

Sexual Health in Leicester: A Summary Needs Assessment

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1. Introduction

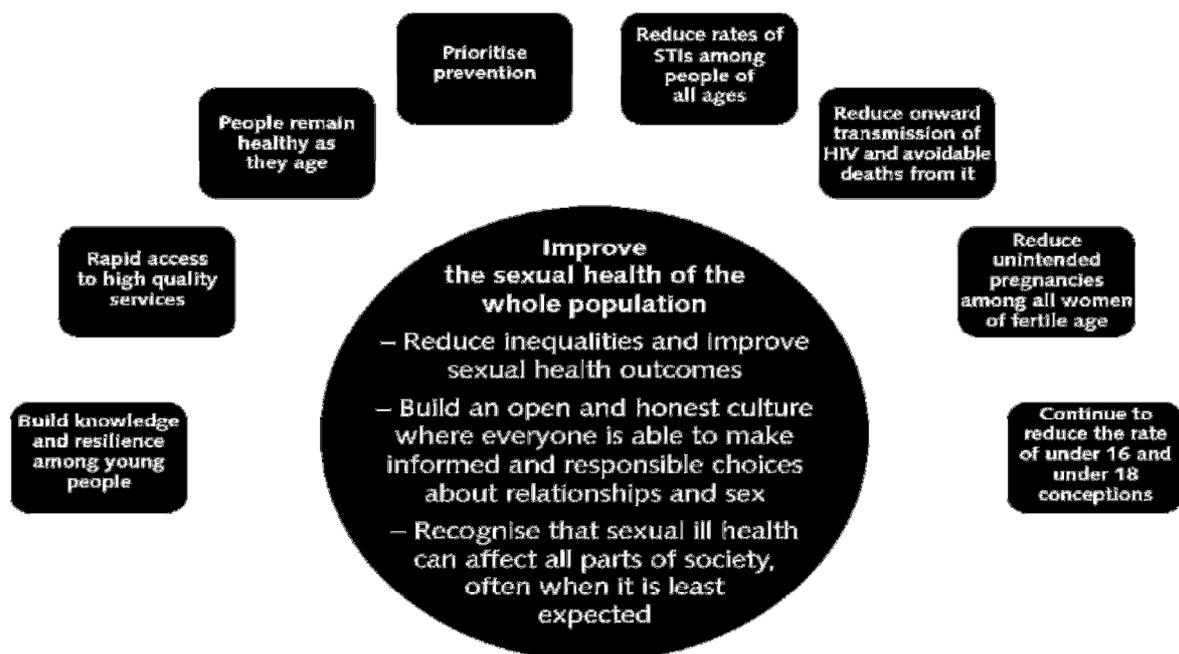
Sexual health affects our physical and psychological wellbeing and can have an enduring impact on our overall quality of life. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. The core elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or diseaseⁱ.

The scope of this document allows discussion about the promotion and maintenance of sexual health including the provision of services for all forms of contraception, detection and treatment of infections that are transmitted sexually (where sexual intercourse is the most common mode of transmission). There are other infections and diseases that can be transmitted sexually but are not covered in this chapter e.g. Hepatitis B and C.

Many people with sexually transmitted infections (STIs), which includes HIV, are unaware that they have a disease and may remain undiagnosed for many years. This not only affects their overall health and wellbeing but increases the risk of onward transmission in the population. Unplanned pregnancies, terminations and teenage conceptions can lead to many long term emotional, health and social consequences. Sexual dysfunction can affect self esteem leading to relationship problems. Therefore, ensuring access to appropriate sexual health information, interventions and services can have a positive effect on population health and wellbeing as well as individuals at risk.

The Department of Health has recently published a *Framework for Sexual Health*ⁱⁱ setting out the nation's ambition and objectives as shown below.

Figure 1: Framework for Sexual Health



The commissioning responsibilities of Sexual Health and HIV services changed on 1st April 2013 with the enactment of the *Health and Social Care Act 2012*, as detailed in the table below.

Table 1: Sexual Health Commissioning Responsibilities

Commissioning Responsibilities		
Local authorities	Clinical Commissioning Groups	NHS England
Comprehensive, open access sexual health services including <ul style="list-style-type: none"> • contraceptive services • STI testing and treatment • HIV testing • National Chlamydia Screening Programme • Psychosexual counselling • Sexual Health specialist services (including young people's services, teenage pregnancy services, outreach, prevention and promotion, services in educational establishments and pharmacies) 	<ul style="list-style-type: none"> • Abortion services • Sterilisation • Vasectomy • Non sexual health elements of psychosexual services • Gynaecology, including contraception for non-contraceptive purposes 	<ul style="list-style-type: none"> • Contraception as provided as additional service of GP contract • HIV treatment and care (including post-exposure prophylaxis) • Promotion of opportunistic testing and treatment for STIs and patient requested testing by GPs • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening • Specialist foetal medicine services

Key Issues and Gaps

Sexual behaviour is a major determinant of sexual and reproductive health. Certain behaviours are associated with increased transmission of STI and HIV, including:

- age at first sexual intercourse
- number of lifetime partners
- concurrent partnerships
- payment for sexual services
- alcohol
- substance misuse

Like many other urban areas, Leicester continues to be an area with significant sexual ill health as evidenced by the high rates of acute STIs and HIV compared to the national picture.

The *Framework for Sexual Health*ⁱⁱ acknowledges the relationship between sexual ill-health, poverty, social exclusion as well as the disproportionate burden of HIV infection on gay and bisexual men and some Black and Minority Ethnic (BME) groups. Many of these factors contribute to the high levels of sexual health need in Leicester, including deprivation and social inequality along with a relatively young and ethnically diverse population. Young people, men who have sex with men

(MSM) and those from black African communities are the groups most at risk of poorer sexual health in Leicester.

When mapping some elements of sexual health in the City, there is a disproportionate disparity between the east and west; with the west side of Leicester carrying more of the burden of chlamydia and under 18 conceptions. However, there are also disparities in the east with Thurncourt ward having significantly higher teenage pregnancies and chlamydia infections.

Leicester is the 6th highest prevalent area for HIV outside London. New diagnoses are identified every year both in clinical and non-clinical services. It is important that these diagnoses are made early to ensure effective treatment and to reduce onward transmission in the population. Those from Black African and MSM communities are the two population groups in Leicester who are most affected by this infection given their relative proportions within the population.

The overall number of new STI diagnoses has increased in Leicester between 2009 and 2012 with young people under the age of 25 being disproportionately represented in these figures. Leicester is working towards delivering a Chlamydia diagnosis rate of at least 2,300 per 100,000 for 2013/14, although current delivery is behind schedule. Greater emphasis needs to be placed on targeting areas where the likelihood of a positive result is increased. There also needs to be a continuation of the focus on embedding chlamydia screening in primary care and sexual health services, emphasising the need for repeat screening as appropriate.

The number of Termination of Pregnancies (TOPs) performed on women in Leicester has gradually decreased from 2006 to 2012. The reasons for this are unclear and need to be explored to ensure that this is a result of service improvements such as improved access to Long Acting Reversible Contraception (LARC) and not due to inadequate access to TOP services. LARC is cited by the National Institute for Health and Care Excellence (NICE) as being the most reliable form of contraception and is recommended for preventing teenage pregnancy and reducing the demand upon abortion services by women of all ages. However, data collection on LARC provision in Leicester needs to be improved and standardised in order to allow for adequate analysis. Furthermore, the psychosexual health needs of Leicester's population are not known. An assessment of need including patient pathways should be undertaken.

A fully Integrated Sexual Health Service (ISHS) has recently been commissioned by the local authorities across Leicester, Leicestershire and Rutland. This newly tendered service commenced on the 1st. January 2014, enabling people to experience a '*one-stop-shop*' of sexual and reproductive health services. In recent years there has been little social marketing commissioned around sexual and reproductive health with few co-ordinated sexual health promotion campaigns in Leicester. The ISHS will be addressing this gap, but its success will be dependent upon increased partnership working with key agencies and organisations.

The management and treatment of those with HIV continues to be provided by University Hospitals of Leicester NHS Trust but within a single service. Ease of access to treatment is essential in order to optimise individual and population health.

The ISHS will be developing specialist services (e.g. for those people with complex HIV problems or co-infections) and exploring how those with HIV who are fit and well can be best supported in the community.

Relationships and Sex Education (RSE) is vitally important for young people in order to equip them with a better understanding on how healthy relationships are made and in having the confidence to negotiate safe sex. RSE is delivered mainly through schools, either as part of the Personal, Health and Social Education (PHSE) curriculum or as standalone RSE lessons. RSE is currently mandatory within local authority maintained secondary schools but not academies, free schools or primary schools. It is left up to individual schools to decide on the content and delivery of these lessons but guidance from the Secretary of State on Sex and Relationships should be taken into accountⁱⁱⁱ.

Recommendations for considerations by Commissioners

No.	Recommendation	Commissioners		
		Leicester City Council	Clinical Commissioning Group	NHS England Area Team
1.	Explore effective ways of engaging service users and community groups in the delivery of sexual health services	X	X	X
2.	Ensure patient satisfaction surveys are undertaken by providers	X	X	X
3.	Ensure clear patient pathways to and from the ISHS to ensure safe and seamless patient journeys	X	X	X
4.	Ensure increased partnership working between key organisations, agencies and community groups with the ISHS	X	X	X
5.	Increase social marketing exercises in order to determine appropriate behaviour change interventions and accessible services in line with national campaigns	X		
6.	Increase sexual health promotion outreach work, especially for vulnerable groups: BME groups, refugees and asylum seekers, children looked after, youth offenders, those with learning disabilities, sex workers, drug and alcohol users etc.	X		
7.	Engage local communities to act as champions and role models to encourage involvement in sexual health promotion and HIV testing activities	X		
8.	Produce sexual health promotional material in partnership with local communities that are tailored to their needs using (where	X		

	appropriate) nationally developed materials			
9.	Update the teenage pregnancy strategy and ensure that those at risk of under 18 conceptions are identified with early help and support	X	X	X
10.	Support schools in their responsibility to provide high quality RSE and ensure provision of high quality RSE out of school in conjunction with the school nursing service, outreach services, youth service, children looked after and teenage pregnancy initiatives	X		
11.	Run programmes to increase self-esteem, communication and negotiation skills targeted at young people at risk of poorer sexual health outcomes	X		
12.	RSE at school and in the community should also raise awareness of sexual violence and rape. This should include partnership working with the local police	X		
13.	Deliver collaborative, holistic and integrated harm reduction interventions that specifically target the most vulnerable communities	X		
14.	Enhance cervical screening awareness, particularly across specific population groups and improve cervical screening pathways	X		X
15.	Ensure that pathways for sterilisation and vasectomy services are understood			X
16.	Develop comprehensive and standardised data collection for all contraceptive services	X	X	X
17.	Further innovative ways of improving access to LARC and EHC should be explored in order to maintain focus on reduction in teenage conceptions	X		
18.	Review the current delivery of all sexual health commissioned services to ensure cost-effective delivery, promote integration, quality, value for money and innovation in the further development of sexual health interventions and service	X	X	X
19.	An assessment of the training and education needs for local primary care teams in order to enable them to confidently undertake risk assessments and treatments should be considered as a mechanism for improving access to services	X	X	X

20.	Prevention efforts, such as increased STI screening and HIV testing should be sustained and continue to focus on groups at highest risk	X		
21.	Ensure Equality Impact Assessments are regularly undertaken by all providers and reported upon	X	X	X
22.	Continue embedding Chlamydia screening in primary care and sexual health services which emphasise regular repeat screenings as appropriate	X		
23.	Continue focus towards achieving a chlamydia diagnosis rate of at least 2,300 per 100,000 (15-24 year olds)	X		
24.	Explore the provision of GP enhanced care for HIV in primary care			X
25.	Develop patient pathways for psychosexual counselling	X	X	
26.	Develop coherent HIV testing policy which increases the accessibility and availability of HIV testing in acute trusts, primary care and community outreach services that is targeted at specific risk groups	X	X	X
27.	Develop optimum HIV health and care pathway	X		X
28.	Support women with unwanted pregnancies to make informed decisions about their options as early as possible		X	
29.	Ensure STI (including HIV) testing as well as contraceptive services are provided by TOPs	X	X	
30.	Develop Sexual Health Strategy and commissioning action plan	X	X	X

2. Who is at risk and why?

There has been a change in the sexual health behaviour of the population of England in the last 60 years. This has been evidenced in the National Sexual Health attitudes Surveys (Natsal)^{ivv} which have been undertaken in 1991, 2001 and 2011, thus providing trend data. The Natsal survey demonstrates an increase in the:

- number of sexual partners over a person's lifetime, particularly for women where this has increased from 3.7 (1991) to 7.7 (2011)
- sexual repertoire of heterosexual partners, particularly with oral and anal sexual intercourse

All sexually active individuals of all ages are at risk of STIs (including HIV) and unplanned pregnancies (in the fertile years). However, the risks are not equally distributed amongst the population with certain groups being at greater risk. Poor sexual health may also be associated with other poor health outcomes. Those at highest risk of poor sexual health are often from specific population groups with varying needs which include:

- Young people
- Some black and ethnic minority groups
- Men who have sex with men (MSM)
- Sex workers
- Victims of sexual and domestic violence
- Other marginalised or vulnerable groups including prisoners

There is also a clear correlation between the acquisition of STIs and deprivation. There could be multiple reasons for this including^{vi}:

- inadequate service provision
- lack of skills, knowledge and confidence about practicing safer sex
- differences in healthcare seeking behaviour

The type of sexual activity that people engage in can also increase the chances of contracting a STI, HIV infection or having an unplanned pregnancy, for example:

- having multiple sexual partners
- anal sex without protection
- inappropriate contraceptive methods

In the case of unplanned pregnancies, women at greater risk are:

- those who do not use any form of appropriate contraception (some may be under the misconception that the withdrawal method is appropriate)
- young women (they are often unaware of their increased fertility)
- older women in stable relationships (misconception that they are no longer at risk)
- those with low educational attainment this is independent of other factors

It is important to recognise that MSM can be and are a marginalised and hard to reach group as they come from all backgrounds. However, it is important to note that not all MSM will identify as being gay or bisexual and they can present themselves as heterosexual to the wider population and healthcare services (as they strive for anonymity). Therefore, there is no one particular characteristic which identifies the MSM population as they not a homogenous group. The reasons for this are diverse but set in a backdrop that societal attitudes to homosexuality remain markedly less liberal than attitudes to premarital sex.

3. The level of need in the population

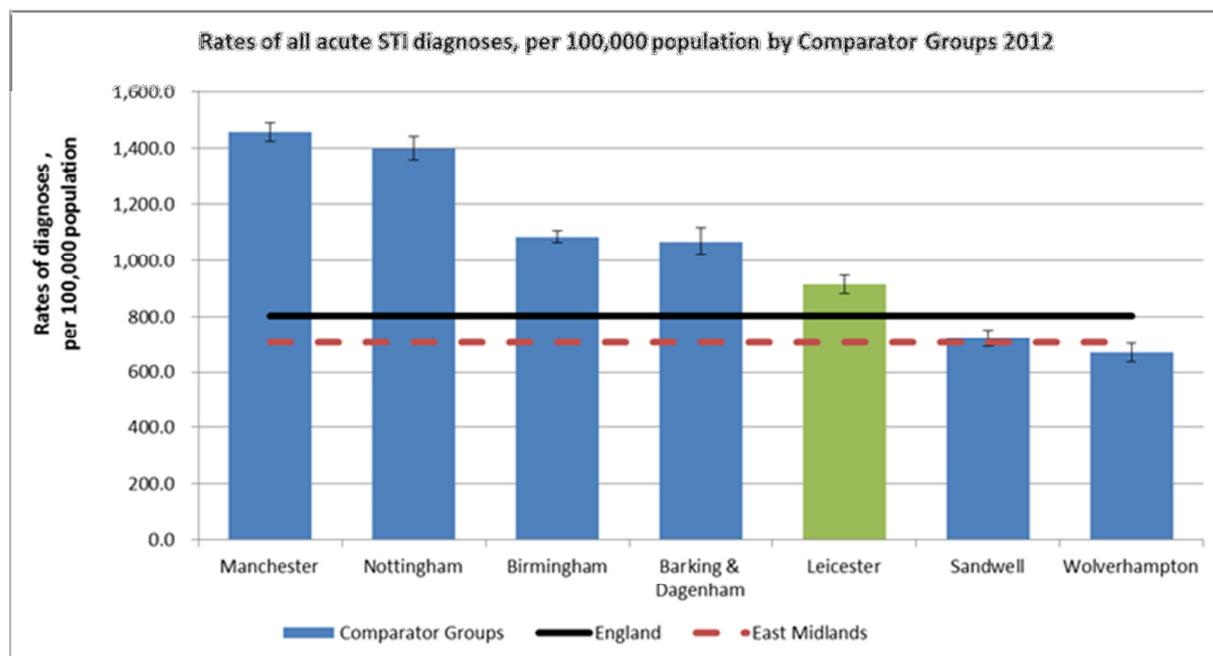
Sexually Transmitted Infections (STIs)

Leicester is currently ranked 60 out of 326 local authorities with rank 1 being the worst for diagnosis of acute STIs. The group of infections conventionally considered as acute STIs are:

- chlamydia
- genital warts
- gonorrhoea
- syphilis
- HIV/AIDS

Figure 2 below shows the rate of acute STIs per 100,000 residents for Leicester and ONS comparators for 2012, which show that although Leicester is above the regional and national averages, it takes the third lowest position when compared against its peers.

Figure 2: Rates of all acute STI diagnoses per 100,000 (2012)



Source: Public Health England, 2013

Re-infection rates

During 2009-2012, 12.3% of women and men presenting with an STI at a Genito-Urinary Medicine (GUM) clinic in Leicester were re-infected. This is slightly higher than the national picture of 9.6% of women and 12.0% of men. For Gonorrhoea, the reinfection rate in Leicester was just under 7% for men and women compared to the national figures of 3.8% for women and 7.3% for men.

Chlamydia

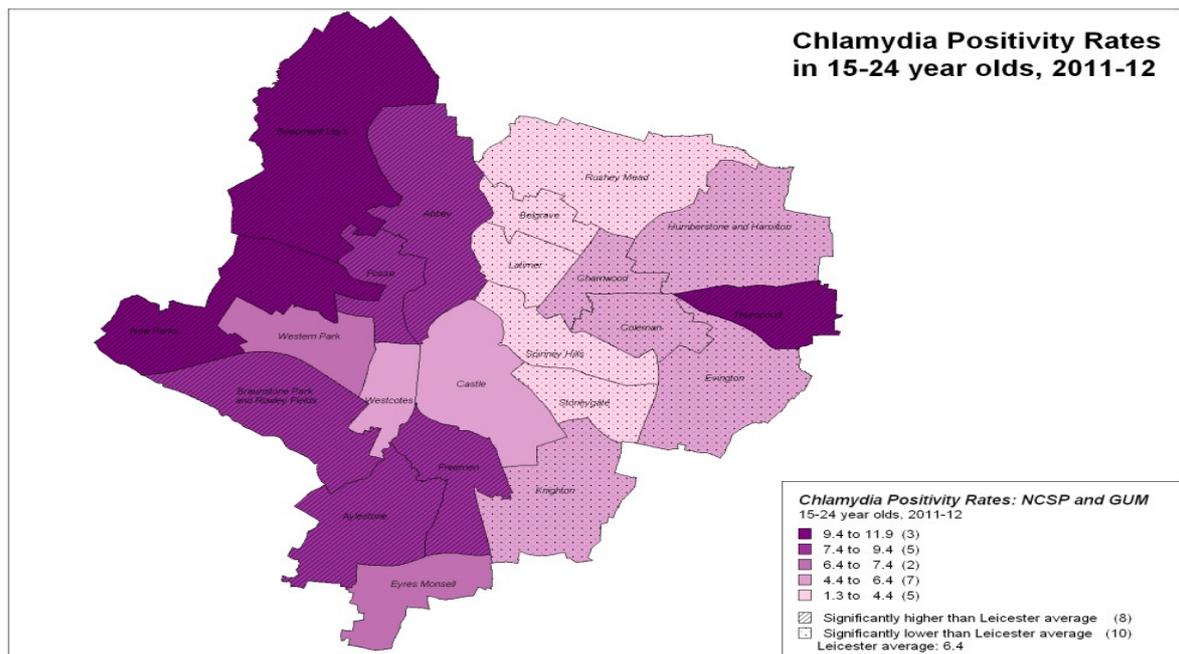
Chlamydia infection is often asymptomatic or goes undiagnosed leading to complications such as pelvic inflammatory disease. Screening for Chlamydia detects asymptomatic infection, allowing for treatment with antibiotics. Chlamydia is the most common bacterial STI in England, the prevalence of which is highest in the young adult population aged 15-24 years.

Leicester's Chlamydia Screening Programme is part of the National Chlamydia Screening Programme which provides opportunistic screening to all sexually active young people aged 15-24 years. This programme is delivered in a variety of settings in Leicester such as GP practices, family planning clinics, pharmacies, youth centres, Further Education colleges and universities. In 2011/12, 28% of young people in Leicester aged 15-24 years were screened, which is higher than the proportion screened nationally at 25.8%.

The diagnosis rate for Chlamydia has been included as an indicator in the *Public Health Outcomes Framework* with the current national aim being 2,300 per 100,000 of the 15-24 year old population (Public Health England, 2013). Although more than a quarter of the target population in Leicester were screened in 2011/12, Leicester's diagnosis rate fell short at 1,791.7 per 100,000 and is lower than the national rate of 1,979.1 per 100,000. The lower diagnosis rate in Leicester may be due to its diverse ethnic population with some young people from certain ethnic backgrounds having a later sexual debut compared to those from other backgrounds. This may suggest that resources could be better targeted at those most at risk of having a positive result.

Chlamydia diagnosis rates cannot be transcribed to ward level. When trying to understand Chlamydia infection rates at ward level, the positivity rate is used instead which reflects the proportion of tests that are diagnosed positive at ward level. Figure 3 shows that the Chlamydia positivity rate varies across Leicester, with the highest proportion being observed mainly in the west of the City, with the exception of Thurncourt in the east.

Figure 3: Chlamydia Positivity Rates in 15-24 year olds (2011-12)



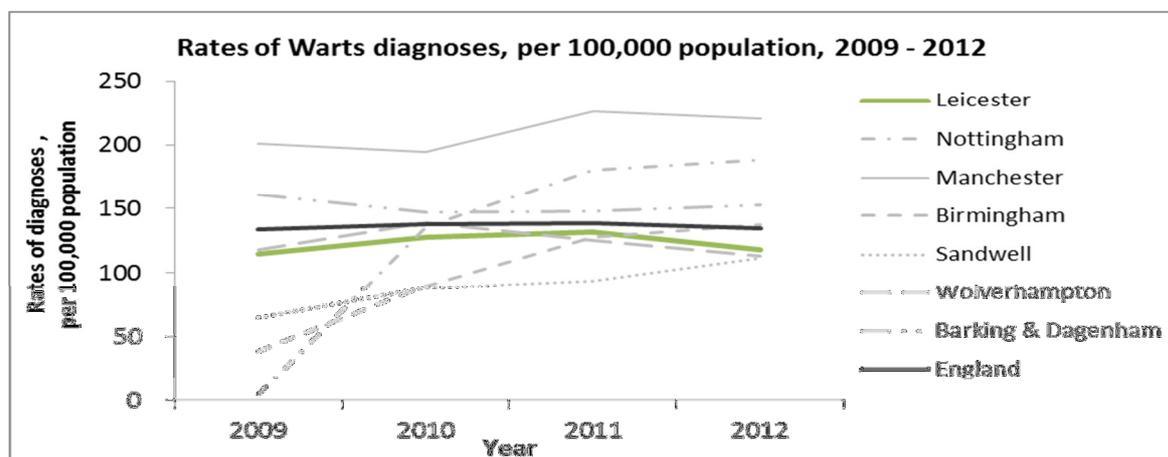
Human Papilloma Virus (HPV)

There are more than forty types of the HPV which can be transmitted sexually. Certain HPV infections can cause cancers (e.g. cervical) and genital warts. In the UK, all 12-13 year old girls are offered HPV vaccination through a national HPV immunisation programme which confers protection against cervical cancer and genital warts.

Genital warts

Genital warts are the second most common STI in the country. Diagnoses of genital warts have been increasing steadily over the last decade. Figure 4 compares Leicester against its peer comparators and shows that Leicester has a very similar trend for genital wart diagnoses as England.

Figure 4: Rates of genital warts diagnosed per 100,000 population (2009-2012)

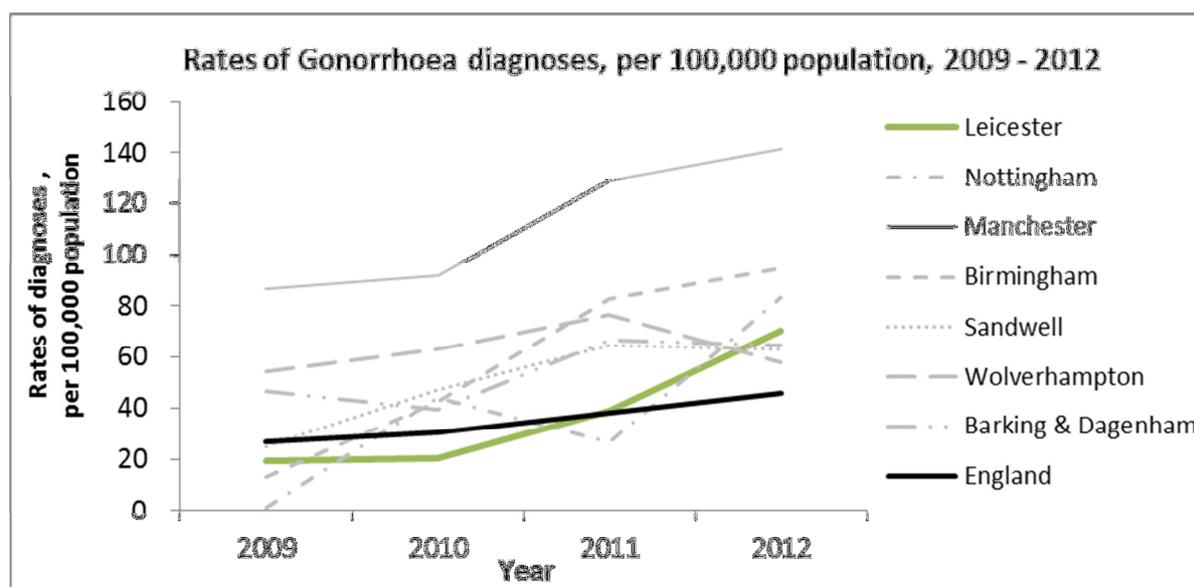


Source Public Health England, 2013

Gonorrhoea

Nationally, the rates of Gonorrhoea infection have been reducing since 2005. However, since 2009 there has been a change in trend coupled with a large increase in 2012 (21% nationally, 80% locally). Whilst there appears to be a statistically significant increase in the rates of Gonorrhoea infection in Leicester for 2012, specialists at Public Health England do not believe that this recent result represents a true increase due to the implementation of national changes to gonorrhoea testing. Some of this increase is thought to be due to the sensitivity of the new Nucleic Acid Amplification Test (NAAT) that has recently been introduced. This may have detected some genetic material from other bacteria similar to gonorrhoea and hence mimicked a positive result. From 2013, double testing of all positive tests has been introduced. It is expected that the rates will fall as a result of this implementation. Nevertheless, it should be noted that Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics. Figure 5 compares Leicester against its peer comparators and illustrates higher rises in gonorrhoea rates occurring in urban areas (Birmingham, Manchester and Nottingham) where more testing occurs.

Figure 5: Rates of Gonorrhoea diagnoses per 100,000 population (2009-2012)

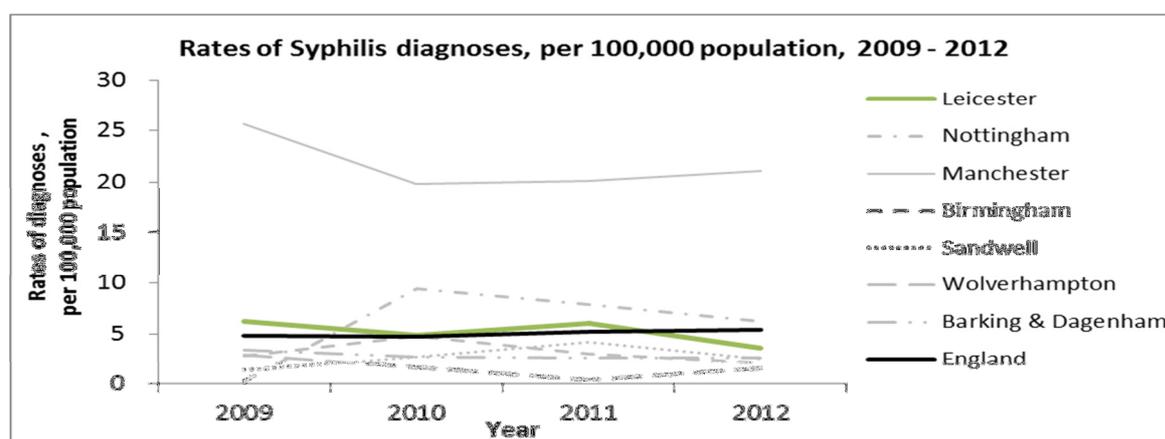


Source Public Health England, 2013

Syphilis

Syphilis is one of the least common STIs in the country with low rates reported locally and nationally. However, when Leicester is compared against peer comparators, Sandwell, Barking and Dagenham and Birmingham have constantly reported lower rates.

Figure 6: Rates of Syphilis diagnoses per 100,000 (2009-2012)



Source Public Health England, 2013

Human Immunodeficiency Virus (HIV)

HIV is one of the fastest-growing serious health conditions in the UK. Although there have been dramatic improvements in survival for people with HIV over the past decade, HIV infection can still be associated with higher risks of serious physical and mental ill health, reduced life expectancy, discrimination and poverty.

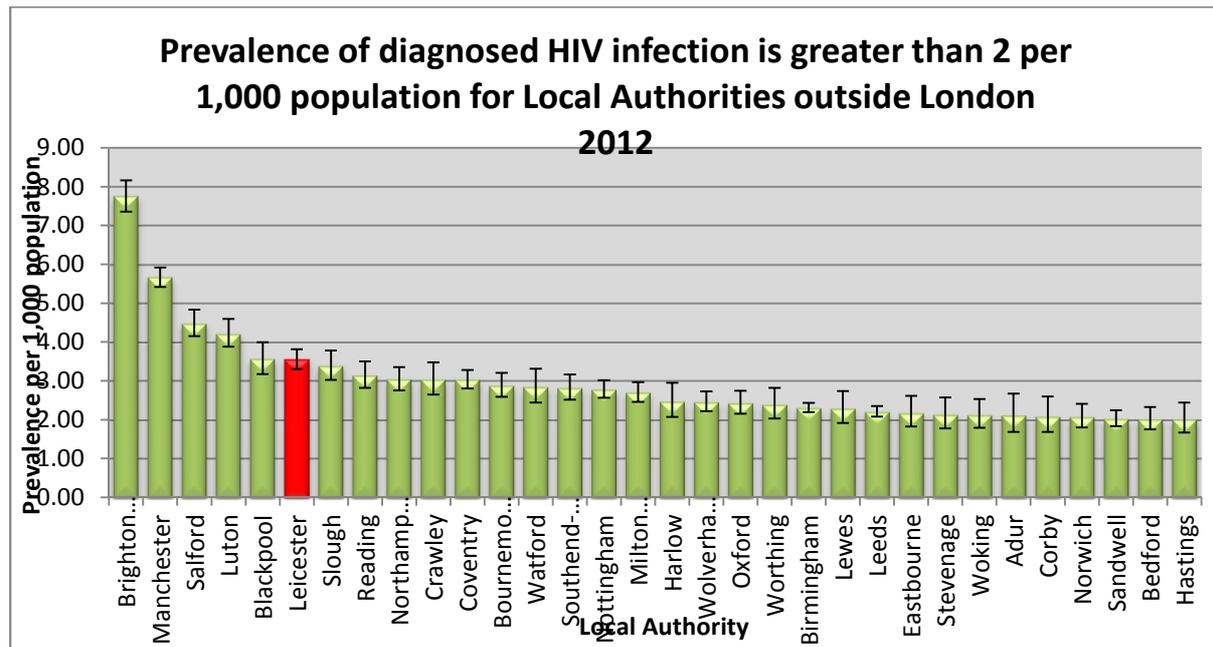
Public Health England estimates that 100,000 people in the UK were living with HIV in 2012, with one in four (24%) being undiagnosed and unaware of their infection. It is also reported that UK acquired infections in MSM and in heterosexuals continue to rise while infections acquired from abroad continue to decline. The two groups most affected by HIV in the UK are MSM and people who have migrated from regions of the world where HIV is common, such as sub-Saharan Africa. In 2011, nearly four out of five (77%) newly diagnosed MSM probably acquired HIV in the UK. Forty eight percent of people diagnosed with HIV in the UK (2011) had been infected heterosexually with 57% of those being black African. There has been a 27% increase of HIV infections acquired within the UK from 2002-2011.

There are other modes of transmission including mother to child transmission, blood products and intravenous drug use. All of these are now either rare or in very low numbers due to a variety of successful public health interventions including antenatal testing, blood screening and needle exchange schemes.

In Leicester, the median age of those seeking care for HIV is between 35 and 44 years. Sixty two percent of people are of Black African ethnicity and 77% of people acquired their HIV heterosexually.

Areas with a diagnosed HIV rate of more than 2.0 per 1,000 population aged 15-59 years are defined as areas of high prevalence. Leicester has a diagnosed HIV prevalence rate of 3.6 and is ranked the 6th highest prevalent area outside London, as illustrated in the figure below.

Figure 7: Areas of high HIV prevalence (outside London) 2012



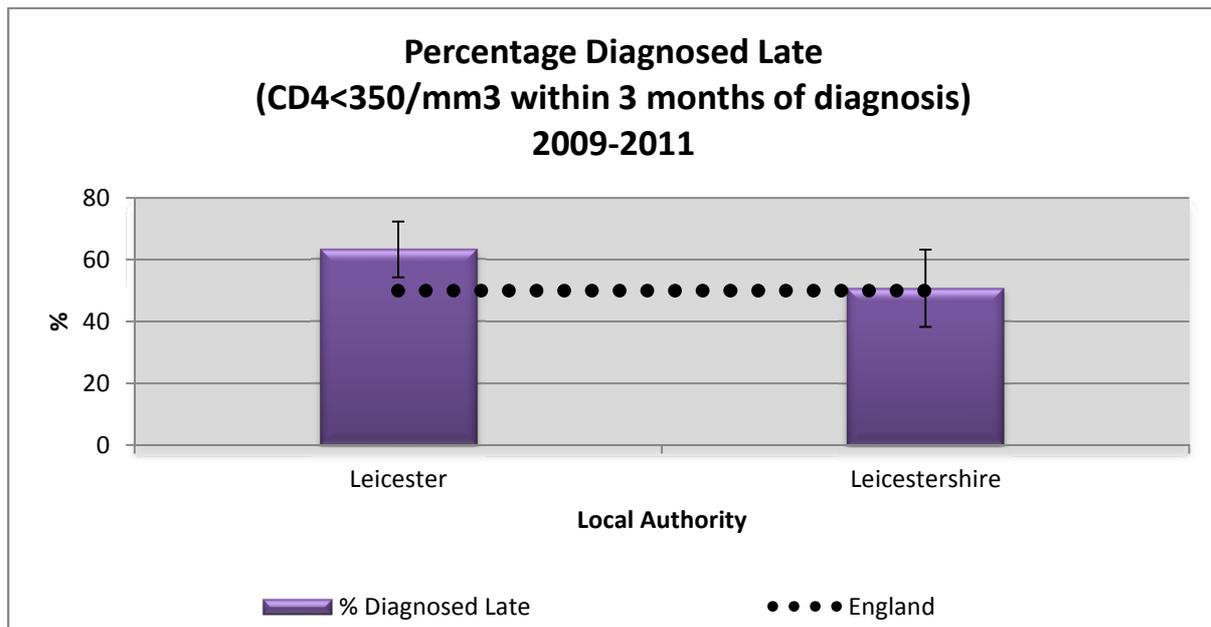
Source: Public Health England 2013

There has been a year on year increase in the number of people diagnosed with HIV in Leicester. In 2012, there were 807 HIV positive people living in Leicester (52% women compared to 48% men) with most of the diagnoses being found in the African (62%) and MSM (13.5%) communities.

The *Public Health Outcomes Framework* includes an indicator for the reduction in the number of people presenting with HIV at a late stage of infection. A person is considered to have been diagnosed late if the number of particular immune cells (CD4 cells) in their bloodstream has dropped below a certain level. Late diagnosis is one of the biggest contributing factors to illness and death for people with HIV, with those diagnosed late having a tenfold increased risk of dying within a year of diagnosis. Early diagnosis is important in order for anti-retroviral treatment to be provided and for further transmission in the population to be reduced. Between 2009 and 2011, 63.3% of adults diagnosed with HIV in Leicester were diagnosed late. This compares badly against the England average of 47% and where late diagnosis between 2009 and 2012 was higher amongst:

- older people
- women
- black ethnicity
- those who inject drugs

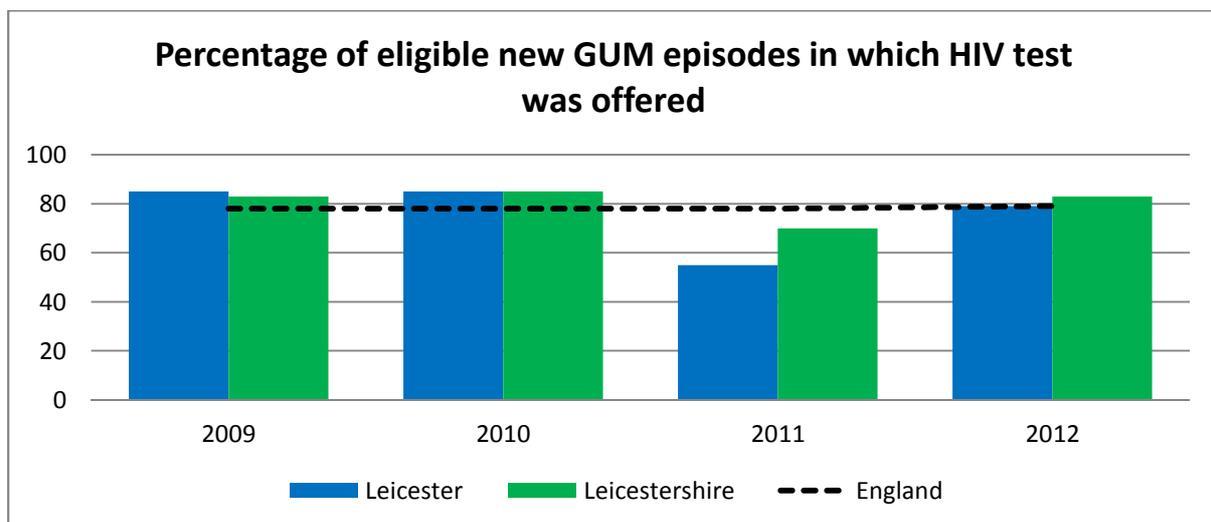
Figure 8: HIV late diagnosis (2009-2011)



Source: Health Protection Agency, 2012

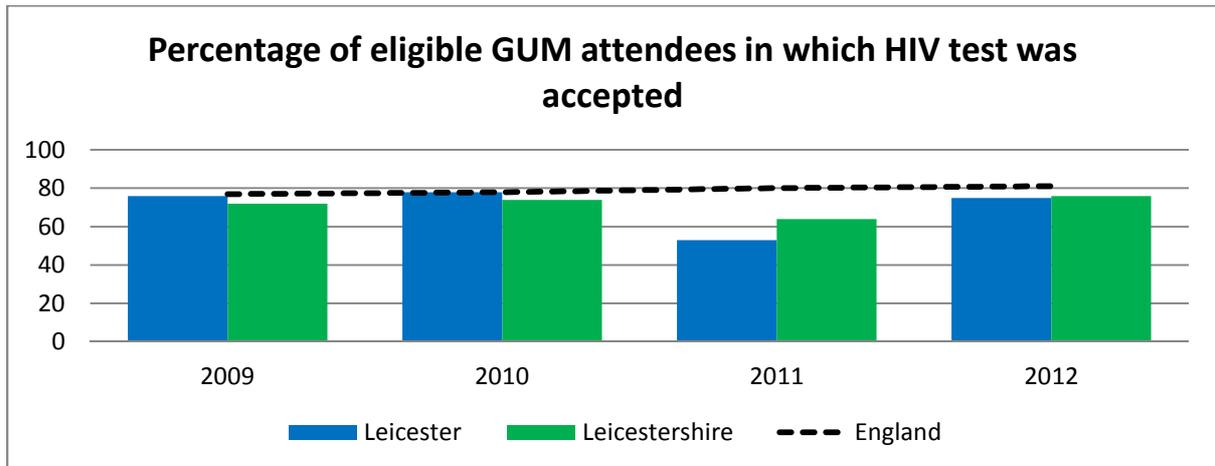
Inpatient and outpatient HIV treatment and care is provided by the Infectious Diseases/HIV service at University Hospitals of Leicester. Post exposure prophylaxis can be accessed at the ISHS and the Accident and Emergency department. There is 100% compliance with the 48 hour access requirements; with the provision of 24 hour medical advice for HIV management. The percentage of eligible new GUM episodes in which HIV test was offered is detailed in Figures 9 and 10 below. With the exception of 2011, the rate of HIV tests that have been offered are comparable to the national picture. However, the take-up rate for HIV testing for GUM attendees is lower than the national average. Considering the fact that Leicester is a high prevalent area for HIV, more should be done to increase these figures locally.

Figure 9: Percentage of eligible new GUM episodes in which HIV test was offered



Source: Public Health England 2013

Figure 10: Percentage of eligible GUM attendees in which HIV test was accepted



Source: Public Health England 2013

Contraception

Information on NHS community contraceptive clinics excludes services provided in out-patient clinics and those provided by General Practitioners (GPs). In 2012/13, there were 2.3 million attendances at NHS community contraceptive clinics made by 1.3 million individuals, nationally. This represented a decrease of 8% on the number of attendances in 2011/12 and a decrease of 5% on the number of individuals in 2011/12.

Oral contraception was the primary contraceptive method of 47% of women who attended NHS community contraceptive clinics, and it remains the most common primary method in almost every age group, nationally. Use of Long Acting Reversible Contraceptives (LARCs) now accounts for 30% of primary methods of contraception among women who attended NHS community contraceptive clinics, nationally. This is an increase on the previous year when it was 28%.

Long acting reversible contraception (LARC)

NICE guidance recommends increased provision of LARC as they are well tolerated by women and cost effective. There are various methods available including:

- Intrauterine Devices and Systems (IUD/S) also called coils
- SubDermal implants(SDi) also called implants
- Depo-Provera Injections
- Contraceptive patches

In 2013/14, 90% of GP practices were signed up to provide IUD/S and 87% of GP practices were signed up to provide SDi through a Locally Enhanced Service (LES) or other agreement in Leicester. Additionally, there were also 7 GP practices providing an integrated open access sexual health service where contraception could be accessed. However, data on the rate of LARC provision in Leicester is currently not available due to various and differing methods of data collection and reporting by different providers.

Emergency Contraception

Emergency contraception can be used to prevent pregnancy after unprotected sexual intercourse or if a method of contraception has failed. There are two methods of emergency contraception:

- the emergency contraceptive pill (the morning-after pill)
- the copper intrauterine device (IUD)

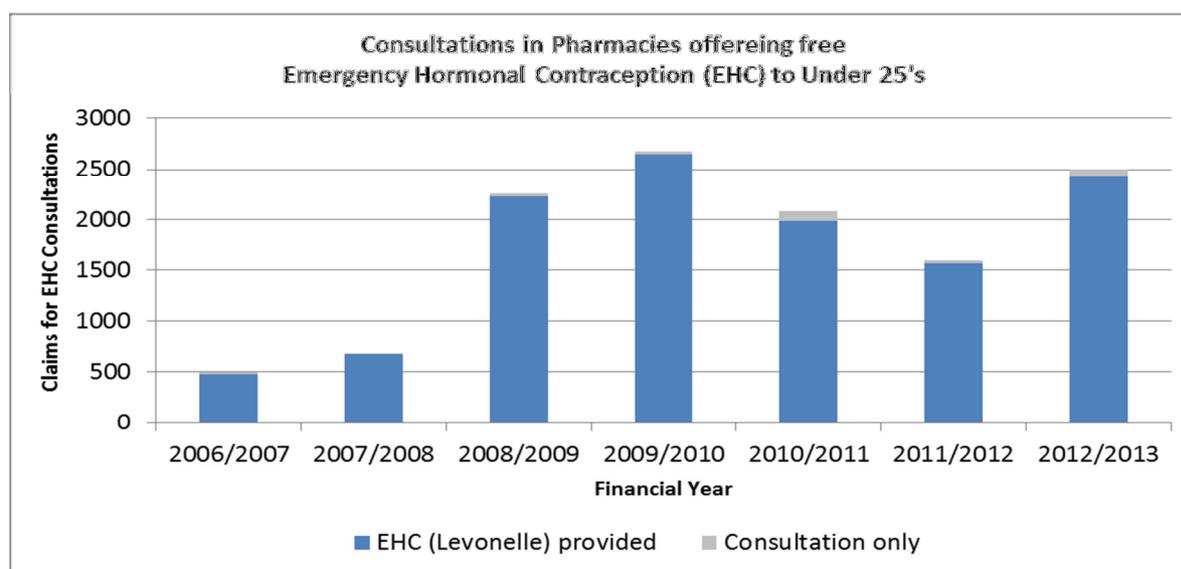
Emergency contraceptive pill

There are two types of emergency contraceptive pill:

- **Levonelle** is the most commonly used. It can be taken up to three days (72 hours) after unprotected sexual intercourse and is available free of charge on prescription or can be bought over the counter.
- **ellaOne** is a newer type of emergency contraceptive pill that can be taken up to five days (120 hours) after unprotected sexual intercourse. It is only available on prescription.

The type of emergency contraceptive pill offered and provided is dependent on the patient's suitability. Levonelle is currently provided as a free scheme, 7 days a week for those under 25 years by 41 local pharmacies across Leicester. The community pharmacy scheme saw 2,425 women in 2012/13 who qualified for Levonelle. The majority of these consultations were provided in five local pharmacies contracted in the scheme. Women attending after 72 hours of unprotected sexual intercourse are redirected to their GP or the Contraceptive and Reproductive Health service where either ellaOne or the IUD can be provided. Data on the number of women not qualifying for Levonelle and requiring redirection to their GP or the Contraceptive and Reproductive Health service is not currently recorded.

Figure 11: Consultations undertaken and provision of Levonelle in pharmacies offering free EHC to under 25's in Leicester City (2006-2012)



Source: Public Health Leicester City Council (2013)

Copper intrauterine device (IUD)

The IUD can be fitted by an appropriately trained clinician within five days of unprotected sexual intercourse or up to five days after ovulation. It is the most effective method of emergency contraception and prevents at least 99.9% of pregnancies. Local data on the provision of IUDs for this situation is not currently available.

Condom and pregnancy testing provision

Free condoms and pregnancy tests are available across Leicester to all young people under 25 in Further Education colleges and Universities as well as youth and community settings. Trained workers provide these along with instructions on their use. In 2012, the Safer Sex team who manage this scheme distributed 21,819 condoms over 68 sites across Leicester. Additionally, the Choices service distributed 18,384 condoms in 20 clinics over 15 sites from Jan-Oct 2012. There is also a free condom distribution scheme for specific at risk groups i.e. MSM and those in the sex industry. There is no data available on the number of pregnancy tests that have been distributed across the City.

Teenage Pregnancy

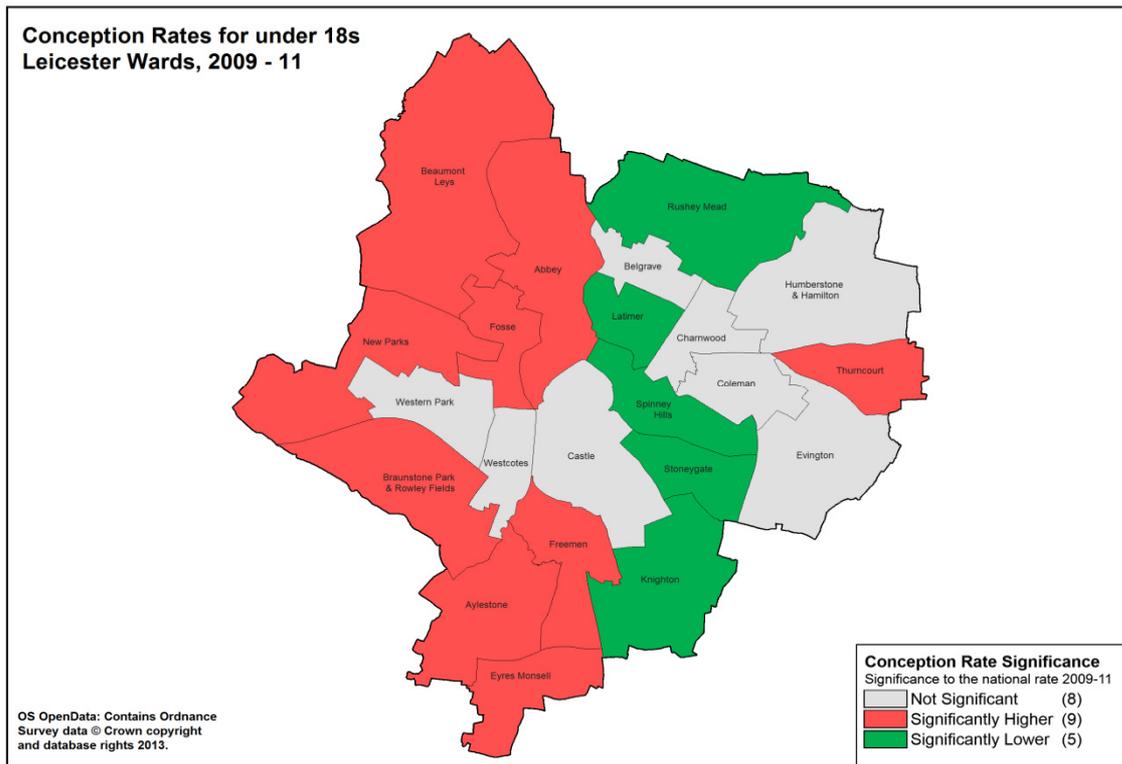
Teenage pregnancy is a significant public health issue. The UK still has one of the highest rates of teenage pregnancy in Western Europe with 32,500 pregnancies reported in England (2010) for those under the age of 18 (approximately 6,000 were under the age of 16).

A partnership strategy has been implemented in Leicester over the last 10 years to support the reduction in under 18 conceptions. This has included an increased effort in improving education in schools along with information on access to contraception and sexual health services. In 2011, the teenage pregnancy rate in Leicester fell below the national average with a rate of 30 per 1,000 15-17 year-olds compared to the national rate of 30.7 per 1,000.

Under 18 conceptions are not evenly distributed across Leicester and the figure below mirrors the Chlamydia positivity map shown earlier. The following characteristics are more common amongst women who conceive under 18 years in Leicester:

- white ethnicity
- low educational attainment
- high levels of truancy
- child of a teenage mother

Figure 12: Under 18 conception rates by ward, Leicester (2009-11)

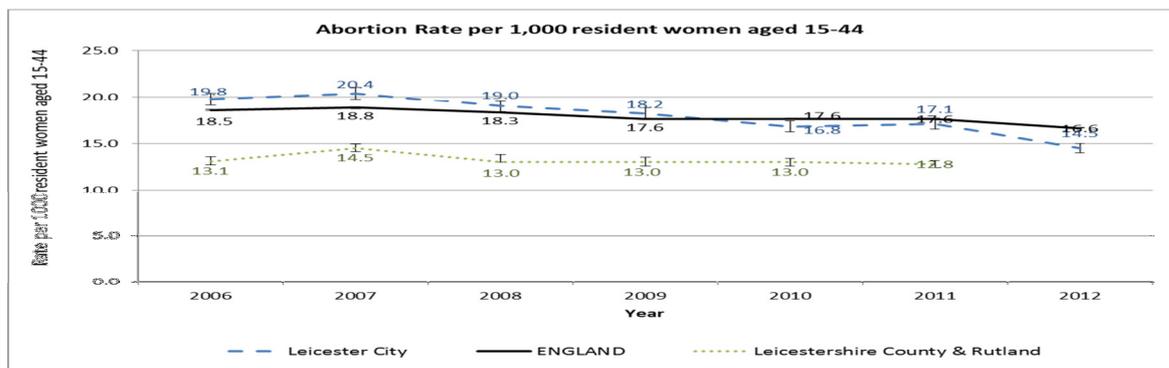


Source: Office for National Statistics, 2013

Termination of Pregnancy

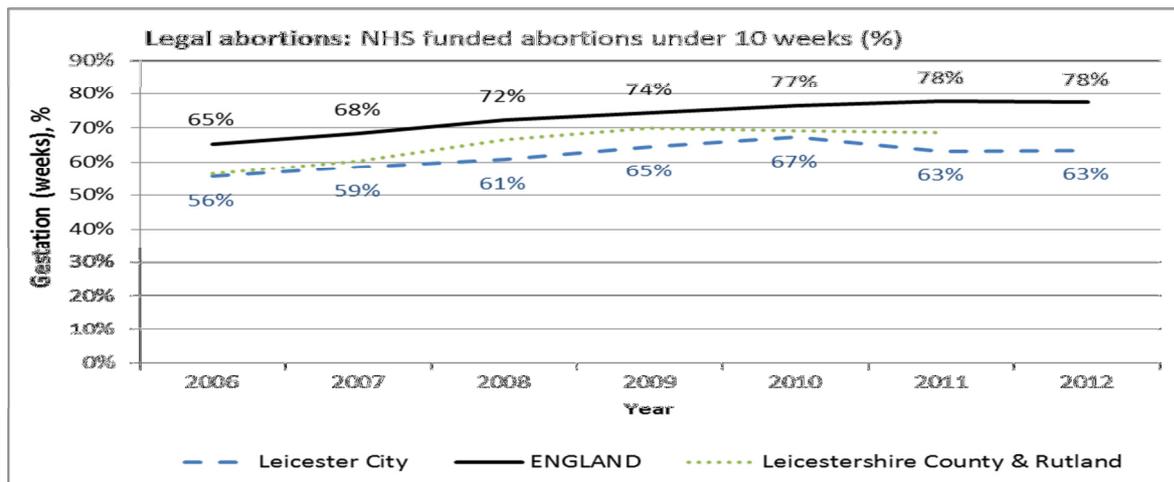
Termination of Pregnancy (Abortion) is governed by the Abortion Act of 1967 which permits terminations up to the 24th week of gestation by regulated providers. These services have been commissioned from University Hospitals of Leicester (up to 12 weeks gestation) and from British Pregnancy Advisory service (BPAS) for terminations between 13 and 24 weeks. BPAS provides service outside Leicestershire and women need to travel to their clinics. Contraception (including LARC methods) is discussed with patients who require any termination in order to reduce the need for a repeated abortion in the future. The figures below show a gradual decline in the rate of terminations in Leicester from 2006 to 2012.

Figure 13: Termination of pregnancy rate per 1,000 women aged 15-44 (2006-2012)



Source: Legal abortions, Department of Health (2006-2012)

Figure 14: NHS funded abortions under 10 weeks



Source: Legal abortions, Department of Health (2006-2012)

The rate of terminations in Leicester for those under 18 (15-17 years of age) in 2011 has fallen from 13.6 per 1,000 population to 11.8 per 1,000 women which is below the England rate of 12.8 per 1,000. Repeat abortions for those aged under 25 during 2012 were as follows:

- Leicester: 22% in comparison to 32% repeat in all ages
- England: 27% in comparison to 37% repeat in all ages

The overall picture on termination of pregnancy in Leicester shows a lower rate when compared against the national average. The reasons for this are unclear and further investigations are required to ensure that poor access to the service is not the cause.

Sterilisation

It was not possible to obtain information on these services.

Vasectomy

It was not possible to obtain information on these services.

Psychosexual counselling

The following data is from the Psychosexual service provision at University Hospitals of Leicester and is not specific to Leicester City residents only. The data below show that there has been a 50% increase in the number of referrals in 2012. This could be an anomaly but could also be due to increased need and therefore should be monitored.

Table 2: Referrals according to psychosexual problem

Problem	2007	2008	2009	2010	2011	2012
Early ejaculation	6	5	8	3	7	3
Erectile dysfunction	4	21	31	31	25	50
Loss of Libido (F)	9	13	8	9	5	3
Loss of Libido (M)	2	2	3	1	2	0
Dyspareunia/Vaginismus	12	28	22	30	30	47
Orgasmic Dysfunction	1	1	0	1	0	0
Non specific	30	0	0	1	1	1
Sex addiction	0	0	0	0	0	1
Total number of referrals	73	70	72	76	70	105

Referrals are often made by the patient's GP but can also be made by the patient themselves. Sometimes the psychosexual problem is picked up by other health professionals e.g. contraceptive clinicians, gynaecologists, genitourinary specialists and midwives. The table below shows a gradual decline in self referrals (from 2009) with an increase in GP and health professional referrals in recent years. The reasons for the changes in referral pathways need to be understood further to ascertain that there are no barriers to self referral in the system.

Table 3: Referral pathways of psychosexual patients

Year	2007	2008	2009	2010	2011	2012
GP	35	34	30	45	39	65
Self	21	28	37	27	22	20
Other health professionals	8	8	5	4	9	20

Waiting times vary according to availability of specialists. The referral to treatment (RTT) target is 126 days. The following table shows that the average waiting times has consistently been exceeding the target (apart from 2009). This should be investigated, especially if there is a true increase in referrals.

Table 4: Waiting times in days

Year	Average waiting time in days
2008	143
2009	96
2010	128
2011	194
2012	131

Cervical screening

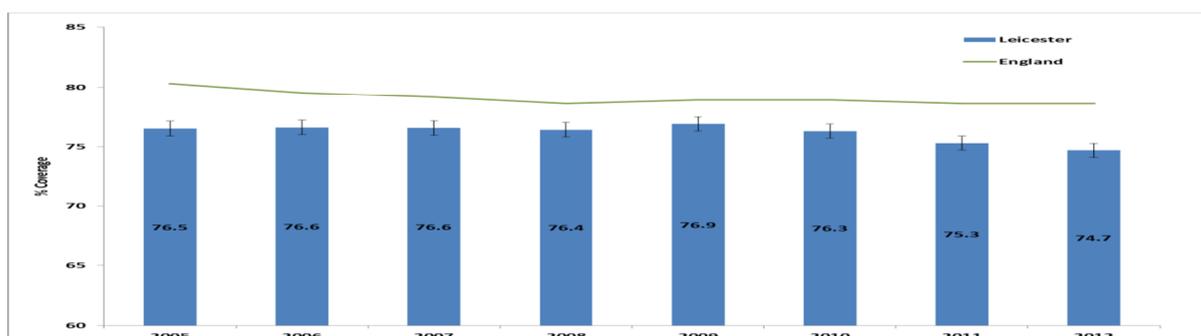
As part of the national screening programme, cervical tests are offered to all women aged 25 to 64 as follows:

- every 3 years to those under the age of 50
- every 5 years to those over 50 years

The test, known as the 'cervical smear' is designed to ascertain the health of the cervix (the lower part of the uterus) which gives an assessment of the risk of developing cancer. Testing for HPV (human papilloma virus) is also now part of the programme. The majority of cervical screening is undertaken in general practice, although GUM clinics and NHS and private hospitals also offer the test.

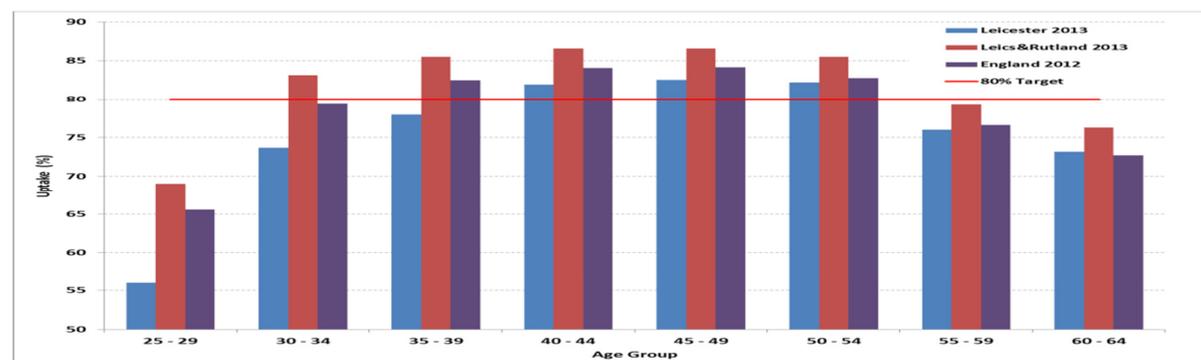
Historically, Leicester has had low uptake rates of cervical screening when compared against the England average. Coverage in Leicester has also been falling steadily since 2009, with coverage in 2012 being statistically significantly lower than the coverage obtained in 2009 (Figure 15). When analysing coverage by age, there is a lower uptake on screening locally from the younger women (25-34 years) and those over the age of 55 (Figure 16). There is no evidence that low screening rates are directly related to deprivation or ethnicity. However, the rates in Leicester are comparable to that of it's peer comparators (Figure 17).

Figure 15: Trend in cervical screening coverage (women aged 25-64, screened within 5 years) in Leicester and England



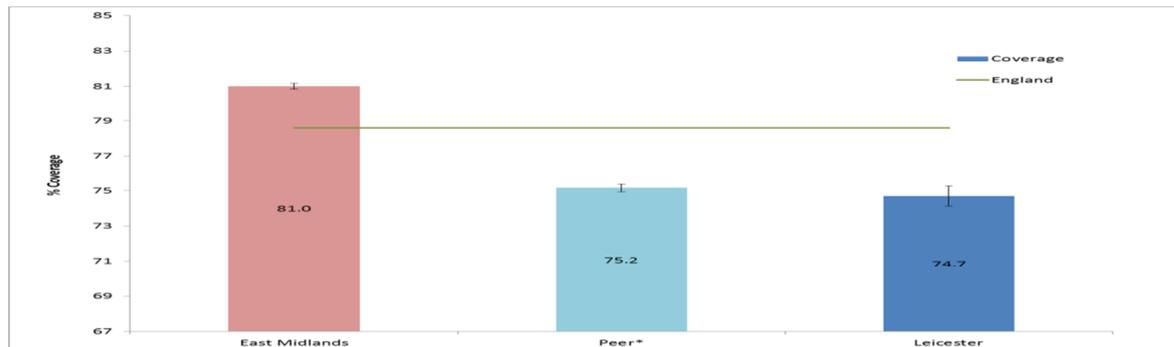
Source: NHS CSP Statistical Bulletins 2005/6 – 2011/12

Figure 16: Coverage of cervical screening by age group in Leicester, compared to Leicestershire and England



Source: NHS Shared Business Service KC53 Statistics 2013

Figure 17: Coverage of cervical screening in March 2012, compared to the national (England) and regional (East Midlands) average



*Peer = average for seven areas with socio-demographic indicators comparable to those in Leicester
Source: Health and Social Care Information Centre 2013

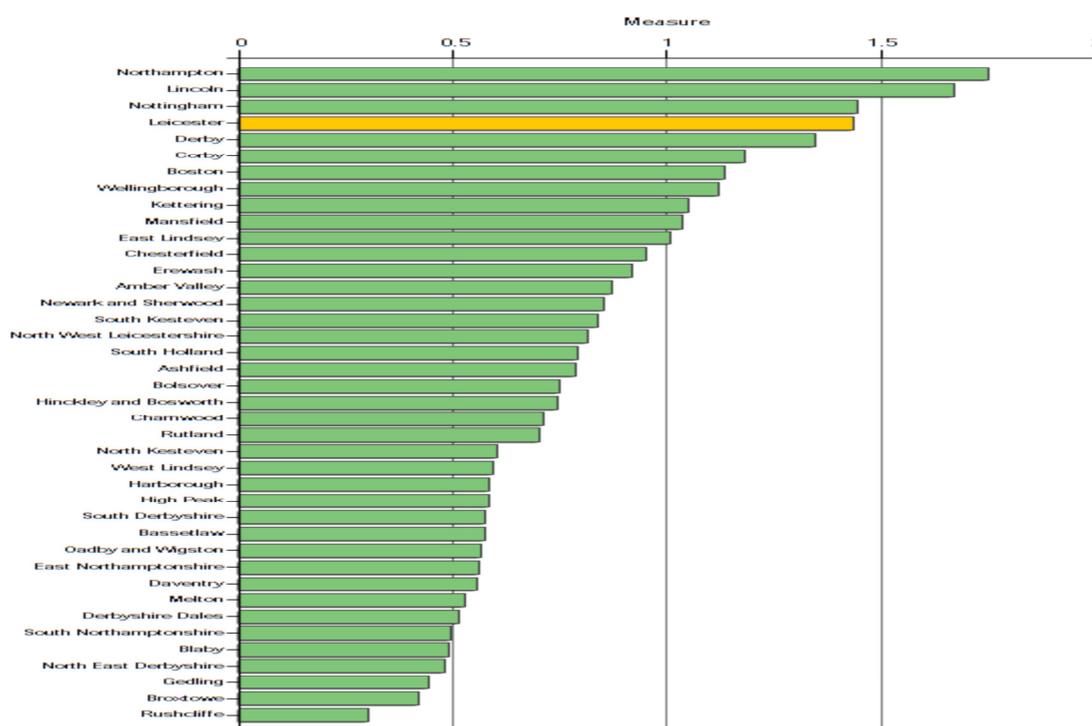
Sexual Violence

A Sexual Violence Needs Assessment was undertaken for Leicester in May 2013, details of which can be found here:

http://consultations.leicester.gov.uk/city-development-and-neighbourhoods/sas/supporting_documents/Sexual%20Violence%20Assessment%20May%202013.pdf

Data collected as part of the national Violence Indicator Profiles in the English Regions (VIPER) data set indicate that the 2011/12 crude rate of recorded sexual offences (1.4 per 1,000 population) for Leicester City is the fourth highest in the East Midlands (Figure 18). The number of sexual offences recorded in Leicester during 2011/12 was 441. Of this number, approximately 180 were seen at the Sexual Assault Referral Centre (SARC) at Juniper Lodge. However, comparison of locally recorded data of estimated numbers suggests that rape and other forms of sexual violence is under reported in Leicester. Estimates suggest that the likely figure lies between 379 (rapes) and 3173 (all sexual assaults). There is potential for approximately 200 unreported rapes/serious sexual assaults and 2732 sexual assaults across the city. Differences in how data is collected across the various services make it difficult to calculate the total number of clients accessing services. The confidential nature of the services provided means that it is difficult to establish whether the clients seen at the various services are all unique i.e. it cannot be established whether some clients are receiving support from more than one source.

Figure 18: Sexual offences, crude rate per 1,000 population (2011/12)



Source: Home Office recorded crime statistics and Office for National Statistics 2010 mid-year population estimates rounded

The Natsal survey (2011)^{vii} further reports that 9.8% of women and 1.4% of men had experienced non volitional sex in the previous year. The median age was 18 years for women and 16 years for men. In most cases the perpetrator was known to the individual. It was also shown that younger people are more likely to have reported to either the police or another individual.

4. Current services and assets in relation to need

There are a variety of sexual health providers within Leicester, covering various levels of service provision. The community of sexual health providers across Leicester, Leicestershire and Rutland is supported by several networks including:

- the Sexual Health and HIV network which meets twice a year in order to share developments and good practice
- a clinically focused group supporting GPs and community nurses with an interest in sexual health led by specialist clinicians in order to share clinical expertise (SHEATH)
- an HIV forum for community and statutory organisations

The **Integrated Sexual Health Services (ISHS)** was commissioned by the local authorities (Leicester City, Leicestershire County and Rutland County). It commenced on the 1st. January, 2014 and provides the following services:

- GUM services
- Contraceptive and Reproductive Health services
- Chlamydia screening programme
- Specific Young People services

- Choices
- Safer Sex Project
- Psychosexual services

From 1st January 2014, Staffordshire and Stoke on Trent partnership Trust (SSOTP) became the new provider for Leicester, Leicestershire and Rutland (LLR) Sexual Health Services (SHS) taking over services from 3 providers: University Hospital of Leicester, Leicestershire Partnership Trust and Leicester City Council:

- GUM and Contraception services from the acute sector at University Hospitals of Leicester (UHL)
- GUM services, Chlamydia Screening Programme and Prevention and Promotion services from Leicester Partnership Trust (LPT)
- Safer Sex Project from Leicester City Council (LCC)

Leicestershire County, Rutland County and Leicester City Councils have commissioned 'Integrated Sexual Health Services' in line with the national approach to commissioning (DH, 2013). The previous services were fragmented with different services being provided at different locations and centres. Additionally, GUM services were provided separately to contraceptive services.

The aim of the ISHS is to provide a range of accessible, high-quality, responsive, cost-effective, confidential services across Leicester, Leicestershire and Rutland (LLR) which support and provide elements of delivery of sexual health services in primary care and other community settings through the provision of professional training and co-ordination of a local managed sexual health service network. This new service is now delivering the following on a phased approach from January 2014:

- An open access Consultant-led Level 3 ISHS with levels 1, 2 and 3 provision in appropriate locations across LLR through a hub and spoke model of sexual health provision meeting all the sexual health needs of an individual in one visit
- Integration of STI management and contraceptive provision into one visit
- Clinicians and nurses who are dual trained and able to meet the needs of the individual no matter what concern or condition they present with, minimising the need to see multiple practitioners
- Multidisciplinary working that utilises the skills of clinicians and non -clinicians in a cost effective and clinically appropriate manner
- Extension of opening hours from/between 9am to 8pm on weekdays (Monday to Friday) and from/between 10am - 3pm on Saturdays
- Young people's specific ISHS (for the under 25s)
- Outreach and targeted work to those most at risk through an integrated Prevention and Promotion model to include but not exclusive to the delivery of education, access to free condoms and lubricant, chlamydia screening and Safer Sex project
- Provision of a domiciliary service for residents who are unable to access local services
- A specialist psychosexual counselling service for clients aged 16 and over
- Delivery of level 1 and level 2 services in primary care through the co-ordination and delivery of professional training, care pathways and the co-ordination of a local sexual health network

The new provider is also moving towards providing the following opening hours by the end April 2014.

Hubs opening times:

- Opening times will be between 09:00 – 20:00 Monday to Friday. The first appointment commencing at 9:00. The last available appointment will be 19:15. Services will be offered as follows:
- 09:00 – 14:00 Monday to Friday – Walk in clinics for levels 1, 2 and 3. Appropriate staff always available to provide advice and treatment.
- 14:00 – 18:00 Booked appointments for levels 1, 2 and 3. To ensure a truly integrated service, users will be seen by a clinician according to their highest level need
- 16:00 – 20:00 Walk in clinics for levels 1, 2 and 3
- Service users under 16 years will be seen at any time of the day, to increase their access to services.
- Appointments will be held for release on the day to enable urgent patients to be seen.
- 10:00 – 15:00 Saturday. A mixture of walk in and booked appointments for levels 1, 2 and 3. Staff will attend the clinic from 09:30am with the first appointment commencing at 10am. The last appointment will be 14:15

Spokes opening times:

Spokes will be grouped into local areas with between two and four open each afternoon and evening across LLR and always at least one open per local area, within the groupings. Evening clinics will run until 20:00. There are ten spokes in Leicester some are provided under the Sexual Health And Contraceptive Clinics (SHACC) system where they are embedded in general practice appointments to maintain confidentiality. Spokes will have an even number of walk in and booked appointments. Timings and location of clinics will be continually reviewed to ensure that these are being delivered in accordance with level of need.

Young people's opening times:

The times and locations for young people's services will be monitored through regular consultation with young people across LLR in order to maximise their possible access. They are currently Beaumont Leys Health Centre, various Further Education colleges, both Universities and some community youth venues. A number of spoke locations will operate in 'young person specific' locations, including schools, colleges and universities. At least 1 evening session and 1 daytime session will be specifically allocated at each Hub for the provision of Young Person specific clinics.

Outreach service times:

Outreach clinics/activities will be delivered at a variety of locations, including but not limited to male saunas, colleges and universities, voluntary sector organisation premises and through the mobile unit. Working in conjunction with the voluntary sector, locations for outreach services will be identified and support provided to these organisations within their established networks. Evenings and weekends will be included.

In addition to the ISHS, there are other services which deliver elements of sexual health services in Leicester as follows:

General Practice provides the majority of contraceptive provision for registered patients via additional services of the General Medical Services (GMS) contract. This does not include the provision of IUDs and Implants. Although it is not a mandatory requirement for GPs to provide this additional element of the contract, all GPs in Leicester have signed-up to providing this service. GMS contracts are commissioned by the Area Teams of NHS England.

Pharmacy EHC is currently available free of charge to those under 25 in 41 community pharmacies in Leicester. Only pharmacists who have undertaken training for the Patient Group Direction are allowed to participate in this scheme. Service provision may not always be consistent or available every day (as not all pharmacists in each pharmacy are trained). Most of the provision for this service has been delivered by 5 pharmacies contracted in the scheme.

Termination of pregnancy services are commissioned by the CCG. Commissioned services are provided by University Hospitals of Leicester up to 12 weeks gestation and by British Pregnancy Advisory service (BPAS) for terminations between 13 and 24 weeks. BPAS service provision is located outside of Leicestershire and therefore women need to travel in order to gain access to the clinics. The service is not open to self-referrals and a referral from a health professional (e.g. GP, community based nurse) or from the ISHS (from Jan 2014) is required.

Vasectomy services are commissioned by the CCG and currently provided in a variety of settings:

- University Hospitals of Leicester where treatment is provided under:
 - local anaesthesia at the Contraceptive and Reproductive Health Services located at St Peters Health Centre
 - general anaesthesia (for complex cases) via their Urology Services
- Two SHACC practices provide vasectomies under local anaesthetic

The CCG has also recently procured a scalpel-less service to replace the contraceptive services and SHACC vasectomy provision. Details of this are not currently available.

Sterilisation services are commissioned by the CCG and delivered locally. However, it was not possible to obtain further detailed information of service provision.

HIV treatment and care is commissioned by NHS England (Area Team) and is primarily provided through secondary care by the specialised departments of Infectious Diseases and HIV at University Hospitals of Leicester. The delivery of HIV care and treatment is supported by a variety of skill-mix within the workforce and associated services:

- Medical specialists
- HIV specialist midwifery
- HIV Health Advisory service
- Clinical HIV psychology service
- HIV Pharmacology service

- Specialist hepatitis C nursing for co-infected Hepatitis/HIV patients,
- HIV clinical nursing for community-based care
- Paediatrics-HIV care with family clinics

Social care is provided by the adult and social care team at the local authority where housing advice and social care support which can be accessed by those living with HIV. Additional support, advice, information, advocacy and mentoring can also be accessed through the voluntary sector organisations (LASS and Faith in People).

There are no general practices providing enhanced care for HIV in primary care. The delivery of post-exposure prophylaxis is commissioned by the local authority, although NHS England funds the costs for the drugs.

Sexual Assault and Rape Centres are currently jointly commissioned by the three Clinical Commissioning Groups and the Police and Crime Commissioner for Leicester, Leicestershire and Rutland, although the commissioning responsibility is due to be transferred to NHS England in 2015. There are 2 Centres in Leicester: 1 for adults and 1 for children and young people. Leicestershire Constabulary provides the current service which is available 24 hours a day for those reporting sexual assaults/violence. These centres are safe locations where victims of sexual assault can receive medical care, counselling and forensic examination quickly and sympathetically. The Independent Sexual Violence Advisor (ISVA) is only available to those over the age of 16. There is currently no ISVA service for those under 16 years. Additionally, victims are offered emergency contraception, STI screening and referral to the GUM clinic for sexual health follow-up.

Prison sexual health services are commissioned by NHS England Area Team. Leicester has one prison, with current provision consisting of 'GP related sexual health services' for prisoners. Those requiring more complex STI or HIV treatment and care are referred to the services at University Hospitals of Leicester. It has not been possible to obtain further information on the level or nature of sexual health service provision at HMP Leicester. LASS (voluntary sector organisation) provides some support to HIV individuals in prison and some testing for prisoners.

Relationship and Sex Education (RSE)

RSE is important to ensure that both healthy and enjoyable sex lives are nurtured and developed. Sex education is a required part of the curriculum in state schools but this is not prescribed. There is, however, guidance from the Secretary of State on what should be provided. In Leicester, there are differing levels of RSE provision in the 19 state secondary schools, with some schools utilising school nurses in RSE provision and some buying in various national and local organisations to provide RSE support to teachers. In the last 2 years, some funding has been allocated to commission:

- a strategic lead to liaise with schools in promoting RSE via an RSE strategy
- a RSE advisory teacher to help schools develop good practice

The funding for these posts is due to cease soon.

Health Shops

These are enhanced school nurse sessions offering weekly scheduled and/or drop-in appointments in participating secondary schools. The health shops operate flexibly

with opening times that are convenient to young people. There is no current data available on the number of contacts made with the health shops.

Independent voluntary organisations

The main independent voluntary organisations providing sexual health services in Leicester are listed below. These organisations receive funding from a variety of sources and provide some services that are not funded by local authority or health commissioners.

TRADE

This service offers a range of sexual health and HIV information (as well as other health information) and support for the MSM community. It provides web and telephone based support and signposting, drop in facilities and undertakes health promotion at a range of targeted events. These include: outreach work and condom distribution at Public Sex Environments (PSEs) in Leicester, face to face work (safer sex messages and issues around sexuality), telephone support, safer sex messages issues around sexuality, sign-posting as well as group work with men who are married to women and attracted to other men. TRADE also works closely with nationally funded HIV and sexual health organisations.

Leicestershire AIDS Support Service (LASS)

This service provides direct support and advocacy to those affected by HIV/AIDS, rapid HIV testing as well as education and awareness raising to promote positive sexual health. This includes drop in and women's groups, help with managing HIV and social support. Rapid testing services are also offered in community settings. Due to low HIV testing uptake in some African communities, LASS trains volunteers from these communities as champions who can provide testing and information. The service also provides regular health education sessions in schools, colleges and a variety of community groups. LASS also works closely with nationally funded HIV and sexual health organisations including Health Promotion England (HPE).

Faith in People with HIV

This service offers pastoral and spiritual support to people affected by HIV. They work with people of all religious faiths, including those with no religious beliefs. The service is open to anyone who is living with HIV or affected by it (e.g. partner, family, carer) irrespective of background, culture, beliefs, ethnicity, sexuality, age or disability. They also help raise the awareness of HIV in faith communities and other groups whilst seeking to foster understanding and to break down barriers of stigma and discrimination.

The New Futures project

This service supports girls and women, boys and men involved in or at risk of exploitation through prostitution. They provide outreach work to both men and women who work in saunas, massage parlours and on the street. Drop in facilities and home visits are also provided.

Sexpressions

This is a national organisation affiliated to students unions whereby medical students are trained to provide peer led RSE in schools and other sexual health promotion activities. The Leicester branch provides this and has potential to expand into more schools and to develop a branch with the Nursing students at DMU.

New Dawn New Day

This is a voluntary sector organisation in Leicester that provides parent and child RSE training.

5. Projected service use and outcomes in 3-5 years and 5-10 years

There is a clear relationship between sexual ill health, poverty and social exclusion. Leicester is the 20th most deprived local authority in England, with almost half of the population living in areas of very high deprivation. It is also one of the most ethnically diverse cities in the country and has a relatively young population, with 45% of the local population being under 29 years of age. According to Census figures, Leicester saw the highest growth in its local population by 47,100 people (almost 17% increase) between 2001 and 2011. Leicester's population growth is expected to continue to rise, with the elderly population being predicted to increase at a much slower pace compared to the increase in the young and working age population.

Whilst the local population has been growing, indicators of sexual and reproductive health need have been deteriorating over the past decade which has been linked to long-term changes in sexual behaviour and patterns of contraceptive usage within the population. New HIV cases among MSM have also shown sustained year-on-year growth. This creates a complex picture of continual need for sexual health services. Population sexual health is however highly amenable to public health interventions, including high quality and age-appropriate RSE, accessibility to contraceptive, treatment and care services; as well as targeted interventions at specific groups with higher needs or risks. Therefore, addressing and reducing, or at least ameliorating, these trends are of significant importance.

Although the full impact of economic migration into Leicester is difficult to quantify, areas in which poverty levels are high are generally those that have the most rapid increases in population and the highest fertility levels. Evidence suggests that halting population growth by investing in sexual and reproductive health and HIV prevention (particularly among adolescents), education, personal empowerment and gender equality can reduce poverty. With a significant continual growth expected in the young adult population in Leicester, a continued increase in the focus on sexual and reproductive health services is required. There is also an increased need to ensure that relationship and sexual health programmes address the greater vulnerability of adolescents to unprotected sex, sexual coercion (including grooming), HIV and other STIs and unintended pregnancies (whilst enabling them to delay pregnancy) as these are also important factors in breaking the intergenerational cycle of poverty.

Late diagnosis of HIV infection adds to the overall cost burden on services as treatment may not always be as successful if presenting co-morbidities exist. This can then also lead to further or extra requirements for both health and social care support. As more people are living longer with HIV infection, there will also be a rise in the number of infected people seeking support and care. Secondary services need to reflect the aging HIV population who develop new

co-morbidities as well as newly diagnosed patients. And, as the number of people affected by HIV infection increases, there will be further expectations of provision as partners, families and carers also require support.

6. Evidence of what works

The cost of treating STIs nationally (excluding HIV) is estimated at £170million. There is evidence demonstrating that spending on sexual health interventions and services is cost effective:

- For every £1 spent on contraception, £11 is saved in other healthcare costs^{viii}
- The provision of contraception saves the NHS £5.7 billion in healthcare costs that would otherwise have been spent if no contraception was provided^{ix}
- Cost savings can be realised if the utilisation of LARC methods is increased^{xiii}
- Early testing and diagnosis of HIV reduces treatment costs: £12,600 per annum per patient, compared with £23,442 with a later diagnosis^x
- Early access to HIV treatment significantly reduces the risk of HIV transmission to an uninfected person with consequential cost savings^{xi}
- Improvements in the rates of partner notification reduces the cost per chlamydia infection detected^{xii}
- Interventions that are evidence-based and lead to behaviour change are cost effective (e.g. free condom provision, assertive outreach health promotion, needle exchanges, sex and relationship education targeted at specific groups)
- Early treatment of STIs and partner notification are cost effective interventions
- Screening strategies targeting high risk populations that lead to early identification and treatment are cost effective as they avert future costs of dealing with complications and onward transmission

Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity; with some groups being at particular risk of poor sexual health. The overall cost of sexual health promotion is minor compared to the costs of treating STIs and unintended pregnancies. There is ample evidence that sexual health outcomes can be improved by:

- accurate, high-quality and timely information that enables people to make informed decisions about relationships, sex and sexual health^{xiii}
- preventative interventions that build personal resilience and self-esteem whilst promoting healthy choices^{viii}
- rapid access to confidential, open-access, integrated sexual health services in a range of settings that are accessible at convenient times^{xiv}
- early, accurate and effective diagnosis and treatment of STIs (including HIV), combined with partner notification^{viii} (in order to manage and control STIs by protecting patients from re-infection, partners from long-term consequences from untreated infection and the wider community from onward transmission)^{xv}
- LARC methods are much more effective at preventing pregnancy than other methods, although a condom should also always be used to protect against STIs^{xvi}
- joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this includes community gynaecology,

antenatal and HIV treatment and care services in primary, secondary and community settings^{xvii}

There is also evidence^{xviii} to show that preventative interventions that focus on behaviour change and are based on behaviour-change theory have been effective in promoting sexual health. NICE has also suggested that helping people to work through their own motivations by encouraging them to question and change their behaviour can form a key part of preventative interventions in reducing STIs (including HIV) and reducing the rate of under 18 conceptions, especially among vulnerable and at risk groups^{xix}. Effective behaviour change interventions:

- draw on a robust evidence base
- are targeted at specific groups and take account of their specific influences and motivations to change
- include provision of basic accurate information with clear messages
- promote individual responsibility and focus on motivating the individual to change; and make use of 'changing contexts' models for 'nudging' people into healthier choices while recognising that such choices are influenced by complicated drivers of human action, including gender roles, inequality and norms around sexuality^{xx}

There is increasing evidence that unplanned pregnancies have poorer pregnancy outcomes with children that are born tending to have a more limited vocabulary with poorer non-verbal and spatial abilities. These differences are almost entirely explained by deprivation and inequalities^{xxi}. Although teenage conception may result from a number of causes or factors, the strongest empirical evidence for prevention are:

- high-quality education about relationships and sex^{xxii}
- access to and correct use of effective contraception^{xxiii}
- educational attainment which has a strong correlation with planned pregnancies.

HIV is responsible for a significant burden on NHS resources. The average lifetime treatment costs for an individual who is HIV positive is around £135,000-£185,000. Due to recent increases in drug costs and longer life expectancy, this amount is more likely to be around £276,000. Nationally, preventing each onward transmission of HIV could save £1million in health benefits and treatment costs, with key recommendations as follows:

- increasing the number of HIV tests in non-specialist healthcare in areas with a high prevalence of HIV^{xxiv}. Findings from pilot projects indicate that offering HIV tests outside sexual health clinics is feasible and acceptable to patients as well as staff^{xxv}.
- increasing the uptake of HIV testing among black Africans in England^{xxvi} and MSM^{xxvii}. A recent review also suggests that rapid testing in community settings and intensive peer counselling (where appropriate) can increase the uptake of HIV testing among gay and bisexual men^{xxviii}.

Furthermore, services for those people living with HIV infection should meet national specialist service standards and quality indicators outlined by the British HIV Association. Secondary care services should provide confidentiality and ease of

access to newly diagnosed patients, and reflect the changing demographics and aging of people living with HIV infection.

7. Unmet needs and service gaps

There is a need to make improvements in the following areas of sexual health services in Leicester:

HIV testing, diagnosis and care:

Significant numbers of HIV cases remain undiagnosed and access to HIV testing requires further improvement. In 2012, HIV testing was offered to 79% of attendances with acceptance rates of 75% by Leicester residents attending GUM clinics. This is against a national figure of 79% of GUM attendances offered HIV testing with an acceptance rate of 81%. There is limited community engagement and testing within community settings and primary care. There is currently no GP enhanced care for HIV in primary care.

Little is currently understood with regards to:

- the pathways for HIV Support and Care
- cost effectiveness of delivering high cost treatments
- the number of post-exposure prophylaxis required and delivered
- the total picture regarding HIV testing across the voluntary and statutory sectors

Chlamydia screening:

Leicester should be working towards achieving the new chlamydia diagnosis rate of 2,300 per 100,000 (*Public Health Outcomes Framework* indicator). The previous target of 2,400 per 100,000 (15-24 year olds) was not met. It is understood that participation in the scheme from pharmacists is low and that the current agreement with GPs remunerates coverage rather than targeting resources at specific young people at the greatest risk of having a positive result.

Termination of pregnancy services:

If the gestation of pregnancy exceeds 12 weeks, patients are referred to BPAS which provides the service outside Leicestershire. This may be an issue for some patients. The overall rate for termination of pregnancy in Leicester is low and the reasons for this need to be explored to ensure that access to services is not a barrier. Further information should also be sought on the proportion of women who are offered and take up LARC methods. It is also not understood if the termination of pregnancy services provide STI testing as well as contraception for their patients.

Long Acting Reversible Contraception:

Information on the promotion and uptake of LARC requires improvement, as current datasets are not standardised, which does not allow for adequate analysis.

Emergency Contraception:

The Contraceptive and Reproductive Health Service, based at St. Peter's Health Centre provides a good service. However, there is currently limited weekend and

out-of-hours provision from this service for those who require emergency contraception after 72 hours of unprotected sexual intercourse. There is a pharmacy EHC scheme in the City and although 41 pharmacies have signed up to the scheme, service provision has not been consistent with only 5 pharmacies providing a regular service. These services do not provide free pregnancy testing due to various issues e.g. accessibility to toilets etc.

Contraceptive provision in General Practice:

Little is currently understood about the contraceptive provision in primary care, which is part of the GP additional services in the GMS contract.

Community contraception:

Community contraceptive and sexual health services are currently offered on an appointment and drop-in basis. Whilst some contraceptive clinics are currently provided during the evenings, there is no weekend provision in the all-age service. Choices nurses are trained to provide LARC (depo-provera injections and SDis) but school nurses only provide condoms and pregnancy testing as there is no routine LARC training for the nurses in Leicester. Furthermore, although school nurses in the County can prescribe EHC under a PGD, this is not available in Leicester, where young people would be directed to Choices or contraceptive services. Anecdotal information states that this is because the schools do not want EHC to be given out on their premises: this issue should be explored further.

There is no C-Card scheme for 13-25 year olds in the City. A C-Card scheme is where community venues e.g. pharmacies act as pick up points to enable those registered on the scheme to pick up free condoms, thereby allowing wider access. The C-Card scheme in the City has been explored in the past but it was concluded that accessibility provided by the Safer Sex team was good.

Relationships and Sex Education:

Leicester City schools play an important contribution in influencing and developing young peoples' sexual health and wellbeing through their responsibility to provide effective RSE. Further and Higher Education establishments also have a key role to play in ensuring that students have access to sexual health information, advice and services. Although there is guidance on RSE, there is no standardisation in terms of RSE delivery in the City.

Cervical screening:

There is a need to improve uptake for cervical screening, particularly for younger women aged 25 -24 years and older women aged 55 and over.

Teenage pregnancy:

There should be a continued focus on reducing teenage conceptions. The current Teenage Pregnancy Strategy is out of date.

Psychosexual services:

The extent of population need and the patient pathway for these services is not fully understood.

Sterilisation and Vasectomy:

The service delivery and patient pathways are not currently understood.

Prison Sexual Health services:

The service delivery and patient pathways are not currently understood.

Voluntary care organisations:

Although there is regular monitoring, there is little data that is currently available on sexual health outcomes.

Behaviour change interventions:

Limited social marketing exercises have been undertaken to determine appropriate behaviour change interventions. It may be possible to explore these in partnership with other services eg Drug and Alcohol services. This would benefit both services.

Integrated Sexual Health Services:

The ISHS commenced in January 2014 and is currently developing patient pathways.

Service user input:

There is limited service user input into the development of services. There is currently no evidence of any patient satisfaction survey undertaken by providers.

8. Recommendations for consideration by Commissioners

No.	Recommendation	Commissioners		
		Leicester City Council	Clinical Commissioning Group	NHS England Area Team
1.	Explore effective ways of engaging service users and community groups in the delivery of sexual health services	X	X	X
2.	Ensure patient satisfaction surveys are undertaken by providers	X	X	X
3.	Ensure clear patient pathways to and from the ISHS to ensure safe and seamless patient journeys	X	X	X
4.	Ensure increased partnership working between key organisations, agencies and community groups with the ISHS	X	X	X
5.	Increase social marketing exercises in order to determine appropriate behaviour change interventions and accessible services in line with national campaigns	X		
6.	Increase sexual health promotion outreach work, especially for vulnerable groups: BME groups, refugees and asylum seekers,	X		

	children looked after, youth offenders, those with learning disabilities, sex workers, drug and alcohol users etc.			
7.	Engage local communities to act as champions and role models to encourage involvement in sexual health promotion and HIV testing activities	X		
8.	Produce sexual health promotional material in partnership with local communities that are tailored to their needs using (where appropriate) nationally developed materials	X		
9.	Update the teenage pregnancy strategy and ensure that those at risk of under 18 conceptions are identified with early help and support	X	X	X
10.	Support schools in their responsibility to provide high quality RSE and ensure provision of high quality RSE out of school in conjunction with the school nursing service, outreach services, youth service, children looked after and teenage pregnancy initiatives	X		
11.	Run programmes to increase self-esteem, communication and negotiation skills targeted at young people at risk of poorer sexual health outcomes	X		
12.	RSE at school and in the community should also raise awareness of sexual violence and rape. This should include partnership working with the local police	X		
13.	Deliver collaborative, holistic and integrated harm reduction interventions that specifically target the most vulnerable communities	X		
14.	Enhance cervical screening awareness, particularly across specific population groups and improve cervical screening pathways	X		X
15.	Ensure that pathways for sterilisation and vasectomy services are understood			X
16.	Develop comprehensive and standardised data collection for all contraceptive services	X	X	X
17.	Further innovative ways of improving access to LARC and EHC should be explored in order to maintain focus on reduction in teenage conceptions	X		
18.	Review the current delivery of all sexual health commissioned services to ensure	X	X	X

	cost-effective delivery, promote integration, quality, value for money and innovation in the further development of sexual health interventions and service			
19.	An assessment of the training and education needs for local primary care teams in order to enable them to confidently undertake risk assessments and treatments should be considered as a mechanism for improving access to services	X	X	X
20.	Prevention efforts, such as increased STI screening and HIV testing should be sustained and continue to focus on groups at highest risk	X		
21.	Ensure Equality Impact Assessments are regularly undertaken by all providers and reported upon	X	X	X
22.	Continue embedding Chlamydia screening in primary care and sexual health services which emphasise regular repeat screenings as appropriate	X		
23.	Continue focus towards achieving a chlamydia diagnosis rate of at least 2,300 per 100,000 (15-24 year olds)	X		
24.	Explore the provision of GP enhanced care for HIV in primary care			X
25.	Develop patient pathways for psychosexual counselling	X	X	
26.	Develop coherent HIV testing policy which increases the accessibility and availability of HIV testing in acute trusts, primary care and community outreach services that is targeted at specific risk groups	X	X	X
27.	Develop optimum HIV health and care pathway	X		X
28.	Support women with unwanted pregnancies to make informed decisions about their options as early as possible		X	
29.	Ensure STI (including HIV) testing as well as contraceptive services are provided by TOPs	X	X	
30.	Develop Sexual Health Strategy and commissioning action plan	X	X	X

9. Recommendations for needs assessment work

- HIV testing audit against CMO and PHE guidance.
- Late diagnosis of HIV retrospective audit.
- Post-exposure prophylaxis audit.
- Contraception services equality access audit.
- Sexual Health Equity Audit.
- Sexual Health Needs Assessment of MSM in Leicester.
- HIV health and care needs assessment.
- Sexual Health needs assessment for Black African communities in Leicester.

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