NORTH EAST LINCOLNSHIRE COUNCIL
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North East Lincolnshire Council

Sexual Health Needs Assessment

Technical Document
September 2016

Unique Improvements

Glossary

NEL	North East Lincolnshire
BME	Black and Minority Ethnic
CASH	Contraceptive and Sexual Health Services
CSE	Child Sexual Exploitation
EHC	Emergency Hormonal Contraception
GUM	Genitourinary Medicine
HSV	Herpes Simplex Virus
IMD	Indices of Multiple Deprivation
IUD	Intrauterine Device
IUS	Intrauterine System
ISH	Integrated Sexual Health Services
LGBT	Lesbian, Gay, Bisexual and Transsexual
NEETS	Not in Education, Employment or Training
SARC	Sexual Assault Referral Centres
SHNA	Sexual Health Needs Assessment
STI	Sexually Transmitted Infections
TV	Trichomonas Vaginalis

Introduction

This document is intended as a companion to the NEL Sexual Health Needs Assessment.

It contains the main detail of the desk based research and excludes the summary detail of the qualitative and engagement phase which is contained within the Qualitative and Engagement Summary.

It is separated out from the needs assessment as to include it will make the needs assessment too big to read and user unfriendly.

This document is intended to be a reference document.

Chapter 1

What does a good sexual health service look like?

Policy, Guidance, Best Practice and Trends.
Sexual Health across the Life Course.

Individuals need different sexual health advice, treatment and support at different times in their lives. There are common challenges and themes which can be applied across all ages and specific information identified at each life course stage. The individual's age and own circumstances will dictate their preference and use of services and the support they will receive.

Life Course	Common Themes	
Challenges	Sexual Content	Building self-esteem and emotional resilience
Information/ Prevention	Honest, age appropriate Use relevant media and technology Education as prevention	How to negotiate relationships and safer sex Protect against unintended pregnancy Protect against STIs and HIV

Services/ Intervention	Rapid, easy access Confidential Non-judgmental Clear signposting to other services Involve local partners including local authorities, NHS, business and voluntary sector	Good quality services, full range of contraceptive methods available Increase testing for HIV particularly in high prevalence areas Available at time and places which are convenient Offer age appropriate services e.g. HPV vaccination, chlamydia screening
Wider Linkages	Comprehensive Good linkages with other appropriate services (including drug and alcohol treatment, smoking cessation, weight management, housing and family support) Promote other healthy behaviour (e.g. eating well, physical activity)	Robust care pathways establish to other services Support vulnerable (including homeless, those with learning difficulties)

Reference: the 'Framework for Sexual Health Improvement in England'.

Challenges				
Age 10	**11 – 15**	**16 – 24**	**25 – 49**	**50+**
Naturally curious – potential exposure to increasingly sexualised imagery.	Sexual content – developing sexuality, self-esteem, emotional resilience – teenage pregnancy – tackling sexual bullying – puberty.	Most sexually active – highest numer sexual partners – STIs unintended pregnancies.	Forming long term relationships – planning families – promoting children's health – sexual dysfunction.	Reticent to seek help – newly forming relationships – menopause – sexual dysfunction.

Information/Prevention				
Age 10	**11 – 15**	**16 – 24**	**25 – 49**	**50+**
Role for parents and schools (including teachers and school nurses).	Use of technology advances range of sources – role for parents and schools.	Protect against unintended pregnancies and STIs – relationships and how to negotiate safer sex.	Cover STIs and HIV and contraception – help for parents to talk to their children about relationships and sex.	Inform about risks faced.

Services/Intervention				
Age 10	**11 – 15**	**16 – 24**	**25 – 49**	**50+**
Support for parents, teachers, school nurses.	Support parents, teachers, school nurses – challenge misconceptions – build resilience.	Good quality (you're welcome) – support for educational professionals.	Full range of contraceptive methods – testing for STIs and HIV.	Take account of particular needs – available at times and places which are convenient.

Wider Linkages				
Age 10	**11 – 15**	**16 – 24**	**25 – 49**	**50+**
Other health behaviours (e.g. eating well, physical activity.	More intensive services for some children.	Smoking, alcohol, drug misuse – support vulnerable (homeless, learning disabilities)	Smoking and alcohol treatment, smoking cessation, weight management, housing and family support.	Robust care pathways.

Reference: the 'Framework for Sexual Health Improvement in England'.

Sexual Health up to 16

The ambition for sexual health services for this group is focused on building knowledge and resilience among young people. The focus of this ambition is:

- All children and young people should receive good-quality sex and relationship education at home, at school and in the community
- All children and young people should know how to ask for help and can access confidential advice and support about wellbeing, relationships and sexual health
- All children and young people understand consent, sexual consent and issues about abusive relationships
- Young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex

Sex and relationships education

The provision of sex education is a statutory requirement for maintained secondary schools. What schools include in their sex-education programme is a matter for local determination; however, all schools must have regard to the Secretary of State for Education's Sex and Relationship Education Guidance.[1]

The guidance ensures that pupils develop positive values and a strong moral framework that will guide their decisions, judgement and behaviour. It ensures that pupils are taught about the benefits of loving, healthy relationships and delaying sex, and provides that pupils are aware of how to access confidential sexual health advice and support.

Academies do not have to teach sex education, but are required through their funding agreements to provide a broad and balanced curriculum. They are also required to have regard to the Sex and Relationship Education Guidance when providing sex education.

Under age sex and exploitation - consent, confidentiality and Safeguarding

All professionals working with children and young people should be aware of the law on consent. The Sexual Offences Act 2003 provides that the age of consent is 16, and that sexual activity involving children under 16 is unlawful. The age of consent also reflects the fact that children under 16 are vulnerable to exploitation and abuse. Most people wait until they are 16 or older before they have sex, and young people report that the legal framework helps them to resist pressure to have sex at an earlier age.

The 2003 Act is designed to protect children – both boys and girls – not to punish them. Where young people are of similar age and the sex was mutually agreed and not exploitative, it is recommended that young people should not be prosecuted but should receive a reprimand of final warning. However, children under 13 are particularly vulnerable therefore sex with any child aged 12 or under will be subject to maximum penalties – whatever the age of the perpetrator.

It was established in 1986 [2] that health professionals can provide confidential medical advice, treatment and examination, including emergency contraception and abortion, to young people aged under 16. Health professionals have a duty to assess the young person's competence to discuss issues around consent, and to encourage them to talk to their parents. This is sometimes referred to as 'Gillick' competency or the Fraser Guidelines.

For the minority of young people aged under 16 who are sexually active, it is important that they have confidence to attend sexual health services and have early access to professional advice, support and treatment to prevent pregnancy and STIs. In addition, all sexual health service providers must be aware of child protection and safeguarding issues and take very seriously the possibility of abuse and/or exploitation.

When teaching sex education in schools, the Guidance makes clear that pupils are to be taught how to avoid being exploited or pressured into unwanted or unprotected sex, and how the law applies to sexual relationships. Schools should, therefore, ensure that pupils learn about issues relating to sexual content.

Sexualisation of children

Many parents feel that their children are under increasing pressure to become consumers, and that the world their children live in is a more sexualised place than when they were growing up. NEL has practice behaviour guidance and procedures for dealing with Harmful Sexualised Behaviour[3] which has been issued by the local safeguarding board.

Building resilience

A wide range of factors has been shown to influence adolescent health outcomes. Many of these are 'deficit' factors, such as growing up in a single-parent family or living in a deprived area. However, these factors are clearly beyond the control of adolescents, and many resilient young people who grow up in difficult circumstances do have positive outcomes.

A more positive approach is to identify the 'strengths' that those resilient young people have, and try and help at-risk young people to develop them. In this way, we can significantly improve their resilience – their ability to 'enjoy life', survive challenges, and maintain positive wellbeing and self-esteem. This also helps young people to challenge and change the taboos that are sometimes associated with sex and sexual health.

Building resilience among young people is a shared objective across government, the Home Office in terms of civic disorder and crime, the Government Equalities Office in relation to body confidence, and the Department for Education in terms of teenage pregnancy.

Age 16 to 24

Most young people become sexually active and start forming relationships between the ages of 16 and 24. Young people in these age groups have significantly higher rates of poor sexual health, including STIs and abortions than older people. There is evidence that reducing the number of sexual partners and avoiding overlapping relationships can reduce the risk of STI acquisition[4].

The ambition for young adults 16 – 24 years is that they will:

- Be able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex
- Prioritise prevention
- Have rapid and easy access to appropriate sexual and reproductive health services
- Have all their sexual – health needs – whatever their sexuality – comprehensively met

Chlamydia is the most prevalent STI in England and often has no symptoms. A significant proportion of STI diagnoses among gay and bisexual men continue to be in younger age groups: 34% of genital warts, 24% of gonorrhoea, 225 of genital herpes and chlamydia and 13% of syphilis cases diagnosed in 2011 were in those aged 15 to 24.

In the consultation, Positive for Youth [5] the Government's youth strategy, young people said that taking the stigma out of asking for sexual health advice was seen as key to helping them take responsibility for making well – informed decisions.

School nursing service

A call to action for school nursing services was published in March 2012 [6]. It sets out an ambition for the service model for school nursing services to meet both current and future needs. To support the programme several pathways have been developed for different public health services, and a sexual health pathway has been published.

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 work 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, STIs 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 STIs.

The SR4YP is a universal programme offered to all 10 secondary schools, which 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 via the Future In Mind 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 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.

Age 25 to 49

At this stage in life many people will be forming long-term relationships and may be thinking about starting to plan families. It is important that women can access the full range of contraception from a choice of providers in order to avoid unwanted pregnancy.

Abortion rates for those over 25 have increased over the past ten years. Unplanned and unwanted pregnancies can cause financial, housing and relationships pressures as well as have an impact on other children in the family.

Provision of high-quality, effective and accessible contraception for women of all ages is crucial to support people to plan and space their families.

While people within this age group do not experience the highest levels of STIs, those aged 25 – 49 are still at risk; 46% of all STIs diagnosed in GUM clinics in 2011 were in this age group.

Within this age group the needs of specific groups, particularly gay and bisexual men and some black and minority ethnic groups who are at high risk of STI and HIV acquisition and unwanted pregnancy, must be considered and planned for within Joint Health and Wellbeing Strategies.

Age 50 plus

As people get older, their need for sexual health services and interventions may reduce. Women will enter the menopause and increasingly not be at risk of pregnancy. However, older people's needs should not be overlooked. While STI rates in this age group only accounted for 3% of all STIs diagnosed in GUM clinics in 2011, they rose by 20% between 2009 and 2011.

Older age groups are more likely to be living with long-term health conditions that may cause sexual health problems. Erectile dysfunction is associated with cardiovascular disease (CVD), diabetes, high blood pressure and a range of other conditions. Erectile dysfunction is recognised as a marker for underlying CVD and health professionals should be alert to this issue, which provides an early opportunity to treat the risks of CVD as well as addressing erectile dysfunction. There is also considerable evidence that cancer impacts on people's sexual health in a negative way, and cancer survivorship services need to reflect this.

Late diagnosis of HIV is more common in older age groups (half of those aged over 50) compared with younger age groups (one third of those aged 16 to 19) [7]. The earlier that HIV is diagnosed, the sooner a person can get access to treatment and improve their individual prognosis while making changes necessary to prevent onward transmission (for example avoiding unprotected sex).

The effectiveness of treatment for HIV means that more people will live well with HIV in old age. However, some will need other health and social care services associated with ageing, from a range of providers who will need to take account of the needs of an ageing population living with HIV and the need for shared care pathways.

Older people who make the transition into residential care may find that it is more difficult for them to access sexual health services and advice as there may be a stigma attached to the issue of older people exercising choice in sexual behaviour.

There are often older people living in residential settings who have not 'come out' as being gay because of fear of repercussions. They grew up in a time when being homosexual was illegal and they learned to access their sexuality in an underground manner which is a difficult habit to break in later life.

Sexual health of specific groups

Lesbian, Gay, Bisexual and Trans Communities (LGBT)

Sexual orientation considers whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Gender re-assignment is the process of transitioning from one gender to another. Lesbian, gay, bisexual and transsexual (LGBT) people are protected from discrimination on the grounds of their sexual orientation under the Equality Act. Information on sexual orientation is limited. Consultation on the content of the 2011 Census questionnaire established a strong user requirement for information on sexual orientation, for the purposes of providing and targeting services and equality monitoring, in relation to the LGBT community. However, a number of issues were taken into consideration in arriving at the final decision to not collect information on this equality strand.

Issues affecting this decision were:

- Conceptual issues of determining what to measure i.e. behaviour, desire or identity
- Difficulties with collection of information in a way respondents understand and accept and the consequent reliability of data
- Potential effects on response rates to the census overall

(Source: Sexual Orientation and the 2011 census - http://www.ONS.gov.uk)

A question on sexual identity was developed and tested as part of several Integrated Household Surveys held since 2009. The question was asked of respondents aged 16 and over.

Data is not published at local authority level.

National trends

Gonorrhoea and Syphilis on the rise in the UK 'amid sexual health crisis'; experts warn.[8]

Sexual orientation considers whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

- New figures released by Public Health England show 41,193 people were diagnosed with gonorrhoea in 2015, representing an increase of 10 per cent on the previous year. 5,288 people were diagnosed with syphilis in 2015, a rise of 76% since 2012
- The largest proportional increase in STI diagnoses between 2014 and 2015 were reported for:
  - syphilis up by 20%
  - gonorrhoea up by 11%
- There was a 7% decrease in in diagnoses of genital warts between 2014 and 2015
- Neisseria gonorrhoea has developed resistance to most antibiotics used for treatment. An outbreak of gonorrhoea with high-level resistance to azithromycin, one of the antibiotics currently used to treat gonorrhoea, is being investigated by Public Health England (PHE). The first case of treatment failure with dual – therapy (ceftriaxone/azithromycin) in a patient with gonorrhoea was reported in England in 2016
- It is believed the diseases are disproportionately affecting men who have sex with men (MSM), with gonorrhoea rising by 21 per cent among gay and bisexual men
- Amongst men diagnosed with STIs in 2015, the following proportions were MSM
  - 99% of lymphogranuloma venereum (LGV) – increase of 39%
  - 88% of syphilis – increase of 18%
  - 72% of gonorrhoea – increase of 21%
- Since 2013 clusters of acute hepatitis B in MSM have been detected
- The population rate of acute bacterial STIs in HIV positive MSM is 2-4 times that of MSM who were HIV negative
- 74% of MSM diagnosed with LGV in the UK in 2014 were HIV positive
- Young people aged 15-24 experience the highest population rates of STIs
- In 2015, among heterosexuals attending sexual health clinics, most diagnoses of chlamydia, gonorrhoea and genital warts were in people 15 – 24 years
- Diagnosed cases of chlamydia have dropped, although health professionals have warned this may be due to a reduction in testing rather than a drop in actual cases

- Just 13 per cent of young men and 32 per cent of young women were tested for STIs in 2015
- In 2015 there were approximately 435,000 diagnoses of STIs made in England
- Black and Minority Ethnic (BME) populations are disproportionately affected by STIs
  - > rates of gonorrhoea and chlamydia in BME people is 3 times that of the general population
  - > for trichomoniasis, the rate in BME people is 9 times that of the general population

Impact (what STIs do)

Some infections can pass to another person through unprotected vaginal, anal or oral sex, by genital contact and through sharing sex toys. Infections spread in this way are known as STIs. Safer sex involves using condoms correctly every time you have sex. If you don't use a condom you are more at risk of getting a sexually transmitted infection. You don't need to have lots of sexual partners to get an infection.[9] Most STIs can be treated and it is usually best if treatment is started as soon as possible.

Some infections, such as HIV, genital warts and genital herpes, never leave the body but there are drugs available that can reduce the symptoms. Drugs can also help prevent or delay the development of complications in HIV.

If left untreated, many STIs can be painful or uncomfortable, and can permanently damage your health and fertility, and can be passed on to someone else.

Risky behaviours/high risk groups (defined by NICE)

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
- Vulnerable10 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

National policy context

The first National Strategy for Sexual Health and HIV (Department of Health, 2001) set out a 10-year plan to:

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

This document made an explicit link between sexual ill health, socio-economic deprivation and poor standards of service provision.

The Choosing Health White Paper (Department of Health, 2004) highlighted the importance of sexual health and made a commitment to modernise services by ensuring prompt access to GUM clinics, provision of a full range of contraceptive services and delivery of a chlamydia screening programme. The White Paper set the agenda for sexual health services to be delivered in community settings, through engagement with primary care.

The Medical Foundation for HIV and Sexual Health (MedFASH) published a review of progress on the national strategy in 2008 and introduced five themes:

- Prioritising sexual health as a key public health issue
- Building strategic partnerships
- Commissioning for improved sexual health
- Investing more in prevention
- Delivering modern sexual health services

The themes supported the move from central decision making to an emphasis on local commissioning.

The 2012 Health and Social Care Act brought wide ranging structural changes to the NHS, including the creation of Clinical Commissioning Groups (CCGs), the setting up of health and wellbeing boards, the creation of Healthwatch and significantly the transfer of public health into local authorities.

This made local authorities responsible for commissioning comprehensive open access sexual health services including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception.

Local authorities also commission specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion and services in schools, college and pharmacies. Some specialised services are directly commissioned by CCGs and at the national level by NHS England.

The Framework for Sexual Health Improvement (Department of Health, 2013) was published to support commissioners and providers. It outlined the Government's ambitions for good sexual health and provides information about what is required to deliver good sexual health services.

The Framework's key principles are:

- Prioritising the prevention of poor sexual health
- Strong leadership and joined-up working
- Focusing on outcomes
- Addressing the wider determinants of sexual health
- Commissioning high-quality services, with clarity about accountability
- Meeting the needs of more vulnerable groups
- Good-quality intelligence about services and outcomes for monitoring purposes (Department of Health, 2013)

Key messages from 'Making it Work' (Public Health England, 2014), a guide on whole system commissioning for sexual health, reproductive health and HIV, focus on establishing seamless integrated care pathways and how this can work in practice.

Public Health Outcomes Framework

Public Health Outcome Framework Indicators

The following public health outcomes were established for local government in 2012 and are included in the Public Health Outcomes Framework (PHOF) for 2013–16 (Department of Health, 2013):

- A continuing fall in the rate of births to women under the age of 18 (No. 2.4)
- An increase in chlamydia diagnoses among young people aged 15–24, to be achieved through testing (No. 3.2)
- A reduction in the proportion of people with HIV whose infection is diagnosed late (No. 3.4)

Related PHOF indicators include:

- Rate of sexual offences (No. 1.12iii)
- Population vaccination coverage of Human Papilloma Virus (HPV) (No. 3.3)

Roles and Responsibilities

Commissioning and co-ordinating sexual health services:

'Sexual health, reproductive health and HIV services make an important contribution to the health of the individuals and communities they serve. Their success depends on the whole system - commissioners, providers and wider stakeholders - working together to make these services as responsive, relevant and as easy to use as possible and ultimately to improve the public's health.'

Duncan Selbie, Chief Executive Public Health England, 'Making it Work', (2015 [11])

'Making it Work' is an important guide for commissioners of sexual health, reproductive health and HIV services in local government, CCGs and NHS England. It doesn't tell us what to commission but it explains the intricacies, complexities and dependencies of a whole system approach to commissioning which has the service user at the heart.

It sets out several key messages:

- Put people at the centre of commissioning, and base decisions on assessed needs
- 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
- Build on the director of public health's role to deliver system stability and integration across the sector
- Draw on the expertise of clinicians and service users, and the public's views, to inform commissioning
- Build trust across commissioning organisations by developing strong relationships and dialogue with counterparts to develop local solutions
- Collaborate – a larger commissioning footprint can make the best use of limited resources to improve outcomes
- Document the approach to collaborative working, with clearly defined individual and collective responsibilities
- Ensure commissioned services have the capacity to educate and train the current and future workforce
- Acknowledge the economic climate requires new thinking and innovation – doing more or less of the same may not radically change outcomes or provide better value
- There is no one right way – it is for local teams to make collaborative commissioning for sexual health, reproductive health and HIV a local reality

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.

Other sexual health services are the responsibility of other partners. The table below explains the different commissioning responsibilities.

Who commissions what?

Local authorities	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

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 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); this would be in partnership with the NEL CCG who has the commissioning responsibility for TOP and abortion services. The LA's role is to ensure that there is a pathway, advice and information both prevention and intervention
- 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 NEL CCG who has the commissioning responsibility for abortion services
- Define the role and responsibility of each service in relation to partner notification (including referral pathways)
- Ensure staff are trained; and
- Ensure there is an audit and monitoring framework in place

Cost Effectiveness

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.

This document has been developed to provide the information, evidence base and support tools (including links where appropriate) to enable everyone involved in sexual health to work collaboratively to ensure that accessible, high quality services and interventions are available.[12]

Sexual health covers the provision of advice and services around contraception, relationships, STIs (including HIV) and abortion. Provision of sexual health services is complex and there is a wide range of providers, including general practice, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector. From April 2013, the commissioning of sexual health services changed and responsibility for commissioning most sexual health work was transferred to local authorities. All commissioners and providers need to work together to improve sexual health services and to ensure good-quality services and good outcomes.

How commissioners implement and take forward work on sexual health at a local level will be influenced by the work of their health and wellbeing board. The boards will be assessing current and future local health and care needs through Joint Strategic Needs Assessments (JSNAs), and will develop Joint Health and Wellbeing Strategies (JHWSs) to meet the identified needs.

These will inform local commissioning by the NHS England, CCGs and the local authority. Local authorities will be required to commission open-access sexual health (STI and contraception) services that meet the needs of their local population.

In 2013 the Department of Health published the Framework for Sexual Health Improvement in England and this was later supported by specific guidance for local authorities. The priorities of the framework are:

- To reduce inequalities
- Improve sexual health outcomes
- Build an open and honest culture where everyone can make responsible and informed choices about relationships and sex
- Some elements of sexual health have improved over time but some aspects still need addressing:
  - > tackling stigma, prejudice and discrimination
  - > reduce the rate of STIs using evidence based, preventative and treatment initiatives
  - > reduce unwanted pregnancies by enabling access to a full range of contraceptive options

Overall sexual health burden of disease and impact

Sexual & reproductive health and HIV are an important part of the nation's public health. There will be real benefits from including these within the scope of national and local work to improve public health.

Health economic benefit

There is a strong evidence base showing that investment in sexual & reproductive health and HIV services to improve public health minimises future NHS costs: - The NHS in England could save over £100m each year by increasing the use of long acting reversible contraception.

The NHS cost of providing lifetime treatment for people with HIV is increasing by £1 billion each year. Each time a person is prevented from acquiring HIV the NHS saves over £350,000.

People whose HIV is undiagnosed are at risk of passing on HIV, and therefore there are also health economic benefits from improving rates of HIV diagnosis.

- Health benefits – early diagnosis of STIs reduce the risk of costly complications and reduce the risk of onward transmission. Furthermore, undiagnosed STIs also increase the likelihood of HIV transmission. There are health benefits for people with HIV from being diagnosed earlier and starting treatment at the right time
- Reducing Health Inequality – Poor sexual health is much more common amongst people who already experience inequality associated with their age, gender, ethnicity, sexuality, or economic status. The benefits of improving sexual & reproductive health and HIV for some, this inequality is compounded by the stigma which is still attached to HIV, poor sexual health and teenage parenthood. Poor sexual health also affects a significant number of people who have other public health needs, in particular alcohol and drug misuse and violence
- Impact on societal and economic well being – The societal cost of poor sexual health is significant. High levels of teenage parenthood reduce the life chances of young people now as well as future generations. Some STIs, if left undiagnosed, cause long term and life threatening complications, including cancers. Failure to diagnose HIV infection early leads to avoidable serious illness and early deaths. HIV is now a long-term condition thanks to effective treatments, but people with HIV experience the effects of ageing earlier, have higher levels of ill health and higher levels of dependence on welfare benefits, than the general population
- Unintended pregnancy, STIs and HIV are avoidable by changing behaviour. Unlike many other areas of public health, STIs and HIV are transmissible, yet they are also avoidable through good quality prevention work, prompt treatment and partner notification to reduce onward transmission, bringing rapid benefits to the NHS, the individual, and the wider community. There is significant expertise in the field of sexual health and HIV care delivery and prevention which can be used to support the development of national and local quality and outcome measures for use by Government and local commissioners

Priority areas should include the following:

- A continuing fall in the rate of births to 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
- A reduction in new diagnoses of other STIs 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 48 hours of seeking care is crucial to controlling STIs

Why is it important?

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, because:

- Poor sexual and reproductive health and ongoing transmission rates of HIV have major impacts on population mortality, morbidity and wider wellbeing, and result in significant costs for health services and local authority budgets
- Sexual relationships, although an intensely private matter, are a major component of the wellbeing of the whole adult population and of wider society
- There is a strong association between poor sexual and reproductive health and other risk behaviours, and by seeking to improve sexual and reproductive health and HIV outcomes, these other determinants of health may also be identified and addressed; and
- Sexual and reproductive ill health is concentrated in many vulnerable and marginalised communities, and improving sexual and reproductive health and HIV outcomes will help in addressing these major health inequalities

Good sexual and reproductive health is important for everyone, but sexual ill health affects some population groups more than others.

This means that many sexual and reproductive health and HIV services need to achieve universal coverage (for example information on sexual and reproductive health); while others need to reach key populations with highest risk of adverse sexual health outcomes (for example HIV tests for men who have sex with men (MSM)). The balance between providing universal and targeted interventions will vary across the area, to reflect the different sexual health needs of our population.

Universal approaches need to be promoted together with targeted interventions aimed at key populations. This needs assessment should be performed to identify the needs of the different local communities/populations, to inform local sexual and reproductive health and HIV services and promotion activities.

For more information visit:

www.bashh.org www.bhiva.org

www.brook.org.uk

www.fpa.org.uk

www.ffprhc.org.uk

www.medfash.org.uk

www.nat.org.uk www.tht.org.uk

Chapter 2

Sexual and Reproductive Diseases and Contraception

STIs are passed from one person to another through unprotected sex or genital contact.

Gonorrhoea

Gonorrhoea is a bacterial STI easily passed on during sex. About 50% of women and 10% of men don't experience any symptoms and are unaware they're infected.

In women, gonorrhoea can cause pain or a burning sensation when urinating, a vaginal discharge (often watery, yellow or green), pain in the lower abdomen during or after sex, and bleeding during or after sex or between periods, sometimes causing heavy periods.

In men, gonorrhoea can cause pain or a burning sensation when urinating, a white, yellow or green discharge from the tip of the penis, and pain or tenderness in the testicles.

It's also possible to have a gonorrhoea infection in your rectum, throat or eyes.

Gonorrhoea is diagnosed using a urine test or by taking a swab of the affected area. The infection is usually easily treated with antibiotics, but can lead to serious long-term health problems if left untreated, including infertility. However, here is recent evidence of growing resistance to anti – biotic therapy (see P12.).

High rates of gonorrhoea and syphilis in a population are an indication for high levels of risky sexual behaviour.

Syphilis

Syphilis is a bacterial infection that in the early stages causes a painless, but highly infectious, sore on your genitals or around the mouth. The sore can last up to six weeks before disappearing.

Secondary symptoms such as a rash, flu-like illness or patchy hair loss may then develop. These may disappear within a few weeks, after which you'll have a symptom-free phase.

The late or tertiary stage of syphilis usually occurs after many years, and can cause serious conditions such as heart problems, paralysis and blindness.

The symptoms of syphilis can be difficult to recognise. A simple blood test can usually be used to diagnose syphilis at any stage. The condition can be treated with antibiotics, usually penicillin injections. When syphilis is treated properly, the later stages can be prevented.

Genital Warts

Genital warts are small fleshy growths, bumps or skin changes that appear on or around your genital or anal area. They're caused by the human papilloma virus (HPV) and are the second most common STI in England after chlamydia.

The warts are usually painless, but you may notice some itching or redness. Occasionally, they can cause bleeding.

You don't need to have penetrative sex to pass the infection on because HPV is spread by skin-to-skin contact.

Several treatments are available for genital warts, including creams and freezing the warts (cryotherapy).

Genital Herpes

Genital herpes is a common infection caused by the herpes simplex virus (HSV), which is the same virus that causes cold sores.

Some people develop symptoms of HSV a few days after encountering the virus. Small, painful blisters or sores usually develop, which may cause itching or tingling, or make it painful to urinate.

After you've been infected, the virus remains dormant (inactive) most of the time. However, certain triggers can reactivate the virus, causing the blisters to develop again, although they're usually smaller and less painful.

It's easier to test for HSV if you have symptoms. Although there's no cure for genital herpes, the symptoms can usually be controlled using antiviral medicines.

Chlamydia

Chlamydia is the most common STI in the UK and is easily passed on during sex. Most people don't experience any symptoms, so they are unaware they're infected.

In women, chlamydia can cause pain or a burning sensation when urinating, a vaginal discharge, pain in the lower abdomen during or after sex, and bleeding during or after sex or between periods. It can also cause heavy periods.

In men, chlamydia can cause pain or a burning sensation when urinating, a white, cloudy or watery discharge from the tip of the penis, and pain or tenderness in the testicles.

It's also possible to have a chlamydia infection in your rectum (bottom), throat or eyes.

Diagnosing chlamydia is done with a urine test or by taking a swab of the affected area. The infection is easily treated with antibiotics, but can lead to serious long-term health problems if left untreated, including infertility.

Trichomoniasis

Trichomoniasis is an STI caused by a tiny parasite called Trichomonas vaginalis (TV). It can be easily passed on through sex and most people don't know they're infected.

In women, trichomoniasis can cause a frothy yellow or watery vaginal discharge that has an unpleasant smell, soreness or itching around the vagina, and pain when passing urine.

In men, trichomoniasis rarely causes symptoms. You may experience pain or burning after passing urine, a whitish discharge, or an inflamed foreskin.

Trichomoniasis can sometimes be difficult to diagnose and your GP may suggest you go to a specialist clinic for a urine or swab test. Once diagnosed, it can usually be treated with antibiotics.

Pubic Lice

Pubic lice ("crabs") are easily passed to others through close genital contact. They're usually found in pubic hair, but can live in underarm hair, body hair, beards and occasionally eyebrows or eyelashes.

The lice crawl from hair to hair but don't jump or fly from person to person. It may take several weeks for you to notice any symptoms. Most people experience itching and you may notice the lice or eggs on the hairs.

Pubic lice can usually be successfully treated with special creams or shampoos available over the counter in most pharmacies or from a GP or GUM clinic. You don't need to shave off your pubic hair or body hair.

Scabies

Scabies is caused by tiny mites that burrow into the skin. It can be passed on through close body or sexual contact, or from infected clothing, bedding or towels.

If you develop scabies, you may have intense itching that's worse at night. The itching can be in your genital area, but it also often occurs between your fingers, on wrists and ankles, under your arms, or on your body and breasts.

You may have a rash or tiny spots. In some people, scabies can be confused with eczema. It's usually very difficult to see the mites.

Scabies can usually be successfully treated using special creams or shampoos available over the counter in most pharmacies, or from a GP or GUM clinic. The itching can sometimes continue for a short period, even after effective treatment.

HIV

The Human Immunodeficiency Virus (HIV) is most commonly passed on through unprotected sex. It can also be transmitted by encountering infected blood – for example, sharing needles to inject steroids or drugs.

The virus attacks and weakens the immune system, making it less able to fight infections and disease. There's no cure for HIV, but there are treatments that allow most people to live a long and otherwise healthy life.

Acquired Immune Deficiency Syndrome (AIDS) is the final stage of an HIV infection, when your body can no longer fight life-threatening infections.

Most people with HIV look and feel healthy and have no symptoms. When you first contract HIV, you may experience a flu-like illness with a fever, sore throat or rash. This is called a seroconversion illness.

A simple blood test is usually used to test for an HIV infection. Some clinics may also offer a rapid test using a finger-prick blood test or saliva sample.

Cervical Screening

What is cervical screening?

A cervical screening test (previously known as a smear test) is a method of detecting abnormal cells on the cervix. The cervix is the entrance to the womb from the vagina. Detecting and removing abnormal cervical cells can prevent cervical cancer.[13]

Why cervical screening is offered?

Cervical screening is offered because it can detect abnormal cell changes in the cervix (the lower part of the womb) that could potentially develop into cervical cancer. Abnormal cells that are picked up during cervical screening often return to normal on their own, so waiting may be recommended. However, if more significant abnormalities are detected at an early stage, there is the option of having treatment to remove them before they have a chance to become cancerous.

Since the screening programme was introduced in the 1980s, the number of cervical cancer cases has decreased by about 7% each year and it's estimated that up to 5,000 cases of cervical cancer are prevented each year in the UK because of cervical screening.

What causes abnormal cell changes in the cervix?

Abnormal changes in the cells of the cervix can be caused by certain high-risk types of human papilloma virus (HPV).

HPV is the name of a family of common viruses that affect the skin and the mucus membranes (moist tissue that lines parts of the body), such as those in your cervix, anus, mouth and throat.

HPV is very common and is passed on through skin-to-skin contact. It's estimated that 8 out of 10 people in the UK are infected with HPV at some point during their lifetime. For most people, the virus goes away without treatment and doesn't cause any harm. However, infection with some types of HPV can cause abnormal cell growth, which can lead to cervical cancer. Other forms of HPV cause genital warts.

The high-risk types of HPV that can cause abnormalities in the cells of your cervix are transmitted through sexual contact. This includes penetrative sex as well as other types of sexual contact, such as skin-to-skin contact of the genital area, or using sex toys. Because most types of HPV, including high-risk types, don't cause any symptoms, you or your partner could have the virus for months or years without knowing it.

Can HPV be prevented?

It can be very difficult to prevent HPV, which is one of the reasons cervical screening is so important.

Using a condom during sex can reduce your risk of developing an HPV infection, but as condoms don't cover the entire genital area and are often put on after sexual contact has begun; they're not guaranteed to prevent the spread of HPV.

A vaccination offering some protection against HPV is now offered to all girls aged 12-13 as part of the NHS Childhood Vaccination Programme.

Studies have already shown that the vaccine protects against HPV infection for around ten years, although experts expect protection to be for much longer.

How common are abnormal results?

For every 100 women who have cervical screening, about 6 will have an abnormal result.

It's very rare for cancer to be diagnosed from the results of a cervical screening test. Less than 1 in 1,000 test results show invasive cancer.

Are there any disadvantages of cervical screening?

Although cervical screening can help to prevent cervical cancer, there are some potential disadvantages associated with it. These include:

- Potential discomfort, embarrassment or (less commonly) pain during the screening test
- A very small chance of getting incorrect results, which could lead to abnormalities being missed or unnecessary distress and treatment
- A chance of having unnecessary treatment if the abnormalities would have corrected themselves naturally
- Some treatments used to remove abnormal cells may increase your risk of giving birth prematurely (before the 37th week of pregnancy) if you get pregnant in the future
- However, cervical screening is offered to women aged 25-64 in England because the potential benefits of screening are believed to outweigh these risks

Hepatitis

Hepatitis is the term used to describe inflammation of the liver. It's usually the result of a viral infection or liver damage caused by drinking alcohol.

There are several different types of hepatitis, most of which are outlined below. Some types will pass without any serious problems, while others can be long-lasting (chronic) and cause scarring of the liver (cirrhosis), loss of liver function and, in some cases, liver cancer.

Hepatitis B is a common infection that is often asymptomatic and can have chronic and serious outcomes, including chronic hepatitis, fulminant liver failure and hepatocellular carcinoma.

Onward transmission occurs via sexual intercourse and blood-blood contact. Hepatitis B is preventable with pre-exposure vaccination. It is therefore important to screen patients for Hepatitis B infection to enable earlier identification of Hepatitis B and to vaccinate at-risk groups to prevent acquisition of infection. In accordance with NICE PH43 guidance, we aimed to improve the awareness and uptake of testing and vaccination for Hepatitis B infection and for high-risk patients attending the sexual health clinic.

These at-risk groups included men who have sex with men (MSM), injecting venous drug users (IVDU), commercial sex workers (CSW) and people who change partners frequently.

The national targets for these at-risk groups were as follows:

- Patients who are not already known to be immune to HBV (Hepatitis B virus), should have serology for HBV done on their initial attendance (Goal: 90%)
- Patients who are not already known to be immune to HBV (Hepatitis B virus), should receive a dose of HBV vaccine on their initial attendance (Goal: 90%)
- Patients who are not already known to be immune to Hepatitis B virus (HBV) and who on testing are not found to be either infected or immune to HBV, should receive 3 doses of HBV vaccine within 6 months of their initial attendance (Goal: 50%)

Symptoms of hepatitis

Short-term (acute) hepatitis often has no noticeable symptoms, so you may not realise you have it.

If symptoms do develop, they can include:

- Muscle and joint pain
- A high temperature (fever) of 38C (100.4F) or above
- Feeling and being sick
- Feeling unusually tired all the time
- A general sense of feeling unwell
- Loss of appetite
- Abdominal (tummy) pain
- Dark urine
- Pale, grey-coloured stool
- Itchy skin
- Yellowing of the eyes and skin (jaundice)

Long-term (chronic) hepatitis also may not have any obvious symptoms until the liver stops working properly (liver failure) and may only be picked up during blood tests. In the later stages, it can cause jaundice, swelling in the legs, ankles and feet, confusion, and blood in your stools or vomit.

Hepatitis A

Hepatitis A is caused by the hepatitis A virus. It's usually caught by consuming food and drink contaminated with the poo of an infected person and is most common in countries where sanitation is poor.

Hepatitis A usually passes within a few months, although it can occasionally be severe and even life-threatening. There's no specific treatment for it, other than to relieve symptoms such as pain, nausea and itching.

Vaccination against hepatitis A is recommended if you're travelling to an area where the virus is common, such as the Indian subcontinent, Africa, Central and South America, the Far East and Eastern Europe.

Hepatitis B

Hepatitis B is caused by the hepatitis B virus, which is spread in the blood of an infected person.

It's a common infection worldwide and is usually spread from infected pregnant women to their babies, or from child-to-child contact. In rare cases, it can be spread through unprotected sex and injecting drugs.

Hepatitis B is uncommon in the UK and most cases affect people who became infected while growing up in part of the world where the infection is more common, such as Southeast Asia and sub-Saharan Africa.

Most adults infected with hepatitis B can fight off the virus and fully recover from the infection within a couple of months. However, most people infected as children develop a long-term infection. This is known as chronic hepatitis B and it can lead to cirrhosis and liver cancer. Antiviral medication can be used to treat it.

In the UK, vaccination against hepatitis B is recommended for people in high-risk groups, such as healthcare workers, people who inject drugs, men who have sex with men, and people travelling to parts of the world where the infection is more common.

Hepatitis C

Hepatitis C is caused by the hepatitis C virus and is the most common type of viral hepatitis in the UK. It's usually spread through blood-to-blood contact with an infected person.

In the UK, its most commonly spread through sharing needles used to inject drugs. Poor healthcare practices and unsafe medical injections are the main way it's spread outside the UK.

Hepatitis C often causes no noticeable symptoms, or only flu-like symptoms, so many people are unaware they're infected.

Around one in four people will fight off the infection and be free of the virus. In the remaining cases, it will stay in the body for many years. This is known as chronic hepatitis C and can cause cirrhosis and liver failure.

Chronic hepatitis C can be treated with very effective antiviral medications, but there's currently no vaccine available.

Hepatitis D

Hepatitis D is caused by the hepatitis D virus. It only affects people who are already infected with hepatitis B, as it needs the hepatitis B virus to be able to survive in the body.

Hepatitis D is usually spread through blood-to-blood contact or sexual contact. It's uncommon in the UK, but is more widespread in other parts of Europe, the Middle East, Africa and South America.

Long-term infection with hepatitis D and hepatitis B can increase the risk of developing serious problems, such as cirrhosis and liver cancer.

There's no vaccine specifically for hepatitis D, but the hepatitis B vaccine (see above) can help protect you from it.

Hepatitis E

Hepatitis E is caused by the hepatitis E virus. It's usually caught by consuming food and drink contaminated with the poo of an infected person. It's now the most common cause of short-term (acute) hepatitis in the UK.

Hepatitis E is generally a mild and short-term infection that doesn't require any treatment, but it can be serious in a small number of people. It can become chronic in people who have a suppressed immune system, such as those who have had an organ transplant.

There's no vaccine for hepatitis E, but risk can be reduced by practising good food and hygiene measures, particularly when travelling to parts of the world with poor sanitation.

Alcoholic Hepatitis

Alcoholic hepatitis is a type of hepatitis caused by drinking excessive amounts of alcohol over many years.

The condition is common in the UK and many people don't realise they have it because it doesn't usually cause any symptoms, although it can cause sudden jaundice and liver failure in some people.

Stopping drinking will usually allow the liver to recover, but continuing to drink alcohol excessively, increases the risk of cirrhosis, liver failure or liver cancer.

Autoimmune Hepatitis

Autoimmune hepatitis is a rare cause of long-term hepatitis in which the immune system attacks and damages the liver. Eventually, the liver can become so damaged that it stops working properly.

Autoimmune hepatitis is a rare cause of long-term hepatitis in which the immune system attacks and damages the liver. Eventually, the liver can become so damaged that it stops working properly.

Treatment for autoimmune hepatitis involves very effective medicines that suppress the immune system and reduce inflammation.

It's not clear what causes autoimmune hepatitis and it's not known whether anything can be done to prevent it.

The British Liver Trust has more information about autoimmune hepatitis.

Contraception

Contraception is the deliberate use of artificial methods or other techniques to prevent pregnancy because of sexual intercourse.

The major forms of artificial contraception are:

- Barrier methods, of which the commonest is the condom or sheath
- The contraceptive pill, which contains synthetic sex hormones which prevent ovulation in the female
- Intrauterine devices, such as the coil, which prevent the fertilized ovum from implanting in the uterus
- Male or female sterilisation

Contraception is free for most people in the UK.

Barrier methods such as condoms also help to protect against STIs and pregnancy.

The 15 methods of contraception available in the UK at present:

1. Caps
2. Combined pill
3. Male condoms
4. Female condoms
5. Contraceptive implants
6. Contraceptive injection
7. Contraceptive patch
8. Diaphragms
9. Intrauterine Devices (IUD)
10. Intrauterine System (IUS)
11. Natural family planning
12. Progestogen – only pill
13. Vaginal ring
14. Female sterilisation
15. Male sterilisation (vasectomy)

Emergency Hormonal Contraception (EHC)

Emergency Hormonal Contraception (EHC) is also called the ‘Morning After Pill’.

If you have had unprotected sex, taking emergency hormonal contraception within 3-5 days can help prevent pregnancy. The pill should be taken as soon as possible after unprotected sex - the earlier it is taken, the more effective it is. EHC can be used if you have had sex without using contraception, or if you have had sex but there was a mistake with your usual contraception (for example, a split condom or if you forgot to take your usual contraceptive pills).

There are two types of ‘morning after pill’ available. One contains a medicine called levonorgestrel which is a female progestogen hormone. The other contains a medicine called ulipristal acetate which works on female hormone receptors within your body. They are both thought to work mainly by delaying or stopping your ovaries from releasing an egg. Although EHC is effective, it is not as reliable as regular planned contraception. Therefore, it should only be used in an emergency. The levonorgestrel pill is available free on prescription as brands called Levonelle® 1500, Isteranda®, and Upostelle®.

It can also be purchased from a pharmacy, without a prescription, as a brand called Levonelle® One Step. It is effective for up to 72 hours (three days) after unprotected sex. The ulipristal acetate pill is effective for up to 120 hours (five days) after having unprotected sex. Ulipristal acetate is available free on prescription through a doctor, one of the ACT service pharmacies within NEL or family planning clinic as a brand called ellaOne®.

A non-hormonal method of emergency contraception is also available. A coil (intrauterine device or IUD) can be inserted by a doctor or nurse up to five days after unprotected sex. This method of emergency contraception is more effective than hormonal tablets.

Long Acting Reversible Contraception (LARC)

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

Women considering LARC methods should receive detailed information – both verbal and written – that will enable them to choose a method and use it effectively. This information should take into consideration their individual needs and should include:

- Contraceptive efficacy
- Duration of use
- Risks and possible side effects
- Non-contraceptive benefits
- The procedure for initiation and removal/discontinuation
- When to seek help while using the method

Counselling about contraception should be sensitive to cultural differences and religious beliefs.

Healthcare professionals should have access to trained interpreters for women who are not English speaking, and to advocates for women with sensory impairments or learning disabilities

Abortion

Abortion (including repeat abortions). Abortion is when a pregnancy is ended so that it doesn't result in the birth of a child. Sometimes it is called 'termination of pregnancy'

There are two types of abortion used in the UK.

Medical Abortion

There are two types of medical abortion

1. Abortion pill (also known as early medical abortion) up to 10 weeks.

- Involves taking medication to cause an early miscarriage (women experience cramping, pain and heavy bleeding)
- After 9 weeks' gestation 2 visits to the clinic will be needed (the visits may be on the same day or up to 3 days apart)
- No surgery or anaesthetic

2. Abortion pill from 10 weeks to 24 weeks.

- Involves taking medication to cause the womb to contract and push out the pregnancy
- 2 visits to the clinic are needed
- Sometimes an overnight stay is needed on the 2nd visit

Surgical Abortion

Surgical abortion involves a quick, minor operation. There are two types of surgical abortion:

1. Vacuum aspiration up to 15 weeks.

- Removes the pregnancy by gentle suction
- Up to 14 weeks of pregnancy this can be done by local anaesthetic. The quicker recovery time for this option means you can leave the clinic unattended and drive sooner
- Up to 15 weeks it can be done with sedation (relaxed and sleepy) and sometimes under general anaesthetic
- One visit to the clinic and you go home the same day

2. Dilatation and evacuation between 15 and 24 weeks.

- Carried our while you are under general anaesthetic
- The pregnancy is removed using narrow forceps passed through the neck of the womb and some gentle suction
- One visit to the clinic and you go home the same day

Chapter 3

What does Sexual and Reproductive Health look like in NEL?

The re-commissioning of sexual health services in the future will require a comprehensive SHNA approach, with some focus on examining the wider determinants of health.

The council will be able to use the information provided by the SHNA to plan its strategy for future sexual health provision within NEL with confidence, ensuring it is meeting the current and future needs of the local population, and to address the:

- Key population groups – targeting interventions towards those who are at risk of, or are particularly adversely affected by, poor sexual and reproductive health and HIV
- Key geographical areas – delivering appropriate and specific interventions and support to areas with poor sexual and reproductive health and with high levels of HIV infection
- Key life stages – focusing preventative interventions on critical periods of risk in people's lives

NEL is a small unitary authority covering an area of 192 square km. Most of the resident population lives in the towns of Grimsby and Cleethorpes with the remainder living in the smaller town of Immingham, or in surrounding rural villages.

NEL has a distinctive economy, built on expertise in manufacturing, engineering, ports and logistics, and food processing. The local area has some significant advantages stemming from its location, labour force, and transport infrastructure that position it for growth in renewables, chemicals, advanced manufacturing and the food and drink sector. Taken together, Grimsby and Immingham constitute the UK's largest port by tonnage shipped [14]

Census figures classify 94.2% of the population of NEL Council as living in an urban environment.[15] However NEL has a wide variety of parks and open spaces. On the Northern border the Humber estuary has been designated as a Site of Special Scientific Interest and to the South the Lincolnshire Wolds are an Area of Outstanding Natural Beauty. Cleethorpes gained 3 Seaside Awards in 2014 for its beaches and holds Blue Flag status.[16]

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.[17]

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.

Expenditure on Sexual and Reproductive Health

Across NEL the commissioning expenditure on contracted out sexual health services is approximately £900,000 per year. This is apportioned as follows:

How funds are invested in Sexual Health in NE Lincolnshire.

Provider	What they provide	£ cost
Virgin Care	A full range of sexual health services from 4 bases	689,800
GPs LARC	Long Acting Reversible Contraception	117,000
Pharmacies	Advice, contraception and testing (ACT)	35,000
3rd sector provider	Outreach for men who have sex with men	9,400
Other costs (materials, postage	Consumables costs such as condoms and other clinical materials	7,200
Out of area costs		24,000
Recharge	Corporate services support	4,700

Demographics

(Source: 'A Snapshot of health and wellbeing in NEL', 2015).

- Life expectancy for males and females in NEL has grown considerably in the last 20years but remains lower than the regional and national average
- NEL has the highest rate of health inequality for males and the joint highest for females with a gap of 12.7 years and 9.3 years respectively between the best off and worst off areas
- ONS data shows that males in the most deprived areas can expect to live 52.2 years in 'good' health, compared with males in the least deprived areas who can expect to live 70.5 years in 'good' health
- Females in the most deprived areas could also expect to live less of their lives (52.4 years) in 'good' health, compared with females in the least deprived areas (71.3 years)
- 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:
  - South 49.7%
  - East Marsh 49.3%
  - West Marsh 42.3%
  - Sidney Sussex 36.9%
  - Heneage 31.5%

Population Density

- The five most deprived areas are overall most densely populated:
  - South 12,728 / 159,727
  - East Marsh 11,835 / 159,727
  - West Marsh 7,754 / 159,727
  - Sidney Sussex 12,789 / 159,727
  - Heneage 12,013 / 159,727

Deprivation

- NEL is ranked as the 31st most deprived local authority in England. (Informed, deprivation bands)
  - 32,567 (20.4%) are income deprived
  - 15,140 (9.5%) are employment deprived
- Unemployment in the 16 – 64 age group is 9%. England rate is 5.9% and Y&H rate is 7.2%
- Despite predictions of substantial population growth in the next 15 years most recent data suggests net migration outflow
- 20.1% of the working age group have a known disability. More women have a disability (22%) than men (18.2%)
- Job Seeker Allowance (JSA) claimants are highest in the five most deprived wards:
  - South 6.61%
  - East Marsh 8.70%
  - West Marsh 6.91%
  - Sidney Sussex 4.24%
  - Heneage 4.99%
- NEL has the worst rate in the country for child KSIs (Killed or Seriously Injured) 48.3 per 100,000 population compared with 19.1 for England. Most child casualties are pedestrians or cyclists and the hotspot areas are East Marsh, Sidney Sussex, Park and Heneage wards
- 1160 out of every 10,000 children in NEL were defined as children in need during 2014/15 which was the highest rate in the country and almost double the England rate (674). 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
- 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[18]. Alcohol and drug dependency has an impact on risky behaviour
- NEL has a lower rate of sexually transmitted infections in the under 25s (excluding chlamydia) than the national rate
- Over 30% of households in NEL do not have access to a car with rates ranging from 64% in East Marsh to 9% in Wolds.
- 7.1% of 16-18yr olds are not in education, employment or training (NEETS) which is the highest in Y&H and well above the national rate of 4.7%

Ethnicity (source JSNA)

- 95.4% of the resident population 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%)
- 90.8% of school pupils in NEL in January 2015 were recorded as White British compared with 95.4% in January 2014. 6.8% of all pupils were recorded as Black and Minority Ethnic (BME) in January 2015; primary stage schools reported 7% BME

Latest survey results estimate that the proportion of the population who have a gay / lesbian or bisexual identity in the Y&H region is 1.4% compared with 1.6% in England. Within the region, the estimate of the gay / lesbian or bisexual population decreased by 0.1% from 2012 to 2013 while the all England figure increased by 0.2%

- The proportion of BME in each ward varies significantly with 9% or over in East Marsh, West Marsh and Croft Baker down to 2.8% in Haverstoe ward. Park Ward, which had the highest proportion of BME in 2014 (10%) reduced to 8.4% in 2015
- In NEL 96.8% of the population felt that they had a British identity; 3.2% (approximately 5,000) people had a non-British identity. 1.9% (approximately 3,000 people had a European identity (APS 20123)

Sexual Identity

Latest data for the region and national.

		2012	2013	2014
		%		
Heterosexual	Yorkshire/ Humber	94.2	93.1	92.9
	England	93.5	92.7	92.8
Gay/Lesbian/ Bisexual	Yorkshire/ Humber	1.6	1.5	1.4
	England	1.5	1.7	1.6
Other	Yorkshire/ Humber	0.3	0.3	0.4
	England	0.3	0.3	0.3
Don't know/ refusal	Yorkshire/ Humber	2.9	3.9	4.0
	England	3.6	3.9	3.9
No response	Yorkshire/ Humber	1.1	1.2	1.3
	England	1.1	1.5	1.4

In NEL, there is no obvious gay scene.

Service Mapping

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 (NEL 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 2015/2016 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 and 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 STIs.

Total Attendances / Individuals

During 2015/16 there were a total of 11670 attendances which equated to 6974 individuals. These figures relate to all aspects of the integrated sexual health service i.e. Stirling Street hub, satellite sites, hard to reach outreach, and chlamydia screening which is primarily a postal service.

Total number of individuals and attendances, NEL residents.

	2013/14	2014/15	2015/16
Attendances	9164	12572	11670
Individuals	5266	7360	6974

Individuals by gender

During 2015/16 approximately three quarters of individuals accessing the ISH service were female.

	2013/14		2014/15		2015/16	
	Number	%	Number	%	Number	%
Male	1718	32.6	2074	28.2	1815	26.0
Female	3548	67.4	5286	71.8	5159	74.0
Total	5266	100	7360	100	6974	100

Individuals by age group

Individuals under 16

	2013/14	2014/15	2015/16
Male	30	45	20
Female	218	266	227
Total	248	311	247

Individuals 16 – 24

	2013/14	2014/15	2015/16
Male	911	1148	920
Female	1918	2714	2536
Total	2829	3862	3456

Individuals 25 – 49

	2013/14	2014/15	2015/16
Male	686	778	761
Female	1321	2222	2301
Total	2007	3000	3062

Individuals 50 +

	2013/14	2014/15	2015/16
Male	89	99	113
Female	87	82	89
Total	176	181	202

Individuals Total

	2013/14	2014/15	2015/16
Male	1716	2070	1814
Female	3544	5284	5153
Total	5260	7354	6967

Unknown

	2013/14	2014/15	2015/16
Male	2	4	1
Female	4	2	6
Total	6	6	7

Sexuality has been recorded for the majority of individuals, and data quality has improved over time. Approximately 98% of all individuals for whom sexuality was recorded were heterosexual.

Individuals by sexuality

Sexuality not known

2013/14	2014/15	2015/16
594	193	56

Bisexual

2013/14		2014/15		2015/16	
Number	%	Number	%	Number	%
23	0.5	18	0.3	30	0.4

Heterosexual

2013/14		2014/15		2015/16	
Number	%	Number	%	Number	%
4544	97.3	7047	98.3	6796	98.2

Homosexual

2013/14		2014/15		2015/16	
Number	%	Number	%	Number	%
96	2.1	100	1.4	86	1.2

Other

2013/14		2014/15		2015/16	
Number	%	Number	%	Number	%
9	0.2	2	0.0	6	0.1

Ward and Lower Layer Super Output Areas (LSOAs) of residence

Following administrative boundary changes effective from 1 April 2003, NEL is comprised of 15 electoral wards. The wards with the highest numbers of individuals using the NEL ISH services were East Marsh, Sidney Sussex, and Heneage wards accounting for approximately 33% of individuals. The resident population structure differs considerably between wards; therefore, individuals using the NEL ISH services have also been additionally expressed as the number per 1000 population aged 15 to 44 years. NEL had an overall rate of 119.7 individuals per 1000 population aged 15 to 44 years accessing the NEL ISH service during 2015/16. Wards with higher access rates than this were East Marsh, Sidney Sussex, Heneage, and Croft Baker.

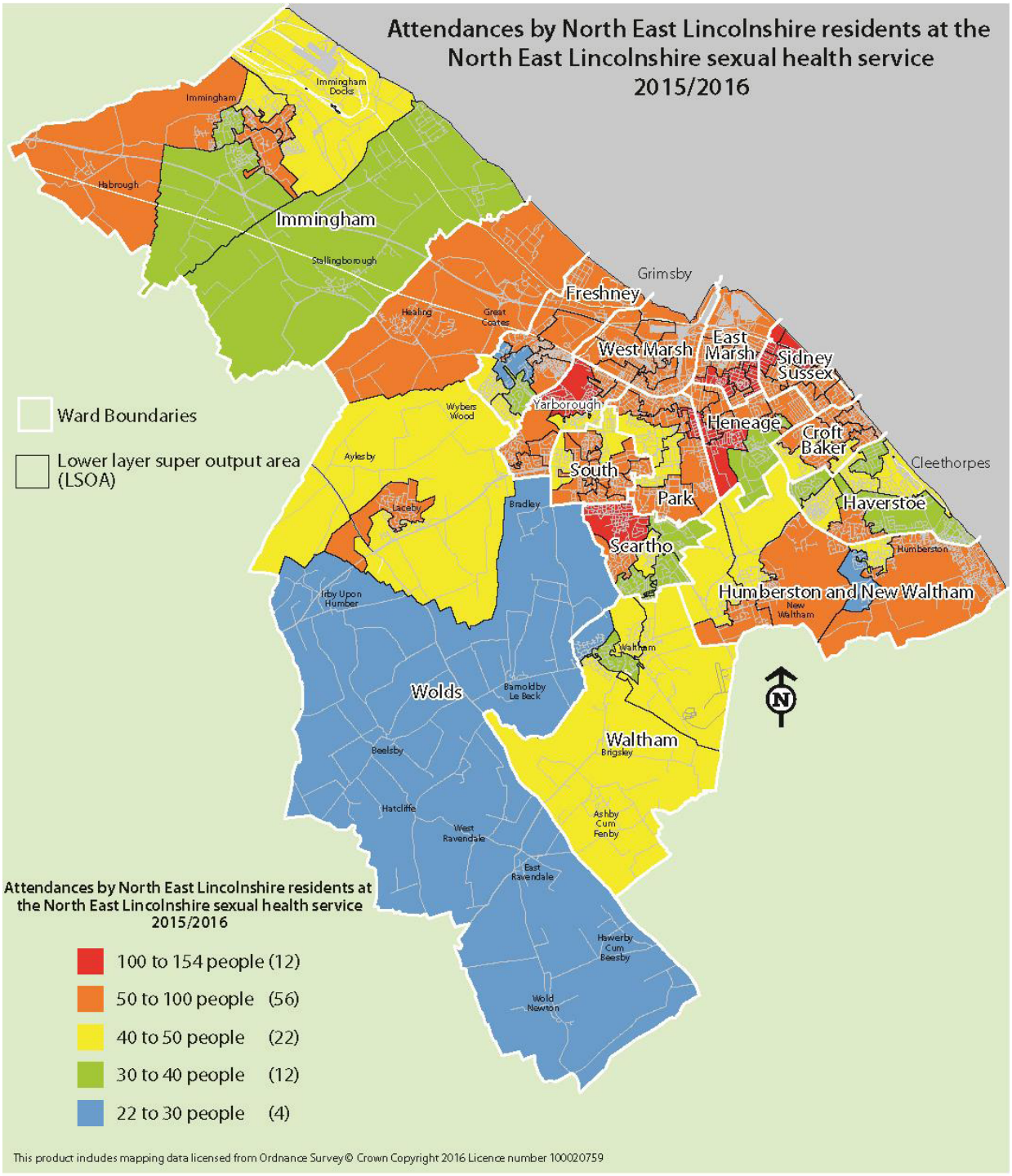
Number of individuals by ward of residence, NEL residents, 2015/16

Ward	Number	%	Aged 15 – 44	% Per 1000
Croft Baker	558	8.2	4262	130.9
East Marsh	811	12.0	4970	163.2
Freshney	316	4.7	3398	93.0
Haverstoe	295	4.3	2738	107.7
Heneage	657	9.7	5004	131.3

Humberston and New Waltham	348	5.1	3146	110.6
Immingham	348	5.1	4048	86.0
Park	491	7.2	4438	110.6
Scartho	375	5.5	3629	103.3
Sidney Sussex	761	11.2	5324	142.9
South	561	8.3	4892	114.7
Waltham	191	2.8	1976	96.7
West Marsh	378	5.6	3487	108.4
Wolds	190	2.8	2358	80.6
Yarborough	502	7.4	4593	109.3
Ward of residence not known	192			

NEL is comprised of 106 LSOAs and the numbers of individuals using the NEL ISH services have been thematically mapped by LSOA of residence. The NEL ISH services reach people from all areas of NEL with particular reach into the East Marsh, Sidney Sussex, Heneage, Yarborough and Scartho Top.

Number of people using the ISH services by LSOA of residence, NEL, 2015/16.



***LSOA of residence not known for 192 individuals.**

Age and gender within the most deprived wards

	All People	% Female	% Male
South	12715	52	48
East Marsh	11659	48.9	51.1
Heneage	12046	49.4	50.6
West Marsh	7830	49.8	50.2
Sidney Sussex	12696	50.2	49.8

	% Female 0 – 15	% Male 0 – 15
South	23.3	24.1
East Marsh	21.3	22.7
Heneage	20.6	22.4
West Marsh	21.6	21.8
Sidney Sussex	22.7	23.3

	% Female 16 – 64	% Male 16 – 64
South	61.3	55.3
East Marsh	64.8	69.5
Heneage	63.7	67.5
West Marsh	65.6	67.9
Sidney Sussex	64.6	64.9

	% Female 65 +	% Male 65 +
South	15.3	12.7
East Marsh	14	12.5
Heneage	15.7	12.5
West Marsh	12.8	11.2
Sidney Sussex	12.8	10.9

Service Locations

Contraceptive and Sexual Health Services (CASH)

CASH services are provided by a combination of providers in NEL. Virgin Care is the largest provider and provides sexual health clinics from five locations in NEL.

Most attendances for NEL ISH services take place at the Stirling Street hub. The number of attendances by service location is detailed in the table below. There were an additional 1272 attendances via the chlamydia screening service which is primarily postal, and 336 attendances via service outreach to hard to reach groups.

Number of ISH service attendances by hub/spoke location, NEL residents, 2015/16.

Location	Number of Attendances
Birkwood Medical Centre	234
Beacon Medical Centre	123
Franklin College	26
Grimsby College	261
Ormiston Maritime Academy	25
Roxton Practice	79
Stirling Street	9314

Hub Service Provision – July 2016

1st Floor Stirling Street
Medical Centre, NEL

Monday **09:00 – 17:00**	**Appointments 13:00 – 17:00** **Walk In 09:00 – 17:00**
Tuesday **10:00 – 20:00**	**Appointments 10:00 – 17:00** **Walk In 17:00 – 20:00**
Wednesday **09:00 – 17:00**	**Appointments 09:00 – 17:00** **Walk In 09:00 – 12.00**
Thursday **12:00 – 20:00**	**Appointments 12:00 – 17:00** **Walk In 17:00 – 20:00**
Friday **09:00 – 17:00**	**Appointments 09:00 – 17:00** **Walk In 09:00 – 12.00**
Saturday **09:00 – 13:00**	**Appointments** **09:00 – 13:00**

Spoke and Outreach Service Provision – July 2016

Grimsby Institute
Nuns Corner, Grimsby, DN34 5BQ

Monday **12:00 – 14:00**	**Walk In (chlamydia screening and contraception)** **Bi-Weekly 1st & 3rd Monday of every month**

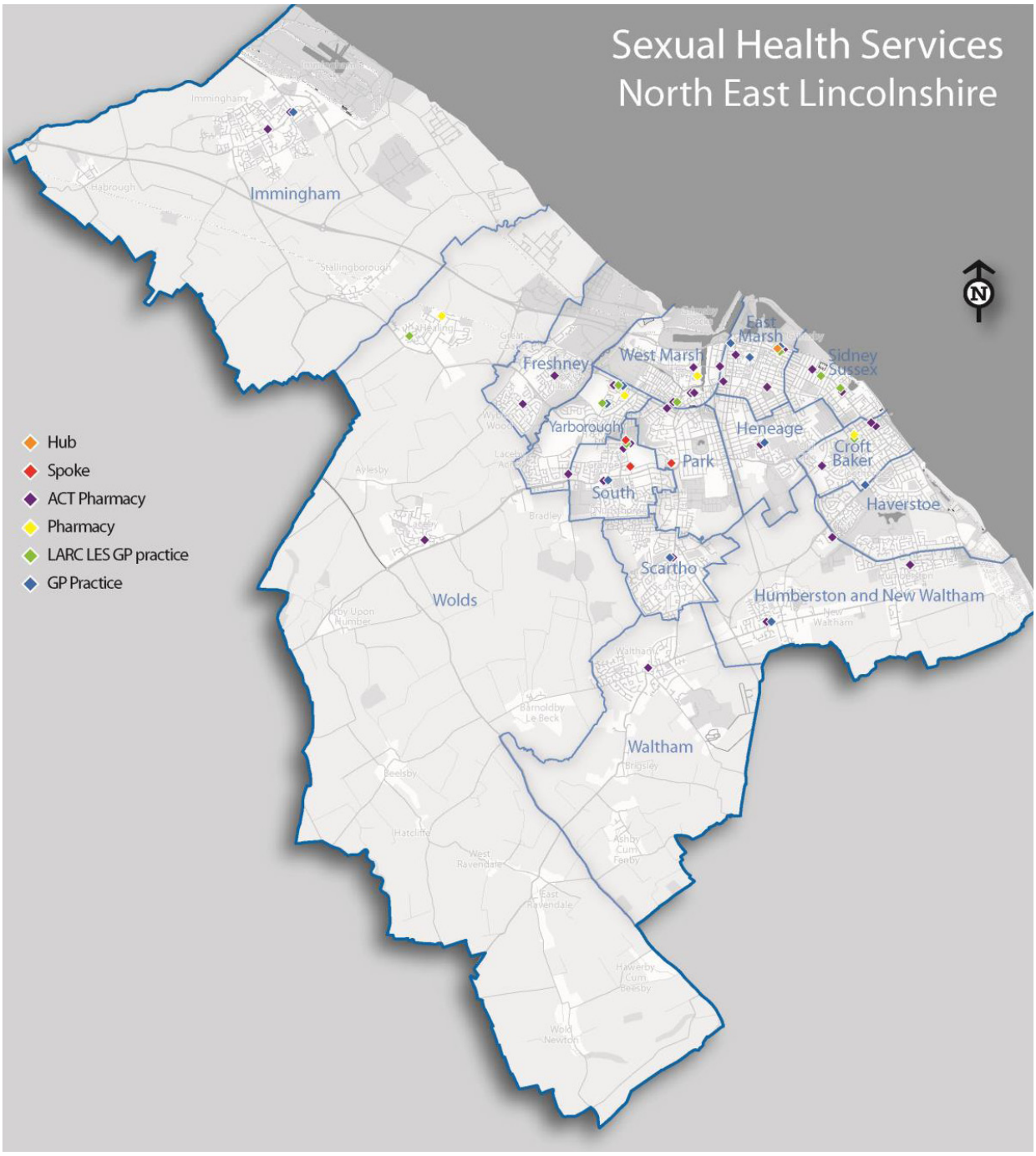
Birkwood Medical Centre
Westward Ho, Grimsby, DN34 5BH

Tuesday **13:00 – 17:00**	**Appointments**

Franklin Sixth Form College
Chelmsford Avenue, Grimsby, DN34 5BY

Tuesday **12:00 – 13:15**	**Walk In (chlamydia screening & signposting) 1st Tuesday of the month**

Sexual health services, NEL, July 2016



There were 5036 attendances at the ISH service during 2015/16 which were by appointment, 3528 attendances via walk-ins, 506 attendances via outreach, and 2600 attendances via the chlamydia screening programme.

Appointment and walk-in ISH service attendances by month

2015/16	Appointment	Walk-In
April	347	390
May	309	383
June	404	396
July	327	456
August	347	363
September	306	489
October	342	454
November	246	420
December	572	36
January	603	73
February	598	60
March	635	8

Appointment and walk-in ISH service attendances by day of the week

2015/16	Appointment	Walk-In
Monday	1148	576
Tusday	1018	555
June	899	879
Thusday	1050	637
Friday	439	873
Saturday	482	6

Out of area patients

During 2015/16 there were 1642 attendances of residents outside of the NEL area.

Of these 65% were female (n=1070) and 35% were male (n=572). Again, of these, 44% were aged 16 to 24 years (n=725), 35% were aged 25 to 34 years (n=578), and 12% were aged 35 to 44 years (n=205). Note that some individuals may have attended more than once.

The out of area individuals resided in 73 different local authorities however the clear majority were from Lincolnshire (73%), followed by North Lincolnshire (17%). The only other local authority areas with 10 or more residents attending the NEL ISH were Liverpool (n=11) and Leeds (n=10).

Lincolnshire residents

During 2015/16 just less than three quarters of attendances of Lincolnshire residents were of females.

Number and percentage of attendances by gender.

2015/16	Number	%
Male	338	28
Female	860	72
Total	1198	100

Most attendances were at the Stirling Street Hub (66%), however 32% were via outreach (n=384) which is primarily college based.

Number of attendances by age and service location.

2015/16	< 19	20-24	25-34	35-44	45+	Total
Hub	136	180	298	106	68	788
Spoke	8	9	5	3	1	26
Outreach	136	75	135	38	0	384
Total	280	264	438	147	69	1198

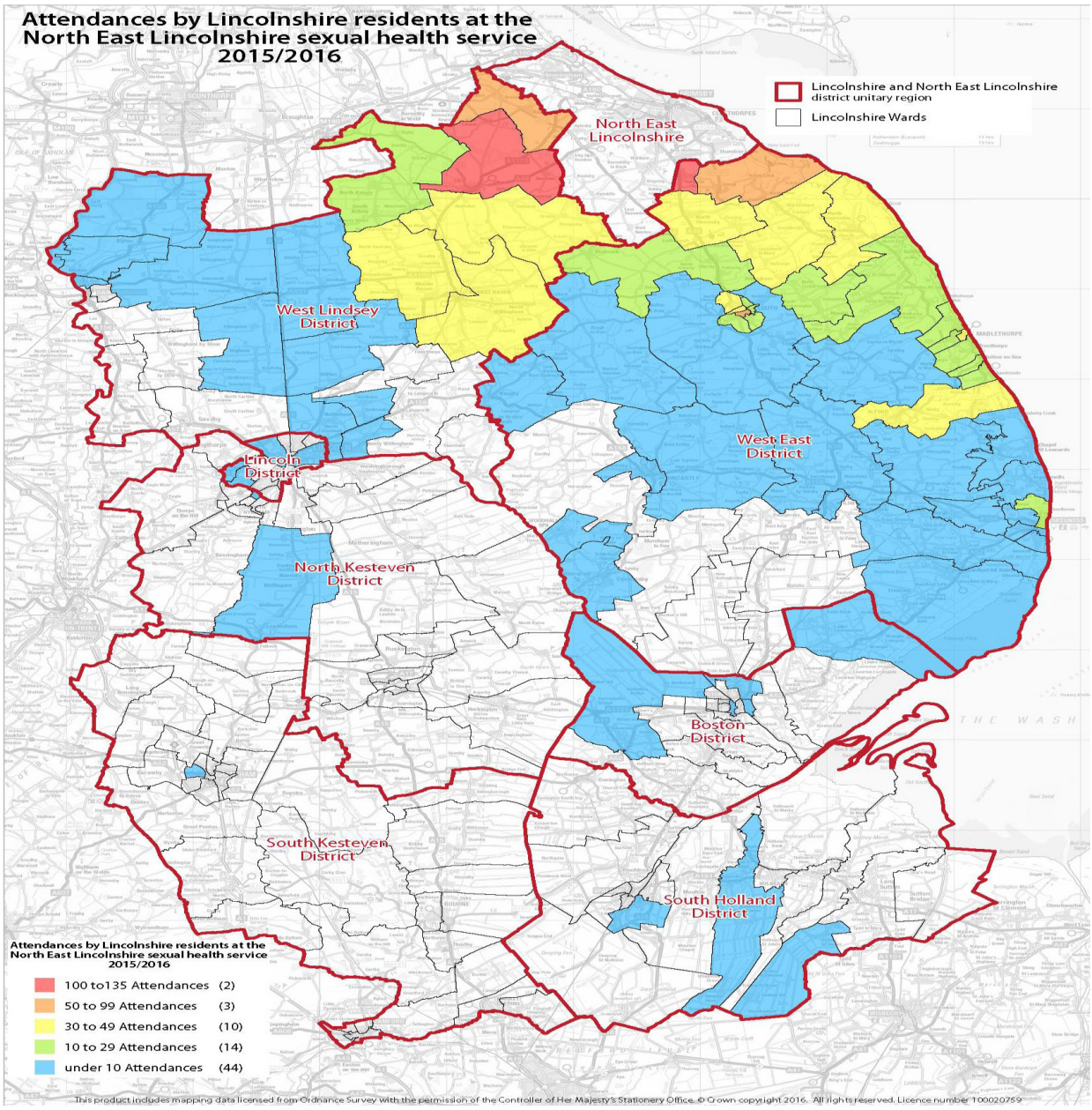
Most attendances were for GUM/screening services (86%), however there were 164 attendances for CASH services which were for LARC (n=64), oral contraception (n=65), and other/condoms (n=35).

Number of attendances by age and service location.

2015/16	< 19	20-24	25-34	35-44	45+	Total
CASH	67	36	35	18	8	164
GUM/ Screening	213	228	403	129	61	1034
Total	280	264	438	147	69	1198

To understand where these Lincolnshire residents reside the number of attendances have been thematically mapped by LSOA of residence.

Number of sttendances at ISH services by LSOA of residence, Lincolnshire residents – 2015/16



As can be seen there is a clear correlation between the number of attendances and the distance from the NEL ISH services, with the highest numbers of attendances from Holton-le-Clay and Caistor, both of which are close to the NEL boundary.

In addition to the sexual health clinics Virgin Care provide a website for information, help and advice www.virgincare.co.uk

The service aims to provide; free, friendly and confidential advice, testing and treatment for sexual health and provides all methods of contraception from a number of locations across NEL (Grimsby, Cleethorpes & Immingham). The Service is focused on providing quality, timely and seamless care and support for people using the services, either from the main site on the First Floor at Stirling St Medical Centre or in community and outreach venues. This is also a 'Hard-to-Reach' nursing team available, to offer support in the community for clients and groups who find it difficult to access mainstream services. Respondents to the surveys who use the services are happy that it meets their needs.

Access to services is 'open' and no referral from a GP is needed[19]

Virgin Care offers a one-stop shop model of care, where sexual health advice, screening for sexually transmitted infections (STIs), diagnosis, treatment and all methods of contraception can be easily accessed at a variety of venues to meet individual needs, with all appointments made via a central booking system on 0300 330 1122.

Services available from the clinic include:

- STI testing • STI treatment
- Free condoms
- Contraception
- Emergency contraception
- Pregnancy testing
- Confidential personal advice regarding contraception or STIs

GP services

GPs and primary care teams are essential to the provision of sexual health services, particularly as many of the survey respondents preferred to go to the GP. However, at the last GP LES (Locally Enhanced Services) for Long Acting Reversible Contraception audit in 2015 there were only 15 practices with trained staff to administer the LES. There is some concern that there are now less actual trained administrators due to staff retiring. This needs to be checked and added to the strategy.

GPs also fit IUCDs under a GP LES with a minimum of 4 implants per year. The LES information is dated 2010 and is currently being reviewed.

Pharmacies

The locally commissioned sexual health service delivered through pharmacies is known as ACT (advice, contraception and testing) in NEL and the initiative has been operating successfully since December 2009.

This service transferred to NEL council on the 1 April 2013 and following a review in 2015 has been recommissioned. ACT offers free EHC, condoms, chlamydia screening and pregnancy testing to all age groups. All pharmacists and staff involved in the provision of ACT must have relevant knowledge, appropriate training and appropriate current accreditation in the operation of the service, including sensitive, client centred communication skills. The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service are aware of and operate within local protocols. There are 32 pharmacies signed up to ACT in 2016.

Payment for the service reflects supply and non- supply of EHC, condoms, chlamydia screening and pregnancy tests, and is now located on the PharmOutcomes Platform.

Under the Human Medicines Regulations 2012, all medicines are assigned to one of three legal categories, which are prescription only medicines, pharmacy only medicines and general sale list (NMHSBSA, 2013). Patient Group Directions (PGDs) provide an exemption from these restrictions, which enable the supply or administration of medicines by named regulated healthcare professionals to groups of people who may not be individually identifiable before presentation (NHSBSA, 2013). An example of this in practice in NEL is the supply of emergency contraception by pharmacists.

Pharmacists link into existing networks for community contraceptive services so that women who need to see a specialist can be referred on rapidly. Pharmacies provide support and 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 and diagnosis and management of STIs.

Emergency Hormonal Contraception (EHC)

EHC is provided by Virgin Care and by local GPs and pharmacists. In the period, May to July 2016 Pharmacists have provided 145 episodes of EHC under the ACT contract.

Specialist services

Condom Provision and Partner Notification

Local authorities are responsible for providing comprehensive sexual health services. The testing and treatment of sexually transmitted infections (STIs) along with contraceptive services are all prescribed public health functions, whilst sexual health advice, prevention, and promotion, are non-prescribed functions.

There were 1247 new STI diagnoses in residents of NEL during 2014 (508 in men and 739 in women), which equates to a rate of 780 per 100,000 population and which is lower (not significantly) than the England average rate of 797 per 100,000 population.

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

* Out of 326 local authorities, 1st rank has the highest rate.

NEL 2013	NEL 2014	% Change 2013/14	* NEL Rank In ENG 2014	ENG 2014
All new STIs				
733.9	780.2	6.3		797.2
New STIs (Excluding those with chlamydia aged 15-24 years)				
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

Number of cases of new STIs diagnosed in NEL – 2012 to 2014

	2012	2013	2014
All New STIs	1246	1173	1247
New STIs (Excluding those with chlamydia aged 15-24 years)	532	494	556

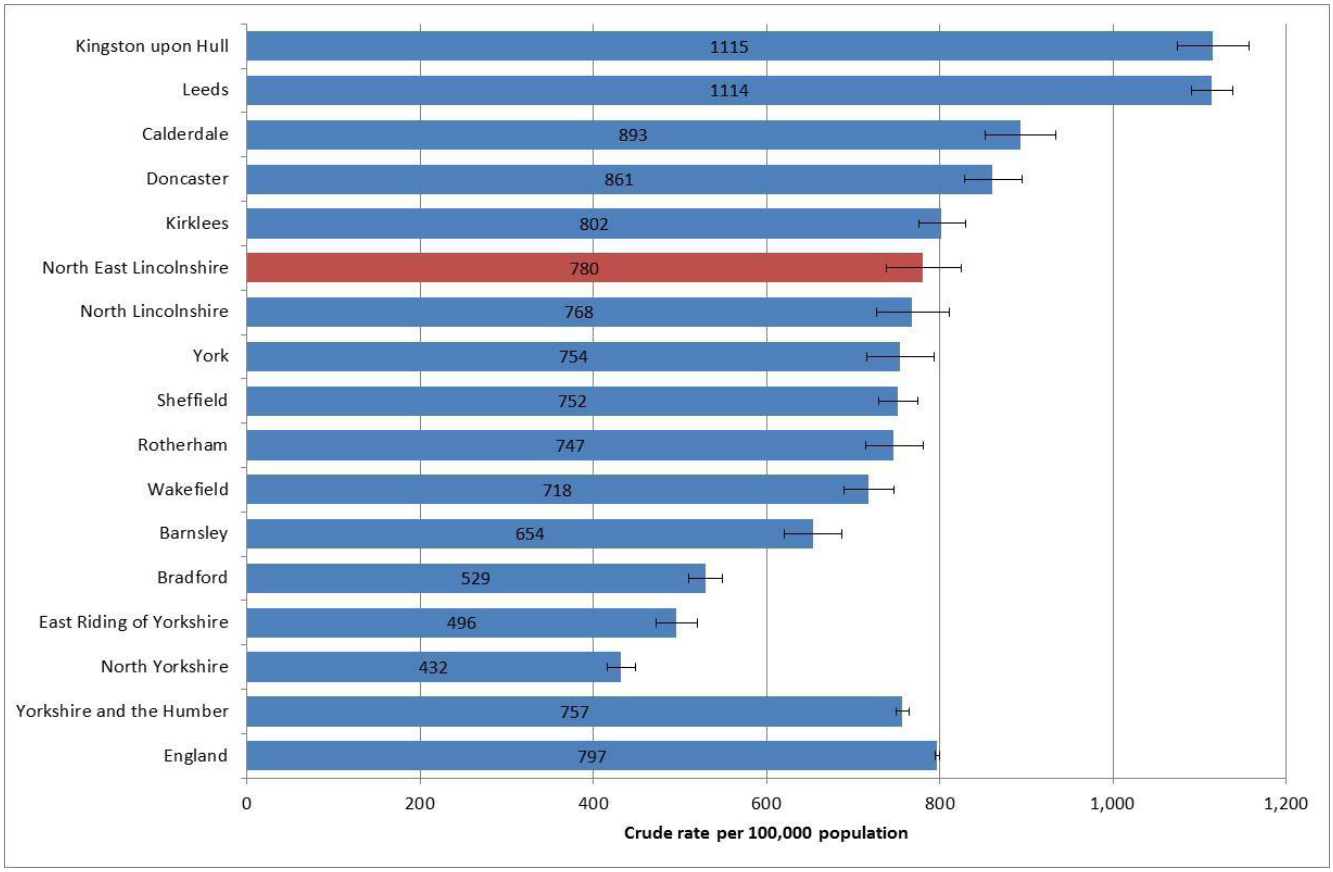
The 2014 NEL rate for new STIs (excluding chlamydia diagnoses in 15-24 year olds) was 556 per 100,000 populations, which was significantly lower than the England average rate of 929 per 100,000 populations.

Chlamydia was the most commonly diagnosed STI with 852 diagnoses during 2014 this is linked to the national screening programme that has been running since 2003.

Note that STI figures are for the number of diagnoses reported and not the number of people diagnosed.

Diagnosis rates per 100,000 population, England, Yorkshire and the Humber and local authorities in Yorkshire and the Humber – 2014

All new STIs



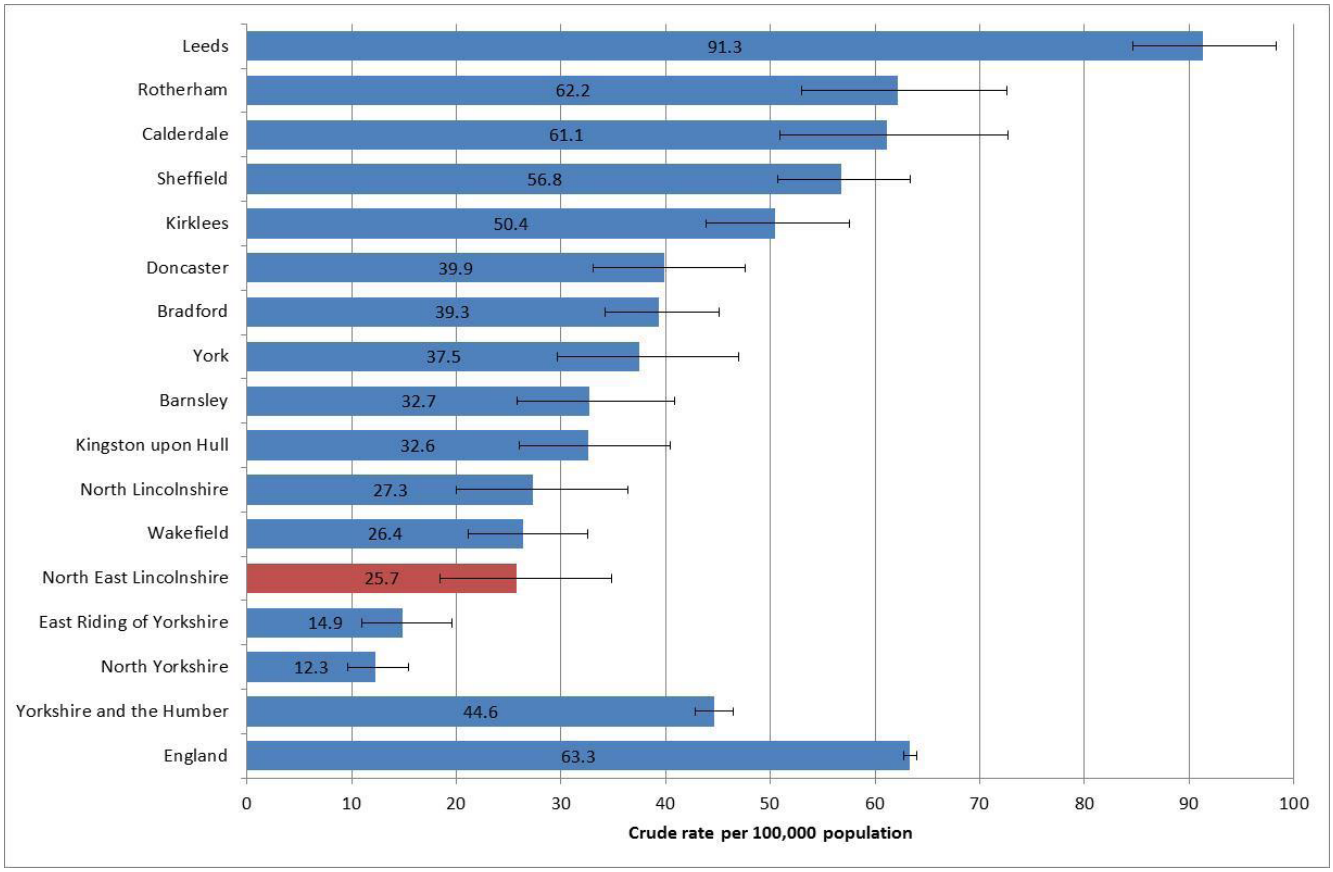
Overall, of all those diagnosed in 2014 with a new STI in NEL, 41% were men and 59% were women.

In NEL in 2014, for cases in men where sexual orientation was known, 7.6% of new STIs were among MSM.

Reinfection with an STI is an indication of continued risky behaviour. In NEL, an estimated 7.4% of women and 6.0% of men presenting with a new STI at a GUM clinic during the five-year period from 2010 to 2014 became reinfected with a new STI within twelve months. Nationally, during the same period, an estimated 7.0% of women and 9.0% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months.

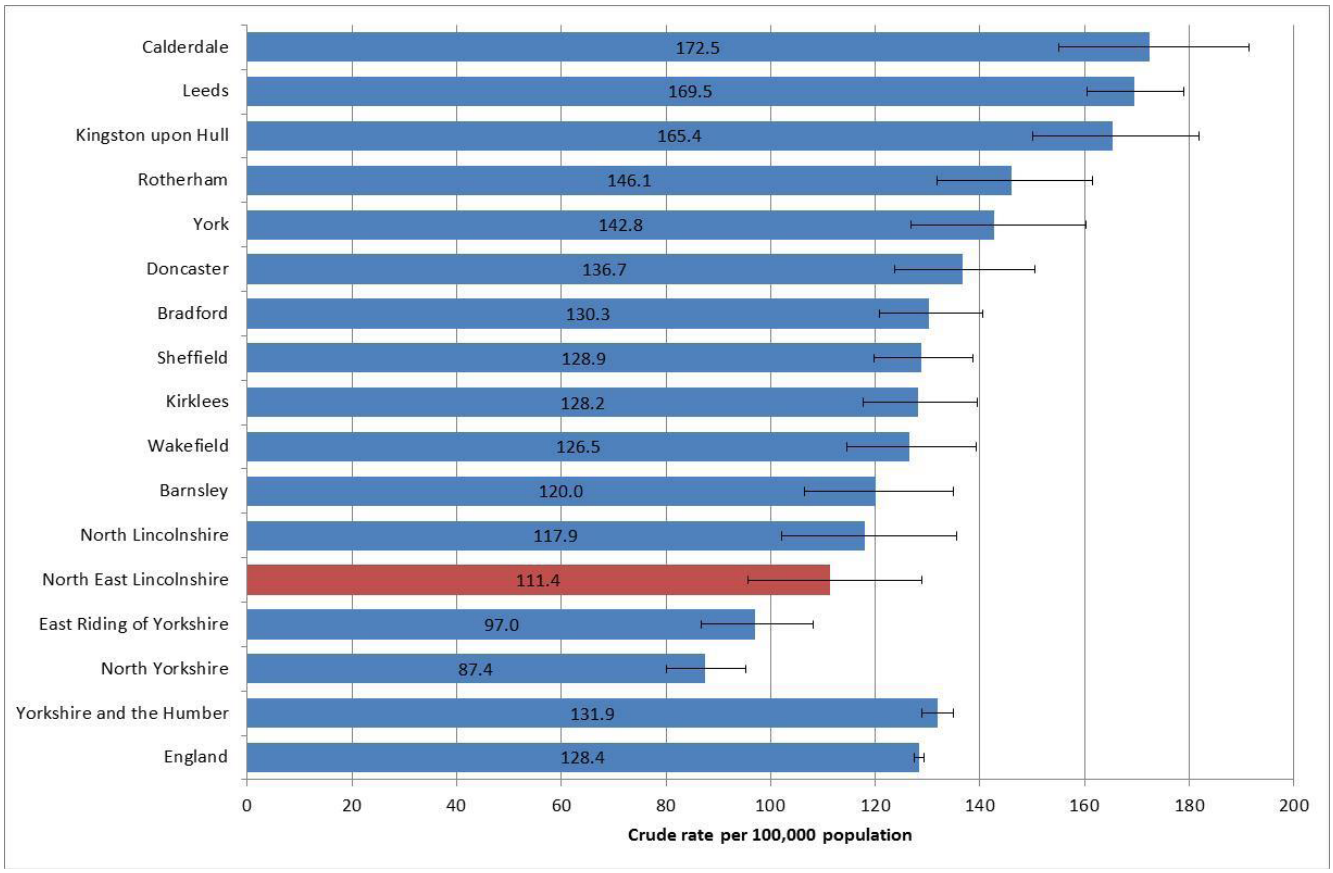
The 2014 NEL rate of gonorrhoea diagnosis was 25.7 per 100,000 population (equating to 41 diagnoses), which was significantly lower than the England average rate of 63.3 per 100,000.

Gonorrhoea



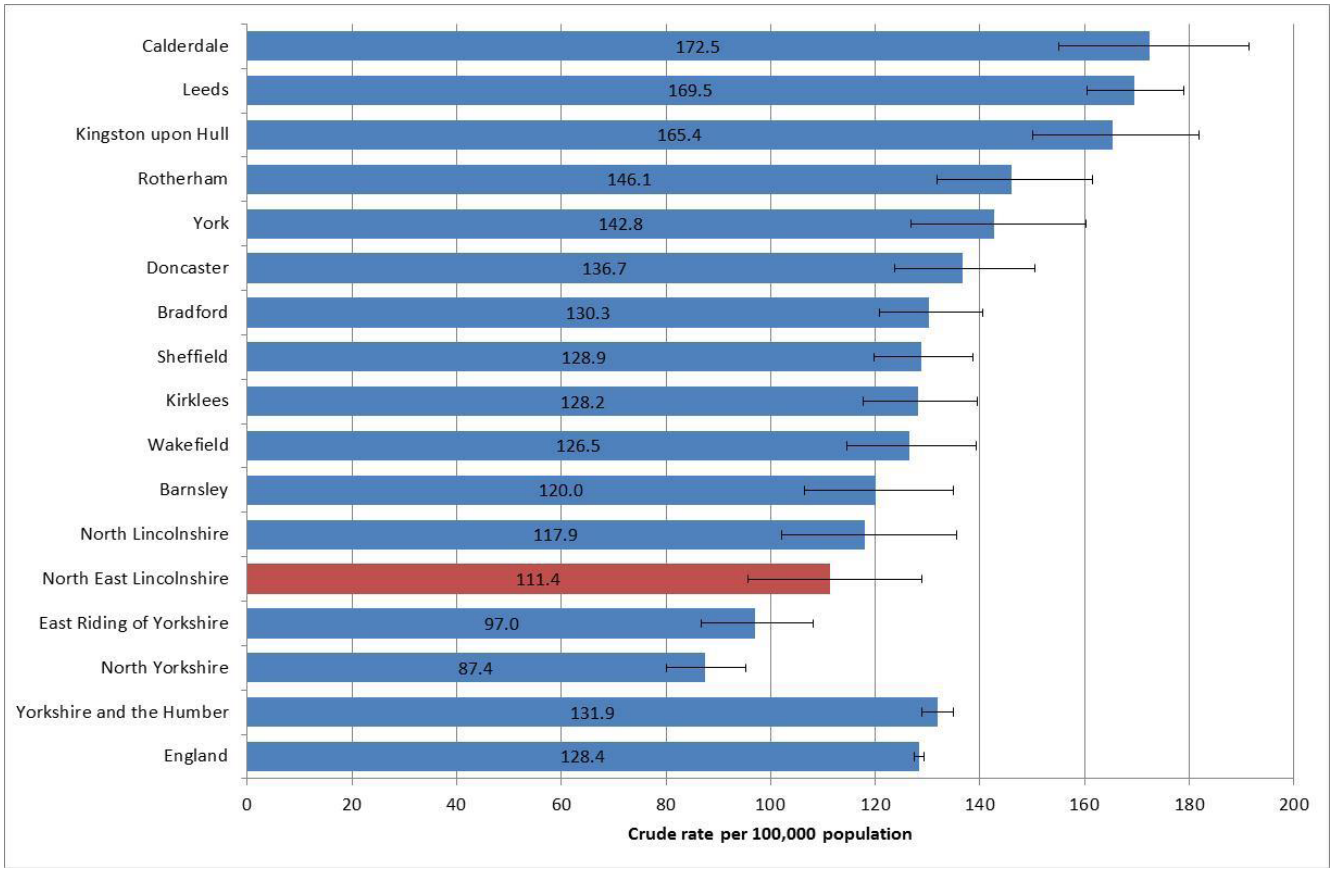
The 2014 NEL rate of syphilis diagnosis was 8.8 per 100,000 population (equating to 14 diagnoses), which was the highest in Yorkshire and the Humber and higher (not significantly) than the England average rate of 7.8 per 100,000.

Syphilis



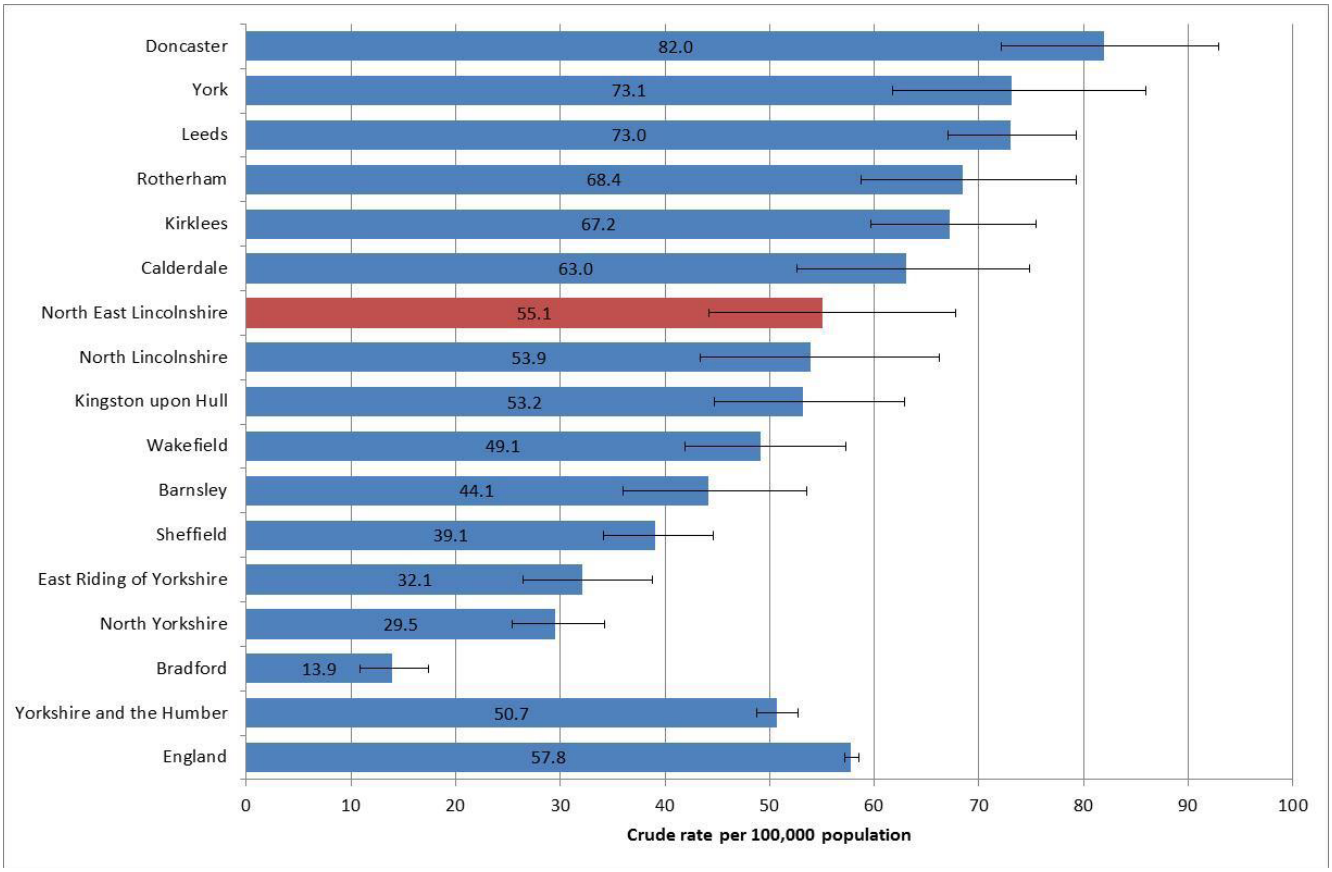
The 2014 NEL rate of genital warts diagnosis was 111.4 per 100,000 population (equating to 178 diagnoses), which was lower (not significantly) than the England average rate of 128.4 per 100,000.

Genital Warts



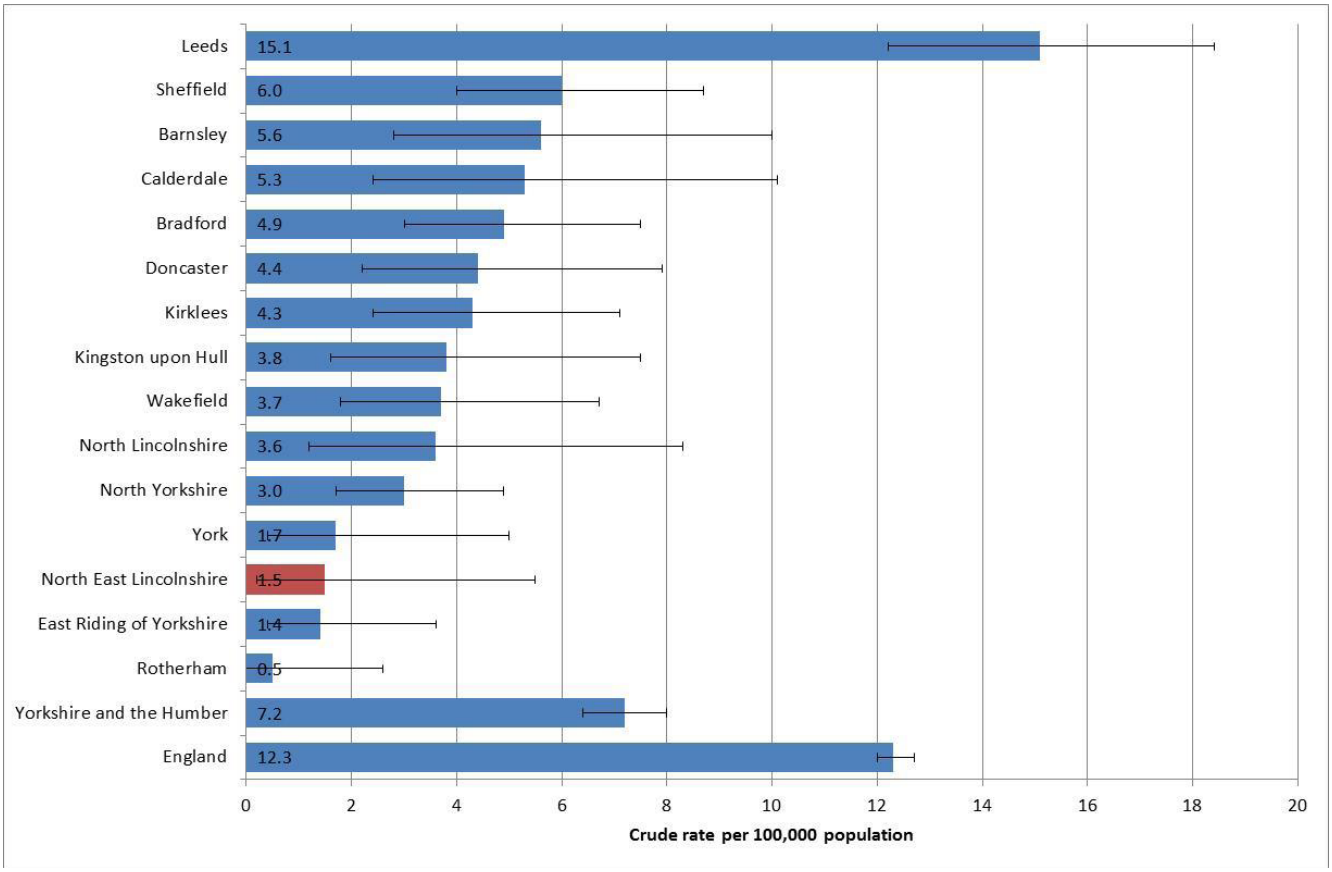
The 2014 NEL rate of genital herpes diagnosis was 55.1 per 100,000 population (equating to 88 diagnoses), which was lower (not significantly) than the England average rate of 57.8 per 100,000.

Genital Herpes



The 2014 NEL rate of new HIV diagnosis was 1.5 per 100,000 population (equating to 2 diagnoses), which is significantly lower than the England average rate of 12.3 per 100,000.

New HIV 15+ years

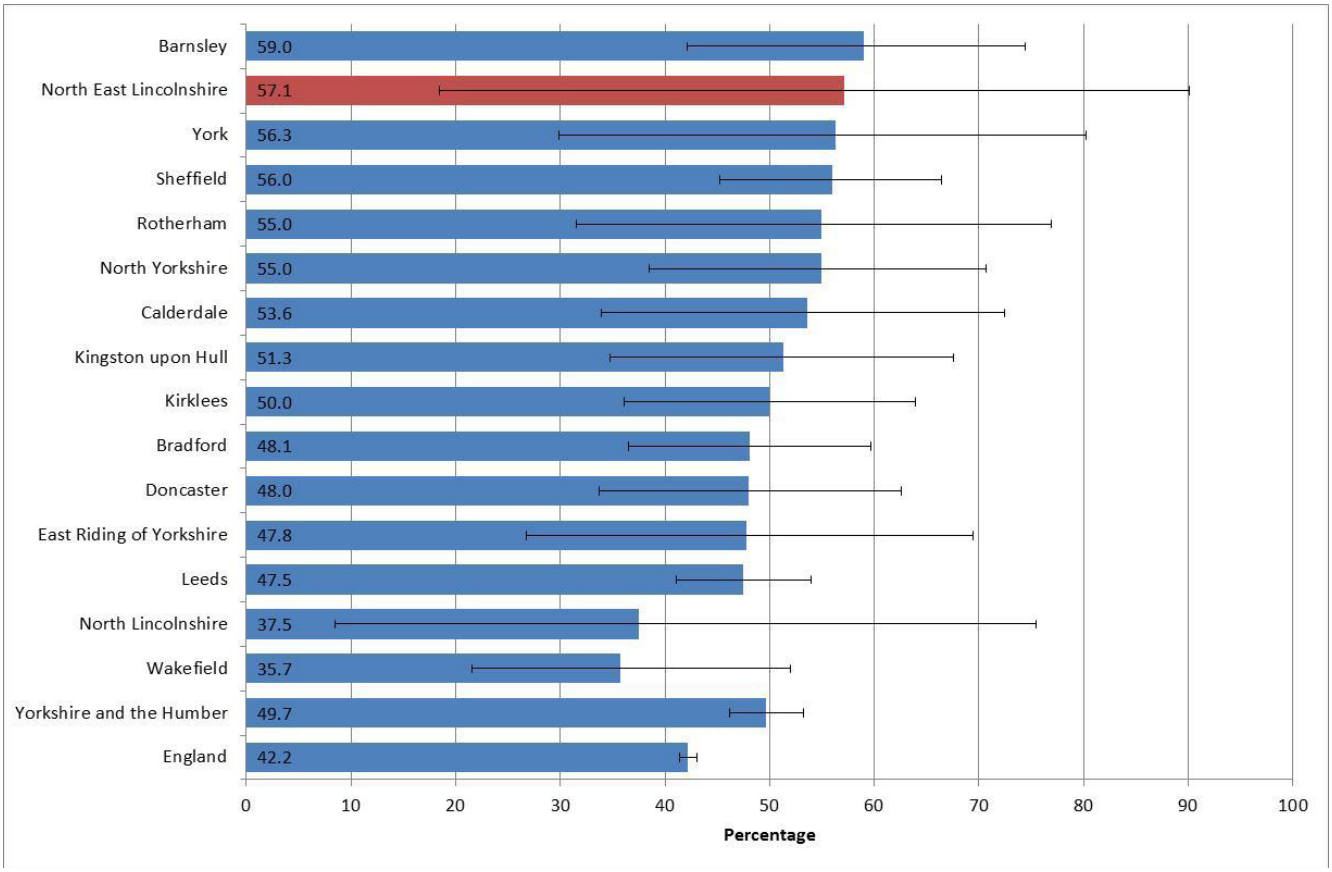


In 2014 the rate of HIV diagnosis was 1.5 per 100,000 populations which equates to 2 diagnoses which is significantly lower that the England average rate of 12.3 per 100,000 however the rate of late diagnoses was 57.1% (equating to 1 person).

Late HIV diagnosis

(Percentage of adults aged 15+ years newly diagnosed with HIV with a CD4 count less than 350 cells per mm3).

2012/14



Number of abortions

There were 502 abortions in NEL during 2015. Most of these abortions (99%) were NHS funded, and again most of these abortions (98%) were performed in an NHS hospital.

During 2015, 81.5% of NEL abortions were carried out at under 10 weeks' gestation which is a higher percentage than the England average (80.4%).

There are several methods of abortion but in general there are two types which are medical (medication) and surgical (minor operation). During 2015, 91.0% of NEL abortions were medical which was much higher than the England average of 54.2%.

Number of abortions, NEL, 2013 to 2015 and 3 year average.

	2013	2014	2015	2013/15 average
Under 18	42	47	36	42
18-19	32	32	54	39
20-24	162	167	153	161
25-29	135	134	123	131
30-34	59	48	46	51
Total	501	511	501	505

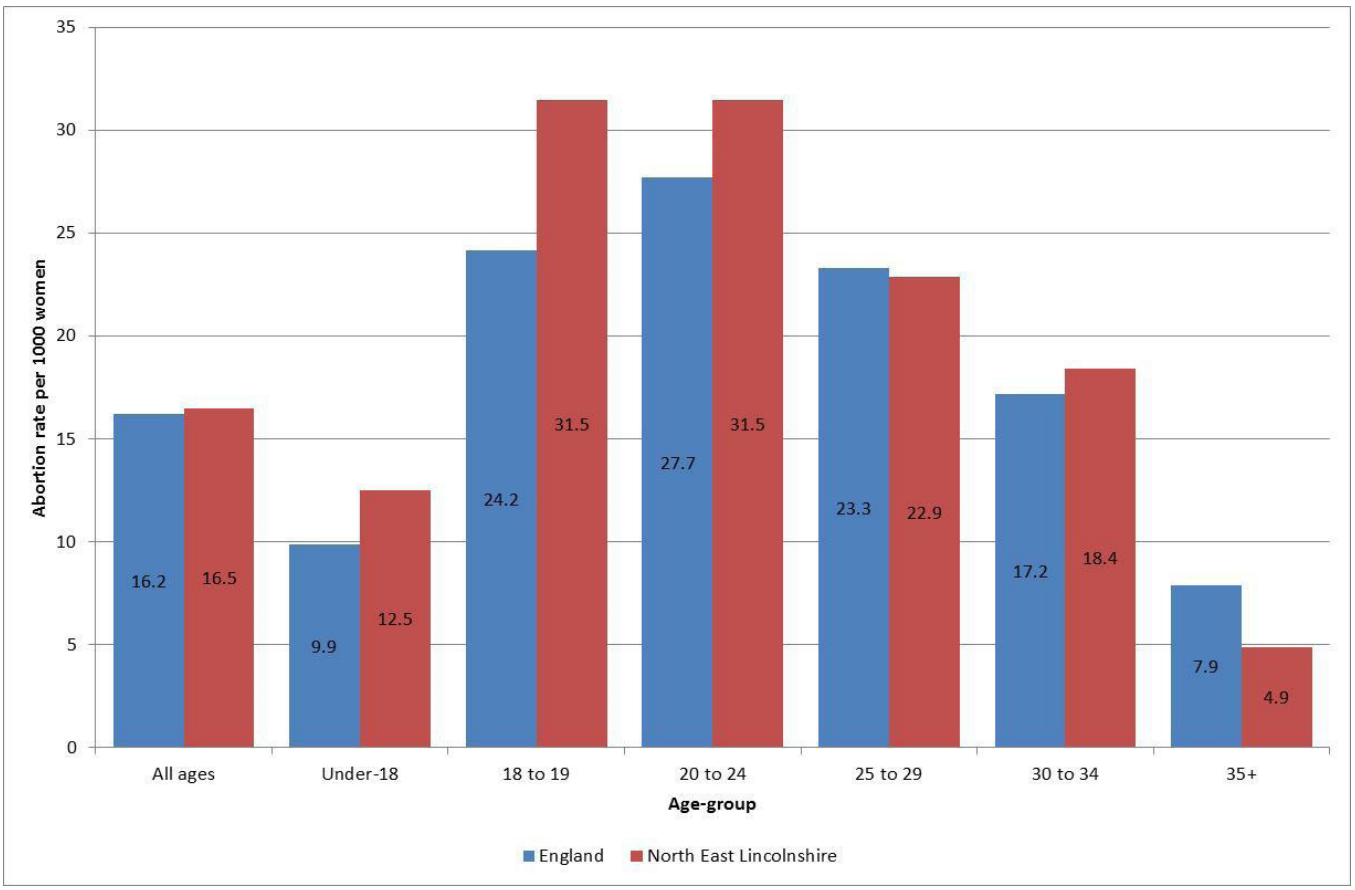
Rate of abortions

The numbers of abortions can be converted to a rate per 1000 women which can then be compared with the England average.

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%	22.9%	24.7%
30-34	5.8%	4.9%	4.9%	5.2%
Total	16.7%	17.3%	16.5%	16.8%

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



The overall NEL abortion rate for 2015 of 16.5 abortions per 1000 women is similar to the England average of 16.2 abortions per 1000 women. The NEL abortion rate peaks at age 18 to 24 years whereas the England rate peaks at age 20 to 24 years.

The NEL abortion rates for the age-groups under 25 years are higher than the England averages, whereas two of the three abortion rates for the age-groups 25 years and over are lower than the England averages.

Repeat abortions

The percentage of NEL abortions where the woman had already had one or more previous abortions i.e. a repeat abortion was 40.6% of abortions during 2015, which was just over the England average of 38.0% of abortions.

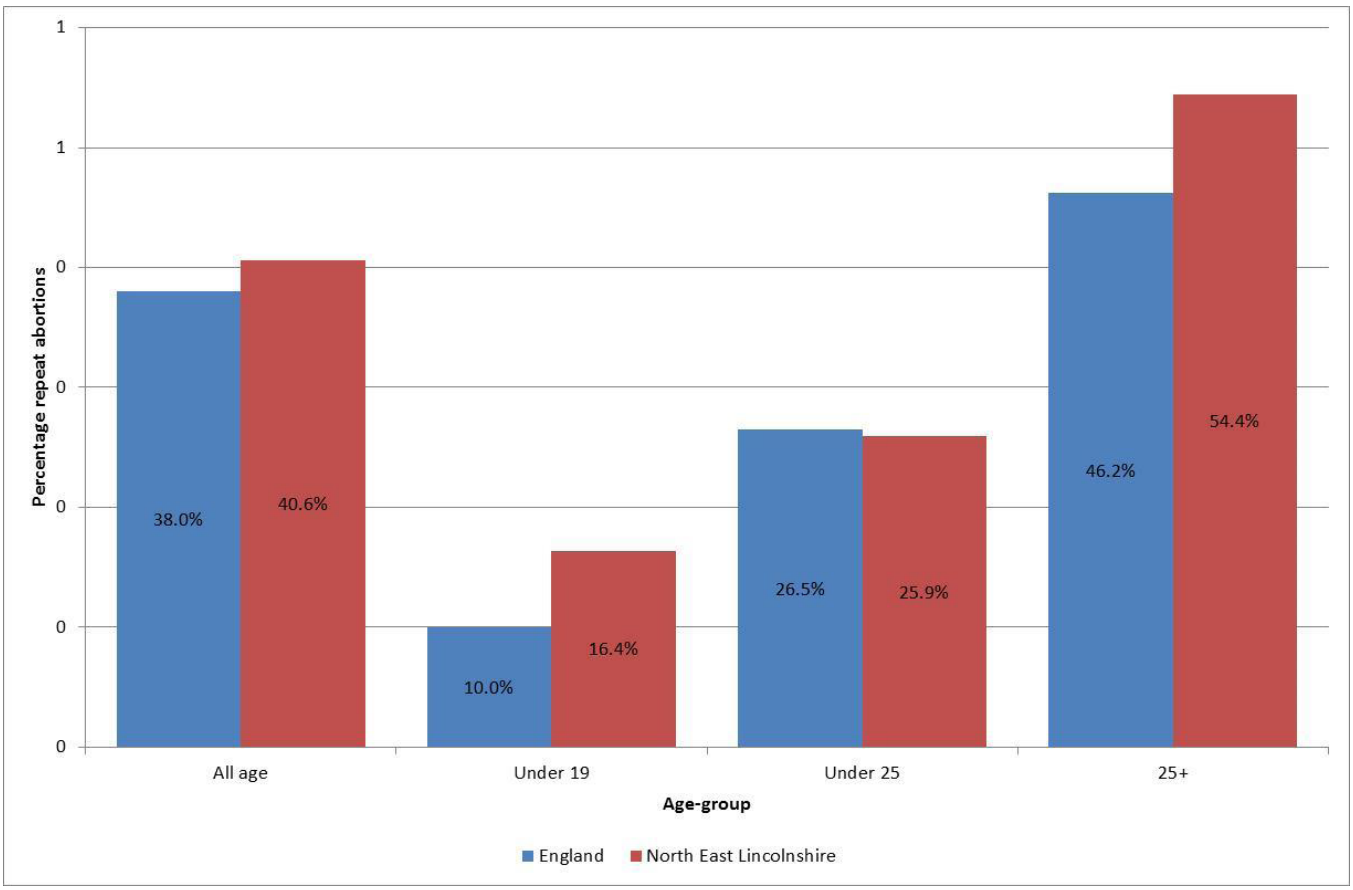
Number of repeat abortions, NEL, 2013 to 2015 and 3 year average.

	2013	2014	2015	2013/15 average
All Ages	501	511	502	505
Under 25	236	246	243	242
25+	265	265	259	263
All Ages	56.9%	39.7%	40.6%	45.7%
Under 25	49.2%	26.0%	25.9%	33.7%
25+	63.8%	52.5%	54.4%	56.9%

The percentage of repeat abortions in the under-25-year age-group for NEL (25.9%) is similar to the England average (26.5%). The main differences in repeat abortions between NEL and the England averages are in the younger and older age groups. The percentage of repeat abortions in the under-19 age-group was 16.4% for NEL, which was higher than the England average of 10.0%.

The percentage of repeat abortions in the 25+ age-group was 54.4% for NEL, which was the eighth highest local authority repeat abortion percentage in the country, and higher than the England average of 46.2%, thus locally over half of abortions in this age-group are repeat abortions. 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.

Percentage of repeat abortions, England and NEL, 2015.



Abortion services

Abortion services are provided by the Northern Lincolnshire and Goole Foundation (NHS) Trust which has sites at Grimsby, Scunthorpe and Goole. For residents of 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

Teenage pregnancy is a situation which involves female adolescents. A teenage female can be pregnant as early as age twelve or thirteen, although it is usually fourteen and older. The fact that teenagers become pregnant is related to many factors.

Teenage pregnancy is a situation which involves female adolescents. A teenage female can be pregnant as early as age twelve or thirteen, although it is usually fourteen and older. The fact that teenagers become pregnant is related to many factors. These are related to the specific situation of the teenager, and the group that she interacts with. The rates of teenage pregnancy vary from country to country and are related to differences of sexual activities, the general sex education being provided and contraceptives being available.

Teenage pregnancy will sometimes involve low birth weight[20]. Social matters also play a role: often, the teenager grew up in poverty. She also often has a lower level of general education. Pregnancy in teenagers in the developed world usually occurs outside of marriage. The lowest levels of teenage pregnancy are in Japan and South Korea. It is recommended that pregnancies are followed throughout by medical and clinical people. Teenage mothers do not normally seek help until the third trimester (Makinson).

- The UK has the highest teenage birth and abortion rates in Western Europe [21]
- Rates of teenage births are five times those in the Netherlands; double those in France and more than twice those in Germany
- In 2006 the teenage pregnancy rate in the USA increased for the first time in 10 years to 71.5 per 1,000 15-19 year olds. Around a third of these ended in abortion
- Groups who are more vulnerable to becoming teenage parents include young people who are: in or leaving care, homeless, underachieving at school, children of teenage parents, members of some ethnic groups, involved in crime, living in areas with higher social deprivation
- Young women living in socially disadvantaged areas are less likely to opt for an abortion if they get pregnant

NEL: Teenage pregnancy – data briefing - May 2016

Key Points

- The most recent rolling annual under-18 conception rate for NEL for quarter 1 of 2015 is 40.8 conceptions per 1000 females aged 15 to 17 years. This is higher than both Yorkshire and the Humber (25.8) and England (22.3) average rates
- The rate of NEL under-18 conceptions has fallen from 69.8 in 1998, to 40.8 in 2014, which is a reduction of 41.5%. This reduction is lower than the reductions achieved for Yorkshire and the Humber (50.3%) and for England (51.1%)
- Within Yorkshire and the Humber, NEL has the highest rolling annual rate of under-18 conceptions for quarter 1 of 2015
- Compared to all local authorities in England, NEL has the highest rolling annual rate of under-18 conceptions for quarter 1 of 2015
- There were 117 NEL under-18 conceptions during 2014 which was the lowest annual number of conceptions since the 1998 baseline
- There were considerable geographical variations of NEL under-18 conception rates at ward level during the period 2011-13, with five wards (Waltham, Wolds, Humberston, New Waltham, and Scartho) having under-18 conception rates which were significantly lower than the NEL average rate, and two wards (East Marsh and West Marsh) having under-18 conception rates which were significantly higher than the NEL average rate
- Within Yorkshire and the Humber, NEL has the highest rate of under-16 conceptions for the period 2012-14 (10.0 conceptions per 1000 females aged 13 to 15 years). The local rate being higher than both Yorkshire and the Humber (6.1) and England (4.9) average rates
- • There were 81 NEL under-16 conceptions during the period 2012-14, which was an increase of 7 conceptions compared to 2011-13

Introduction

The latest available under-18 conception data (2015 quarter 1 figures) were released on 24 May 2016. These figures published by the Office for National Statistics (ONS), include the number of conceptions, and the rate of under-18 conceptions per 1000 female population aged 15 to 17 years. These figures are released quarterly and enable trend analysis over time and benchmarking with peer authorities.

The report also included under-18 conception data at ward level (2011-13). These figures were released during July 2015 by the Office for National Statistics and are published annually.

Under-16 conception data for 2012-2014 were released on 9 March 2016. These figures published annually by the Office for National Statistics include the number of conceptions, and the rate of under-16 conceptions per 1000 female population aged 13 to 15 years.

Conception statistics include pregnancies that result in one (or more) live or still births (a maternity), and pregnancies that result in a legal abortion under the Abortion Act 1967. The statistics do not include miscarriages during the first 23 weeks of gestation or illegal abortions. The date of conception is estimated using recorded gestation for abortions and stillbirths, and assumes 38 weeks' gestation for live births.

Progress since 1998

Figure 1 details the progress that has been made regarding reducing the under-18 conception rate since 1998 which was the baseline period for the 1999 Teenage Pregnancy Strategy.

The latest rolling annual under-18 conception rate for NEL for quarter 1 of 2015 is 40.8 conceptions per 1000 females aged 15 to 17 years. This is higher than both Yorkshire and the Humber (25.8) and England (22.3) rolling annual rates.

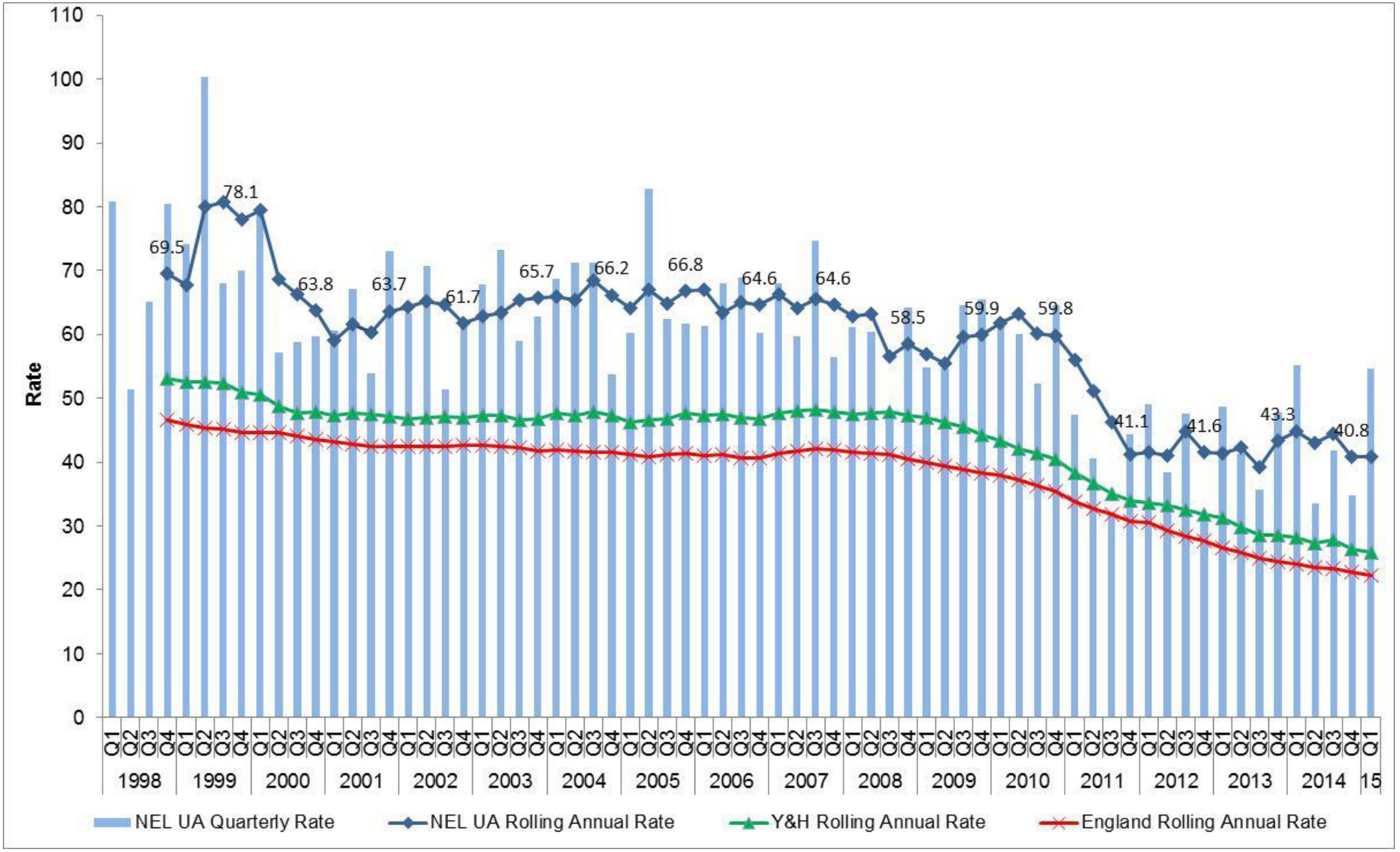
The rate of NEL under-18 conceptions has fallen from 69.8 in 1998, to 40.8 in 2014, which is a reduction of 41.5%. This reduction is lower than the reductions achieved for Yorkshire and the Humber (50.3%) and for England (51.1%).

Between 1998 and 2014 there has been a small closing of the absolute gap between the NEL rate and the England average rate, however the relative gap has increased.

Individual quarter figures are prone to fluctuation due to the small numbers involved, hence the use of the more robust rolling annual rate.

Under-18 conception rates per 1000 female population aged 15-17 years, for England, Yorkshire and the Humber, and NEL UA, 1998 to quarter 1 2015

Figure 1



Source: Office for National Statistics (www.ons.gov.uk), © Crown copyright 2016.

Figure 2 shows the annual number of NEL under-18 conceptions since 1998. The number of conceptions decreased year on year from 2005 to 2011. There were 122 under-18 conceptions during 2012 which was the same number as during 2011, and the number then rose by 4 conceptions during 2013 to 126. The number of under-18 conceptions decreased to 117 during 2014, which is 9 fewer conceptions than during 2013, and 95 fewer conceptions than during 1998. 117 conceptions is the lowest annual number of conceptions since the 1998 baseline. During 2014, 39.3% of NEL under-18 conceptions led to an abortion, which is lower than both Yorkshire and the Humber (46.0%) and the England (51.1%) averages.

Number of under-18 conceptions for NEL UA, 1998 to 2014.

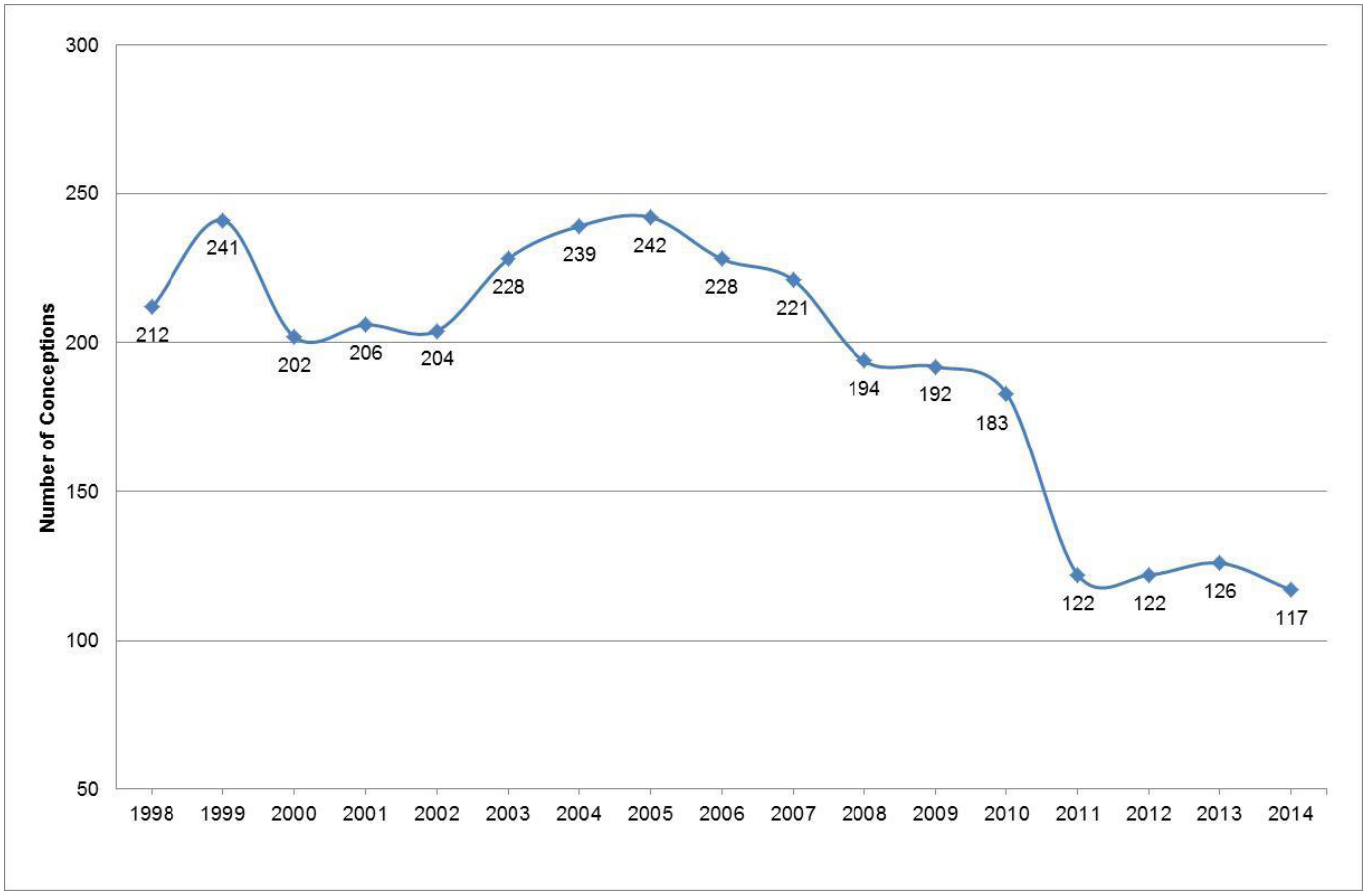


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Figure 3

Benchmarking

Within Yorkshire and the Humber, NEL has the highest rate of under-18 conceptions. The rolling annual under-18 conception rates for all the local authorities within Yorkshire and the Humber for quarter 1 of 2015 are detailed in Figure 3. Of all the local authorities in England, NEL has the highest rolling annual under-18 conception rate for quarter 1 of 2015.

Under-18 conception rates per 1000 female population aged 15-17 years, for England, Yorkshire and the Humber, and the 15 LAs in Yorkshire and the Humber, rolling annual rates for quarter 1 2015.

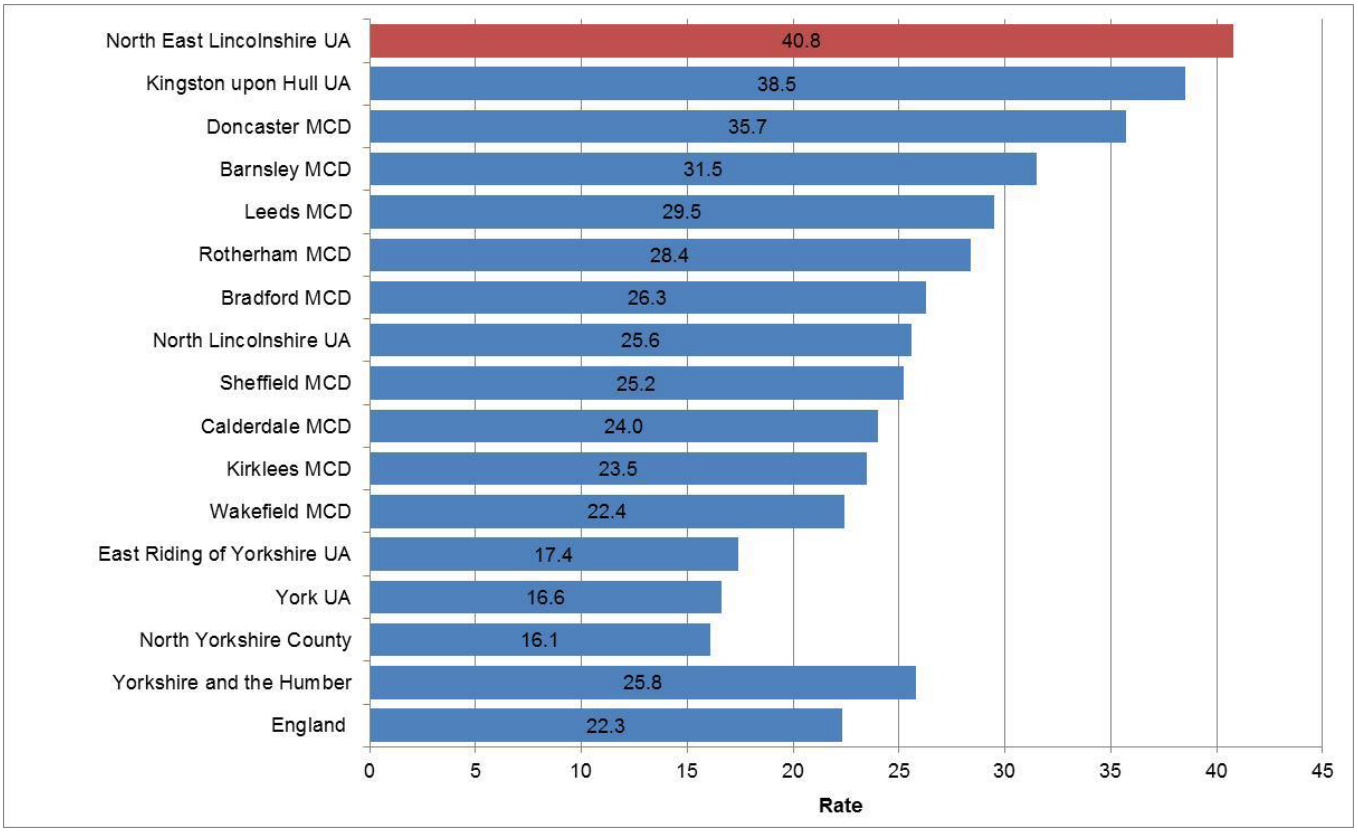

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Figure 2

Compared to NELs statistical neighbour authorities, NEL has the highest rate of under-18 conceptions.

The rolling annual under-18 conception rates for all these local authorities for quarter 1 of 2015 are detailed in Figure 4.

Under-18 conception rates per 1000 female population aged 15-17 years, for England, NEL UA, and NEL UA DFE statistical neighbour authorities, rolling annual rates for quarter 1 2015.

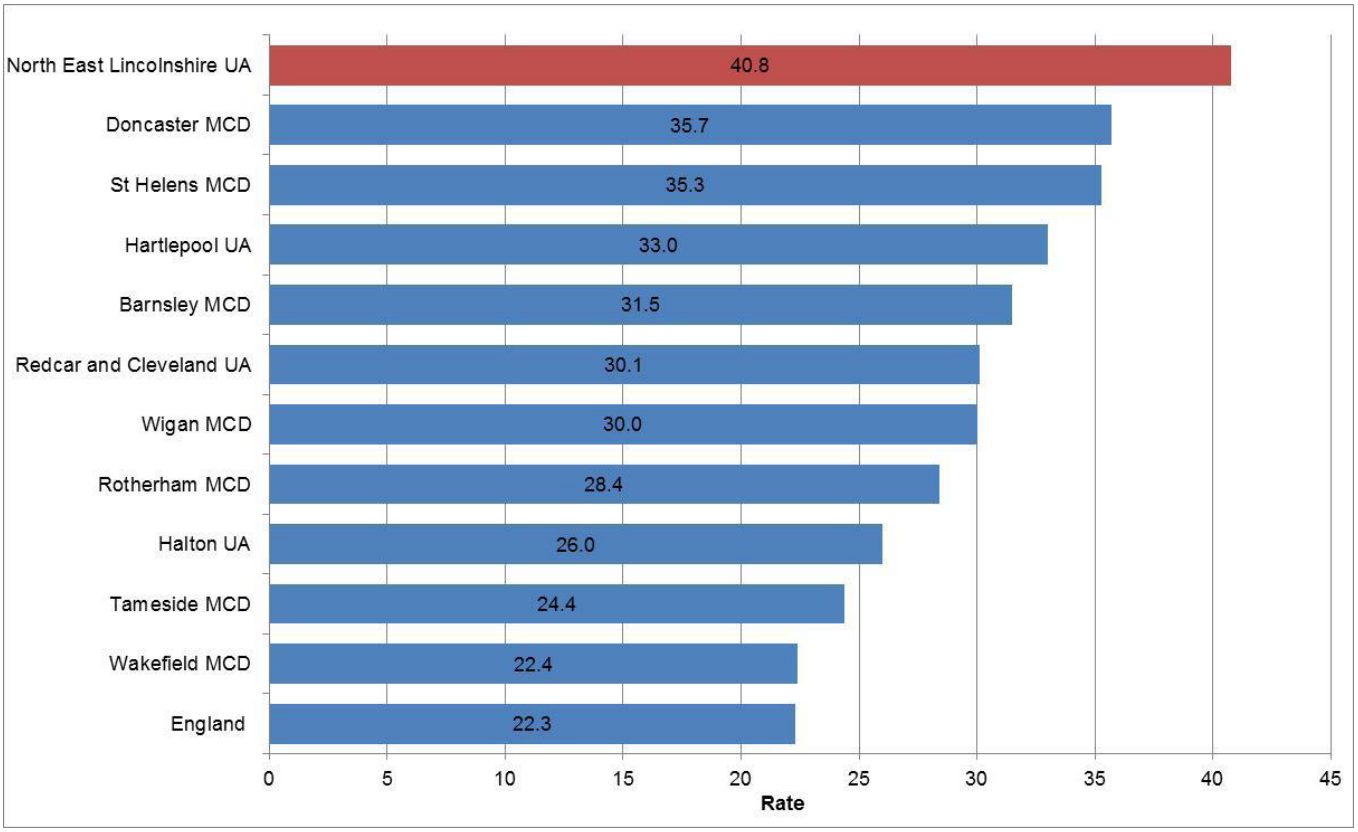

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Figure 4

Geographic inequalities

The most recent teenage conception data available at ward level are for the period 2011-2013 (aggregated).

There are considerable variations in under-18 conception rates between wards. Five wards (Waltham, Wolds, Humberston, New Waltham, and Scartho) have under-18 conception rates which are significantly lower than the NEL average rate, and two wards (East Marsh and West Marsh) have under-18 conception rates which are significantly higher than the NEL average rate. Wards with the highest rate of conceptions are not necessarily the wards with the highest number of conceptions. This geographic pattern appears to confirm the general association between deprivation and under-18 conception rates.

Geographic inequalities

Under-16 conception data for 2012-2014 were released on 9 March 2016. These figures published by the Office for National Statistics (ONS) include the number of conceptions, and the rate of under-16 conceptions per 1000 female population aged 13 to 15 years.

Figure 5 shows the under-16 conception rate trend since 2001-03. For the period 2012-14, NEL has an under-16 conception rate of 10.0 conceptions per 1000 female population aged 13-15 years. This is higher than both Yorkshire and the Humber (6.1) and England (4.9) average rates. Year on year reductions of the NEL rate were achieved from 2007-08 to 2011-13, however the most recent figures for 2012-14 show an increase in the local rate. The reduction achieved for NEL from the 2001-03 baseline is lower than the reductions achieved for both Yorkshire and the Humber and England, with the local 2012-14 rate now being double that of the England average.

Under-16 conception rates per 1000 female population aged 13-15 years, for England, Yorkshire and the Humber, and NEL UA, 2001-03 to 2012-14.

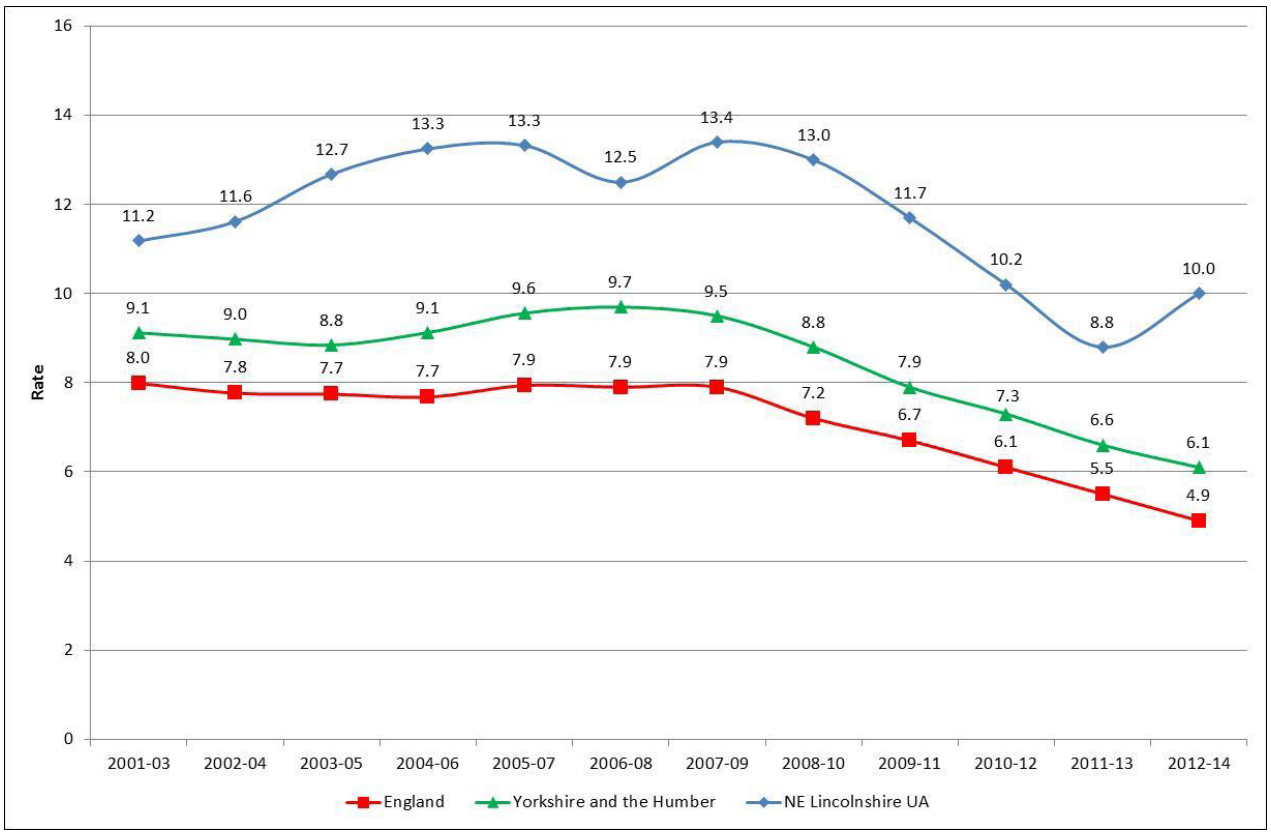

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Figure 5

Figure 6 shows the number of NEL under-16 conceptions since 2001-03. Year on year reductions had been achieved from 2007-09 to 2011-13, however the number of conceptions increased by 7 to 81 conceptions during 2012-14.

During the period 2012-14, 49.4% of NEL under-16 conceptions led to an abortion, which is lower than both Yorkshire and the Humber (57.1%) and England (61.5%) averages.

Number of NEL UA under-16 conceptions, 2001-03 to 2012-14.

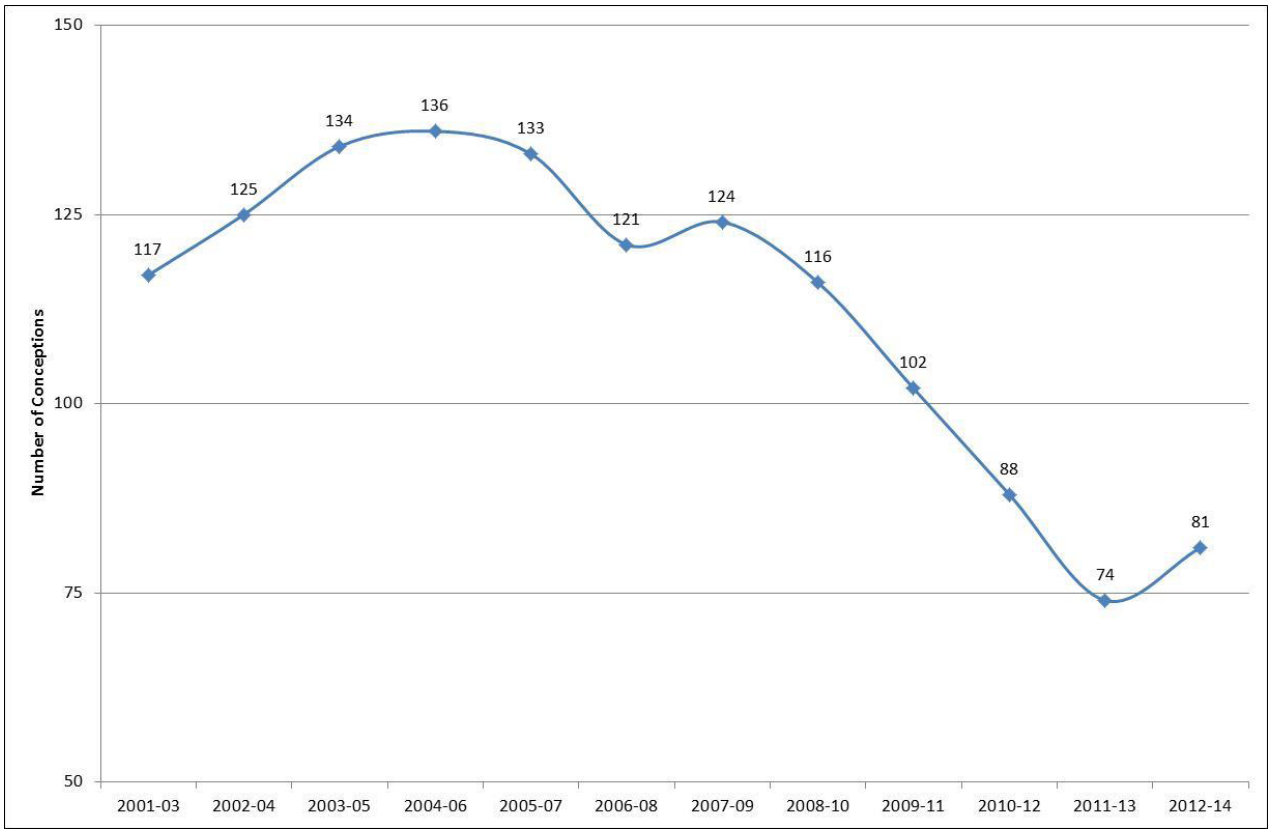

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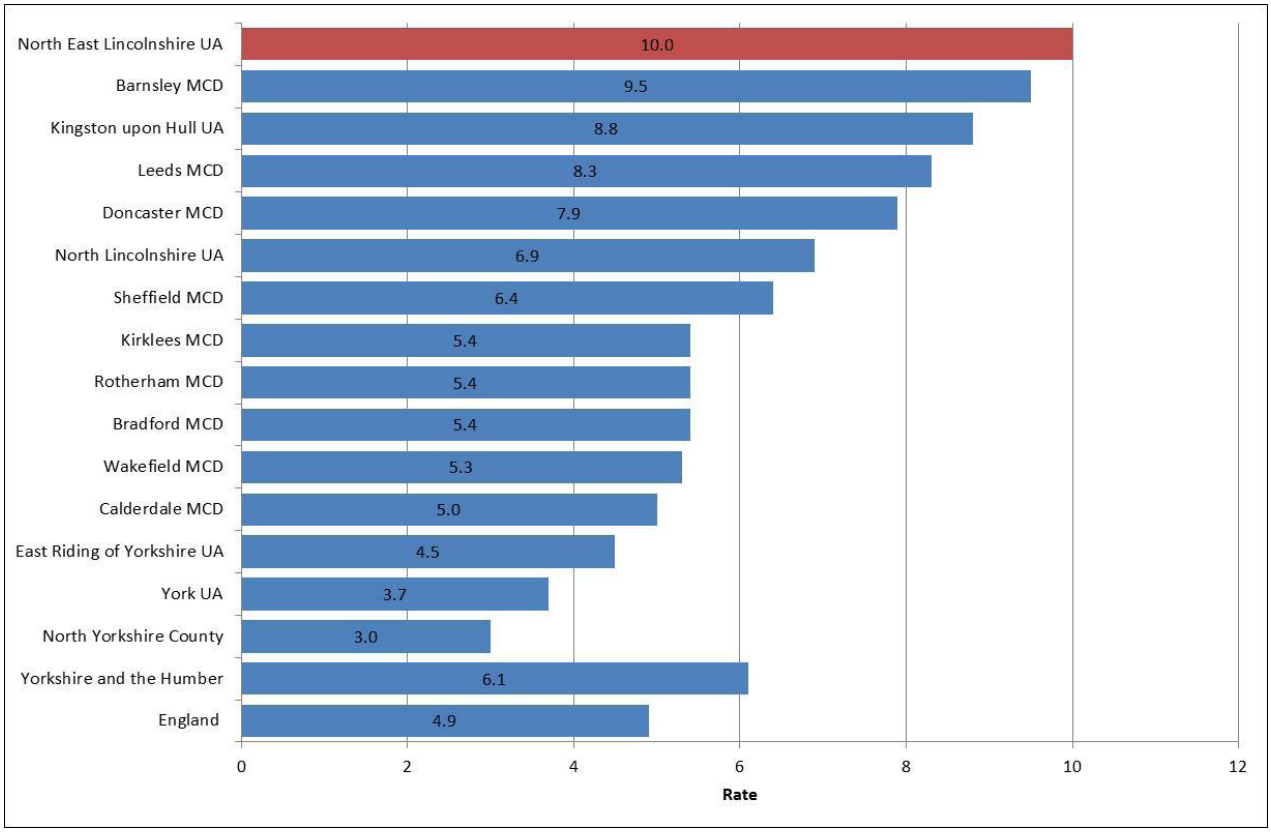
Figure 6

Within Yorkshire and the Humber, NEL has the highest rate of under-16 conceptions, and the joint second highest rate of all local authorities in England.

The under-16 conception rates for all the local authorities within Yorkshire and the Humber for 2012-14 are detailed in Figure 7.

Under-16 conception rates per 1000 female population aged 13-15 years, for England, Yorkshire and the Humber, and the 15 LAs in Yorkshire and the Humber, 2012-14



Source: Office for National Statistics (www.ons.gov.uk), © Crown copyright 2016.

Figure 7

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%

Sexual Violence

Sexual and domestic violence and sexual exploitation and abuse can be issues for men, women and children. More than one-third (38%) of all rapes recorded by the police in England and Wales in 2010/11 were committed against children under 16 years of age[22], and 49% of gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16.

Although routine enquiry about domestic violence in pregnancy has been undertaken for several years in antenatal settings, there has been less focus on screening in women having an abortion. Studies show an association between domestic violence and termination (and repeat termination) of pregnancy[23].

There were 150 incidences of child sexual violence and rape in the last year in Grimsby.[24]

The shocking figures were compounded by a rise in domestic abuse and sexual violence of all ages in NEL.

There were 490 cases of high-risk domestic abuse involving 619 children in Grimsby and Scunthorpe in the year up to April last year, figures show.

The rate of sexual offences both nationally and locally has risen since 2010/11. There were 1.27 sexual offences per 1000 population in NEL during 2010/11 which rose to 2.13 offences during 2014/15.

Female Genital Mutilation

Female genital mutilation (also referred to as FGM, female circumcision or cutting) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female organs for non-medical reasons.[25]

It is a criminal offence under the Female Genital Mutilation Act 2003 to subject a girl of woman to FGM or to assist a non–UK person to carry our FGM overseas on a UK national or permanent resident (the 2003 Act covers mutilation of the labia majora, labia minora or clitoris.) However, no offence is committed by a specified approved person who performs a surgical operation that is necessary on physical or mental health grounds or is for purposes connected to childbirth.

It is estimated that more than 66,000 women and girls living in Britain have experienced FGM. The procedure can have long-lasting physical and psychological effects, such as chronic pain, sexual difficulties and complications in pregnancy and childbirth and can increase the risk of HIV and other STIs.

In a study by City University of London and Equality Now (2014, updated 2016) it was estimated that in 2011 137,000 women and girls who were born in another country and now resident in the UK were affected by FGM.

Women with FGM do not only live in urban areas but can also be scattered in rural areas.

The highest levels of FGM are found in the London boroughs with Southwark recording the highest prevalence rate of 4.7% per 1,000 women in the population.

No local authority area is likely to be free from FGM entirely and the affected populations are from countries where the practice is still in existence.

The prevalence rates for NEL are:

- Estimated prevalence rate for women affected by FGM is 0.5%/1,000
- Estimated prevalence rate for maternities born to women affected by FGM is 0.14% / 1,000 population

http://www.city.ac.uk/news/2015/july/no-local-authority-area-in-england-and-wales-free-from-fgm

Vulnerable Young People

The Department for Education (DfE) wants to improve the aspirations and achievement of vulnerable young people. Of interest are young people who experience substance misuse, emotional health concerns, teenage parenthood, low attainment, those who are not in education, employment or training (NEET) and those involved in crime. The DfE has a wealth of evidence on each of these issues and the ways in which young people are disadvantaged. However, there is less evidence on how these disadvantages overlap for some young people and the outcomes for those affected by multiple disadvantages.

Whilst the experience of a single disadvantage can create difficulties for young people, multiple disadvantages can interact and exacerbate one another, becoming more harmful and costly for both the young person and society as a whole.

Vulnerable young people are identified as those young people who experience challenges in their daily life which have an impact on them understanding advice, identifying and dealing with issues of harm to them or seeking appropriate help.

These challenges can be identified and classified as:

- Living in a deprived area
- Not in education, employment or training (NEETS)
- Having substance misuse issues
- Having emotional wellbeing issues
- Looked after young people
- Teenage parents
- Poor educational attainment
- Those involved in crime
- Those whose parents suffer from mental ill health or substance misuse

In some areas of NEL young people will suffer from multiple challenges and whilst there is little research on the multiple dependencies and their impacts there is clear evidence from those in services that they have multiple issues and impacts.

Looked After Children

Looked after children (LAC), currently have access to a priority sexual health service, provided by a LAC sexual health nurse in Virgin Care. Despite this fact the number of teenage pregnancies in this group has increased over the past two years.

It is a statutory requirement that LAC receive a health assessment, with a paediatrician in the first 20 days so that a health care plan can be put in place and shared with everyone involved in the care of that child. The assessment is holistic and covers physical and mental health. After 6 weeks in care a Strengths and Difficulties Questionnaire (SDQ) is completed. For the 4 – 17 year olds this is undertaken by the allocated nurse.

Under 5's have 2 assessments per year and over 5's have one assessment per year by the named nurse for that child.

Within the health assessments sexual health is included annually. A LAC nurse works in the Virgin Care service. Problematic teenagers are allocated to her. In the last 2-years there has been an increase in pregnancies and the subsequent removal of babies born to young women in care. There is currently a local authority work stream and an action plan. There had been a dip in these numbers and now it is increasing. Since 2012 there has been a steady increase.

Learning Disability

The Human Rights Act states that every human being has the right to respect for private and family life. It is estimated that there are more than one million people living in England with a learning disability, but research has found that young people with learning disabilities do not have good access to sex and relationship education or information.

It is recommended that there be more accessible information and support for young people with learning disabilities, and for their parents. This needs to include information about sexuality, abuse and consent and practical information about contraception and safer sex where appropriate.

Homeless People

Homeless people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money. This makes it vital to address the sexual and physical health needs of this group.

Mental and Emotional Needs

The World Health Organization defines sexual health as: 'a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled'. How we think and talk about sex, sexual attraction, sexual practice, relationships, sexual ability, sexually transmissible infections (STIs) and HIV, can play a part in how we feel about ourselves, emotionally, psychologically and physically.

If not dealt with appropriately they can affect our mental health leading to:

- Depression
- Stress
- Anxiety
- Manic depression
- Self-harm
- Post natal depression
- And many others

In addition people who have these diagnoses can find that their enjoyment of sex is impaired leading to other stresses and pressures. People with impaired mental health can find it difficult to understand information about sexual health and how to access services. Emotional wellbeing in relation to sexual health, as well as our life in general, can be a time for understanding, change and growth.

Learning the skills needed to handle emotional problems will give you a foundation of mental and emotional health. Emotional health has many aspects. Put simply, it is based on self-esteem, how you feel about yourself and behaviour that is appropriate and healthy.

Someone who is emotionally healthy:

- Understands and adapts to change
- Copes with stress
- Has a positive self-concept
- Has the ability to love and care for others
- Can act independently to meet his or her own needs

Endnotes

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