NORTH EAST LINCOLNSHIRE COUNCIL
www.nelincs.gov.uk

North East Lincolnshire Council

Sexual Health Needs Assessment

Unique Improvements

Chapter 1

What does a good sexual and reproductive service look like?

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STI's, including HIV) and abortion. Provision of sexual health services is complex and there are a wide range of providers, including general practice, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector.

There have been several public health papers which look at the provision of sexual and reproductive health services in England. The first of these being the national strategy for sexual health and HIV (Department of Health, 2001) which set out a 10-year plan to:

- Prevent infection and subsequent transmission
- De-stigmatise HIV
- Enhance HIV / AIDS care services
- Dramatically reduce teenage pregnancy rates

In the years since 2001 the focus around sexual health is the importance to provide prompt access to Genitourinary Medicine (GUM) clinics, along with the provision of a full range of contraceptive services and delivery of a chlamydia screening programme in a community setting through primary care.

According to national policy a good sexual and reproductive health service should provide an easily accessible community based service that focuses on prevention along with detection and treatment.

From April 2013, the commissioning of sexual health services changed and responsibility for commissioning most sexual health work was transferred to local authorities.

This responsibility involves commissioning HIV prevention and sexual health promotion, open access genitourinary medicine and contraception services for all age groups. Local authorities are not responsible for the NHS England contracted element of sexual health services but can commission sexual health services in primary care. This includes services commissioned from general practice and pharmacy as 'local enhanced services', such as long acting forms of contraception, chlamydia screening, emergency hormonal contraception, sexual health aspects of psychosexual counselling.

Who commissions what?

All commissioners and providers need to work together to improve sexual health services and to ensure good quality services and outcomes.

Local authorities	Clinical Commissioning Groups (CCGs)	NHS England
Comprehensive sexual health services including: • Contraception including LESs (implants) and NESs (intra-uterine contraception) and all prescribing costs, excluding contraception provided as an additional service under the GP contract • Sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing and partner notification for STIs and HIV • Sexual health aspects of psychosexual counselling • Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies	• Most abortion services (but there will be further consultation about the best commissioning arrangements in the longer term) • Female sterilisation • Male sterilisation (vasectomy) • Nonsexual health elements of psychosexual health services • Gynaecology, including any use of contraception for non-contraceptive purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure) • Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs • All sexual health elements of healthcare in secure and detained settings • Sexual Assault Referral Centres • Cervical screening • Specialist foetal medicine services

It is important that commissioners, providers and wider stakeholders work together to make sure that sexual and reproductive health services are responsive, relevant and as easy to use as possible (Duncan Selbie, Chief Executive Public Health England, Making it Work, 2015). "**Making it Work**" also outlines the importance of a whole system approach which has the service user at the heart.

The key messages from "Making it Work" are as follows:

- Put people at the centre of commissioning decisions and base them on assessed need
- Take service user pathways as the starting point for commissioning with the aim of ensuring people experience, integrated, responsive services
- Review whether existing service provision and configuration best meet identified needs for the area
- Maximise opportunities to tackle the wider determinants of health

It is important to understand that the commissioning of sexual and reproductive health (STI testing and treatment services, and contraception services) and HIV services across NEL is a statutory requirement for the council.

The local authority must commission:

- Open access sexual health services including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception, and to ensure these are in place to meet local needs. All services should include arrangements for the notification, testing, and treatment and follow up of partners of people who have a sexually transmitted infection (STI) (partner notification)
- Some specialised services are directly commissioned by CCGs and at the national level by NHS England. For abortion (termination of pregnancy - TOP) services this would be in partnership with the NEL CCG who has the commissioning responsibility for most abortion services. The LA's role is to ensure that there is a pathway, advice and information both prevention and intervention
- Define the role and responsibility of each service in relation to partner notification (including referral pathways)
- Ensure staff are trained
- Ensure there is an audit and monitoring framework in place

Priority areas should include:

- A continuing fall in the rate of births to girls and young women under the age of 18
- Giving women of all ages control of their fertility through access to a full range of contraceptive choices and abortion services
- A reduction in avoidable HIV deaths, ill health and onward HIV transmission through a reduction in the proportion of people with HIV whose infection is diagnosed late
- A reduction in the prevalence of chlamydia through increased screening of young people 15-24
- A reduction in new diagnoses of other STI's including gonorrhoea and genital warts

To be able to optimise the likelihood of achieving these outcomes it will be important to ensure that people have open access to services in a timely manner. There is strong evidence to show that open access to sexual health services within 48hrs of seeking care is crucial to controlling STI's.

The National Institute for Health and Care Excellence (NICE) publish guidance on sexual and reproductive health which is intended to be used by commissioners, service providers and other agencies to ensure high quality and consistent services.

NICE identify several risky behaviours and high risk groups and offer advice and guidance on how best to identify and treat them.

Specific groups identified by NICE are:

- Men who have sex with men (MSM)
- People who have visited or come from areas of high prevalence of HIV
- Injecting venous drug users
- Commercial sex workers
- Vulnerable [1] young people under 18 or vulnerable young women who are pregnant or who may already be mothers. This may include young people:
  - > from disadvantaged backgrounds
  - > who are in – or leaving – care
  - > who have low educational attainment

Behaviours that increase the risk of STIs include:

- Misuse of alcohol and/or substances
- Early onset of sexual activity
- Unprotected sex and frequent change of and/or multiple sexual partners

Chapter 2

Local Demographics

The total population of NEL is estimated at 159,727. The percentage of the local population who are of working age, (16 to 64), is slightly below the England figure of 63.3% at 61.4% (97,980). 19.5% (31,149) of the local population are 65+, which is higher than the England figure of 17.7%. The percentage of children and young people (0 to 15), is in line with England figure (19.0%) at around 19.1% (30,441) of the population.[2]

For further statistics regarding NEL please visit the council's data observatory.

www.nelincsdata.net

NEL Council Plan priorities are:

Stronger Economy **focusing upon skills and employability, business support and innovation, local employment and sustainable environment and** ***Stronger Communities*** **focusing upon independence, sustainable housing, active citizens and healthy lives.**

The five most deprived areas are overall, densely populated

Ward Area	Population (Out of total population 159,727)
South	12,728
East Marsh	11,835
West Marsh	7,754
Sidney Sussex	12,789
Heneage	12,013

- The child (<16s) poverty rate has remained steadfastly high at 28.5%, compared with 20.8% for the region and 19.2% nationally. A large majority of children (0-15) in NEL live in the five most deprived wards.

Those wards with the highest child poverty rates for under 16s are:

Ward Area	Population (Percentage of children <16 living in poverty)
South	49.7%
East Marsh	49.3%
West Marsh	42.3%
Sidney Sussex	36.9%
Heneage	31.5%

- NEL is ranked as the 31st most deprived local authority in England. (NEL Informed, deprivation bands):
  - 32,567 (20.4%) are income deprived
  - 15,140 (9.5%) are employment deprived
- Despite predictions of substantial population growth in the next 15 years most recent data suggests net migration outflow
- 1,160 out of every 10,000 children in NEL were defined as children in need during 2014/15 which was amongst the highest rates in the country (England average: 674, England highest: 1,501). During the same year 65.9 out of every 10,000 children had a child protection plan which was significantly higher than the England average of 42.9 [3]
- NEL has the third highest rate of Looked After Children (LAC) in Yorkshire and Humber (Y&H) (77.2 rate per 10,000) compared to a Y&H average of 63.6 and an England[4] average of 60)
- NEL has the 2nd highest rate of admissions for mental health conditions in 0-17 year olds in Y&H (source: A snapshot of Health and Wellbeing in NEL 2015)
- The number of opioid drug users in NEL had been falling for many years but has now increased. The treatment outcomes for opioid and non-opioid drug users are poor. There is also anecdotal evidence of increasing use of 'legal highs' but little data exists on this
- In NEL prevalence rates for opiate and crack users for 2011/12 were 15.41 per 1000 compared with 8.40 per 1000 in England. [4] Alcohol and drug dependency has an impact on risky behaviour
- During 2015 the NEL rate of new STI diagnoses was lower than both the Y&H regional and overall England rates
- In 2015, 7.1% of 16-18yr olds were not in education, employment or training (NEETS) which is the highest in Y&H (average rate of 4.8%) and well above the national rate of 4.4%
- Teenage pregnancy rates have fallen from 69.8 per 1000 girls aged 15-17 in 1998 to 36.3 in the 12 months up to Qtr3 2015. This reduction is lower than the regional and national reduction. NEL has the highest teenage pregnancy rate in Y&H
- The teenage pregnancy rates in under 16 pregnancies are the joint second highest of all local authorities in England. The rate of conceptions per 1,000 in females aged 13 – 15 is 10.0 compared to an England average of 4.9 (2012-2014)
- South, East Marsh and West Marsh wards have under 18 conception rates which are significantly higher than the NEL average

These are all factors which contribute to the description of ‘at risk groups’ classified by NICE.

NICE publish guidance on sexual and reproductive health which is intended to be used by commissioners, service providers and other agencies to ensure high quality and consistent services.

NICE identify several risky behaviours and high risk groups and offer advice and guidance on how best to identify and treat them. NICE identify several risky behaviours and at risk groups, these are detailed in chapter 1.

People who fall within the classification of ‘at risk’ are more likely to have a lifestyle which leaves them vulnerable to poor sexual and reproductive health care.

Ethnicity

- 95.4% of the resident population within NEL are White British
- The largest ethnic group in NEL is Other White, with 1.7% of the overall population
- The proportion of ethnic minorities in NEL (4.6%) is significantly lower than seen in the Y&H region (14.2%) and in England (20.2%) [5]

Sexual Identity

Sexual identity is a very difficult area to obtain data on but it is relevant as there is a need to ensure there is equity in service provision and that services can be targeted to be most effective.

Asking questions about sexual identity is a very sensitive area and even in 2016 there is considerable under reporting of sexual identity, particularly in areas such as NEL where there remains, in some parts, a homophobic attitude and no obvious Lesbian, Gay, Bisexual and Trans* (LGBT) 'Scene'. Establishing a sexual health network, which could be potentially facilitated by the Integrated Sexual Health (ISH) Service and which could be responsible for sharing information across key partners, would help this to be highlighted and could improve future recording approaches. In 2009, a question on sexual identity was developed and asked of all respondents aged 16 and over as part of a number of the integrated Household Surveys by ONS.

Reliable estimates of the LGBT community are unknown at local authority level and in fact from all sources. Estimates of LGBT prevalence are widely under reported as they are sensitive issues and defining sexual identity is complex. Organisations tend not to standardise the collection of identifiers and people often do not answer correctly or prefer not to answer the question.

Data on sexual identity is not published at local authority level, however the 2015 ONS Annual Population Survey results estimate that 1.8% of the Y&H population identify as gay/lesbian or bisexual, compared to 1.7% of the overall England population.[6]

Predicting prevalence is important as we need to be able to plan services. There are several estimates for predicting prevalence which depend upon the organisation who is predicting. Estimates range from 0.3 to 10%. The Department for Trade and Industry predicts a 5 to 7% rate in the population which is drawn from a wide range of data sources and settings. Within a sample of 10 different government and social surveys, based on identity questions, this indicates a range of 0.3 % to 3%. The Citizenship Survey[7] gives a lower proportion of 1.5%. None of these methods of assessment adjust for under reporting or deliberate misreporting which is a recognised feature within non-NEL LGBT communities. We can reasonably expect the issue to be greatly under reported in NEL.

The LGBT community estimates that prevalence is more likely to be 10% of the population. (Equality and Human Rights Commission 2009)

If we used a reasonable assessment of LGBT population prevalence of 5% (assuming people aren't going to come to NEL if it is not 'LGBT friendly') then using the 2014 based population projections for the year 2039 we would potentially need a sexual health service for 5,500 people aged 16 to 74 years or for 6,740 people aged 16 years and over.

Chapter 3

What does sexual and reproductive health look like in NEL?

Contraceptive and sexual health services are provided by a combination of providers in NEL. Virgin Care is the largest provider, providing the NEL Integrated Sexual Health service (ISH), offering sexual health clinics from five locations in NEL. There is one hub at Stirling Street, a spoke at Birkwood Medical Centre and three outreach clinics at further and higher education settings.

In addition to face to face services, Virgin Care offer a virtual hub which is an online service that provides online access to appointments 24/7 and advice on a wide range of sexual health services such as contraception and STI testing.

In the year 2015/16 there were 11,670 attendees at services provided by Virgin Care with just under 80% of the attendances taking place at the Stirling Street Clinic, which is located within the East Marsh area. In addition, during 2015/16 there were 1,642 out of area attendances utilising the NEL ISH.

The NEL ISH main site is based at Stirling Street Clinic and offers a mix of appointment and walk in sessions and in 2015/2016 these attendees are split as 59% appointment and 41% walk in service users.

In addition to the NEL ISH there is also sexual and reproductive health services provided by 32 local pharmacies. This service is known as ACT (advice, contraception and testing) in NEL and has been operating since December 2009. ACT offers free Emergency Hormonal Contraception (EHC), condoms, chlamydia screening and pregnancy testing to all age groups. These pharmacists also link into existing networks for community contraceptive services so that women who need to see a specialist can be referred on rapidly. There is extensive coverage by ACT in NEL with all but three of the local retail pharmacies taking part.

Pharmacies provide support (both verbal and written information) to clients accessing the service, including advice on the avoidance of pregnancy and sexually transmitted infections through safer sex and condom use, information on the use of regular long term contraceptive methods and provide onward signposting to services that provide long term contraceptive methods, diagnosis and management of STI's.

STI infection rates in NEL tend to be lower than the England average, however the infection rates for chlamydia and syphilis are higher than the national average. The biggest increases in disease specific infections between 2013 and 2014 were syphilis (mainly younger heterosexual males) which saw a 363.2% increase and gonorrhoea which saw a 96.2% increase in the number of infections reported. Although the national trend is increasing the rate of gonorrhoea in NEL is well below the England average. Overall those who were diagnosed with a STI in 2014 in NEL 41% were men and 59% were women.

Rates per 100,000 populations of new STIs in NEL and England, 2013 to 2014

Diagnoses	NEL Rate 2013	NEL Rate 2014	% Change 2013 to 2014	NEL rank in England 2014*	England Rate 2014
All new STIs	733.9	780.2	6.3		797.2
New STIs**	494.3	555.6	12.4	197	828.7
Chlamydia	531.2	533.1	0.4		374.9
Gonorrhoea	13.1	25.7	96.2	184	63.3
Syphilis	1.9	8.8	363.2	37	7.8
Genital Warts	103.2	111.4	7.9	172	128.4
Genital Herpes	33.2	55.1	66.0	135	57.8

Source: Public Health England
*** Out of 326 local authorities, 1st rank has the highest rate**
**** Excluding those with chlamydia aged 15-24 years**

In 2014 the rate of HIV diagnosis was 1.5 per 100,000 populations which equates to 2 diagnoses which is significantly lower that the England average rate of 12.3 per 100,000 however the rate of late diagnoses was 57.1% (equating to 1 person).

In the period of May to July 2016 pharmacies have provided 145 episodes of Emergency Hormonal Contraceptive.

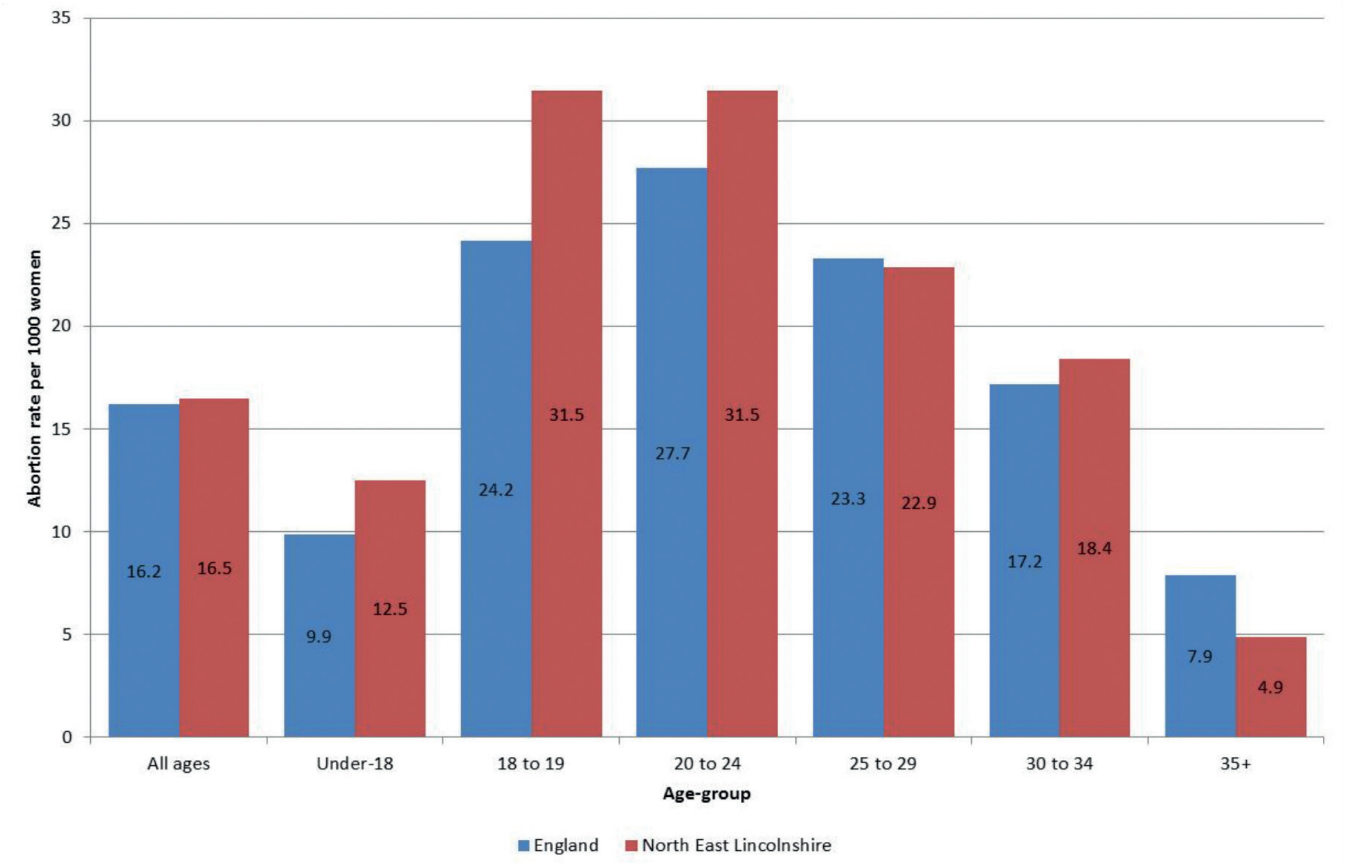
The Department of Health stratifies the age of females when the abortion was carried out, into six bands and also reports on total abortions.

Abortion rates per 1000 women, NEL, 2013 to 2015 and 3-year average

	2013	2014	2015	2013-15 average
Under-18	14.3	16.2	12.5	14.3
18-19	16.4	17.3	31.5	21.7
20-24	31.2	33.6	31.5	32.1
25-29	26.1	25.0	22.9	24.7
30-34	15.6	17.6	18.4	17.2
35+	5.8	4.9	4.9	5.2
Total	16.7	17.3	16.5	16.8

Source: Department of Health

Abortion rates per 1000 women, England and NEL – 2015



The abortion rates for five of the seven age ranges are higher than the England average and the overall abortion rate is 16.5 abortions per 1000 women compared to the England average of 16.2. The NEL abortion rate peaks at age 18-24, whereas the England rate peaks at age 20-24. The only age groups to see a rate lower than the England average are 25-29 which is 22.9, compared to 23.3 per 1000 and the 35+ age group which has a rate of 4.9 compared to the England average of 7.9 per 1000.

During 2015, there were 502 NEL abortions of which 40.6% were repeat abortions, this being similar to the England repeat abortion figure of 38.0%.

The relationship between age and repeat abortions is complex since as women age they have had a longer period to have already had a previous abortion.

During 2015 the percentage of repeat abortions in the under-19 age group was 16.4% for NEL compared to 10.0% for England overall. The percentage of repeat abortions in the under-25 age group was 25.9% for NEL compared to 26.5% for England overall.

The percentage of repeat abortions in the 25 and over age group was 54.4% for NEL compared to 46.2% for England overall.

The main differences in repeat abortions between NEL and England are therefore in the younger and older age groups, with the percentage of repeat abortions in the 25 and over age group being the eighth highest local authorities repeat abortion percentage in the country.

Most abortion services in NEL are provided by the Northern Lincolnshire and Goole (NHS) Foundation Trust which has sites in Grimsby, Scunthorpe and Goole. For residents in NEL the nearest service is the Diana, Princess of Wales Hospital in Grimsby. Other provision is available dependent upon referral and need; NEL CCG also commissions abortions from the British Pregnancy Advisory Service (BPAS).

Teenage pregnancy is an issue in NEL with the under 18 conception rate for quarter 1 of 2015 being 40.8 conceptions per 1000 females aged 15-17, this is higher than both the Y&H (25.8) and England (22.3) average rates.

The rate in under 18 conceptions has fallen from 69.8 in 1998, to 40.8 in 2014 which is a reduction of 41.5%. However this reduction is lower than the both the Y&H (50.3%) and England (51.1%) reductions.

Compared to all local authorities in England, NEL has the highest rolling annual rate of under 18 conceptions for quarter 1 of 2015. However, there were 117 NEL under 18 conceptions during 2014 which was the lowest annual number for conceptions since the 1998 baseline. The wards with the highest level of under 18 conceptions are East Marsh and West Marsh.

NEL also has the highest rate of under 16 conceptions within Y&H for the period of 2012-14 (10.0 conceptions per 1000 females aged 13-15). This local rate is higher than both the Y&H average (6.1) and the England average (4.9). There were 81 under 16 conceptions in NEL during the period of 2012-14 which was an increase of 7 conceptions compared to 2011-13.

Across NEL the commissioning expenditure by the council on contracted out sexual health services is approximately £900,000 per annum. This is split between Virgin Care, GPs, pharmacies and the 3rd sector with a small amount being spent on consumables such as condoms. Other organisations such as Virgin Care, Foundations and Positive Health Lincolnshire have their own arrangements for purchasing condoms, lubes and consumables. There may be scope for bulk buying and economies of scale if this was brought together to increase the availability of condom supply without costing more. In addition to contracted out services, the council also delivers in house sexual health provision that is funded by the public health grant. These services include school nursing and young people's support services.

NEL Adolescent Lifestyle Survey 2015. Sexual Health and Deprivation Analysis.

An Adolescent Lifestyle Survey (ALS) was undertaken in NEL during 2015. The ALS was offered to all young people of secondary school age (years 7 to 11; ages 11 to 16 years), and was facilitated by the academies with eight of the ten secondary academies in NEL participating. The final report included an analysis of the responses of 52% of the registered secondary school population.

This data summary provides analysis of the questions relating to sexual health from the ALS at a local deprivation quintile level. Analyses are intended to show where, if any, differences occur between the sexual health responses of adolescents living in different deprivation quintiles in NEL. Deprivation quintiles were calculated using the 2015 Indices of Multiple Deprivation (IMD) based on postcodes given by survey respondents and analyses were grouped for each question by quintile.

Not all respondents to the survey gave their postcode, therefore it was only possible to undertake analysis on a proportion of the dataset; 59% of those who responded to the survey gave a recognisable postcode which equated to 30% of the registered secondary school population. Furthermore, due to sensitivity issues, some schools opted out of their pupils responding to the sexual health questions and this reduced the sample size further. To ensure that the age distribution amongst each quintile was not weighted towards younger or older children, only 13 to 16 year olds were included in the following analysis. This left an approximate response rate for the sexual health questions of 24% of the registered secondary school population aged 13 to 16 years. However, the minimum response rate for each quintile was as follows:

Local 2015 IMD Quintile	Minimum number of responses
1 Most Deprived	116
2	131
3	172
4	266
5 Least Deprived	453

A separate report which presents the full survey methodology and more in depth findings is available for download: http://www.nelincsdata.net/resource/view?resourceId=372.

The data presented below should be interpreted along with information provided in the 'Happiness and Home Life' section in the main Adolescent Lifestyle Report (available from the link above). This will give clarity and context to the information provided in this data summary.

Sexual Health Social Norms

ALS 2015 Sexual Health	Local 2015 IMD Quintile				
	1 Most Deprived - 5 Least Deprived				
	1	2	3	4	5
"young people should wait until they are 16 before they have sexual intercourse" Proportion who agreed	39.0%	42.3%	43.3%	43.0%	42.6%
"How many people your age do you think have had sex?" Proportion who thought at least half have had sex	47.0%	55.7%	41.5%	46.8%	50.3%

Sexual Experience

"Have you ever had sex"

Proportion who answered 'Yes'

	1 Most Deprived - 5 Least Deprived				
	1	2	3	4	5
	6.7%	5.8%	7.1%	8.3%	9.7%

Knowledge of STI's

"Look at the list of STIs and tick the box which best describes what you know about each."

Proportion who answered 'never heard of it'

	1 Most Deprived - 5 Least Deprived				
	1	2	3	4	5
Genital herpes	26.5%	20.3%	20.0%	21.3%	17.7%
Genital warts	30.8%	25.6%	27.7%	22.8%	19.9%
Gonorrhoea	35.0%	27.1%	28.7%	26.8%	22.6%
Syphilis	43.6%	30.5%	31.4%	29.3%	25.2%
HIV/ Aids	10.3%	6.8%	5.7%	6.4%	5.9%
Chlamydia	22.2%	18.0%	17.7%	17.2%	12.7%

Knowledge of STI's

"Look at the list of STIs and tick the box which best describes what you know about each."

Proportion who have correctly answered whether the following STI's 'can be treated but not cured' or 'can be treated and cured'

	1 Most Deprived - 5 Least Deprived				
	1	2	3	4	5
Genital herpes	8.5%	6.8%	5.1%	9.0%	9.4%
Genital warts	3.4%	6.8%	2.3%	6.3%	6.3%
Gonorrhoea	17.9%	16.5%	11.5%	15.5%	16.0%
Syphilis	11.1%	11.5%	8.7%	16.2%	13.5%
HIV/ Aids	34.5%	42.1%	38.9%	43.4%	43.2%
Chlamydia	28.2%	30.1%	21.7%	24.3%	25.2%

Contraception

"Do you know where to get free contraception?"

Proportion who answered 'yes'

	1 Most Deprived - 5 Least Deprived				
	1	2	3	4	5
Proportion who answered 'yes'	57.8%	64.9%	59.1%	57.1%	59.4%

Contraception

"Look at the list of contraceptives and tell us if you have heard of them or not."

Proportion who answered 'heard of'

	1 Most Deprived - 5 Least Deprived				
	1	2	3	4	5
A condom	91.5%	97.0%	96.0%	96.6%	95.9%
The pill	85.5%	94.0%	90.3%	90.3%	92.2%
Emergency contraception	73.5%	83.5%	77.3%	81.3%	82.0%
Implant	81.2%	84.2%	81.8%	80.9%	85.9%
Injection	84.5%	83.5%	79.4%	85.4%	85.7%

In NEL, there are innovative approaches in existence to reach the harder to reach and more at risk groups widening the availability of contraceptive advice and screening services:

MSM outreach

An outreach service for men who have sex with men (MSM) is provided by Positive Health Lincolnshire.

An outreach worker is available in known 'cruising' areas one day per week and he offers information leaflets, advice, condoms, signposting and screening.

Sex worker outreach

There is a sexual health outreach worker who works within Foundations (drug and alcohol service). The worker provides condoms, advice, guidance, signposting and testing for STI's on one day per week. The outreach worker predominantly works with street based sex workers and those in the 'sex parlours and flats', and provides support for the clients of Foundations within clinic and group settings, and works with and refers in to the integrated sexual health service based at Stirling Street Medical Centre.

School nursing

School nursing is provided by the council and some academies have their own provision. Within the school nursing service pupils can access help, advice and guidance on a range of issues. School nurses provide an extensive sexual health offer. There are weekly drop in sessions at secondary schools with school nurses providing sexual health information and signposting, condoms, pregnancy and chlamydia testing, and emergency contraception. During the school holidays, clinics are run in a variety of venues to ensure a continued service. School nurses run a health chat line for all secondary pupils to access and this is publicised through assemblies with an emphasis on gaining access to the pupils whose schools will not allow sexual health support. There is a school nurse to directly support home educated children and pupils in alternative provision.

There is also a school nurse based in the Youth Offending Service who provides sexual health support, advice, and testing. All school nurses are trained in the Multi Agency Child Exploitation (MACE) management and risk tool to identify and support children at risk of CSE, and are also trained in female genital mutilation (FGM). The school nurses are developing level 1 sexual health training for all staff. A joint weekly clinic is run with the integrated sexual health service. Overall the school nurses report good working relationships with the YPSS and Virgin Care teams. In general, it appears that provision can be inconsistent and demand varies so the length of time and availability of appointments is variable

Young People's Support Service

The Young People's Support Service (YPSS) is part of NEL Council and is the umbrella service for a range of teams and functions that support young people including the statutory Youth Offending Service (YOS).

The YPSS works with a range of partners and primarily with 13 to 19 years olds but up to 25 years of age for young people with special educational needs.

The YPSS contribute to the resilience and relationships (R&R) programme, which is the umbrella programme to provide a strategic and coordinated approach to improve safer relationships education and emotional health and well-being for young people in NEL.

The YPSS vulnerability team provide a considerable sexual health offer. The vulnerability team are a team consisting of 7 x FTE based at the Molson Centre in Grimsby. All vulnerability team staff are trained to at least level 2 in sexual health, condom management, and pregnancy testing.

The safe relationships for young people (SR4YP) programme, is the PSHE offer for school years 8 to 11; a year 7 programme is currently being developed.

The year 8 SR4YP programme includes life choices, self-esteem, body image, puberty and anatomy, and respect.

The year 9 SR4YP programme includes understanding yourself and others, exploring relationships, child sexual exploitation and domestic violence, sexually transmitted infections, and contraception.

The year 10 SR4YP programme includes understanding yourself and others and child sexual exploitation, risky situations, laws and legalities, drugs and alcohol, and contraception and sexually transmitted infections.

The SR4YP is a universal programme offered to all 10 secondary schools, and has been taken up by 8 of the schools to date. The programme is also delivered to alternative and special secondary school provision.

The vulnerability team deliver 'health days' in secondary schools which are free to schools as they are funded by both prevention and wellbeing, and via the Future in Mind (FiM) programme, which is a national programme to transform the delivery of services for children with emotional and mental health needs.

The vulnerability team run a teen parent group to support teen parents and to reduce the incidence of second pregnancies.

The vulnerability team participate in local missing children debriefs. Young people who have run away could be at increased risk of CSE.

For young people who have been missing overnight, alcohol could have been involved and if there has been sexual activity there could be a need for EHC. During September 2016, there were 82 instances of missing and absent children and young people.

YPSS use the Multi Agency Child Exploitation (MACE) management and risk tool to identify and support children at risk of CSE.

YPSS support the NSPCC to help children and young people who display harmful sexual behaviour. Both the vulnerability team and the YOS include staff who have been Assessment, Intervention and Moving on (AIM) trained. The YPSS lead on amber interventions whilst the NSPCC lead on red interventions.

Young people who are with the YOS all have an appointment with the YOS nurse and this holistic appointment includes screening and sexual health needs.

The YOS operate an attendance centre at the Molson Centre on Saturday mornings, which involves signposting and support, including sexual health and healthy relationships, grooming, and CSE.

The vulnerability team offer more targeted early help to vulnerable young people and those of increased risk of child sexual exploitation or pregnancy who require more than a universal service provision. This 'case work' is operational in all 10 secondary schools.

The vulnerability team report a good relationship with the integrated sexual health (ISH) service provided by Virgin Care, and the team will signpost to the ISH service and when necessary transport young people to the ISH service hub at Stirling street for screening / STI treatment.

There is no longer a C-Card scheme operating in NEL. This scheme provides free condoms and sexual health information and signposting to young people and continues to operate in many other areas in England. All YPSS street based staff are Fraser competency and sexual health trained including in condom management, and this includes the outreach staff who operate the mobile unit and work up to 6 evenings per week in hotspot areas and up to 10pm. There would be several benefits to reintroducing this scheme locally. Firstly, it would add extra capacity to the system by allowing the existing trained workforce to distribute condoms. Secondly it would increase efficiency as if some provision could be delivered on site it would reduce the need to transport young people to the ISH service; it would also free up capacity for school nurses and the ISH service by reducing the number of condom supply appointments, which in turn frees up appointments at the ISH service for STI testing and treatment. Thirdly it would reach many additional young people in their own neighbourhood who would not access services otherwise. The scheme would contribute to achieving the outcomes of preventing the spread of STIs and protecting against unintended pregnancy. To realise a C-Card scheme in NEL the council will need a policy on condom management and it is therefore recommended that a policy is developed and the C-Card scheme is reintroduced in NEL.

Family hubs are located in the heart of communities and reach a considerable number of people who may not access mainstream services, it is therefore recommended that rolling out sexual health training to the wider family hub workforce is considered.

Chapter 4

Cost effectiveness, cost utility, cost minimisation and cost saving in sexual health services.

There is clear evidence of the potential for return on investment and benefit from preventative sexual health services. In 2005 the Department of Health commissioned a literature review (of 148 documents) and convened an expert panel to look at the evidence and conclude on the cost benefit of preventative sexual health services.

Health Promotion and Disease Prevention

There are numerous cost-effective and importantly, cost saving interventions aimed at promoting sexual health especially due to the high costs associated with HIV/AIDS. Interventions are more cost-effective when they effectively target high-risk groups.

- Free condom provision for medium and high risk groups (mainly men who have sex with men (MSM) and sex workers) (9 papers)
- Outreach health promotion and safe sex programmes for high risk groups (mainly MSM and sex workers) and hard to reach groups (5 papers)
- Provision of AIDS risk reduction messages in LGBT bars (12 papers)
- Safer sex skills training session / cognitive behavioural intervention for MSM (6 papers)
- Peer – leader interventions for MSM (4 papers)
- High quality integrated Sex and Relationships Education (12 papers)

Long Acting Reversible Contraception (LARC) – Intrauterine Devices (IUD) – Intrauterine System (IUS)

Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods. They should be provided with the method of contraception that is most acceptable to them, provided it is not contraindicated.

Contraceptive service providers should be aware that:

- all currently available LARC methods (intrauterine devices [IUDs], the intrauterine system [IUS], injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use
- IUDs, the IUS and implants are more cost effective than the injectable contraceptives
- increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies

Screening

Screening strategies such as targeting all pregnant women for HIV, and young women for chlamydia, are clearly cost-effective, they help lead to early treatment, averting costs of complications (such as infertility), and onward transmission.

- Antenatal syphilis screening (1 paper)
- Antenatal screening for HIV in high risk women (2 papers)
- Many modelling studies conclude chlamydia screening is cost-saving:
  - for selected population groups at high risk (7 papers)
  - for young women (16 papers)

Treatment and interventions for STIs

Comprehensive and accessible (including extended outreach) STI treatment services are cost saving especially in groups at high risk of HIV (3 papers).

Prompt treatment of STIs and effective partner notification are key elements of cost-effective prevention interventions.

Fertility Control Services (including contraception and abortion)

Accessible contraceptive services which reflect women's preferences are cost saving.

- Contraceptive services, in themselves, result in reduced cost and increased benefit (2 papers)
- Provision of an "ideal" profile (the choice women would make if given full information and offered the range of methods) of contraceptive services that better reflect women's preferences could save NHS at least £500 million over 15 years. (This is mostly a move from combined oral hormonal to longer acting methods) (1 paper)
- Reducing the delay in obtaining an abortion – savings to the NHS of from £645,000 to £30 million per annum is estimated depending on women's choice of method (1 paper)
- Access to over the counter oral contraception (1 paper)
- Access to emergency contraception (2 papers)

Chapter 5

Needs Assessment Process

The approach used within this sexual health needs assessment draws on the methodology used within the 'How To Guide' commissioned by the Department of Health's National Support Teams for Sexual Health and Teenage Pregnancy.

The approach adopted draws largely from the rapid sexual health needs assessment (SHNA) methodology but is augmented by specific data collection from key stakeholders and communities identified by the commissioner upon commencement.

The work was conducted between April-July 2016. The scope of this SHNA was devised in the context of no previous needs assessments being performed and prioritised engagement with specific communities and stakeholders.

To ensure comprehensive and effective needs assessment every attempt was made to identify the appropriate people to interview. As there was a parallel needs assessment being completed for Children and Young People's Emotional and Mental Wellbeing, it was possible in some areas to connect the two needs assessments.

The general approach of an SHNA (Figure 1) is to use existing data sources and information to map need, examine demand, map service provision and then to understand the gaps between these factors. At its conclusion, a SHNA will produce a better picture of local sexual health needs and determine whether the supply of services is right to meet them. We accordingly make a series of recommendations within this report for consideration.

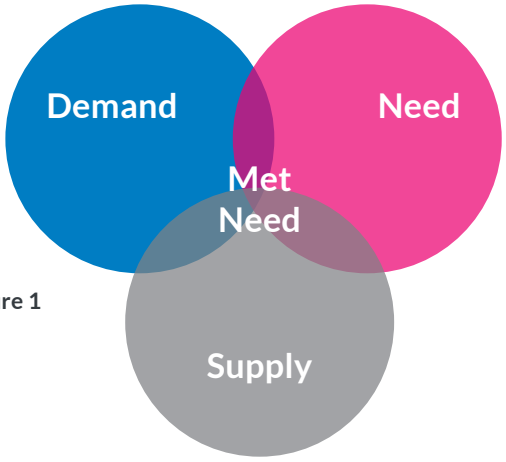


Figure 1

During this SHNA we have adopted the following approaches:

1. Identify who to speak to: a stakeholder list (Annex A) of key people who had an interest in sexual health services in NEL was developed. This list comprised service providers, commissioners, schools and colleges. The list was supplemented with 3rd sector organisations and charities working with sexual health services or targeted groups.

2. We spoke to Virgin Care, Primary Care Teams (mainly GPs, practice nurses, and practice managers), pharmacists and pharmacy staff, schools/pupils, the Pupil Referral Unit, commissioners, and senior managers with strategic responsibility for commissioning and delivery of sexual health and allied services. Virgin Care provided Friends and Family Test data (See Page 41 Annex C).

3. A set of questions were designed for this group who were all contacted and offered a face to face meeting, a telephone interview or a link to an online survey. The survey was also provided via the Releasing Community Capacity website and Twitter account, the Council and CCG networks and intranets, via the Grimsby Telegraph, community researchers and emailed out to all contacts and known networks. 27 service users completed the online survey, 6 focus groups were conducted with schools, parents and carers and the Youth Action Group (60 young people); 48 one to one meetings and telephone interviews were held.

4. An additional community questionnaire was developed to be delivered in person in the community with service users and potential service users, and five community researchers were trained in how to perform research in the community. The community researchers completed 20 questionnaires and the paper surveys were also used by the Youth Action Group, the Street Outreach team, Bridge Friends (a faith based group working with vulnerable women), the sexual health outreach worker completed 15 questionnaires with sex workers and the MSM outreach worker completed 6 questionnaires with MSM. NEL ISH gave out 100 questionnaires to be completed in sexual health clinics and 46 were returned. An additional 23 questionnaires were completed in older people's groups. In total, 104 questionnaires were completed.

5. An advert and article were published into local newsletters and promoted the online survey for service users and information was twice placed in the Health Watch e-bulletin to encourage people to come forward.

6. In addition to the community consultation that has taken place a review of available data pertinent to NEL has been performed, this included audits from the Looked After Children Service.

7. A desk-top review of known evidence, national trends and best practice has also been performed.

Face to Face interviews and Telephone calls

Jane Fell
NLAG – LAC Lead Nurse

Steve Kay
Director Prevention and Early Years

Bill Geer
Commissioner Drugs and Alcohol Services

Diane O'Keefe
FAST Service

Claire Parfrement
Participation Officer

Jenny King
Cluster Coordinator, Family Hubs

Dawn Trigg
Macmillan Specialist Nurse

Alfie Hallett
Deputy Chair of Youth Parliament

Pauline Bamgbala
Service Lead Planned Care and Commissioning, NEL CCG

Jill Ladlow
Virgin Care

Paul Caswell and Jodie Yarborough
YPSS

Scott Jacques
Pupil Referral Unit

Jo Hudson
Foundations Sexual Health Outreach Worker

Steve Milner
Positive Health Lincolnshire (MSM) Outreach Worker

8 men at outreach session

Caroline Wilkinson
Positive Health Lincolnshire

Vans Braddock-Mead
Foundations, Drug and Alcohol Service

Sue Proudlove and Stef Fox
NSPCC

Sue Jewitt and Volunteers
Bridgefriends

3 sex workers

Sue Sheriden
Barnardos

Paul Glazebrook
Healthwatch

Sarah Wise
Consultant Midwife Teenage Pregnancy and Sexual Health

Sharon Ainslie
Public Health England

John Noton, PM
Dr E Hopper and Ptnrs

Debbie Woodward
Empower and VCSE Alliance

Linda Dellow
Centre 4 and VCSE Alliance

Stephen Pintus
Director of Public Health

Matt Clayton
Service Manager, Safeguarding and Youth Offending Team

Carolyn Beck
Healthier Lifestyle Services

Jim Hudson and John Manton
YMCA

Joanne Hewson
Deputy Chief Executive

Paul Cordy
Director Children's Social Care

Nathaniel Heath
Head of Behaviour Services

Claire Thompson
Communications and Marketing

Debbie Haines
Learning and Development Team Manager

Michelle Barnard
Assistant Director Women's and Children's Services, NEL CCG

Focus Groups

- NSPCC
- Youth Action Group
- Middlethorpe Primary Academy
- East Ravendale Primary School
- Havelock Academy
- Oasis Academy Immingham

Summary of issues raised

Commissioners and staff with a strategic responsibility across all sectors who were interviewed.

"There has never been as much provision of sexual health support and advice as there is now. There are more outlets and it is easier to access"

"Young people have never been better informed about sexual health issues. They know the issues and what they need to do but they (PRU) still choose to undertake risky behaviour. They don't think about nor understand the consequences; think it won't happen to them. For pregnancy - it is often the norm in the family or they haven't been nurtured to aspire to better things so a baby at 15 seems okay"

"Young people have chaotic lifestyles and sometimes this involves harmful sexual behaviour and negative 'power relationships' in families which needs addressing"

"There is a specific LAC pathway and an 'embedded' nurse helps with supporting the increasing number of LAC who get pregnant"

Need a push on the use of LARC and IUCDs as an alternative to the contraceptive pill"

"Need to increase education and outreach to the most vulnerable and at risk groups"

"Staff in the services are committed, caring and responsive"

Staff within sexual health services, both NEL ISH and other sexual health outreach who completed an online survey.

The respondents were drawn from a range of different services including, GPs, Children's and Family Services, practice nurses, managers in both the statutory and charitable sectors and outreach workers.

The strengths of their services included:

- Having highly trained staff and easy to access services
- Having good partnerships and relationships with others

The challenges to their services included:

- Not enough staff/manpower. Some of the outreach services for marginalised groups are only one day per week which isn't enough now and the situation and demand is increasing. Lack of manpower was the most cited challenge from most respondents and in addition to the issues for outreach other services said lack of manpower and the need to attend meetings meant they couldn't always respond in the way they would like to
- Lack of funding for training courses or no readily available courses. Hull University no longer provides the sexual health module
- Concerns about the sustainability of the outreach and the NEL ISH services due to fears for the continuity of service. This comment was made in all outreach services and by others as there is concern about the lack of continuity when the staff member or outreach worker is off sick or on leave and there are concerns where a staff member or outreach worker may retire. What are the arrangements for a smooth transition of the service? The outreach work is highly specialised and often dangerous and not something you can step into without supervision from someone experienced in outreach sexual health work

Service users who completed the online survey or the paper questionnaire.

Difficult to determine whether they refer to sexual health outreach or NEL ISH services.

- Most people knew where the service was located and could identify the services
- Preference for services was shared between the GP and the NEL ISH based in the GP surgery (although this isn't the case for young people)
- Most respondents said this was because they go regularly, confidentiality, comfort and ease
- Where appointments were offered, they were in plenty of time and as required
- The majority were happy with the service provided and would use the service again
- There was only one negative comment about the doctor not being young person friendly

The paper questionnaire – this was handed out by outreach teams for marginalised groups and young people and was placed in the NEL ISH clinics for patients to use.

- A high proportion knew where the sexual health services were and how to access them. They could describe the different venues for services
- Their choice of venue for sexual health services was driven by convenience, ease of access and getting appointments or they had an existing relationship with the doctor
- A third of the respondents suggested that there needs to be more advertising of services in surgeries, schools, community buildings and the media
- They use services as they need them
- More than half (63%) got the appointment when they needed it. However, where the sexual health outreach worker was specified it was noted that it is sometimes difficult to see her “she could be on holiday”
- 71% felt they were treated confidentially, sensitively and professionally
- Where the sexual health outreach worker was specified it was noted that the service was professional and delivered in a caring way. There were comments where it was impossible to identify the service provider which talked about “feeling judged” and “being looked down on”
- There is a consistent comment across all providers of how professional and respectful the service is
- 71% would use the service again. Regardless of which professional provided the service, the comments were very positive about the care received

When asked, what would improve the service? The responses included:

> More staff – stop cutting back on the clinics and the staff

> More appointments and late night openings

> More advertising to increase public awareness

> More private waiting area

> Calling patients by a number and not name

> “Bring back smears for women”

Virgin Care Friends and Family Test

- Nearly all found the receptionist friendly and welcoming
- A majority liked the waiting area and facilities
- Just over half were happy with the waiting time in clinic
- Suggestions for additional clinics included town centre and GP surgery
- Other professionals that respondents would like to talk to about sexual health issues included GP, practice nurse, health visitor, Sure Start staff and school nurse
- 20% requested evening appointments
- 99% of respondents would recommend the service and there was only 1 negative comment

Focus groups and group discussions

- Children of all ages prefer to talk about problems face to face. They are much less likely to speak to people on the phone in case they can be overheard and they worry about the internet in case they are being overlooked while using it
- The environment is important to them and they want somewhere private to go to. They are not happy having to ask the teacher for permission to visit the school nurse as the teacher wants to know the reason for them going
- *"The school nurse service is awful. She only comes one day a month and there is a big queue for her so you may not get seen"*
- *"We don't like going to the sexual health clinic in East Marsh as everyone knows what it is and why you are there. There should be more places you can go that are mixed in with other services so that no one knows why you are there"*

Chapter 6

Conclusions

Over the past decade, we have seen great improvements in the quality and scope of sexual and reproductive health and HIV services. However, sustaining and expanding interventions to address sexual and reproductive health and HIV outcomes must remain a priority.

Levels of satisfaction with the service received are high across all services. This is highlighted in services for marginalised groups such as sex workers and MSM where the relationship is strong between the individual outreach worker and the client. There is articulated concern about the threat of loss of these services and continuity. However, there is a considerable risk with these services and the fear of funding stopping. The service for these groups needs to be maintained as they carry a greater risk of STIs and BBVs by the nature of their lifestyle and the amount of service being provided.

Going forward consideration needs to be made of the changes to the demographic structure in NEL and services need to be shaped to meet this.

The total population of NEL is estimated at 159,727. The percentage of the local population who are of working age, (16 to 64), is slightly below national and regional comparator estimates at 62.1% (99,276). 18.9% (30,145) of the local population are of pensionable age. The percentage of children and young people, (0 to 15), is in line with national average at around 19% (30,406) of the population (NEL Economic Assessment 2011).

	Total Pop	0 - 15	16 - 64	65 - 74	75+
2014	158,700	30,400	96,600	16,400	14,400
2037	163,600	28,800	91,000	19,100	24,700
% Increase	+2%	-5%	-8%	+17%	+72%

Source: ONS 2014 based subnational population projections.

The table above illustrates the predicted changes expected in the population over the next 25 years.

Clearly the population is an ageing one and will require a different focus on sexual health services. During the interviews and surveys with 50+ residents they preferred the GP as a venue for sexual health advice although this may be confused as the NEL ISH clinic is provided in a building with a GP presence and one of the clinic outreach services is provided at Birkwood Medical Centre. Over time services for younger people need to remain at the same activity levels but services for the 50+ age group need to be slowly built up year by year.

The existing service provision meets the needs of the current population profile and the priorities of (Making it Work: 2015):

- Reducing teenage pregnancy
- Providing a full range of contraceptive and abortion services
- A reduction in avoidable HIV deaths and HIV transmission
- A reduction in the prevalence of chlamydia through increased screening of young people
- A reduction in new diagnoses of other STI's including gonorrhoea and genital warts

Whilst chlamydia testing is available to all, the local approach is for a focus and targeting of the most at risk groups within the 15-24 age group. Figures published by PHE for 2015, show that 25.4% of the NEL population aged 15 to 24 were screened for chlamydia. This is a significantly higher proportion than the 22.5% screened overall in England. Unless the patient is deemed vulnerable or at risk, chlamydia screening is on the whole by request of the patient and no proactive programme is in place other than where a LARC is fitted. Staff during consultations with at risk patients or perceived vulnerable patients, offer chlamydia screening. Pharmacies and GPs who offer sexual health services, identify at risk and vulnerable patients and offer chlamydia testing kits. As part of cervical screening chlamydia screening is offered. Education about gonorrhoea and syphilis also needs to be increased. Plans to increase screening need to be considered in the short and medium term.

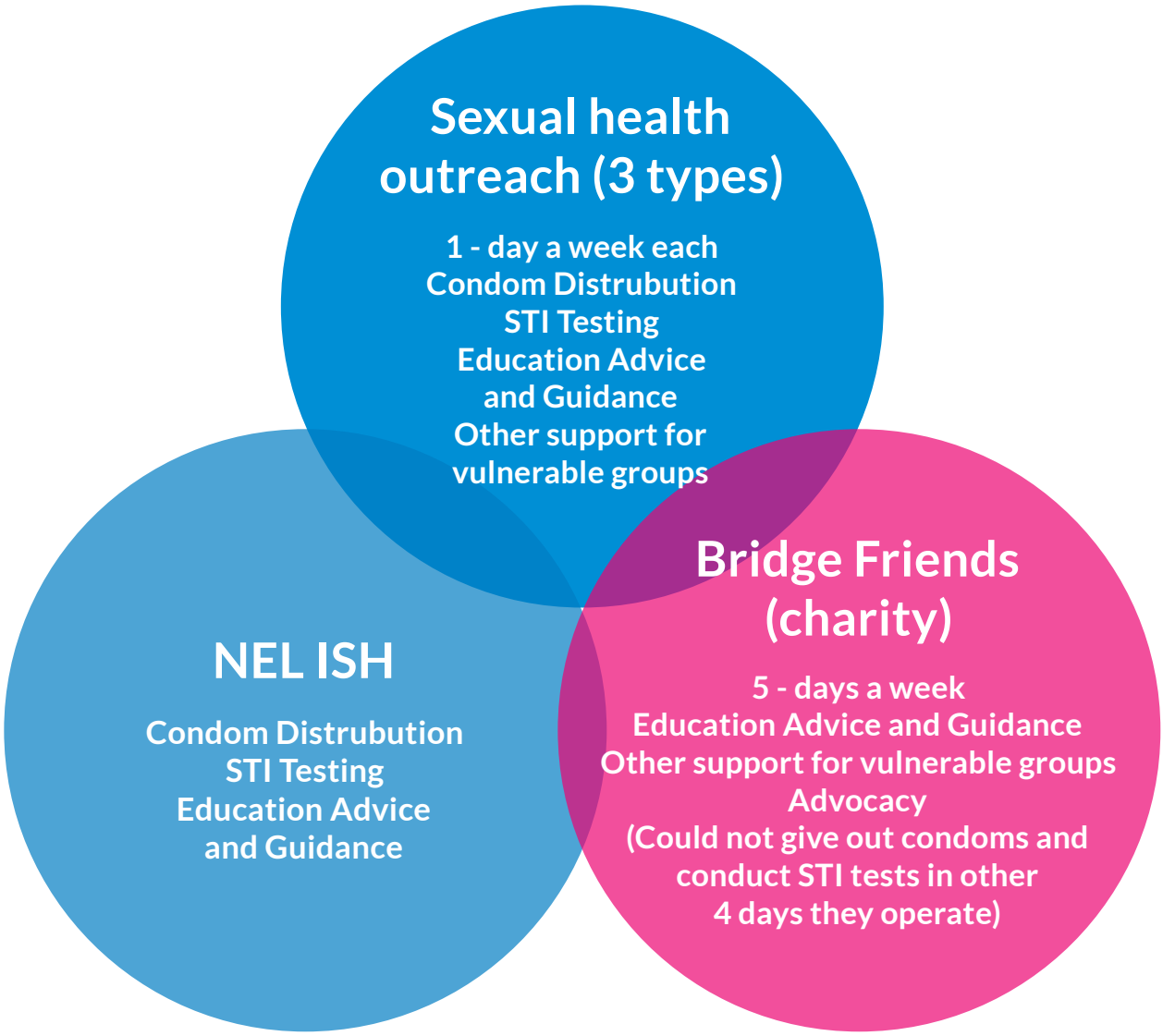
The chlamydia detection rate amongst under 25 year olds is a measure of chlamydia control activity. Public Health England recommends that local authorities should be working towards achieving a detection rate of 2,300 diagnoses per 100,000 population aged 15 to 24 years. This rate was achieved by NEL during 2015, the local rate of 2,694 diagnoses per 100,000 population being higher than the detection rate for England overall of 1,887 diagnoses per 100,000 population.

Staff are generally satisfied with the services provided but have indicated a desire for more sexual health training as this is no longer available as it was. Some staff and volunteers (not currently providing sexual health services) indicated they would be happy to have opportunistic conversations about sexual health if they felt confident to give it. Examples include people working in youth services or outreach. Young people who volunteer for these services would be happy to have conversations about sexual health and give out condoms with the appropriate training.

GPs and other primary care staff indicated they would like more regular educational updates and training. Virgin Care provides training and updates which are well received and well attended but they may not be accessible to everyone. Further work can be done to establish what the need for primary care education is.

Whilst relationships across many of the public sector service are good, there are clearly areas where they could be improved through a process of better understanding what each other has to offer. There is evidence of multi-professional and multi-agency partnership working but this is on a topic by topic basis. Partnerships with the third sector could be beneficial but there isn't the mechanism to explore this at the moment.

Potential for partnerships with the 3rd sector



Out of Area Patients

There are also significant numbers of people using NEL sexual health services from out of the area. Discussion across the region would allow economies of scale and better region wide planning. An analysis of attendances at the NEL integrated sexual health service by Lincolnshire residents, determined a clear correlation between the number of attendances and the distance from NEL.

The highest number of Lincolnshire residents was from Holton-le-Clay and Caistor which are close to NEL and likely to be closer to sexual health services provided by NEL rather than Lincolnshire County. As distance from NEL increases there are fewer attendances of Lincolnshire residents at NEL services.

Number of attendances at the NEL integrated sexual health service by out of area residents

There are risks regarding succession planning in some of the key roles such as the MSM and sex worker outreach, and these are recognised by both the commissioner and the providers. As these are sole workers who provide one day per week for these client groups, if they are off sick or on leave there is no one to cover the service and these client groups are growing. These are not roles which can be taken on without practical experience, which makes these services vulnerable as these are priority groups for the management of STIs.

There are opportunities to be creative about sustaining and widening these services, including different types of screening and widening screening for STIs more generally by working with Bridge Friends and the Young People Street Outreach teams.

There is neither an obvious LGBT scene nor any obvious services specifically for young LGBT people in NEL. There is also reporting of a homophobic attitude across the area so much so that the interviewed female sex workers reported that male sex workers left the area as they were threatened. Whilst the police do what they can to control hate crime such as this it is still an issue. Older MSM do not describe themselves as gay and often are married or in a relationship with a woman. This lack of acceptance coupled with the lack of materials for MSM and lack of display areas means that MSM 'go underground' which could make them vulnerable to abuse or to unsafe sexual practices. Within the timescale of the needs assessment we were not able to speak to older people in residential care where we believe there are older gay people living.

Chapter 7

Recommendations: - What should we do about it?

1. Develop a cross sector sexual health forum including providers in Lincolnshire to share best practice, identify gaps and pressures, and provide a seamless service for cross border patients. This doesn't need to be an onerous responsibility and could meet twice per year and be supported by a 'virtual network' in between meetings.

2. Development of a sexual health strategy and action plan for the next 5 years to target services to areas of need.

3. Focus on targeting the general public, LGBT people and MSM with literature, processes and services that normalise differences in sexual orientation within the population as a way of better meeting the needs of these groups. This should include a review of current STI and HIV screening and treatment and its availability to these groups in conjunction with clients and the people who currently provide the services. A strategy can be developed to introduce a mixed media approach to delivering the messages.

4. Develop a plan which considers the succession and sustainability for the critical services such as the two sexual health outreach workers for MSM and sex workers and to consider succession planning for the wider sexual health team within NEL ISH and sexual health trained GPs and practice nurses.

5. Develop an immediate and specific focus on young people 15-24 with a targeted information programme, STI screening (chlamydia audit) and review of contraception advice and service availability, building on the local approach of a targeting of the most at risk groups within the 15-24 age group. This to have a particular focus on teenage pregnancy and Looked After Children as the rates of teenage pregnancies in this vulnerable group is increasing. Consider the possibility of enabling the YPSS street outreach teams to facilitate chlamydia screening.

6. NEL Council develops a policy on condom management and reintroduces the C-Card scheme.

7. Family hubs are located in the heart of communities and reach a considerable number of people who may not access mainstream services, it is therefore recommended that rolling out sexual health training to the wider family hub workforce is considered.

These recommendations confirm the understanding and needs identified by commissioners, providers, and other sexual health professionals in NEL.

Annex A
Stakeholders List

Name	Organisation	Role
Joanne Hewson	NEL Council	Deputy Chief Executive
Stephen Pintus	NEL Council	Director of Public Health
Beverley Compton	NEL Council	Assistant Director Adults Services and Health Improvement
Steve Kay	NEL Council	Director Prevention and Early Intervention
Paul Cordy	NEL Council	Director Children's Social Care
Caroline Barley	NEL Council	Prevention and Wellbeing Manager
Bob Ross	NEL Council	Head of Children's Health Provision

Karen Goy	NEL Council	Interim School Nurse Manager
Janet Burrows	NEL Council	Health Visiting Team Manager
Deb Simpson	NEL Council	Developing Healthier Communities
Sarah Impey	NEL Council	Workforce Development
Sue Walton	NEL Council	Workforce Development
Alison Jollands	NEL Council	Family Hubs – Health Lead
Megan Dennison	NEL Council	Children's Social Services
Wendy Shelbourn	NEL Council	Head of Integrated Family Services
Matt Clayton	NEL Council	Youth Offending Services
Paul Caswell	NEL Council	Youth Services
Bill Geer	NEL Council	Commissioner Drugs and Alcohol Services
Helen Willis/ Sue Sheriden	NEL Council	NEL Local Children's Safeguarding Board
Claire Thompson	NEL Council	Communications and Marketing

Clare Parfrement	NEL Council	Participation Officer
Councillor Hyldon-King	NEL Council	Portfolio Holder
Geoff Barnes	NEL Council	Deputy Director of Public Health
Glynn Thompson	NEL Council	Commissioning and Strategic Support Unit
Jenny King	NEL Council	Cluster Co-ordinator (Teenage Pregnancy)
Michelle Barnard	Clinical Commissioning Group	Assistant Director
Jane Fell	Northern Lincolnshire and Goole NHS Foundation Trust	NLAG Lead LAC Nurse
Pauline Bamgbala	Clinical Commissioning Group	Service Lead – Planned Care & Cancers - Service Planning & Redesign
Paul Glazebrook	NEL Healthwatch	Partnership Co-ordinator
Sue Proudlove	NSPCC	
Ruth Prentice	Maternity Services Liaison Committee	Parent Chair of the Board

Annie Darby	NaviGo	Adult and Children's Safeguarding
Julie Dixon	Northern Lincolnshire and Goole NHS Foundation Trust	Head of Midwifery
Dr Omobolaji Wilson	Northern Lincolnshire and Goole NHS Foundation Trust	Child Development Centre
Sarah Wise	Northern Lincolnshire and Goole NHS Foundation Trust	Consultant Midwife, Teenage Pregnancy and Sexual Health / Supervisor of Midwives
Caroline Wilkinson	Positive Health Lincolnshire	Manager
Jill ladlow	Virgin Care	Service Manager / Consultant Nurse
Charlotte Harrison	Foundations	Foundations Young People's Substance Services
John Berry	Northern Lincolnshire and Goole NHS Foundation Trust	Service Manager Family Nurse Partnership
Dr Marcia Pathak	GP at Raj Medical Centre	Clinical Lead for Women and Children

Caroline Hayward LPC	Community Pharmacy Humber (LPC)	Professional Development Pharmacist
Rachel Staniforth	YH Commissioning Support	Senior Pharmacist NEL
Sharron Ainslie/ Simon Padfield	Public Health England	Sexual Health Facilitator for Yorkshire, Humber and North East (Dr Simon Padfield - Consultant Epidemiologist and Consultant in CDC)

Annex B
Consultation Summary Table

Online Survey Service Providers	Online Survey Service Users	Paper Forms Service Users	Telephone Calls and Meetings Senior Managers Service Users Providers Commissioners
11 replied online. Professions ranged from Children's and Family services, GPs, practice nurses, managers within the charities sector, practice management, outreach workers in the 3rd sector and within previously statutory service sectors.	27 replied online. 52% were in the 16-24 age group and 37% in the 50+ age group. 70% were male and 26% were female with the remaining 4% being undisclosed. 55% identified as straight with 33% bi-sexual and 11% as gay.	104 forms completed in a variety of settings. Some were completed by the outreach services taking the forms out to clients; some were completed on the street some by the newly trained community researchers and some were completed within the sexual health clinics.	48 meetings and calls were held. Respondents included the local authority senior management team, people with strategic responsibilities, lead CCG commissioners, Heads of Service, and front line practitioners.

Online Survey Service Providers	Online Survey Service Users	Paper Forms Service Users	Telephone Calls and Meetings Senior Managers Service Users Providers Commissioners
They identified strengths of their service including highly qualified staff, providing easy access to services and building trusting relationships.	73% knew where the local sexual health service was located with 85% and 88% identifying with the GP and Virgin Care (respectively) as the providers they use. Both these providers being the preferred providers for services 54% selected both.	A high proportion of respondents were satisfied with the service; 81% know where to go for help / service, choice of service was based on trust and confidence with the service provider and 69% would use the service again.	Main themes: Acceptance that under age conceptions and issues of power within relationships were concerns. Acknowledgement of the need to increase the provision of the use of LARC in the community. Concerns about risk of STI spread in the community.

Online Survey Service Providers	Online Survey Service Users	Paper Forms Service Users	Telephone Calls and Meetings Senior Managers Service Users Providers Commissioners
They identified lack of funding for training and lack of local provision of training along with lack of staff /manpower as challenges to their services.	They chose consistency, confidentiality, comfort and ease as the reasons for preferring these providers.		They identified the strengths of the current service, highly trained and committed staff that the public trusts.
	People tend to use the services as needed and could be seen when needed (94%).		
	100% found the service satisfactory and 100% of those responding would use the service again.		

Annex C
Detail from the Engagement Exercise

What Professionals told us – Professionals Online Survey

- 11 people responded online and 48 were interviewed in depth
- Professions ranged from Children's and Family services, GPs, practice nurses, managers within the charities sector, practice management, outreach workers in the 3rd sector and within previously statutory service sectors
- They deal with a range of different issues relating to sexual and reproductive health including:
  - > teenage conception
  - > child sexual exploitation
  - > outreach with marginalised groups
  - > child health surveillance
  - > provision of a comprehensive sexual and reproductive health service
- The strengths of their services, in relation to sexual health provision, can be categorised as:
  - > building relationships and trust and team work
  - > providing contraception and advice
  - > supporting children who exhibit harmful sexualised behaviour
  - > having highly trained staff
  - > providing easy access to services
- Their perceived weaknesses of their own sexual health service provision include:
  - > not enough staff/manpower – some of the marginalised services are only for one day per week. Could do a lot more if they had the resource
  - > lack of funding for training courses and lack of available local sexual health training courses from the Engagement Exercise

What service users and potential service users told us

During April to August 2016 several different approaches were used to elicit the views of service users and potential service users.

- An online survey which was anonymous
- Paper questionnaires handed out to people in the community and at clinic or service delivery locations
- Virgin Care Friends and Family test information
- One to one conversations with individuals in school focus groups or by outreach

Online Survey – 27 people responded

Age	Under 16	16 – 24	25 – 49	50 +	Total
	0	14	3	10	
Gender	Male	Female	Undisclosed	Total	
	19	7	1	27	27
Orientation	Hetrosexual	Gay	Bisexual	Total	
	15	3	9	27	

- The majority of respondents were young heterosexual men
- They knew where sexual health services were (73% yes/27% no)
- The preference for service location was equally split between their GP and the Virgin Care Clinic. They had less preference for the other routes mentioned such as pharmacy, school nurse or youth group
- The main reasons for choosing these options were confidentiality, 'they see them regularly' (could be consistency in provider) and comfort and ease
- Respondents didn't have any significant suggestions for improving information as only 7 answered the question and they suggested the usual leaflets, website etc

- 10 of the 27 never use sexual health services and those that responded predominantly use them as needed (30%)
- Those that use services tend to go to the Virgin Care clinic (69%)
- 95% got an appointment when they needed it. With 64% getting the appointment the next day which suggests that a wait is reasonable
- 95% were happy with the way they were treated. 100% of those who responded thought the service was satisfactory
- 100% of those who used the service would use it again (18 respondents)
- When asked, what could be done to improve the service only one of five respondents had a criticism of the doctor not being 'young person friendly'

Paper Questionnaire – 104 people completed the surveys. 81 females (78%), 23 makes (22%)

Paper questionnaires were produced and delivered in a range of settings by service delivery staff and the trained community researchers. The questionnaire (see appendix A) was designed to ask a combination of qualitative and quantitative questions giving the respondent the opportunity to tick boxes from a multiple-choice menu or to complete a free text box.

Age	Number	%
Under 15	3	2.8
16 – 24	29	27.8
25 – 49	55	52.8
Over 50	17	16.3
Total	104	-

- A sexual orientation question was added to the questionnaire at a later stage, 41 responses were received

Orientation	Gay	Bisexual	Hetrosexual	No Response
41 responses	1 (2.4%)	2 (4.8%)	32 (78%)	6 (14.6%)

- Where they live

Postcode	Number	%
DN14 – DN29	2	2
DN30 – 34	48	46
DN35 – 40	49	47
DN 41 – other	5	5
Total	104	-

- 84% know where the local sexual health service is
- 39% of respondents would prefer to use the local sexual health service provision which could be either the NEL ISH clinic or an outreach service as the questionnaires are anonymous it is difficult to establish this; with 37% preferring to use the GP and 11% the pharmacy. Smaller numbers preferred to use the GUM service (some respondents in the pilot related to this term) (9%), voluntary sector (1.6%) and school nurse (0.54%) A high proportion of these forms (approx. 30%) were completed by sex workers or MSM who made repeated mention that they tend not to use the traditional clinics as the receptionists are unfriendly to them, and as they get repeated STI tests completed by the outreach worker they would not want these being known in the local area. They all make the point they value the service of free condoms and STI testing and the therapy provided, and that they may not use these services if the form of provision was altered
- When asked, what would be the preference for a sexual health service the answers were skewed by some not following the instructions to rank their preference. However, those options with the most answers were GP, local sexual health service (outreach) and pharmacy
- Of those wanting an appointment, 94% of respondents got an appointment when they needed it
- When asked why they chose the preferred option, 28% chose the option because of convenience and ease of access, 21% because of relationship and 14% because the service provider helps them in other ways. 5% didn't know of anywhere else they could go
- When asked, what could be done to improve their knowledge of what is provided – 30% suggested more advertising, posters and leaflets in surgeries and schools, community buildings and the media. 18% already knew and one said they don't have a 'sexual health' problem which is probably a health literacy issue and a good reminder that we need to be asking questions people understand in their own language
- When asked how often they use sexual health services:
  - never – 37%
  - once every 6 months – 10%
  - once a year – 5%
  - as needed – 52%

Of these 43% used the local sexual health service provision which could either be the NEL ISH or the sexual health outreach as it is hard to differentiate, 29% the GP and low numbers for the other options with 26% saying it wasn't appropriate. 64% got an appointment when they needed it.

Of these respondents, there is a skew in the responses as 30% of them (sex workers and MSM) have a one – day a week service provided by one individual. If that person is off sick or on leave, then there is no cover and the service does not happen. Using a different service in these cases is less preferable than a wait as a lot of the consultation is dependent upon the relationship the individual has with the worker.

- 71% of respondents felt they were treated with confidentiality, sensitivity and professionalism. They cited the relationship, trust and respect as reasons why. A very small number 2.1% felt that this was not the case and talked about not being treated like a person. 27% did not answer the question
- 71% of respondents feel the service is satisfactory and cite relationship, trust, and respect amongst the reasons why
- 71% of respondents said they would use the service again, 27% ticked the 'not appropriate' box and there were zero returns for the response 'NO' they would not use the service again

There were several free text responses which included:

- *"Prefer using GP"*
- *"I would always use the service with Jo's support"*
- *"I think if the service stops the girls wouldn't use condoms because they won't buy them. And they would put themselves at risk which would spread more STI - BBV More cost to the NHS"*
- *"Because if there wasn't this service I wouldn't know where to go and who to see"*
- *"I'm used to seeing the nurse"*
- *"Feel comfortable and works well for me"*
- *"Had a good experience"*
- *"Good service. Convenient, get help and advice, don't have to wait ages for an appointment"*
- *"Easily accessible"*
- *"It's my local GP service"*
- When asked 'could the service provider deal with your issue or where they needed to refer you did they know where to send you?' 45% said yes and cited:
  - > *"questions answered immediately"*
  - > *"outreach can keep people informed i.e. police information, dangers to working girls"*
  - > *"signposted to GP for smear as clinic not allowed doing this anymore which is a shame"*

When asked, what could be done to improve the service the answers included the following themes:

- *"More appointments"*
- *"Clinic stop cutting back on staff and number of clinics"*

  "Have the service at the same time as another so people don't know why you are there/be called by a number not name/private waiting area – issues of confidentiality"
- *"More advertising/in the community"*
- *"More late night openings"*
- *"Bring back smears"*

Virgin Care Friends and Family Test

Information was provided by Virgin Care who collect responses from service users relating to their experience and also, they have a text service to ask a limited number of questions for the 'Friends and Family' report. From their own service users' experience, using a Five point Likert Scale, the following was noted:

- 98% of 585 responses found the receptionist friendly and welcoming
- 83% liked the waiting area
- 57% were happy with the waiting time, with 11.45% being unconcerned about the wait and 4.95% being unhappy with the wait
- 80.2% of the respondents were happy with the location of the service. When asked for other suggestions, they asked for a range of venues closer to them, in the town centre and at the GP surgery
- 60% arrived by car
- 62% had no preference for the day the clinic should be held
- When asked which other professionals, they would talk to about sexual health issues they replied with 'GP, practice nurse, health visitor, Sure Start centre staff and school nurse
- The majority 53% 'didn't mind what time the service was held, with 15% wanting morning appointments and 20% wanting evening appointments
- Preference for appointment or walk in was pretty equally balanced
- When asked about gender and age 219 (37%) females did not respond and 372 (66%) males did not respond

The age breakdown of those who did respond is as follows:

Age	Under 16	16 – 24	25 and Over	Total
Male	5	97	111	213
Female	18	186	162	366

Virgin Care does not collect the data to differentiate between 25 – 49 year olds and over 50s which is something that may be useful given the population predictions for the area. Three months of text data from the service was provided for January to March 2016. During this time:

- 55 people responded by text
- There were no negative comments and on the whole the experience was positive
- 99% of the respondents chose 'Extremely likely' as the action they would take when asked whether they would recommend the service

Endnotes

1. For a more detailed description of Vulnerable Young People see Department for Education and skills (2006) Teenage Pregnancy: accelerating the strategy to 2010.
2. ONS, 2015 Mid-year estimates
3. http://www.nepho.org.uk/pdfs/cypmh/E06000012.pdf
4. http://fingertips.phe.org.uk/profile/cyphof/data#page/0
5. Drug Data: JSNA Support Pack, 'Key data to support planning for effective drugs prevention, treatment and recovery in 2016/17, PHE
6. Source JSNA, ONS Annual Population Survey 2013, ONS Mid-year population estimates by ethnic group (2011 Census)
7. Source: Sexual Orientation and the 2015 census - http://www.ONS.gov.uk
8. Equality and Human Rights Commission 2009. ISBN 9781842062258, PJ Aspinall, University of Kent, 'Estimating the size and composition of the lesbian, gay and bisexual population in Britain.'