worcestershire county council

Worcestershire
Health and Well-being Board
Joint Strategic Needs Assessment (JSNA)

Worcestershire Health and Social Care
Sexual Health Needs Assessment

August 2015

http://www.worcestershire.gov.uk/cms/jsna.aspx

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Worcestershire Sexual Health Needs Assessment

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Strategic priority	**Prevention & Early Intervention**
Care pathway	**NICE guidelines PH3, PH51, PH49, PH34,PH43, CG30, FRSH, MEDFASH, BASHH & BHIVA Standards**
Date	**24/08/2015**
Clinical lead	

1. Executive Summary

1.1.1. Since 1st April 2013, local authorities have had the responsibility to improve the health of the population through the provision and commissioning of effective and efficient sexual health services.

1.1.2. Through a review of current sexual health outcomes, service delivery data, views of users and stakeholders and evidence and best practice, this sexual health needs assessment has been conducted to offer a strategic review of the sexual health needs of Worcestershire and to offer recommendations for improving sexual health and reducing sexual health inequalities. The findings will be used to inform commissioning decisions, and influence future service configuration and development.

1.1.3. The main findings of the needs assessment were:

- In Worcestershire poorer sexual health is more common amongst young people/adults, men who have sex with men (MSM), black and minority ethnic (BME) populations and in areas of greater deprivation. Although the population of reproductive age 15-44 years is projected to decrease, the sexual health needs of more at risk groups such as deprived young people, looked after children (LAC) & care leavers, MSM, BME and needs of the rising older population are likely to increase.

- Sexual health outcomes in Worcestershire are better than the national average with lower rates of sexually transmitted infections (STIs), HIV, unintended pregnancies and abortions and high rates of prescribing of all methods of contraception. However of concern are teenage pregnancy rates in some parts of the county, poor chlamydia screening and detection rates amongst young people and the variability of sex and relationship education (SRE) provision.

- Within the county sexual health outcomes are poorer in Worcester and Redditch districts, with significantly higher STI and teenage conception rates and lower rates of contraceptive and long acting reversible contraception (LARC) prescribing in primary care. In comparison Wyre Forest has similar STI and teenage conception rates as the rest of the county and has high rates of contraception and LARC prescribing.

- The majority of spend and sexual health provision is predominantly focussed on clinical activity and treatment generated through the use of clinical sexual health services. Much of this activity relates to secondary prevention, for example treating infections to reduce onward transmission, rather than primary prevention by preventing the acquisition of STIs.

- There is a higher % of genitourinary medicine (GUM) attendances not requiring treatment (34%) than nationally (24%) possibly indicating inappropriate attendances or attendances

with lower levels of need. There also appears to be a high and rising proportion of "rebooks" where patients return to GUM for new episodes of care indicating a lack of sexual behaviour change and potentially a dependency on service provision.

- Feedback from users and stakeholders identified a need for more sexual health promotion and targeted support and for better information through utilising digital platforms and social media. Service users expressed a requirement to modernise services, improve access with more available local provision at better times (outside of working hours), advertised more widely. Stakeholders and providers expressed concern regarding inappropriate use of services and suggested the walk-in facilities at GUM and contraception and sexual health (CaSH) made it easy for people to use the service for issues that were non sexual health related. They expressed a need for more prevention, early intervention and targeted work for most at risk and point of care testing. They felt services were poorly marketed and the Playinitsafe website was outdated and primarily focussed towards young people.

- The current sexual health system does not have a significant focus on primary prevention; there is little resource on outreach or sexual health improvement activities, and insufficient targeting of high risk groups. Location and access of service provision appears historical rather than focussed on population needs. The system does not appear to be adequately joined up with other services or provision resulting in other frontline staff lacking the capability to influence sexual health behaviours. Current services do not make use of new technologies to support provision or to promote sexual health information, advice and support.

- A range of primary preventive interventions have been identified that can impact on sexual health behaviours and improve sexual health outcomes across the life course. Increased community development activities such as community champions and peer educators can influence sexual behaviours and increase safe sex practices. Condom distribution interventions can increase the availability, accessibility and acceptability of condoms in clinical, social and commercial venues to increase condom use. Provision of high quality SRE can result in young people more likely to delay having sex until they are older, use contraception and have fewer sexual partners. Improving service provision in terms of acceptability, accessibility and quality improvement and increasing the extent of community outreach for those at greatest risk are effective in changing behaviour, improving outcomes and encouraging appropriate attendance at mainstream services. In addition social marketing methods can influence behaviour change.

1.1.4. Based on these findings the following recommendations have been made:

- Ensure sexual health provision is in accordance with need across the county. In particular ensure that all sexual health services understand and are able to meet and target the sexual health needs and accessibility needs of all young people, MSM, BME population, deprived population, LAC & care leavers and the needs of older people, in light of the ageing population.

- Review the local arrangements to increase the coverage of chlamydia testing amongst 15-24 year olds. This should be through increased testing in primary care, pharmacies and colleges, and through targeted outreach. Maximise screening through contacts at sexual and other health services. Ensure that the risks of chlamydia and the internet testing service are better promoted and more accessible to young people through social marketing techniques. Develop young sexual health champions.

- Tackle the teenage conception rates, particularly in Redditch and Worcester. Influence and support the provision of high quality SRE in all schools. Increase knowledge and awareness of

safe sex and contraception options, including promoting LARC and emergency contraception to young people through social marketing and young sexual health champions. Enhance the condom distribution scheme. Target interventions to young at risk teenagers (deprivation, school absenteeism, lack of academic development, not in education, employment or training (NEET). Provide comprehensive outreach to looked-after young people and care leavers. Ensure sexual health is included in annual LAC health review.

- Identify and review local pathways for termination services to increase proportion of terminations under 10 weeks.

- Review and expand levels of HIV testing in GUM and in community and outreach settings. Ensure accessibility of HIV services for risk groups (MSM). Consider the routine offer of an HIV test for new general practice registrants in practices within a high prevalence areas (>=2/1,000).

- To tackle unintended pregnancies use social marketing to promote safer sex and use of LARC as the most effective method. Ensure equitable access and availability of emergency hormonal contraception (EHC) and LARC. Develop pathways for subsequent regular contraception following EHC and chlamydia testing. Targeted interventions for those with a history of unintended pregnancy and repeated use of emergency contraception.

- Address variation in choice, access and uptake of all contraception and LARC particularly in primary care, ensuring all women have access to contraception services and LARC.

- Redesign the model of sexual health towards a joined up approach, ensuring a greater proportion of activity is based on primary prevention. Redesign ensuring activities predominantly focus on the promotion of good sexual health behaviour through the use of safer sex, and the appropriate planned use of long acting reversible contraception to reduce the need for treatment.

- Sexual health services to be fully integrated as a hub and spoke model, ensuring adequate spokes within the community to meet health & access need. Enhance outreach activities to target all high risk and vulnerable groups. Review and improve pathways across the system to ensure sexual health becomes everybody's business. The sexual health system to focus on sexual behaviour change within service provision, sexual health promotion activities and training and upskilling of front line staff. Introduce new technologies to improve information, advice, support, self-help, self-testing and point of care testing.

2. Statement of the Problem

2.1. Scope

2.1.1. The aim of this needs assessment is to offer a strategic review of the sexual health needs of the Worcestershire population together with a review of current provision and best practice. The intention is to provide recommendations to improve sexual health and wellbeing and to reduce inequalities in sexual health outcomes. The needs assessment will inform future commissioning and delivery of sexual health services.

2.2. Objectives

2.2.1. The key objectives of this sexual health needs assessment are to:

- Provide an overview of the current picture of sexual health and sexual health outcomes for the population of Worcestershire;

- Identify the likely need for sexual health support & provision including views of the population and stakeholders
- Outline the current provision of sexual health services in Worcestershire and consider in light of evidence and best practice
- Identify gaps in support and delivery and provide recommendations for addressing any unmet need.

2.3. Background.

2.3.1. While sexual relationships are essentially private matters, good sexual health is important to individuals and to society. It is therefore important to have the right support and services to promote good sexual health. Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (including HIV) and abortion to prevent and reduce STIs and unintended pregnancies. Sexual health outcomes can be improved by;

- accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health;
- preventative interventions that build personal resilience and self-esteem and promote healthy choices;
- rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times;
- early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk; and
- joined-up provision that enables seamless patient journeys across a range of sexual health and other services.

3. Needs Assessment Process

3.1. Public, service user, patient and carer involvement

3.1.1. The process of completing this needs assessment has involved engagement with service users, parents and carers, and the general public. Engagement has been achieved through the use of digital and paper-based questionnaires, focus groups, and workshops to ascertain views on the key concerns for local people, and also the delivery of services currently available throughout the county.

3.2. Clinical/professional engagement

3.2.1. Stakeholders were given the opportunity to put forward their views and concerns relating to the current delivery of services via the online questionnaire, and through a workshop event held in June 2015. The workshop included representation from the incumbent provider, CCGs, Community Pharmacies, primary care, and the private and voluntary sectors.

4. Population Trends and Needs

4.1. Population trends

4.1.1. Sexual health crosses the life course. For convention, the reproductive age group 15-44 years is used in this needs assessment to determine and compare rates and services, however for sexual health, the needs of all age groups should be considered to ensure age-appropriate information, support and services are available. Table 1 provides population projections over the next 10-15 years for Worcestershire by age band. The current 15-44 population of Worcestershire is estimated to total 198,000 (99,100 males and 98,900 females). Over the next 10-15 years the population aged 15-

44 is projected to decrease by 5%. However, the population over 45 year is projected to increase by 13%.

Table 1: Population projections for Worcestershire 2014-2029

					change	change	change
Age band	**2014**	**2019**	**2024**	**2029**	**2014-19(%)**	**2014-24(%)**	**2014-29(%)**
15-19	32400	29400	31500	32500	-9%	-3%	0%
20-24	32000	28600	26200	28400	-11%	-18%	-11%
25-29	31400	34200	31400	29200	9%	0%	-7%
30-34	31700	32200	34700	32300	2%	9%	2%
35-39	31400	33100	33700	36100	5%	7%	15%
40-44	39000	32200	34000	34800	-17%	-13%	-11%
aged 15-44	**98800**	**93900**	**94300**	**94200**	**-5%**	**-5%**	**-5%**
45-49	43300	39400	32700	34800	-9%	-24%	-20%
50-54	41300	43300	39500	33100	5%	-4%	-20%
55-59	36800	41200	43200	39500	12%	17%	7%
60-64	37000	36300	40800	43000	-2%	10%	16%
65-69	38800	35900	35600	40200	-7%	-8%	4%
70-74	28600	36700	34200	34100	28%	20%	19%
75-79	22300	25900	33600	31500	16%	51%	41%
80-84	16300	18800	22200	29100	15%	36%	79%
85-89	10200	12000	14400	17400	18%	41%	71%
90+	6200	7700	9900	13100	24%	60%	111%
aged 45+	**280700**	**297100**	**306200**	**315800**	**6%**	**9%**	**13%**
All ages	**572400**	**583300**	**594800**	**604800**	**2%**	**4%**	**6%**

4.1.2. Young adults have a greater need for sexual health services and have the highest access rates, particularly the 20-29 age groups. However, the numbers of young adults is predicted to reduce considerably over the next 10 to 15 years. In addition the numbers of middle-aged adults age 40-54 is projected to decrease by up to 20% and the over 55s to increase. Sexual health services will need to ensure they are able to understand and meet the particular sexual health needs of an ageing population.

4.2. Sexual Health needs across the life course

4.2.1. Sexual health need for information, services and interventions, changes as people move through their lives. For under 16s there is a need to build knowledge and resilience amongst young people through good quality SRE at home, at school and in the community. Most people become sexually active and start forming relationships between the ages of 16 and 24. Young people have significantly higher rates of poor sexual health, including STIs and abortions, than older people, so there is a need to focus on prevention and ensure rapid and easy access to appropriate sexual and reproductive health services. Adults age 25-49 may be forming long-term relationships and planning families so there is a need for individuals to understand the range of choices of contraception and where to access them and to have information and support to access testing and earlier diagnosis to prevent the transmission of HIV and STIs. As people get older, their need for sexual health services and interventions may reduce. However, older people's needs should not be overlooked, although STI rates for over 50s are low, they have risen in recent years. Older age groups are more likely to be living with long-term health conditions that may cause sexual health problems.

4.3. High Risk Groups

4.3.1. Sexual health provision covers all ages, however there are a number of population groups whose circumstances or behaviours puts them at a greater risk of poorer sexual health than others. This can lead to a higher risk of unintended pregnancies, engagement in risky behaviours such as unprotected sex, having multiple partners, or injecting drugs, which increases the risk of a sexually transmitted infection. These groups are also at greater risk of coercion and sexual exploitation. They include:

- Young People;
- People living in deprived areas;
- BME groups;
- Young people living in or leaving care;
- Lesbian, gay, bisexual and transgender people (LGBT);
- Substance misuse and alcohol
- People with learning difficulties;
- Homeless people;
- Sex workers, and;
- The prison population.

4.4. Sexual health needs and key prevention activities

4.4.1. STIs: Young adults and gay and bisexual men are at greatest risk of getting an STI. STI rates are greater in areas of deprivation. Reducing the burden of HIV and STIs requires a sustained public health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour. To prevent STIs, effort should be made to eliminate local barriers to testing, made available free and confidentially at easily accessible services. Alongside an effective clinical response, promoting safer sexual behaviour among individuals, including condom use and regular testing, is crucial. Prevention messages should be promoted to all sexually active men and women, highlighting that individuals can significantly reduce their risk of catching or passing on HIV or an STI by:

- Always using a condom correctly and consistently when having sex with casual or new partners, until all partners have had a sexual health screen.
- Reducing their number of sexual partners and avoiding overlapping sexual relationships.

4.4.2. To control chlamydia amongst sexually active young adults it is recommended that sexually active under 25 year olds should be screened for chlamydia every year, and on change of sexual partner. Local areas should seek to achieve an annual chlamydia diagnosis rate of at least 2,300 per 100,000 15-24 year old resident population. To reduce gonorrhoea transmission, and to ensure treatment resistant strains of gonorrhoea do not persist and spread prompt diagnosis, prescribing guideline adherence, identifying and managing potential treatment failures effectively, and reducing transmission is required.

4.4.3. HIV: HIV is a serious communicable disease for which there is no cure or vaccine. However most people living with HIV can now expect a near-normal life expectancy if diagnosed early and they take their treatment correctly. It is estimated that up to a quarter of those with HIV are unaware of their infection. The most deprived areas have the highest prevalence of HIV. Gay and bisexual men are most at risk. Regular HIV testing and early diagnosis is key parts of HIV prevention. In areas with a diagnosed HIV prevalence greater than 2 per 1,000, implementation of routine HIV testing for all general medical admissions and for all new registrants in primary care is recommended. It is recommended that MSM having unprotected sex with casual or new partners should have a HIV/STI screen at least annually, and every three months if changing partners regularly. MSM should also

avoid having unprotected sex with partners believed to be of the same HIV status (serosorting), as there is a high risk of STI and hepatitis infection and, for the HIV negative, a high risk of HIV infection as 18% of MSM are unaware of their HIV infection. Black African and Caribbean men and women should have a HIV test, and a regular HIV and STI screen if having unprotected sex with new or casual partners.

4.4.4. Contraception and Unintended Pregnancy: It is estimated around 50% of pregnancies are unplanned. Condoms and the pill remain the most popular methods of contraception although there have been recent increases of use of Long Acting Reversible Contraception (LARC). Although access to abortion has increased there are still high levels of repeat abortions. All women of reproductive age are at risk but younger women are at greater risk. Increasing access, choice and knowledge of all methods of contraception, including LARC methods and emergency hormonal contraception, for women of all ages and their partners can reduce unwanted pregnancies. LARC methods are more effective at preventing pregnancy than other hormonal methods and condoms.

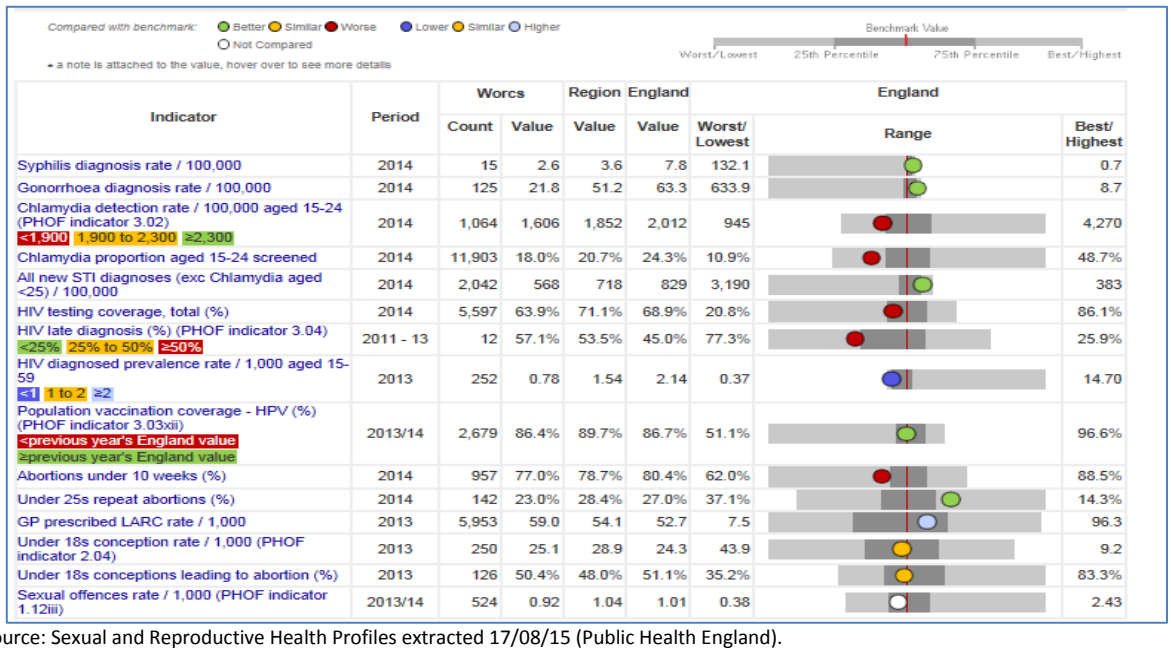
4.4.5. Preventing Teenage Conceptions: Teenage pregnancy is associated with poverty, low aspirations and not being in education, employment or training. There is evidence of an association between alcohol use and teenage conception, regretted sex or forced sex. Evidence suggests that, for effective prevention work, young people need a comprehensive programme of sex and relationships education, and access to young people-centred contraceptive and sexual health services

5. Sexual Health Outcomes Assessment

5.1. Outcomes

5.1.1. The most recent Sexual Health and Reproductive Profile for Worcestershire provides a snapshot of sexual health outcomes. The 'spine chart' summary below shows various sexual health indicators for Worcestershire compared to the England average identifying whether significantly worse, better or no different using a RAG rating.

Chart 1: Public Health Outcomes Framework – Key indicators for sexual health.



Indicator	Period	Worcs		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnosis rate / 100,000	2014	15	2.6	3.6	7.8	132.1		0.7
Gonorrhoea diagnosis rate / 100,000	2014	125	21.8	51.2	63.3	633.9		8.7
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300	2014	1,064	1,606	1,852	2,012	945		4,270
Chlamydia proportion aged 15-24 screened	2014	11,903	18.0%	20.7%	24.3%	10.9%		48.7%
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	2014	2,042	568	718	829	3,190		383
HIV testing coverage, total (%)	2014	5,597	63.9%	71.1%	68.9%	20.8%		86.1%
HIV late diagnosis (%) (PHOF indicator 3.04) <25% 25% to 50% ≥50%	2011 - 13	12	57.1%	53.5%	45.0%	77.3%		25.9%
HIV diagnosed prevalence rate / 1,000 aged 15-59 <1 1 to 2 ≥2	2013	252	0.78	1.54	2.14	0.37		14.70
Population vaccination coverage - HPV (%) (PHOF indicator 3.03xii) <previous year's England value ≥previous year's England value	2013/14	2,679	86.4%	89.7%	86.7%	51.1%		96.6%
Abortions under 10 weeks (%)	2014	957	77.0%	78.7%	80.4%	62.0%		88.5%
Under 25s repeat abortions (%)	2014	142	23.0%	28.4%	27.0%	37.1%		14.3%
GP prescribed LARC rate / 1,000	2013	5,953	59.0	54.1	52.7	7.5		96.3
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	2013	250	25.1	28.9	24.3	43.9		9.2
Under 18s conceptions leading to abortion (%)	2013	126	50.4%	48.0%	51.1%	35.2%		83.3%
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2013/14	524	0.92	1.04	1.01	0.38		2.43

Source: Sexual and Reproductive Health Profiles extracted 17/08/15 (Public Health England).

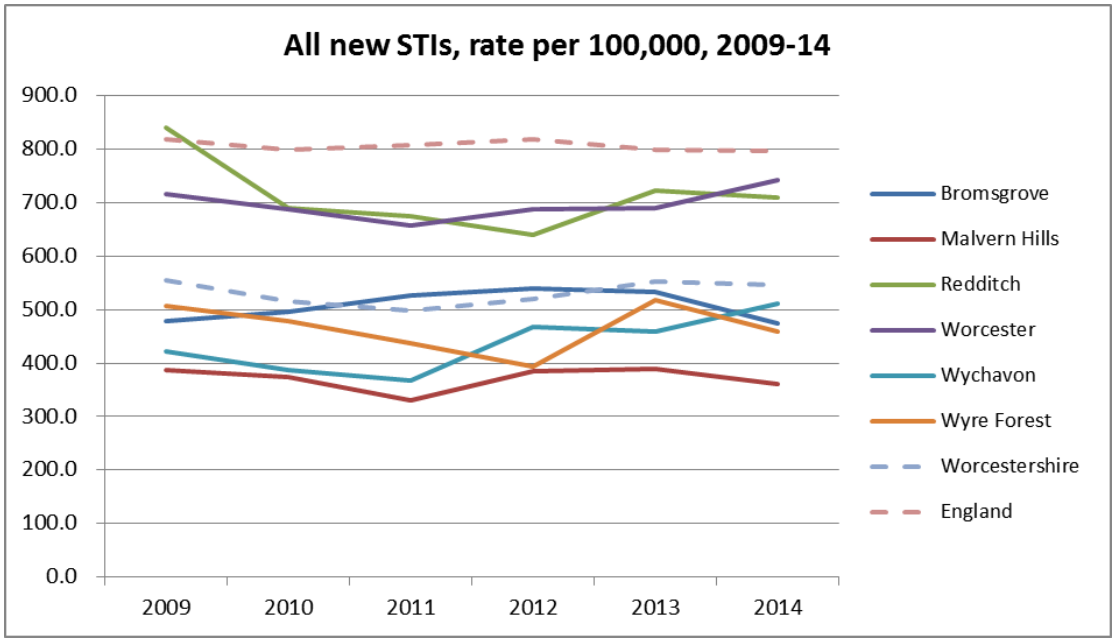
5.1.2. The "red", significantly worse outcomes are

- Chlamydia (screening and detection rates for 15-24 year olds)
- HIV (testing coverage, testing of MSM and late diagnosis)
- Early abortions under 10 weeks.
- The teenage conception rate (red for Worcester and Redditch)

5.2. Sexually Transmitted Infections

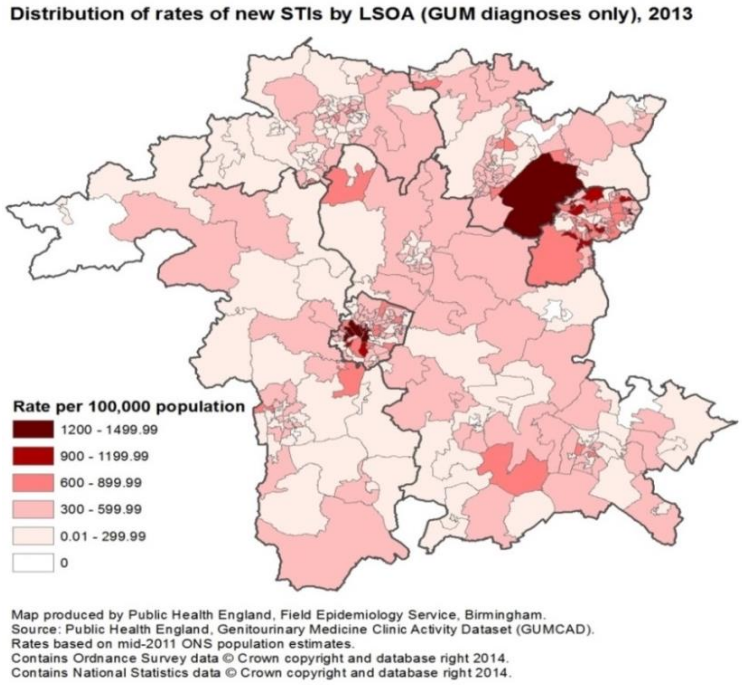
5.2.1. There are on average 2200 new STI diagnoses per year in Worcestershire. Of those 58% are for males, 42% females. In 2013, 7% of all new STIs in Worcestershire were for MSM, compared to 8.5% nationally. The rate of new STIs is much lower than national average in Worcestershire. However the graph below suggests appear to have increased over the last two years whereas nationally they have decreased. The STI rate is higher for Worcester and Redditch Districts than the rest of the county.

Chart 2: All new STIs, 2009-14.



5.2.2. Nationally, STI rates are higher amongst young heterosexuals, gay and bisexual men, people in areas of high deprivation and some black and minority ethnic (BME) populations. In Worcestershire new STI rates are highest for females aged 15-24 years and males aged 20-34 years. The STI rates are higher in areas of greater deprivation (as shown by the map below). The % of new diagnoses that were for MSM was 7%. The % of new STIs in 2013 for BME population was 6.7% compared to 4.3% of BME in the population.

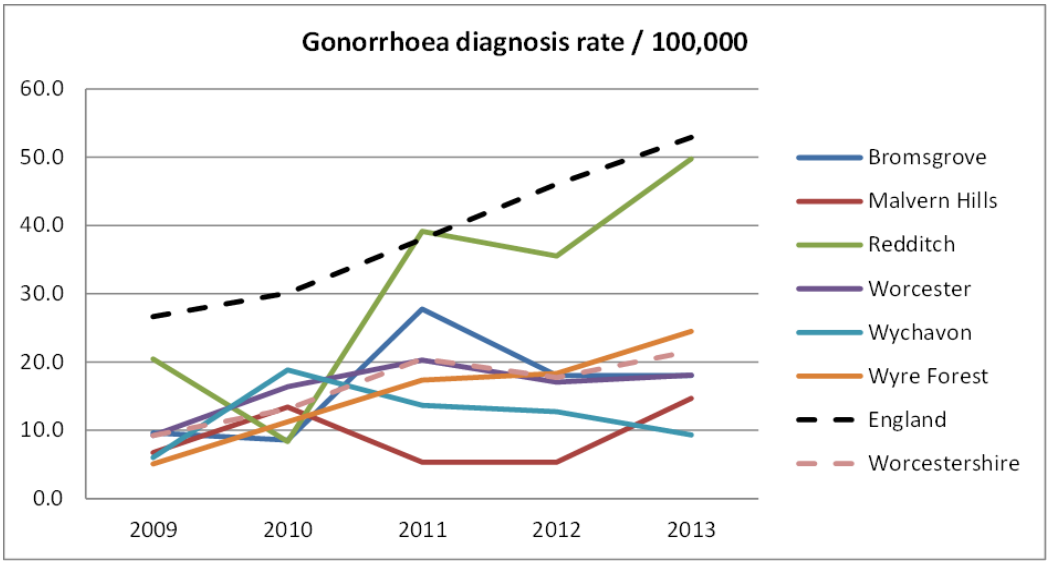
Map 1: Distribution of rates of new STIs.



5.2.3. High rates of gonorrhoea and syphilis in a population generally reflects high levels of risky sexual behaviour. Worcestershire has significantly low rates of both syphilis and gonorrhoea. The numbers of new diagnosed syphilis are small each year making statistical comparisons unreliable. However, the Worcestershire rate is significantly lower than the national rate (2.3 per 100,000 in Worcestershire, 5.2 per 100,000 for England), although Worcestershire has a higher rate than its statistical neighbours.

5.2.4 The gonorrhoea diagnosis rate for Worcestershire is well below the national average, it has increased in recent years but at a slower rate than nationally. The number of cases detected in Redditch has increased in recent years (42 gonorrhoea cases in 2013). It now has a diagnosis rate which is similar to England but significantly above all the other districts.

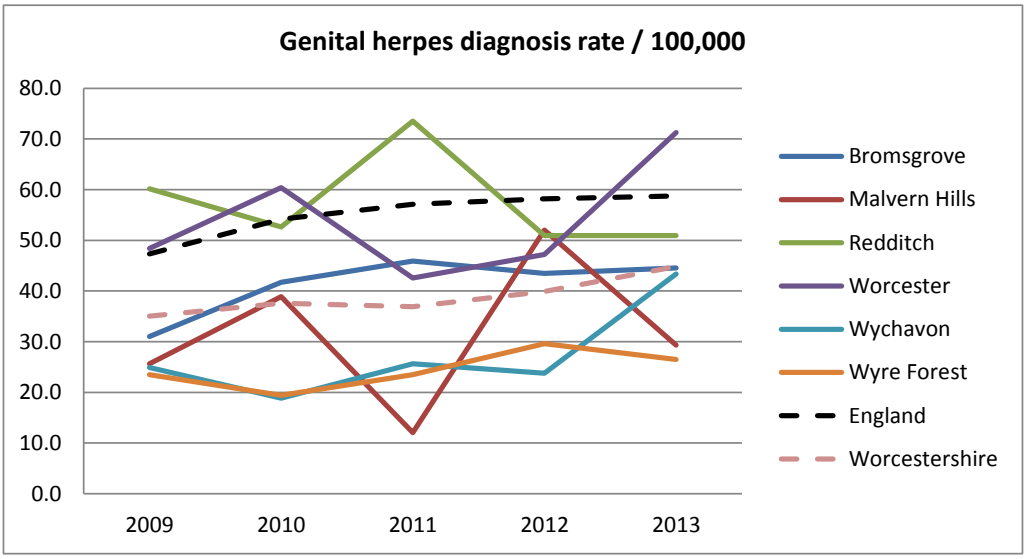
Chart 3: Gonorrhoea diagnosis rate per 100,000 population.



Source: Sexual and Reproductive Health Profiles 2015, Public Health England

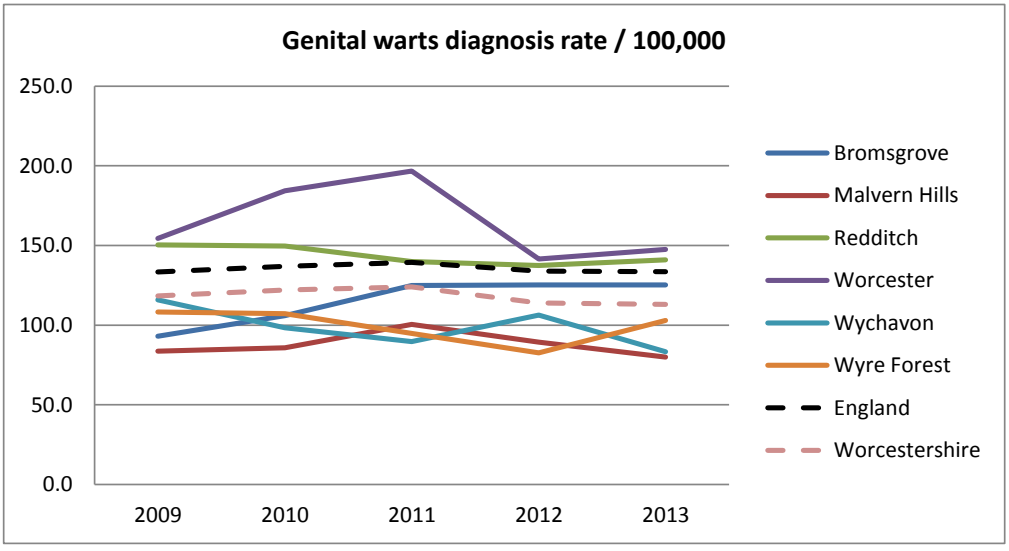
5.2.5 Genital herpes due to the herpes simplex virus is the most common ulcerative diagnosed STI. Recurrent infections are common with patients returning for treatment. The diagnosis rate in 2009-13 was significantly lower in Worcestershire (44.8 per 100,000) than in England (58.8). However rates are continuing to increase as they are nationally. Herpes diagnosis rates are highest in Worcester and Redditch and similar to the national level.

Chart 4: Genital herpes diagnosis rate.



5.2.6. Genital warts are the second most commonly diagnosed STI in the UK and are caused by infection with specific subtypes of human papillomavirus (HPV). Recurrent infections are common with patients returning for treatment. The genital wart diagnosis rate in Worcestershire is lower than the national average and appears to be stable; however the rate in Worcester and Redditch districts is higher.

Chart 5: Genital warts diagnosis rate.

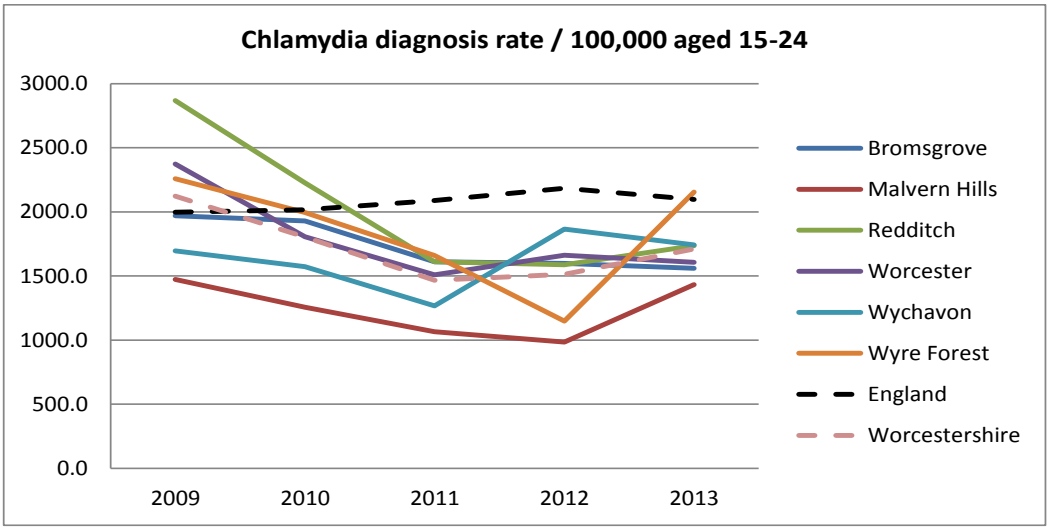


5.2.7. Rates of chlamydia are substantially higher in young adults than in any other age group. Launched in 2003, the National Chlamydia Screening Programme (NCSP) aims to test all sexually active people under the age of 25 annually or with each change of sexual partner as a routine part of primary care and sexual health consultations. The Public Health Outcomes Framework includes an indicator to assess progress in controlling chlamydia in sexually active young adults. This

recommends local areas achieve an annual chlamydia diagnosis rate of at least 2,300 per 100,000 15-24 year old resident population. The chlamydia diagnosis rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care, sexual and reproductive health and genitourinary medicine services.

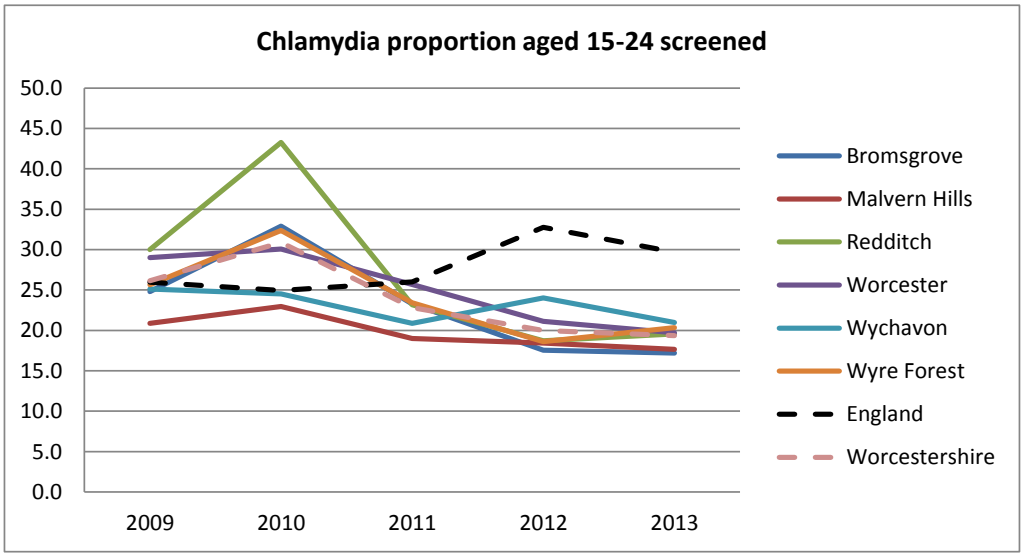
5.2.8. The chlamydia detection rate in Worcestershire is significantly lower than the national rate (1606 per 100,000 15-24 year olds in Worcestershire 2014, England 2012). The rate has reduced significantly since 2010 whereas the national rate has increased during the same period.

Chart 6: Chlamydia diagnosis rate (aged 15 – 24).



5.2.9. To achieve the recommended detection rate it is anticipated that 25% of young people likely to be most at risk would need to be tested assuming a positivity rate of 8-10%. However, the proportion of young people screened for Chlamydia has fallen in Worcestershire since 2011 down to 18% by 2014, whereas nationally there has been an increase during the same period.

Chart 7: Proportion chlamydia screened (aged 15-24).

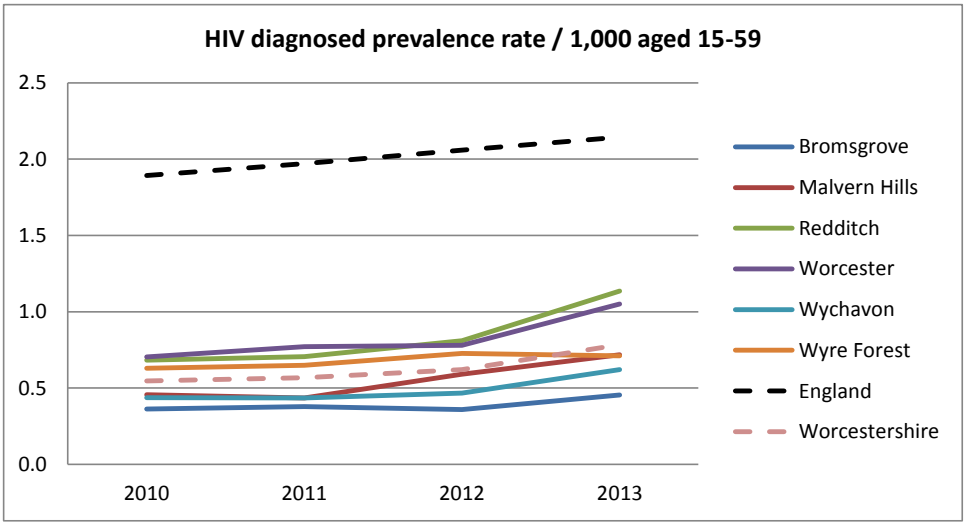


5.3 HIV

5.3.1 The HIV diagnosed prevalence (i.e. numbers living with HIV) in Worcestershire is low: in 2013 the rate per 1,000 people aged 15-59 was 0.78 (252 people) compared with 2.14 for England. Prevalence in Worcestershire has increased since 2010 when the rate was 0.55 which mirrors the

national trend over the period. Prevalence rates are highest in Redditch & Worcester. Over 50% of diagnosed HIV are MSM.

Chart 8: HIV diagnosed prevalence rate.



5.3.2. HIV late diagnosis in 2011-13 for Worcestershire (57.1%) was significantly higher than England (45%). However an analysis of statistical neighbours identified Worcestershire ranks in the middle (6th of 11). These neighbours mostly have low prevalence rates and there is some evidence nationally that areas with low prevalence appear to have higher rates of late diagnosis.

5.3.3. HIV testing coverage is significantly worse than the national average (In 2014 Worcestershire (84.8%) England (94,5%). Coverage refers to the number of 'Eligible new GUM Episodes' where a HIV test was accepted as a proportion of those where a HIV test was offered. In addition, HIV testing coverage in MSM (men who have sex with men) was lower (92.3%) than the England average (94.8%).

5.4. Contraception & Unintended Pregnancy

5.4.1. It is understood that up to 50% of pregnancies are unplanned. Improving knowledge, access and choice for all women and men to all methods of contraception can reduce unintended pregnancies. LARC methods such as contraceptive injections, implants, intrauterine systems (IUS) or intrauterine devices (IUD) are more effective and cost effective in reducing unintended pregnancies.

5.4.2. Population take up of Long Acting Reversible Contraception (LARC) - LARC services are provided through GP surgeries and Sexual Health Services. The % of LARC prescribed by general practice in Worcestershire is higher than the national average. The % of attendances for LARC in sexual health services is similar to the national average (48%). However, in Redditch there appears to be low uptake of LARC as a percentage of all contraception for both sexual health services and primary care.

Chart 9: Percentage uptake of LARC in Sexual health services. (2013).

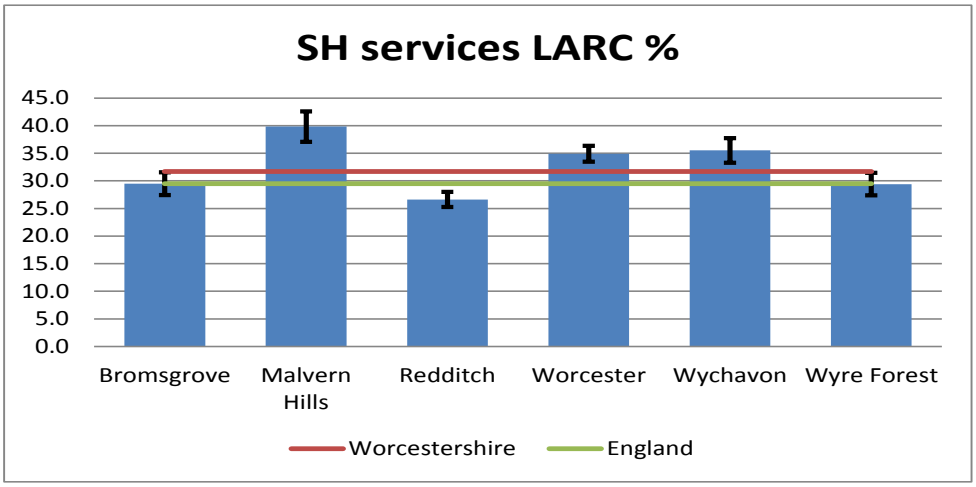
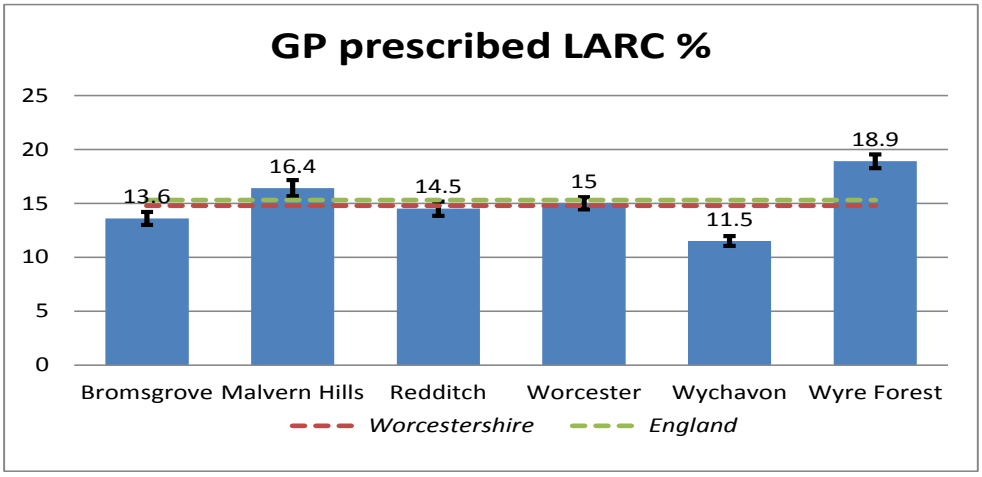


Chart 10: Percentage uptake of LARC in GP practices (2013).



SH graph source: Contraceptive Services, England - Additional Analysis from the Sexual and Reproductive Health Activity Dataset, 2013 – Tables
Note: only data submitted by SRHAD (missing data for both GUM clinics in Q1)
Note: data refers to the percentage of attendances for contraceptive services
GP graph source PHE (LASER contraception appendix)
% of prescriptions issued, not people

5.4.3. High numbers of abortions can reflect poor access to contraception. Worcestershire has a low abortion rate for all ages (12.6/1000 2014) compared to nationally (16.5/1000), and it is also low compared to statistical neighbours (rank 8th out of 10**).** Repeat abortions amongst those under 25 (where previously had an abortion) is an indicator of lack of access to good quality contraception services and advice for younger people as well as problems with individual use of contraceptive method. In Worcestershire, in 2014 23% of abortions for this age group were repeat abortions which are lower than the national figure (27%).

5.4.4 The earlier that abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality. The rate of abortions under 10 weeks in Worcestershire is significantly higher than the national rate. However, Worcestershire was not significantly higher when compared to statistical neighbours.

Table 2: Percentage of Abortions under 10 weeks, Worcestershire.

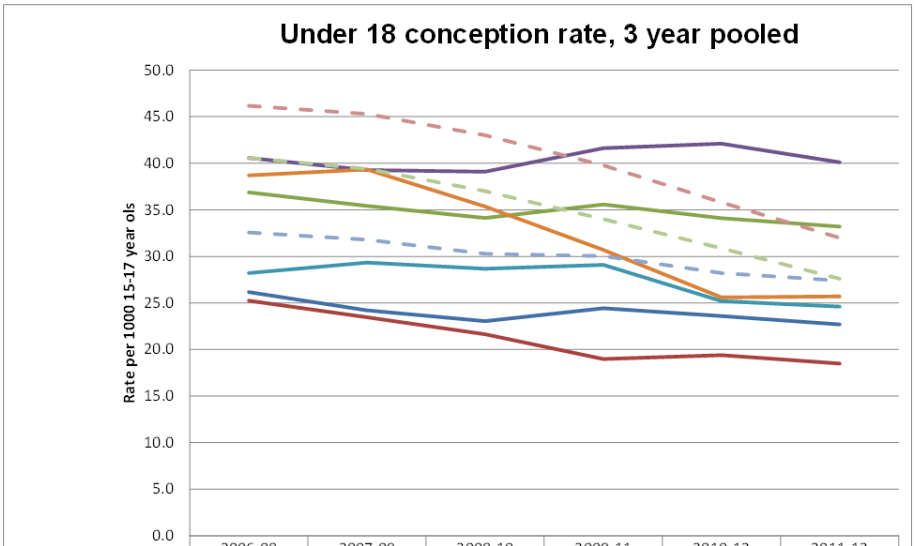
Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012		983	79.7	77.3	81.8	78.0	77.5
2013		901	75.4	72.9	77.8	78.4	79.4
2014		957	77.0	74.6	79.2	78.7	80.4

Source: Department of Health based on data from abortion clinics

5.5 Teenage Conceptions

5.5.1. Most teenage pregnancies are unplanned and around half end in an abortion. Teenage pregnancy is associated with poorer outcomes for both young parents and their children since 1998; teenage conception (TP) rates have been falling locally and nationally. However, the reduction in Worcestershire (22%) has not been as large as nationally (50%).The TP rates in Worcester & Redditch Districts are the highest and do not appear to have reduced over the last decade as elsewhere.

Chart 11: Rates of under 18 teenage conceptions (3-year pooled).



	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13
Bromsgrove	26.2	24.2	23.0	24.4	23.6	22.7
Malvern Hills	25.2	23.5	21.6	19.0	19.4	18.5
Redditch	36.9	35.4	34.1	35.6	34.1	33.2
Worcester	40.6	39.3	39.1	41.6	42.1	40.1
Wychavon	28.2	29.3	28.7	29.1	25.2	24.6
Wyre Forest	38.7	39.3	35.4	30.7	25.6	25.7
Worcestershire	32.6	31.8	30.3	30.0	28.2	27.4
West Midlands	46.2	45.3	43.0	39.8	35.8	32.0
England	40.6	39.4	37.0	34.0	30.9	27.6

5.5.2. There is a strong link between under 18 conceptions and deprivation. There were eleven wards with a significantly high teenage pregnancy rate in 2010-12 (the latest period available), and all the wards are ranked in the most deprived 22 of the 121 wards in Worcestershire based on the Index of Multiple Deprivation 2010.

Table 3: Wards significantly above county rate of U18 conceptions and deprivation.

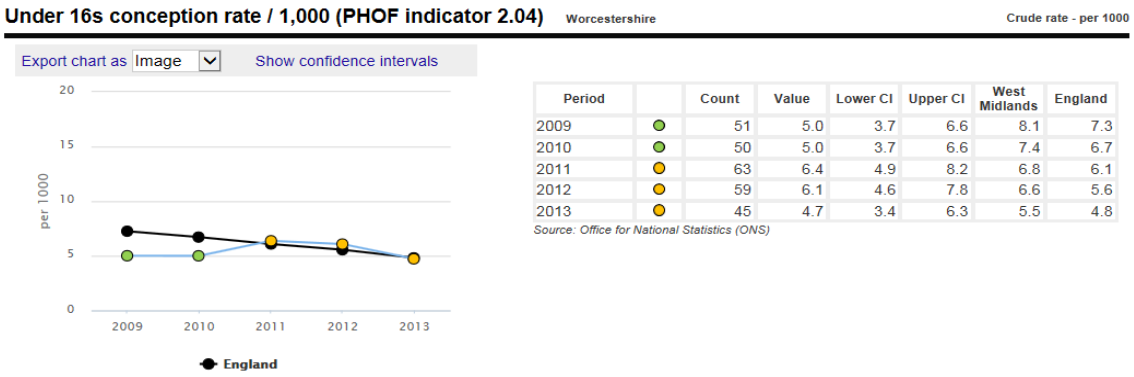
LA Area	Ward	2010 – 2012 Significantly high U18 conceptions?	Worcestershire deprivation rank (of 121,1=most deprived)
Malvern Hills	Pickersleigh	Yes	6

Redditch	Batchley & Brockhill	Yes	5
	Central	Yes	15
	Greenlands	Yes	7
Worcester	Cathedral	Yes	12
	Gorse Hill	Yes	3
	Nunnery	Yes	22
	Rainbow Hill	Yes	4
	Warndon	Yes	1
Wychavon	Droitwich West	Yes	11
Wyre Forest	Areley Kings	Yes	14

Source: ONS, Index of Multiple Deprivation

5.5.3. The Worcestershire Under 16 conception rate recently increased in Worcestershire and is similar to the national rate.

Chart 12: Under 16s conception rate/1000.

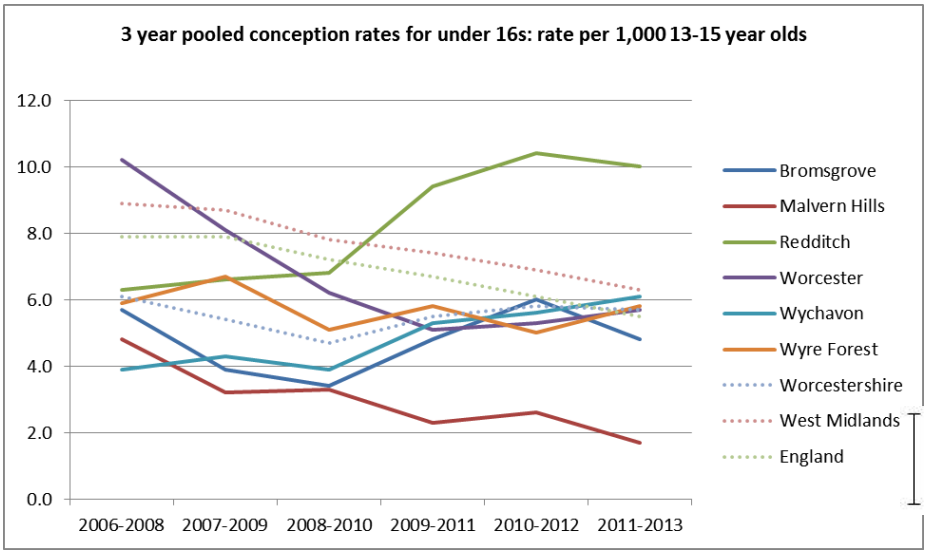


Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2009		51	5.0	3.7	6.6	8.1	7.3
2010		50	5.0	3.7	6.6	7.4	6.7
2011		63	6.4	4.9	8.2	6.8	6.1
2012		59	6.1	4.6	7.8	6.6	5.6
2013		45	4.7	3.4	6.3	5.5	4.8

Source: Office for National Statistics (ONS)

5.5.4 The number of Under 16 conceptions is small and the rate varies by District, however there is a significantly higher rate in Redditch.

Chart 13: Rates of under 16 conceptions (3-year pooled).



Source: ONS

6. Policy and Financial Context

6.1 Statutory duties

6.1.1. As part of the Health and Social Care Act reforms, Worcestershire County Council (WCC) has a mandated responsibility to commission open access sexual health services. In particular, The Local Authorities Regulations 2013 require Council's to arrange for the provision of certain services. These are:

- Open access sexual health services for everyone present in Worcestershire; covering
  - free sexually transmitted infections (STI) testing and treatment, and notification of sexual partners of infected persons; and
  - free contraception and reasonable access to all methods of contraception.

6.2. National Drivers

6.2.1. Since 1st April 2013, the *Health and Social Care Act* (2012) has defined new ways of commissioning sexual health services. Public Health teams within Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England have all become the responsible commissioning organisations for various elements of sexual health. These are as follows:

Table 4: Sexual health commissioning responsibilities.

Local authorities	Comprehensive, open access sexual health services, including: **Contraception** (including implants, intrauterine contraception, emergency contraception), including all prescribing costs – but excluding contraception provided as an additional service under the GP contract; **STI testing and treatment**, including Chlamydia and HIV testing; **Sexual health aspects of psychosexual health services**; and **Sexual health specialist services**, e.g. young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work.
CCGs	**Termination of pregnancy services**; **Sterilisation**, including vasectomy; **Non-sexual health elements of psychosexual health services**; and **Community gynaecology**, including use of contraceptive services for non-contraceptive purposes (e.g. menorrhagia; part of hormone replacement therapy).
NHS England	**Standard contraception provided under the GP contract**; **HIV treatment and care**, including post-exposure prophylaxis (PEPSE); **Promotion of opportunistic testing and treatment for STIs** (including patient-requested testing by GPs); **Sexual health elements of prison health services**; **Sexual Assault Referral Centres**; and **Cervical Screening**

6.2.3 The *Public Health Outcomes Framework* provides indicators against which local areas can be benchmarked on progress in improving, protecting and promoting population health. Indicators in the framework include Under 18 conceptions, chlamydia diagnoses in young people, and the proportion of people presenting with HIV at a late stage of infection.

6.3. The Financial challenge

6.3.1 Sexual Health services commissioned by WCC are funded by the Public Health Ring-fenced Grant (PHRFG).

6.3.2. Based on spending levels prior to 2013, the Department of Health estimated that approximately 25% of the PHRF transferred to local authorities would be for sexual health services. In Worcestershire, the sexual health budget for 2015/16 currently accounts for 18% of the public health budget. Of the sexual health services currently commissioned, approximately 90% are for mandatory elements of delivery (when all forms of STI testing and contraception are taken into consideration).

6.4. Unit Costs

6.4.1. The average unit price for the delivery of sexual health services varies considerably throughout the country. Table 6 provides the unit cost for the delivery of services in Worcestershire compared to England, and both its geographical and statistical neighbours. The table also shows the cost per diagnosed STI infection.

Table 5: Worcestershire sexual health spend per head of population aged 15 – 44, and cost per STI diagnosis.

Local authority	*14-15 budget	Spend per head of pop. (15-44)	**STI Diagnoses in 2013	Cost per diagnosed STI
Cumbria	£2,882,000	£17.31	2233	£1,290.64
Derbyshire	£7,478,000	£27.30	4865	£1,537.10
East Sussex	£4,608,000	£26.87	3072	£1,500.00
Gloucestershire	£4,206,000	£24.52	3591	£1,171.26
Herefordshire UA	£1,600,000	£25.80	1178	£1,358.23
Worcestershire	**£4,937,400**	**£24.63**	**3139**	**£1,572.92**
Suffolk	£9,858,000	£38.21	4116	£2,395.04
Leicestershire	£5,371,000	£22.05	4001	£1,342.41
North Yorkshire	£5,132,000	£25.71	2543	£2,018.09
Northamptonshire	£5,367,000	£19.94	5145	£1,043.15
Staffordshire	£8,875,000	£28.61	4764	£1,862.93
Warwickshire	£4,486,000	£22.30	3599	£1,246.46
ENGLAND	**£671,343,000**	**£31.31**	**439892**	**£1,526.15**

*Total 14/15 net expenditure for STI testing and treatment, Contraception services, and sexual health advice, prevention and promotion
**STI diagnoses includes chlamydia, gonorrhoea, herpes, syphilis, warts, and HIV

6.4.2. In Worcestershire, the current spend per head of population (aged 15-44) is £24.63, which sits slightly below the average of its geographical and statistical neighbours (£25.28), and significantly below the cost of England as a whole (£31.31). However, in terms of STIs, Worcestershire pays £1572.92, which is more per diagnosis than the average cost of its geographical and statistical neighbours (£1529.58), and the England cost of £1526.15. The higher diagnosis cost is likely due to lower than average infection rates in the county. In addition 34% of attendances in GUM do not result in a positive diagnosis compared to 24% nationally. This suggests that the current level of PbR spend on treatment services could potentially be reduced or reassigned into greater prevention activity.

7. Aspirations of the Population

7.1. Views on current services

7.1.1. To gain a broad understanding of the views on current sexual health services, engagement took place in April and May 2015 to explore a range of issues relating to delivery from the point of view of users of both adult and young people's services. Engagement took the form of online questionnaires, hard copy questionnaires placed in clinics, and focus groups.

7.2. Young people

7.2.1. Unsurprisingly, the responses from young people produced a wide range of specific suggestions from their experiences of using services. Where accessed, services were generally regarded in a positive manner, with the exception of Sex and Relationship Education (SRE) delivered in schools. SRE was frequently seen as poor due to the inconsistency of delivery between schools, the sometimes ad-hoc nature of lessons, and the narrow content of the topics covered**.**

7.2.2. Their views on improving services typically fell into 3 separate themes. Firstly, better access was frequently cited with requests for more locations for services (including those in rural areas), different opening times (including evenings and weekends), and for more outreach work to be undertaken. Secondly, improved promotion of services was called for. It was generally felt that they lacked any real understanding of exactly which services were available, from which locations, and whether they were walk-in , or if appointments or referrals were needed prior to attendance. Finally, there was a general view that young people needed better information to help them gain greater understanding of the different issues relating to sexual health. This included improvements in SRE, targeted information for different groups, and the use of modern information platforms such as apps and social media.

7.2.3. Overall, current services for young people were seen as working well although it was felt that there was room for improvements. These improvements generally focussed on an increase in service provision around location and opening times. Other improvements such as better promotion of services and information, and greater provision and co-ordination of the services available suggest that there is scope for changes in the ways and methods that services are currently being delivered, rather than just an expansion of the services on offer.

7.3. Adults

7.3.1. As with the young people's surveys, engagement took place with adult service users to explore a range of issues relating to the current delivery of services. The results showed that there was sufficient awareness of the wide range of sexual health services that are currently available in Worcestershire, although termination of pregnancy services and the sexual health counselling service were less well known.

7.3.2. Although there was generally positive feedback to the delivery of services in GUM and sexual health clinics, the key areas where it was felt that improvements could be made were as follows:

- Widening opening times would be enormously beneficial e.g. before/after school/work and at the weekends.
- Employing more staff in order to address the question of understaffing, and the perception of long waiting times.
- Focusing upon good sources and systems of advertising to ensure that people are aware that services are in place and accessible.

7.3.3. In summary, along with the views of young people, there is a need to modernise services so that they meet the needs of modern life. Essential elements required within this includes improving

access so that services are available more locally, and at times that are better suited to their needs (i.e. outside of normal working hours). Additionally, it is vital that services are advertised more widely so that people are aware of what is available to them and how they can be easily accessed.

7.4 Stakeholder feedback

7.4.1. On the 24th June 2015 a stakeholder event was held at St George's Community Centre in Worcester to gauge the views and opinions of the service providers that are currently delivering sexual health services in Worcestershire.

7.4.2. With reference to the main GUM and CaSH services, it was felt that the hub and spoke model, which is offering level 1 - 3 services, is a real asset that offers service users from all backgrounds with a choice of when and where to be seen, and also access to the full range of sexual health services. The outreach service, which is delivered as part of the CaSH contract, was also seen as valuable and effective for accessing and offering services to the most vulnerable people in the community.

7.4.3. Other services that were viewed as working well were the Sexual Health Counselling Service, and also Time 4U, which was seen as an important first point of call for young people. LARC was seen as a vital service because it provides easy community based access to contraception for many people, and is pivotal for preventing unplanned pregnancies. Likewise, the ability to order chlamydia testing kits over the internet or pick them up from community based locations was seen as extremely positive.

7.4.4. A key aspect of what was perceived to not work so well was the inappropriate use of services. It was felt that the current system of walk-in at GUM and CaSH made it very easy for people to use the service for issues that were non sexual health related. However, in contrast it was also felt that the service needed to do more targeted work to increase access, but only for those that are the most vulnerable or most at risk; point of care testing outreach was seen as potential way to reach more people from high risk communities.

7.4.5. Poor marketing of services, and the lack of knowledge from both service users and professionals of what services are available and how they can be accessed was a common theme. It was also felt that the Playinitsafe website was old and outdated, not well known, and primarily focussed towards young people.

7.4.6. Finally, sexual health promotion which focuses on prevention and early intervention was seen as vital to improving sexual health outcomes. It was felt that this should take the form of greater targeted outreach work, and that activity should be specifically focused to offer targeted classroom based interventions and 1-2-1 in schools where levels of teenage pregnancy is problematic.

8. Current Service Provision

8.1. Model of delivery

8.1.1. Based on the recommendations of the 2013 Sexual Health Needs Assessment, Sexual Health Services commissioned by WCC are currently set up to provide a range of interventions via clinics and outreach to meet the needs of the local population. These services are delivered in broad accordance with the Level 1, 2 and 3 service model which is well established for sexual health service provision[1]. A full breakdown of Level 1, 2 and 3 services can be found in Appendix A.

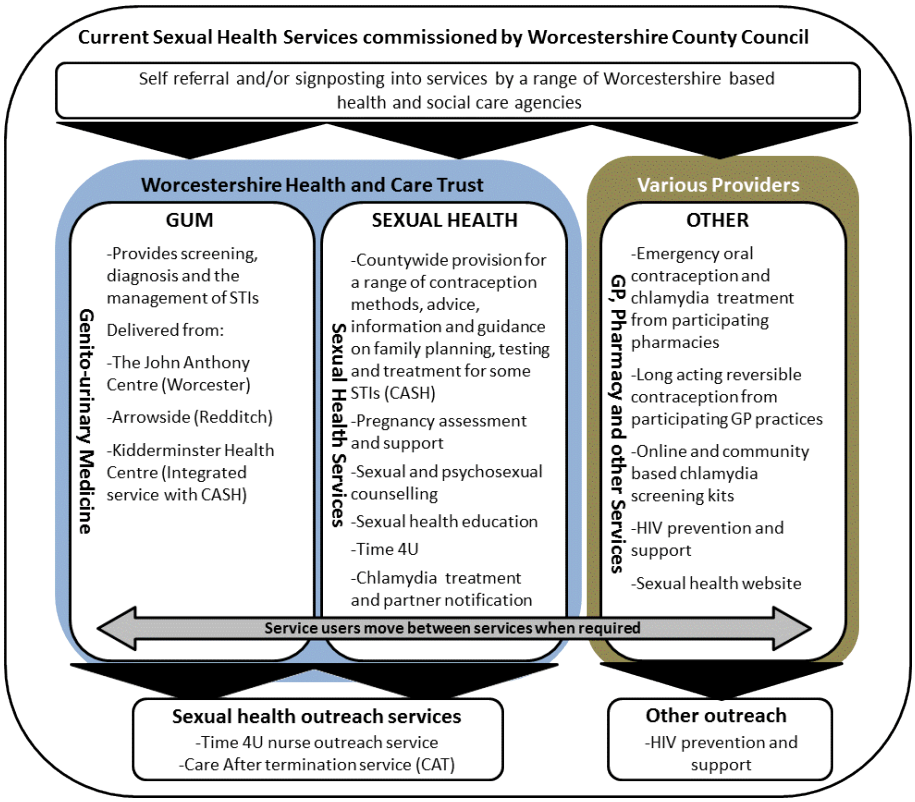
8.2. Description of current service provision in Worcestershire

[1] Department of Health (2001).*The National Strategy for Sexual Health and HIV* (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133)

8.2.1. Worcestershire County Council currently commissions a number of providers to deliver a range of mandatory and discretionary sexual health services throughout the county. The main provider of these services is the Worcestershire Health and Care Trust (WHACT) who provide genito-urinary medicine, and contraception and reproductive services. These services are open access, accessible via walk-in or booking, and there aim is to see all clients within 48 hours of contact. They are available to both young people and adults, and offer the full range of sexual health, HIV, and contraception services. Genitourinary medicine is delivered against the National tariff model, and contraception and reproductive health services are delivered through a single sexual health block contract.

8.2.2. In addition to the services delivered by WHACT, the Council also commissions a number of other providers to deliver a range of sexual health services throughout the county. These services, some of which are mandatory, and some that are discretionary are as follows: Long Acting Reversible Contraception (LARC) available from GP practices, Emergency Hormonal Contraception (EHC) available from community pharmacies, Online and community venue based chlamydia screening kits, HIV prevention and support, and a sexual health information website.

Figure 1: Sexual health services commissioned by Worcestershire County Council.



8.3. Genito-urinary Medicine (GUM) Services

8.3.1. These are delivered through specialised clinics that provide services for the prevention, treatment and control of sexually acquired infections including HIV and other genital conditions. They are consultant led, free, confidential, and accessible providing holistic care. The service is open access, and especially attracts those with specialist sexual health needs such as young people, men who have sex with men, people who have HIV, and sex workers. There are 3 GUM clinics in Worcestershire, which are situated in Worcester city, Redditch and Kidderminster. The service available in Kidderminster is a fully integrated sexual health service.

8.4. Contraception and Reproductive Health (CaSH) Services

8.4.1. Worcestershire's Contraception and Reproductive Health (CASH) clinics are open access clinics offering specialist contraception and sexual health services in a variety of locations across the county. The clinics are open Monday to Saturday and are available to anyone present in Worcestershire, including those resident outside of the county. The clinics are consultant led; offering free and confidential services on a drop-in basis, along with appointments for certain other services. e.g. fitting of contraceptive implants and IUDs/IUCDs. The CaSH service also hosts the C-Card scheme and the Sexual Health Advisor who manages treatment, follow up and partner notification for those tested positive for chlamydia.

8.5. Sexual Health Education

8.5.1. The Sexual Health Education team is part of HACW and provides two strands of work. These are high-quality training, advice and support to staff from a range of disciplines that work with young and vulnerable people, and educational sessions delivered directly to staff around sexual health and relationships. Training and/or education is delivered from a variety of locations across the county, including Schools, Further Education (FE) Colleges, Higher Education (HE) institutions, Local Authority Teams and Voluntary Sector organisations.

8.6. Pregnancy Assessment and Support

8.6.1. The Pregnancy Assessment and Support Service (PASS) is provided from two locations: Moor Street Clinic for South Worcestershire patients and Arrowside Unit for Redditch & Bromsgrove patients. The service can be accessed via a referral from a GP or contraception clinic where patients are allocated a one hour appointment. Patients requesting a termination of pregnancy as an outcome of the PASS appointment are referred on to HACW Early Medical Termination service or MSI Calthorpe Clinic in Birmingham (or other provider if outside scope of services provided by MSI Calthorpe).

8.7. Termination of Pregnancy

8.7.1. As above, if the patient is suitable for early medical termination they are referred to the appropriate provider. This provider is MSI Calthorpe in Birmingham unless they live in south Worcestershire. The South Worcestershire service is a nurse led service at Moor Street Clinic.

8.7.2. If a patient is beyond 9 weeks gestation they are referred to MSI Calthorpe, and if they are beyond 19 weeks gestation they are referred to BPAS in Birmingham.

8.8. Time 4U

8.8.1. Time 4U is a free, confidential and non-judgmental service offering advice and support to young people in a relaxed and friendly environment. The service aims to support young people with relationships, stress, bullying, smoking cessation, healthy lifestyles, drugs, contraception, pregnancy and chlamydia testing. The service is easily accessible and available via drop-in clinics around the county, for example in schools and FE Colleges, or through an outreach service. Time 4U provides Level 1 and Level 2 services. Level 1 includes the provision of condoms, chlamydia, pregnancy testing and emergency contraception and Level 2 is specialist sexual health and long acting contraception (LARC).

8.8.2. School nursing Time 4U. At the universal level, the school nursing service provides weekly Time 4U holistic drop-ins at all High Schools and short stay schools. The Time 4U service offers confidential, young person friendly Level 1 sexual health services and advice. This includes individual appointments, sexual health services (condoms, emergency contraception, Chlamydia testing, pregnancy testing), emotional health and well-being, signposting, referrals to other agencies, and

support and guidance. School nurses also offer confidential age appropriate support and advice to pupils concerned with issues of body change, sexual identity, relationships, sex, pregnancy, and risk taking behaviour. At an enhanced level the school nursing service offers 'early help' (for example through care packages for children with additional health needs which includes sexual health) through providing care and/or by referral or signposting to other services. Early help can prevent problems developing or worsening.

8.9. Time 4U Outreach

8.9.1. Time 4U Outreach (including care after termination project) is a county-wide, confidential and accessible sexual health service for vulnerable young people. Sexual Health Outreach Nurses engage and work with young people who struggle to access mainstream services. They help young people to make informed choices about their sexual health as well as supporting them with contraception methods. Visits are made to any appropriate settings e.g. youth centres, schools, home or an arranged venue. Referrals can be made to the nurses from a variety of different agencies.

8.9.2. The Care After Termination (CAT) project refers all young women aged 19 and under who access the Pregnancy Advice Service to an outreach nurse. These young women are then contacted by phone call as this enables the young person to discuss any on-going concerns following the termination. They establish whether they have a contraceptive method, concordance of this method and when appropriate, the nurse will arrange a follow up appointment.

8.9.3. The sexual health outreach nurses provide the following range of services:

- Contraception
- Implant fitting
- STI screening
- Pregnancy advice
- Advice around termination
- Delaying first sex
- Relationships and self-esteem
- Protective behaviours

8.9.4. Outreach nurses also support older clients including home visits to provide contraception, smear tests and STI screening.

8.10. Sexual Health and Psychosexual Counselling

8.10.1. This service uses trained counsellors to listen to a client's issues, and then support them to help make them feel more in control of their current situation or circumstances. Gender identity, rape/abuse, miscarriage, erectile difficulties, sexual addiction and dyspareunia are some of the issues that the service aims to provide support for. The service provides individual and/or couple sexual health counselling therapy (short-term) or Psychosexual Counselling Therapy (longer term). Referrals can be made via the telephone from sources such as statutory and non-statutory organisations, parents, teachers, social workers, youth workers, GPs, other primary care colleagues and sexual health staff.

8.11. C – Card Scheme

8.11.1. The C-Card Scheme provides countywide condom distribution and is aimed at improving access to free condoms, advice and information to young people aged 19 and under. Training is provided by the Sexual Health Education Unit to new staff in accredited providers, and once completed staff receive free supplies of condoms, posters and leaflets. The C-Card scheme is available from the following:

Youth/Community Settings	School Health providers
Kidderminster College	Stourport Health Centre
HoW College Redditch	Kidderminster Health Centre
HoW College Worcester	Catshill Clinic
Bewdley Youth Centre	Pershore Health Centre
Bromford (Youth Support Workers)	Henwick Halt Medical Centre
The Green Centre, Dines Green, Worcester	Crabbs Cross Clinic
Time 4U Clinics	
Perdiswell Young People's Centre	
Our way Self Advocacy Service, Kidderminster	
St Basils Young Homelessness, Bromsgrove & Kidderminster	

8.12. Sexual Health services provided by other providers.

8.12.1. The main service provision is also supported by a number of contracts that are delivered by partner organisations. These cater for the sexual health needs of both adults and young people, and include:

8.13. Long Acting Reversible Contraception (LARC)

8.13.1. Accredited GP practices currently offer an enhanced service for long acting reversible contraception (LARC). This includes the assessment, fitting and removal of forms of LARC (IUD/IUS and implants). GPs are also contracted via the Standard Medical Service Contract to offer certain sexual health services. These include assessment and referral for STI, oral hormonal contraception, cervical cytology, pregnancy testing, and advice and information about sexual health and STIs. There are currently 57 GP practices providing LARC services across the county.

8.13.2. Under the terms of the General Medical Contract (GMC), all GP practices are also responsible for the opportunistic testing and treatment of STIs, and also where STI testing is requested by the patient. They are also responsible for basic contraception services.

8.14. Emergency Hormonal Contraception (EHC) and Chlamydia treatment

8.14.1. Accredited community pharmacies currently offer emergency hormonal contraception. This service provides consultation and free supply of Levonagestorol under a Patient Group Directive (PGD). The service aims to reduce the number of unwanted pregnancies and terminations for eligible women aged 13 years and over and also provide advice on STIs and contraception, and signposting to other sexual health services. There are currently 79 community pharmacies offering EHC throughout the county.

8.14.2. In addition, community pharmacies also provide treatment for chlamydia. This service enables 15 -24 year olds that have tested positive to receive consultation and treatment by either Azithromycin or Doxycycline, and also receive advice about STIs and signposting to other services. There are currently 50 community pharmacies offering chlamydia treatment in Worcestershire.

8.15. Online and community based chlamydia screening

8.15.1. Chlamydia screening is currently provided by Source Bioscience Ltd. This service offers free access to chlamydia testing kits for 15 – 24 year olds via a website (dontpassiton.co.uk), and from numerous community venues situated throughout the county. Any screens that test positive are referred to the Sexual Health Advisor at HACW for treatment, follow up, and partner notification.

8.16. HIV Support Services

8.16.1. HIV support services are currently provided by the Worcester Foundation. The service focuses on emotional support for those suffering from HIV, advocacy and support for accessing generic services such as housing, employment and benefits, and support for managing chaotic lifestyles.

8.17. Sexual Health Website

8.17.1. www.playinitsafe.co.uk is Worcestershire's sexual health website, which is predominantly aimed at young people. Managed by Diva Creative Ltd, it provides a range of sexual health information and advice (including an interactive question and answer facility), and lists local services and sexual health promotion messages.

8.18. HIV Treatment and Management

8.18.1. The management and treatment of HIV is provided by the Infectious Diseases department at Worcestershire Acute Hospitals Trust. The commissioning responsibility for these services sits with NHS England.

8.19. Termination of pregnancy and vasectomy services.

8.19.1. These services are the responsibility of the CCGs. If the patient is suitable for an early medical termination they are referred to the appropriate provider. This provider is MSI Calthorpe unless the patient lives in South Worcestershire. The South Worcestershire service is a nurse led service at Moor Street clinic in Worcester.

8.19.2. If a patient is beyond 9 weeks gestation, they are referred to Calthorpe clinic in Birmingham, or if they are beyond 19 weeks gestation, they are referred to BPAS in Birmingham.

8.19.3. For vasectomy, there are three strands to the service; counselling, the vasectomy procedure and follow up semen analysis. The service operates at Moor Street Clinic for South Worcestershire patients, and Smallwood House and Arrowside Unit, Alexandra Hospital for Redditch & Bromsgrove patients.

Table 6: Vasectomy provision in Worcestershire.

Area	Procedure	Counselling
Wyre Forest	Calthorpe Clinic	Calthorpe Clinic
South Worcestershire	Moor Street, Worcester	Moor Street, Worcester
Redditch and Bromsgrove	Smallwood House, Redditch	Arrowside, Redditch

9. Assessment of Current Services

9.1. Reinfection of STIs

9.1.1. Reinfection with an STI is a marker of persistent risky behaviour. In Worcestershire, reinfection rates are lower than average, an estimated 5.6% of women and 7.7% of men presenting with a new STI at a GUM clinic during the five year period from 2009 to 2013 became reinfected with a new STI within twelve months. Nationally, during the same period of time, an estimated 6.9% of women and 8.8% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months.

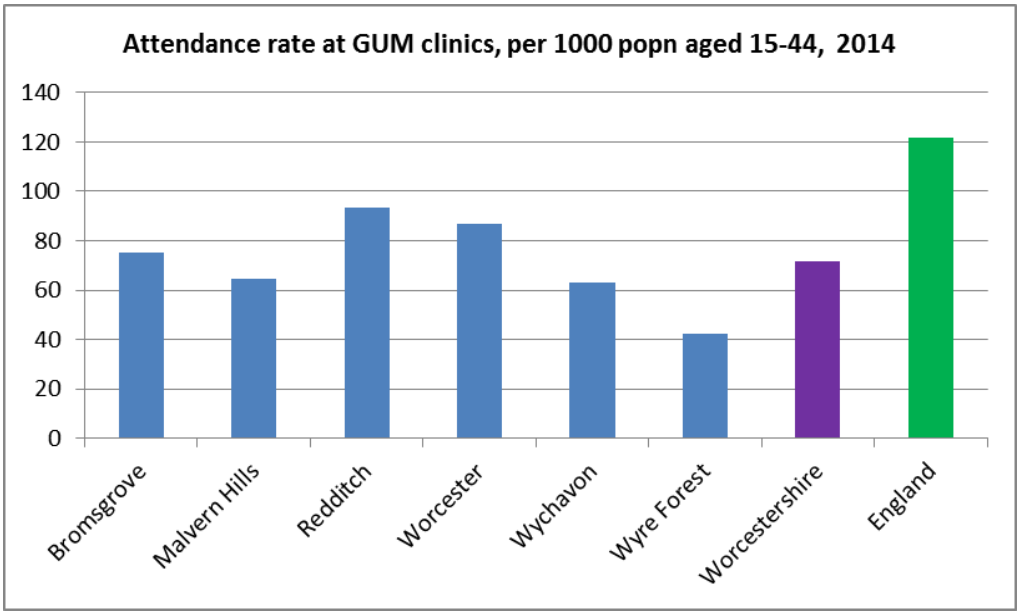
9.1.2. In Worcestershire, reinfection rates are higher amongst young people. An estimated 8.2% of young women and 8.9% of young men aged 15-19 years presenting with a new STI became

reinfected with a new STI within twelve months. However, this is below the national average where 9.9% of young women and 10.1% of young men became reinfected within twelve months.

9.2. GUM Attendance rates

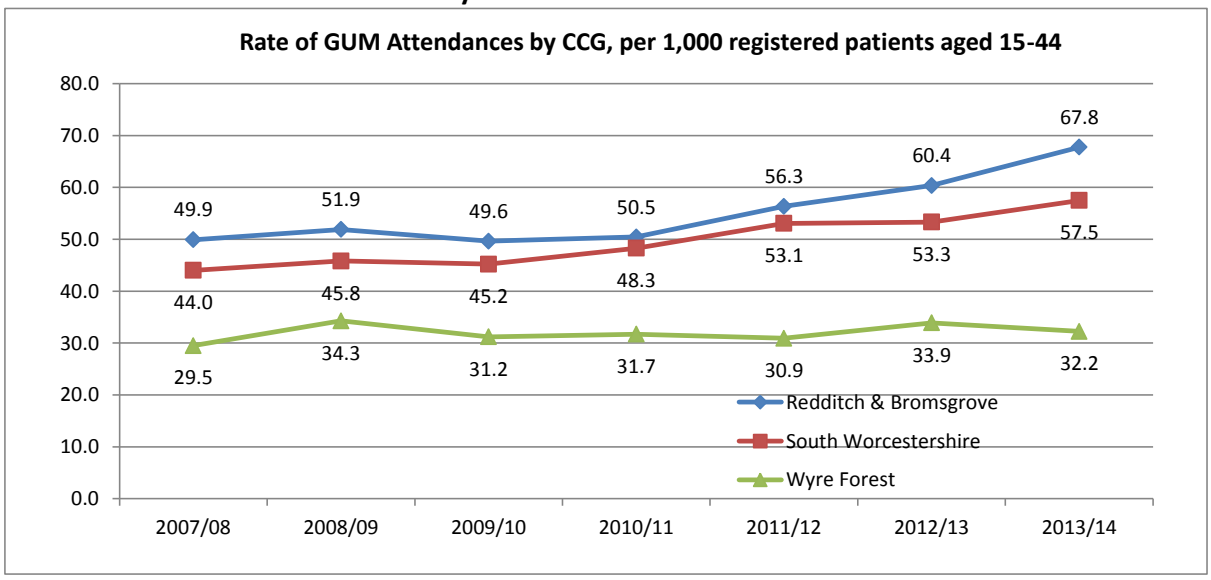
9.2.1. GUM attendance rates at all GUM clinics in England & Wales are highest for Redditch & Worcester districts as would be expected as STI rates are higher. However the local GUM clinics are geographically located in these districts and so easier to access. Wyre Forest district has the lowest GUM attendance rate although it has an STI rate similar to the other Districts.

Chart 14: GUM attendance rates 2014.



9.2.2. The rate of GUM attendances at HACW GUM clinics (JAC & Arrowside) by CCG indicates that attendance rates have been increasing in recent years. There are higher attendance rates from R&B CCG and low rates from WFCCG.

Chart 15: Rate of GUM attendances by CCG.

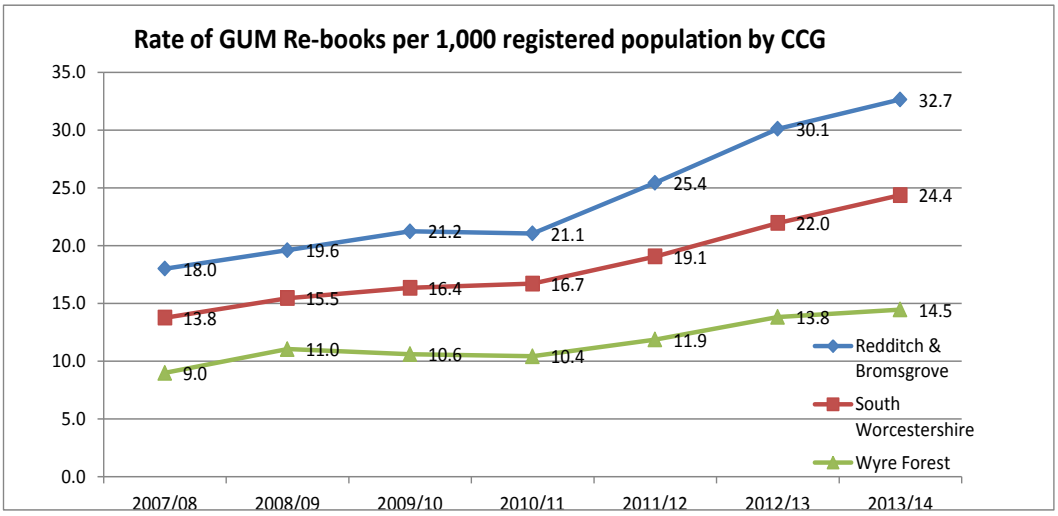


Source: Health & Care Trust

9.2.3. There are a very high number of "rebooks" attending GUM services. A rebook is where a patient is attending again for another new episode of care. The rebook rate has been increasing over

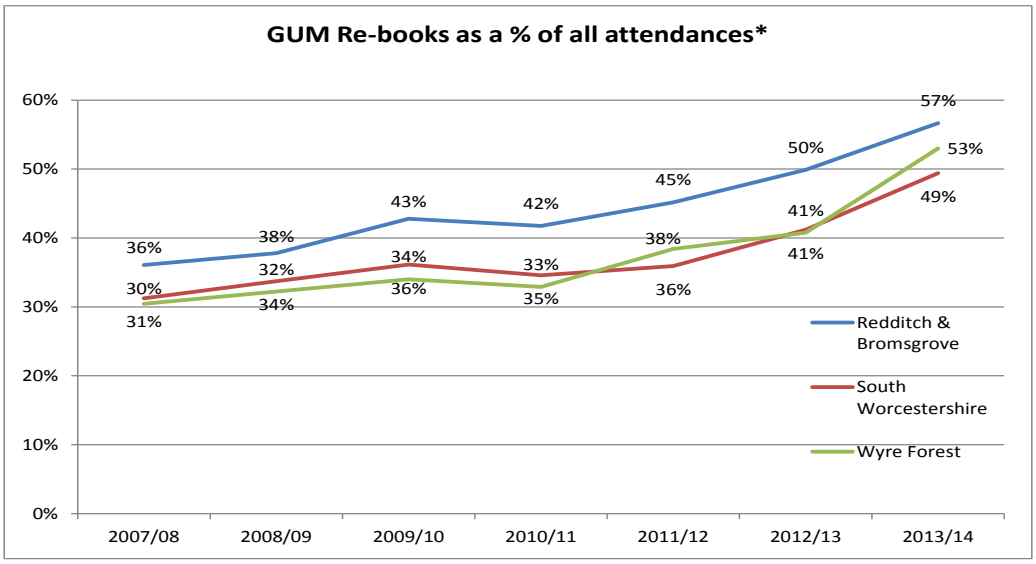
recent years and is highest for R&BCCG. A rebook suggests that patients are returning to the GUM service for a new episode of care following previous treatment and support for a previous episode of care. It should be noted however, that there is concern that rebooks are being miscoded and some might be follow ups for the same episode.

Chart 16: Rate of GUM rebooks by CCG.



9.2.4. The percentage of all GUM attendances that are rebooks have risen to around 50% for all CCGs. This suggests that up to half of those attending GUM attending for a new episode of care have attended for previous episodes of care.

Chart 17: GUM rebooks as a % of all attendances.



9.3. GUM episodes not requiring treatment

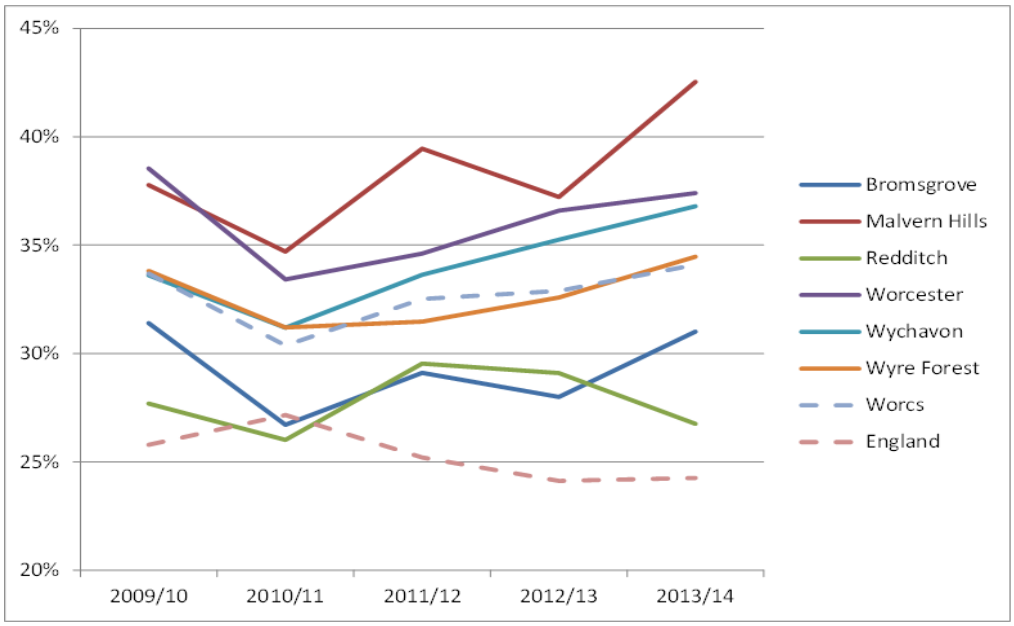
9.3.1. In 2013/14 there were nearly 5000 GUM attendances that did not require treatment – this includes both first and follow up attendances. The % of attendances not requiring treatment in Worcestershire was 34% compared to 24% nationally. Clearly this includes follow ups where treatment might not necessarily be required but it is considerably high. The percentage is higher in the John Anthony Centre (JAC) GUM (40%) than in Arrowside GUM (30%). The percentage of follow ups of all attendances is also lower at JAC (19%) than Arrowside (26%) suggesting that there are potentially a high number of first attendances at the JAC that do not require treatment.

Table 7: GUM episodes not requiring treatment.

	Attendances not requiring treatment as a percentage of total attendances (first + follow-up)			Follow-up as % of all attendances		
	JAC	Arrowside	all England	JAC	Arrowside	all England
2009/10	37%	28%	26%	23%	26%	32%
2010/11	34%	27%	27%	21%	30%	31%
2011/12	36%	31%	25%	22%	29%	28%
2012/13	37%	31%	24%	21%	25%	26%
2013/14	40%	30%	24%	19%	26%	25%

9.3.2. The percentage of attendances not requiring treatment appears to be increasing in Worcestershire. The percentage is higher for those Districts that attend the JAC and lower in Bromsgrove & Redditch who are more likely to attend Arrowside**.**

Chart 18: Percentage GUM attendances not requiring treatment by district.



9.4 Chlamydia Screening

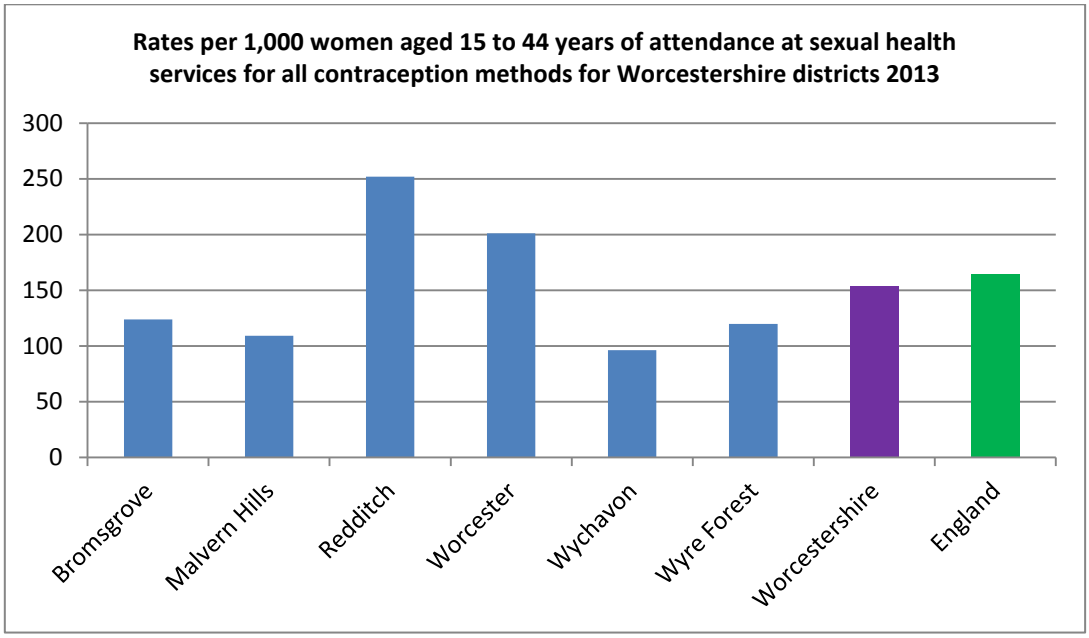
9.4.1 The Chlamydia Screening Programme (CSP) aims to prevent and control chlamydia through early detection and treatment of asymptomatic infection, reduce onward transmission to sexual partners, and prevent the consequences of untreated infection. Sexually active men and women aged between 15 and 24 years who are at risk of genital chlamydia infection, are tested in core services and opportunistic targeted testing in other settings attended by young people. The chlamydia detection rate per 1000 age 15-24 is significantly low in Worcestershire as is the screening coverage rate. The positivity rate (proportion of tests that are positive), however, in Worcestershire (8.8%) is higher than the national average (7.1%). This suggests that those being tested are the most likely to be at risk but that not enough are being tested. The numbers of young people tested has reduced over the last three years. It is important to understand that more testing and a higher detection rate in an area will lead to better control of the infection in the population. A good positivity rate alone will not lead to the recommended detection rate if an insufficient proportion of the population is being tested (PHE, Chlamydia detection rate: considerations for commissioning, 2014).

9.5. Contraception

9.5.1. Contraception is available free of charge from: general practices, SRH services, young person's clinics, NHS 'walk-in centres (emergency contraception only), Sexual Assault Referral Centres (SARCs) (emergency contraception only), some Genitourinary Medicine (GUM) clinics (emergency contraception and male condoms), some pharmacists under a Patient Group Direction (just emergency contraception) and abortion providers, a significant proportion of which is long acting reversible contraceptives (LARCs). Condoms are not prescribable, and are therefore not available from prescription data from general practices (GPs). Condoms can also be purchased from pharmacies, supermarkets, and other retailers. Emergency hormonal contraception can also be bought over the counter at some pharmacies and private clinics. It is therefore difficult to identify contraceptive uptake at a population level. Data on contraception are only collected from attendances at SRH services and young person's clinics and from NHS prescription forms within primary care. Data from other providers are not available.

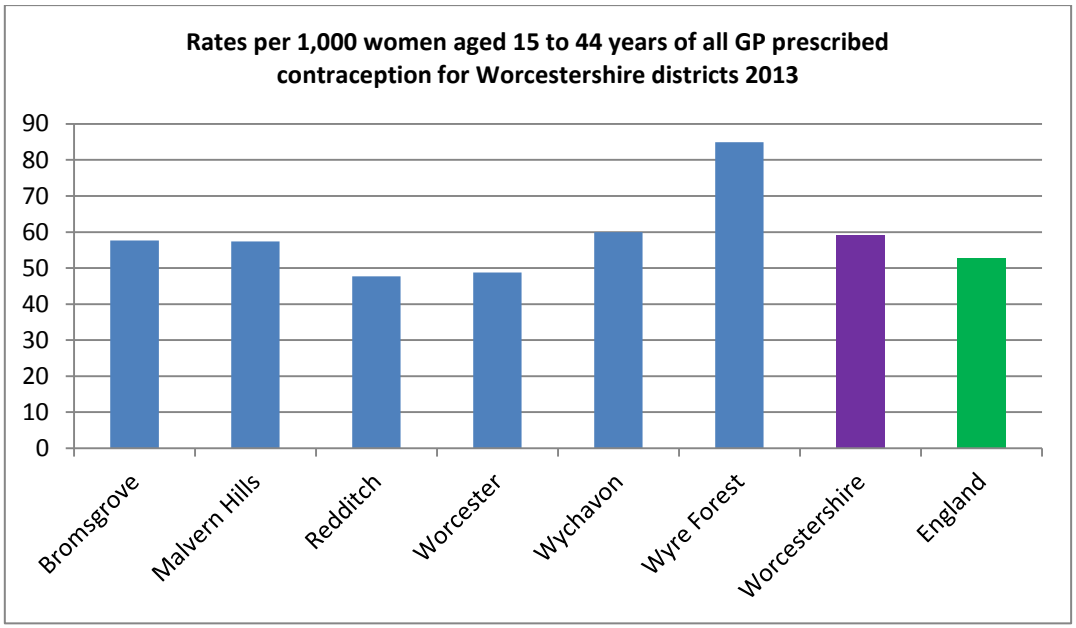
9.5.2. In 2013, the attendance rate at community sexual health clinics for all contraception methods in Worcestershire (154.12) was significantly lower than the rate for England (164.80). The rate for Redditch (252.13) and Worcester Districts (201.30) were significantly higher than the national rate and Bromsgrove, Malvern, Wychavon and Wyre Forest significantly lower.

Chart 19: Service attendance for all methods of contraception.



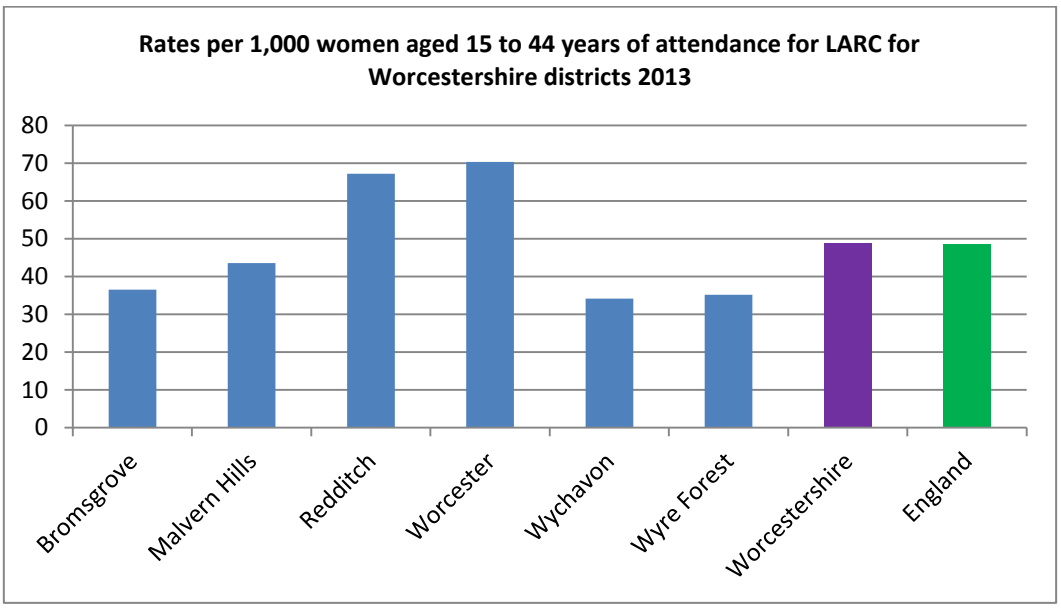
9.5.3. In 2013, the prescribing rate for all contraception in primary care was significantly higher in Worcestershire (847.2) than the national rate (803.3). The contraceptive prescribing rate in primary care for Bromsgrove, Malvern, Wychavon and Wyre Forest are significantly above the national rate. The rate in Redditch and Worcester Districts are significantly lower. The data suggests that more women in Redditch and Worcester attend sexual health clinics for contraception than their GP, compared to other Districts; however the main reproductive sexual health (RSH) and young person clinics are geographically based in these Districts.

Chart 20: GP attendance for all prescribed contraception.



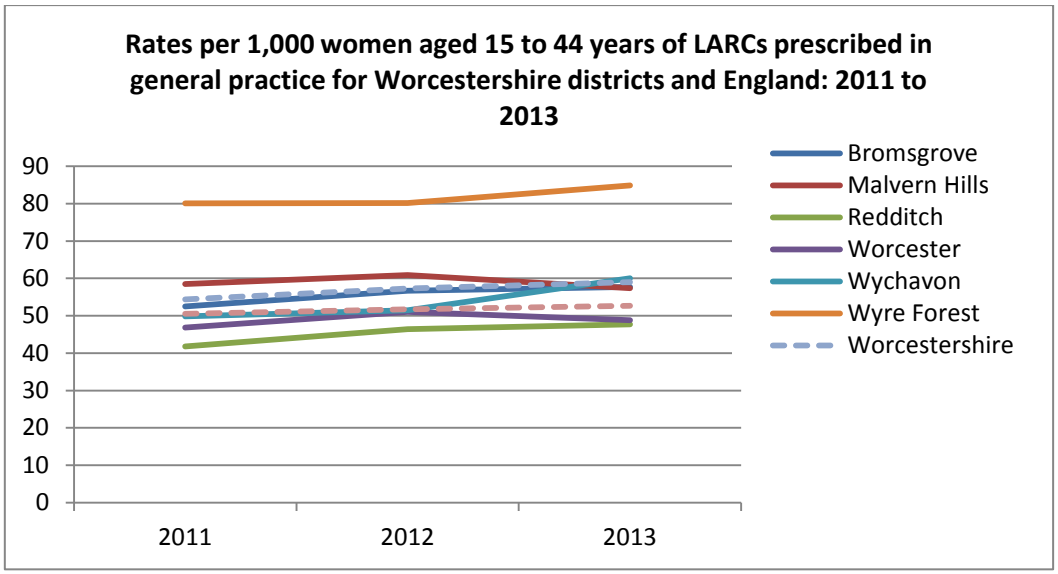
9.5.4. A similar picture is evident for the provision of LARC. In 2013 the rate of attendances for LARC in Worcestershire sexual health clinics was similar to the national average (48.5). The LARC attendance rate however was significantly higher in Redditch and Worcester districts and significantly lower in other districts than the national rate.

Chart 21: Attendance for LARC by district.



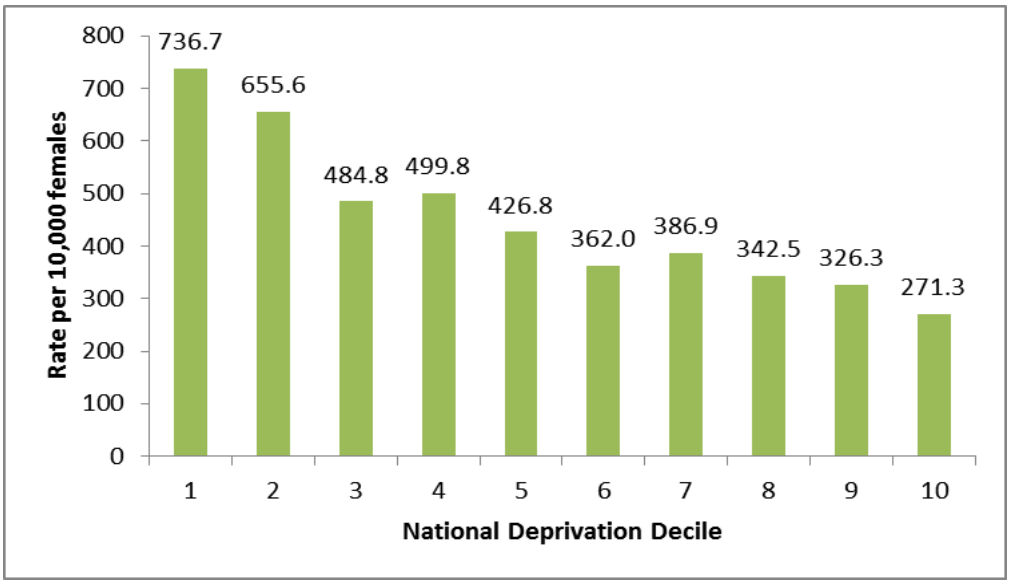
9.5.5. The prescribing rate for LARC in 2013 from general practice in Worcestershire (59.0) is significantly higher than the national rate (52.7) and has increased over the last three years. The rate is significantly higher in Bromsgrove, Malvern, Wychavon and Wyre Forest and significantly lower in Redditch and Worcester. Of note is the very high LARC prescribing rate amongst general practice in Wyre Forest.

Chart 22: LARC prescribed in general practice.



9.5.6. Encouragingly there appears to be quite a strong relationship between attendance rates for LARC in sexual health clinics and multiple deprivation. The rate in the most deprived areas is three times that in the least deprived areas in 2013/14

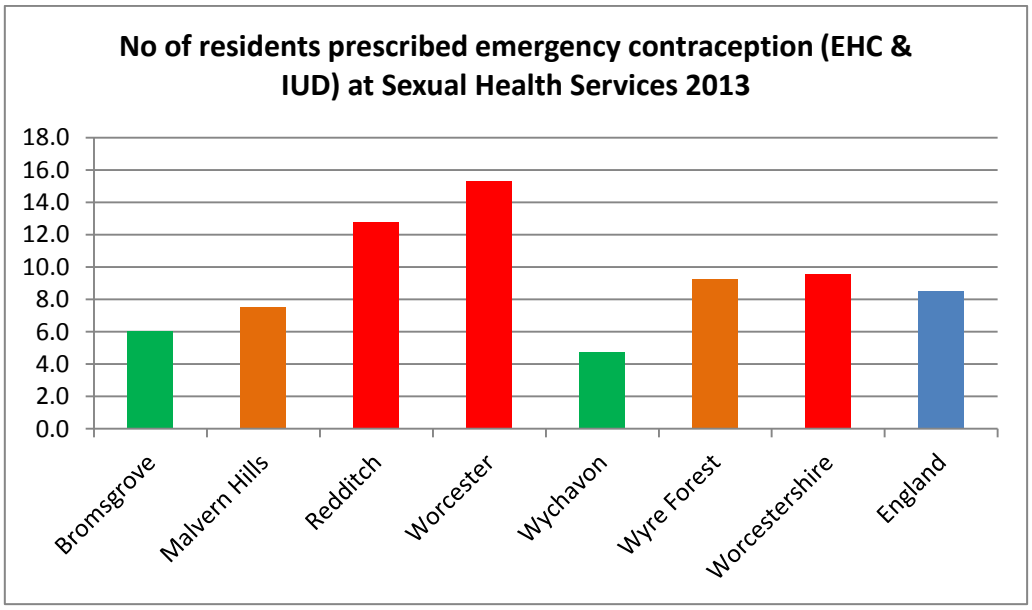
Chart 23: LARC related attendances at Sexual Health Services in Worcestershire, females, rate per 10,000 females aged 15-44 by Deprivation Decile, 2013/14.



Source: Worcestershire Health & Care NHS Trust, Indices of Deprivation 2010
Note: Deprivation decile relates to the LSOA of residence. 1=most deprived, 10=least deprived
Note: all attendances where usual method of contraception is a LARC (IUD, IUS, Implant or Depo-Provera)

9.5.7. Rates of emergency contraception prescribed by the community sexual health service is significantly high in Redditch and Worcester Districts.

Chart 24: Emergency Contraception prescribed at Sexual Health Services 2013 by District.



9.5.8. An analysis of all contraception and of LARC by practice indicates variation by practice in both rates of contraception and LARC and in terms of accessing contraception either at sexual health services or in general practice. In general where practices are geographically close to a community sexual health clinic the contraceptive and LARC prescribing rates by GPs is lower. Practices that are not geographically close to community sexual health clinics have higher contraceptive and prescribing rates by GPs. However, of concern, there are some practices that have low contraception and/or low LARC rates from both sexual health services and from GPs. Of note Wyre Forest practices appear to have significantly higher rates of overall contraception and LARC prescribed by general practice and practices in Redditch and Worcester have lower prescribing rates. Rates by Practice are contained in Appendix 2.

9.6. SRE provision

9.6.1. Sex and relationships education (SRE) is offered to pupils so that they can learn about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health. It should equip children and young people with the information, skills and values to have safe, fulfilling and enjoyable relationships and to take responsibility for their sexual health and well-being.

9.6.2. In England, Local authority maintained schools are obliged to offer SRE as part of the National Curriculum (within PHSE) to pupils aged from 11 years. The content of what is offered must have regard to the Governments SRE guidance, but what is offered is non-prescriptive, so the quality and quantity of what is taught is left to the responsibility of individual schools. Academies and free schools do not have to follow the National Curriculum, but they do have to follow national guidance if they decide to teach SRE.

9.6.3. Following a survey conducted in Worcestershire schools, of those that responded (18 in total) the majority provided some details of the SRE that they provide for their students. The information provided shows that there is variation in what is taught, and at what age. Some schools do not provide SRE until year 8 and others offer sexual health within their curriculum from year 7. The amount of SRE that is offered varies from schools that offer an extensive programme that starts in year 7 and continues through to year 11, to others that only offer it in set years (e.g. years 7 and 9).

9.6.4. The content also varies, and ranges from puberty in earlier years through to STIs, risk taking, domestic abuse, and consent and rape in later years. Only 1 school stated that they provided content

that covered LGBT relationships. Of the schools that responded, all also offered a Time 4U service that was either available via a school nurse or a sexual health nurse.

10. Evidence based approaches to sexual health improvement and models of sexual health provision

10.1. Evidence of effectiveness

10.1.1 A number of preventative approaches can be commonly utilised to improve sexual health and wellbeing and reduce sexual health inequalities. Evidence for each approach will be identified and followed by consideration of their application to improving specific sexual health outcomes.

10.2. Community Engagement

10.2.1. Community engagement interventions are those that involve communities in the planning, development and management of services or activities which aim to improve health or reduce health inequalities. The approach includes community champions and the collaborative methodology.

- A 2007 NICE rapid review of the effectiveness of community engagement approaches found that peer educators may be effective in delivering health promotion related education and changing behaviours towards safer sex practices[2].
- Use of a School Health Promotion Council to plan and design activities may enable young people to make safer sex choices. A systematic review of HIV behavioural risk-reduction interventions identified 19 studies targeting adult MSM in developed countries[3]. The review found evidence that individual-level, group-level and community-level person-to-person interventions are effective at changing risky sexual behaviour as measured by the reduced odds of engaging in unprotected anal intercourse in those targeted by the interventions.

10.3. Condom distribution

10.3.1. Condoms remain a key method for the prevention of HIV and STIs. Although, other forms of contraception, especially LARC, are more effective in preventing unintended and teenage pregnancies. Structural-level interventions aim to increase condom use by making them easily available. Condom distribution schemes aim to promote the use of condoms by increasing their availability, accessibility and acceptability. Such interventions can include c-card schemes as well as making free condoms available in clinical, social and commercial venues.

- a systematic review examining the efficacy of structural-level condom distribution interventions on HIV and STI risk behaviours found significant effects on condom use, condom carrying, delayed sexual initiation and reduced incidence of STIs[4] .
- a systematic review of the effectiveness of contraception service interventions for young people found that interventions combining discussion and demonstrations of condom use

[2]Swainston K, Summerbell C. The effectiveness of community engagement approaches and methods for health promotion interventions . Rapid Review Phase 3. 2007;(May):1–224

[3] Herbst JH, Beeker C, Mathew A, McNally T, Passin WF, Kay LS, et al. The effectiveness of individual-, group-, and community-level HIV behavioral risk-reduction interventions for adult men who have sex with men: a systematic review. American Journal of Preventive Medicine 2007; 32(4 Suppl):S38-S67

[4] Charania MR, Crepaz N, Guenther-Gray C, Henny K, Liau A, Willis L, et al. Efficacy of structural-level condom distribution interventions: a meta-analysis of U.S. and international studies, 1998-2007. AIDS and behavior 2011; 15(7):1283-1297

are associated with increased condom use and continued high levels of engagement with clinical services[5]

- a review of interventions to increase condom use found that they do not increase the overall frequency of sexual behaviour . Reductions in frequency of sexual events and partner numbers were seen for some high risk subgroups (e.g. MSM, sex workers)[6] .
- NICE cost effectiveness model found that distribution of condoms within schools resulted in cost savings compared with no dispensing of condoms within schools[7]

10.4. Improved service provision

10.4.1. There are three types of intervention under this theme: acceptability, accessibility and quality improvement, each of which is intended to produce changes to behaviour among a different population. Acceptability to reduce barriers for accessing sexual health services among the general population; accessibility to reduce barriers to attendance; and quality improvement is to ensure that service users receive timely and effective sexual health care when they attend medical settings**.**

- Acceptability: a clinic-based intervention which aimed to reduce barriers to contraceptive use among teenage women showed reduced rates of emergency contraception, pregnancy testing and pregnancy rates in the intervention group[8] .
- Accessibility: a review of the evidence of the impact of integrating STI or HIV prevention, care and treatment into family planning settings in developed countries found that integration can have a positive impact on client satisfaction and access to services and it is cost effective[9]
- Quality improvement: the Chlamydia Intervention Randomised Trial found an intervention, which involved educational sessions and on-going support from a chlamydia screening specialist, improved general practice engagement in chlamydia screening and increased detection rates[10] .
- Quality improvement: a longitudinal study found that a multifaceted education intervention, that included training sessions for GPs on clinical and communication skills relevant to sexual health, substantially increased general practice HIV testing rates without the use of financial incentives[11]

10.5. Outreach work

'Outreach' in the context of health promotion essentially entails services being taken out from clinical settings and being provided in local community settings.

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[5] Blank L, Baxter SK, Payne N, Guillaume LR, Squires H. Systematic review and narrative synthesis of the effectiveness of contraceptive service interventions for young people, delivered in health care settings. Health education research 2012; 27(6):1102-1119

[6] Smoak ND, Scott-sheldon LAJ, Johnson BT, Carey MP. Sexual Risk Reduction Interventions Do Not Inadvertently Increase the Overall Frequency of Sexual Behavior : A Meta-analysis of 174 Studies With 116,735 Participants. J Acquir Immune Defic Syndr. 2006;41(3):374–84

[7] Pilgrim H, Payne N, Chilcott J, Blank L, Guillaume L, Baxter S, et al. Modelling the cost-effectiveness of interventions to encourage young people , especially socially disadvantaged young people , to use contraceptives and contraceptive services April 2010. 2010.

[8] Martin J, Sheeran P, Slade P, Wright A, Dibble T. Durable effects of implementation intentions: reduced rates of confirmed pregnancy at 2 years. Health Psychology 2011; 30(3):368-373

[9] Church K, Mayhew SH. Integration of STI and HIV Prevention , Care , and Treatment into Family Planning Services : A Review of the Literature. Stud Fam Plann. 2009;40(3).

[10] McNulty CA, Hogan AH, Ricketts EJ, Wallace L, Oliver I, Campbell R, et al. Increasing chlamydia screening tests in general practice: a modified Zelen prospective Cluster Randomised Controlled Trial evaluating a complex intervention based on the Theory of Planned Behaviour. Sex Transm Infect 2014; 90(3):188-194

[11] Pillay TD, Mullineux J, Smith CJ, Matthews P. Unlocking the potential: longitudinal audit finds multifaceted education for general practice increases HIV testing and diagnosis. Sex Transm Infect. 2012;89(3):191–196

- a systematic review of HIV testing in community settings found that community testing initiatives are successful in diagnosing previously undiagnosed HIV infections among MSM communities[12] .
- NICE public health guidance from 2014 suggests considering using outreach services to provide information, advice and a full range of contraceptive services . This is based on evidence that suggests that outreach programmes may be effective in encouraging young people to attend mainstream sexual health services, increase consistent condom use and reduce unintended pregnancies. There was strong evidence that school-based interventions that include community outreach components can be effective in preventing teenage pregnancy and reducing risky sexual behaviour[13]
- NICE public health guidance from 2007 states that there is good evidence that multi-session support and home visiting for disadvantaged low income pregnant women or mothers can prevent repeat pregnancies, with studies showing a significant reduction in repeat pregnancies in the intervention group compared to control subjects[14]

10.6. Sexual and Relationship Education

10.6.1. The provision of high quality sex and relationships education (SRE) provides an opportunity to provide children and young people with information and knowledge to increase personal resilience and address risky behaviour at an early stage. Some elements of SRE are a compulsory part of the national curriculum: in maintained primary and secondary schools it is expected that the broader topic of SRE is delivered through Personal, Social, Health and Economic Education (PHSE).

- International evidence shows that young people who have a broad programme of relationships and sex education that starts early in schooling are more likely to delay having sex until they are older, use contraception and have fewer sexual partners. This should be delivered by competent and confident educators[15]
- a systematic review and economic evaluation of SRE found that it can bring about improvements in knowledge and increased levels of self-efficacy among young people. Young people reported that the quality of the SRE provider, and a supportive school culture, affected whether the interventions were acceptable and engaging. Teacher-led interventions were more cost-effective than peer-led interventions

10.7. Social marketing

10.7.1. Interventions included under social marketing range from advertising, through either small or mass media outlets, to the employment of interactive marketing principles and techniques. Increasingly, the use of simple media is superseded by more sophisticated social marketing to support individual behaviour change

- a review of HIV prevention mass media campaigns targeting MSM identified twelve studies from high-income countries, seven of which took place in the UK, concluded that mass-media interventions can reach large audiences at low costs per individual and direct individuals towards more in-depth interventions[16]
- a meta-analysis of evaluations of mass media-delivered HIV prevention interventions which targeted youth or the general population found that campaigns were associated with

[12] Thornton AC, Delpech V, Kall MM, Nardone A. HIV testing in community settings in resource-rich countries: a systematic review of the evidence. HIV Med 2012; 13(7):416-426
[13] NICE. Contraceptive services with a focus on young people up to the age of 25. 2014
[14] NICE. Clinical guideline 20: long-acting reversible contraception. 2013
[15] LGA, Relationships and Sex Education - A Briefing for Councillors, 2013
[16] French RS, Bonell C, Wellings K, Weatherburn P. An exploratory review of HIV prevention mass media campaigns targeting men who have sex with men. BMC public health 2014; 14(1):616

increases in condom use, and improved knowledge of HIV transmission and prevention. Longer campaigns and those which matched their message content to the target audience showed greater increases in condom usage[17]

- the 'Sex Worth Talking About' campaign, launched in 2009, was aimed at young people (16-24 years old) and included specific campaigns on contraceptive choice and chlamydia screening. Evaluation of the campaign found that it raised awareness of LARCs among young people, and had a positive influence on their views of contraception and the importance of being tested for chlamydia. A time-series analysis of chlamydia screening data demonstrated that during the campaign there was a higher than expected increase in high risk individuals being screened and in positivity rates[18]

10.8. Key approaches for reducing rates of sexually transmitted infections

10.8.1. Sexually transmitted infections (STIs) cause morbidity and mortality and some, such as gonorrhoea, have increasing levels of antibiotic resistance. If not successfully treated they can lead to a number of sequelae, such as pelvic inflammatory disease and ectopic pregnancy. The treatment and care of patients with STIs incurs substantial costs. The three most at-risk populations for STIs are young people, MSM and black ethnicity. The following preventive interventions are considered to be key, but not exclusive, approaches to achieve a reduction in STIs.

Table 8: Evidence-based approaches to reducing STIs.

Outcome-specific objectives	Social marketing	Community engagement	Condom distribution	Outreach work	Improved service provision	SRE
Build knowledge and resilience						
Individuals should understand what STIs are, how to reduce transmission risk and prevent infection	x	x				x
Encourage an open and honest culture around sexual health	x	x				x
Reduce the stigma and discrimination associated with many aspects of sexual health	x	x			x	x
Prioritise prevention						
Promote safer sex and condom use	x	x		x		x
Establish and maintain appropriate condom distribution			x	x	x	
Individuals should understand how to access prompt and confidential testing for STIs.	x	x		x	x	x
Encourage the routine offer of a chlamydia test to young adults attending general medical services	x				x	
Promotion of self-sampling (and self-testing) though internet and other easily accessible settings	x				x	
Provide rapid access to high quality services						
Ensure accessibility of HIV services for risk groups (young people, MSM, black Caribbean)		x			x	
Rapid referral into care after diagnosis				x	x	

[17] Lacroix JM, Snyder LB, Huedo-medina TB, Johnson BT. Effectiveness of Mass Media Interventions for HIV Prevention, 1986 GÇô 2013 : A Meta-analysis. 2014; 66:329-340

[18] Gobin M, Verlander N, Maurici C, Bone A, Nardone A. Do sexual health campaigns work? An outcome evaluation of a media campaign to increase chlamydia testing among young people aged 15--24 in England. BMC Public Health. 2013;13(1):484. doi:10.1186/1471-2458-13-484

Maintain sexual health as people age						
Provision of appropriate advice on protection from infection for older men and women		x			x	

10.9. Approaches to increase the chlamydia detection rate

10.9.1. The Worcestershire chlamydia detection rate and screening coverage is significantly below average and appears to be decreasing. The evidence indicates internet testing as an essential element of local arrangements but is not sufficient on its own and areas should commission a wide range of providers and testing opportunities for young people. Good practice identifies general practice and pharmacies as effective testing settings as well as ensuring annual testing (& with change of partner) in all mainstream sexual health service provision. Outreach activities should be limited only to those that effectively target hard-to-reach young people who would not otherwise access screening services or where positivity is five percent or greater. Explore innovative options to incorporate sexual health into other local authority and NHS services Other options include testing within prison healthcare, link with services for young people with mental health needs and substance misuse, link with services for young people who are NEET and incorporate local large scale testing populations such as universities.

10.10. Key approaches for reducing HIV transmission, acquisition and avoidable deaths

10.10.1. Individuals diagnosed early in their HIV infection have near-normal life expectancies, but those diagnosed late (CD4 count less than 350 cells/mm3.) have a poorer prognosis, experiencing greater mortality and morbidity. Each new case of HIV infection is estimated to represent between £280,000 and £360,000 in lifetime treatment costs. Most HIV transmission and acquisition in the UK occurs through sexual contact (both between people of the same and opposite sex). The two groups at highest risk of HIV infection are: men who have sex with men (MSM) and black African heterosexual men and women. The following preventive interventions will contribute to a reduction in HIV transmission.

Table 9: Evidence-based approaches to reducing HIV transmission.

Outcome-specific objectives	Social marketing	Community engagement	Condom distribution	Outreach work	Improved service provision	SRE
Build knowledge and resilience						
Individuals should understand what HIV is, how to reduce transmission risk and prevent infection	x	x				x
Encourage an open and honest culture around sexual health	x	x				x
Reduce the stigma and discrimination associated with many aspects of sexual health	x	x			x	x
Prioritise prevention						
Promote safer sex and condom use	x	x		x		x
Establish and maintain appropriate condom distribution			x	x	x	
Individuals should understand how to access prompt and confidential testing for HIV	x	x		x	x	x
Encourage the routine offer of an HIV test for general medical admissions and new general practice registrants in high prevalence areas (>=2/1,000)	x	x			x	
Promotion of self-sampling (and self-testing) though internet and other easily accessible settings	x				x	
Provide rapid access to high quality services						
Ensure accessibility of HIV services for risk groups (MSM, black Africans,		x			x	

people who inject drugs)						
Rapid referral into care after diagnosis					x	
Maintain sexual health as people age						
Retention in care of people living with HIV and treatment of HIV-related co-morbidities					x	
Provision of appropriate advice on protection from infection for older men and women		x			x	

10.11. Reduce unintended pregnancies

10.11.1. Estimates of the proportion of pregnancies that are unintended vary from nearly 1 in 3 (30%) to one in six (16%) pregnancies . In a national survey, among women aged 16-44 who self-reported their pregnancy as unplanned, the majority (57%) resulted in a termination, with only 6% being carried to full-term. Unintended pregnancies are associated with poorer pregnancy outcomes and increased risk of maternal mental health problems. While pregnancies among women aged 16-19 are most likely to be unplanned (45.2%), this group have lower rates of pregnancy overall: the majority of unplanned pregnancies take place among women aged 20-34 (62.4% of unplanned pregnancies). Factors strongly associated with unplanned pregnancy include first sexual intercourse before 16 years of age, current smoking or non-cannabis drug use and lower educational attainment. The following preventive interventions will contribute to a reduction in unintended pregnancies

Table 10: Evidence-based approaches to reducing unintended pregnancies.

Outcome-specific objectives	**Social marketing**	**Community engagement**	**Condom distribution**	**Outreach work**	**Improved service provision**	**SRE**
Build knowledge and resilience						
Individuals should understand contraception options, including LARC and emergency contraception	x				x	x
Encourage an open and honest culture around sexual health	x					x
Encourage discussion of contraception needs within relationships	x					x
Prioritise prevention						
Promote safer sex and use of regular contraception	x	x	x	x		x
Establish and maintain appropriate condom distribution			x	x	x	
Individuals should know where to access contraception	x	x			x	x
Targeted interventions for those with a history of unintended pregnancy and use of emergency contraception		x		x	x	
Promote use of LARC as the most effective method of contraception	x	x		x	x	x
Provide rapid access to high quality services						
Ensure access to emergency contraception (including IUDs) and subsequent regular contraception including the most effective LARC methods				x	x	
Include contraceptive advice and access as part of abortion, pregnancy loss and maternity care					x	
Ensure access to pregnancy testing, adoption and abortion services in timely and convenient manner				x	x	
Maintain sexual health as people age						
Increase awareness of risks of pregnancy among older age groups	x	x			x	

10.12. Reduce rate of under 16 and under 18 conceptions

10.12.1. 60% of Under 16 and 50% of under 18 conceptions end in abortion. For some young people, becoming a parent is a positive choice. However, under-18 conception is often associated with poor health and social outcomes for both the mother and child. It has been estimated that every £1 invested in teenage contraception saves the NHS £11 plus additional welfare costs. All sexually active teenagers are at risk of under 18 conceptions, however the strongest associated risk factors are: free school meals eligibility, or areas of deprivation, persistent school absence by the age of 14 and slower than expected academic progress between ages 11-14. In addition looked after children and care leavers are at risk. The following preventive interventions will contribute to a reduction in under 18 conceptions.

Table 11: Evidence-based approaches to reducing under 16 and under 18 conceptions.

Outcome-specific objectives	Social marketing	Community engagement	Condom distribution	Outreach work	Improved service provision	SRE
Build knowledge and resilience						
Increase knowledge and awareness of contraception options, including LARC and emergency contraception	x					x
Encourage an open and honest culture around sexual health and use of contraception	x	x				x
Encourage discussion of contraception needs within relationships	x			x		x
Prioritise prevention						
Promote safer sex and use of regular contraception	x	x	x	x		x
Establish and maintain appropriate condom distribution			x	x	x	
Individuals should know where to access contraception	x	x			x	x
Targeted interventions for those with a history of unwanted pregnancy and use of emergency contraception		x		x	x	
Promote use of LARC as the most effective method of contraception	x	x		x	x	x
Provide rapid access to high quality services						
Ensure access to emergency contraception and subsequent regular contraception including the most effective LARC methods and postpartum family planning services				x	x	
Include contraceptive advice and access as part of abortion, pregnancy loss and maternity care					x	
Ensure access to pregnancy testing, adoption and abortion services in timely and convenient manner				x	x	

11. Conclusions and Recommendations

11.1. Conclusions - Projected need

11.1.1. Sexual health is important for both individuals and communities and covers the life course. In Worcestershire there is an ambition to improve sexual health outcomes and reduce sexual health inequalities. Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. Poor sexual health is more common amongst young adults, MSM, ethnic minority populations and in areas of greater deprivation.

11.1.2. Access and need for sexual health information, support and services is greatest amongst adults of reproductive age 15-44 years. In Worcestershire this age group are projected to decrease by 5% over the next 10-15 years, with the greatest decrease being for younger adults. The over 55 population is projected to increase so it will be important to meet the sexual health needs of an ageing population. Although the 15-44 years population overall is decreasing, there are projected increases in those at risk groups, such as numbers of young people living in most 20% deprived communities, numbers of BME population and numbers of children in care and care leavers.

11.2. STIs

11.2.1. STI rates are significantly lower in Worcestershire than nationally, however the rates are not reducing as they appear to be of late elsewhere. STI rates in Worcestershire are higher amongst young people, MSM, BME and in more deprived areas as they are nationally. STI rates are significantly higher in Redditch and Worcester districts than the rest of the county. There are very low rates of syphilis and gonorrhoea in the county, however the number of gonorrhoea cases detected in Redditch have increased over the last 4 years. The rates of genital herpes and genital warts are lower in Worcestershire than nationally, however herpes rates appear to be increasing.

11.2.2. The prevalence of diagnosed HIV in Worcestershire is low however is increasing as it is nationally. HIV prevalence is greater in more deprived areas. Over 50% of diagnosed HIV are MSM. HIV testing coverage in GUM is lower than average and late diagnosis is high.

11.2.3 The chlamydia diagnosis rate amongst young people is significantly lower than the national rate. The chlamydia diagnosis rate has significantly reduced since 2010 whereas the national rate has increased during the same period. The percentage of young people (16-24) tested for chlamydia has fallen in Worcestershire since 2011, whereas nationally there has been an increase during the same period. This indicates there has been a significant reduction in both chlamydia testing and detection in the county.

11.3. Contraception & Unintended pregnancy.

11.3.1. It is estimated that up to 50% of pregnancies are unplanned. However, in Worcestershire, the rate of all contraception prescribed by GPs in primary care is significantly above the national average and is particularly high in Wyre Forest district. The rate of attendances at community sexual health clinics for all methods of contraception is similar to the national average and is significantly high in Redditch and Worcester districts. Long Acting Reversible Contraception (LARC) is more effective in reducing unintended pregnancies, in Worcestershire the % of LARC prescribed by GPs and provided in community sexual health clinics is above the national average.

11.3.2. Worcestershire has a low abortion rate compared to nationally. However the % of repeat abortions amongst those under 25 was 23% in 2014. The earlier that abortions are performed the lower the risk of complications. The early abortion rate (under 10 weeks) in Worcestershire is significantly higher than the national rate.

11.4. Teenage Conceptions

11.4.1. Most teenage pregnancies are unplanned and around half end in an abortion. Teenage pregnancy is associated with poorer outcomes for both young parents and their children. Since 1998, teenage conception rates have fallen; however, the reduction in Worcestershire (22%) has not been as great as elsewhere (50%). Under 18 teenage conception rates are strongly related to areas of deprivation. Worcester & Redditch Districts have the highest rates and have not reduced over the last decade. The Under 16 conception rate has not decreased and is significantly high in Redditch district.

11.5. Sexual health spend

11.5.1. The spend per head on sexual health commissioned by WCC is less than the national average, however as sexual health outcomes are better this would be expected. The spend per STI however is higher than national average suggesting greater spend on treatment than prevention.

11.6. User & stakeholder feedback

11.6.1. Young people expressed concern regarding poor quality and inconsistent provision of SRE in schools, improved access to services (better times & locations) and better promotion and information through digital platforms and social media. Adults service users expressed a need to modernise services to meet modern life by improving access through more available local provision at better times (outside of working hours) that are advertised more widely. Stakeholders and providers felt outreach services and the ability to access chlamydia tests on line were effective. They expressed concern regarding inappropriate use of services and suggested the walk-in facility at GUM and CASH made it easy for people to use the service for issues that were non sexual health related. They expressed a need for more prevention, early intervention and targeted work for most at risk and point of care testing. They felt services were poorly marketed and the Playinitsafe website was outdated and primarily focussed towards young people.

11.7. GUM service

11.7.1. Attendance rates at GUM and STI rates are high in Redditch & Worcester (where GUM clinics are located). GUM attendance rates are lowest in Wyre Forest, however STI rates are similar to the other districts. This may suggest high levels of inappropriate attendances at a GUM service where access to the clinic is easier. To examine this further the numbers and rates of GUM episodes not requiring treatment were considered. The % of attendances not requiring treatment is 34% in Worcestershire compared to 24% nationally. This is higher in JAC GUM (40%) than in Arrowside GUM (30%) and appears to be increasing. To ascertain if these attendances were all follow ups, the % of follow ups were examined. The percentage of follow ups of all attendances is also lower at JAC (19%) than Arrowside (26%). This does then indicate that there are a high number of GUM first attendances that do not require treatment particularly at JAC.

11.7.2. The number of rebooks in GUM - where a patient is returning for a new episode of care after a 6 month period – has increased over recent years and is highest for R&BCCG. The % of attendances that are rebooks has risen to 50%. Concern has been expressed that some of these may be follow ups that have been miscoded, however the high and increasing numbers suggest that many of the same patients are returning to GUM services. The STI reinfection rates within 12 months, however are lower than average in Worcestershire indicating that the rebooks are most likely to be attendances not requiring treatment. The data that has been analysed suggests there is potentially a high level of inappropriate attendances at GUM particularly from those geographically close to the GUM clinics.

11.8. Chlamydia screening

11.8.1. To control chlamydia infection amongst young people it is recommended all sexually active 16-24 year olds are tested annually and at each change of sexual partner. In Worcestershire the chlamydia detection rate and the % tested aged 16-24 has reduced considerably over the last 4 years. Following the previous sexual health needs assessment (2012), young people are offered testing via sexual health services and are able to access an internet service; there is no targeted testing taking place in the community or in other settings. The positivity rate of those tested is fairly high (8.8%) but an insufficient proportion of the population are being tested.

11.9. Contraception

11.9.1. Attendance rates for all contraception at community sexual health clinics are significantly lower than the national rate. However rates are significantly higher in Worcester and Redditch districts where the main community contraceptive clinics are located. Prescribing rates for all contraception by general practice is significantly higher across the county than national average but lower in Redditch and Worcester districts suggesting in these districts more women are choosing to attend community clinics. LARC is a more effective method in reducing unintended pregnancies. Rates of LARC across the county are above national average in both sexual health community clinics and prescribed by GPs. The % of contraception that is LARC is lowest however is in Redditch which has high teenage conception rates. Of concern is the variation in LARC prescribing rates by GP practice and some practices are not prescribing LARC. In general practices that are geographically close to community sexual health clinics have lower rates of contraception and LARC. Wyre Forest practices have significantly high levels of contraception and LARC prescribed by GPs.

11.10. Provision of SRE in schools

11.10.1. High quality SRE provides children and young people with information and knowledge to increase personal resilience and address risky behaviour at an early stage. In England, Local authority maintained schools are obliged to offer SRE as part of the National Curriculum (within PHSE) to pupils aged from 11 years. The content of what is offered must have regard to the Governments SRE guidance, but what is offered is non-prescriptive, so the quality and quantity of what is taught is left to the responsibility of individual schools. A survey of SRE provision in Worcestershire High schools identified there is variation in what is taught, the quantity of SRE provided and at what age it is taught.

11.11. Assessment of current model of provision.

11.11.1. The current model of sexual health provision is a treatment focussed model where most of the funding, resource and capacity is focussed on secondary prevention, contained within STI testing and treatment in GUM centres and contraception and abortion provision in community clinic settings or general practice. The current system is not focussed on primary prevention and early intervention and has little resource spent on outreach or sexual health improvement activities. Services are open access with insufficient targeting of high risk groups. Location and accessibility of service provision seems historical rather than meeting the needs of the population. There appears to be some inappropriate use of service provision within GUM demonstrated by high rates of attendances requiring no treatment and a lack of prevention activity to influence behaviour change and subsequent future attendances. The system does not appear to be joined up with other services or provision resulting in other frontline staff lacking the capability to influence sexual health behaviours. Current sexual health services do not make use of new technologies to support service provision or digital and social media to promote sexual health information, advice and support.

11.12. Evidence of effectiveness

11.12.1. A range of preventive interventions have been identified that can impact on sexual health behaviours and improve sexual health outcomes across the life course. 1) Community development activities such as community champions, peer educators and collaborative approaches can change risky sexual behaviours and increase safe sex practices. 2) Condom distribution interventions to increase the availability, accessibility and acceptability of condoms in clinical, social and commercial venues can increase condom use. 3) Provision of high quality SRE can result in young people more likely to delay having sex until they are older, use contraception and have fewer sexual partners. 4) Improving service provision in terms of acceptability, accessibility and quality improvement to change behaviours. 5) Increasing the extent of community outreach to target on those at greatest

risk can be effective in changing risky sexual behaviour, improving outcomes and encouraging attendance at mainstream services. 6) Social marketing methods can influence behaviour change.

11.3. Recommendations

11.3.1. Ensure sexual health provision is in accordance with need across the county. In particular ensure that all sexual health services understand and are able to meet and target the sexual health needs and accessibility needs of all young people, MSM, BME population, deprived population, LAC & care leavers and the needs of older people in light of the ageing population.

11.3.2. Review the local arrangements to increase the coverage of chlamydia testing amongst 15-24 year olds. This should be through increased testing in primary care, pharmacies and colleges, and through targeted outreach. Maximise screening through contacts at sexual and other health services. Ensure that the risks of chlamydia and the internet testing service are better promoted and more accessible to young people through social marketing techniques. Develop young sexual health champions.

11.3.3. Tackle the teenage conception rates, particularly in Redditch and Worcester. Influence and support the provision of high quality SRE in all schools. Increase knowledge and awareness of safe sex and contraception options, including promoting LARC and emergency contraception to young people through social marketing and young sexual health champions. Enhance the condom distribution scheme. Target interventions to young teenagers at risk (deprivation, school absenteeism, lack of academic development, NEET). Provide comprehensive outreach to looked-after young people and care leavers. Ensure sexual health is included in annual LAC health review.

11.3.4. Identify and review local pathways for termination services to increase proportion of terminations under 10 weeks.

11.3.5. Review and expand levels of HIV testing in GUM and in community and outreach settings. Ensure accessibility of HIV services for risk groups (MSM). Consider the routine offer of an HIV test for new general practice registrants in practices within a high prevalence areas (>=2/1,000).

11.3.6. To tackle unintended pregnancies use social marketing to promote safer sex and use of LARC as the most effective method. Ensure equitable access and availability of EHC and LARC. Develop pathways for subsequent regular contraception following EHC and chlamydia testing. Targeted interventions for those with a history of unintended pregnancy and repeated use of emergency contraception.

11.3.7. Address variation in choice, access and uptake of all contraception and LARC particularly in primary care, ensuring all women have access to contraception services and LARC.

11.3.8. Redesign the model of sexual health to achieve a joined up approach, ensuring a greater proportion of activity is based on primary prevention. Redesign ensuring activities predominantly focus on the promotion of good sexual health behaviour through the use of safer sex, and the appropriate planned use of long acting reversible contraception to reduce the need for treatment.

11.3.9. Sexual health services to be fully integrated as a hub and spoke model, ensuring adequate spokes within the community to meet health & access need. Enhance outreach activities to target high risk and vulnerable groups. Review and improve pathways across the system to ensure sexual health becomes everybody's business. The sexual health system to focus on sexual behaviour change within service provision, sexual health promotion activities and by training and upskilling of front line staff. Introduce new technologies to improve information, advice, support, self-help, self-testing and point of care testing.

Table 12: Commissioning responsibilities of recommendations

Needs Assessment Recommendation	Commissioning responsibility	Key Strategic partners	Tier
1. Redesign and modernise the sexual health delivery model to a whole systems approach through the commissioning process.	WCC	NHS, CCG, VCS, NHSE, PHE, Private sector	1, 2 and 3.
2. Sexual health provision should be re-shaped to match need across the county, enabling a focus on higher risk populations.	WCC	NHS, CCG, VCS, NHSE, PHE, Private sector	1, 2 and 3.
3. Review & amend the chlamydia screening programme for 15-24 year olds, using evidence based approaches, to achieve improved outcomes.	WCC	CCG, private sector, VCS, Pharmacy	1 and 2.
4. Tackle teenage pregnancy in Redditch and Worcester, including all relevant partners, through influencing SRE in schools and supporting at risk teenagers.	WCC	District Councils, CCG, NHS, VCS	1.
5. Local pathways for termination services should be reviewed so as to increase proportion of terminations under 10 weeks.	CCG	WCC	2.
6. HIV testing in GUM and in community and outreach settings should be expanded so as to reduce late diagnosis.	WCC	VCS, CCG, Pharmacy, NHS	1, 2 and 3.
7. Increase and modernise sexual health improvement and promotion through improved SRE in schools, use of sexual health champions, peer educators, condom distribution and social marketing techniques.	WCC		1.
8. Review and develop specifications for a revised service model, including provision in primary care. Inequitable access and availability of EHC and LARC should be addressed within the service.	WCC/CCG	PHE, CCG	1, 2 and 3.

12. Glossary of Terms

AIDS	Acquired Immune Deficiency Syndrome: the later effects of HIV infection
BME	Black and Minority Ethnic
CaSH clinic	Contraception and Sexual Health Clinic: an integrated Family Planning and STI clinic
CCG	Clinical Commissioning Group
Cervical Screening	Often referred to as the "smear test", this is a method of cervical cytology used to detect potentially pre-cancerous and cancerous processes in the cervix
Chlamydia	A sexually transmitted infection (STI) caused by bacteria
Condom	A thin latex or plastic sheath placed over the penis (male) or in the vagina (female) to prevent sperm reaching and fertilising the female egg and therefore preventing pregnancy. Also protects against STIs
Contraception	A range of methods for preventing pregnancy, including use of hormones, surgery and devices
Contraceptive injection	A type of long acting reversible contraceptive (LARC)
EHC	Emergency Hormonal Contraception commonly known as the "morning after" pill. Used to prevent pregnancy after unprotected (without a condom) sex
FGM	Female Genital Mutilation
Genital warts	A viral infection of the genital area
Genital herpes	A sexually transmitted viral infection of the genitals
Gonorrhoea	A sexually transmitted bacterial infection
GUM	Genitourinary Medicine; the diagnosis and treatment of sexually transmitted infections (STIs)
GUM clinic	Genitourinary Medicine clinic: also known as sexual health clinic – they provide a range of sexual health services to treat and prevent sexually transmitted infections. Sometimes combined with family planning clinics
Hepatitis B	A blood bourne virus that can be spread by having sex or sharing needles
HIV	Human Immunodeficiency Virus: a sexually transmitted virus that attacks the immune system and may lead to AIDS
LARC	Long Acting Reversible Contraceptive: a range of "fit" and "forget" contraceptives which tend to be highly effective.
LGBT	Individuals or groups who identify as Lesbian, Gay Bisexual or Transgender
Looked after children	A child is 'looked after' if they are in the care of the local authority for more than 24 hours
MSM	Men who have ever had male-male sexual contact. This definition is used because it describes sexual behaviour, regardless of how men perceive their sexual identity
PHE	Public Health England is an executive agency of the Department of Health in the United Kingdom that began operating on 1 April 2013. Its formation came as a result of reorganisation of the National Health Service in England outlined in the Health and Social Care Act 2012
Primary care	Non specialised, first contact health care given by a health care provider (e.g. general practice or community pharmacy)
Screening	Range of testing methods for sexually transmitted infections
Serosorting	Serosorting is the practice of choosing a sexual partner who has the same

	serostatus as you. Usually, serosorting is used as a method of engaging in unprotected sex.
Sexual health clinics	Provide a range of sexual health services to treat and prevent sexually transmitted infections, sometimes combined with family planning clinics
Sex workers	Women, men and transgendered people who receive money or goods in exchange for sexual services, and who consciously define those activities as income generating even if they do not consider sex work as their occupation
SRE	Sex and Relationship Education, delivered in schools provides learning content on the emotional, social and physical aspects of growing up, sex, relationships, human sexuality and sexual health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections – i.e. infections passed by oral, vaginal and anal sexual contact
Symptoms	Any feeling of illness or physical or mental change which is caused by a particular infection or disease
Syphilis	A bacterial infection that can be passed by sexual contact with an infected person
Termination of Pregnancy	Also known as abortion or terminations: the medical process of ending a pregnancy
Unintended pregnancy	An unintended pregnancy is a pregnancy that is mistimed, unplanned, or unwanted at the time of conception
Unprotected sex	Sex without using a condom or other barrier of contraception
Unrestricted age	Refers to those instances where young people under the age of 16 are able to access a service
Virus	An extremely small organism which causes disease.

Appendix A

Self-Managed Care

Via community outreach services, the Playinitsafe, WCC and HACW websites, service users of all ages are able to access the following without the need to see a specific sexual healthcare practitioner (although this is available if required):

- Health information;
  - Generic information on pregnancy, and STIs including HIV prevention/safer sex advice
  - Information on the full range of contraceptive methods and where these are available
- Primary prevention initiatives to improve overall sexual health to the community;
- Male and female condoms and lubricant;
- Chlamydia home sampling kits for under 25 year olds[19];
- Pregnancy testing kits.

Those aged under the age of 16 that are accessing physical services are seen by a worker trained to assess competence to receive sexual health advice and interventions in the absence of a parent or guardian, and to ensure that safeguarding issues are identified and appropriately referred on[20,21,22]

Basic and Intermediate Care (Level 1 and 2)

- Information on services provided by local voluntary sector sexual health providers including referrals and/or signposting
- Full sexual history taking and risk assessment (all practitioners)[23]
- Pregnancy testing
- Supply of male and female condoms and lubricant
- All methods of oral emergency contraception and the intrauterine device for emergency contraception[24]
- First prescription and continuing supply of combined hormonal contraception (combined and progestogen only) including oral, transdermal, transvaginal methods of delivery and a choice of products within each category where these exist
- First prescription and continuing supply of injectable contraception
- IUD and IUD uncomplicated insertion, follow up and removal
- Diaphragm fitting and follow up

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[19] Home sampling kits for dual chlamydia and gonorrhoea testing may be appropriate in high prevalence areas. Availability of such kits should be in line with national guidance (http://www.chlamydiascreening.nhs.uk/ps/standards.asp and *Standards for the Management of Sexually Transmitted Infections* (BASHH & MEDFASH 2010) and commissioners must ensure that appropriate pathways are in place for the confirmation and case management of gonorrhoea cases.

[20] Department of Health (2004). *Best Practice Guidance for Doctors and other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health* (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960)

[21] Gillick v West Norfolk & Wisbech Area Health Authority [1985] UKHL 7 (17 October 1985) (http://www.bailii.org/uk/cases/UKHL/1985/7.html)

[22] Sexual Offences Act 2003 (http://www.legislation.gov.uk/ukpga/2003/42/contents)

[23] Full sexual history taking and risk assessment should include brief interventions as part of harm reduction techniques with high risk individuals to reduce STIs, HIV and under 18 conceptions. Where agreed locally, brief interventions for problematic drug and alcohol use should be covered with onward referrals to local services as appropriate. Questions regarding intimate partner violence may also be considered where appropriate.

[24] Faculty of Sexual and Reproductive Healthcare (2011) *Clinical Guidance Emergency Contraception* August 2011(Updated January 2012)

- Uncomplicated contraceptive implant insertion, follow up and removal
- Assessment and referral for difficult implant removal
- Natural family planning
- Cervical cytology
- Direct referral for antenatal care
- Direct referral for abortion care and to support self-referral
- Counselling and direct referral for male and female sterilisation
- Domestic abuse screening and referral (all practitioners)
- Assessment and referral for psychosexual issues
- Assessment and referral for Alcohol Brief Interventions (ABIs)
- Referral for Female Genital Mutilation (FGM) specialist advice and care
- STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM)[25] and women excluding:
    - Men with dysuria and/or genital discharge
    - Symptoms at extra-genital sites e.g. rectal or pharyngeal
    - Pregnant women (except women with uncomplicated infections requesting abortion)
    - Genital ulceration other than uncomplicated genital herpes
- Chlamydia screening for sexually active under 25 year olds
- Case Management of uncomplicated Chlamydia
- HIV and syphilis testing and pre and post-test discussions (with referral pathways in place)
- Initiation of Post Exposure Prophylaxis with referral to Level 3 for on-going management
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups
- Hepatitis C testing and discussion (with referral pathways in place)
- Uncomplicated contact tracing/partner notification
- Management of first episode uncomplicated vaginal discharge (low risk)
- Management of contacts of gonorrhoea and TV (excluding symptomatic men)
- Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of syphilis/LGV (Lymphogranuloma Venereum)
- Assessment and referral of sexual assault cases
- Holistic sexual health care for young people including child protection / safeguarding assessment
- Outreach services for STI prevention and contraception[26]
- Problems with choice of contraceptive methods

[25] The testing and management of men who have sex with men (MSM) has been defined as an element of care at Level 3 as the majority of infections in this group are in the rectum and/or pharynx rather than the urethra (with prevalence in a GUM clinic sample found to be 20% vs 7% respectively for gonorrhoea, and 10% vs 5% for chlamydia). Therefore, adequate testing requires access to NAATs, and gonorrhoea cultures from extra-genital sites. No NAATs are approved for use on extra-genital samples, so these should only be used in liaison with the local microbiologists and culture is often not feasible in Level 2 services because it requires immediate transport of samples to the laboratory. However, for the management of asymptomatic MSM there may be exceptions in Level 2 services which have the full range of investigations available and the necessary clinical and prevention skills.

[26] Outreach defined as a service provided outside a (hospital or community) clinical setting that is flexibly tailored to specific local needs and that is reviewed on a regular basis.

- Management of problems with hormonal contraceptives
- Urgent and routine referral pathways to and from related specialties (general practice, urology, A&E, gynaecology) should be clearly defined. These may include general medicine /infectious diseases for inpatient HIV care
- Urgent and routine referral pathways to and from social care
- Regular audit against national guidelines

Complex (Level 3) Service Provision in addition to Levels 1 and 2**

- Management of complex contraceptive problems including UK Medical Eligibility Criteria (UKMEC)[27]
- Management of complicated/recurrent STIs (including tropical STIs) with or without symptoms
- Management of STIs in pregnant women (except women with uncomplicated infections requesting abortion)
- Management of HIV partner notification[28]
- Management of sexual health aspects of psychosexual dysfunction[29]
- Management of organic sexual dysfunction[30]
- Coordination of outreach clinical services for high risk groups
- Interface with specialised HIV services as commissioned by NHS England
- Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. with appropriate diagnostic services (e.g. ultrasound) to support this
- Provision and follow up of post-exposure prophylaxis after sexual exposure to HIV
- Coordination of contraceptive and STI care across a network including:
    - Clinical leadership of contraceptive and STI management
    - Co-ordination of clinical governance
    - Co-ordination and oversight of training in SRH and GUM
    - Co-ordination of pathways across clinical services
    - Co-ordination of partner notification for STIs and HIV

[27] *UK Medical Eligibility Criteria and Contraceptive Use*, FSRH 2009 (updated 2010) http://www.fsrh.org/pdfs/UKMEC2009.pdf

[28] Cross reference: NAT (National AIDS Trust (2012). *HIV Partner Notification: A Missed Opportunity?* (http://www.nat.org.uk/media/Files/Publications/May-2012-HIV-Partner-Notification.pdf)

[29] The American Psychiatric Association (2013) classifies sexual dysfunction as including 'delayed ejaculation, erectile disorder, female orgasmic disorder, female sexual interest/arousal disorder, genito-pelvic pain/penetration disorder, male hypoactive sexual desire disorder, premature (early) ejaculation, substance/medication induced sexual dysfunction, other specifies sexual dysfunction and unspecified sexual dysfunction'.

[30] It is recognised that the provision of psychosexual services may form part of a separate agreement and will therefore contain further details on specific service requirements. Additional information can be found at www.ipm.org.uk www.cosrt.org.uk and www.bacp.co.uk or by cross referencing *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* The American Psychiatric Association (2013)

Appendix B

Contraception by GP Practice

Practices with significantly high rates of attendance at SHS and significantly high LARC prescribing rates

			No.	Rate	prescription	Prescribing rate	Female popn aged 15-44
Code	GP practice	High	SHS	SHS	GP	GP	
M81017	Elbury Moor Medical Centre	Moor Street Clinic, 89%	128	488.5	197.1	752.4	2620
M81089	Church Hill, McGregor	Smallwood House, 94%	71	593.6	84.3	705.1	1196
	All Worcestershire practices			*404*		*464*	

Practices with significantly low rates of attendance at SHS and significantly low LARC prescribing rates

Code	GP practice	District	High	No.	prescription	Rate	Prescribing rate	Female popn aged 15-44
				SHRAD	GP	SHRAD	GP	
M81064	Hollywood Medical Practice	Bromsgrove	Smallwood House, 56%	18	22.9	168.7	214.2	1067
M81629	New Court Surgery	Malvern Hills	Moor Street Clinic, 98%	43	53.4	237.2	294.5	1813
M81007	Bredon Hill Surgery	Wychavon	Evesham, 80%	5	9.3	63.9	119.0	782
M81058	Merstow Green	Wychavon	Evesham / Moor St 39%	46	57.4	247.2	308.7	1861

SHS high/GP low

Code	GP practice	District	High	No.	prescription	Rate	Prescribing rate	Female popn aged 15-44
M81070	Churchfields	Bromsgrove	Bromsgrove POWCH, 86%	122	82.0	507.6	341.4337	2403
M81084	Catshill Surgery	Bromsgrove	Bromsgrove POWCH, 91%	56	15.3	661.9	181.4283	846
M81087	Woodrow Medical Centre	Redditch	Smallwood House, 91%	80	7.2	979.1	88.24115	817
M81617	Crabbs Cross Surgery	Redditch	Smallwood House, 83%	65	15.5	781.25	187.2764	832
M81006	Severn Valley Medical Practice	Worcester City	Moor Street Clinic, 94%	193	141.3	474.085	347.2663	4071
M81063	St John's House,	Worcester City	Droitwich, 57%	92	80.3	555.8912	485.3509	1655

	Worcester							
M81072	Albany House	Worcester City	Moor Street Clinic, 96%	113	69.1	589.4627	360.7866	1917
M81065	Kidderminster Health Centre	Wyre Forest	Moor Street Clinic, 94%	208	34.1	929.8167	152.8209	2237
M81002	Elgar House	Redditch	Smallwood House, 86%	264	35.8	903.5	122.6	2922
M81019	Winyates Health Centre	Redditch	Smallwood House, 91%	211	82.6	674.8	264.2	3127
M81092	Bridge Surgery	Redditch	Smallwood House, 87%	70	30.3	662.9	286.5	1056

SHS low/GP high

M81045	Knightwick	Moor Street Clinic, 100%	9	44.8	169.2	842.4	532
M81005	Northumberland House	Kidderminster, 92%	48	208.0	214.3	928.6	2240
M81083	Hollyoaks Medical Centre	Arrowside Unit, 50%	*	*	*	*	*
M81042	Tenbury Wells	Moor Street Clinic, 70%	10	96.0	78.1	749.6	1280
M81094	Abbey Medical Practice	Evesham, 59%	17	106.0	117.0	729.4	1453
M81627	DeMontfort Medical Centre	Evesham, 77%	13	78.9	107.0	649.1	1215
M81068	Aylmer Lodge	Kidderminster, 92%	48	171.6	210.0	750.7	2286
M81073	Stourport Health Centre	Kidderminster, 96%	23	140.2	165.5	1008.5	1390
Y03602	Grey Gable Surgery	Bromsgrove POWCH, 100%	*	*	*	*	*

* **suppressed due to small numbers.**

Rates of attendance at SHS for patients registered at practices where no IUD/IUS/Implants were prescribed in 2014/15

Code	GP prac	District	Sig shs rate	Patients attending SHS	SHS no	SHS rate
M81002	Elgar House	Redditch	Higher	Smallwood House, 94%	131	448.3
M81084	Catshill Surgery	Bromsgrove	Higher	Bromsgrove POWCH, 96%	24	283.7
M81087	Woodrow Medical Centre	Redditch	Higher	Smallwood House, 86%	20	244.8
M81605	Glebeland Surgery	Bromsgrove		Bromsgrove POWCH, 74%	16	245.8
M81616	Crabbs Cross Medical Centre	Redditch		Smallwood House, 81%	12	236.7
M81617	Crabbs Cross Surgery	Redditch	Higher	Smallwood House, 94%	34	408.7
M81007	Bredon Hill Surgery	Wychavon	Lower	Evesham, 67%	*	*
M81011	Ombersley Medical Centre	Wychavon	Higher	Moor Street Clinic, 88%	23	424.4
M81058	Merstow Green	Wychavon		Moor Street Clinic, 50%	22	118.2
M81063	St John's House	Worcester City	Higher	Moor Street Clinic, 95%	81	362.1
M81072	Albany House	Worcester City	Higher	Moor Street Clinic, 98%	53	458.1

M81081	St Saviours	Malvern Hills	Higher	Moor Street Clinic, 94%	28	387.8
All Worcs practices						**1479**

* **suppressed due to small numbers.**

Significance compared to Worcestershire of OC and Larc 2014/15

		GP prescribed rate		SHS attendance rate	
		sig	sig	sig	sig
		OC	LARC	Non LARC	LARC
CRABBS CROSS SURGERY	M81617	higher	lower	higher	higher
ABBEY MEDICAL PRACTICE	M81094	higher	higher	lower	lower
MERSTOW GREEN MEDICAL PRACTICE	M81058	higher	lower	lower	lower
CHADDESLEY SURGERY	M81090	higher	not sig	not sig	not sig
ST. JOHNS SURGERY	M81082	higher	not sig	lower	lower
THE WOODROW MEDICAL CTRE	M81087	lower	lower	higher	higher
GREY GABLE SURGERY	Y03602	higher	higher	lower	lower
WOLVERLEY SURGERY	M81608	higher	not sig	not sig	lower
CORNHILL SURGERY	M81055	higher	not sig	lower	lower
ABBOTTSWOOD MEDICAL CENTRE	M81046	higher	not sig	lower	lower
DEMONTFORT MEDICAL CENTRE	M81627	lower	higher	lower	lower
ST MARTIN'S GATE SURGERY	M81035	not sig	not sig	not sig	not sig
NEW ROAD SURGERY (RUBERY)	M81025	higher	not sig	lower	lower
SEVERN VALLEY MEDICAL PRACTICE	M81006	lower	lower	higher	higher
THE CHURCH STREET PRACTICE	M81056	higher	not sig	not sig	lower
ELBURY MOOR MEDICAL CENTRE	M81017	lower	higher	not sig	higher
WINYATES HEALTH CENTRE	M81019	lower	lower	higher	higher
OMBERSLEY MEDICAL CENTRE	M81011	higher	not sig	higher	higher
RIVERSIDE SURGERY	M81004	higher	not sig	lower	lower
BREDON HILL SURGERY	M81007	higher	lower	lower	lower
KNIGHTWICK SURGERY	M81045	higher	higher	lower	lower
PERSHORE MEDICAL PRACTICE	M81074	higher	higher	lower	not sig
HILLVIEW MEDICAL CENTRE	M81041	not sig	not sig	higher	not sig
NEW ROAD SURGERY BROMSGROVE	M81021	lower	not sig	lower	lower
MAPLE VIEW MEDICAL PRACTICE	M81089	lower	higher	higher	higher
NORTHUMBERLAND HOUSE SURGERY	M81005	lower	higher	lower	lower
BARBOURNE HEALTH CENTRE	M81049	lower	not sig	higher	higher
CORBETT MEDICAL PRACTICE	M81091	higher	not sig	lower	lower
TENBURY SURGERY	M81042	higher	higher	lower	lower
GREAT WITLEY SURGERY	M81033	higher	not sig	not sig	lower
ST STEPHENS SURGERY	M81001	lower	not sig	higher	higher
THE GLEBELAND SURGERY	M81605	higher	not sig	lower	not

					sig
AYLMER LODGE COOKLEY PARTNERSHIP	M81068	higher	higher	lower	lower
SPRING GARDENS GROUP MEDICAL PRACTICE	M81008	lower	not sig	higher	higher
ALBANY HOUSE SURGERY	M81072	not sig	lower	higher	higher
LINK END SURGERY	M81079	higher	higher	lower	not sig
DAVENAL HOUSE SURGERY	M81069	higher	not sig	lower	higher
SPA MEDICAL PRACTICE	M81047	not sig	higher	not sig	not sig
HOLLYWOOD MEDICAL CENTRE	M81064	not sig	lower	lower	lower
CHURCHFIELDS SURGERY	M81070	lower	lower	not sig	higher
BARNT GREEN SURGERY	M81078	not sig	not sig	lower	not sig
CATSHILL VILLAGE SURGERY	M81084	lower	lower	not sig	higher
THE DOW SURGERY	M81020	lower	lower	higher	not sig
HARESFIELD HOUSE SURGERY	M81022	lower	not sig	higher	higher
BARN CLOSE SURGERY	M81029	higher	not sig	lower	lower
STOURPORT HEALTH CENTRE	M81073	not sig	higher	lower	lower
MALVERN HEALTH CENTRE	M81075	not sig	not sig	lower	lower
THE BRIDGE SURGERY	M81092	lower	lower	higher	higher
THORNELOE LODGE SURGERY	M81037	lower	not sig	higher	higher
ST SAVIOURS SURGERY	M81081	not sig	not sig	not sig	higher
STANMORE HOUSE SURGERY	M81015	lower	higher	not sig	not sig
YORK HOUSE MEDICAL CTR.	M81040	not sig	not sig	lower	lower
ELGAR HOUSE	M81002	lower	lower	higher	higher
NEW COURT SURGERY	M81629	lower	lower	lower	lower
HAQQANI PRACTICE	M81616	lower	not sig	higher	not sig
THE RIDGEWAY SURGERY	M81077	not sig	not sig	not sig	not sig
ST JOHNS HOUSE SURGERY	M81063	lower	lower	higher	higher
WHITEACRES MEDICAL CENTRE	M81039	not sig	not sig	lower	lower
HAGLEY SURGERY	M81027	lower	not sig	lower	lower
FOREST GLADES MEDICAL CTR	M81010	lower	not sig	higher	not sig
KIDDERMINSTER HEALTH CENTRE	M81065	lower	lower	higher	higher
UPTON SURGERY	M81038	not sig	not sig	lower	lower
HOLLYOAKS MEDICAL CENTRE	M81083	not sig	higher	lower	lower
SALTERS MEDICAL PRACTICE	M81034	lower	not sig	higher	higher
BEWDLEY MEDICAL CENTRE	M81057	lower	not sig	lower	lower