Report of the Overview Task Group

Improving the sexual health of young people in Brent

TASK GROUP MEMBERS:
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Cllr Gideon Fiegel (Vice Chair)
Cllr Izaharul Halder
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Cllr Harihar Patel

Executive
12 September 2005

Report from Chair of the Health Scrutiny Panel

Improving the sexual health of young people in Brent

1.0 The Health Overview Panel

1.1 In January 2003 all social services local authorities in England were given a new power by government to undertake the Overview and Scrutiny of health in their localities. This formed part of a broader agenda to change and improve the way that patients and the public engage with health issues and health providers.

1.2 In May 2003, the Council agreed to the creation of the Health Overview Panel as a sub committee of the Overview Committee. The remit of the Panel is to look at the broader health issues affecting the population of Brent and to engage with health providers, other local public services, the voluntary sector, the private sector and the public as appropriate. The Panel meets quarterly but has also met to undertake this time-limited review of sexual health of young people.

1.3 Members of the Health Overview panel are;

Mary Farrell (Chair)
Gideon Fiegel (Vice Chair)
Izaharul Halder
Sandra Kabir
Neil Nerva
Chandubhai Patel
Harihar Patel

2.0 Executive Summary

2.1 Recent national data on sexual health has indicated that sexually transmitted infections (STIs) are rising alarmingly, particularly among the under-20s. While much good practice exists, services are often stretched in disseminating a coordinated and coherent message of safer sex to children and young people.

2.2 Brent teaching Primary Care Trust is devising a strategy for 2005 to improve the sexual health of all groups in the borough. It comes in the wake of the publication of the first ever National Strategy for Sexual Health and HIV three years ago. It will complement the Teenage Pregnancy Strategy produced by the Council.

2.3 The Brent Local Strategic Partnership identified the sexual health of children and young people as one of a number of priorities relating to provision of services to young people. The LSP proposed that to complement the development of the PCT strategy the Health Scrutiny Task Group should examine the *effectiveness* of services and assist partnership relations in promoting the sexual health of young people in the borough with the following emphasis:

- Understanding and influencing work on prevention of ill sexual health and teenage pregnancy
- Identifying how partnership working can contribute to the prevention of sexual ill health and teenage pregnancy
- Investigating the provision of young peoples access to appropriate sexual health services

2.4 The Panel gathered information through a number of different mechanisms including existing literature and reports, consultation and discussion with those services and organisations involved with young people in Brent, and with young people themselves. This information has been used to produce the main report and recommendations within it.

2.5 It is clear that in a deprived, multi cultural borough such as Brent there are many contributory factors which have led to a rise in sexually transmitted diseases and teenage pregnancies. A multi-pronged approach is required to address these issues involving good co-operation and communication and co-ordinations of services between the relevant agencies at a strategic level. The panel found that there is some excellent practice in working with young people but that provision of services is uneven and patchy across the borough. Consideration of these issues has led to the following recommendations aimed at the Primary Care Trust, and Brent Council's Executive.

Members of the 'Sexual health of Young People' Task Group were;

Cllr Mary Farrell (Chair)	Co opted members included
Cllr Sandra Kabir	Sharon Carson (tPCT)
Cllr Gideon Fiegel	Clementine Femiola (tPCT)

The task group would particularly like to thank Dr John McSorley and Dr Connie Smith for their contributions and advice during their investigations.

2.6 Recommendations

Recommendation 1. Annual analysis of locally and centrally held data available for teenage pregnancy and Sexually Transmitted Infections' (STI's) should be undertaken to allow improved targeted planning of initiatives and follow-up care to meet the needs of young people in 'hotspot' wards.

Recommendation 2. The lack of adequate provision of *dedicated* young peoples' contraceptive, sexual health and maternity provision in Brent needs to be addressed. This will require a review and mapping of access and use of General Practitioner (GP) and community contraceptive and sexual health sessions by young people in Brent. This should lead to more effective planning, increased funding and capacity development in provider services, in order to supply more appropriate provision to young people.

Recommendation 3 The teaching Primary Care Trust (tPCT) and Teenage Pregnancy Board should use this mapping to clarify the current role and investigate the potential for extending of the role of other agencies (both voluntary and statutory) who come into contact with young people, to include the development of limited health roles, educational or information roles, and signposting roles.

Recommendation 3a. An expansion of medical services needs to be considered as part of the overall review of provision. For STI's this can be done simply via the expansion of newer DNA based technologies which can be taken into the community and made available by a wider range of providers. Increased funding should be directed towards these new technologies.

Recommendation 4. The tPCT should request and use shared datasets and information from all adjoining Acute Trusts whose services Brent patients access, to help inform the planning and delivery of Genito Urinary Medicine (GUM) and Contraceptive Services.

Recommendation 5. That projects similar to the tPCT funded initiative 'U can expect' are rolled out across more GP services in Brent, and outside Brent where young Brent residents also access. This should be carried out alongside a wide review and identification of the capacity of GP services to see young people quickly, with a view to strengthening this type of provision across the borough.

Recommendation 6. That as part of the wider review of services (outlined in recommendation 3,) the Patrick Clements clinic and Contraceptive clinics and youth settings explore the possibility of providing Saturday sessions to enable greater access for young people.

Recommendation 7. The tPCT and the Council should work together to develop a joint or universal logo (alongside the service provider's own logo) for services which both agencies support, and who subscribe to a core set of defined values in service provision such as guaranteed confidentiality. This should be part of their joint work towards an awareness raising campaign among young people.

Recommendation 8. Establish clear partnership arrangements and lines of accountability between the tPCT and the Council, to ensure that the sexual health

and teenage pregnancy functions are strongly linked, and to enable the effective co-ordination of services between the agencies. This should ensure a stronger links for policies, protocols and operational arrangements between the Council and the tPCT.

Recommendation 9. Establish a joint (tPCT and Council) and comprehensive system of performance management for all services dealing with sexual health and young people, including work undertaken in schools, to allow effective evaluation to take place.

Recommendation 10. That children and young people are enabled to actively participate in the design and evaluation of sexual health and contraceptive services.

Recommendation 11. Map the whereabouts of young people on a typical day and match this information with the mapping of current services to further inform the fit between need and service provision.

Recommendation 12. That mainstream funds allocated to Teenage Pregnancy remain ring fenced for the next 2 years to ensure it receives sufficient priority.

Recommendation 13. That the tPCT and Council work together to develop a program of support for School Governors in promoting the adoption of good practice SRE across schools in Brent where this is needed.

Recommendation 14. The Council and PCT should appoint a dedicated lead for PHSE/SRE to map, review, oversee and expand the delivery of SRE in schools, which must include work with primary schools. This should link in with the Extended Schools agenda, but should also involve the co-ordination and development of voluntary and community sector work in schools and faith schools. This expansion of SRE should include to other youth and community settings as well.

Recommendation 15. Parents and guardians should be involved in the design and delivery of SRE programs.

Recommendation 16. That the tPCT and Council establish a jointly hosted annual forum involving all agencies working with young people and/or sexual health and contraception. This should act as a focal point for education and training and communication issues as well as informing and developing the strategic framework.

Recommendation17. The Health Overview Panel should receive a regular update on progress with these recommendations from the tPCT and Council on a 6 monthly basis.

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3.0 Introduction

3.1 Against an national backdrop of a 50% increase in the rates of sexually transmitted diseases (STIs) over the last decade, and the position that England holds as having the highest rates of teenage pregnancy in Western Europe, the Brent Health Overview Task Group was asked to examine the state of sexual health of young people in Brent. The attached report outlines the task group's findings.

3.2 Local and national data does indicate that Brent has high rates of teenage pregnancy and sexually transmitted disease which should be of concern. While there is evidence of good practice amongst service providers, this report concludes that if we really want to give young people in Brent the best life chances, we need to develop stronger partnership working processes at strategic level to facilitate better co-ordination and provision of sexual health services; address some of the issues around data collection to aid effective planning; build up the capacity of agencies currently delivering sexual health services, and of *other* agencies to deliver sexual health services where appropriate so that access points may be increased; and strengthen provision of SRE in schools. Work has commenced to address a number of these issues, but ongoing prioritisation and commitment will be needed to secure the progress required.

Sexual Health

3.3 Sexual health affects peoples physical and psychological well being, and is central to some of the most important and lasting relationships in their lives. It follows that protecting, supporting and restoring sexual health is important. Recent national data on sexual health has revealed that sexually transmitted infections (STIs) are rising at an alarming rate, particularly amongst young people. In the past decade, the number of new episodes of STIs diagnosed in Genitourinary Medicine (GUM) clinics in England Wales and Northern Ireland has doubled from 708,538 in 1992 to 1,533,816 in 2002. (Health Protection Agency – Data Source: KC60 statutory returns and ISD(D)5 data- 1990-2002)

3.4 These statistics exclude all or most STIs managed in primary care and are a substantial underestimate. Meanwhile figures suggest that visits to GUM clinics have doubled to around a million a year, and that these services are struggling to meet the demands placed on them.

3.5 The consequences of not addressing poor sexual health amongst young people are potentially serious, leading to long term health problems, disease and premature death, as well as abortions and unwanted pregnancies. This in turn can lead to poor educational, social and economic outcomes for teenage mothers.

Teenage Pregnancy

3.6 England currently has one of the highest rates of teenage pregnancy in Western Europe, with some 90,000 teenagers becoming pregnant every year.

These figures include nearly 8,000 who are under 16. While some of these teenagers, and their children, live happy and fulfilled lives many do not. Research indicates that teenage mothers are far less likely to finish their education, to find a good job, and more likely to end up both as single parents and bringing up their children in poverty. There are strong correlations between teenage pregnancy as both a cause and a result of social exclusion. The children of teenage parents themselves run a much greater risk of poor health, and have a much higher chance of becoming teenage mothers themselves. These high rates of teenage pregnancies are not inevitable. While the rate of teenage pregnancies in Western Europe has fallen rapidly, it has remained high in England.

3.7 **Note:** The legal definition of children and young under the Children Act 2004 is up to 19 for children with disabilities, 18 for others - and up to 24 for young people who are care leavers

3.8 A range of policies have informed the government's response to these issues.

4.0 The National Policy Overview

Teenage Pregnancy Strategy 1999

4.1 The Teenage Pregnancy Strategy followed the Social Exclusion Units report into teenage pregnancy. Managed by the Teenage Pregnancy Unit (TPU), the dual aims are to halve under 18 conception rates by 2010 and to minimise social exclusion experienced by teenage parents by increasing the participation of teenage mothers in education, training or work by 60% by 2010.

4.2 The strategy recommended prevention measures including:

- new guidance for schools on sex and relationships education (SRE)
- new school inspection and better teacher training;
- a new emphasis on consulting parents about tuition and practical help;
- information campaigns for parents;
- local implementation funds for integrated and innovative programmes for high rate areas;
- new health service standards for effective contraceptive advice and treatment for young people
- clear and credible guidance for health professionals on the prescription, supply and administration of contraceptives to under 16s,
- More help to: finish education; find a job; claim benefits; access housing or healthcare, gain parenting skills and child care, gain CSA support

National Strategy for Sexual Health and HIV 2001

4.3 In 2001 the government published the first National Strategy for HIV and Sexual Heath setting out a vision of user centred, locally delivered care and education

4.4 A clear link between sexual ill health, poverty and social exclusion was identified, as was the unequal impact of HIV on gay men and certain ethnic minorities. The unacceptability of the variations in quality of sexual health services across England was highlighted, and the key aims of the strategy were focused on: reducing STI transmission, reducing undiagnosed STI's, reducing unintended pregnancies, reducing the stigma associated with STI's and improving health and social care for those with HIV.

4.5 While these aims appear specific, they are challenging and heavily dependant on adapting the way organisations work and interact together and with service users, on promoting knowledge and ability to respond to knowledge and on changing attitudes within society.

The House of Commons Health Select Committee Report on Sexual Health 2002-03

4.6 This committee concluded that sexual health is one of the most major public health challenges facing the United Kingdom. Published 2 years after the National Strategy for Sexual health and 4 years after the Teenage Pregnancy Strategy it identified:

- A failure of NHS organisations to recognise and deal with this major public health problem
- A lack of political pressure and leadership over many years
- The absence of a patient voice
- A lack of resources
- A lack of central direction to suggest that this is a key priority
- An absence of performance management

4.7 The Select Committee recommended a dedicated National Service Framework for Sexual Health, as yet unrealised.

White Paper 'Choosing Health' 2004

4.8 In the interim, the Government published its Public Health White Paper 'Choosing Health, Making Healthy Choices Easier'.

4.9 This paper recognises that society's approach has changed, demanding choice, information and responsiveness to individual need in healthcare, and aims to address inequality of access and provision through support in education, access and partnership. It also elevates the role of the local authority as a key partner in improving the health of their local communities and addressing health inequalities. Pilots on 'Communities for Health' Local Public Service Agreements and local area agreements reflect this.

4.10 While responsibility is shifted towards the individual, services are expected to facilitate and respond to change. Key sexual health measures include:

- £50 million investment for a new sexual health aimed at younger people
- Boosting the current campaign targeting people aged 16 to 30 years with the 'use a condom' message.
- New research, a helpline, website and other sources funded nationally.

4.11 There are two important qualifications in the White Paper:

- Firstly, a special responsibility to children and those unable to make informed choices for themselves.
- Secondly, particular arrangements are necessary where one persons choice may affect the health of another.

4.12 These qualifications are particularly important if we are to improve the sexual health of young people in Brent. This White Paper is supported by two further measures which legislate for a fundamental reshaping of service delivery responsive to the individual needs of children and young people.

National Service Framework for Children, Young People and Maternity Services 2004

4.13 The Children's NSF is a 10-year programme intended to set clear quality standards for health and social services in dealing with children, young people and pregnant women. It aims to lead a cultural shift, resulting in services being designed and delivered around the needs of children and families, and is aimed at everyone who comes into contact with children, young people or pregnant

women. Improving Sex and Religious Education, promoting health and wellbeing, supporting parents, developing flexible and young person and familly centred servcies, confidentiality, maternity servcies and support are all part of the 11 Standards laid out.

The Children Act 2004

4.14 The Children Act represents the biggest reorganisation of children's and young peoples services in England for 30 years and proposes a number of wide ranging measures to improve the coordination of child protection and overarching universal services to children within an ambitious whole systems approach. The key focus is a responsibility to deliver better outcomes for children and young people.

4.15 The main measures of the Children Act include; An independent Children's Commissioner to protect the rights of children and young people; Directors of Children's Services responsible for integrated local authority children's services including education and children's social services; New duties on local agencies to work together to improve the well -being of children and young people and safeguard their welfare in partnership with pooled funds. Statutory New Local Safeguarding Children Boards responsible for child protection; Lead councillors for children's services taking political responsibility for local child welfare; A new and joint approach to inspection, involving five inspectorates (2) will judge how well services are *integrated* and working together to *improve outcomes* for local children's lives. This includes preventative measures around promotion of good sexual health.

Comprehensive Performance Assessment

4.16 Finally, the new CPA regime has key indicators around improving local community health and how the local authority is (in partnership with others) addressing health inequalities for all groups. There is a new emphasis on the leadership role of the Council in the community and with partners, as the body with democratic accountability.

4.17 These legislative initiatives which focus to developing services tailored to the individual, demonstrate a need to move away from seeing sexual health within a strictly 'medical' model and as solely the responsibility of health services, to a recognition of a more 'social' model, requiring services which address a range of factors which impact upon the sexual health of young people.

5.0 Key issues around teenage pregnancy and contraception

With contributions from Dr Connie Smith Consultant in Family Planning and Reproductive Health Care, Co-director Westside Contraceptive Services

The Brent Teenage Pregnancy Profile

In Brent the following incidence of teenage pregnancy has been reported:

Table 1: Incidence of teenage conceptions in Brent

Brent	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Under 18 conceptions	218	239	259	236	253	280
Conception rate/1000 under 18s	47.8	50.8	53.7	47.1	51.4	56.2
London Conception rate/1000 under 18s	51.1	50.5	50.4	50.3	52.0	51.1
England Conception rate/1000 under 18s	46.6	44.8	43.6	42.5	42.6	42.1

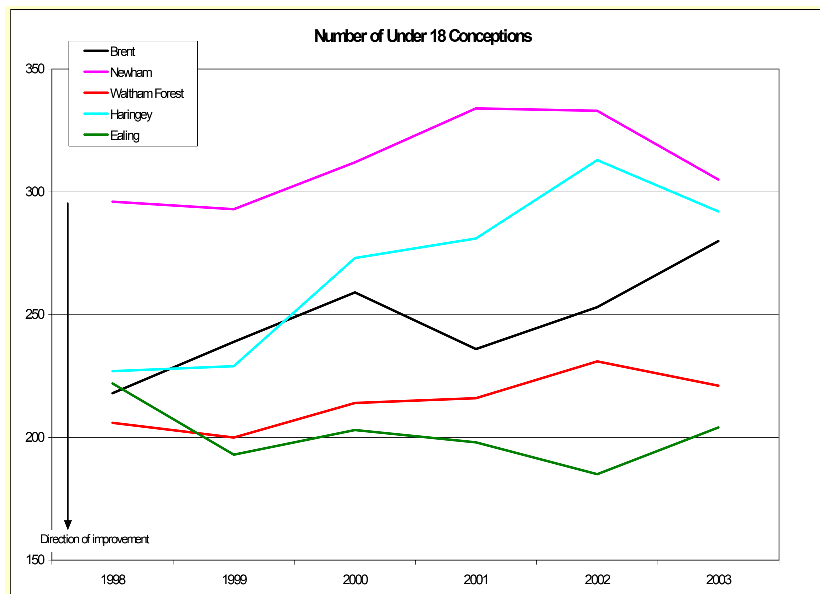
Source: National statistics

Brent under 18 Conception rates in comparison with statistical neighbours

The Audit Commission 'Family Boroughs' information shows from 1998 to 2003 an overall reduction in conception rates, compared with an increase of over 17% in Brent. The chart below shows Brent conception numbers in comparison to other boroughs

Brent conception numbers Vs Teenage Pregnancy Unit Comparators.

Under 18 Conception Numbers - Brent Vs. Teenage Pregnancy Unit Comparators (based on deprivation indices).



	1998	1999	2000	2001	2002	2003	Deprivation Score
Brent	218	239	259	236	253	280	26
Newham	296	293	312	334	333	305	40.4
Waltham Forest	206	200	214	216	231	221	30.2
Haringey	227	229	273	281	313	292	37.7
Ealing	222	193	203	198	185	204	23.4

Strategic Goals from the Teenage Pregnancy Unit

The national and local targets set by the Teenage Pregnancy Unit for under 18 year old conceptions are:

Table 2: National and Local goals for Teenage Pregnancy

Target area	Target reduction by 2004	Target reduction by 2010
England and Wales	15%	50%
Brent	15%	50%

In order to meet the local and national target of a reduction in under 18s conception rates of 15% in 2004 and 50% in 2010 (1998 baseline), the DfES Teenage Pregnancy Unit have identified the trajectory for Brent, outlined in Table 3.

Table 3: Trajectory to reduce teenage conceptions in Brent 2004-2010

Brent	2004	2005	2006	2007	2008	2009	2010
Conception rate/1000 under 18s	40.6	37.8	35.0	32.2	29.5	26.7	23.9

Conceptions and actual births

During 2003 the rate of conception for females aged under 18 in Brent (see table 1) was higher than the average rate for London and England.

The number of actual births to under 20 year olds in Brent in given below:

Table 4: Number of births to under 20 year olds in Brent

Age	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004
<16	4	5	5	3	4
16-20	225	197	195	198	205
All <20	229	202	201	201	209

Source: Brent Strategy for Sexual Health and HIV 2004

The figures consistently start to rise from age 16.
The following table gives **ward level data** for the wards with the highest number of conceptions based on all live births during 1997-2001 for mothers under the age of 20.

Table 5: Brent Locality data for Localities with highest number of under 20 year old births

Locality	<16	%<16	16-20	%16-20	21-24	%21-24	All ages	% all ages
Harlesden	7	33.3	270	26.5	549	22.1	3613	19.0
Kilburn	4	19.0	178	17.5	359	14.4	3398	17.9
Kingsbury	5	23.8	111	10.9	341	13.7	3127	16.5
Wembley	3	14.3	256	25.1	761	30.6	5244	27.6
Willesden Green	2	9.5	205	20.1	475	19.1	3597	19.0

Source: Brent Strategy for Sexual Health and HIV 2004

The largest peak can be seen from between ages 16 to 20, a smaller proportion of under 16 year olds are represented.

Information on terminations is given in the Table 6 below:

Table 6: Under 18 Pregnancy Terminations Data in Brent

Under 18 pregnancy termination data	Number of under 18 terminations	% of under 18 terminations funded by NHS	% of under 18 terminations performed before 13 weeks
1998 (baseline)	176	92.0	82.4
1999	195	91.3	76.9
2000	213	86.9	76.1
2001	133	91.0	82.7

Source: Brent Teenage Pregnancy Performance Assessment and Evaluation 2003/2004

In 2003, there were 217 terminations provided by British Pregnancy Advisory Service and Marie Stopes International for Brent tPCT. The number of people receiving terminations within 3 weeks of presentation to services was 88.5%. The number of NHS sponsored terminations within 9 weeks was 72%. Access to services for early unintended pregnancy was awarded a score of above average performance by the Commission for Health Improvement inspection for 2002/2003.

Determinant factors for teenage pregnancy

Links with deprivation

5.1 The three Brent wards with the highest rates of pregnancy under 18 years (Stonebridge, Harlesden and Wembley Central) are among the wards with highest deprivation. Kilburn, Willesden Green, Tokyngton, Barnhill and Queensbury are also 'hotspot' wards with 4% or more of total pregnancies in those wards in women under 18 years (TPU 1/05).

5.2 Brent PCT Health Visitor registrations of mothers under 20 make up 5-6% of all new mother registrations annually and Harlesden, Wembley and Willesden localities have the highest levels of youngest mothers.

5.3 Across England, the geography of teenage pregnancy is strongly correlated with levels of deprivation. Within outer London, this strong association is apparent at a Borough level, with the highest rates seen in the most deprived outer London Boroughs. However, the large variation in deprivation levels *within* inner London Boroughs means this pattern is only evident at a ward level, with high rates of teenage pregnancy concentrated in the most deprived wards.

5.4 Around one third of all London wards are within the 20% of wards with the highest under 18 conception rates in England. These high rate wards are typically among the most deprived 20% in England and are predominantly located in the deprived areas of south east and north east London, although there are distinct 'hotspots' throughout inner and outer London (Source, an analysis of teenage conception trends in London. TPU)

Educational attainment

5.5 It is also well established that teenage pregnancy rates are strongly associated with low levels of educational attainment. An analysis of GCSE results by pupils' ward of residence shows higher under 18 conception rates in areas with poorer GCSE outcomes. This association between educational attainment and teenage pregnancy is still apparent *after adjusting for the role of deprivation*. Table 8 shows that among the most deprived 20% of wards in London, those with a smaller proportion of girls achieving 5 or more A*-C GCSEs, or having a higher proportion of girls with no GCSE passes, had higher under 18 conception rates on average than those deprived wards with better GCSE outcomes. (Source, an analysis of teenage conception trends in London. TPU)

Table 8: Educational outcomes and under 18 conception rates in the most deprived quintile of wards

	Most deprived 20% of wards		
% of girls achieving 5+ GCSEs at A to C*	*over 50%*	*40-50%*	*under 40%*
Average under 18 conception rate	46.1	67.3	75.9
% of girls with no GCSE passes	*under 3%*	*3-5%*	*over 5%*
Average under 18 conception rate	60.6	70.5	73.7

Notes: Under 18 ward conception rates for 2000
GCSE residence based data 2002

School attendance

5.6 Available information on absence rates by LEA suggest a link between teenage pregnancy and levels of school attendance, with higher under 18 conception rates associated with higher levels of authorised and unauthorised absence at secondary school. London Boroughs with fewer than 8% of half days missed averaged an under 18 conception rate of 39.2, compared with a rate of 52.1 in areas where more than 8% of half days were missed. A similar pattern is seen nationally where local authorities with less than 8% half days missed had rates

averaging 33.6, compared to a rate of 47.7 in areas where more than 8% of half days were missed. (Source, an analysis of teenage conception trends in London. TPU)

Ethnicity

5.7 There is evidence that rates of teenage motherhood are higher among particular Black and minority ethnic (BME) groups. Assessing this association is often problematic given the lack of routine conception data by ethnicity, and because large BME populations are overly represented in deprived areas where high teenage pregnancy rates would be expected. However, there is evidence that ethnicity may have an impact on local teenage pregnancy rates, even after taking account of the effects of deprivation. For example, the strong association between deprivation and teenage pregnancy evident nationally suggests the highly deprived Borough of Tower Hamlets, which has a large Bangladeshi population, should have an under 18 conception rate significantly higher than its actual rate in 2002 of 46.5. In contrast, Lambeth and Southwark, both with large Black populations, have teenage conception rates markedly higher than would be expected given their overall levels of deprivation.

5.8 Research evidence also shows that some Black ethnic groups are of higher risk of teenage motherhood, whilst data from abortion notification forms shows those of Black and Black British ethnicity are over-represented among teenage abortions with 9.4% of all abortions under 18 in 2002. STI data also show a disproportionate impact on BME groups. For example, heterosexually acquired HIV infections amongst Black women exceeded those in white women by more than 6:1 (Source HPA, 2005).

Teenage pregnancy and family planning in Brent

5.9 The national policy direction from the Teenage Pregnancy Unit (TPU) is to focus on the majority of vulnerable young people most at risk of early pregnancy who are likely to live in the 'hotspot' areas of high deprivation and under 18 conception rates. However, it is recognised that some vulnerable groups requiring intensive support may live outside these geographical neighbourhoods or be part of very mobile populations. This may include looked after children and care leavers, asylum seekers and young offenders.

5.10 Local work therefore needs to be targeted to both high rate areas and vulnerable groups in the community. It is also important that targeted work focuses on the schools, colleges and professionals most likely to be in contact with those most at risk.

Current targeted work to hotspot areas

5.11 Under the new partnership arrangements between the Council and the tPCT, the Children and Young Peoples Strategic Partnership Board has commissioned a new programme of needs assessment analysis in order to support the provision of ‘local, personal needs-led ‘services’. The first stage of a new profile of all children and young people aged 0 – 19 years olds in Brent is in progress. The profile will provide household and ward level data which can be used to assess the needs of individual neighbourhoods. As part of the Teenage Pregnancy Action Plan, this data will be correlated against Teenage Pregnancy information to further map the high risk areas and deliver services accordingly.

5.12 In addition to this, the Brent Local Strategic Partnership have identified £100,000.00 for specific projects targeted to Harlesden and Stonebridge.

Access to contraceptive services for young people in Brent

5.13 In order to keep themselves safe young people need the basic information about how their bodies work, how pregnancy occurs, about the choice and use of contraception and the life skills to negotiate and maintain safe sexual practices.

5.14 Nationally it is estimated that the average age of first sex for men and women is 16 years, that approximately 25% of young people become sexually active before the age of 16 and that approximately 75% of young people who visit services for advice do so only after they have become sexually active.

5.15 The formation of young peoples' understanding and capability to be sexually healthy is dependent on their experience of:

- Individual family circumstances (for example the generational cycle of early and/or lone parent pregnancy) and what is learned within the family about sex and sexuality,
- support from school and community groups
- the attitudes and behaviour of peer group and wider society
- information about and use of contraception and prevention of sexually transmitted infections (prevention services)
- access to, and appropriate use of services to treat STIs and abortion services (treatment services)

Data and information issues

5.16 Understanding the use of contraception by Brent residents is only possible by looking at services where there is recording and analysis of care provided. Many people will use condoms that they have purchased from non-NHS suppliers and are not recorded. The large majority of GP practices provide basic contraceptive services (the pill and contraceptive injections) for those registered with the practice but here has been little analysis of the methods prescribed or estimation of use of GP services by young people. Access to the full range of contraceptive methods is commissioned from Westside Contraceptive Services by Brent PCT at 29 sessions at ten sites in Brent and detailed information is available for analysis.

5.17 Of the 2,037 abortions performed by Brent PCT in 2003-4, 143 (7%) were for women under 18 years (Source Brent tPCT) Further analysis of locally and centrally held data available would allow improved targeted planning of initiatives and follow-up care to meet the needs of young people in 'hotspot' wards, with a particular focus on support for young women with repeated unwanted pregnancies.

Recommendation 1. Annual analysis of locally and centrally held data available for teenage pregnancy and Sexually Transmitted Infections' (STI's) should be undertaken to allow improved targeted planning of initiatives and follow-up care to meet the needs of young people in 'hotspot' wards.

5.18 There are current difficulties with STI data collection, outlined in para 6.17-6.19.
The tPCT has recently commissioned an IT data management consultancy to investigate the issues around data collection, recording and reporting mechanisms for STI's and sexual health data from all providers, in all settings across the borough. The recommendations are expected in July to August 2005. This will be an important step to aid more effective planning of services.

5.19 In the absence of current detailed data for STI's teenage pregnancy data could be used as a substitute marker for STI's in the short term, as in most instances the hotspots are likely to be the same

Access to contraceptive services in Brent.

5.20 The standards for contraceptive services for young people have been published by the TPU and others (Standards for sexual health services 2005 DoH). All local residents are entitled to GP registration and the vast majority of GPs provide basic contraception (oral contraceptives and injections) which can be accessed in general surgery times, a few practices have sessions set aside for contraceptive consultations. Many young people are comfortable and confident to consult their 'family doctor' for sexual health, but for others a more specialised and discrete service will encourage use of contraception and condoms to prevent infection
Recent evidence from the local teenage pregnancy and abortion statistics demonstrates that young people in Brent are at risk as demonstrated in comparison with immediate geographical neighbours with whom there will be considerable cross-boundary flow for services:

5.21 There is a network of community contraceptive clinics at ten sites in Brent offering 29 sessions during each working week at various times (morning, afternoon and evening). Across the service network there is access to all the contraceptive methods (except the patch for which no funding has been available) 17, 400 attendances were made at these services in 2002-3 and there were 1,700 visits from Brent residents under 20 years to Westside Contraceptive Services clinics in that year.

5.22 There is only one dedicated walk-in session specifically for young people on Tuesday evenings, which is being re-sited to the new Willesden facility and could be further expanded at the new site. There is a limited domiciliary service with a small caseload of very vulnerable teenagers and mothers. There is no catchment or age restriction for access to the clinic services and most sessions can provide a limited walk-in service. The open-access and self-referring nature of the community contraceptive services enables women and men to choose to attend a clinic outside their borough of residence and this means that there is considerable cross-PCT flow in the use of services. Some of the current community and general practice premises in Brent currently suffer in terms of basic amenities. Work carried out by provider teams needs to ensure that services are young-people friendly and provide properly skilled care.

5.23 The idea of providing specific GP services for teenagers has been explored in Rotherham, South Yorkshire, where a network of clinics and drop in centres for teenagers working in partnership with GP's and the Youth Service, was developed. Rotherham PCT now oversees 13 of them; several are cited on

school campuses, and all are holistic in their approach to health. Even more innovative is a plan to allow some GPs to put special emphasis on teenage patients, designating them as having an official 'young person friendly' status. Source Guardian G2 p7.

5.24 There is also a need to review maternity services to teenage mothers as part of the overall review of dedicated provision to young people. Activity and review of maternity services is presently underway with the Healthcare Commission, and increased investment expected as part of this review.

Recommendation 2. The lack of adequate provision of *dedicated* young peoples' contraceptive, sexual health sessions and maternity provision in Brent needs to be addressed. This will require a review and mapping of access and use of GP and community contraceptive and sexual health sessions by young people in Brent. This should lead to more effective planning, increased funding and capacity development in provider services, in order to supply more appropriate provision to young people.

Recommendation 3 The tPCT and Teenage Pregnancy Board should use this mapping to clarify the current role and investigate the potential for extending of the role of other agencies (both voluntary and statutory) who come into contact with young people, to include the development of limited health roles, educational or information roles, and signposting roles.

Recommendation 3a. An expansion of medical services needs to be considered as part of the overall review of provision. (See section 5) For STI's this can be done simply via the expansion of newer DNA based technologies which can be taken into the community and made available by a wider range of providers. Increased funding should be directed towards these new technologies.

5.25 It is also necessary to increase capacity in GP and community services to provide expert and effective young-people friendly care.

5.26 Addressing inadequate dedicated provision should involve developing a mixture of reorientation of current generic sexual health services towards young people specifically, expansion of services and the creation of innovative services in settings that are attractive to young people or are embedded in settings not currently part of health services.

Expanding the role of other 'youth' agencies

5.27 The need for dedicated young person sexual health services is operating in a milieu of poor access for all the population thus it is imperative that providers co-opt capacity that already exists and maximise the function of those groups already engaging with young people, (but not necessarily in the area of sexual health), potentially taking on limited health roles eg screening tests for infections taking place in youth centres etc by non health personnel. (Note: It is not necessary for all services however to provide every aspect of a genitourinary medicine or contraception service. Specialist services can function as a hub for the more specialised components.)

5.28 This means involving other providers, such as the youth service, connexions advisors, the voluntary and community sector, and services in schools to potentially deliver sexual health education, advice, or signposting to services.

This would involve mapping all current services to young people with a view to scoping the potential for expanding the role of these agencies.

6. Key issues around sexually transmitted infections

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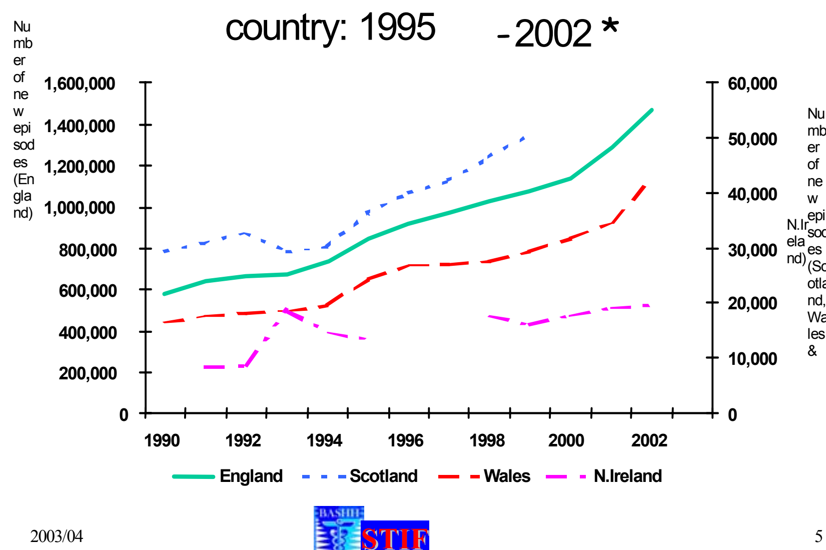
April 2005

Sexually Transmitted Infections (STI's) in Brent – an overview

6.1 In the past decade, the number of new episodes of STIs diagnosed in Genitourinary Medicine (GUM) clinics in England Wales and Northern Ireland has doubled from 708,538 in 1992 to 1,533,816 in 2002. (Health Protection Agency – Data Source: KC60 statutory returns and ISD(D)5 data- 1990-2002)



6.2 Rates of STI's in Brent mirror the national trends, and Brent contributes an excess of STI's per capita. Under pressure of increased need, GUM services have had to change working patterns significantly to maximise efficiency and manage demand for access. The Patrick Clements Clinic at Central Middlesex Hospital is a recognised leader nationally in addressing effectiveness of service delivery. A "one stop shop" model is employed and a mixed "walk-in"/booked appointment strategy has been shown to maintain access. Nationally services had almost universally withdrawn "walk-in" services in an attempt to manage demand. This merely reduced access for those most in need.

6.3 Notwithstanding the changes introduced locally, the milieu remains that of service incapacity to meet demand. Queues regularly form 1 ½ hours before the clinics open, and sexual health services within Brent remain inadequate to

meet current need. The majority of demand is met in primary care where provision is patchy ill equipped and inconsistent.

New diagnoses of selected STIs in GUM clinics

England, Wales & Northern Ireland: 2002

HPA CDSC (England, Wales & Northern Ireland), DHSS&PS (Northern Ireland) and Scottish ISD(D)5 Collaborative Group (ISD, SCIEH & MSSVD)

		% change	
	2002	2001 - 2002	1996 - 2002
1st Genital warts	69417	2%	17%
Chlamydia	81680	14%	139%
Gonorrhoea	24953	9%	106%
1st Genital herpes	18392	3%	16%
Syphilis, 1° & 2°	1193	63%	870%

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6.4 These statistics *exclude* all or most STIs managed in primary care and are a substantial underestimate.

6.5 The common infections include:

Chlamydia and Gonorrhoea

6.6 These are bacteria which live on mucosa (the raw inner linings of the body) eg throat, penis and cervix. They can cause local symptoms eg discharge or spread internally to cause significant disease eg pelvic inflammatory disease (PID) or arthritis. PID is a major cause of morbidity. It can be clinically evident leading to pain and discomfort or “silent”; These infections can contribute to miscarriage, ectopic pregnancy, infertility and death. These bacterial infections are transmitted by sexual contact. Condoms are very effective at reducing their transmission.

Herpes simplex virus (HSV) and Human papilloma virus (HPV)/wart virus

6.7 These are spread through skin contact which is usually sexual. HSV causes painful blisters which heal. The virus retreats into the spinal cord through nerves supplying the skin. Once in the spinal cord HSV becomes dormant but infection is lifelong. It may reactivate and cause recurrent blisters at which time the individual becomes infectious again. Recurrences and indeed primary infection may not be recognised.

6.8 HPV is an extremely common skin infection and often not recognised. Infection is often only visible in a minority (less than 10%). HPV infection is not treatable although the consequences can be managed. HPV can persist for years. Condom usage has limited impact in the reduction of transmission of these viruses.

6.9 The lower relative rate rise in these viral infections in recent years reflects their inexorable rise since the 1960s. Bacterial infections became temporarily less common in the 1980/90s as earlier HIV related health promotion led to increases in condom usage. The latter effect has dissipated.

6.10 Other common sexual infections locally include **Trichomonas vaginalis (TV)**, a mucosal parasite which causes discharge in men and women. Diagnosis requires microscopy in a laboratory.

Bacterial Vaginosis (BV)

6.11 This is a significant issue. BV is not an infection, rather an imbalance in the normal vaginal flora which leads to vaginal discharge. It has been associated with recurrent miscarriage and may facilitate HIV infection. It is particularly prevalent in women of African or Afro-Caribbean origin. Diagnosis is dependant on microscopy in a laboratory.

HIV and other Blood Borne Viruses (eg Hepatitis B)

6.12 These viruses are transmitted in blood and in other body fluids. Transmission can be sexual and in the case of HIV is usually so. Condoms offer excellent protection. HIV infection is lifelong. It is treatable in the UK. Treatment is cost effective but maximal effectiveness depends on early recognition and testing. Prevention of HIV infection may prevent an estimated £1M lifetime cost. Hepatitis B infection can be lifelong but can also provoke a severe even fatal reaction in adults. Hepatitis B is vaccine preventable.

6.13 **Key Features of Sexually Transmitted Infections**

- All infections are infectious and may be transmitted to others
- Someone else is already the source
- All infections can be asymptomatic (Note: For some STIs this is the majority)
- The risk for one STI is the risk for all (Note: The need to test for all STIs)
- Some groups are particularly at risk (Note: The need to target these groups)
- All STIs facilitate acquisition of HIV
- STIs are a marker of social vulnerability

6.14 **Risk Groups for Sexually Transmitted Infections**

- Young people, especially those in or leaving care
- Certain Black and ethnic minority groups. (Note: the reasons for this are complex and not fully understood, but they are linked to greater propensities to deprivation, poorer educational attainment, poor information flows and difficulties in accessing services)
- Gay and bisexual men
- Injecting drug misusers
- Adults and children living with HIV
- Sex workers
- People in prisons and youth offending institutions
- Migrant populations both within and between countries

- People with mental health needs or physical disability
- Urban Residents

6.15 The situation in Brent reflects the national picture of rising rates of sexually transmitted infections**.** The greatest rates of infection are amongst 'at risk' groups, and STI's preferentially afflict the vulnerable in society. Brent is particularly ethnically diverse with pockets of significant social deprivation, and a relatively young population with almost a quarter of residents under the age of 18, clearly a number of significant risk factors coexist in our population.

Data and Information issues

6.16 Accurate data for STIs is not available for a range of reasons:-

1. An unknown majority of STIs are managed in primary care. Clinical syndromes may be managed without the capacity existing to make accurate diagnosis. There is no system for recording and centrally collating diagnoses.

2. GUM clinics are by necessity "open access". Clients may and do attend any service, may seek care outside local services and may remain anonymous. Brent clients attend GUM clinics throughout London and the Home Counties. GUM clinics submit data on STI diagnoses and attendances (KC60) to national databases but data is aggregated. There is currently no capacity to link diagnoses of STIs to residence reliably.

3. Clients attending The Patrick Clements Clinic are overwhelmingly local however a significant number travel significant distances to access what is one of the few remaining "walk-in" services in the UK.

6.17 Thus limited inferences can be drawn from Clinic specific (KC60) data.

6.18 The Health Protection Agency collects national data on HIV and STI's, (KC60 data). The data collected is anonymous, aggregated and relates only to Genitourinary Medicine clinics. The information thus generated is general disease surveillance and whilst helpful, does not currently contain sufficient patient residence based information to enable focussed population commentary. There is currently no system of diagnosing, coding or reporting STI's (the Majority) managed in community settings, mainly Primary Care. Provision of a reliable and complete dataset of STIs poses significant logistic problems though there is no disagreement as to the utility of such a dataset. A pilot project in Bristol is underway which is attempting complete data capture of *all* STI's from *all* sources, (GUM, Acute services and Primary Care), which would include postcode information, the objective being to roll this out across England eventually to facilitate top level needs assessment and resource allocation for STI management.

6.19 A Medical Research Council funded pilot study (ASSIST) addressing the particular issues of community management of STIs for London is due to start in Brent in Summer 2005. The success of this study and future capacity to manage STIs will be highly dependant on the cooperative sharing of relevant information across boundaries. In the interim, it would be a very useful start for GUM service planning to be able to access and share the admittedly limited

current datasets from (and with) neighbouring centres, for example St Mary's, Ealing and Northwick Park.

Recommendation 4. The tPCT should request and use shared datasets and information from all adjoining Acute Trusts whose services Brent patients access, to help inform the planning and delivery of Genito Urinary Medicine (GUM) and Contraceptive Services. This sharing would be similarly useful for community contraceptive data.

6.20 High rates of STI's are to be predicted as the Brent population contains significantly higher proportions of risk groups for STI's.

7. Young peoples experience and raising awareness - Key priorities

Young peoples access to sexual health services

7.1 Current sexual health services for young people in Brent are patchy and variable, as outlined in the previous section, and knowledge about and access to services remains an issue. Clearly it is important when developing services which young people will actually use, to understand what their main concerns are, and to identify their potential barriers to access.

7.2 From a young persons point of view there are multiple concerns when accessing sexual health services. Research from the TPU and Health Development Agency indicates that confidentiality and convenience of both location and opening times are amongst their top priorities.

7.3 Surveys have shown that for young women aged 16 to 19 the most popular source of advice or services for those who sought them, were GPs or practice nurses, followed by family planning clinics. (P3 top section) while surveys of young people aged 13 to 21 indicated the main sources of advice were schools (teachers and or school nurses) 31%, GPs 22%, and family planning clinics 16%. For supplies, pharmacies, 21%, family planning clinics 18%, GPs 18% and vending machines were the main source. (2nd section p 3)

7.4 Young people describe their ideal contraceptive service as confidential; easily accessible with minimal fear and embarrassment; located on a side street near the town centre; having clean, smart premises with frequent opening times; and operating as a walk-in centre with no appointment necessary. Other desirable features include having reception and waiting areas designed to minimise embarrassment, and staff who are warm, friendly, respectful and non-judgemental, who use non-medical language, who are well informed on gay and lesbian issues and make no assumptions about sexual orientation. Brook (1998). ('Someone with a smile would be your best bet...' What young people want from sex advice services. London: Brook Advisory Centres.)

7.5 The Health Overview task group undertook its own survey of young people in Brent, the results of which mirror most of the national research findings to date.

7.6 A majority of young people (64%) interviewed said that they did feel well informed about sexual health issues, although this may be quite subjective, as 46% of young people cited friends as the most likely source of advice. Youth workers or sexual health project workers in second place and GP's in third place. For questions around where young people would prefer to go and also NOT go to for sexual health advice, the same proportion of young people (around 25%) cited that they would and wouldn't approach their GP for advice. The most unpopular source of advice was parents, (44%) and school nurses (42%) Note: this result is not always reflected in other national research studies. Embarrassment and confidentiality are clearly major worries for young people, with 60% and 50% (respectively) of interviewees citing these as reasons why accessing *any* kind of sexual health service is difficult. (The survey information is available from the consultation team at Brent Council.)

Confidentiality issues

7.7 Confidentiality is a major concern, and perceptions of diminished confidentiality will act as a significant barrier to access. Research shows that GPs are often perceived to be less confidential than some other settings. Peckham, S., Ingham, R. and Diamond, I. (1996). Teenage pregnancy: prevention and programmes. Southampton: Institute for Health Policy Studies, University of Southampton.

7.8 Services do need to be very clear and proactive in confirming confidentiality and have a well advertised policy on this that is adhered to. The PCT has recently undertaken a successful campaign with GPs entitled 'U can expect' which advertises via a poster and leaflet logo, that a GP is signed up to a guarantee of confidentiality for young people and that they can access services there even if they are not registered. The task group would recommend that the tPCT extend this project to include more Brent GPs as part of a wider program of further work with GPs to raise their awareness of the specific needs of young people.

Recommendation 5. That projects similar to the tPCT funded initiative 'U can expect' are rolled out across more GP services in Brent, and outside Brent where young Brent residents also access. This should be carried out alongside a wide review and identification of the capacity of GP services to see young people quickly, with a view to strengthening this type of provision across the borough.

7.9 There is also strong evidence to suggest that Sexual Health services for young people should remain open access. Young people tend to present late for help and treatment and often some time *after* they become sexually active. A 1999 survey revealed that around 61% of young people first used a service *after* intercourse, with only 29% accessing services before first intercourse. The interval between sex and first visit varied from one day to 6 years. (Stone and Ingham R 2003) p 3.

7.10 Long waits for appointments are also clearly inappropriate in the context of infections which can and are still spread to others, during the period of waiting to be seen, or waiting for treatment. Young people do have a tendency to "go away" before receiving assistance if it is not provided quickly. "Gatekeepers" to services need to recognise this as a priority and have good systems in place to facilitate rapid transition into services. Ideally there should be a mixture of mainly "walk-in" provision and a capacity to book, so that urgent requests can be seen immediately. This is equally true for contraception and abortion provision.

Timing and location of services.

7.11 To be accessible, young persons services need to be provided when and where young people can attend. This means providing services that operate in the late afternoon and early evenings or at weekends, as 9 to 5 services are not conducive to young people attending. Services should also be sited where young people are or can get to.

7.12 In Genitourinary Medicine, there are currently only 2 clinical sessions per week specifically for teenagers. One (Thursday pm) at Patrick Clements Clinic at Central Middlesex Hospital in South Brent and One at Northwick Park Hospital (Wednesday pm) in North Brent. The Patrick Clements clinic has considered the possibility of providing Saturday sessions for young people, and the task

group would recommend that this is explored further, as part of the review of young person appropriate services outlined in Recommendation 4.

Outreach

7.13 There are no targeted Genitourinary Medicine Sexual Health Outreach Services at present. There is no domiciliary service. Two “outreach” clinic sessions currently operate. A GUM mini clinic (one session per week) at Chalkhill Health Centre is in effect a satellite clinic. It is untargeted and is labour and resource intensive. It may discontinue as “Community Screening” by PCR (DNA based tests) by community staff is likely to become a more effective model for the future. A Drug users service exists at the Junction Project. This is primarily a “Blood Borne Virus” and Vaccination Service, and is now nurse led. Outreach services should be reviewed as part of the mapping of services referred to in recommended in 5 a), alongside work to address current gaps in services which include work with Lesbian Gay or Bisexual population and young people in care or institutions.

Recommendation 6. That as part of the wider review of services (outlined in recommendation 3,) the Patrick Clements clinic and other Contraceptive clinics and youth settings explore the possibility of providing Saturday sessions to enable greater access for young people.

7.14 While many young people do feel comfortable attending their GPs, the actual capacity for testing for STIs in General Practice is limited. Genitourinary Medicine hitherto has been limited in its flexibility as diagnoses depended on onsite laboratory facilities and technically capable staff. The advent of highly reliable and relatively user friendly nucleic acid (PCR) based testing for common infections has the potential to revolutionise community based STI care. The Chlamydia Screening Programme which is based on this technology is a major advance and is in the process of being rolled out in Brent. Its progress is dependant at present on the need for education for service providers, interest and capacity to absorb the extra work by these providers. This extended role of other agencies is explored further on in this report.

Awareness of services and sexual health issues.

7.15 At national level indications are that generally young people are aware of what services exist. A 2003 British Market Research Bureau (BMRB) tracking survey found that 73% of young people aged 13–21 said they were aware of a clinic or other place they could visit in their local area if they wanted advice on sex. Girls (77%) were more likely than boys (70%) to be aware of a service, as were older rather than younger respondents (61% 13–15, 79% 16–17, 80% 18–21).BMRB International (2003). (Evaluation of the Teenage Pregnancy Strategy. Tracking survey. Report of results of nine waves of research. October 2003. London: BMRB International.)

7.16 In the task groups own survey of young people in Brent aged between 12 and 17 years, 44% of young people interviewed said that they did not know where to go for sexual health advice. Suggested solutions included distribution of leaflets and literature, information in schools, services including GU Med clinics to advertise via the internet, and have interactive question and answer facilities where a young person could ask questions of a professional, anonymously.

More work needs to be done in Brent around raising awareness and advertising services.

Advertising of services and raising awareness

7.17 There is at present a lack of really effective advertising or promotion of all local sexual health services for young people and no local NHS funding identified for development or dissemination of effective advertising materials. In addition, coordination needs development and awareness between services or clarity on service pathways is presently quite poor. There is major need for coordination and clarity on this. Many services seem "ambivalent" on advertising as they are functioning at or beyond capacity. There is an understandable unwillingness to create an expectation that cannot be met, but this is a false economy which belies the need for overall capacity expansion and investment.

7.18 Careful thought needs to be given to advertising the availability and access to services for young people, and there are a number of examples of good practice within Brent such as the credit card style cards which seem to work well with young people and could be further developed. Overall current advertising materials seem inadequate. There is currently patchy distribution of clinic service timetables which need attention to design and proper funding for distribution.

7.19 Different services are using different logos, for example the Council's teenage pregnancy projects use a different logo to the tPCT commissioned projects, such as 'U can expect' mentioned earlier. The new drive towards a more integrated approach to services for children and young people within the Children Act and National Service Framework should provide a focus to stronger joint working between the tPCT and the council, and this is a clear case where joint working between PCT and the Council could increase accessibility of services to young people at risk.

7.20 As part of the plans for developing a jointly supported marketing campaign between the tPCT and the Council to raise awareness amongst young people of sexual health issues and services available, a joint or universal logo between the tPCT and the Council for young people's sexual health services in Brent should be considered. This, perhaps alongside the provider's own logo, could provide greater clarity to young people, plus give the reassurance of an endorsement of key values within the specific service such as respecting the right to confidentiality. Within the extended role of other youth agencies, this could also provide some clarity and credibility.

Recommendation 7. The tPCT and the Council should work together to develop a joint or universal logo (alongside the service provider's own logo) for services which both agencies support, and who subscribe to a core set of defined values in service provision such as guaranteed confidentiality. This should be part of their joint work towards an awareness raising campaign among young people.

7.21 The North West London Strategic Health Authority has recently commissioned some work around raising awareness among young people using celebrities and the media. 'Dr Foster' a market research company specialising in health promotion has been appointed by NW London SHA to conduct a project,

across Brent PCT, to analyse and intervene with the high teenage pregnancy rates across certain parts of the borough in 2005. Using neighbourhood level classification techniques and in-depth qualitative analysis of media and consumption habits traditionally only used in the private sector, Dr Foster aims to deliver an engagement strategy targeted towards the at-risk groups within society most likely to show high levels of teenage pregnancy. This project follows the success of a campaign across Slough PCT focusing on diabetes, which produced a 164% increase in the level of referrals in just three months. This is a very welcome aspect of what needs to be a broad marketing campaign across schools, youth agencies and other places where young people spend their time, to raise the profile of sexual health services and sexual health issues.

8. Service delivery and partnership approach

The need for a partnership approach

8.1 Progress with implementing the National Sexual Health Strategy and the Teenage Pregnancy Strategy has been slow in Brent to date with problems in the governance structures and working of the partnership and commissioning functions between the Council and the tPCT.

8.2 Both the Sexual Health and Teenage Pregnancy remit has suffered from a lack of prioritisation and clear vision, with a fragmented and uncoordinated approach to developing and delivering services based around whose responsibility it was. This has resulted in a lack of clarity about which services exist and match local priorities, alongside the specific needs of young people. Information and Data problems have been compounded by the fact that there has been a lack of performance management data with which to evaluate some services provided, which in turn makes it difficult to assess and evidence the success or failure of certain projects, or where there are gaps, and where there is duplication.

8.3 The recently re formed Teenage Pregnancy Board offers a good opportunity to strengthen governance structures and partnership arrangements for a more focussed, committed and sustained approach from both the council and the tPCT, which is vital if the situation is to improve. The new Children and Young People's Strategic Partnership Board, formed as part of Brent Council's response to the implementation of the Children Act, will be the joint lead agency with which to develop, plan and deliver services between the Council, the PCT and the voluntary and community sector using pooled funds. This should help to ensure that funding leads to sustainable projects which young people can get used to accessing, rather than those which disappear after 1 year or so after initial pump priming funding runs out. Chaired by the Director of Children's services the CYPSPB should link directly into education services, social services and the tPCT as well as the broader partnership networks. This should help to facilitate a more wholistic approach to sexual health issues.

Recommendation 8. Establish clear partnership arrangements and lines of accountability between the tPCT and the Council, to ensure that the sexual health and teenage pregnancy functions are strongly linked, and to enable the effective co-ordination of services between the agencies. This should ensure a stronger links for policies, protocols and operational arrangements between the Council and the tPCT.

Recommendation 9. Establish a joint (tPCT and Council) and comprehensive system of performance management for all services dealing with sexual health and young people, who do not currently including work in schools, to allow effective evaluation to take place.

8.4 This will need to link in with the inspection regimes for schools, and the outcomes for children under the Children Act. As part of the new inspection regime, and the legislative drive to tailor services to the specific needs of children and young people, they are expected to be consulted, and to participate in the design of services. The task group would strongly endorse this approach and would also recommend that children and young people are also involved in the evaluation of services.

Recommendation 10. That children and young people are enabled to actively participate in the design and evaluation of sexual health and contraceptive services.

8.5 During the writing of this report the tPCT has commissioned a ‘mystery shopping’ tour of sexual health services. This will be a very useful starting point to inform providers and commissioners about the experience of young people accessing services. There are other innovative methods and good practice examples for involving children and young people in the design and delivery of services which should be explored, such as using video technology to engage young people and facilitate discussions and retrieve views and ideas on services for example.

8.6 The challenge will be to ensure that Sexual Health issues (covered by the Sexual Health Priority Action Group at the tPCT) are strongly linked with Teenage Pregnancy Board within the Council, and the CYPSPB. These first two groups will need to report to the Health and Social Care Board. Clear lines of accountability need to be established.

8.7 Basic mapping (recommended earlier) of current sexual health provision as well as a better picture of what is currently happening with SRE in local schools are necessary first steps. Publication and co-ordination of the new Sexual Health and Teenage Pregnancy Strategies for Brent and effective cross-organisational implementation should provide the spring-board for better services and support for young people’s sexual health in Brent.

8.8 The notable tPCT success of obtaining funding and starting to provide chalmydia testing could provide the practical foundation for strengthening sexual health provision between NHS providers in hospital, GP and community services and perhaps in the future at schools and other sites outside NHS facilities.

8.9 There may be a need to redesign and refinance current services commissioned to provide a better fit with identified needs so that gaps and key priorities are addressed, and duplication avoided. The tPCT is moving from a grant based approach to issuing contracts which should assist the realignment of commissioning services to match local priorities for certain projects.

Taking services to young people

8.10 There is a tendency to focus on services, but it would be a useful exercise to identify where young people in Brent spend their time in during an average day. This may be school, youth clubs, being educated out of school, certain restaurants, high street shops, voluntary clubs etc. An assessment of what information could be given to them and where, who does receive information and who is missed out? Where are services duplicating? And where services could be refocused, and rationalised. There should be a focus on the vulnerable as well as the general population of young people.

Recommendation 11. Map the whereabouts of young people on a typical day and match this information with the mapping of current services to further inform the fit between need and service provision.

Funding arrangements

8.11 Alongside mapping services and young people, there is a need to review how current money is spent on sexual health, particularly Teenage Pregnancy money as a considerable amount is spent on overheads over projects. This is now in progress. Teenage Pregnancy funding is no longer to be ring fenced from next year. The task group would strongly recommend that this money remains allocated to teenage pregnancy, and is not diverted to other areas for the next 2 years, in order to ensure that sufficient priority is given to Teenage Pregnancy.

Recommendation 12. That money allocated to Teenage Pregnancy remains ring fenced for the next 2 years to ensure it receives sufficient priority.

The role of schools

8.12 A 2001 study in the Lancet concluded that children and young people are ’consistently failed by an education system which persistently delivers too little, too late (and which) often places a mistaken emphasis on sex at the expense of young peoples’ wider concerns about relationships’

8.13 It is currently a statutory requirement for schools to have an Sex and Relationships Education (SRE) Policy. (DfES 2000). The guidance states that the policy should define SRE; describe how SRE is provided and who is responsible; describe how SRE is monitored and evaluated; include information about parent's right to withdrawal and be reviewed regularly.

8.14 In addition, the Children Act 2004, now places a clear duty on agencies to work together to promote the health of children and young people and includes specific measures around outcomes which prevent sexual ill health. The Act also proposes that local governing bodies and local authorities open up their schools to provide wider services for pupils, families and the community under the Extended Schools agenda. This might include adult education, study support, ICT facilities, but also might involve placing other statutory and voluntary sector services for example social workers in schools.

Current work with schools on sexual health

8.15 Westside Contraceptive Services has for many years provided outreach as part of Sex and Relationship Education (SRE) to local schools. In the last two years it has not proved possible to maintain this input. This work had not been co-ordinated and coverage of schools very incomplete (including some of those with the highest rates of teenage pregnancy). Other agencies involved in schools in Brent include the Healthy Schools Co-ordinator from Education who can promote SRE via this initiative, the Schools Nurse Co-ordinator from the PCT, a Health Advisor for Looked After Children from the PCT, and a Health Development Manager from the PCT working to a Health Promotion remit who distributes training packages for work in youth settings and specific projects. Provision by or involvement of other medical specialist services in SRE is ad hoc at present because of the severe constraints on resources.

8.16 Schools have a critical role in educating and informing young people on issues surrounding sexual health. The task group found that whilst there are examples of excellent practice amongst professionals in the field, there are large and worrying gaps in the support for negotiating safer sex and in knowledge about available services to support young people in Brent schools, with little or no

basic provision in some schools. Provision of SRE is patchy and variable across Brent.

8.17 There are considerable difficulties for professionals in accessing and engaging schools for a number of reasons. Schools are not currently inspected on how they deliver SRE so it can be a low priority, although this will change with the new framework for inspection. Schools vary in how willing they are to deliver comprehensive SRE, and in their willingness to signpost services, some of this is attitudinal, and there may be specific concerns around what parents think, and from faith schools regarding potential conflicting beliefs.

8.18 Many schools do not sign up to the voluntary 'healthy schools' initiative which is a key leverage point for the Council and PCT to promote SRE. (Only 5 out of 14 secondary schools are currently signed up).It is difficult for the current healthy schools co-ordinator to target all schools as the post is only part time, as is the faith schools coordinator post. School Nurses do not appear to be accessing the specialist Health Promotion training offers, and there are theoretically not enough nurses to cover the need in schools, the key issue being frequency of school visits.

8.19 There also appears to be a lack of clarity around the role of the school nurse, and what they should be able to deliver. This role has clear scope for expansion under the Extended Schools agenda. Teacher training is also an issue with many teachers lacking confidence to deliver SRE, and additional staffing INSET issues around releasing teachers for training. There appears to be a range of perspectives on what SRE should actually contain, from the purely scientific approach to a more holistic approach including broader themes such as negotiating relationships for example.

8.20 The task group carried out its own survey of school governors in primary and secondary schools who are responsible for overseeing SRE policies. Around 53% of school governors stated that their school did teach SRE. Only 16% stated that SRE was taught holistically taking account of social factors, while 11% stated it was taught through biology lessons, 60% did not reply to this question of how SRE was delivered. School Governors had considerable insight into where young people would go for sexual health advice, reflecting a lot of what young people said themselves, namely friends, media and internet. A majority of 70% stated that they would be prepared to promote the issue of young people's sexual health in their school, and 67% said they would like to receive support in the form of training and workshops. The survey demonstrated a positive and very realistic attitude among governors, and there is clearly room for the Council to support Governors to develop better policies and practices where these are needed.

Recommendation 13. That the tPCT and Council work together to develop a program of support for School Governors in promoting the adoption of good practice SRE across schools in Brent where this is needed.

8.21 Improving the sexual health education and information for all ages must be a top priority, including SRE from Key Stage 1 to Key Stage 4. It is perfectly feasible to provide age appropriate SRE at primary level. This might focus on relationships and friendships, making choices and so on. There also has to be clear outreach to those not in school, who are more vulnerable. Recent Reviews by the Health Development Agency (2003) conclude that there is good evidence that school based SRE, particularly when linked to

contraceptive services, can have an impact on young peoples knowledge and attitudes, can effectively delay sexual activity, and/or reduce teenage pregnancy rates.
Swann, C., Bowe, K., McCormick, G. and Kosmin, M. (2003). *Teenage pregnancy and parenthood: a review of reviews. Evidence briefing.* London: Health Development

8.22 Evidence suggests that SRE programmes which encompass a broader approach, including information about the risks of sexual activity, but also activities to resist social pressures, examples of and practice with communication, negotiation and refusal skills, alongside participatory teaching methods are particularly highly rated amongst young people. (Kirby, D. 2001USA: National Campaign to Prevent Teen Pregnancy.)

8.23 There is no evidence meanwhile, to support the view that increased provision of SRE increases the onset or frequency of sex, or the number of sexual partners. (Kirby, D. (2001). *Emerging answers: research findings on programs to reduce unwanted teenage pregnancy*. Washington, DC, USA: National Campaign to Prevent Teen Pregnancy.)

8.24 National surveys indicate strong support for sex and relationships education (SRE). Eighty-eight per cent of young people and 86% of parents see SRE as helping young people be more responsible about sex. Three quarters of young people and two thirds of parents were ***not*** of the opinion that sex education encourages young people to have sex too early. BMRB International (2001). *Evaluation of the Teenage Pregnancy Strategy. Tracking survey. Report of results of benchmark wave.* January 2001. www.teenagepregnancyunit.gov.uk

8.25 Research also suggests that Children value external providers who are not seen as part of the establishment, and there are a number of partner agencies who could be brought into deliver SRE, particularly given the resources and constraints outlined above for professionals. The reluctance or lack of capacity of some schools to deliver adequate SRE needs to be addressed proactively and as a matter of urgency, and consistent levels of SRE established. A critical issue is one of coordination between the various services from the Council and the PCT so that joint planning and effective targeting can take place. An agreed lead on this needs to be established. This could be via the appointment of a PHSE/SRE Coordinator, which many authorities have, Brent currently does not have.

8.26 It is also crucial to involve parents in the design and delivery of SRE, which will help to combat some of the fears expressed by schools and agencies who are concerned about parental views. This may also help to re engage some parents with this issue, and help to build confidence around talking openly with young people about sexual health issues. The government has within the last month highlighted the increasing importance of parental involvement, against a backdrop of rising rates of teenage pregnancies (2.5% between 2003 and 2004, Source ONS) for girls aged between 13 and 15 year olds, despite the considerable investment and teenage pregnancy strategy. Overall rates for under 18 year olds have reduced since 1998, apart from within this more vulnerable age group.

Recommendation 14. The Council and PCT should appoint a dedicated lead for PHSE/SRE to map, review, oversee and expand the delivery of SRE in schools, which must include work with primary schools. This should link in with the Extended Schools agenda, but should also involve the co-ordination and development of voluntary and community sector work in schools and faith

schools. This expansion of SRE should include to other youth and community settings as well.

Recommendation 15. Parents and guardians should be involved in the design and delivery of SRE programs.

Parental awareness does need to be raised, in order to assist the promotion of effective communication with young people. A clear strategy, action plan and funds will be required to develop this. This could include parents working with School Governors and other youth groups to design and approve and participate in teaching or discussing sexual health issues.

8.27 Other key features of SRE expansion should include:

- More focused work with and support for School Governors to raise awareness, develop protocols and develop consistent SRE provision
- Address the capacity issues around Healthy Schools (part-time post) in order to facilitate further take up of services
- Involving parents in the design and delivery of SRE
- Extend current good practice work with faith schools (I.e. using same faith professionals, or proven 'good practice' specialist community groups)
- Withdraw specialist medical professionals from adhoc 'shop floor' involvement to a more limited advisory role, or the co-ordinated provision of appropriately skilled staff
- Develop incentives for teachers to attend training as part of career development
- Involve the School Improvement Service in setting common standards for SRE across Brent
- tPCT to consider more flexible work contracts for school nurses to facilitate recruitment where appropriate.
- tPCT to consider developing and expanding the role of the school nurse to be able to provide signposting, advice and services in schools where appropriate.

The role of other agencies and the Voluntary sector.

8.28 The potential extension of the role of other agencies who work with children and young people, to either signpost to services; deliver sexual health advice or even deliver a limited health care role has already been discussed earlier in this report. This should include agencies like the Youth Service and Connexions for example, negotiation around their role and further training would be required as these agencies may have particular concerns.

8.29 There is a clear and to some extent, untapped resource within some of the voluntary sector agencies working with children and young people.
There is evidence of innovative and good practice amongst some of the agencies commissioned by the tPCT who work specifically within the sexual health sphere, particularly around work with Looked After Children, and different faith groups, which could be replicated, or referred to in developing work with schools.

8.30 Many agencies interviewed however expressed the need for further education, training and updating on key issues such as legal frameworks and child

protection policies, as well as information on which services exist and where. Agencies interviewed expressed that there was no clear strategic framework for them to work to, and there seemed to be a number of networks and forums to which some where invited, and some were not aware of. There is duplication on this and some rationalisation would be advisable. It was also clear that evaluation is problematic, and that performance management systems once established need to include work undertaken by the voluntary sector. This is now a legal requirement under the Children Act. The key requests were for more education, better communication between voluntary agencies and the statutory sector, better integration or cooperation between services, and most importantly better coordination of services.

8.31 All of these requirements should be dealt with within the new legislative framework established under the Children Act, which requires Local Authorities to take a lead on coordinating arrangements with partners and the voluntary sector. As outlined earlier in this report, partnership arrangements are in place and a clear strategic framework is under development with agreed priorities, into which the strategies for sexual health and teenage pregnancy should fall. Further rationalisation of networks and forums could be achieved as part of the mapping and review of services recommended earlier in this report.

8.32 Regarding education, keeping up to date, and the continuing professional development of voluntary and other agencies, the task group would recommend that the tPCT and Council jointly support or host an annual forum involving all agencies dealing either with young people, or specifically with sexual health. This could provide a good and clear focal point for coordination, education and training, integration of services and could make better use of the expertise of clinicians and medical staff whose time is currently so constrained. This event should be open to all sectors (and schools) including those not being directly funded for work, so that information collected can be used to plan services

8.33 Regarding training across all agencies, present arrangements are adhoc. Economies of scale could be achieved in identifying training needs across all disciplines, and creating a pan Brent and Harrow Sexual Health Training Organisation where resources could be pooled or channelled to allow dedicated staff to co-ordinate, support and oversee at all levels. There would also be significant possibilities for income generation.

8.34 Specific training and development of work with GP practices using the support and audit materials developed by TPU with the Royal Colleges of General Practice and of Nursing will need dedicated support from the PCT. On-going training and updating on working with young people and child protection is also needed in community contraceptive services.

Recommendation 16. That the tPCT and Council establish a jointly hosted annual forum involving all agencies working with young people and/or sexual health and contraception. This should act as a focal point for education and training and communication issues as well as informing and developing the strategic framework.

9. Conclusion

9.1 While some progress (outlined in this report) has been made since the start of this task groups investigations, there remains much work to be done if we are

to offer children and young people in Brent good access to services which are appropriate for them, and tailored to their specific needs. Stronger partnership working processes at strategic level are required to facilitate better co-ordination and provision of sexual health services; Issues around data collection and performance management need to be addressed to aid effective planning; The capacity of current providers needs further review; The capacity of other agencies to deliver sexual health services or to signpost to services needs to be built up where appropriate so that access points may be increased; and the provision of SRE in schools needs to be strengthened and expanded. Work has commenced to address a number of these issues, but ongoing prioritisation and commitment will be needed to secure the progress required. Further monitoring would be useful to ensure progress continues at the necessary pace.

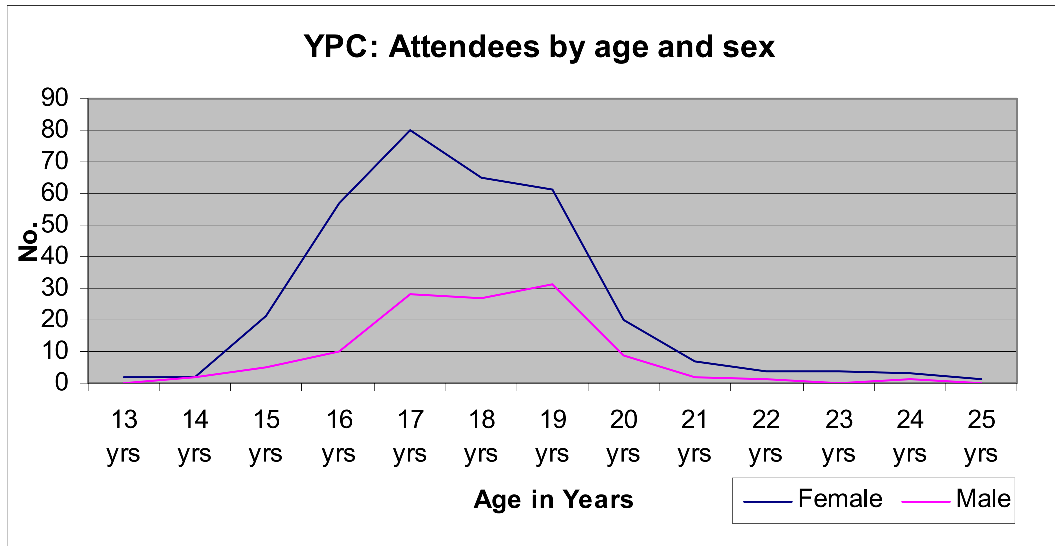
Recommendation 17. The Health Overview Panel should receive a regular update on progress with these recommendations from the tPCT and Council on a 6 monthly basis.

Appendix 1

Sexual health profile of attendance

6.16 The table below shows attendance by age and sex, for girls this starts to rise from age 14, while for men this starts to rise from age 16.

Table A: Attendance at Patrick Clements Young Person's Clinic Oct '03 to July '04



Source: Sexual Health Commissioner :Brent Teaching Primary Care Trust.

Background Papers None

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