Appendix 3.
Local Service Mapping

1. Introduction
This section provides an overview of current sexual health service provision available in Haringey. For each aspect of service provision key issues arising from the consultation process are highlighted which will be carried forward in the context of the broad strategic approach to developing and delivering an integrated sexual health service in the borough. For coherence, issues arising from each service have been grouped into the following subheadings:

- Capacity and resources;
- Accessibility;
- Inequalities;
- Partnership working; and
- Training and development

2. Genitourinary Medicine Services – St Ann’s Sexual Health Centre
St Ann’s Sexual Health Centre (SASHC) has operated from the St Ann’s Hospital site since 1987 and is currently the only GUM service within Haringey. A comprehensive range of sexual health services are offered through SASHC including full sexual health screening, diagnosis and treatment of all STIs, same day HIV counselling and testing, psychological support, contact tracing and client education and support. Dedicated or special clinical sessions are provided for known risk groups such as young people under 18 (4YP Clinic), gay and bisexual men (Zone 15), women that have been sexually assaulted (Hazel Clinic) and female sex-workers (fast track appointments). A full list of the main components of GUM services provided at SASHC is provided in Table 7.

<table>
<thead>
<tr>
<th>Service</th>
<th>Nature of service provided</th>
<th>Target Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genitourinary Medicine</td>
<td>Diagnosis, treatment, care and prevention of all sexually transmitted infections.</td>
<td>All.</td>
</tr>
<tr>
<td>Health Adviser HIV Appointment Service</td>
<td>Counselling and HIV testing by appointment with including same day testing.</td>
<td>All and at risk populations.</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>CNS led sessions for diagnosis, treatment, care of STI’s</td>
<td>All</td>
</tr>
<tr>
<td>4YP</td>
<td>Dual Family Planning and Sexual Health Service. Diagnosis, treatment, care and prevention of all sexually transmitted infections; contraceptive advice and methods.</td>
<td>Young people aged 18 and under.</td>
</tr>
<tr>
<td>Zone 15</td>
<td>Diagnosis, treatment, care and prevention of all sexually transmitted infections (including HIV).</td>
<td>Gay and bisexual men and other men who have sex with men.</td>
</tr>
<tr>
<td>Hazel Clinic</td>
<td>Diagnosis, treatment, prophylaxis and care of all sexually transmitted infections, health advice and psychological support.</td>
<td>For women and men who have experienced sexual assault.</td>
</tr>
<tr>
<td>HIV Clinic</td>
<td>Management and care of HIV+ patients</td>
<td>HIV+ patients</td>
</tr>
<tr>
<td>Turkish Clinic</td>
<td>Diagnosis, treatment, care and prevention of all sexually transmitted infections (including HIV)...</td>
<td>Turkish speaking communities</td>
</tr>
<tr>
<td>Sex worker fast track appointments</td>
<td>Dedicated appointment slots within genitourinary medicine service, walk-in access to Health Advisers, STI screening, immunisation and health advice.</td>
<td>Sex workers</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>Assessment and therapy for people affected by HIV / sexual health problems</td>
<td>All adults</td>
</tr>
<tr>
<td>Sexual Health Promotion</td>
<td>Patient education, literature, professional training (GP &amp; Practice Nurse), community awareness.</td>
<td>All and appropriate professional groups.</td>
</tr>
</tbody>
</table>
Approximately 25 staff are employed within SASHC and comprise of 3.8 WTE medical staff, 8 (WTE) nurses, 5 (WTE) Health Advisers and administration staff (6.76 WTE). The full compliment of SASHC staff with their roles and responsibilities is provided in Table 8. In addition to GUM service provision, medical and nursing staff also undertake training with a variety of health professionals including junior Doctors (on rotation from Royal Free Hospital) and community nurses. A programme of Primary Care training for GPs and Practice Nurses is also currently being provided.

Table 8 – Roles and responsibilities of GUM staff at SASHC

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Roles and responsibilities</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff</td>
<td>Medical consultation for diagnosis and treatment of STI’s, advising and educating patients on sexual health matters, GUM leadership, clinical supervision, medical training and assessment for prophylaxis.</td>
<td>3.8 (+ 5 clinical sessions)</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>Assisting in clinical exam, laboratory microscopy examination, venepuncture, KC60 data, support and advice, triage, pharmacy work, emotional support and Nurse training and placements.</td>
<td>8</td>
</tr>
<tr>
<td>Health Advisers</td>
<td>Information and support re STI diagnosis, partner notification, pre and post test HIV counselling, sexual health promotion and service development.</td>
<td>5</td>
</tr>
<tr>
<td>Secretarial and administration staff</td>
<td>Reception, Telephone Bureau, management of patient records, secretarial and administration.</td>
<td>6.76</td>
</tr>
</tbody>
</table>

SASHC is open 5 days a week (Monday to Friday) and is open to 6.30 p.m. Monday and Thursday and to 8.30 p.m. on Tuesday and Wednesdays. A late Family Planning Clinic (to 7.00 p.m.) is also available at SASHC on Fridays. In total 25 GUM and 3 Family Planning sessions are held at SASHC each week (Table 9). The full opening and clinic times of SASHC are contained in Table 9.

Table 9 – Clinic times and sessions at SASHC

<table>
<thead>
<tr>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.00-12.30</td>
<td>2 GUM sessions (M &amp; F)</td>
<td>4.30-6.30</td>
</tr>
<tr>
<td>3 GUM sessions (M &amp; F)</td>
<td>2 GUM sessions (M &amp; F)</td>
<td>2 GUM sessions (M &amp; F)</td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.00-12.30</td>
<td>1.30-5.00</td>
<td>5.30-8.30</td>
</tr>
<tr>
<td>3 GUM sessions (M &amp; F)</td>
<td>4YP Young Peoples Clinic</td>
<td>Zone 15 - Gay &amp; Bi Men</td>
</tr>
<tr>
<td>1.30-5.00</td>
<td>2 Sessions (GUM/FP &amp; M &amp; F)</td>
<td>1 GUM session (M)</td>
</tr>
<tr>
<td>Wednesday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic closed for administration</td>
<td>1.30-5.00</td>
<td>5.30-8.30</td>
</tr>
<tr>
<td>1.30-5.00</td>
<td>Hazel Sexual Assault Clinic (F)</td>
<td>2 GUM Sessions (M &amp; F)</td>
</tr>
<tr>
<td>1 GUM session</td>
<td></td>
<td>1 GUM session (M)</td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.00-12.30</td>
<td>2.00-4.30</td>
<td>4.30-6.30</td>
</tr>
<tr>
<td>3 GUM sessions (M &amp; F)</td>
<td>2 GUM sessions (M &amp; F)</td>
<td>2 GUM sessions (M &amp; F)</td>
</tr>
<tr>
<td>2.00-4.30</td>
<td>1 HIV Session</td>
<td>4.30-6.30</td>
</tr>
<tr>
<td>Friday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.00-12.30</td>
<td>1.30-4.00</td>
<td>5.00-7.00</td>
</tr>
<tr>
<td>2 GUM sessions (F)</td>
<td>1 GUM session (M)</td>
<td>2 Family Planning Sessions</td>
</tr>
<tr>
<td>1.30-4.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As of June 2002, walk-in clinics at SASHC were replaced with an appointment only system, in which all appointments are booked through a centralised telephone bureau. This was in response to acute service pressures arising from patient demand for GUM services. The replacement of the walk-in clinics with an appointment service has enabled SASHC to prioritise clients (through triage), where clients are now seen according to clinical urgency. Whilst additional capacity has been provided since October 2002 through the Clinical Nurse Specialist providing dedicated clinical sessions, it is noted that the switch to an appointment only system has resulted in an approximate decline of 9% in total attendances (2001 to 2003). Of particular concern, given the national regional context of the increasing prevalence of STIs, is the decline in the number of new patients attending SASHC, where a 15% reduction was recorded between 2001
and 2003 (Table 10). Contributory to the decline in new and total attendances has been the increase in the level of DNAs since the inception of the appointment only system at SASHC: the DNA rate for appointments currently averages between 15-20%. In an effort to reduce DNAs the Centre currently only offers appointments 48 hours in advance and all clients are pre-called before their appointment. Ongoing technological problems with the telephone appointment system (excess demand) are known to compound access problems and the Centre is currently trying to resolve these issues. Increasing the accessibility of the current appointment system and reducing the DNA should retain administrative priority.

Table 10 - Attendances at SASHC by type 2001-2003

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>% change 2001-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patients</td>
<td>5,010</td>
<td>4,380</td>
<td>4,262</td>
<td>-15%</td>
</tr>
<tr>
<td>Follow up</td>
<td>9,537</td>
<td>8,977</td>
<td>8,831</td>
<td>- 8%</td>
</tr>
<tr>
<td>Rebook Patients</td>
<td>3,641</td>
<td>3,487</td>
<td>3,550</td>
<td>-3%</td>
</tr>
<tr>
<td>Rebook Patients (re-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>representing after 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>months)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18,188</td>
<td>16,184</td>
<td>16,643</td>
<td>-9%</td>
</tr>
</tbody>
</table>

SASHC consistently attracts equal numbers of new male and female patients to the service; 51% of new patients were female and 49% of new patients were male in 2003 (Table 11). Illustrating the prevalence of STIs among young people, in excess of 40% of new attendances at SASHC were aged 24 years or under (Table 11). The make of ethnic groups using SASHC broadly reflects the ethnic and cultural diversity of the local population. However, the disproportionate burden of STIs among Black and other ethnic minority groups is also reflected in these figures: whereas Black Caribbean’s make up 10% of local population estimates, they contribute 16-22% of new attenders at SASHC (Table 11). A similar discrepancy is evident in the population of Black African communities locally (9%) and the proportion of new attendances at SASHC (16%). In total, 257 gay and bisexual men attended SASHC in 2003.

Table 11 – Demography of new patients attending SASHC 2003

<table>
<thead>
<tr>
<th>Ethnicity (4,262)</th>
<th>Gender (4,262)</th>
<th>Age (4,262)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White UK</td>
<td>Male 30%</td>
<td>49%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>Female 16%</td>
<td>51%</td>
</tr>
<tr>
<td>Black UK</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>16% Under 15</td>
<td>33 (&lt;1%)</td>
</tr>
<tr>
<td>Black Other</td>
<td>4% 15</td>
<td>58 (1%)</td>
</tr>
<tr>
<td>Turkish / Turkish Cypriot</td>
<td>8% 16-19</td>
<td>617 (15%)</td>
</tr>
<tr>
<td>Greek / Greek Cypriot</td>
<td>3% 20-24</td>
<td>1,047 (25%)</td>
</tr>
<tr>
<td>Asian (All)</td>
<td>5% 25-34</td>
<td>1,509 (35%)</td>
</tr>
<tr>
<td>Mixed race</td>
<td>4% 35-44</td>
<td>671 (16%)</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>8% 55-64</td>
<td>297 (7%)</td>
</tr>
<tr>
<td>Gay/ bisexual attenders</td>
<td>257</td>
<td>65+</td>
</tr>
</tbody>
</table>

SASHC is under acute pressure to cope with the competing demands for generic GUM service provision alongside that of providing dedicated or culturally sensitive services for those populations at greater risk of STI infection. These competing and complex pressures are faced within the overall context of rising STI prevalence and demand for GUM services. Analysis attendance data trends at SASHC illustrates the competing service pressures where: the number of young people attending 4YP has increased 60% in the period 2001/2 to 2002/3; attendance by gay men at Zone 15 has fallen by 26% and the total number of gay men attending SASHC has fallen by

---

1 Includes all gay and bisexual males attending in 2003 (new and rebook).
36% (Table 12). To ensure that SASHC remains open and accessible to these key population groups, further consideration will need to take place concerning the capacity and resources available for furthering dedicated service provision for young people. An increase in service advertising and promotion of Zone 15 is also recommended, as it is most likely that the fall in numbers at this service is due to poor client awareness, as the decline in attendance is predominantly among new clients (Bradford, 2003).

<table>
<thead>
<tr>
<th>Table 12 – Attendance at Zone 15 and 4YP 2001-2003</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4YP Young people (under 18) clinic</strong></td>
</tr>
<tr>
<td>2000/1 2001/2 2002/3</td>
</tr>
<tr>
<td>Attendances</td>
</tr>
<tr>
<td>- 667 1066</td>
</tr>
<tr>
<td><strong>Zone 15 (Gay &amp; Bisexual Men)</strong></td>
</tr>
<tr>
<td>Attendances</td>
</tr>
<tr>
<td>630 537 469</td>
</tr>
<tr>
<td><strong>Total number of gay men attending SASHC</strong></td>
</tr>
<tr>
<td>397 257 2</td>
</tr>
</tbody>
</table>

SASHC shares current accommodation with the administrative arm of Haringey Family Planning Services and the Clinical Psychology in HIV & Sexual Health service. Whilst this accommodation is of reasonable quality, there are few (if any) opportunities to increase GUM capacity or develop further services from these existing premises given the overall shortage of consultation and client counselling rooms. A capital bid has been submitted to the TPCT to develop an adjacent site to SASHC with the aim of developing further consultation and staff accommodation. The Centre is awaiting the result of this application. Whatever the outcome of this application, further development of the SASHC site needs to be explored in the wider context of the development of satellite services to increase accessibility and increasing GUM capacity.

In compliance with Clinical Governance regulations, SASHC has undertaken annual client satisfaction audits since 1996. These audits have proved critical in assessing the overall accessibility and quality of GUM services and an essential tool in the service development process. Data from the annual survey also allows SASHC to monitor the equity of the patient service experiences in relation to age, gender, ethnicity and sexuality. Trend data in overall satisfaction with GUM services at SASHC demonstrates that client satisfaction has increased at the Centre: 81% of clients perceived the service to be very good or good in 2003 compared to 69% in 1999 (Figure 25).

---

2 12 month period of 2003
ISSUES FOR CONSIDERATION:

**Capacity & Resources**
- There is clearly increasing demand for GUM services within the borough beyond the level or capacity of existing service provision. There is a need to conduct a review of existing provision with appraisal of options for increasing future capacity in relation to: increasing capacity of the current site, development of satellite services, collaborative ventures with Primary Care and or Family Planning Services.
- Satellite service provision should assume priority in future GUM development plans given that this service format may facilitate access, target head to reach groups and reduce stigma traditionally associated with GUM service attendance.
- There is an urgent need to expand, develop and strengthen existing HIV testing services across the borough. The GUM should be at the centre of, and take the lead for co-ordinating, such testing processes. Extension and development of HIV testing sites needs to occur within both NHS settings (Ante-natal, TB clinics and Primary Care) and community settings, and offer walk-in same day and rapid testing services.
- Young people are attending in greater numbers as is seen in the growth of 4YP clinic attendances. The development of further dedicated services for young people is clearly warranted, though these may not necessarily be provided from the SASHC site (given current accommodation limitations) but through the possible development of other more accessible satellite services.
- In recognition of current and future demand, there is a need to develop GUM capacity within the district. In doing so, future development plans should acknowledge that between 50-60% of current SASHC users are resident within just 3 postcode districts (N15, N17 & N22).

**Accessibility**
- Urgent action is needed to resolve ongoing technological problems associated with the telephone appointment system (call handling system) to minimise service accessibility problems this currently presents.
- The service is currently performing well in reaching Black and other ethnic communities who bear a disproportionate burden of STIs. Any future service
developments in relation to increasing GUM capacity should critically assess their impact on the accessibility and appropriateness of new service configurations on this important client group.

- Whilst acknowledging that effective nurse triage systems have been integrated within the new appointment system, there is a further need to increase the capacity of this service to ensure that all those clients who are not offered an appointment or whose concern is noted to be urgent should be referred to triage. (It is noted that other GUM services in appointment only systems triage up to 50% of new patients).

Inequalities

- There is an urgent need to stem the decline in the number of gay & bisexual men accessing SASHC. Further promotional and advertising of dedicated (Zone 15) and generic GUM service at local venues at which gay and bisexual men attend, or other services working with this group alongside gay media should be undertaken. Acknowledging staffing problems of Zone 15, there is evidently a need to further integrate this service within core GUM staffing arrangements.

- It is broadly acknowledged that the cultural perspectives of sexual health need greater acknowledgement in the provision of GUM services. Access to interpreting services and the availability of culturally sensitive and appropriate information and resources remain problematic for SASHC and other community services in the borough.

Partnership Working

- There is an ongoing need to further develop collaborative working between GUM and Family Planning services in the locality. A number of initiatives are recommended to further integrate GUM and Family Planning Services including ensuring that relevant GUM and Family Planning staff are dual trained; sharing GUM and Family Planning posts and further developing joint Family Planning and GUM clinics especially for those at risk groups: young people, ethnic communities.

- In line with promoting access to GUM services (and in meeting the need for developing Level 1 sexual health service requirements), there is need for ongoing collaborative work with Primary Care providers, most importantly: ongoing training for GP and Practice Nurses and the development of clear GUM referral pathways from Primary Care through to GUM services.

Training & Development

- The limited career pathways and professional development opportunities for GUM staff generally have been compounded by local service pressures.

- There is a need to develop the role of Health Adviser to enable further community outreach work in schools, youth centres and other voluntary groups to strengthen the links between SASHC and the community.

KEY PRIORITIES FOR ACTION:

- There is an urgent need to expand, develop and strengthen existing HIV testing services across the locality. The GUM should be at the centre of such testing processes but there needs to be expansion in to Primary Care and satellite services offering walk-in same hour testing.

- There is a need to conduct a review of existing provision with appraisal of options for increasing future capacity in relation to: the
development of the current SASHC site, development of satellite services, collaborative ventures with Primary Care and/or Family Planning Services.

- There is an ongoing need to further integrate work of GUM and Family Planning Services to develop access and increase capacity.
- Urgent action is needed to stem the decline in the number of gay and bisexual men accessing the service.

3. HIV/AIDS

3.1 HIV/AIDS Clinical Services – Coleridge Unit (T1) North Middlesex Hospital

HIV/AIDS clinical services are provided predominantly through the Coleridge Unit (T1) at the North Middlesex Hospital (NMH).3 The Unit, which opened in 1996, provides inpatient, outpatient and day care services. There is a 10 bed capacity for inpatients at the Unit (two of which are for high dependency patients) and there are two negative pressure rooms to help prevent the transmission of airborne viruses. The Centre is staffed by 3.0 WTE Consultants, 3 SHOs, 14 nurses (grades I to G), 2 Counsellors and X administration and support staff. A full time nurse is responsible for ante-natal HIV screening programme and the care of HIV+ women in pregnancy. A designated TB nurse supports the Unit and is responsible for the follow up of co-infected patients. A dedicated HIV Pharmacist, HIV dietician and technician also liaise with the clinical team at the Coleridge Unit.

From a recent audit of services, in a two-year period (April 2001-April 2003) 272 new patients were seen at the Coleridge Unit, 240 (88%) were those with a new diagnosis of HIV and a further 32 were individuals who had transferred their HIV care to NMH. In this same period, of those that were newly diagnosed with HIV infection, 24% were referred through A & E, 18% through Ante-natal and 28% through local GUM services (20% SASHC in Haringey and 8% Town Clinic in Enfield) (Table 13). Late presentation of HIV infection continues to be a significant problem where almost two-thirds (63%) of new patients presenting at the Unit were HIV symptomatic and 36% with an AIDS defining illness. To illustrate this further, the proportion of HIV infected patients that are referred to the Coleridge Unit having presented at acute services symptomatic of HIV infection (35%) is greater than from local GUM services (20%). 14% of those new patients referred from acute service subsequently died, whereas none of those referred from GUM services died. In an effort to reduce late presentation there has been a focus on ensuring medical staff (NMH) recognise symptoms of HIV infection for speedier referral to the Coleridge Unit.

<table>
<thead>
<tr>
<th>Table 13 - HIV Audit data 4/01-4/03</th>
<th>Ethnic origin of non UK residents 4/01-4/03 (n=209)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral to T1</strong> 4/01-4/03 (n=240)</td>
<td><strong>Zimbabwe</strong> 55 (26%)</td>
</tr>
<tr>
<td>A &amp; E 57 (24%)</td>
<td><strong>Uganda</strong> 38 (16%)</td>
</tr>
<tr>
<td>GUM Haringey 49 (20%)</td>
<td><strong>West African Countries</strong> 21 (10%)</td>
</tr>
<tr>
<td>Antenatal 42 (18%)</td>
<td><strong>Congo, Burundi, Rwanda</strong> 16 (8%)</td>
</tr>
<tr>
<td>Doctor Referral 27 (11%)</td>
<td><strong>Caribbean</strong> 16 (8%)</td>
</tr>
<tr>
<td>Self 20 (8%)</td>
<td><strong>Other</strong> 63 (30%)</td>
</tr>
<tr>
<td>GUM Enfield 19 (8%)</td>
<td></td>
</tr>
<tr>
<td>Unknown 26 (11%)</td>
<td></td>
</tr>
</tbody>
</table>

3 Some HIV treatment services are provided through the GUM service at St Ann’s Hospital.
Of those newly diagnosed with HIV, 87% (209/240) were among those whose ethnic origins were outside the UK. New patients predominantly came from Central (Zimbabwe and Uganda) and West African countries (Table 13). Underlining the relationship between HIV infection in the UK and inward migration, 67% of non British patients presenting at the Coleridge Unit entered the UK between 1998 and 2000. In contrast to other London HIV Centres, proportionally, the Coleridge Unit sees more new infections among Black African communities, fewer among gay men and more presenting HIV symptomatic.

The increasing number of HIV infections seen nationally and locally is reflected in bi-annual SOPHID monitoring data (for Enfield and Haringey residents). Attendance data for those having HIV treatment at either of the localities treatment centres (NMH and SAH) has risen 155% in the period 1998 to 2002 (Figure 26). The number of new HIV patients receiving treatment in the borough also continues to increase, with 70 new patients seen within the final 6 months of 2002 (Figure 26).

With HIV services being utilised by a greater number of HIV infected people; this has consequently increased the workload of the Coleridge Unit. For outpatient services, the number of patient episodes has increased 117% to 3,034 in the period 1997/8 to 2002/3 (Table 14). For inpatients services, the total number of bed nights increased 60% to 3,650 nights and the occupancy rate was 82% in 2002/3 (Table 14).

Tuberculosis (TB) is the commonest opportunistic infection among HIV patients presenting at the Coleridge Unit and is managed by clinical staff within Unit when this is diagnosed. In a two-year audit (April 01- April 03) of HIV testing in the Chest Clinic at NMH, of those 58 individuals testing for HIV, 15 (26%) were diagnosed with HIV infection and all were of African origin. In this same period, 44 patients were
treated for TB, where most HIV infection was diagnosed at the same time or shortly before TB was diagnosed.

### 3.2 HIV/AIDS Social Care

A range of services are commissioned locally to provide social support to those living with HIV/AIDS. An HIV Social Work team comprising of one Practice Manager, three (WTE) Social Workers, 1 housing worker and a drop-in coordinator (0.5 WTE) support those people living with HIV in Haringey. Individual care packages and transfer payments (accommodation and subsistence support) are provided to those affected by HIV within the locality. A weekly drop in service is operated from the Winkfield Resource Centre where a range of support staff are present. A rights worker is employed to work with local HIV/AIDS service users through the Citizens Advice Bureau (CAB)(funded through Haringey AIDS Support Grant) and works from CAB offices Monday to Thursday and at the Winkfield Drop in on Fridays.

Social Work data / activity data / issues / care package data to be supplied - LBH

### ISSUES FOR CONSIDERATION:

**Capacity & Resources**

- The funding of anti-retroviral therapies represents a significant spend in this arena and is likely to remain so. Additional pressures may be placed on drug budgets in relation to increasing prevalence of drug resistance and subsequent reduced effectiveness therapies.
- Whilst there were no concerns voiced about the level and nature of funding for drug therapies available locally, increased demand for HIV services at the Coleridge Unit has placed pressures on physical resources and accommodation available and specific cost pressures attached to HIV sensitivity tests (i.e. viral load CD4 tests).
- There is a growing recognition that HIV is moving toward a model of chronic disease management where there is potential for HIV to be managed alongside other chronic diseases. The potential of such a move should be explored between local commissioners and providers in developing a future model of service planning and delivery.
- There is a high level of mental health need among patients (in patient and outpatient), which are currently unmet. Particular problems within the NMH are noted to be the absence of Clinical mental health assessment process (in T1 or NMH generally) as this has to be undertaken outside at St Ann's Hospital or the Mental Health Trust where the patient is resident. This often means that patient’s mental health concerns are inappropriately managed within the Coleridge Unit.
- Acute cost pressures are faced within the AIDS Support Grant (ASG) in funding social care packages for HIV infected individuals, with individual packages currently costing up to £100,000. Additional commitments in providing transfer payments for HIV infected Asylum seekers have precipitated a combined cost pressure of £200,000, which has already prompted new service configuration.

**Accessibility**

- It is evident that there is a need to undertake a more detailed investigation of

---

4 This is the new service configuration for 2004/5 in response to a reduction in AIDS Support Grant to London Borough of Haringey.
the health and social needs of HIV service users in the locality, particularly in relation to the aspects of social care. Such needs assessment may bring more coherence to current service provision as well as to inform and guide the strategic direction HIV services.

- There is broad consensus that the development of the Winkfield drop-in would provide greater access to HIV service users and enable services to respond to the complicated socio-legal welfare aspects of many HIV+ patients. Expansion of this site / service would offer greater opportunity to develop social care for HIV patients, dietetics support, exercise as well as other more traditional social support.
- Audit and monitoring data has demonstrated a fundamental need to further develop access and promote HIV testing services among at risk population groups and within specific services (e.g. antenatal, TB, NMH general, Black African communities).

Inequalities
- There are acute concerns around the provision of HIV services of those with HIV who are seeking Asylum in the UK. There are difficulties around having three main providers in the area (NMH, Whittington, Royal Free & St Ann’s) who operate different guidelines for accessing HIV services for Asylum seekers. Different operational guidelines and procedures around accessibility and eligibility to HIV services among this community have presented distortions in the uptake of services and lengthy wrangles as to determine ultimate responsibility for care (with other external authorities). Large HIV+ Asylum Seeker population face additional pressures through the paucity of language and interpreting services and a reduction in legal advice (legal aid now decreased to 4 hours). Asylum seekers are also typically late presenters in terms of HIV management and often very ill on presentation. The Asylum dispersal system also presents problems in the continuity of care and general management of the patient and considerable resources / staff time is currently used to determine medical-legal matters relating to immigration status of patient.
- There are further inequality issues associated with immigration and HIV infection where many women may not be in a position of power in terms of immigration status and dependent on male application for asylum. In this context, sexual health, contraception and HIV issues are subsumed below that of obtaining immigration status.
- Antenatal HIV infections are one of the highest in the country, emphasising the need for increasing testing and early detection and planning for children and family services for those affected by HIV.
- There is a perception that there needs to be some adaptation to the voluntary sector makeup to respond to growing number of Black Caribbean mothers/children identified through antenatal testing to provide further community support.

Partnership Working
- Health and Social Services need to be working together at a strategic level to plan and co-ordinate services.
- Whilst clinical care pathways are perceived to work well, there is a need to develop pathways of care to social support and housing. There are currently difficulties in the ability of local practitioner’s to prescribe and manage drug therapies in the context of abject social need (i.e. not able to discharge from care with no housing). Further collaborative working with local authorities to
resolve these issues is needed.

- Given prevalence of co-morbidity factors in HIV and TB patients, there needs to be more strategic links between these work programmes to further develop respective testing services for speedier diagnosis and referral to care (i.e. testing for TB at antenatal clinics).
- Given the high level of mental health needs exhibited among HIV patients accessing services there is a need for strategic and operational links with Mental Health Services to be developed, to help in the identification, assessment and support of HIV patients with mental health needs.
- Where appropriate and desired, there are clearly development opportunities for the management of HIV patients in Primary Care. These will need to be developed with appropriate clinical care pathways.
- The current configuration of antenatal counselling (1.0 WTE at NMH and 0.5 Chase Farm Hospital) may warrant review given that current utilisation, positive identifications and resultant pressures are based within NMH.

**Training & Development**

- There is a need for workforce development in social care sector as currently there is an inability to recruit Social Workers, HIV Social Workers and Care Coordinators to the posts lost in social work reorganisation.

**KEY PRIORITIES FOR ACTION:**

- Evidence presented here and elsewhere in this strategy indicates the necessity for a comprehensive review of the HIV needs of those seeking asylum within Haringey (and Enfield) and the ability of the current configuration of services to respond to these needs.
- Similarly, the social care needs of all those affected by HIV/AIDS also necessitates further investigation and documentation to inform the operation and future development of these services locally.
- Late presentation of HIV infection remains a significant concern for local services. There is a need to further develop awareness of HIV infection among key health services alongside developing access to HIV testing at key sites and among key population groups.
- There is an urgent need for the provision of psychological assessment and support service for Out-Patient and In-Patient Services within NMH. This may be undertaken within the broader review of psychological support services for sexual health and HIV suggested elsewhere in this strategy.
4. Family Planning Services
The family planning service is currently provided by Haringey Teaching Primary Care Trust. The service is consultant led and supported by 10 doctors working on a sessional basis. The service has 1 full-time family planning nurse and 24 who work on a sessional or locum basis. 16 clerical staff supports the service. The service runs 19 doctor sessions (2 are double doctor) and 3 nurse-led sessions from 13 community clinics. The clinics are evenly distributed across the borough (See Figure 27).

Figure 27

There are 12 clinics held in the evening; 4 in the afternoon; 3 in the morning and 1 on a Saturday morning. All clinics are open access although sometimes numbers have to be controlled. Sessions are outlined in Table 15.

<table>
<thead>
<tr>
<th>Venue</th>
<th>No. of sessions per week</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bounds Green Health Centre, N11</td>
<td>1</td>
<td>Tue, 6-7.30pm</td>
</tr>
<tr>
<td>Broadwater Farm</td>
<td>1</td>
<td>Mon, 6.30-8pm</td>
</tr>
<tr>
<td>Burgoyn Road Clinic, N4</td>
<td>1</td>
<td>Thu, 1.30-3.30pm</td>
</tr>
<tr>
<td>Crouch End Health Centre, N8</td>
<td>3</td>
<td>Mon, 6.30-8pm, Tue, 6.30-8pm, Fri, 1-3pm</td>
</tr>
<tr>
<td>Fortis Green Clinic, N10</td>
<td>1</td>
<td>Thu, 6.30-8pm</td>
</tr>
<tr>
<td>Lansdowne Road Clinic, N17</td>
<td>1</td>
<td>Thu, 6-7.30pm</td>
</tr>
<tr>
<td>Lordship Lane Clinic, N17</td>
<td>1</td>
<td>Wed, 5.30-7pm (Nurse led)</td>
</tr>
<tr>
<td>North Middlesex Hospital, N18</td>
<td>2</td>
<td>Tue, 6.30-8pm &amp; Fri, 9.30-11am</td>
</tr>
<tr>
<td>St Ann’s Sexual Health Centre, N15</td>
<td>1</td>
<td>Fri, 5-7pm</td>
</tr>
<tr>
<td>Stroud Green Road Clinic, N4</td>
<td>1</td>
<td>Mon, 6-7pm (Nurse led)</td>
</tr>
<tr>
<td>Stuart Crescent Health Centre, N22</td>
<td>2</td>
<td>Tue, 9.30-11am, Sat, 9.30-11am</td>
</tr>
<tr>
<td>Tynemouth Road Health Centre, N15</td>
<td>3</td>
<td>Tue, 6.30-8pm, Thu, 6.30-8pm, Fri, 9.30-11am</td>
</tr>
<tr>
<td>Laurels Healthy Living Centre, N15</td>
<td>1</td>
<td>Wed, 1.30-3pm</td>
</tr>
</tbody>
</table>

The family planning service also operates a restricted domiciliary service that is run by the Consultant together with one nurse, two psychosexual sessions per week, two termination of pregnancy assessment clinics and one termination of pregnancy
follow-up cum family planning clinic per week, and one restricted menopause Hormone Replacement Therapy prescribing clinic per week.

**Attendances**
Attendances at the family planning clinics have increased by 15% between 1997 and 2003 from 16,532 to 19,024 respectively (Christopher, 2004). The clinics are most used by women aged 20-29 years as is shown in Table 16. Although a significant number of young people aged under 19 use the service (1,407 in 2003), there has been an 11% decrease in the numbers attending in the last 2 years (Christopher 2004).

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>46</td>
</tr>
<tr>
<td>30-34</td>
<td>17</td>
</tr>
<tr>
<td>35-39</td>
<td>11</td>
</tr>
<tr>
<td>16-19</td>
<td>11</td>
</tr>
<tr>
<td>40-44</td>
<td>7</td>
</tr>
<tr>
<td>45+</td>
<td>6</td>
</tr>
<tr>
<td>Under 16s</td>
<td>2</td>
</tr>
</tbody>
</table>

Christopher, 2004

Robust ethnic monitoring data is collected by the service. In 2003/04 72% of new or first time attendees were from Black and minority ethnic communities or ‘White other’ which is reflective of the ethnic mix of Haringey as a whole (Table 17).

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>%</th>
<th>Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Black &amp; other Black</td>
<td>30</td>
<td>Asian</td>
<td>6</td>
</tr>
<tr>
<td>UK White</td>
<td>28</td>
<td>Other Ethnic Group</td>
<td>19</td>
</tr>
<tr>
<td>European West &amp; East</td>
<td>9</td>
<td>No response given</td>
<td>1</td>
</tr>
<tr>
<td>Turkish Speaking</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Christopher, 2004

The clinics that had the greatest numbers of attendances in 2003/04 were: Crouch End (all sessions) which averages between 40-45 people per session, Fortis Green, Stuart Crescent (Saturday morning) and the North Middlesex Hospital. The total number of attendances at each clinic between 1994 and 2004 is shown in Figure 28 below. Crouch End and Fortis Green Clinic are the clinics most attended by the under 19 year olds (Christopher, 2004).

Figure 28 - Total Attendances at Family Planning Clinics 1994-2004 (Christopher, 2004)
Young People’s Attendance at mainstream Family Planning Services
1,427 teenagers attended mainstream family planning services during 2003/04. The clinics most attended by young people were Crouch End Health Centre, Fortis Green and St Ann’s Sexual Health Centre. Teenagers attended the clinics for 4 main reasons: oral contraception; condoms; pregnancy tests and emergency contraception. 99 teenagers were referred for a termination (15% of the total number of women referred). The majority of young people attending were UK Black or other Black (34%) and UK White (29%).

Choice of contraception
Data from the Family Planning Service for 2003/04 indicates that the most common form of contraception chosen by new/first time users of the service was oral contraception (33%). This was followed by the male condom (21%), the Intrauterine Devise (10%) and the Depo-Provera Injection (7%). Only 1% of first time clinic attenders had an implant fitted and 1% a cap (Christopher, 2004).

It is not possible to compare this local data to the national picture, as data from the Office of National Statistics records the primary method of contraception chosen by all clinic attenders rather than the method chosen by the first time attenders as is recorded by the local family planning service. However the national data has been included in this strategy to provide additional background information.

This ONS data for 2003/04 indicates that 41% of family planning clinic attenders in England chose oral contraception as their primary method of contraception. This was followed by the male condom (35% of attenders), the Depo-Provera Injection (8%), and Intrauterine Devise (5-6%). Only 1% used the cap (ONS, 2004).

The issuing of Emergency Hormonal Contraception (EHC) through the Family Planning Service has reduced significantly since 2001. This was also the time when pharmacists were first able to provide emergency contraception over the counter without a prescription. In 2000/01, 1671 prescriptions were issued which reduced to 957 in 2003/04, a reduction of 43%.
Data from the Office of National Statistics (2003/04) shows that the most popular source for EHC is the women’s own GP or Practice Nurse (41%), followed by a chemist or pharmacy (27%) and a family planning clinic (21%). However the proportion of women using a family planning clinic for EHC has fluctuated over the past 3 years since the introduction of ‘over the counter’ sales in pharmacies in 2001. In 2001/02 31% of EHC users obtained it from a family planning clinic but this decreased to only 18% in 2002/03. The proportion of women obtaining EHC from a walk-in centre or minor injuries unit increased between 2002/03 and 2003/04 from less than 1% to 11% respectively.

There is very little demand in Haringey for vasectomies. However those who do require a vasectomy are referred to the urology department at the Whittington Hospital.

Other services
During 2003/04, 1,080 swabs Chlamydia swabs were taken of which 3% were positive. A total of 58 clients were seen for psychosexual counselling.

ISSUES FOR CONSIDERATION:

Capacity & Resources
- The Family Planning Service has no identifiable base or centre from where it operates it’s core business and although the network of community settings offers good access for the local community it also provides a challenge in terms of administration, staffing and staff training. There are also concerns about health and safety issues for staff and clients due to adequacy of some accommodation and facilities. There is therefore a need to develop a “Hub and Spoke model” where an identified family planning centre provides the ‘hub’ for the service and the community clinics are the ‘spokes’. This would enable the development of a cohesive service with a strong identity and a well-supported and trained network of staff.
- There are concerns about the potential increase in workloads of family planning staff if GPs no longer provide specific forms of contraception due to the new GMS contract.
- Budget pressures are making it impossible to introduce new contraceptives and new technologies into the service i.e. the Evra patch and Nuva (ring) and additional resources are needed to develop the IT systems.

Accessibility
- Access to family planning services is very good due to the well established network of community clinics which operate an out of hours service. However the increase in attendances generally, but particularly at Crouch End and Fortis Green clinics, means that clinics are beginning to be unable to meet demand and sometimes need to turn people away. However everyone attending the clinics are triaged and all those with urgent issues will be seen. Those with non-urgent issues are given the details of clinics operating later that day or the next day.
- The Willows clinic at St Ann’s Clinic recently closed and was replaced by a new clinic at the Laurels. Due to the success of this new clinic and its ability to reach those women in most need, opportunities for increasing capacity through additional clinics and additional doctors is currently being explored.
Inequalities
- There are concerns about access issues for asylum seekers and for those that do not speak English. Access to link workers can be difficult.
- There is a need to review the service offered to men, particularly through the provision of condoms, as the uptake of services is currently very low.

Partnership Working
- There is a need for further partnership working with Genito-Urinary Medicine in order to develop a greater body of integrated family planning and sexual health services.
- There is an urgent need to develop strong partnership working with Primary Care due to the introduction of the GMS contract for GPs. This will enable a model for contraceptive services and training to be developed that responds to need and improves access for all groups.

Training & Development
- The shortages of both medical and nursing staff in Haringey and the London wide recruitment difficulties are having implications on the quantity and quality of the service that can be provided.
- Providing training across a multi sited service with a predominantly part-time workforce provides challenges.
- There needs to be imaginative and creative job sharing between family planning and sexual health, giving experience and training in both specialities. Family planning nurses may need training to a higher standard so that more can become nurse prescribers and nurse consultants.

KEY PRIORITIES FOR ACTION:
- To carry out a review of the family planning service in the community settings in order to highlight core difficulties and identify possible solutions.
- To undertake an options appraisal to explore the feasibility of the further integration of sexual health and family services.
- To work with Primary Care in the context of the GMS contract arrangements to develop a model for contraceptive and sexual health services that responds to need and improves access for all groups.
- Identify opportunities to increase clinical capacity through staff training and development.

5. Termination of Pregnancy Service (Enfield and Haringey)
The Enfield and Haringey Termination of Pregnancy (TOP) Service is managed by Enfield Reproductive and Sexual Health Service on behalf of the two boroughs and is based at the Town Clinic in Enfield. Clients requiring a TOP are first required to telephone the central booking service where eligibility for NHS care and residency are checked. Clients are then given a date for an appointment at one of assessment clinics. There are 2 assessments clinics in Haringey, which operate from Tynemouth Road Health Centre, and two in Enfield that operate from the Town clinic. At the assessment clinic clients are seen by a doctor for assessment, blood is taken and the women are screened for Chlamydia. They are also booked for the procedure.

Any client requiring a medical abortion (which can take place up to 9 weeks gestation) will be referred directly to the British Pregnancy Advisory Service (BPAS) in Bedford Square, Central London without needing to go via the assessment clinic.
Surgical TOPs are carried out on a Saturday at North Middlesex Hospital and usually take place the week following the assessment clinic. However, those with medical problems are referred to the Royal Free Hospital. The TOPs service aims to ensure that all women that book into the service are seen at an assessment clinic within a week. If the service is unable to meet demand they will refer women directly to BPAS without going through the assessment clinic.

**ISSUES FOR CONSIDERATION:**
There is an aim to provide a high quality service that is easily accessible and patient centred. However there are a number of areas that need to be addressed if this is to be achieved.

**Capacity & Resources**
- Local services at the North Middlesex Hospital need to be developed for medical abortions so that women do not have to travel out of area e.g. Bedford Square.
- There is a need to improve the support provided to women having an abortion including improved pre- and post counselling and particularly for those aged under 16.

**Accessibility**
- The numbers of women accessing a NHS funded termination and those accessing prior to 10th week of conception are lower than the averages for the sector, London and England.
- There are concerns that the Termination Service is still too bureaucratic which may lead to delays in access. There are particular concerns about young peoples ability to access the service.
- There are concerns about the numbers of women that present late for an abortion (particularly young women) and work need to be done to ensure they access the service at an earlier stage in the pregnancy.
- There have been a number of suggestions for how access to the service could be improved and for how women can be encouraged to seek help at an earlier stage:
  - Increasing and improving the telephone booking system.
  - Developing a 4YP Young Peoples Fast Track assessment clinic, which would include child protection assessment & counselling on the spot.
  - Developing innovative and targeted advertising campaigns using a range different medium.
  - Developing free or subsidised pregnancy testing services from a range of easily accessible settings such as pharmacies and community and youth sites.
- Access to abortion via Primary Care needs to be improved particularly where GPs have a conscientious objection to abortion and are single-handed or a smaller practice.
- There is a need to develop innovative sexual health promotion initiatives to reduce the number of women requiring an abortion and the numbers of women having repeat abortions.

**Inequalities**
- There are concerns about access issues particularly for asylum seekers where there are immigration issues and difficulties proving residency. Access to link workers can be difficult.

**Partnership Working**
Communication with all services that refer into the service needs to be enhanced. This could be achieved through the development of care pathways.

There is a need to ensure that care pathways are in place for those GPs who have a conscientious objection to abortion. With the introduction of the new GMS contract for GPs a model for improving access to termination services could be developed.

There is a need to develop links with services that have a remit to provide Personal, Social and Health Education (PSHE) to young people e.g. schools, school nursing, youth settings and drugs and alcohol services, in order to improve the advice and information provided to young people.

**Training & Development**

Training needs to be developed and offered to all staff (those that operate the service as well as those that refer into it) which provides an opportunity to reflect on personal attitudes and values and which addresses issues of individual choice.

**KEY PRIORITIES FOR ACTION:**

- To improve the data collection and IT systems so that information about women seeking abortions can routinely be collected and shared with commissioners. The data is also required to measure progress against the MEDfash and London-wide Sexual Health Framework standards.

- To undertake a review of the service including a review of access into the service and provision for asylum seekers and those that do not speak English.

- To work with Primary Care in the context of the new GMS contact to review access into the service via GPs and to consider the development of additional services that would improve access for all groups.

- To develop care pathways between key services.

- To consider the development of a Young Peoples fast track service which would include child protection assessment and access to high quality pre-and post counselling.

- To develop sexual health promotion initiatives including information campaigns and the development of publicity materials to address the high numbers of abortions and repeat abortions. These initiatives should take into account those that do not speak English.

- To develop and facilitate an abortion training programme.

**6. Primary Care and sexual health**

The broad focus of the National Strategy for Sexual Health and HIV is to shift the balance of sexual health service provision whereby those working within the Primary Care setting (GPs and Practice Nurses) will assume a greater role in the provision of such services within the community. It is also anticipated that greater access to sexual health services will be achieved through developing the role of Primary Care provision. Greater Primary Care involvement will primarily be achieved through the development of ‘managed networks of care’ in which mainstream genitourinary medicine services (GUM) and other specialist sexual health and family planning practitioners will co-ordinate sexual health service provision across a broad range of services, including Primary Care. In consultation with all stakeholders, PCT’s are expected to provide structural support and guidelines in helping to develop Level 1 provision (see section 2.3) within GP practices.
In Haringey there are approximately 160 GPs working from 59 practices (Figure 29). There are proportionally more single handed GPs in the locality than neighbouring boroughs; the capacity and level of services that may be provided from single handed practices may be restricted. Practice Nurses (PNs) have for many years been recognised as key players in the provision of extended services within Primary Care and the development of a local Practice Nurse Bank system now ensures that all practices may have access to this key professional group.

The magnitude of the project in achieving Level 1 provision across Primary Care can be illustrated by a number of local audits. The degree to which GPs currently manage and treat STIs within the primary care setting is to a large degree unknown in that nationally collated data only focuses on those people presenting at GUM clinics (KC60). In a recent audit of GPs in Haringey however, it was apparent that the majority of patients requiring sexual health services continues to be redirected to GUM services when presenting in Primary Care (Bradford, 2002b). In this audit, it was found that just under ½ (49%) of GPs always referred patients requiring sexual health to GUM services, whereas just 17% generally treated these concerns within their practice (Table 18). This data would appear to indicate that GPs currently manage a relatively small proportion of GUM concerns currently presented within the Primary Care setting. Future arrangements for STI and family planning data collection between are being clarified between the Health Protection Agency and the Department of Health to ensure that all providers (including Primary Care) will contribute to national and local datasets (IAG, 2004).
Further evidence of the enormity of the scale of developing sexual health services across Primary Care is illustrated from another local audit assessing practitioners comfort in discussing sexual health issues with their patients (Bradford, 2003a). In this survey of GPs and PNs in Haringey and Enfield it was revealed that whilst there was a high level of comfort talking about sexual health issues with women (93%), proportionally fewer felt as comfortable talking to teenagers (83%), Black and minority groups (81%), men (76%) or gay men (61%) (Table 19). Of particular note, was that GPs and PNs felt least comfortable talking about HIV/AIDS (68%) and a majority (82%) indicated that they required updating on this issue (Table 19). Over 2/3rds of those practitioners surveyed indicated that they needed generic sexual health training (Table 19).

<table>
<thead>
<tr>
<th>GPs &amp; PNs feeling comfortable</th>
<th>GP &amp; PNs feeling comfortable talking about:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males 76%</td>
<td>Contraception 97%</td>
</tr>
<tr>
<td>Females 93%</td>
<td>Abortion 85%</td>
</tr>
<tr>
<td>Black &amp; minority groups 81%</td>
<td>STI’s 84%</td>
</tr>
<tr>
<td>Teenagers 83%</td>
<td>HIV/AIDS 68%</td>
</tr>
<tr>
<td>Gay men 61%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GP &amp; PNs requiring updating for:</th>
<th>GP &amp; PNs wanting training for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS 82%</td>
<td>Generic sexual health 67%</td>
</tr>
<tr>
<td>STIs 66%</td>
<td>Cultural awareness 72%</td>
</tr>
<tr>
<td>Abortion 43%</td>
<td>Joint working skills 60%</td>
</tr>
<tr>
<td>Contraception 38%</td>
<td>Working with teenagers 58%</td>
</tr>
<tr>
<td></td>
<td>Communication skills 57%</td>
</tr>
</tbody>
</table>

Under guidelines within the National Sexual Health Strategy, it is expected that General Practices will be expected to deliver 8 basic components of sexual health and HIV services to comply with Level 1 provision. This was the subject of an audit undertaken in September 2002 (Bradford, 2002b). Table 20 shows the 8 components services that GPs will be required to undertake, their current provision of these services and desire for further training in the provision of these services among GPs in Haringey. High levels of service provision were recorded among GP for basic family planning and sexual health service provision such as contraceptive services, cervical cytology and pregnancy testing (Table 20). Hepatitis B immunisation provision was also high where approximately 9 out of 10 GP respondents indicated that their practice provided this service. Other sexual health services are provided by far fewer local practices; 53% of GP respondents indicated that they undertook assessments of males with STIs, 41% undertook STI testing with females and just 22% performed HIV testing (Table 20). Of most interest however, is the gap between actual service provision and the need for further training to provide sexual health services. Whilst only 22% of GPs currently undertake HIV testing, only 19% wanted further training to develop this service, which would appear to suggest little enthusiasm for this development locally (Table 20). A similar pattern of responses were seen for STI testing for men and women and sexual history taking (Table 23).
A number of initiatives are planned to further develop the sexual health role and capacity of those working in the Primary Care sector in Haringey. The GUM service has undertaken a programme of sexual health training for local GPs and PNs for a number of years, though evidently there has been more success in reaching and training the latter group of practitioners. A number of recent developments however, have presented further opportunities to develop sexual health within Primary Care. Firstly, the establishment of the new GMS contract for GPs (2004) provides opportunities for the development of sexual health services through Enhanced Service specifications for those GPs who are able to undertake specialised sexual health services and the quality & outcome framework within GMS. The conditions and requirements for the provision of enhanced services have been agreed in conjunction with the BMA (2004). There are concerns however, that more specialised family planning services (such as IUD fitting) may no longer be provided by a number of GPs as this does not form part of the main GP contract. Actual provision of family planning and sexual health services however has yet to be fully audited post the new Contract in Haringey.

Haringey TPCT has recently appointed a Primary Care Facilitator to help develop a strategy for developing sexual health service provision in this sector and £150,000 has been allocated by the Trust to this end. Plans are currently in preparation but the broad intention of this strategy is to employ senior level nurses to provide nurse led sexual health clinics, training and development and a liaison link between Primary Care and Family Planning, GUM & HIV services (Table 21). The premise of this model of development is that the majority of local practices are insufficiently developed to undertake sexual health work and that the competing demands for GPs will render sexual health service development as a low priority at present. Thus an increase in the nature and level of sexual health service provision will be best achieved through a proactive model of recruitment and service development and facilitation.

Table 21 - Haringey Primary Care Development Strategy (2004)

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Haringey (%)</th>
<th>GP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical cytology screening and referral</td>
<td>84%</td>
<td>9%</td>
</tr>
<tr>
<td>Pregnancy testing and referral</td>
<td>72%</td>
<td>6%</td>
</tr>
<tr>
<td>Sexual history and risk assessment</td>
<td>63%</td>
<td>16%</td>
</tr>
<tr>
<td>Assessment and referral of men with STI symptoms</td>
<td>53%</td>
<td>22%</td>
</tr>
<tr>
<td>STI testing for women</td>
<td>41%</td>
<td>22%</td>
</tr>
<tr>
<td>HIV testing and counselling</td>
<td>22%</td>
<td>19%</td>
</tr>
</tbody>
</table>

**ISSUES FOR CONSIDERATION:**

**Capacity & Resources**

- There is a fundamental need to undertake a systematic review of the current provision of sexual health and family planning services provided in Primary Care to establish baseline data on current provision. This is essential to guide and inform service developments and also provide a base from which to assess the impact of planned developments in this field.
- It is not yet apparent whether the £150,000 allocated to the development of sexual health services in Primary Care is a one off grant or recurrent funding. This would emphasise the need for broad service wide development among all
GPs alongside the establishment of more dedicated or strategic provision of services (such as the planned satellite services).

**Accessibility**
- High levels of economic deprivation and sexual health & family planning needs are exhibited within the A10 Corridor (N15, N17) beyond any other area in the locality, thus the planned development of Nurse led clinics in Primary Care should initially focus on these areas.
- Capital development opportunities for sexual health service expansion in Primary Care are presented through LIFT (local finance initiatives) that may require further exploration.

**Inequalities**
- There are current concerns concerning the availability of IUD and emergency contraception among General Practices in the locality. This would further support the need to audit current sexual health and family service provision.
- There has been much local concern as to the suitability and appropriateness of HIV testing being undertaken in Primary Care. These concerns would appear to be verified where data presented in this report has highlighted greater training needs among practitioners in dealing with HIV/AIDS and a major risk group, gay and bisexual men.

**Partnership Working**
- Clear and transparent clinical care pathways should accompany the expansion of sexual health (and indeed family planning) services in Primary Care. The lead GUM, HIV & Family Planning Physicians need to be closely involved in Primary Care initiatives to ensure clinical accountability and clinical governance of services.
- Given the prevailing conditions within this area, the development of sexual health service provision within the A10 Corridor is a shared aspiration of the Enfield Sexual Health Strategy. It is therefore suggested that exploratory dialogue be undertaken to establish the feasibility of joint commissioning in attaining this shared strategic aim.
- The issue of patient sharing is known to be problematic in developing satellite services locally. The existence of ‘clustering’, where services are provided by GPs for patients of their own and neighbouring GPs is in operation for other treatment and care issues locally, and does provide some encouragement in principle for the development of (nurse led) satellite sexual health services. This process will clearly need to be facilitated to ensure full cooperation of practices in targeted areas.

**Training & Development**
- The current format for delivering sexual health and family planning training to PNs and GPs may require some alteration, where local research indicates that a practice based multi-disciplinary approach may be more acceptable and accessible to local practitioners.
- As has already been highlighted there is an ongoing need for training and development on a very broad scale within Primary Care. The nature of training needed in Primary Care clearly goes beyond the development of clinical practice, but is also required to develop the communication, joint working and cultural awareness of this setting in relation to sexual health.
- A contraceptive services audit carried out in 2002 as part of the Teenage Pregnancy Strategy highlighted that many GPs were uncomfortable prescribing
contraception to under 16 year olds without parents knowledge and some were still confused about confidentiality issues pertaining to under 16 year olds. Training around these issues is therefore required.

**KEY PRIORITIES FOR ACTION:**

- There is a fundamental need to undertake a systematic review of the current provision of sexual health and family planning services provided in Primary Care to establish baseline data on current provision.
- Primary Care is the most critical area for the development of sexual health services in the locality, thus the importance of a defined and agreed local strategy with partners in Primary Care is of paramount importance. This should be established as a priority.
- High levels of economic deprivation and sexual health & family planning needs are exhibited within the A10 Corridor (N15, N17) beyond any other area in the locality. Thus the planned development of Nurse led clinics in Primary Care should initially focus on these areas.

7. Clinical Psychology in HIV & Sexual Health Services

Given the nature and uncertain prognosis of HIV infection, positive diagnosis of this infection can have a profound psychological impact on partners and families as well as those individuals concerned (Kalichman & Sikkema, 1994). Within GUM services there is also growing evidence of psychological support that may be needed for patients diagnosed with sexually transmitted or bacterial infections such as herpes (Green & Kocsis, 1997), genital warts (Reitano, 1997) and vaginal candidiasis (Irving et al, 1998). High levels sexual assault have been also been identified among both male and female GUM attenders (Pettrak et al, 1995) further underlining the need for psychological support within this setting (Matthews et al, 2000). Further still, studies have found high levels (39%) of depressive symptoms among attenders at sexually transmitted infection clinics (Erbeling et al, 2000).

In response to these and other areas of psychological need, the Sexual Health/HIV Clinical Psychology service was established in Enfield & Haringey in 1994. The service provides specialist psychological assessment and interventions for those people affected by HIV, sexual health or reproductive health problems. The service also provides consultation and supervision for staff working in local sexual health and HIV organisations. The service has been based at St Ann’s Sexual Health Centre since 1996 and is staffed by two full-time Clinical Psychologists. The service works closely with the HIV Unit (T1) at the NMH and St Ann’s Sexual Health Centre (including the sexual assault clinic and Zone 15).

<table>
<thead>
<tr>
<th>Table 22 – Clinical Psychology in Sexual Health 2003/4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments offered</td>
</tr>
<tr>
<td>Client referrals</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Client Problems (n=174)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Assault</td>
</tr>
<tr>
<td>HIV other adjustment</td>
</tr>
<tr>
<td>Erectile problems</td>
</tr>
<tr>
<td>Other psychosexual</td>
</tr>
<tr>
<td>HIV suicide/ depression</td>
</tr>
<tr>
<td>Adapt. Herpes/Warts</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>
Data monitoring from 2003/4 for Sexual Health/HIV Clinical Psychology service indicates that in excess of 1,000 appointments were offered to 174 clients during this period (Table 22). The most common problems that were presented by clients at the service were sexual assault (26% of clients), adjustment to HIV+ status (23%) and erectile dysfunction (12%) (Table 22). A majority of client referrals for psychological support came from St Ann’s Sexual Health Centre (68%) or the HIV Unit (T1) at the NMH (Table 22). In reflection of local HIV epidemiology and GUM usage, 76% of clients were resident in Haringey and 21% resident in Enfield (Table 22). Due to discontinuation of funding, clinical psychology services are no longer available to the Town Clinic (Enfield).

In consultations with the service it was evident that the level and nature of psychological need among its clients was increasing; a 10% increase in client contacts since 2001/2; clients presenting with more acute psychological needs, particularly refugee populations where a high incidence of sexual assault or adjustment to HIV+ status was noted. Additional demand for psychological support for the service has been precipitated through increased local pathology and the expansion of clinical sexual health & HIV sessions and staffing. Service gaps for clinical psychology input have been identified for young peoples sexual health services, family planning and antenatal HIV. Together, these factors would appear to suggest the need for additional clinical psychology support and is the focus of a current growth bid for the service.

**ISSUES FOR CONSIDERATION:**

**Capacity & Resources**
- The current growth in demand for Clinical Psychology in sexual health and HIV services, in terms of the nature and level of psychological needs would support the need for further investment in this service. Evidence from other services (T1) would also indicate high levels of co-morbidity of emotional and HIV medical concerns. Further resourcing would also enable the service to respond to identified service gaps in relation to psychological support needed for young people’s services, primary care and family planning (particularly termination of pregnancy).
- Problems remain for acute psychiatric assessment and there is a need for more developed partnership working across the sector and the establishment of liaison psychiatry service.

**Inequalities**
- The multiple and complex health needs of asylum seekers, particularly those who are HIV+ or have been sexually assaulted are further complicated through delays resulting from the uncertainty of administrative responsibility or accountability for this population group.

**Partnership Working**
- Work with all sectors to ensure that psychological and emotional aspects of health are fully integrated within assessment, treatment and care of patients in all sexual health sites.
- As Clinical Psychology spans a number of service areas (St Ann’s GUM, T1 and Social Services) and there is no linkage to the Sexual Health Partnership Group, there is some difficulty in locating the strategic link for this service. There is a need to embed the service further in to the broad family of sexual health and family planning services in the locality and identify management
and commissioning links with them.

- Psychosexual work is also undertaken by Family Planning, Halliwick Mental Health Centre & Health Psychology which would infer the need for a review of this aspect of Psychological support in the borough.
- In lieu of the above, there is a need to develop, with Family Planning Service, more defined client pathways to address the psychological needs of this client group.

**KEY PRIORITIES FOR ACTION:**

- The need to further develop the strategic commissioning and management link for the service.
- Additional resourcing to respond to increased demand and identified service gaps.
- There is no current provision for acute psychiatric assessment and there is a need for the development of liaison psychiatry.
- Given the number of current providers, the identified service gaps and resource pressures, it is evident there is a need for a review of psychosexual services.

**8. 4YP Young People’s Clinic**

4YP Haringey was established in March 2000. It was initially funded though money from the Teenage Pregnancy Implementation Grant but in 2004 half of the funding for the clinic was picked up by the TPCT.

4YP Haringey operates on a drop-in basis every Tuesday afternoon between 2.30-4.30pm from St Ann’s Sexual Health Centre. It is an integrated sexual health and contraception clinic staffed by 2 GU Doctors, 2-3 GU Nurses, one Family Planning Consultant, one family planning nurse, one Health Adviser and 2 admin staff. In addition, two educators from the Sexual Health Education Project (see section 4.12) spend time in the waiting area with the young people providing informal sex and relationships education and reassurance while the young people wait to be seen.

When the clinic first began in 2001 it was for young people aged 20 and under. However, since January 2004 the age limit has been reduced to under 18s due to clinics being unable to manage the very large demand. It is thought that many ‘older’ young people i.e. those aged 18-20, were unable to secure appointments at mainstream sexual health clinics so were making use of the drop-in service offered by 4YP Haringey. Since the reduction in age limit there are concerns that these older young people may not be accessing services but who are at the greatest risks of STIs.

4YP Clinic data for 2002-3 demonstrated that there were 1,066 attendances. Of these 1,066 attendances, only 28.5% were male. In comparison 71.5% of the attendances were by females. Approximately 1 in 7 (15%) of the new and rebook attendees were young people under the age of 16. The most numerous ethnic groups in attendance at the service were young people of Black Caribbean (24.2%), Black UK (22.6%), Black African (15.9%) and White UK (14.3%) ethnic origin. Attendance at the 4YP service overall demonstrated that young people of Black and other minority ethnic backgrounds made up in excess of 85% of the new and rebook attendees, which is significantly higher than comparable data for St Ann’s Sexual Health Centre as a whole (approximately 70%). Attendees were predominantly heterosexual (99.6%), though a small number of gay and bisexual young men and women (0.4%) used the service (Bradford, 2002c).
Of the new and rebook attendees, 74% were resident within the borough of Haringey and 16% within Enfield. Of particular note was that just under one-half (49%) of all new and rebook attendees were resident in just two postcode districts (N17, N15), the postcodes where St Ann’s Sexual Health Centre is most closely situated.

Data on the services used by the young people showed that in excess of 600 sexually transmitted infection screens were undertaken in 2002-3, making this the most numerous activity within the service. STI screens were undertaken with ¾ of all new and rebook attendees. Among female new and rebook attendees, 25% discussed contraceptive methods, 18% received contraceptive advice, 30% had a pregnancy testing and 6% were administered emergency contraception.

**8.1 4YP Contraceptive Nurse**

A need was identified by the Teenage Pregnancy Strategy for more young people’s contraceptive and sexual health services in areas of high rates of teenage conception and in the more deprived areas of the borough. A successful bid was made to Neighbourhood Renewal for funding to recruit a 4YP Contraceptive Nurse to develop and deliver such services within the regeneration areas. The 4YP Nurse came into post in August 2004. Two sites (Wood Green and Northumberland Park) which have already been established as 4YP advice and information drop-in sessions will be developed to include the prescribing of contraception via the 4YP Nurse. In addition, further new sites will be identified through close working with Haringey Youth Service and Connexions.

**KEY PRIORITIES FOR ACTION:**

**Capacity & Resources**
- Neighbourhood Renewal funding for the 4YP Contraceptive Nurse ends in March 2006.
- There is a need for more counselling provision in young people’s services.

**Accessibility**
- There is a need for more dedicated young people’s services in other parts of the borough where the numbers of teenage conceptions and rates of STIs are high.
- There is also a need for services for ‘older’ young people who are the highest risk of STIs but who may find it difficult to access the mainstream sexual health service due to the appointment system and who are now no longer able to access the 4YP clinics.

**Inequalities**
- Whereas young men make up 70% of the users of the 4YP Bus, in 2001/02 only 28.5% of the young people accessing the 4YP Clinic were young men. It may be that the % of young men accessing the 4YP increased during 2003/04, however further research may be needed to gain a better understanding of this issue.
- Early data from ‘Stepping Up’, the Teenage Parents Support Project in Haringey is showing that about 30% of the teenage parents in Haringey are asylum seekers. However, the sexual health needs of young asylum seekers and unaccompanied minors are currently unknown and they are thought not to be accessing the 4YP services. Research into this area is being undertaken and will be completed at the end of 2005.
Training & Development
- Training needs to be provided to all staff (including those working in Primary Care) about confidentiality and the under-16s and working with young people.

KEY PRIORITIES FOR ACTION:
- To develop young people’s integrated sexual health and contraceptive services in other parts of the borough.
- To work with Primary Care in the context of the GMS contract arrangements to develop a model for contraceptive and sexual health services that meets the needs of young people.
- To develop and facilitate a training programme for effective working with young people.

9. Chlamydia Screening Pilot Programme
Enfield and Haringey are part of Phase 2 of the National Chlamydia Screening Programme (NCSP) funded by the Department of Health. The goal of the NCSP in England is to control Chlamydia through the early detection and treatment of asymptomatic infection; to prevent the development of sequelae; and reduce onward disease transmission.

The programme's vision is to implement, by 2008, a multi-faceted, evidence based and cost-effective national prevention and control programme for genital Chlamydial infection in England in which all sexually active adults are aware of Chlamydia, its effects, and are able to access a range of prevention and screening services to reduce their risk of infection or onward transmission.

Under the NCSP, opportunistic screening for genital Chlamydial infection will be offered to all sexually active women and men, aged under 25 years, attending a variety of health care settings in England. The national programme is being implemented in phases, with successive annual waves of local programmes being brought on board.

The aim of the Chlamydia screening programme in Enfield and Haringey is that women and men under 25 years old who have ever been sexually active will be offered a Chlamydia test when they attend various sites in the two boroughs. In Haringey the identified screening sites are the young people's services under the 4YP banner (including the bus, Northumberland Park and Wood Green); family planning clinics (although this will commence as a women only service); antenatal and gynaecology clinics at North Middlesex Hospital; College of North East London and Middlesex University and a pilot scheme using postal return of specimens will run for 6 months at selected pharmacies. The screening began in the 4YP services in November 2004, with roll out in the family planning clinics soon after. Follow up of results are carried out at the Chlamydia Screening Office based at Enfield Town Clinic where clients are contacted and treated, and follow up and partner notification arranged.

KEY PRIORITIES FOR ACTION:
- To embed the Chlamydia screening programme into the mainstream family planning and sexual health services by 2006 so that the service continues to operate once the funding ends.
10. Sexual Health on Call - Working Women’s Project
Numerous investigations into the health needs of commercial sex workers have highlighted the vulnerability of this group to HIV and other sexually transmitted infections (Day & Ward, 1997; Philpot et al, 1991; Barton et al, 1987). Further still, the associations between commercial sex work and injecting drug misuse (Green et al, 2000) makes this population further susceptible to HIV, Hepatitis and other blood borne infections. Sexual Health on Call (SHOC) was established in 1995 in response to the sexual health and broader health and welfare needs of female commercial sex workers within the London boroughs of Barnet, Enfield and Haringey. SHOC works in collaboration with local sexual health services\(^5\), substance misuse services agencies\(^6\) to provide a broad range of outreach services to indoor sex workers based in flats and saunas and to outdoor sex workers who work the South Tottenham ‘beat’ area in Haringey. SHOC is jointly funded through the Haringey TPCT and Haringey Drugs Action Team (DAT).

Satellite drop-in services operate on both Monday and Friday evenings between 7.00 p.m. and 11.00 p.m. from premises conveniently located on the ‘beat’ area within South Tottenham. At the Monday satellite a full sexual health screening and treatment service together with a general medical service is available. At the Friday satellite service a programme of specialist support sessions (employment / retraining, life-skills and alternative therapies) is offered to enable working women to make substantial life changes and support those wishing to exit prostitution. Both satellite services offer safer sex supplies (condoms, lubricants) and clean injecting equipment for safer drug use (syringes and sterile accompaniments). Project workers are also present to provide harm reduction services as well as information, advice and support to working women on a range of health and welfare issues. SHOC also undertakes two outreach sessions per week on Wednesday and Friday evenings, where project workers provide condoms, information and facilitate access to the satellite services whilst women are working from the ‘beat’ area in Haringey.

<table>
<thead>
<tr>
<th>Indoor Work (Flats &amp; Saunas)</th>
<th>Street and satellite clinic contacts</th>
<th>Satellite Medical Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total contacts 2003/4</td>
<td>292</td>
<td>164</td>
</tr>
<tr>
<td>Area of residence</td>
<td>Area of residence</td>
<td>Area of residence</td>
</tr>
<tr>
<td>(n=239)</td>
<td>(n=139)</td>
<td>(n=53)</td>
</tr>
<tr>
<td>Haringey</td>
<td>Haringey</td>
<td>Haringey</td>
</tr>
<tr>
<td>24%</td>
<td>52%</td>
<td>47%</td>
</tr>
<tr>
<td>Enfield</td>
<td>Enfield</td>
<td>Enfield</td>
</tr>
<tr>
<td>16%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Other London</td>
<td>Other London</td>
<td>Other London</td>
</tr>
<tr>
<td>47%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>13%</td>
<td>2%</td>
<td>17%</td>
</tr>
<tr>
<td>No of migrant sex workers</td>
<td>No of migrant sex workers</td>
<td>No of migrant sex workers</td>
</tr>
<tr>
<td>149 (51%)</td>
<td>13 (8%)</td>
<td>9 (15%)</td>
</tr>
</tbody>
</table>

Analysis of contact data reveals that 292 contacts were made with female commercial sex workers at off street flat and sauna sites in 2003/4 (Table 23). Flat and sauna contacts were made at 22 sites which were equally distributed in Haringey and Enfield locations. Of those women working from flats and saunas 24% were resident in Haringey and 16% in Enfield (Table 23). In line with pan London

\(^5\) Clare Simpson House, Barnet. St Ann’s Sexual Health Centre, Haringey
\(^6\) Drugs Advisory Service Haringey (DASH)
longitudinal studies (Ward H et al, 2004), there has been a significant increase in the number of migrant sex workers (sex workers who are not born in the United Kingdom) in contact with the project, indeed, these represent over a half of all off street contacts (Table 23). There were 164 contacts with female sex workers in the two satellite services (Monday & Friday) and within street outreach sessions. Just over a half of all outreach contacts were with working women resident within Haringey (Table 23).

The satellite medical service (which offers sexual health screens, general medical service, Hepatitis B immunisation and Hepatitis C screening) had contact with 60 women, of whom just under one half (47%) were among women resident in Haringey (Table 23). Commercial sex work and drug use are closely associated (Green et al, 2000) which is verified among local sex worker contacts, where 43% of working women were identified as drug users (heroin, crack cocaine, cannabis) of which 68% were multiple drug users (Bradford, 2002).

Working with clients with acute and multiple needs inevitably presents a number of service coordination issues, particularly for those working women not resident within the borough. Whilst sexual health concerns of working women may be supported through local genitourinary medicine services, obtaining drug support services for non Haringey residents remains problematic. A lack of dedicated accommodation for SHOC has limited the nature and scope of work that can be undertaken with working women in the locality and is perceived to be a significant impediment to service development. Whilst there has been recent progress in moving the project to a more secure funding base, on the evidence of a recent service review there is need for more strategic support in enabling SHOC to develop clear multi-agency pathways to support working women.

**ISSUES FOR CONSIDERATION:**

**Capacity & Resources**
- Lack of dedicated accommodation currently restricts opportunities for health promoting interventions. There is already a crowded programme of activities from the two satellite sessions (general drop-in, medical service and ‘exiting’ workshops) limiting the potential for other important work that can be done in relation to women’s drug & other health needs.

**Inequalities**
- The number of migrant working women in contact with SHOC has increased for all on and off street services. Problems are encountered in relation to providing adequate translating services for these women at local services.
- Securing appropriate drug treatment services for non-Haringey residents remains unresolved.

**Partnership Working**
- SHOC has identified the need to work more closely with local housing, health and drug services to enable it to respond to the multiple and complex needs of working women.
- Ongoing need to develop fast track access to local drug treatment services for working women.

**KEY PRIORITIES FOR ACTION:**
- Securing dedicated accommodation.
Identifying drug service support for non-Haringey residents.
Development of multi-agency pathways of care for SHOC clients.

11. Community Pharmacies & St Ann’s Hospital Pharmacy
There are 55 community pharmacies in Haringey (see Figure 30)

Figure 30. Community Pharmacies in Haringey

Pharmacies have a key role to play in the delivery of sexual health and contraceptive services. Emergency Hormonal Contraception (EHC) can be sold over the counter to women aged over 16 years as can condoms, and pharmacists can provide advice and information about sexually transmitted infections and contraception. Some pharmacies provide pregnancy testing. There is capacity to improve the provision of health advice in pharmacies. Pharmacies are presently contracted by the TPCT to display 8 general health promotion leaflets. The TPCT could encourage them to display sexual health promotion leaflets and encourage them to site them with their condom display.

In September 2002, a free Emergency Hormonal Contraception scheme was introduced in Enfield and Haringey as part of the Teenage Pregnancy Strategy. The scheme was initially funded by the Department of Health as part of a national pilot. In January 2004, Haringey TPCT took over it’s funding.

The most recent figures (September 2002 to December 2003) indicate that by December 2003 the number of requests for EHC was averaging at about 250 per month across the two boroughs. A total of 2,904 requests had been made since the project started. However, only 36% of these requests were from young women living in Haringey. In addition, the data showed that 28.3% of the women requesting EHC in Haringey were Black Caribbean, 26.5% were White British, 17.9% were Black African, 14% were mixed race and 13.3% fell under one of the other ethnic categories.

The data also shows that of the young women requesting EHC in Haringey, 52% were aged under 18 years, with 15% of these being under 16. 48% were aged 18
and over. Initially the scheme was aimed at young people aged 20 and under. However due to the very large number of young women accessing the service and the limited budget available the age limit of the scheme was reduced in January 2004 to those under 18 years. This was bought the target age group in line with the Teenage Pregnancy Strategy.

Links are also being developed between the pharmacists that are part of the Emergency Contraception scheme for young people and the Chlamydia Screening Pilot (see section 9). It is envisaged that from September 2004 a pilot scheme using postal return of specimens will run for 6 months from selected pharmacies.

The Pharmacy Department at St Ann’s Hospital provides a range of services to the family planning and GUM clinics in both Enfield and Haringey. These include the provision of a full range of contraceptives and antibiotics, emergency kits for anaphylactic and vagal shock, and training on various aspects of the above. The Head of the Pharmacy Department has also been involved in the writing and updating of Patient Group Directions and other related procedures. HIV related services consist of the dispensing of prescriptions for anti-retrovirals, feeds for the HIV dieticians and other medication as well as patient advice and counselling as requested.

For the last 5 years condoms and lubricants have also been provided to the Sexual Health Outreach Project (SHOC) see section 10. SHOC also runs a sexual health clinic at Seven Sister and stocks of antibiotics are supplied from the Pharmacy at St Ann’s.

Condoms are also being supplied to a number of other service providers in both Enfield and Haringey. These arrangements stem from the HIV prevention work that was established a number of years ago and which was funded by the ring-fenced HIV funding that was held by the Health Promotion Department. The service providers across the two boroughs include drugs services, Middlesex University, colleges, post-natal units, Health Visitors, Sure Start, Mental Health Services and voluntary groups. In addition, two GP surgeries continue to obtain free condoms from the Pharmacy department from a pilot scheme that was initiated in 1994.

It is envisaged that the role community and hospital pharmacists will play in the delivery of the sexual health and contraceptive services will develop considerably with the introduction of the new Pharmacy contractual framework in April 2005. The proposed framework aims to improve the range and quality of services that community pharmacy offers to patients and to support the integration of community pharmacy in the NHS. The new framework provides for categorisation into essential, enhanced and local additional services. Local additional services are those that will be commissioned by PCTs. Sexual health and contraceptive services will fall under this category.

**ISSUES FOR CONSIDERATION:**

**Partnership Working**

- There are concerns that some community pharmacists are not aware of the sexual health and contraceptive services that are available locally and therefore are not making onward referrals.
- There is a need to develop stronger links between sexual health and family planning services and the pharmacists that provide methadone and needle
KEY PRIORITIES FOR ACTION:
- To work with the Pharmaceutical Advisers in the context of the new pharmacy contractual arrangements to develop a model for contraceptive and sexual health services that responds to need and improves access for all groups.
- To ensure that pharmacists receive up to date and easily accessible information about local sexual health and contraceptive services and how to refer into them.
- To develop and facilitate a sexual health and contraception training programme for pharmacists.
- To review and clarify the role of the pharmacy department in relation to sexual health, contraceptive and HIV services and in the provision of condoms.
- To clarify the funding arrangements for the provision of supplies by St Ann’s Hospital Pharmacy Department to services in Enfield and Haringey.

12. NHS Walk-in Centre
The North Middlesex Hospital Walk-In Centre is open from 7am until 10pm Monday to Friday and 9am until 10pm Saturday and Sunday and offers fast and convenient access to local NHS advice, information and treatment. It is ideally situated in Edmonton offering easy access to residents of both Enfield and Haringey. Like community pharmacists, the Walk-in Centre has a key role to play in the provision of advice and information on sexual health and contraceptive services.

In addition, due to its accessibility and long opening hours, the Walk-in Centre is one of the key providers of Emergency Hormonal Contraception (EHC). During 2003/04, 118 prescriptions of EHC were administered to women from both Enfield and Haringey. There is no data about the age, ethnicity or area of residence of these women.

KEY PRIORITIES FOR ACTION:
- To develop partnerships with key staff at the Walk-in Centre to ensure that the services provided by the Centre are integrated in the wider network of sexual health and contraceptive services.
- To ensure that staff working in the Walk-in Centre can access regular sexual health and contraception training.
Appendix 4.
HIV Prevention & Sexual Health Promotion

1. Introduction
The rise in the number of people diagnosed with STIs and HIV over the past 6 years emphasises the need for targeted and effective health promotion interventions. The underlying factors behind the increase in HIV and STI infections (see 3.2) are multiple and complex and the burden of new infections do not fall evenly between or within populations and subgroups. Therefore, the national strategy acknowledged that the most effective actions to prevent sexual ill-health and HIV infection are those which are multi-faceted and where national (and indeed regional) campaigns provide a vital backdrop for more targeted sexual health promotion and HIV prevention work undertaken locally. Implicit within this, is the recognition that there needs to be greater co-ordination between national and local levels of sexual health promotion activity.

The National Strategy for Sexual Health & HIV presents three key aims for HIV prevention, these being:
- Reduction of newly acquired HIV infections;
- Reduce the levels of unsafe sex; and
- Raise awareness of services.

The strategy also provides two clear targets:
- Reduce by 25% the number of new HIV infections by 2007; and
- Reduce by 25% the number of new gonorrhoea infections by 2007.

2. HIV Prevention & Sexual Health Promotion – what works
The Health Development Agency (HAD) were commissioned to undertake a review of reviews to ascertain the effectiveness of HIV and STI prevention interventions (HDA, 2004). This substantive body of work provides critical information to guide and inform the nature of locally commissioned HIV and STI prevention work. A summary of those interventions which were noted to be effective are summarised in Table 24.

<table>
<thead>
<tr>
<th>Table 24 – Effectiveness reviews (HAD, 2004)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clear evidence:</strong></td>
</tr>
<tr>
<td><strong>Interventions that are effective:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Interventions more likely to be effective if:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

The Health Development Agency continues to update this work on the basis of new research evidence and intends to regularly republish the effectiveness reviews with new guidance. The following (Table 25- Table 27) provides a summarised guide to
effective interventions for HIV Prevention, STI Prevention and the prevention of Teenage Pregnancy.

Table 22 - HIV Prevention evidence base

- Interventions that are placed within the broader context of gay men's lives, addressing the range of factors which influence risk at both the personal level (e.g. knowledge, skills) and the structural level (e.g. discrimination towards gay men, gay community norms towards condom usage).
- Tailored and targeted to specific sub-populations of men who have sex with men, for instance black gay men and working class gay men.
- Multi-component (using small group work), focusing on risk education, sexual negotiation and communication skills training and rehearsal (e.g. through role-play or identifying ‘triggers’).
- There is some evidence to conclude HIV counselling and testing can influence sexual risk behaviours among those that newly test positive, and their partners. However, the effects of a negative diagnosis are not clear as some research suggests that negative tests may reinforce unsafe behaviour. Therefore, on current evidence voluntary testing and counselling should be targeted only at high-risk individuals who are likely to test positive (the exception being all GUM attenders are offered HIV testing as part of their overall STI screening).
- One of the most effective strategies for the prevention of HIV transmission is that of mother to baby. The ranges of intervention put in place have reduced the transmission from an average of 30% to less than 1%.

Table 26 - STI Evidence Base

- Sexual health promotion can be effective if targeted at high-risk individuals and groups and placed within the broader context of their lives influencing risk at personal & structural level.
- Partner notification is more effective if by provider referral than patient referral.
- Patient referral incurs less service costs but needs to be supported in order to become more effective (contradictions of effectiveness would indicate patient choice may be the most appropriate).
- It is important to emphasise that partner notification has a potential to cause harm such as inciting ‘domestic’ violence – this is an area requiring further research.

Table 27 - Teenage Pregnancy Evidence Base

- School based sex education, particularly when linked to contraceptive services, can delay sexual activity and reduce the pregnancy rates.
- Community-based education, development and contraceptive services.
- Interventions, which develop young people’s education, vocational skills, interpersonal skills and confidence, can increase contraceptive use and reduce pregnancy rates.

These interventions and programmes are most likely to be effective if they:

- Are based on theory, and have clear behavioural goals and outcomes.
- Focus on improving contraceptive use and at least one other behaviour likely to prevent pregnancy and STI transmission.
- Are long term.
- Tailor services to meet local needs, and target local high-risk groups.
- Have clear, unambiguous messages.
- Use participatory teaching methods.
- Are accessible (in terms of opening hours, location, and level of information provided) to young people.
- Use staff who have been trained and are committed to the programme and to working with young people.
- Whenever possible, respect young people’s confidentiality and views
- Are in place before young people become sexually active.
- Focus on both young women and young men.
- Foster an open, communicative atmosphere for talking about sex and sexuality.
Even with the above guidance, promoting sexual health clearly remains a complex issue given the range of social, economic and cultural influences on an individual’s sexual well-being. Therefore it is essential that local interventions have the flexibility and adaptability to be able to respond to the locality of HIV and sexual health needs. To ensure this approach, HIV prevention and sexual health promotion need to embody a number of key principles and values:

- Sexual health promotion and HIV should aim to provide good quality services and information to all whilst ensuring that target groups get the resources and developments they need;

- The burden of poor sexual health and HIV infection is not equal and that programmes and interventions should ensure that those who are disproportionately affected get the resources and developments they need (e.g. young people, Gay and bisexual men, African and other ethnic communities).

- Interventions need to be delivered at different levels: **individual** (e.g. counselling, help lines and other one to one interventions), **group** (e.g. group work, sex education) and **community** (e.g. community development and advertising campaigns).

- Interventions need to address the modifying factors (e.g. self esteem, peer opinion, stigma, and assertiveness) that influence individual’s sexual behaviour.

- Given the multitude of modifying factors that may influence sexual health behaviour, a more programmatic response is necessary to sexual health promotion and HIV prevention to bring together single interventions with an underpinning aim.

- Local programmes must be delivered using the known evidence base and fully evaluated by measuring outcomes i.e. outcomes that relate to changes in the modifying factors (personal and structural), together with immediate outcomes (behaviour change) and health outcomes (clinical).

### 3. Local HIV Prevention

HIV prevention work is commissioned jointly by Enfield and Haringey. In total, £410,000 was made available for local preventative work with contributions from Haringey TPCT, Enfield TPCT and the London Borough of Enfield (Table 28). A number of projects are commissioned with this funding including work with African communities, young gay men and lesbians and generic work with those infected or affected by HIV. Work with African communities includes a condom provision scheme for Black African males, work with faith communities, peer support for newly diagnosed and general HIV awareness raising within African communities (Table 28). Work to increase awareness of Female Genital Mutilation (FGM) is also funded within this programme of work. Outzone, a lesbian and gay youth group, is supported through the local HIV prevention funds. Generic work funded through HIV prevention resources includes contributions to World AIDS Day, National AIDS Manual (NAM) and legal service support through Terrence Higgins Trust (Table 28).
Table 28 – Haringey & Enfield HIV Prevention Programme - HIV prevention contributions and spending 2004/5

<table>
<thead>
<tr>
<th>Contributions:</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haringey TPCT</td>
<td>304,000</td>
</tr>
<tr>
<td>Enfield PCT</td>
<td>95,000</td>
</tr>
<tr>
<td>Enfield AIDS Support Grant</td>
<td>11,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>410,000</strong></td>
</tr>
</tbody>
</table>

**African Communities**
- Condom distribution & Safer sex programme with African Men (Innovative Vision Organisation) | 50,000 |
- Enfield Community HIV Prevention Support Service (Innovative Vision Organisation) | 30,000 |
- Outreach & Support with African women in Enfield & Haringey (Innovative Vision Organisation) | 60,000 |
- Horn of Africa Coordination Project (Ethiopian Community Centre) | 65,300 |
- African HIV & Health Improvement Forum | 36,500 |
- **Subtotal** | **241,800**

**Gay Men**
- Outzone at PACE | 20,000 |
- **Subtotal** | **20,000**

**General**
- Secondary Prevention & Treatment Compliance (NMH ????) | 20,000 |
- Specialist Legal Immigration Advice Terence Higgins Trust (THT) | 30,000 |
- World AIDS Day | 13,600 |
- Positively Women, NAM, HIV Awareness for people from Eastern Europe (CARIS) | 13,000 |
- Pilot HIV information and awareness programme for Young Caribbean People | 10,000 |
- **Subtotal** | **86,600**
- **TOTAL** | **348,400**

Total HIV prevention allocation to Enfield & Haringey in 2001/2 was £1,063,000, though with the loss of ring fencing there has been a decline in the total funds available for preventative work in the two boroughs. Devolving HIV prevention commissioning to the PCT level has potentially brought greater local harmonisation to HIV prevention commissioning processes, where the PCT will be commissioning HIV services at the same level as the Local Authority (with whom they are geographically co-terminus) and who are responsible for the distribution of the AIDS Support Grant.

3.1 London Gay Men’s HIV Prevention Partnership (LGMHPP)
The London Gay Men’s HIV Prevention Partnership (formerly the London Gay Men’s Provider initiative) began operating in its original form in 1996. LGMHPP commissions, manages and evaluates a programme of HIV prevention work that is delivered to gay men across London. The development of pan London commissioning was seen as essential in that it provided stability for HIV prevention providers (through strategic commissioning), maintained the level of spending on gay men as a priority group for HIV prevention (by tying in individual district commissioners to pan London work) and developing accountability (in that there were fewer HIV prevention contracts to monitor). At present, 9 contracts are provided through a range of agencies for the provision of a range of HIV prevention initiatives to gay men across the capital (Figure 31). Haringey TPCT contributed £64,548 to LGMHPP in 2004/5, which equates spend of £14 per gay male resident in Haringey (LGMHPP,
The amount each PCT spends on LGMHPP is predominantly historical and not
determined by the estimated size of the male or gay populations (2.3% outer London
and 10.3% inner London).

<table>
<thead>
<tr>
<th>Initiative</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass Media</td>
<td>213,00</td>
</tr>
<tr>
<td>Internet/Newsletter</td>
<td>105,000</td>
</tr>
<tr>
<td>Counselling</td>
<td>150,000</td>
</tr>
<tr>
<td>Group-work</td>
<td>323,00</td>
</tr>
<tr>
<td>Detached outreach</td>
<td>458,000</td>
</tr>
<tr>
<td>Free condom distribution</td>
<td>211,00</td>
</tr>
<tr>
<td>Small media</td>
<td>101,000</td>
</tr>
<tr>
<td>Responsive funding</td>
<td>48,000</td>
</tr>
<tr>
<td>Programme coordination</td>
<td>86,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,775,000</strong></td>
</tr>
</tbody>
</table>

In terms of where LGMHPP interventions occur in Haringey there are two outreach
sites Catch 22 and The White Hart, both of which are Freedoms sites where condoms
are distributed freely but there are no detached work sites. There are no counselling
or group work sites in Haringey. In terms of where the men who get the face-to-
face interventions live, it is estimated that 2.8% of all gay men living in London live
in Enfield & Haringey, which compares with an estimated 3.1% of counselling clients,
6.3% of group-work attenders, and 3.2% of detached work contacts who live Enfield
& Haringey. This would indicate that local gay and bisexual men are being reached
for face-to-face HIV prevention interventions.

In terms of exposure to the media interventions, of the 115 gay men living in Enfield
& Haringey who took part in the Gay Men's Sex Survey 2003: 42% recognised the
'Express Yourself' mass media adverts (which had an average recognition across
London of 44%; 37% recognised the 'Condoms - Just as Safe' mass media adverts
(which had a London average of 40%); 36% recognised the 'Relationships - testing,
telling, trusting' mass media campaign (London average 36%); 19% recognised the
'Condoms - everything a gay man needs to know' small media booklet (London
average 26%); 23% recognised the 'Need Help?' small media booklet (London
average 28%). This would indicate that proportionally less local gay and bisexual
men are being reached through media campaigns than other gay men throughout
London.

This would underline the importance of linking the work of LGMHPP to locally
commissioned work with this population group in Enfield and Haringey. There is
currently little or no infrastructure (dedicated gay men’s work or primary HIV
prevention programmes) to support this at present. On the basis of the local review
of HIV prevention with gay men, it is apparent that the development of local
infrastructure for working with gay men needs to be addressed:

*It is clear that the development of pan London HIV prevention commissioning should
not be seen to stifle or replace local HIV prevention commissioning with gay men, but
where some degree of local commissioning flexibility is maintained though actively
linked to pan London commissioning. (Moving On, 2002)*
ISSUES FOR CONSIDERATION:

Capacity & Resources
- There is clearly a need to develop current HIV prevention spending (£489,000) within Enfield & Haringey as spending does not reach 2001/2 targets for HIV prevention (£797,000).
- Given the epidemiology of HIV infection, it is a fair assessment to reflect that current HIV prevention spend in the borough is predominantly focused on secondary prevention of this infection. The need to develop primary prevention and more locally targeted work with gay and bisexual men and Black Caribbean's, should be provided through additional resources to this budget rather than a reconfiguration of existing spend.

Access
- There is an ongoing need for capacity building of local African and gay community groups to continue to build local infrastructure through which HIV prevention and sexual health promotion interventions may be targeted.

Inequalities
- The absence of a dedicated gay men’s HIV prevention worker in the locality means that there is no impetus for targeted gay men’s work within the locality. Moreover, with no dedicated local gay men’s HIV prevention worker there are no opportunities to link the work of pan London interventions (or indeed national campaigns) with local work. Similarly, there is no sexual health promotion link to local services (Zone 15).
- In 1998/9 the proportion of HIV allocation spent on gay men locally was 20%, far below the average of other London boroughs. In 2004/5, the proportion spent on gay men has remained at approximately the same.

Partnership Working
- There is a need to review HIV prevention and sexual health promotion commissioning to ensure a greater recognition of primary prevention interventions, broader inclusion and involvement of local services and agencies and its inter-relationship with other local strategies (Teenage Pregnancy). This will help to raise the profile, awareness and inclusion of the sexual health promotion and HIV prevention work in the locality. It is suggested that a dedicated group be formed for this purpose (see strategy development).
- There continues to be sound working relationships between commissioning authorities making use of limited resources available. Though future joint commissioning for HIV prevention and sexual health promotion between Enfield and Haringey should be careful to recognise the differences in the underlying epidemiology of each borough.
- There is a need for the LGMHPP to promote the work of the partnership so that this can be coordinated and planned within the local preventative strategy and action plan.

Training & Development
- There is a need to develop local audit and monitoring of HIV prevention and sexual health promotion work. This may be incorporated in to capacity building of local voluntary services.

KEY PRIORITIES FOR ACTION:
- To develop primary HIV prevention and sexual health promotion within the borough.
There is a need for more structural sexual health promotion work to link national and pan London initiatives to other local work. Generic or dedicated workers may provide such a link.

4. Local Sexual Health Promotion
4.1 Teenage Pregnancy Prevention

Teenage Pregnancy has been identified as a key priority for both the London Borough of Haringey and the TPCT, which is highlighted by the fact that in 2003 teenage pregnancy was identified as one of the boroughs three main floor targets.

The Teenage Pregnancy and Parenthood 10-year Strategy has been in existence since March 2001. This document sets out the local strategy for how Haringey plans to reduce conceptions among the under 18 year olds in the borough and better support teenage parents. The strategy also lays out the targets that have been set for the Borough of Haringey by the national Teenage Pregnancy Unit which are:

- To reduce the rate of conceptions among under 18 year olds by 15% by 2004, and by 55% by 2010;
- To set a firmly established downward trend in conception rates for under 16 year olds by 2010; and
- To increase the participation of teenage parents in education, training and employment to 60% by 2010 so as to reduce their risk of long term social exclusion.

These targets are also included in Haringey’s Community Plan, the Neighbourhood Renewal Strategy and the TPCTs 3-year Local Delivery Plan. Teenage Pregnancy & Parenthood Strategy is inextricably linked to the Sexual Health Strategy and shares some of its tasks.

A number of activities and initiatives are in place to help progress towards a reduction in the local teenage pregnancy conception rate. These are detailed more fully in the Teenage Pregnancy & Parenthood Annual Report (2004/05) and Action Plan (2005-06) but there are clear links to the development of the local sexual health strategy.

All of the young people’s services in Enfield and Haringey have been branded with the 4YP logo. This branding allows young people to easily recognise and identify the service as well as indicating that it is ‘young person friendly’.

4.1.1 4YP Bus

The 4YP bus was established in September 2001 as part of the local Teenage Pregnancy and Parenthood Strategy. The bus goes out to where young people ‘hang out’ within Enfield and Haringey providing advice and information on sexual health and contraception issues. The bus also provides free condoms. The bus acts as a stepping-stone referring young people onto mainstream clinical services as required.

The bus has 3 regular sites in Haringey; Wood Green, West Green and Hornsey. The bus also delivers regular sessions with organisations such as the Youth Offending Service, Leaving Care Team and Connexions Positive Activities for Young People (PAYP) scheme, which aims to divert young people from crime. The bus can also be booked for one-off events such as community events. In October 2004 the bus became one of the sites for Chlamydia screening pilot programme.
Data from the 1st years Evaluation report (2001/02) indicated that the majority of attendances at the 4YP Bus were by young men (59%), among those aged under 16 years (71%) and by young people from Black and other minority ethnic communities (64%). Most of those young people attending were resident within either Haringey (58%) or Enfield (35%). 81% of those attending the 4YP Bus were attending school or college within the area, of which 58% attended these in Haringey and 42% in Enfield (Bradford, 2002d).

Due to staff changes the bus was off the road between August 2003 and March 2004. However from March 2004 to June 2004 a total of 611 young people accessed the bus at the Haringey sites. In addition, over 175 young people have accessed the bus through the Connexions Positives Activities for Young People (PAYP) scheme, an ATG Entertainment event and Tottenham Carnival. Attendance on the bus has predominantly been by Black Caribbean, Black African and Black English young people and 70% of users are young men.

4.1.2 4YP Drop-ins
In October 2004, the Teenage Pregnancy Team established new Sexual Health Drop-in advice and information sessions in youth projects in Northumberland Park and Wood Green. These drop-in services link in with already existing youth provision.

It is envisaged that these drop-in services will become Chlamydia screening sites for the Chlamydia screening pilot programme.

4.1.3 4YP Young Men’s Project
A 4YP Young Men’s drop-in was set up in 2004 and operates from Kenneth Robins Centre in Northumberland Park every Friday evening between 4pm and 8pm. The drop-in provides advice and information about sexual health and free condoms. There are also open forum discussions and workshops.

4.1.4 Sex & Relationships Education (SRE) in school and non-school settings
As part of the local Teenage Pregnancy Strategy, each year almost every school in the borough receives SexFm, an interactive theatre project, for their Year 9 pupils and every school has been offered a Protection kit; a resource to help teach about contraception and condoms.

Some schools invite the Sexual Health Education Project (SHEP); one of the Teenage Pregnancy initiatives, to deliver part of the SRE curriculum. School Nurses also support the delivery of SRE in the classroom (see section 4.12)

Non-school youth organisations have a key role to play in the delivery of informal SRE. Through the work of the Teenage Pregnancy Strategy organisations such as Youth Service, Looked After Children’s Service, Leaving Care Team, Youth Offending Service, Unaccompanied Minors Team and Connexions are developing a SRE Policy that will provide a framework for the delivery of SRE in each of the settings. In addition, there are plans to develop a condom distribution for young people during 2004/05 that will include the above settings as key distributors. Training will be provided to staff on the policy and in the distribution of condoms.

SRE is also delivered directly to young people in a wide range of youth settings through the Sexual Health Education Project (SHEP). SHEP also provides sexual health training to professionals that work with young people.
4.1.5 Media and Information Campaigns
The Teenage Pregnancy Strategy however has a strong media and communications element and a Media and Participation Manager has been appointed to lead and develop this work. A Media and PR Strategy has been developed, as has a wide range of publicity materials. There is a Website (www.4yp.co.uk), which provides information about all 4YP services and a Freephone number, which provides information about how to access the 4YP Bus. Pro-active press releases are issued each month and the Teenage Pregnancy Team contribute to a Pan-London teenage pregnancy weekly radio show on Choice Fm. Young people have been involved in all aspects of the media work.

ISSUES FOR CONSIDERATION:

Capacity & Resources
- Funding from Teenage Pregnancy Implementation Grant becomes un-ring fenced in 2006. This grant currently funds the 4YP Bus and the 4YP Drop-ins.
- The 4YP Bus and Drop-ins need to become incorporated into mainstream family planning and sexual health services by 2006.

Inequalities
- Early data from ‘Stepping Up’, the Teenage Parents Support Project in Haringey is showing that about 30% of the teenage parents in Haringey are asylum seekers. However, the sexual health needs of young asylum seekers and unaccompanied minors are currently unknown and they are thought not to be accessing the 4YP services. Research into this area is being undertaken and will be completed in the summer of 2005.

Training & Development
- Training needs to be provided to all staff (including those working in Primary Care) about confidentiality and the under-16s and working with young people.

KEY PRIORITIES FOR ACTION:
- To ensure that the work of the Teenage Pregnancy Strategy is complimentary to and integrated with the work of the Sexual Health Strategy.
- To embed the 4YP services (Bus, Drop-ins and 4YP Contraceptive Nurse) into the mainstream family planning and sexual health services by 2006 so that the services continue to exist once the ring-fencing of the Teenage Pregnancy Implementation Grant has been lifted and the NRF funding ends.
- To work with the Youth Service, Looked After Children’s Service, Leaving Care Team, Asylum Team, Youth Offending Team, Connexions and voluntary sector organisations to develop a strategic and targeted approach to the delivery of SRE in non-school youth settings.
- To develop and facilitate a training programme for effective working with young people.

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

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

Currently, 55 of the 63 primary schools in Haringey are involved to some degree in the Healthy Schools Programme; 6 of the 10 secondary (the LEA does not include Grieg City Academy) and all of the 4 specials schools. The government has targeted schools with 20%+ Free School Meals Entitlement to be at level 3 of the Standard by 2006.

As part of the NHSS, the Healthy Schools Co-ordinator and Personal, Social and Health Education (PSHE) Adviser have been working with schools to ensure that they have up to date SRE Policies. Training has also been provided to teachers to enable them to deliver SRE in the classroom. This has included dedicated training for male teachers. In July 2004, the PSHE Adviser’s contract ended and the post has been vacant since. This post is crucial if schools are to deliver high quality SRE and if teachers are to be enabled and supported to deliver this. School nurses used to be a valuable resource for delivering SRE in schools. However due to recruitment issues and the nurses having to prioritise immunisations they are no longer able to be so involved in delivery of SRE.

Funding has been received from the national Teenage Pregnancy Unit for 2004/05 to support a number of teachers through the PSHE Certification scheme. Currently 7 primary and one secondary school teachers are participating in the training.

**KEY PRIORITIES FOR ACTION:**

- To work with the LEA to support the development of a strategic approach to the delivery of SRE in schools.
- Through the work of the Teenage Pregnancy Strategy, explore with the LEA the feasibility of developing sexual health and contraceptive services in the school setting.

**6. School Nursing Service**
The School Nursing Service is committed to the health improvement of children and young people of school age. There are 13 school nursing posts, which operate through 4 teams; 2 in the West of the borough and 2 in the East. The West teams are based at Crouch End and Bounds Green Health Centres and the East teams are based at Burgoyne Road Clinic and Tynemouth Road Health Centre. The Service is situated in the Strategy, Performance and Children's Services Directorate.

The 13 School Nursing posts cover 63 primary schools, 11 secondary schools (which includes Grieg City Academy), 4 special schools and 3 Pupil Support Centres/Units.

School Nurses offer expert advice and support on a range of health issues including sexual health. Some school nurses offer ‘drop-in’ services within schools where pupils may just call in or make an appointment to see the nurse with a specific issue. No school nurses currently offer condoms or emergency contraception within the school setting.
The School Nurses also deliver Sex & Relationships Education (SRE) in the classroom in Primary schools and contribute to SRE in Secondary schools were they are able. However capacity issues can make this difficult.

The school nurses are not part of the PSHE Certification programme. It is anticipated that this will be initiated in 2005/06

KEY PRIORITIES FOR ACTION:

- To review the capacity of school nurses to deliver SRE in schools and to develop mechanisms for the school nurses to become more involved in the delivery of SRE in Secondary schools.
- To ensure that the school nurses have access to regular sexual health, contraception and SRE training and are aware of all new service developments.

7. Media and Information Campaigns
There is currently no identified lead for developing this area of the local sexual health work. Each service is responsible for developing and distributing their own publicity materials. Media and information campaigns have been limited although there is usually some press coverage around Christmas and New Year about how to access the services as well as how and where to obtain emergency contraception.

KEY PRIORITIES FOR ACTION:

- To develop a Media and Communications Strategy.
- To develop local media campaigns to link with the national information campaigns and awareness events e.g. Contraceptive Awareness Week, National Condom Week and Sexual Health Week.
- To develop publicity materials to promote all local services and to update the Sexual Health and Contraceptive Service in Enfield and Haringey Directory and re-distribute to local services.
- To pro-actively use the local press and radio to promote local services and positive and open discussions about sexual health.
- To consider the possibility of developing a local sexual health web site, which would contain information for both the public and local professionals.
Appendix 5.
Commissioning Services for Sexual Health

1. Introduction
The effective implementation of this strategy hinges on good local planning and commissioning of services. This section details the current commissioning processes in Haringey including clarification of the funding profile for 2004/05, a description of the purpose and function of the multi-agency sexual health partnership group and the reporting and accountability arrangements. It also describes how local needs assessments and user and community involvement are used in service planning and commissioning.

2. Commissioning Processes
Following the abolition of Barnet, Enfield and Haringey Health Authority and the formation of the new borough based PCTs in 2002, it was decided that Enfield PCT would be the strategic lead for sexual health across Enfield and Haringey and that they would host the sexual health team. At the time the team consisted of a Health Promotion Manager for HIV and African Communities, a Senior Sexual Health Promotion Adviser and a Gay Men’s Health Promotion Manager. The reciprocal arrangement was that Haringey TPCT would be the strategic lead for Teenage Pregnancy across the two boroughs and that they would host the Teenage Pregnancy Co-ordinator and the Teenage Pregnancy Team.

In addition to the above arrangement a Sexual Health Lead was nominated within each PCT. In Haringey TPCT the Sexual Health Lead is the Director of Health Improvement and in Enfield PCT it is the Specialist in Public Health. However it is important to note that this role is taken on, as a part of their wider remit and the time they have available to allocate to the sexual health work is limited.

It is also important to note that even though there are nominated Sexual Health Leads, there is no lead Sexual Health Commissioners in either PCT. However a number of people have within their remit a responsibility for commissioning specific elements of the sexual health work. In Haringey the following arrangements exist.

1. The Director of Planning and Commissioning (Haringey TPCT) has a remit for commissioning the GUM, Family Planning and Termination of Pregnancy Services.
2. The Specialist HIV Commissioner in the Planning & Commissioning Directorate (Haringey TPCT) commissions the HIV clinical services on behalf of the North London Central Sector.
3. The Health Promotion Manager for HIV and African Communities in Enfield PCT and the Health Policy Officer in the London Borough of Haringey commission the HIV prevention work in the voluntary sector across both Enfield and Haringey.
4. The Social Services Sexual Health Lead for the London Borough of Haringey commissions the HIV social care for Haringey.
5. HIV Prevention work for men who have sex with men is commissioned through the London Gay Men’s HIV Prevention Partnership, in which Haringey PCT and Enfield PCT are financial contributors.

In the summer of 2004, three new posts were created within the sexual health team at Enfield PCT. These posts will replace the Gay Men’s Health Promotion Manager post, which has been vacant since 2002, and the Senior Health Promotion Adviser
post, which has been vacant since 2003. The Health Promotion Manager for HIV and African has remained in post since the formation of the PCTs and this post will continue. The three new posts are a Sexual Health Co-ordinator for Enfield and Haringey and a Sexual Health Manager for each borough. All three posts will be based at Enfield PCT and they will play a key role in providing leadership and implementing the strategy. However, none of these posts have a lead responsibility for commissioning.

3. Haringey Funding Profile

Tables 1 summarise how existing funding is applied in relation to the provision of sexual health services for Haringey residents.

| Table 1 - Mainstream and Grant Funding for 2004/05 |
|-----------|-------------------|
| **Service** | **2004/05** |
| **Mainstream Funding:** | |
| Genito Urinary Medicine | £1,381,951 |
| Family Planning Service | £377,421 |
| Termination of Pregnancy Service | |
| • Booking Service & Assessment Clinic | £39,198 |
| • British Pregnancy Advisory Service (BPAS) | £360,000 (approx) |
| HIV - Treatment & Care | Awaiting info |
| HIV Prevention (Haringey TPCT) | £304,000 |
| Sexual Health On Call | £101,000 |
| Emergency Contraception Scheme for Young People in Pharmacies | £21,667 |
| **Total** | |
| **Grant funding:** | |
| Teenage Pregnancy: | |
| • Local Implementation Grant | £189,000 |
| • Neighbourhood Renewal Fund | £40,000 |
| Chlamydia Screening Programme (for Enfield & Haringey) | £150,000 |
| **Total** | £379,000 |
| **TOTAL** | |

4. The Sexual Health Partnership Board (SHPB)

The Sexual Health Partnership is a multi-agency and multi-disciplinary group that has a leadership role in developing the strategic approach for sexual health services in Haringey. The group meets quarterly and is chaired by the Director of Planning and Commissioning in Haringey TPCT. The Vice Chair is the Social Services Sexual Health Lead for London Borough of Haringey. The terms of reference for the Partnership were revised in September 2004 and are as follows:

**Core Aims**
- To coordinate planning for the delivery of equitable services in Haringey, and to Haringey residents, that deliver the national programme and meet local need.
- To performance manage delivery of local services by keeping them under constant review and ensuring that there is a regular monitoring process.
- To act as a mechanism for incorporating user views into service planning and delivery and for wider consultation where required.

**Objectives**
1. To plan for the delivery of the National Strategy for Sexual Health and HIV to the residents and service users of Haringey, based on identified health need where possible, and the implementation of any London-wide strategic reviews.
2. To draw up plans to meet gaps in service where identified to inform the commissioning process.
3. To ensure that plans take account of inequalities in health and social care and are coordinated with the Health Improvement Programme, Local Delivery Plan & Neighbourhood Renewal Strategy.
4. To keep local services under constant monitoring and review to ensure that they are meeting local, regional and national targets; this to include audit and best value analysis.
5. To agree corrective action where problems in service delivery are identified and monitor the outcome.
6. To agree advise on competing priorities when funding of services against restricted budgets is required and agree partnership budgets.
7. To ensure that users and carers are fully involved in the work of the partnership and that there is an agreed process of consultation on key service changes and planning documents.
8. To oversee the production of information on service planning and delivery that is available on a wide basis.
9. To provide progress reports to the HSCPE as required.

The membership of the Partnership is as follows:

- Director of Planning and Commissioning – Haringey TPCT (Chair)
- Social Services SH Lead – London Borough of Haringey (Vice Chair)
- Director of Health Improvement – Haringey TPCT
- Primary Care Pathways lead – Haringey TPCT
- Health Promotion Lead (Sexual Health) – Enfield and Haringey PCTs
- Sexual Health Coordinator – Enfield and Haringey PCTs
- Sexual Health Manager – London Borough of Haringey
- Sexual Health Service Manager – North Middlesex Hospital
- Sexual Health Consultant – North Middlesex Hospital
- Sexual Health Service Manager – Haringey TPCT
- Sexual Health Consultant – Haringey TPCT
- Reproductive Health Consultant – Haringey TPCT
- Two User Representatives
- Voluntary Sector Representative
- North Central Sector HIV commissioning lead

It is the intention that membership of the group places on the individual the responsibility to provide an effective communication channel and action management process within the organisation they are representing. The Sexual Health Partnership also has the ability to co-opt additional members to meet specific obligations as required. The HIV Workers Group has been in operation across the Enfield and Haringey locality since 1994, though its interrelationship with the Sexual Health Partnership and individual services has not been formalised.

5. Reporting and Accountability Arrangements
The group is currently accountable to Health and Social Care Partnership Executive and has been established as a sub-group of this Executive since 2001. The Health and Social Care Partnership Executive reports to the Local Strategic Partnership. Full reporting mechanism is as set out below in Figure 1.

Figure 1. Current reporting arrangements for the SHP
6. Data, Information and Needs Assessment
Local assessments of need and individual service reports are required in order to identify and understand the local sexual health needs, identify priority population groups and highlight gaps in services. There also needs to be a process in place for collating and reviewing this data and information on a regular basis and feeding it into the planning cycle and commissioning processes. It is recommended that needs assessment processes should be a pivotal part of an active commissioning process and be undertaken at a minimum of 3 year intervals (or where needs determine). A number of areas have been highlighted within the strategy process for which additional needs assessment information is required including (e.g. HIV social care needs and sexual health needs of refugee and asylum seekers).

In Haringey a Sexual Health and Family Planning Baseline Assessment was carried out in 2003. The purpose of this report was to identify broad trends and needs within the borough, to map out current service provision, to identify service gaps and future pattern of services based on the above, and to identify strategic direction for sexual health and family planning services in the locality for the next 3 years.

In addition to the baseline assessment each year the GUM, Family Planning, SHOC, Clinical Psychology in Sexual Health and the Teenage Pregnancy Strategy provide an Annual Report of activities and service usage. However there are no publicly available reports available from the Termination of Pregnancy Service, apart from what is included in the Family Planning Service Annual Report and there has been no data available for at least the last 5 years. Likewise there are no monitoring reports available from HIV Clinical Services (T1), HIV Prevention Programme, HIV Social Care or School Nursing. This represents a significant omission, given that the availability of such data would contribute greatly to the overall sexual health intelligence data available within the borough and would further promote awareness and understanding between partner agencies within the sexual health sector. There is also currently no process for collating and reviewing such reports and it is unclear how this data and information is utilised in the planning and commissioning processes.
7. Public and User Involvement
At an individual service level there is evidence that users have been consulted in a number of different ways. Family Planning and GUM services carry out regular client satisfaction audits (as required under Clinical Governance guidelines). These audits have been integral to the planning, monitoring and development of FP and GUM services.

The Teenage Pregnancy and 4YP services have utilised a number of different mechanisms for involving young people in the development of new services and a Media and Participation Manager has been recruited to lead this work. A 4YP Forum was established as a way of involving young people in the wider discussions about implementation of the teenage pregnancy strategy and interviews, focus groups and questionnaires have been used to consult young people on the development of the 4YP bus, 4YP clinics and drop-ins.

However, to date, the public and users of services have not been consulted on, or involved in, discussions regarding the future strategic direction of sexual health provision in the borough. In addition, users have so far not been represented on the Sexual Health Partnership.
References

Ainsworth J  NMUH HIV Patient Audit
NMH Unpublished

British Journal of Hospital Medicine  July pp34-35

BMA 2004  National Enhanced Service – more specialised sexual health services  
(2/5/2003)

Bonell C 2001  Into the mainstream: The implications for HIV services of greater integration with sexual and other health services in the UK. National AIDS Trust

Bradford, 2002  Sexual Health on Call  
Service Review Barnet, Enfield Haringey MHT


Bradford, 2002b  SASHC: Appointment system Review  
Haringey TPCT


Haringey TPCT

Bradford, 2003a  Developing sexual health in Primary Care: An audit of GP and Practice Nurse views of sexual health & contraceptive services in Enfield & Haringey

Catchpole M, McGarrigle A, Rogers P, Jordan L Mercey D & Gill O 2000  
Surveillance of prevalence of undiagnosed HIV-1 infection in homosexual men with an acute STI.  BMJ 321: 1319-1320

CDR, 2004  Gonorrhoea in England & Wales & NI.  
STI quarterly report: an update on gonorrhoea.  Vol.14 No.18 29th April

CDSC, 2003  HIV & STI surveillance data

Day S & Ward H 1997  STD control and commercial sex workers.  
Genitourinary Medicine (73) pp161-168

Christopher E, 2004  Family Planning Service Annual Report (2003/04)  
Haringey TPCT

Dardamissis E, 2002  Measuring access to GUM clinic services  
PHLS Communicable Diseases Surveillance Centre

Djureric T, Catchpole M, Bingham J, Robinson A, Hughes G & Kinghorn G 2001  
GUM services in the UK are failing to meet current demand.  Int. Journal of STD & AIDS (12) pp571-2

Dawe & Meltzer  2002  Contraception & Sexual Health, 2002  
Office for National Statistics (ONS Omnibus Survey)

DH 2004  Expert advisory Group on Chlamydia Trachomatis  
(www.doh.gov.uk/chlamyd.htm)

DH, 2002  Hepatitis C Strategy  
Press release 2002/0350

49


DH, 2005  Choosing Health; Making Healthy Choices Easier.

Erbelding et al, 2000  High rates of depressive symptoms in STD clinic patients  *Sexually Transmitted Diseases* 28 (5): 281-284

Foley E, Patel R, Green N & Rowen D 2001  Access to GUM clinics in the UK.  *Sexually Transmitted Infections* (77) 1 pp4-12


Haringey TPCT 2003  Annual Public Health Report  Haringey TPCT


HDA 2004  Prevention of STI's: a review of reviews into the effectiveness of non-clinical interventions.  Health Development Agency

HPA 2004  Epidemiological Data (http://www.hpa.org.uk/infections/topics_az_/hiv_and_sti/epidemiology/sti_data.htm)

HPA 2004a  Diagnoses of selected STIs, total diagnoses and workload seen at GUM clinics.  Health Protection Agency

HPA 2004b  Renewing the focus: HIV infections and STIs in the UK in 2002.  Health Protection Agency


HPA 2004d  Survey of prevalent HIV infections Diagnosed (SOPHID)


Kalichman S & Sikkema K 1994  Psychological sequelae of HIV infection and AIDS: a review of empirical findings
Kelley P, Pebody R and Scott P 1996
How far will you go? A survey of London gay men’s migration and mobility.

Keogh P et al, 2004
Doctoring Gay Men: Exploring the contribution of General Practice
Sigma/ THT/ Community HIV Prevention Strategy

Kinghorn G, Robinson A & O’Mahony C 2002
Report to Parliamentary Health Select Committee on behalf of the speciality
societies for Genitourinary Medicine.

Lacey et al 1997
BMJ 314: 1718-1719

LGMHPP 2004
All Aboard: Approaching equitable input to LGMHPP from PCTS

London Specialised Commissioning Group, 2005
London HIV Strategy

Low et al 1997
Gonorrhoea in Inner City London: results of a cross sectional study
BMJ 314; 1719-1723

Lucas G 2002
Positive changes: A review of progress on African HIV prevention in Enfield
and Haringey 1997-2002. Barnet, Enfield and Haringey Health Authority

Matthews M et al 2000
Psychological consequences of sexual assault among female attenders at a
genitourinary medicine clinic Sexually Transmitted Infections Feb

MEDFash, 2004
National Recommended Standards for Sexual Health Services

Nageswaran A, 2002
St Ann’s Sexual Health Centre - Annual Report
Haringey TPCT

NAT 1999
Are health authorities failing gay men? HIV prevention spending in England

North West London Strategic Health Authority, 2004
London-Wide Sexual Health Framework

NSPCT, 2004
Sexual Health Plan for North Staffordshire PCT

Petrak J et al 1995
The prevalence of sexual assault in a genitourinary medicine clinic: service

PHLS, 2002
Sexual Health in Britain: recent changes in high risk sexual behaviours and the
epidemiology of STI’s and HIV

Philpot C et al 1991
A survey of female prostitutes at risk of HIV infection and other sexually
transmitted diseases. Genitourinary Medicine (67) pp384-388

Reitano m, 1997
Physical and psychological effects of ano-genital warts on female patients.
American Journal of Medicine 1997;102:38

Vyse A et al 2000
The burden of infection with HSV-1 and HSV-2 in E & W: implications for the
changing epidemiology of genital herpes. Sexually Transmitted Infections 2000 76: 183-7

Ward H et al, 2004

WHO
see www.who.int

51