emergency contraception against protocols through patient group directions (PGDs).

**Table 2.7: Emergency hormonal contraception provided by the NHS in the North West, 1997/98-2001/02**

	Year				2001-02 change on 1998-99	2001-02 change on 2000-01
	1998-99	1999-00	2000-01	2001-02		
Number of occasions prescribed	37,534	41,178	40,880	40,240	7%	-3%

Source: NHS Contraceptive Services, England, Department of Health.

Table 2.7 shows the trend in emergency contraception (post-coital contraceptive) prescribing in the North West by NHS community contraceptive services and Brook Advisory Centres from 1998/99 to 2001/02. Associated with its reclassification (from prescription only), there was a reduction of around 3% in emergency contraception prescribed at community contraceptive services from 2000–01 to 2001–2. However, during the period from 1998/99 to 2001/02 there has been an increase in prescribing of 7%.

Emergency contraception community pharmacy schemes are being developed by more than 60% of North West PCTs. The first scheme was set up by Manchester, Salford and Trafford Health Action Zone in December 1999. Findings from the scheme, which now includes six PCTs, emergency contraception scheme suggest that Monday is the most common day of the week for requests (24% of the total) for emergency contraception, with unprotected sex as the most frequently cited reason for requesting emergency contraception. During the twelve-month period from April 2001 to March 2002, 18,402 clients presented for emergency contraception. Of these, the 20-29 age range followed by 16-19 year olds are the highest users (52% and 25% respectively), with just 5% under 16 years.

<sup>13</sup> Department of Health (2002) National Statistics Bulletin 2001-2

**Table 2.8: Emergency hormonal contraception provided at Brook Advisory Centres, 2000/1 to 2001/2**

Brook Advisory Centre	2000/1	2001/2	Change from 2000/1 to 2001/2
Birkenhead	3,038	2,860	-6%
Liverpool	2,857	5,962	109%
Blackburn	1,367	1,658	21%
Burnley	573	624	9%
Eccles	519	465	-10%
Manchester	2,523	1,990	-21%
Oldham	487	1,012	108%
Wigan & Leigh	1,149	1,307	14%
Total	12,513	15,878	27%

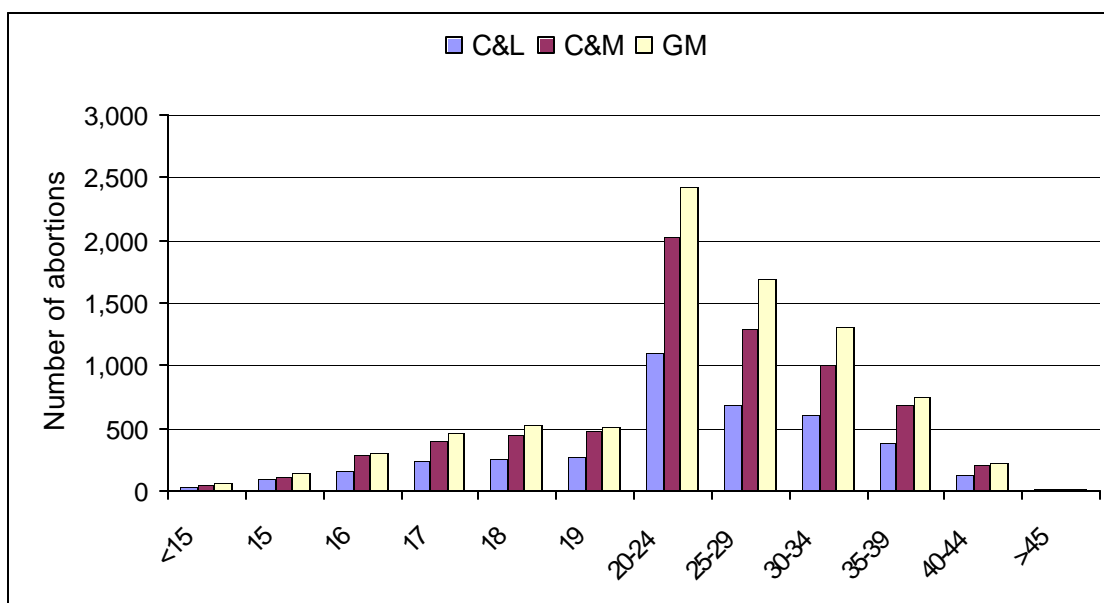
Source: Brook Advisory Centres

Over the period from 2000/1 to 2001/2 there has been an increase of 27% in emergency contraception provided through the Brook Advisory Centres (BAC) (Table 2.8). However, there is significant variation across the eight BACs in the North West, ranging from an increase in Liverpool BAC of 109% to a decrease in Manchester BAC of 21%.

### 2.3.2 Termination of pregnancy data

A requirement of the Abortion Act 1967, which came into effect on 27 April 1968, is that all legally induced abortions are notified within seven days to the Chief Medical Officer of the Department of Health. These data are collated by the Office for National Statistics and presented annually.<sup>14</sup>

**Figure 2.12: Legal abortions by age and SHA in the North West (excluding N. Cumbria), 2001**

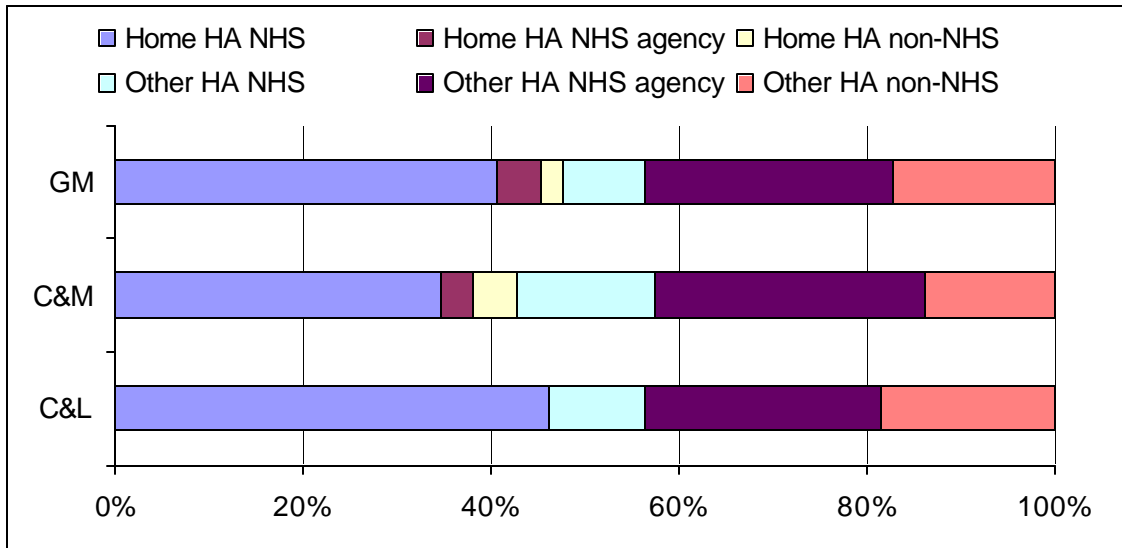


Source: Series AB no 28 Abortion Statistics, National Statistics, 2002.

<sup>14</sup> Office of National Statistics, Abortion Statistics, London: The Stationery Office.

Figure 2.12 presents a demographic profile of women undergoing pregnancy termination in the North West of England. The 20-24 age group accounts for the largest share of terminations undertaken in each of the SHAs in the North West. For each age category, Greater Manchester has the most terminations followed by Cheshire & Merseyside and Cumbria & Lancashire.

**Figure 2.13 Percentage of abortions in 2001 by area of usual residence (HA and SHA, excluding N. Cumbria), area of termination and purchaser**



Source: Series AB no 28 Abortion Statistics, National Statistics, 2002.

Figure 2.13 presents information on terminations by area of usual residence, area of termination and category of 'purchaser'. By all purchasers the health authority of termination was the home health authority for 48% of terminations in Greater Manchester, 46% in Cumbria & Lancashire, and 43% in Cheshire & Merseyside.

**Table 2.9: Percentage change in abortions 2001 on 1998 by SHA, North West (excluding N. Cumbria) and England**

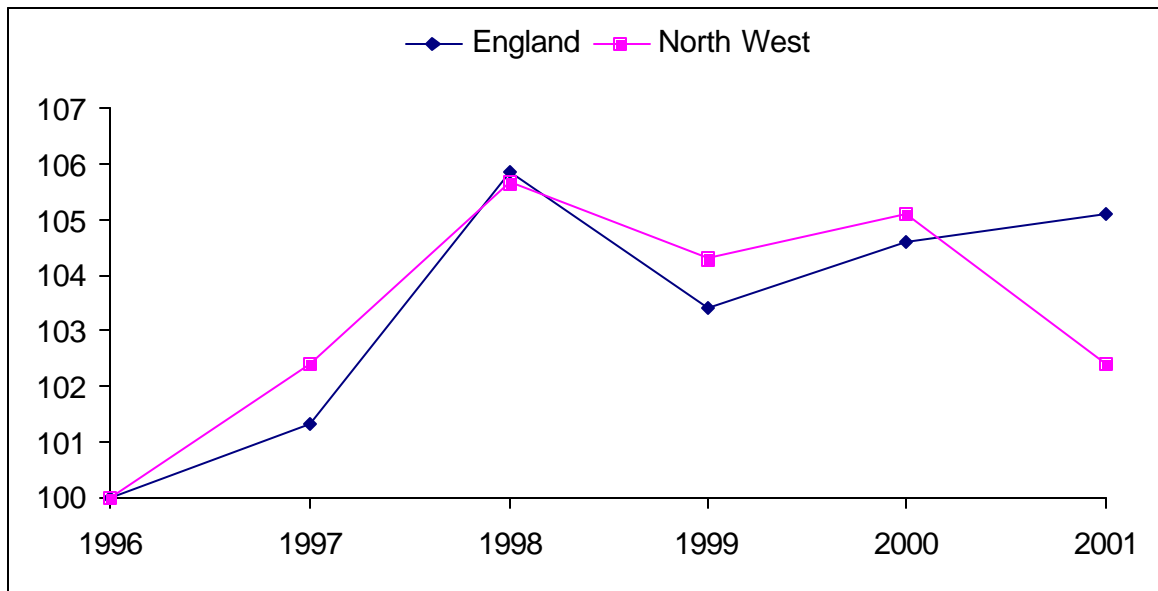
	Age											
	All	<15	15	16	17	18	19	20-24	25-29	30-34	35-39	40-44
	Percentage change in 2001 on 1998											
C&L	-6%	-11%	-2%	20%	2%	-6%	7%	1%	-26%	-3%	-4%	2%
C&M	-8%	3%	2%	1%	-1%	-9%	-1%	-1%	-20%	-13%	-9%	3%
GM	3%	14%	4%	11%	10%	4%	8%	6%	-8%	3%	4%	11%
North West	-3%	4%	2%	8%	4%	-3%	4%	3%	-16%	-4%	-3%	6%
England	-1%	-2%	-2%	6%	0%	-4%	3%	6%	-9%	-5%	5%	10%

Source: Series AB no 28 Abortion Statistics, National Statistics, 2002.

Table 2.9 shows the percentage change in abortions for 2001 on 1998. For all ages across the North West as a whole there has been a 3% decrease in terminations over 1998, which compares with a decrease of 1% for England. There is variation within the region, however, with a 3% increase in Greater Manchester and decreases of 6% and 8% in Cumbria & Lancashire and Cheshire & Merseyside respectively. At 20% the largest increase by age is for 16 year olds

in Cumbria & Lancashire, which is more than three times the percentage increase for England.

**Figure 2.14: Indexed abortion trend in North West (excluding N. Cumbria) compared with England, 1996 to 2001.**



Source: Series AB no 28 Abortion Statistics, National Statistics, 2002.

Figure 2.14 illustrates the trend change in abortions for the North West and England during the period 1996 to 2001. For comparison purposes all data are indexed. The reference base of 100 for both data sets (i.e. England and the North West) is 1996. The difference in index numbers for 2001 shows that a gap has now developed between the North West and England. For England as a whole there has been a 5% increase in abortions, while in the North West the increase is just 2%.

## 2.4 Summary bullet points

### 2.4.1 HIV epidemiology

- The number of people living with HIV in the North West has almost doubled since 1996, to a total of 1964 individuals
- Whereas in the rest of the UK there are more heterosexually acquired new HIV cases, in the North West there are more new cases of HIV that are homosexually acquired
- The anonymous seroprevalence survey suggest a slight increase in the prevalence of HIV from 1.7 per 10,000 in 2000 to 2.2 per 10,000 pregnant women in 2001
- There has been a national objective to increase the proportion of HIV infections diagnosed prior to delivery to 80% by the end of 2002. Currently in the North West an estimated 50% of infections are diagnosed during pregnancy.

#### 2.4.2 Epidemiology of sexually transmitted infections

- For selected STIs there have been sharp increases in new diagnoses at GUM clinics in the North West
- There have been increases in excess of 200% for the 16-19 age group for new episodes of gonorrhoea and chlamydial infections (see Table 2.1 ).
- Outside London, the North West has the highest number of new episodes of syphilis, gonorrhoea, and chlamydia seen at GUM clinics

#### 2.4.3 Reproductive health data

- First contacts by females at contraceptive services (family planning) in the North West from 1997/98 to 2001/02 have increased by 9% and for males by 8%
- At the regional level under 18 conception rates exhibit a downward trend over the period 1998-2001. However, there are three local authorities where rates have increased from the 1998 baseline
- Post-coital contraceptive prescribing in the North West has increased by 15% during the period from 1997/98 to 2001/02
- Over the period from 2000/1 to 2001/2 there has been an increase of 27% in emergency contraception provided through the Brook Advisory Centres
- Associated with its reclassification (from prescription only) and hence wider availability, there was a reduction of -2% in emergency contraception prescribed at community contraceptive services from 1999/00 to 2000/01.
- The 20-24 age group accounts for the largest share of terminations undertaken in each of the SHAs in the North West. For each age category, Greater Manchester has the most terminations followed by Cheshire & Merseyside and Cumbria & Lancashire
- Many people travel for terminations. The health authority of termination was the home health authority for just under half of terminations provided in all three SHAs in the North West
- For all ages across the North West there has been a 3% decrease in terminations from 1998 to 2001. However, by age there has been a 20% increase for 16 year olds in Cumbria & Lancashire

## **3 Services**

### **3.1 HIV/AIDS service provision**

In the North West there are 46 statutory treatment centres for HIV/AIDS: of these 27 are in GUM clinics, two in infectious diseases units, four in haematology departments and 13 in specialist clinics.

In 2001, for the third year running, an increasing number of people with HIV and AIDS have been contacting statutory treatment centres in the North West; an increase of 18% in the number of HIV positive individuals attending in 2000.

As in 1999 and 2000, in 2001 North Manchester General Infectious Disease Unit provided the highest number of outpatient visits, day cases, inpatient episodes and inpatient days. Outpatient visits to this unit accounted for 28% of all attendances in the North West, with Department of GUM at the Royal Liverpool University Hospital reporting second highest number of visits. The Department of GUM at Arrowe Park Hospital and Alder Hey Children's Hospital provided the highest mean number of outpatient visits per HIV positive patient (each with 17.7 visits).

North Manchester General Infectious Diseases Unit also provided the highest number of inpatient episodes (51% of the total) and inpatient days (54%) with the Victoria Hospital in Blackpool and the Department of GUM at the Royal Liverpool University Hospital providing the next highest numbers of inpatient episodes (10% and 11% of the total respectively) and days (6 and 14%).

Some of the treatment centres provided a significant number of home visits, with the Queen Street Clinic in Blackpool providing the most at 270 (an average of 3.6 per HIV positive person). Bury General Hospital and Royal Oldham Hospital provided the highest number of visits per HIV positive person, at 5.8 and 6.5 respectively.

### **3.2 Genitourinary medicine service provision**

For the majority of patients, the genitourinary medicine (GUM) service is the main choice for diagnosis and treatment of sexually transmitted infections (STIs) rather than through other primary care services such as general practice. There are 34 GUM services in the North West region each of which serves a vital role in meeting specialised sexual health needs.

Data on genitourinary medicine services (GUM) were gathered through an administered questionnaire survey of all 34 GUM services in the North West (see section 1.3.3 for details).

**Table 3.1: Services provided by genitourinary medicine departments**

	Percentage of GUM services			
	C&M	C&L	GM	NW
HIV testing and counselling	100 (9)	100 (13)	100 (12)	100 (34)
Emergency contraception	89 (8)	85 (11)	83 (10)	85 (29)
Condoms	100 (9)	100 (13)	100 (12)	100 (34)
Other contraceptives	100 (9)	15 (2)	42 (5)	47 (16)
Outreach services	89 (8)	62 (8)	42 (5)	62 (21)
Partner notification to attendees	100 (9)	100 (13)	100 (12)	100 (34)
Sexual health information to attendees	100 (9)	100 (13)	100 (12)	100 (34)
Other services	67 (6)	46 (6)	83 (10)	65 (22)

Source: Centre for Public Health GUM survey. The number of services is given in brackets.

In addition to providing diagnosis and treatment for STIs, there is little difference reported across GUM services in the range of other services that they provide (Table 3.1) - although, importantly, this reflects the availability of GUM services rather than their utilisation. Even so, the majority of services (85%) provide emergency contraception and all (100%) provide condoms and HIV testing and counselling. However, proportionately fewer services (15%) provide 'other' contraceptives in Cumbria & Lancashire, while more services in Cheshire & Merseyside report providing outreach services than the other two SHAs in the North West.

### 3.3 General practice service provision

The North West has 1512 general practices, 40% of which are in Greater Manchester SHA, 30% each in Cheshire & Merseyside SHA and Cumbria & Lancashire SHA. Data on general practice services were derived from three sources. Section 1.3.4 has details, but briefly: the first source was a random sample of GPs in the North West Region was surveyed for this review (referred to as the Centre for Public Health GP survey) yielding a total 73 questionnaires (overall return rate of 30%). The second source of data was a survey carried out as part of the Teenage Pregnancy Audit, where every GP in England was sent a questionnaire on contraceptive services for young people. A relatively high return rate of 46% (615 out of the 1330 North West GP practices) was achieved. The final source of data was a survey carried out by George House Trust, who sent out a questionnaire to every GP in the UK<sup>15</sup> and received 192 returns from the North West (a return rate of 14%).

<sup>15</sup> George House Trust (GHT) 2002 HIV: what role for the GP? Insight Briefing 01.

**Table 3.2 Contraceptive services provided by GPs**

	Percentage of GPs			
	C&M	C&L	GM	NW
Hormone – oral	100	100	95.8	98.6
Hormone – injectable	100	96.3	100	98.6
Hormone – implant	28.6	40.7	29.2	33.3
IUD fitting	61.9	77.8	62.5	68.1
IUS fitting	42.9	51.9	33.3	43.1
Diaphragm	57.1	51.9	50	52.8
Emergency contraception	100	100	100	100.0
Pregnancy test	81	74.1	87.5	80.6
Pregnancy counselling	95.2	85.2	95.8	91.7
Abortion counselling	87.5	85.2	87.5	86.1
Sexual dysfunction	85.7	66.7	83.3	77.8
Psychosexual	85.7	25.9	41.7	48.6

Source: Centre for Public Health GP survey.

Table 3.2 shows that of those GPs responding to the CPH survey, the vast majority provided oral and injectable contraceptives (99%), while fewer provided implants (33%), IUD and IUS fitting (68% and 43%) or diaphragms (53%). All GP services provided emergency contraception, while 86.1% provided abortion counselling.

**Table 3.3 Sexually transmitted infections services provided by GPs**

	Percentage of GPs			
	C&M	C&L	GM	NW
Screening	33.3	51.9	37.5	41.7
Gonorrhoea test (men)	14.3	51.9	33.3	34.7
Gonorrhoea test (women)	23.8	59.3	29.2	38.9
Gonorrhoea treatment (men)	9.5	48.1	25.0	29.2
Gonorrhoea treatment (women)	14.3	48.1	25.0	30.6
Chlamydia test (men)	42.9	70.4	50.0	55.6
Chlamydia test (women)	90.5	85.2	83.3	86.1
Chlamydia treatment (men)	42.9	66.7	45.8	52.8
Chlamydia treatment (women)	57.1	70.4	50.0	59.7
HIV test	28.6	37.0	29.2	31.9
HIV pre-test counselling	33.3	44.4	29.2	36.1
HIV post-test counselling	23.8	37.0	25.0	29.2

Source: Centre for Public Health GP survey.

Table 3.3 shows that around one third of GPs responding to the CPH survey test and treat gonorrhoea (ranging from a half of GP services in Cumbria & Lancashire to around one in ten in Cheshire & Merseyside). More GP services reported providing testing and treating of chlamydia for women (86% and 60% respectively) than for men (55.6% and 52.8% respectively). Around one third of GPs offered HIV testing and counselling. More GPs in Cumbria & Lancashire undertook screening, gonorrhoea testing and treatment, chlamydia testing and treatment and HIV pre- and post-test counselling than GPs in the other strategic health authorities.

**Table 3.4 Percentage of GPs offering services for young people**

	C&M		C&L		GM		NW	
	Percentage of GPs offering services for those aged							
	Under 16	Over 16	Under 16	Over 16	Under 16	Over 16	Under 16	Over 16
Oral contraceptives	91	97	96	96	93	95	93	96
Injectable contraceptives	63	92	74	95	66	90	66	91
Contraceptive implants	10	24	12	29	7	17	9	22
IUD/IUS	13	61	17	76	14	64	14	65
Condoms	31	32	57	58	45	49	43	45
Emergency contraception	86	95	94	99	88	94	88	95
Chlamydia screening	67	80	77	87	75	83	73	83
Chlamydia treatment	70	80	80	86	74	80	74	81
Pregnancy test	79	85	93	94	89	89	86	88
Pregnancy counselling	80	85	89	91	83	82	83	84
NHS abortion referral	86	94	96	100	88	91	89	94

Source: CPH analysis of TP GP audit.

Results of the teenage pregnancy audit of general practices, which had a relatively high response rate and large sample size (see section 1.3.4), suggest that the vast majority of GPs provide services for young people (Table 3.4). The most reported services were oral (93% and 96% for under and over 16 respectively) and injectable contraceptives (66% and 91% for under and over 16 respectively), emergency contraception (88% and 95% for under and over 16 respectively), pregnancy testing (86% and 88% for under and over 16 respectively), and NHS abortion referral (89% and 94% for under and over 16 respectively). The least reported service for young people was contraceptive implants (9% and 22% for under and over 16 respectively).

In the CPH survey of GPs, GPs were asked which level one services could be a problem to provide in the future. GPs listed the following services as being a potential problem:

- Sexual history and risk assessment (27% of GPs)
- STI testing for women (34%)
- HIV testing and counselling (60%)
- Pregnancy testing and referral (6%)
- Contraceptive information and services (3%)
- Assessment and referral of men with STI symptoms (26%)
- Cervical cytology screening and referral (3%)
- Hepatitis B immunisation (8%)

In the same survey, GPs were asked what the barriers were to providing the level one services. GPs identified the following as barriers:

- Funding (44%)
- Staffing/capacity (45%)
- Lack of interest (4%)
- Lack of knowledge (41%)
- Moral objection to providing sexual health services (3%)

When asked which services they would be interested in providing in the future, GPs were interested in the following:

- IUD insertion (53%)
- Testing and treating STIs (37%)
- Vasectomy (11%)
- Contraceptive implant insertion (32%)
- Partner notification (10%)
- Invasive STI testing for men (16%)

In the George House Trust HIV GP survey, 40% of GPs were interested in providing more services for HIV positive people. Of these, most (73%) thought they could support treatment adherence, 53% were interested in HIV testing and diagnosis, 43% in taking bloods for CD4/viral load monitoring, 39% in prescribing anti HIV drugs and 8% were interested in being involved in resistance testing. The biggest perceived difficulties with providing care for those with HIV were the complexity of HIV (65%) and keeping up to date (56%). Ten percent identified the reaction of other patients as a difficulty.

### 3.4 Services provided by voluntary agencies

Brief questionnaires were sent to 18 voluntary agencies, of whom, 13 responded. Agencies that had already been included elsewhere in this review are not included here (i.e. Brook Advisory Services, which are included in young peoples services). Of the thirteen agencies, six were HIV specific. Most (62%) agencies provided social care and others provided counselling (six services), alternative therapies (six services) and training programmes for HIV positive people (six services). Eleven provided 'other services'. In the space available, agencies listed many services not included on the questionnaire. The most frequently provided services were: support work, HIV prevention, safe sex awareness, information resources and health promotion.

**Table 3.5: Voluntary sector funding sources**

	Yes	No	Average Contribution	1 Year Fund	More than 1 Year Fund	Not applicable	Not recorded
PCT	9	4	55.94%	8	0	4	1
Local Authority	10	3	40.79%	7	0	3	3
Fundraising	8	5	17.18%	1	0	5	5
Lottery	4	9	31.72%	1	1	9	2
Other	8	5	12.17%	3	1	5	4

Source: Centre for Public Health voluntary agency survey.

Table 3.5 shows the funding sources of the voluntary agencies surveyed. Where voluntary agencies received PCT or local authority (LA) funds in 44% and 50% of cases respectively more than one PCT or LA contributed. The funds for each agency were usually from a number of sources. No agency received funding from a PCT or LA that was longer than a one-year basis.

### 3.5 Reproductive health service provision

In the North West NHS contraceptive services are provided through 28 Trusts and eight Brook Advisory Centres. The findings here are taken from a survey of contraception and advice services for young people, which was carried out as part of the Teenage Pregnancy Strategy. Each provider in the country was sent a self-administered questionnaire on services for young people. The 171 returns for the North West are analysed for this review, with findings split into specialist young people's contraceptive services (62 services) and community contraceptive services (109 services).

**Table 3.6: Distribution of specialist young people's contraceptive services**

	C&M		C&L		GM		NW	
	No.	%	No.	%	No.	%	No.	%
Mainstream	33	69	27	59	48	63	108	63
Full Specialist YP Service	16	31	18	39	28	37	62	36
Mainstream with Specialist YP Session	0	0	1	2	0	0	1	1

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Of those contraceptive services that took part, the distribution by whether they were specialist young people's contraceptive services or community contraceptive services is proportionately similar across the North West (Table 3.6). For each SHA, around one third of reporting services are full specialist young people's services and two thirds are community contraceptive services.

#### 3.5.1 Community contraceptive services

**Table 3.7: Free services offered by community contraceptive services**

	Percentage of contraceptive services			
	C&M	C&L	GM	NW
Condoms	97	100	98	98
Hormonal contraception	91	100	98	96
Full range	85	75	71	76
Emergency contraception	100	100	100	100
Chlamydia screening and treatment	28	46	44	40
STI screening and treatment	13	18	2	9
Staff trained in counselling skills	16	46	17	24
Qualified counsellors	5	46	27	28
Pregnancy testing	94	100	100	98
Unbiased info	94	89	98	94
Non-judgemental counselling	16	57	31	33
NHS abortion services referral	91	100	98	96
Help with accessing antenatal care	30	75	92	69

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Of the community contraceptive services 98% offered free condoms, 100% offered free emergency contraception, 98% offered free pregnancy testing and just 9% offered STI screening and treatment (Table 3.7). NHS abortion referral was offered in 96% of services across the North West.

### 3.5.2 Specialist young people's services

**Table 3.8: Free services offered by specialist young people's services**

	Percentage of young people' services			
	C&M	C&L	GM	Total
Condoms	100	100	89	95
Hormonal contraception	87	100	50	73
Full range	38	50	25	35
Emergency contraception	88	100	57	77
Chlamydia screening and treatment	27	56	43	42
STI screening and treatment	0	19	11	10
Staff trained in counselling skills	47	63	64	59
Qualified counsellors	27	50	43	41
Pregnancy testing	94	100	79	88
Unbiased info	100	100	89	95
Non-judgemental counselling	60	69	64	64
NHS abortion services referral	87	100	50	73
Help with accessing antenatal care	67	100	61	72

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people. NB Missing cases excluded from calculations.

Of the specialist young people's services 95% offered free condoms, 77% offered free emergency contraception, 88% offered free pregnancy testing and just 10% offered STI screening and treatment (Table 3.8). NHS abortion referral was offered in 73% of services, ranging from 50% in Greater Manchester to 100% in Cumbria & Lancashire.

### 3.5.3 Emergency contraception schemes

Information for clients about availability of emergency contraception is through sexual health services, young people's drop cards and services directories and local newspapers. Information provided would indicate the need for use of emergency hormonal contraception within the 72 hour period after unprotected sex.

The following PCTs have community pharmacy schemes set up to provide emergency hormonal contraception free to all ages with agreed protocols:

- Manchester, Salford & Trafford
- Morecambe Bay
- Bury
- Rochdale
- Wigan & Leigh
- Bolton
- Burnley, Pendle & Rossendale
- Blackburn

- Hyndburn & Ribble Valley
- Knowsley
- St Helens
- Stockport
- Birkenhead
- Central Cheshire
- Cheshire West
- Ellesmere Port & Neston
- East Cheshire

### 3.5.4 Termination of pregnancy service provision

There are 32 licensed termination of pregnancy (TOP) providers in the North West. Although most TOP providers are in the statutory sector (i.e. National Health Service) many terminations in the non-statutory sector are purchased by the NHS or privately. The following data is taken from a survey undertaken by the Centre for Public Health, using a self-administered questionnaire sent out to all termination of pregnancy services in the North West. Of the 32 services, 20 statutory (out of 25) and five non-statutory (out of 7) responded (a response rate of 78%).

**Table 3.9 Pre-termination counselling provision by termination of pregnancy services**

	Percentage of TOP services				
	C&L	C&M	GM	Statutory total	Non-statutory total
Is pre-termination counselling provided	100	100	100	100	100
Doctor provides pre-termination counselling	50	50	50	56	40
Nurse counsellor/social worker provides pre-termination counselling	100	67	75	78	60
Specialist referral provides pre-termination counselling	0	0	25	11	20

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

All statutory and non-statutory services (100%) report providing pre-termination counselling, which in the majority of services is most likely to be provided by a nurse counsellor/social worker (Table 3.9).

**Table 3.10: Post-termination counselling provision by termination of pregnancy services**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory total
Is post-termination counselling provided	100	75	78	84	100
Doctor provides pre-termination counselling	33	25	22	26	20
Nurse counsellor/social worker provides pre-termination counselling	33	50	67	53	40
Specialist referral provides pre-termination counselling	0	0	33	16	20
At request of patient only	67	25	33	42	20

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

Post-termination counselling was offered in 84% of statutory sector services, compared with 100% of non-statutory services (Table 3.10). In the majority of services post-termination counselling is most likely to be provided by a nurse counsellor/social worker. However, in 42% of statutory sector services counselling is offered at the request of the patient only, ranging from 25% in Cumbria & Lancashire to 67% in Cheshire & Merseyside.

**Table 3.11: Aftercare provided by termination of pregnancy services following termination procedure**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory total
Contraceptive services	100	100	100	100	80
Follow up appointment	83	75	38	61	100
Post-abortion symptoms information	83	75	88	83	80
24-hour helpline	33	75	63	56	80

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

All statutory services (100%) and the majority of non-statutory services (80%) report the provision of post-termination contraceptive aftercare (Table 3.11). Most non-statutory services (80%) and just over half (56%) of statutory services offer a 24-hour helplines.

**Table 3.12: Termination of pregnancy services that offer Chlamydia testing**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory total
Chlamydia testing offered	100	60	86	81	100
Chlamydia contact tracing offered	50	0	33	27	0

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

Table 3.12 shows that Chlamydia testing is offered in 86% of statutory sector services and all non-statutory services, ranging from 60% in Cheshire & Merseyside to 100% in Cumbria & Lancashire. Chlamydia contact tracing is offered in 27% of statutory services but not at all in services in Cheshire & Merseyside or the non-statutory sector.

### 3.6 Summary bullet points

#### 3.6.1 Service provision for sexually transmitted infections and HIV

- There are 46 statutory treatment centres providing HIV related care in the North West
- North Manchester General Hospital Infectious Diseases Unit provides the largest number of outpatient (28% of all attendances), with the Department of GUM at the Royal Liverpool University Hospital providing the next highest number

- A significant amount of HIV care is provided in the community, with Bury General Hospital and Royal Oldham Hospital providing the highest number of visits per HIV positive person, at 5.8 visits and 6.5 visits respectively
- The majority of GUM services (85%) provide emergency contraception and all (100%) provide condoms and HIV testing and counselling. Proportionately fewer services (15%) provide 'other' contraceptives in Cumbria & Lancashire

### 3.6.2 General practice service provision

- The vast majority of GPs surveyed provided oral and injectable contraceptives (99%), while fewer provided implants (33%), IUD and IUS fitting (68% and 43%) or diaphragms (53%)
- Around one third of GPs test and treat gonorrhoea (but this level was much higher in Cumbria & Lancashire – around half – compared to Greater Manchester – one quarter – and Cheshire & Merseyside – around one in ten). Levels of testing and treating chlamydia, especially in women, were higher (86% and 60% respectively)
- Around one third of GPs offered HIV testing and counselling
- The vast majority of GPs surveyed claimed to provide services for young people, the most commonly reported being oral and injectable contraceptives, emergency contraception, pregnancy testing, and NHS abortion referral. The least reported service for young people was contraceptive implants
- When asked about possible future service provision, 27% of GPs stated that carrying out a sexual history and risk assessment could be a problem, with 34% stating that testing for STIs in women could be a problem. 60% suggested HIV testing and counselling could be problematic. These are all services that should be provided within level one, i.e. primary care.
- Major barriers to carrying out additional services in the future were funding and staffing (45% of GPs) and lack of knowledge (41%). Lack of interest and moral objection to providing sexual health services was reported by only a tiny minority
- Services that GPs were interested in providing in the future included IUD insertion (53% of GPs), testing and treating STIs (37%) and contraceptive implant insertion (32%). In a different survey, 40% of GPs were interested in providing more HIV services, predominately offering support on treatment adherence

### 3.6.3 Voluntary Sector Services

- The voluntary sector provides a key role in care and support for people affected by HIV or AIDS in the North West.
- Where voluntary agencies received PCT or local authority (LA) funds in 44% and 50% of cases respectively more than one PCT or LA contributed. The funds for each agency were usually from a number of sources. No agency received funding from a PCT or LA that was longer than a one-year basis

### 3.6.4 Reproductive health services

- Of the community contraceptive services 98% offered free condoms, 100% offered free emergency contraception, 98% offered free pregnancy testing and

just 9% offered STI screening and treatment. NHS abortion referral was offered in 96% of services across the North West

- Of the specialist young people's services 95% offered free condoms, 77% offered free emergency contraception, 88% offered free pregnancy testing and just 10% offered STI screening and treatment. NHS abortion referral was offered in 73% of services
- All statutory and non-statutory TOP services provided pre-termination counselling
- Post-termination counselling was offered in 84% of statutory TOP services, compared with 100% of non-statutory services
- Chlamydia testing is offered in 81% of statutory sector TOP services, with just 27% offering contact tracing
- All statutory sector TOP services (100%) and the majority of non-statutory services (80%) report the provision of post-termination contraceptive aftercare. While most non-statutory services (80%) and just over half (56%) of statutory services offer 24-hour helplines.

## 4 Access

### 4.1 Access to genitourinary medicine services

Most of the GUM services in the North West provide clinics in the evening. However, four do not run clinics beyond 4pm and a further three do not run clinics beyond 5pm. In other words, seven of the 34 services in the North West would not be accessible to clients after 5pm. Moreover, no services reported opening at the weekend.

**Error! Not a valid bookmark self-reference.** shows the percentage of services where various access characteristics do not pose a problem. Two-thirds of services across the North West are clearly signposted from the main entrance (i.e. the interviewer could find the service without having to ask for directions). Most services have a direct phone line (91%) but less than two-thirds provide 'out of hours' recorded telephone information. Similarly, only half (53%) of the services in the region report having a clinically qualified phone operator. Table 3.2 also shows that only a quarter (26%) of services across the North West regularly review the satisfaction of patients. Cumbria & Lancashire reports the lowest positive response to this issue, with only one out of 13 services reviewing the satisfaction of patients.

**Table 4.1: Access characteristics of genitourinary medicine services**

	Percentage of GUM services			
	C&M	C&L	GM	NW
Clearly signposted from main entrance	67 (6)	62 (8)	67 (8)	65 (22)
Accessible to those with physical disabilities	100 (9)	92 (12)	100 (12)	97 (33)
A dedicated, clinically qualified phone operator	56 (5)	38 (5)	67 (8)	53 (18)
Direct phone line	89 (8)	92 (12)	92 (11)	91 (31)
Out of hours queries and/ or answer phone	56 (5)	46 (6)	83 (10)	62 (21)
Clinic regularly reviews the satisfaction of its patients	33 (3)	8 (1)	42 (5)	26 (9)

Source: Centre for Public Health GUM survey. The number of services is given in brackets.

Table 4.2 covers a range of issues addressing access in the context of service delivery. Nearly all the GUM services (94%) operate an appointment system for new and re-registered patients. Of the three SHAs in the North West, patient choice on gender of doctor is most restricted in Cumbria & Lancashire. However, in the majority of services across the North West (82%), patients who attend without an appointment are likely to be assessed by a clinical member of the team. Most of the services employ an informal system of triage to differentiate between acute and non-acute patients who attend without an appointment (74%) or who telephone for an appointment (74%).

**Table 4.2: Access in service delivery in genitourinary medicine departments**

	Percentage of GUM services			
	C&M	C&L	GM	NW
Do staff levels allow a patient to see a doctor of the gender of their choice?	67 (6)	31 (4)	67 (8)	53 (18)
Do staff levels allow a patient to see a doctor of the gender of their choice at a time of their choice?	33 (3)	8 (1)	33 (4)	24 (8)
Is there an appointment system for 'first ever' new patients?	89 (8)	92 (12)	100 (12)	94 (32)
Is there an appointment system for re-registered patients?	89 (8)	92 (12)	100 (12)	94 (32)
Are patients who attend without an appointment always assessed by a clinical member of the team?	78 (7)	69 (9)	100 (12)	82 (28)
Is there an informal system in place for differentiating between acute and non-acute patients who attend without an appointment?	67 (6)	85 (11)	67 (8)	74 (25)
Is there a formal (i.e. written) system in place for differentiating between acute and non-acute patients who attend without an appointment?	22 (2)	8 (1)	33 (4)	21 (7)
Is there a formal (i.e. written) system in place for differentiating between acute and non-acute patients who telephone for an appointment?	22 (2)	38 (5)	17 (2)	26 (9)

Source: Centre for Public Health GUM survey. The number of services is given in brackets.

Half of services (50%) report seeing patients with urgent appointments on the 'same day'. For 'same day' and 'next day' this increases to more than three quarters (91%) of services. However, two services in Cheshire & Merseyside report patients having to wait in excess of 14 days for an urgent appointment. Moreover, to reduce attendance defaulting, two services in Greater Manchester report that the maximum appointment wait that they allow is one week. This means that clients may have to contact these services more than once to secure an appointment.

When asked the longest time that patients have to wait for urgent appointments one third of services across the North West report seeing patients for urgent appointments 'same day' or 'next day'. Moreover, a quarter (27%) of services report that patients may have to wait 4-7 days or more. The longest time that patients have to wait for non-urgent appointments contrasts with the reported times given for urgent appointments. In this scenario, two thirds (65%) of services across the North West report that patients for non-urgent appointments may have to wait 4-7 days or more. Moreover, nearly half (44%) of services report that patients may have to wait in excess of 14 days.

The perception of GPs of access to GUM was somewhat different: the Centre for Public Health survey of GPs asked how long patients would have to wait at the local GUM clinic. Of those who responded, 24 (42%) thought that GUM waiting time was three or fewer days. Only four (7%) thought the waiting time was more than four weeks. GPs in Cheshire & Merseyside were particularly likely to think that waiting times for GUM were three or fewer days (62%).

The bulk (79%) of GUM service promotion is undertaken by the services themselves. All services advertised in one form or another. Almost all the services in the North West (97%) advertised their services with general practitioners. Less advertising was reported with youth services in Greater Manchester (67%) and in the telephone directory for Cumbria & Lancashire (67%).

**Table 4.3: Location and setting of GUM services**

	Percentage of GUM services*			
	C&M	C&L	GM	NW
In a dedicated department	44 (4)	23 (3)	75 (9)	47 (16)
Hospital-based, part of, and located in main out-patients department	22 (2)	31 (4)	17 (2)	24 (8)
Hospital-based, part of, and located in main out-patients department but separate from other out-patient clinics	11 (1)	8 (1)	17 (2)	12 (4)
Hospital-based but not part of out-patients department	67 (6)	31 (4)	58 (7)	50 (17)
Community-based	0 (0)	31 (4)	8 (1)	15 (5)

Source: Centre for Public Health GUM survey. The number of services is given in brackets.

\*One service is in temporary accommodation.

Table 4.3 shows that across the North West fewer than half the services (47%) are in a dedicated department. There are fewer still in Cumbria & Lancashire where just a quarter (23%) of services are in a dedicated department. Overall, the majority (85%) of services are in a hospital setting, with 50% hospital based but not part of an outpatients department. Just 15% of services in the North West (five services) are community-based.

Across the North West, GUM services were more likely to have links with community contraceptive services and HIV services. Of the three SHAs, Greater Manchester has proportionately fewer GUM services linking with drug services.

## 4.2 Access to general practice services

The Teenage Pregnancy national audit of contraceptive service provision by general practice (2001) found that the median number of doctors per practice with a family planning qualification was 2, in the North West this was 3. Nationally 13.2% of practices ran specific sessions or clinics for young people. In the North West this was 7.2% and most were run by practice nurses. Nationally 14.4% of practices reported there were GPs within the practice that would not see a young person without parental consent. In the North West, this was similar, at 15.3%.

**Table 4.4: Access to general practices (all ages)**

	Percentage of GPs			
	C&M	C&L	GM	NW
One or more evening sessions	65	74	78	72
Advertising services	57	70	52	59
Drop in anytime	19	22	12	18
Emergency contraception	100	100	92	97
Emergency contraception advertised	95	74	60	75

Source: Centre for Public Health GP survey.

In the survey carried out by the Centre for Public Health, GPs were asked for their usual opening hours. Most had at least one evening session (defined as the surgery being open after 5.00pm), although this differed by PCT, with those in Greater Manchester being most likely (78%) and Cheshire & Merseyside the least likely to have at least one evening session (65%) (Table 4.4).

**Table 4.5: Access to general practices for young people**

	Percentage of GPs			
	C&M	C&L	GM	NW
Access to emergency contraception	64.1	81.6	69.7	69.8
Staff specially trained for working with young people	28.9	55.3	31.8	34.7
Special young people's sessions on sexual health*	42.1	52.6	58.3	52.7
See under 16s without parent	81.2	93.9	84.0	84.7
Written policy on confidentiality	75.5	76.2	71.6	73.7
Visible notices about confidentiality	8.2	16.3	15.6	13.2
Conscientious objection to abortion	29.4	15.6	25.6	25.2

Source: CPH analysis of Teenage Pregnancy General Practice Audit 2001 (unpublished).

NB cases excluded due to missing data

\*A particularly high proportion (76%) of data were missing

The Teenage Pregnancy GP audit identified specific issues around access for young people. In the North West, relatively few GPs (24%) responded to the question on whether they offered specific sexual health sessions for young people. Of those that did, 53% offered special sessions. Of those not offering sexual health sessions for young people, several stated that young people could have immediate access to a GP or practice nurse. A quarter of general practices had doctors with a conscientious objection to abortion, ranging from 16% of Cumbria & Lancashire practices to 29% of Cheshire & Merseyside practices (Table 4.5).

### **4.3 Access to HIV voluntary agencies**

In the voluntary agency questionnaire, agencies were asked to list their opening times. Opening times were divided into sessions, a session being defined as a period in the morning, afternoon, or evening (after 5pm). The 13 voluntary agencies surveyed had between five and 21 sessions each week. Four had no evening sessions and the remaining nine had one to seven evening sessions each week.

### **4.4 Access to reproductive health services**

#### **4.4.1 Access to community contraceptive services**

In the North West NHS contraceptive services for all ages are provided through 28 Trusts and eight Brook Advisory Centres. The findings here on community contraceptive services (109 services) are taken from the Teenage Pregnancy Strategy audit of contraceptive services for young people and refer to services where provision is identified as mainstream (i.e. services that cater for all age groups and not specifically young people).

**Table 4.6: Organisations in partnership with community contraceptive services**

	Percentage of community contraceptive services			
	C&M	C&L	GM	NW
Youth services	9	0	0	3
Social services	0	0	0	0
Voluntary sector	0	0	0	0
Education sector	0	4	0	1
School nurses	0	0	0	0
Other contraceptive services	15	0	25	16
GUM	9	25	27	21
Primary Care	0	4	10	6
Other	6	0	29	15

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

The most frequently reported partner organisation by community contraceptive services was GUM Services at 21%, ranging from 27% in Greater Manchester and 25% in Cumbria & Lancashire to just 9% in Cheshire & Merseyside (Table 4.6). Primary care as a partner organisation was reported in just 6% of services across the North West, with 10% in Greater Manchester, 4% in Cumbria & Lancashire and none in Cheshire & Merseyside.

**Table 4.7: Specific groups targeted by community contraceptive services**

	Percentage of community contraceptive services			
	C&M	C&L	GM	NW
No specific group	97	86	98	94
Young women	0	14	0	4
Young men	0	14	0	4
Black & minority ethnic young people	0	0	0	0
Gay, lesbian and bisexual young people	0	0	0	0
Other	3	0	0	1

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Across the North West most services (94%) did not have a specific target group (Table 4.7). The only reported target groups were young men (4%) and young women (4%), both of which are accounted for by services in Cumbria & Lancashire. None of the services reported targeting black and minority ethnic young people.

**Table 4.8: Confidentiality policies of community contraceptive services**

	Percentage of community contraceptive services			
	C&M	C&L	GM	NW
Policy on confidentiality	100	86	100	96
Written policy	85	78	96	88
Mention of under 16s having equal rights	85	61	65	70
New staff sign up	39	42	70	54
Displayed notices	18	23	35	27
Discuss application	45	64	48	51

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

The majority of services (96%) report having a policy on confidentiality (a written policy in 88% of services), ranging from 100% in Cheshire & Merseyside and Greater Manchester to 86% in Cumbria & Lancashire (Table 4.8). In 54% of

services across the North West new staff have to 'sign up' to the confidentiality policy.

**Table 4.9: Appointment systems in place in community contraceptive services**

	Percentage of community contraceptive services			
	C&M	C&L	GM	NW
Drop-in only	79	11	13	33
Appointment Only	3	0	15	8
Both	18	89	72	59

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Table 4.9 shows that at the regional level a third of services (33%) had a drop-in only service, but the majority had appointments and drop-in (59%), with only 8% employing an appointment only system. However, in contrast, for the majority of services in Cheshire & Merseyside (79%) a drop-in service is employed.

**Table 4.10: Community contraceptive service opening times**

	Percentage of community contraceptive services			
	C&M	C&L	GM	NW
Monday Open	39	33	33	35
Tuesday Open	42	32	30	35
Wednesday Open	39	21	38	34
Thursday Open	52	39	30	39
Friday Open	27	7	13	16
Saturday Open	9	4	4	6
Sunday Open	6	0	4	4

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Apart from Friday, across the region around a third of services are likely to be open during the week (Table 4.10). Just 16% of services report opening on a Friday, ranging from 7% in Cumbria & Lancashire to 27% in Cheshire & Merseyside. Over the weekend, 6% of services were open on a Saturday and 4% were open on a Sunday (except in Cumbria & Lancashire).

**Table 4.11: Location of community contraceptive services**

	Percentage of community contraceptive services			
	C&M	C&L	GM	Total
Own premises	3	0	4	3
Health centre	42	57	38	44
Community clinic	42	32	52	44
School	0	0	0	0
Youth club	0	0	0	0
Advice shop	0	0	0	0
Outreach	0	0	0	0
Other	21	11	10	14

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Across the region, the majority of services were reported as located in either a health centre (44%) or a community clinic (44%) (Table 4.11). Just 3% of services are located in own premises.

#### 4.4.2 Access to specialist young people's contraceptive services

In the North West, NHS contraceptive services are provided through 28 Trusts and eight Brook Advisory Centres. The findings here on specialist young people's contraceptive services (62 services) are taken from the Teenage Pregnancy Strategy audit of contraceptive services for young people and refer to services where provision is identified as specifically for young people (i.e. full specialist services catering for young people).

**Table 4.12: Organisations in partnership with young people's contraceptive services**

	Percentage of young people's contraceptive services			
	C&M	C&L	GM	NW
Youth services	50	61	43	50
Social services	0	6	11	6
Voluntary sector	0	22	14	13
Education sector	6	0	14	8
School nurses	6	6	11	8
Other contraceptive services	0	6	7	5
GUM	0	0	7	3
Primary Care	6	0	7	5
Other	6	17	46	27

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

As can be seen in Table 4.12, the partner organisation that was most frequently reported by specialist young people's contraceptive services was youth services at 50%; the least reported was GUM at just 3% (Greater Manchester only). Primary care as a partner organisation was reported in just 5% of services across the North West, with 6% in Cheshire & Merseyside, 7% in Greater Manchester and none in Cumbria & Lancashire.

**Table 4.13: Specific groups targeted by specialist young people's contraceptive services**

	Percentage of young people's contraceptive services			
	C&M	C&L	GM	NW
No specific group	81	89	68	77
Young women	13	17	11	13
Young men	13	17	14	15
Black & minority ethnic young people	0	6	0	2
Gay, lesbian and bisexual young people	6	17	11	11
Other	6	17	14	13

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Most services (77%) did not have a specific target group (Table 4.13). The most frequently reported target groups were young men (15%) and young women (13%). Only 2% of services targeted black and minority ethnic young people (Cumbria & Lancashire only).

**Table 4.14: Confidentiality policies of specialist young people's contraceptive services**

	Percentage of young people's contraceptive services			
	C&M	C&L	GM	NW
Policy on confidentiality	94	81	100	93
Written policy	93	71	86	84
Mention of under 16s having equal rights	81	73	58	68
New staff sign up	88	50	81	75
Displayed notices	94	63	82	80
Discuss application	94	83	82	85

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

The majority of services (93%) report having a policy on confidentiality (a written policy in 84% of services), ranging from 100% in Greater Manchester to 81% in Cumbria & Lancashire (Table 4.14). In 75% of services across the North West new staff have to 'sign up' to the confidentiality policy.

**Table 4.15: Appointment systems in place in young people's contraceptive services**

	Percentage of young people's contraceptive services			
	C&M	C&L	GM	Total
Drop-in only	69	61	69	67
Appointment Only	0	0	4	2
Both	31	39	27	32

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Most services across the North West (67%) had a drop-in only service or appointments and drop-in (32%), with only 2% employing an appointment only system (Greater Manchester only) (Table 4.15).

**Table 4.16: Opening times of young people's contraceptive services**

	Percentage of young people's contraceptive services			
	C&M	C&L	GM	NW
Monday Open	60	59	72	65
Tuesday Open	40	47	50	47
Wednesday Open	47	35	65	52
Thursday Open	60	35	62	53
Friday Open	27	18	32	26
Saturday Open	40	12	32	28
Sunday Open	0	0	0	0

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

By region and SHA, Monday was the most likely day during the week for services to be open (Table 4.16). Around a quarter of services (26%) were open on a Friday, ranging from 32% in Greater Manchester to 18% in Cumbria & Lancashire. Over the weekend, 28% of services were open on a Saturday and none were open on a Sunday.

**Table 4.17: Location of young people's contraceptive services**

	Percentage of young people's contraceptive services			
	C&M	C&L	GM	NW
Own premises	20	17	39	28
Health centre	13	28	18	20
Community clinic	20	11	18	16
School	0	0	7	3
Youth club	27	11	21	20
Advice shop	27	39	11	23
Outreach	27	6	14	15
Other	19	6	18	15

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Across the region 28% of services were reported as located in own premises, 23% in advice shops, 20% in health centres, 20% in youth clubs, and 16% in community clinics (Table 4.17). Services are twice as likely to be located in own premises in Greater Manchester (39%) than in Cheshire & Merseyside (20%) and Cumbria & Lancashire (17%).

#### 4.4.3 Access to condom distribution services

Condom distribution may take place through general practices, services targeting specific groups such as young people, gay men or through generic contraceptive services. Distribution schemes vary and may be linked to campaigns or events. The findings here are based on the 21 questionnaires from responding primary care trusts (PCTs) (a response rate of 50%) in the North West.

**Table 4.18: Percentage of primary care trusts with condom distribution schemes in place**

	Percentage of PCTs			
	C&M	C&L	GM	NW
Scheme(s) in place	83	71	88	81
Secure scheme	40	80	43	53
Protocols on distribution	80	100	57	76

Source: North West Regional Office Survey. NB findings refer to the responding PCTs only.

Of the 21 out of 42 PCTs that responded to the survey, 84% have condom distribution schemes in place, with little difference across SHAs (Table 4.18). However, only 56% of these schemes are secure (several of these schemes are funded through HIV prevention monies). Three-quarters of the condom schemes in operation have protocols on distribution, ranging from 57% in Greater Manchester to 100% in Cumbria & Lancashire.

Manchester condom panel is a collaboration of agencies providing HIV prevention throughout Manchester. An annual budget (£43,500 in 2002) is allocated to the panel exclusively for the purchase of condoms and other related sexual health items (i.e. lubricants, spermicides). There are currently 40 agencies who receive items directly from the Manchester condom panel. Organisations whose primary function is HIV prevention take priority in the allocation, including those that work directly with sex trade workers, drug users, people living with HIV and young people. However, various other agencies may receive part of the allocation if they meet the criteria set out in the principles for allocation of condoms document. In addition to the condom panel provision the Lesbian & Gay Foundation (LGF) provide the city's primary Condom and Lube Distribution Scheme for men who have sex with men. During the year 2001-2002 LGF distributed 428,820 condoms and 427,820 sachets of lubricant to venues across the gay village including bars, clubs and saunas. Two extra strong condoms and two sachets of lubricant are packed into specially printed card wallets to form a gay mans' safer sex pack. The safer sex packs are freely available through 80 city centre distribution points in addition to loose condoms and sachets of lubricant that are still available in some bars and clubs.

#### 4.4.4 Access to emergency contraception services

There are many providers of emergency hormonal contraception: community contraceptive services, general practice, community pharmacy schemes (free provision systems), community pharmacy by prescription or to purchase, NHS walk in centres, GUM services and other providers e.g. departments of accident & emergency.

#### 4.4.5 Access to termination of pregnancy services

There are 32 licensed termination of pregnancy (TOP) providers in the North West, 25 of which are in the statutory sector and seven in the non-statutory sector. However, although most TOP providers are in the statutory sector (i.e. National Health Service) many terminations in the non-statutory sector are purchased by the NHS or privately.

Advertising of statutory sector TOP services was not extensive. The most common form of advertising was GP services (50% of services) and at other sexual health clinics (43%). Some services advertised in schools/colleges (14%).

**Table 4.19: Geographical area covered by termination of pregnancy services**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory
Specific and local	80	50	78	72	0
Extends to region	20	50	25	28	100

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

Table 4.19 shows that two-thirds of services covered their local population only. All non-statutory sector services covered the whole region (two of the five non-statutory services responding had fewer than five abortions for the year).

**Table 4.20: Referral route to termination of pregnancy services**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory
Self-referral	33	50	22	32	60
GPs	83	100	100	95	100
Family Planning	83	100	89	90	40
Young People's services	50	50	78	63	60
Pregnancy Advisory Services	17	25	56	37	60
Other	33	25	22	26	20

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

Table 4.20 shows that one third of statutory services accepted self-referrals, almost all had referrals from GPs (95%) and community contraceptive services (family planning services (90%). Overall, GPs and family planning were identified as the main referral routes for both statutory and non-statutory services.

**Table 4.21: How appointments for assessment are made at termination of pregnancy services**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory
Telephone	83	100	100	95	60
Through centralised telephone booking	60	50	14	38	40
Fax	83	100	100	95	20
Letter	83	100	89	89	40
Other	33	0	0	11	40

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

The majority of statutory sector services reported the use of telephone, fax or letter for assessment appointments (Table 4.21). Proportionately fewer non-statutory sector services reported the use of telephone for making assessment appointments. However, over a third of services (statutory and non-statutory) made appointments through a system of centralised telephone booking.

**Table 4.22: Policy on young women aged under 16 years seeking termination**

	Percentage of TOP services				
	C&M*	C&L	GM	Statutory total	Non-statutory*
Parental or legal guardian consent required	33	25	11	21	20
Gillick competence applied	50	100	100	84	60

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations. Two statutory sector services indicated that either policy could apply. \*Not applicable to one TOP service as terminations for foetal abnormality only.

Table 4.22 shows that, for most services, the Gillick competence applied, with just one fifth of services (statutory and non-statutory) requiring parental or legal guardian consent for girls aged under 16 years old seeking a termination.

**Table 4.23: Policy on staff in termination of pregnancy services with conscientious objection to abortion**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory
Policy on conscientious objection to abortion	67	100	75	78	25
Measures to ensure non-judgemental staff:					
Training	40	67	29	40	40
Monitoring	40	33	43	40	50
Other	60	0	29	33	40

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

The majority of statutory sector services reported having a policy on conscientious objection to abortion, ranging from 100% in Cumbria & Lancashire to 67% in Cheshire & Merseyside (Table 4.23). Across the region 40% of services reported that they used training as a measure to ensure non-judgemental staff.

**Table 4.24: Choice of method of induced abortion offered up to 13 weeks**

	Percentage of TOP services*				
	C&M	C&L	GM	Statutory total	Non-statutory
Medical termination only	0	0	11	5	0
Surgical termination only	0	25	33	21	40
Medical and surgical termination	83	75	56	68	60

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

\*Not applicable to services providing therapeutic abortions for foetal abnormality.

More than two-thirds of statutory sector services offer choice of medical or surgical termination up to 13 weeks (Table 4.24). However, this differed by SHA, with those in Cheshire & Merseyside being most likely (83%) and Greater Manchester the least likely to offer a choice (56%) of induced abortion method.

**Table 4.25: Choice of method of induced abortion offered at more than 13 weeks**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory
Medical termination only	50	50	33	42	0
Surgical termination only	17	0	0	5	60
Medical and surgical termination	17	25	0	11	20
No terminations provided	17	25	67	42	20

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

Choice of method of induced abortion at more than 13 weeks is restricted in the statutory sector with just 11% offering either medical or surgical termination (Table 4.25). Many statutory sector services (42%) do not provide terminations at all beyond 13 weeks and, for those that do, medical termination (42%) is the most likely method to be provided.

**Table 4.26: Maximum waiting time for an assessment appointment at termination of pregnancy services**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory
Within 5 days	0	25	22	16	75
More than 5 days	83	75	78	79	25

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

The maximum waiting time for an initial assessment was reported as more than five days in the majority of statutory sector services but within five days for the majority of non-statutory sector services (Table 4.26).

**Table 4.27: Maximum time from when abortion agreed to being undertaken by termination of pregnancy services**

	Percentage of TOP services				
	C&M	C&L	GM	Statutory total	Non-statutory
1 week	17	50	44	37	25
2 weeks	83	25	33	47	75
3 weeks	0	0	22	11	0
More than three weeks	0	25	0	5	0

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

In the statutory sector, once abortion is agreed, the maximum waiting time was reported as three or more weeks in 16% of services (Table 4.27). By contrast, in the non-statutory sector, once abortion is agreed, all are reported as undertaken within two weeks. However, for the majority of services the maximum wait is up to two weeks.

In the GP survey carried out by the Centre for Public Health, of those GPs expressing an opinion about waiting time for a termination, a few (9%) thought three or fewer days, the most common responses were 4 to 13 days (48%) and two to four weeks (42%).

**Table 4.28: Average time in weeks between referral and abortion reported by community contraceptive services**

	Percentage of community contraceptive services			
	C&M	C&L	GM	NW
1.0 week	0	0	43	24
1.5 weeks	4	9	0	2
2.0 weeks	4	45	28	23
2.5 weeks or more	93	45	28	50

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Across the region, at 24% the most frequently reported average time between referral and abortion by community contraceptive services was one week (Table 4.28). However, this was entirely accounted for by Greater Manchester (43% of services). At 93% Cheshire & Merseyside reports the most services where clients have to wait 2.5 weeks or more between referral and abortion.

**Table 4.29: Average distance to access NHS abortion services reported by community contraceptive services**

	Percentage of community contraceptive services			
	C&M	C&L	GM	NW
0.0 miles	0	0	2	1
0.5 miles	0	0	2	1
1.0 miles	0	7	2	3
2.0 miles	0	26	15	14
3.0 miles	0	0	13	6
4.0 miles	0	4	8	5
5.0 miles	4	11	10	9
6.0 miles	0	4	6	4
7.0 miles	0	0	4	2
7.5 miles	4	0	0	1
8.0 miles	0	0	2	1
10 miles or more	95	48	35	56

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Across the region more than half of community contraceptive services (56%) reported that average distance to NHS abortion services was 10 miles or more (Table 4.29). However, this disguises differences between SHAs. In Cheshire & Merseyside 95% of services reported that clients have to travel 10 miles or more to access abortion services, which compares with Greater Manchester where the figure is just 35%.

**Table 4.30: Average time in weeks between referral and abortion reported by specialist young people's services**

	Percentage of specialist young people's contraceptive services			
	C&M	C&L	GM	NW
1.0 week	10	31	13	18
1.5 weeks	0	0	6	3
2.0 weeks	0	46	44	33
2.5 weeks or more	90	23	38	48

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Across the region, at 33% the most frequently reported average time between referral and abortion by Specialist YP Services was 2 weeks, with 48% reporting the average time as 2.5 weeks or more (Table 4.30). At 90% Cheshire & Merseyside reports the most services where clients have to wait 2.5 weeks or more between referral and abortion.

**Table 4.31: Average distance to access NHS abortion services reported by specialist young people's services**

	Percentage of specialist young people's contraceptive services			
	C&M	C&L	GM	NW
2.0 miles	0	0	13	5
3.0 miles	0	0	19	7
4.0 miles	0	7	6	5
5.0 miles	10	7	0	5
6.0 miles	0	13	13	10
8.0 miles	0	0	19	7
10 miles or more	90	74	32	58

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Across the region more than half of Specialist YP services (58%) reported that average distance to NHS abortion services was 10 miles or more. However, this disguises differences between SHAs (Table 4.31). In Cheshire & Merseyside 90% of services reported that clients have to travel 10 miles or more to access abortion services, which compares with Greater Manchester where the figure is just 32%.

## 4.5 Summary bullet points

### 4.5.1 Access to genitourinary medicine services

- Seven of the 34 GUM services in the North West are not accessible to clients after 5pm and none are open at the weekend
- Inadequacies with signposting, facilities for disabled, and telephone contact are likely to pose access problem for clients of several GUM services
- Only a quarter of GUM services regularly review the satisfaction of patients
- The majority of GUM services employ appointment systems for new and re-registered patients
- The majority of GUM services employ an informal system of triage to differentiate between acute and non-acute patients
- Half of GUM services report that patients for urgent appointments will be seen on the 'same day'
- Almost half of GUM services report that patients for non-urgent appointments could be waiting more than two weeks before being seen

### 4.5.2 Access to general practice services

- 72% of GPs who responded to the CPH survey had evening access (after 5pm) on at least one day of the week
- 85% of GPs saw under 16s without a parent
- A quarter of GPs had a conscientious objection to abortion, ranging from 16% in Cumbria & Lancashire to 29% in Cheshire & Merseyside

### 4.5.3 Access to reproductive health services

- The majority of community contraceptive services (96%) have a policy on confidentiality

- A third of community contraceptive services (33%) had a drop-in only service, but the majority had appointments and drop-in (59%)
- 35% of community contraceptive services were open on a Monday, 16% were open on a Friday, 6% were open on a Saturday and 4% were open on a Sunday
- The majority of community contraceptive services were reported as located in either a health centre (44%) or a community clinic (44%)
- The most frequently reported (23%) average time between referral and abortion for community contraceptive services was 2 weeks, with 50% reporting the average time as 2.5 weeks or more
- More than half of community contraceptive services (56%) reported that average distance to NHS abortion services was 10 miles or more
- The most frequently reported partner organisation for young people's contraceptive services was youth services at 50%, the least reported was GUM at just 3%
- The majority of young people's contraceptive services (93%) have a policy on confidentiality
- Most young people's contraceptive services (67%) had a drop-in only service or appointments and drop-in (32%)
- 65% of young people's contraceptive services were open on a Monday, 26% were open on a Friday, 28% were open on a Saturday and none were open on a Sunday
- Young people's contraceptive services were reported as located in own premises (28%), health centre (20%), youth club (20%), and community clinic (16%)
- The most frequently reported (33%) average time between referral and abortion by young people's contraceptive services was 2 weeks, with 48% reporting the average time as 2.5 weeks or more
- More than half of young people's contraceptive services (58%) reported that average distance to NHS abortion services was 10 miles or more
- The most frequently reported partner organisation for community contraceptive services was GUM Services at 21%
- Of the PCTs reporting 84% have condom distribution schemes in place but only 56% are reported as secure
- The majority of condom distributions schemes reported having protocols on distribution
- Nearly half of PCTs in the North West have community pharmacy schemes in place
- Two-thirds of TOP services covered their local population only
- Overall, GPs and community contraceptive services (family planning) were identified as the main referral routes for both statutory and non-statutory TOP services
- More than two-thirds of statutory sector TOP services offer choice of medical or surgical termination up to 13 weeks
- Just 11% statutory sector TOP services offer choice of method of induced abortion at more than 13 weeks, with 42% not providing terminations at all

- The maximum waiting time for an initial assessment was reported as more than five days in the majority of statutory sector TOP services but within five days for the majority of non-statutory sector services
- In the statutory sector, once abortion is agreed, the maximum waiting time was reported as three or more weeks in 16% of TOP services. In the non-statutory sector, all are reported as undertaken within two weeks

## 5 Staffing and training

### 5.1 Genitourinary medicine services

**Table 5.1: Adequacy of genitourinary medicine department staffing levels**

	Percentage of GUM services (%)			
	C&M	C&L	GM	NW
Doctors	33 (3)	8 (1)	25 (3)	21 (7)
Nurses	44 (4)	8 (1)	33 (4)	26 (9)
Health advisers	56 (5)	15 (2)	33 (4)	32 (11)
Administrative staff	33 (3)	8 (1)	50 (6)	29 (10)

Source: Centre for Public Health survey of GUM services. The number of services is given in brackets.

Table 5.1 presents responses by the services to the adequacy of staffing levels. Less than a third of services considered staffing levels to be adequate. In Cumbria & Lancashire, the equivalent of one service only reports adequate staffing levels for doctors, nurses and administrative staff.

Half or more GUM services across the North West report that all non-administrative staff work beyond contracted hours. However, across the region more staff vacancies are reported for doctors than for other GUM staff. In Greater Manchester, vacancies for doctors are reported in two thirds (67%) of services.

For a quarter (26%) of GUM services across the North West in-house staff training of doctors is reported as 'good'. Staff training outside the unit is rated slightly higher, with more than two thirds (76%) reporting it as 'good' or 'adequate'. In-house staff training of non-administrative staff is reported as 'good' for a quarter (24%) of GUM services across the North West. Training outside the unit for non-administrative staff is rated slightly higher, with more than two thirds (69%) reporting it as 'good' or 'adequate'.

**Table 5.2: Weekly doctor, nurse and health adviser led sessions\* per million of population\*\* in genitourinary medicine departments**

	C&M	C&L	GM	NW
GUM only nurse led sessions	15.4	3.5	9.7	10.0
All nurse led sessions	18.6	6.6	10.4	12.2
GUM only health adviser sessions	1.6	2.0	5.6	3.2
All health adviser sessions	8.0	8.1	7.8	7.9
GUM only doctor sessions	48.2	35.4	53.5	46.7
All doctor sessions	67.0	40.5	62.8	58.1

Source: Centre for Public Health survey of GUM services. \*Usually run concurrently with doctor sessions. \*\*Population numerator uses estimates based on 1991 census.

To standardise for different staffing levels of clinics between and within GUM services, one nurse/health adviser per session is the adopted comparator. Table 5.2 shows the weekly number of nurse and health adviser led sessions per million of population. Cumbria & Lancashire has fewer nurse led sessions per million of population whether by GUM only (3.5 per million) or all nurse led sessions (6.6 per

million). Cheshire & Merseyside has fewer health adviser led sessions for GUM only (1.6 per million). However, for all health adviser led sessions there is little difference between the SHAs. Cumbria & Lancashire has fewer doctor sessions per million of population whether by GUM only or all doctor sessions. However, while there are proportionately more GUM only doctor sessions in Greater Manchester (53.5 per million) than in Cheshire & Merseyside (48.2 per million), for all doctor sessions the situation is reversed (Cheshire & Merseyside has 67 per million compared to 62.8 in Greater Manchester).

**Table 5.3: Whole time equivalent health advisers and nurses in genitourinary medicine departments by grade**

	C&M	C&L	GM	NW
WTE health advisers	14.7	8.96	11.72	35.3
WTE health advisers grade G and above*	12.9 (93%)	7.8 (65%)	9.7 (75%)	30.4 (80%)
WTE nurses**	42.6	15.7	32.8	91.0
WTE nurses grade E and above	23.4 (55%)	10.3 (66%)	22.9 (70%)	56.6 (62%)

Source: Centre for Public Health survey of GUM services. \*Excludes three instances of non-standard grade. \*\*Includes health care assistants. Percentages in brackets are by SHA.

Table 5.3 presents the distribution of health advisers and nurses. In the North West there are 35.3 whole-time equivalent (WTE) health advisers and 91.0 WTE nurses. 80% of the health advisers are grade G and above and 62% of the nurses are grade E and above. Cheshire & Merseyside has more WTE health advisers (14.7) and WTE nurses (42.6) than the other two SHAs. Similarly, Cheshire & Merseyside has more grade G and above WTE health advisers (12.9) and grade E and above WTE nurses (23.4) than the other two SHAs.

**Table 5.4: Actual and recommended whole time equivalent medical staff and consultants in genitourinary medicine departments**

	C&M	C&L*	GM	NW
WTE medical staff (including consultants)	19.4	8.1	20	47.5
WTE consultants	8.9	4.2	9.8	22.9
RCP recommended WTE consultants	21.2	14.2	23.1	58.5

Sources: Mersey & Cheshire Confederation, Lancashire & South Cumbria Education & Training Confederation, Greater Manchester Workforce Development Confederation.

\*Does not include data for Carlisle Hospital NHS Trust and West Cumbria Health Care NHS Trust.

Table 5.4 presents actual (at 31<sup>st</sup> March 2001) and recommended medical staffing levels by SHA. Cheshire & Merseyside and Greater Manchester have double the number of WTE medical staff and consultants reported for Cumbria & Lancashire. However, using the Royal College of Physicians (RCP) recommendation (see Adler and colleagues) of one GUM consultant per 113,000 of population, each of the three SHAs is understaffed with fewer than half the recommended number. For the North West as a whole the shortfall is 35.5 WTE consultants. Moreover, for each SHA the total number of WTE medical staff falls short of the RCP recommendations for WTE consultants.

## 5.2 General practices

In the Teenage Pregnancy General Practice audit, GPs were asked how many of their staff had family planning qualifications. In the majority of practices, all the

GPs had qualifications. However, when considering the proportion of nurses with family planning qualifications, practices tended fall into one of two categories: around half of practices had no nurses with family planning qualifications and in the other half all nurses had qualifications.

**Table 5.5 Staff training provision in general practices**

Training in:	Percentage of GPs			
	C&M	C&L	GM	NW
Taking sexual histories	59	59	29	49
Clinical subject area	53	59	29	47
PGD	47	44	33	41
Nurse prescribing	59	52	42	50

Source: Centre for Public Health survey of GP services

Around half of GPs participating in the TP audit stated they would be interested in a seminar on confidentiality, and two thirds were interested in training for working with young people (Table 5.5). Levels of interest in confidentiality seminars and training for working with young people were the same across the three strategic health authorities.

General practices identified significant training needs if they were to undertake the services suggested in the National Strategy for Sexual Health and HIV (see section 3.3).

### **5.3 HIV voluntary agencies**

Training in HIV voluntary agencies was linked to staffing within the services. Three of the 13 voluntary agencies had no paid members of staff, the other ten agencies recorded between two and 27 paid members of staff, with 8 being the most common number of paid staff. All but one voluntary agency who completed the questionnaire had unpaid members of staff, these figures differed considerably between two and 107 unpaid members. Of the ten agencies who had paid staff, four provide no training and one did not record anything. The training information provided in the remaining five cases showed HIV information training and helpline training as the most common forms of training at voluntary agencies for paid staff. Twelve voluntary agencies have unpaid staff members. Two of these agencies provide no training and one did not record the information; the remaining nine agencies revealed that volunteer training, HIV information training and helpline training were the most common provided for unpaid staff members.

## 5.4 Reproductive health services

### 5.4.1 Community contraceptive services

**Table 5.6: Training of staff in community contraceptive services**

	Percentage of community contraceptive services			
	C&M	C&L	GM	NW
Sexual health communication skills	76	82	53	68
Confidentiality training:				
Receptionist	73	46	75	67
Doctor/nurse	73	50	75	68
Non clinical staff	21	18	4	13

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Staff training in sexual health communication skills was reported by 68% of services, ranging from 82% in Cumbria & Lancashire to 53% in Greater Manchester (Table 5.6). Doctor/nurse training on confidentiality was reported in two-thirds of services (68%), with just 13% for non-clinical staff.

### 5.4.2 Specialist young people's services

In the Teenage Pregnancy Strategy audit of contraceptive services for young people, recruitment of staff with skills/experience of working with young people was reported by 89% of services across the region, ranging from 75% in Cheshire & Merseyside, 83% in Cumbria & Lancashire to 100% in Greater Manchester.

**Table 5.7: Training of staff in specialist young people's contraceptive services**

	Percentage of specialist young people's contraceptive services			
	C&M	C&L	GM	NW
Young people	75	69	89	80
Black & minority ethnic young people	19	11	36	24
Gay, lesbian and bisexual young people	44	56	43	47
Young people with special needs	38	33	36	35
Sexual health communication skills	75	78	54	66
Confidentiality training:				
Receptionist	50	33	54	47
Doctor/nurse	63	33	46	47
Non clinical staff	63	22	54	47

Source: Teenage Pregnancy Strategy audit of contraceptive services for young people.

Staff training in sexual health communication skills was reported by 66% of services, ranging from 78% in Cumbria & Lancashire to 54% in Greater Manchester. Training for all staff in community contraceptive services on confidentiality was reported in just less than half of services (47%) across the region.

### 5.4.3 Condom schemes

Of the condom schemes in operation across the North West 71% have related staff training sessions in place, ranging from 60% in Cumbria & Lancashire, 71% in Greater Manchester to 80% in Cheshire & Merseyside.

### 5.4.4 Emergency contraception community pharmacy schemes

Comprehensive guidance on best practice for the supply of emergency contraception was sent to all pharmacists by the Royal Pharmaceutical Society (England, Scotland and Wales), which was supported by training from the Centre for Pharmacy Postgraduate Education (CPPE). In addition, supplementary training for pharmacists was provided for all schemes by the Manchester team, which included skills in communication with young people, use of Fraser Guidelines together with data collection and monitoring systems.

### 5.4.5 Termination of pregnancy services

The only training issue for TOP services addressed by the Centre for Public Health survey of TOP services related to conscientious objection to abortion. Across the region 40% of services reported that they used training as a measure to ensure non-judgemental staff (see Access to termination of pregnancy services, section 4.4.5).

## 5.5 Summary bullet points

### 5.5.1 Genitourinary medicine services

- Most GUM services report inadequate staffing levels, along with excess working and vacancies
- In a quarter of GUM services no in-house training is provided for non-administrative staff
- The deployment of nurses shows marked variation across the North West, with far fewer nurse led sessions in Cumbria & Lancashire per million of population
- The number of doctor led sessions shows marked variation across the North West, with far fewer sessions in Cumbria & Lancashire per million of population

### 5.5.2 General practices

- In the majority of practices, most GPs within the practice had family planning qualifications. However, it is not clear in how many cases training is kept up to date
- Around half of general practices stated that staff had access to training in taking sexual histories, clinical subject areas, PGDs and nurse prescribing
- Around half of GPs expressed an interest in a seminar on confidentiality and two thirds were interested in training for working with young people

### 5.5.3 Reproductive health

- Doctor/nurse training on confidentiality was reported in two-thirds of community contraceptive services (68%), with just 13% for non-clinical staff

- Staff training for receptionists, doctors, nurses and non-clinical staff on confidentiality was reported in just less than half of young people's contraceptive services (47%), with training in sexual health communication skills reported by 66%
- Recruitment of staff with skills/experience of working with young people was reported by 89% of Young people's contraceptive services
- The vast majority of condom distribution schemes reported training programmes
- Of TOP services, 40% reported having a policy on conscious objection to abortion, with 40% reporting the use of training as a measure to ensure non-judgemental staff

## 6 Data collection

### 6.1 HIV/AIDS

For brief details of HIV/AIDS surveillance in the North West see section 1.3.2.

### 6.2 Genitourinary medicine services

The main data sources for GUM service activity are the KC60 and KH09 quarterly statistical returns. Aggregate data collected on form KC60 include total number of episodes of each STI diagnosed and, for selected conditions only, age group and male sexual orientation. Aggregate data collected on form KH09 include total number of attendances by new and follow-up patients.

**Table 6.1: Data held on clients of genitourinary medicine departments**

	Percentage of GUM services							
	C&M		C&L		GM		NW	
	Computer	Paper	Computer	Paper	Computer	Paper	Computer	Paper
Age	89 (8)	89 (8)	38 (5)	100 (13)	92 (11)	92 (11)	71 (24)	94 (32)
Sex	89 (8)	89 (8)	38 (5)	92 (12)	92 (11)	92 (11)	71 (24)	91 (32)
1st part post code	89 (8)	89 (8)	31 (4)	69 (9)	83 (10)	83 (10)	65 (22)	79 (27)
1st digit 2nd part post code	89 (8)	89 (8)	31 (4)	62 (8)	75 (9)	92 (11)	62 (21)	79 (27)
Infection(s) identified	89 (8)	89 (8)	38 (5)	100 (13)	83 (10)	92 (11)	68 (23)	94 (32)
Ethnicity	67 (6)	67 (6)	31 (4)	38 (5)	75 (9)	75 (9)	56 (19)	59 (20)
Sexual orientation	56 (5)	89 (8)	31 (4)	92 (12)	75 (9)	92 (11)	53 (18)	91 (32)
Occupation	78 (7)	78 (7)	31 (4)	62 (8)	83 (10)	83 (10)	62 (21)	74 (25)
No objection to allowing CDSC and NWPFO access to data	89 (8)		85 (11)		83 (10)		85 (30)	

Source: Centre for Public Health survey. The number of services is given in brackets.

Table 6.1 shows that a wide range of computerised and paper data are reported as collected by GUM services in the North West, although fewer services – only

38% in Cumbria & Lancashire - report holding ethnicity data on clients. Fewer than half of services in Cumbria & Lancashire report holding any computerised data. Moreover, where data are held on computers the hardware and software in many of the services are antiquated. However, of the 34 GUM services surveyed, the vast majority (85%) expressed no particular objection to allowing CDSC and North West Public Health Observatory (NWPHO) access to data held on clients.

Many GUM services in the North West still use paper-based systems for data collection. Much of the data held by GUM services could be used to support epidemiological surveillance and inform workload issues.

### 6.3 General practices

Over 90% of GPs had computer based information systems that recorded age, sex and first part postcode. Two thirds had computerised information on the reason for attendance, 28% recorded ethnicity, 24% sexual orientation and 18% asylum seeker status.

### 6.4 Voluntary agencies

**Table 6.2: Numbers of voluntary agencies that hold client data and in what form**

	Number of agencies			
	Computer	Paper	Computer & Paper	Not Held
Client Age	2	10	0	1
Sex	2	9	2	0
Client 1 <sup>st</sup> Part Postcode	2	7	2	2
1 <sup>st</sup> Digit 2 <sup>nd</sup> Part Postcode	2	4	2	5
Reason for Attendance	1	9	0	3
Ethnicity	3	7	0	3
Sexual Orientation	1	3	1	8
Occupation	0	2	0	11
Asylum Seeker Status	0	4	0	9

Source: Centre for Public Health survey of voluntary agencies.

The results from Table 6.2 show that the most popular form of record keeping by HIV voluntary agencies is on paper. However, sexual orientation, occupation and asylum seeker status are rarely recorded.

### 6.5 Reproductive health services

#### 6.5.1 Contraceptive services

Conception data are collected at birth registration (from local registrars) and notification of abortions by service providers (i.e. NHS Trusts) all of which are sent to the Department of Health. These data are then compiled by Office for National Statistics and released 14 months later (9 months from conception to birth, 6 weeks to register birth, and 3 months to publish data). NHS Trusts complete KT31 forms which provide information on contraceptive activity in clinics, domiciliary visits, first contact in the financial year, the main method of contraception and post coital contraception. The form also records clinic sessions for people aged less than 20 years and includes non-NHS clinics funded wholly or in part by the NHS

(e.g. Brook Advisory Centres). However, it does not include services provided by general medical practitioners or consultants in outpatient clinics. The data includes first contact in the financial year and main method of contraception and post coital contraception. All of this information is available by Government Office Region, Strategic Health Authority and provider Trust in the National Statistics Bulletin published by the Department of Health.

### 6.5.2 Condom schemes

For condom schemes there is at present no systematic collection or collation of data.

### 6.5.3 Emergency contraception schemes

There are many providers of emergency hormonal contraception (see Section 3.4.5), which means that data comes from a number of sources including prescribing data, DoH form KT31, PCT data collection systems, and sales data. However, the diversity and extent of provision makes the quantification of emergency hormonal contraception supplied problematic.

### 6.5.4 Termination of pregnancy services

A requirement of the Abortion Act 1967, which came into effect on 27 April 1968, is that all legally induced abortions are notified within seven days to the Chief Medical Officer of the Department of Health. These data are collated by the Office for National Statistics and presented annually.<sup>16</sup> Available data include age, marital status, area of usual residence, category of purchaser and complications.

**Table 6.3: Data held on termination of pregnancy clients**

	Percentage of termination of pregnancy services									
	C&M		C&L		GM		Statutory Total		Non-statutory	
	Computer	Paper	Computer	Paper	Computer	Paper	Computer	Paper	Computer	Paper
Age	100	83	100	75	67	89	84	84	75	75
1st part post code	100	83	100	75	67	89	84	84	50	75
2nd part post code	100	83	100	75	67	89	84	84	50	75
Reason for attendance	67	83	50	75	33	78	47	79	25	50
Ethnicity	67	67	50	25	44	56	53	53	0	50
Occupation	33	67	25	75	56	78	42	74	25	50
Asylum seeker status	0	0	0	0	0	11	0	5	0	25
Repeat terminations	33	67	0	50	11	89	16	74	0	50
No objections to CDSC/NWFPO accessing data	100		75		100		92		75	

Source: Centre for Public Health survey of TOP services. NB Missing cases excluded from calculations.

<sup>16</sup> Office of National Statistics, Abortion Statistics, London: The Stationery Office.

Table 6.4 shows that a wide range of computerised and paper data are reported as collected by TOP services in the North West (which includes some data additional to the statutory requirement). However, data on asylum seeker status is held by only a couple of services across the region. Many services report having data on clients seeking repeat terminations but this is mostly kept on paper. On the issue of whether CDSC and North West Public Health Observatory (NWPHO) would be given access to data held on clients the vast majority (92% and 75% respectively) expressed no particular objection.

## **6.6 Summary bullet points**

- Many GUM services in the North West still only use paper-based systems for data collection and storage. Where data are held on computers, in many instances, the hardware and software are in need of replacement. The majority of services express no particular objection to allowing Communicable Disease Surveillance Centre (CDSC) and North West Public Health Observatory (NWPHO) access to data held on clients
- Over 90% of GPs had computer based information systems that recorded age, sex and first part postcode. Two thirds had computerised information on the reason for attendance, 28% recorded ethnicity, 24% sexual orientation and 18% asylum seeker status
- A wide range of computerised and paper data is reported as collected by TOP services in the North West. Many services report having data on clients seeking repeat terminations but this is mostly kept on paper. The vast majority (92% and 75% respectively) expressed no particular objection to allowing Communicable Disease Surveillance Centre (CDSC) and North West Public Health Observatory (NWPHO) access to data held on clients.
- A range of data on reproductive health including conceptions, contraception, and terminations is available by Government Office region, SHA and provider trust in the National Statistics Bulletin published by the Department of Health.

## 7 General Summary

### 7.1 Sexually transmitted infections including chlamydia

Diagnosis and treatment for STIs currently predominantly takes place in GUM services. Five-year trends for syphilis, gonorrhoea, genital herpes, genital warts, and chlamydia, all show a gradual and sustained increase in total episodes seen at GUM services in the North West. In a regional comparison, excluding London, the North West has the highest number of new episodes of syphilis, gonorrhoea, and chlamydia seen at GUM clinics. However, limited clinic accessibility and the presence of asymptomatic infections such as gonorrhoea and chlamydia will have implications for the number of STIs diagnosed hence data on workload will underestimate the need for GUM services.

Clearly, GUM services in the North West are overstretched. However, as envisaged in the National Strategy for Sexual Health and HIV, some diagnosis and treatment of STIs could take place at GP services. Access to GPs was reported as easier (72% of GPs had evening access - after 5pm - on at least one day of the week). Indeed, survey findings suggest that around a third of GPs surveyed already provide testing and treatment for gonorrhoea, with others indicating that they would be willing to provide testing and treatment for STIs in the future. Moreover, testing and treating of chlamydia is already well established in GP services, especially in women, at 86% and 60% respectively. Additionally chlamydia testing is offered in 81% of statutory sector TOP services. However, there are significant issues regarding efficacy of diagnostic tests currently used and a survey in 2001 (carried out by the Regional Communicable Disease Task Group) found vast variation in clinical practice.

There are, however, major barriers to carrying out additional services like treatment of STIs in GP services, especially funding and staffing (45% of GPs) and lack of knowledge (41% of GPs). Over a quarter (27%) of GPs thought that it would be a problem to take a sexual history and provide a risk assessment – a cause of concern, because it is a basic level of care. Survey findings also suggest that a small proportion of young people's and community contraceptive services provide STI screening and treatment. Although it is noticeable that the least reported partner organisation for young people's contraceptive services was GUM at just 3%. This compares with community contraceptive services in which the most frequently reported partner organisation was GUM Services at 21%.

### 7.2 HIV/AIDS

The number of people living with HIV in the North West has almost doubled since 1996, to a total of 1964 individuals. Whereas in the rest of the UK there were more heterosexually acquired new HIV cases, in the North West there are more new cases of HIV that were homosexually acquired. For the third year running an increasing number of people with HIV and AIDS have been contacting statutory treatment centres in the North West, an increase of 18% in the number of HIV positive individuals attending.

There are 46 statutory treatment centres, including GUM clinics and specialist services, providing HIV related care in the North West. North Manchester General Hospital Infectious Diseases Unit provides the largest number of outpatient (28% of all attendances), with the Department of GUM at the Royal Liverpool University Hospital providing the next highest number. In one of the surveys used in this review, evidence suggests that 40% of GPs were interested in providing more HIV services, predominately offering support on treatment adherence. However, in another survey, when asked about possible future service provision, 60% of GPs suggested HIV testing and counselling could be problematic.

In addition to statutory treatment centres, the voluntary sector provides a key role in care and support for people affected by HIV or AIDS in the North West. However, funding of voluntary services is predominantly (91% of all recorded funds) on a limited annual basis.

### **7.3 Contraception**

First contacts by females at contraceptive services (family planning) in the North West from 1997/98 to 2001/02 have increased by 9% and for males by 8%. Post-coital contraceptive prescribing in the North West has increased by 15% during the period from 1997/98 to 2001/02. Associated with its reclassification (from prescription only) and hence wider availability, there was a reduction of 2% in emergency contraception prescribed at community contraceptive services from 1999/00 to 2000/01. Conversely, over the period from 2000/1 to 2001/2 there has been an increase of 27% in emergency contraception provided through the Brook Advisory Centres. Moreover, nearly half of PCTs in the North West now have community pharmacy schemes in place.

Most young people's contraceptive services (67%) had a drop-in only service, which compares with access into Community contraceptive services were only a third (33%) were by drop-in only. 28% of young people's contraceptive services were open on a Saturday and none were open on a Sunday. Conversely, 6% of community contraceptive services were open on a Saturday and 4% were open on a Sunday. 28% of young people's contraceptive services were reported as located in own premises compared with just 3% of community contraceptive services.

The vast majority of young people's and community contraceptive services offered free condoms, free emergency contraception, and free pregnancy testing. Similarly, most GPs provide a range of contraceptive services including oral and injectable contraceptives (99%), implants (33%), IUD and IUS fitting (68% and 43%) and diaphragms (53%). Also, the vast majority of GPs provide services for young people in particular oral and injectable contraceptives, emergency contraception, pregnancy testing, and NHS abortion referral. The majority of GUM services (85%) also report providing emergency contraception and all (100%) provide condoms, although the uptake of these services is not known. Around a third of PCTs in the North West have condom distribution schemes in place. Of these the vast majority reported having training programmes for staff. However, only 56% of these schemes are reported as secure.

#### **7.4 Termination of pregnancy**

For all ages across the North West there has been a 3% decrease in terminations from 1998 to 2001. However, by age there has been a 20% increase for 16 year olds in Cumbria & Lancashire. The 20-24 age group accounts for the largest share of terminations undertaken in each of the SHAs in the North West. For each age category, Greater Manchester has the most terminations followed by Cheshire & Merseyside and Cumbria & Lancashire.

NHS abortion referral was offered in 96% of community contraceptive services compared with 73% in young people's contraceptive services. Overall, GPs and community contraceptive services were identified as the main referral routes for both statutory and non-statutory termination of pregnancy (TOP) services. This needs to be seen in the context of survey findings suggesting that 23% of GPs had a conscientious objection to abortion. The majority of statutory sector TOP services reported having a policy on conscientious objection to abortion, with 40% reporting the use of training as a measure to ensure non-judgemental staff.

More than two-thirds of statutory sector TOP services offer choice of medical or surgical termination up to 13 weeks, with just 11% statutory sector TOP services offer choice of method of induced abortion at more than 13 weeks and 42% not providing terminations at all. By all purchasers the health authority of termination was the home health authority for just less than half of those provided in all three SHAs in the North West. Indeed, more than half of young people's and community contraceptive services reported that average distance to NHS abortion services was 10 miles or more. In the majority of statutory sector TOP services the maximum waiting time for an initial assessment was reported as more than five days.

PCTs need to ensure that women who meet the legal requirement have access to an abortion within three weeks of the first appointment with the GP or other referring doctor by 2005. The maximum waiting time once abortion is agreed was reported as three or more weeks in 16% of TOP services. However, the most frequently reported average time between referral and abortion by young people's and Community contraceptive services was 2 weeks, with around half reporting the average time as 2.5 weeks or more.

#### **7.5 Data collection**

A range of data on reproductive health including conceptions, contraception, and terminations is available by Government Office Region, Strategic Health Authority and provider Trust in the National Statistics Bulletin published by the Department of Health. However, efforts to assess the state of sexual health in the North West are hampered by the lack of good quality epidemiological information. Currently there is no information on STIs by residence (except for HIV).

In the specialist provider sector, surveillance systems are well established i.e. GUM clinics, HIV treatment centres and TOP. However, even with these data collection systems there are problems, most notably the use of aggregate returns. Because data are not collected on individuals, no information on concurrent STIs

or previous STI history is available. Also, the lack of residence-based information means that PCT based data cannot be produced, making the setting and monitoring of local-level targets impossible. Currently the only STI information that can be analysed at PCT level is the prevalence (number of people) living with HIV.

While the situation with specialist service providers is far from ideal, there is little data available from primary care. Thus, if more STIs are diagnosed and treated in primary care, STI data will become a less reliable measure of the extent of the burden of sexual ill health. Moreover, many GUM services in the North West still only use paper-based systems for data collection and storage. Where data are held on computers, in many instances, the hardware and software are in need of replacement. This situation is likely to get worse if (when) more treatment takes place in GP services.

Over 90% of GPs had computer based information systems that recorded age, sex and first part postcode. Two thirds had computerised information on the reason for attendance, 28% recorded ethnicity, 24% sexual orientation and 18% asylum seeker status. Similarly, a wide range of computerised and paper data is reported as collected by TOP services in the North West. Significantly, however, the majority of sexual health services across the North West expressed no particular objection to allowing Communicable Disease Surveillance Centre (CDSC) and North West Public Health Observatory (NWPHO) access to data held on clients.