SEXUAL HEALTH IN LEICESTER: A SUMMARY NEEDS ASSESSMENT

March 2023

Leicester City Council

Contents

1.0 Executive Summary

According to the World Health Organisation, sexual health is 'a state of physical, emotional, mental and social wellbeing related to sexuality' and about more than just the absence of disease. In terms of sexual health care and services, the local authority commissions a wide range of services to meet the needs of the population including:

- Sexually Transmitted Infections (STI) testing and treatment
- Contraception
- Human Immunodeficiency Virus (HIV) prevention and community care
- Sexual health aspects of psychosexual counselling
- Sex and relationships education for children and young people
- Specialist sexual health services and support to those with greatest need

The requirement for these services is enshrined in the terms of the Public Health Grant, reflecting the importance of sexual health services to the population, as well as their efficacy and cost efficiency; interventions funded by the public health grant provide excellent value for money.

In Leicester, an Integrated Sexual Health Service (ISHS) provides access to these services via a city centre hub, and various outreach 'spoke' clinics. In addition, GPs are commissioned to provide long-acting reversible contraception (LARC) and community pharmacies to provide emergency hormonal contraception (EHC) to under 25s free of charge.

Leicester City has a population of 369,600 people according to the 2021 census (ONS) and this is growing at a faster rate than the rest of the country. Leicester also has a younger than average population, and a very diverse one, with people from many different ethnic backgrounds living in the community. These aspects of Leicester's population create specific challenges when it comes to sexual health. This needs assessment looks at sexual health outcomes in the city, along with current services, gaps in provision and recommendations for commissioners.

<u>Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV)</u>

Overall, Leicester ranked 53rd out of 149 Upper Tier and Unitary Local Authorities for new STI diagnoses (excluding chlamydia) in 2021. Rates of new STI diagnoses in the city are decreasing and in 2021 there were 1,239 new STIs diagnosed, equal to a rate of 350 per 100,000 population which is significantly lower than the national average of 394 per 100,000. If you include chlamydia diagnoses, Leicester's rate becomes 570.8 per 100,000 which in contrast is *higher* than the national average of 550.3 and third highest in its comparator group.

Around 61% of all new STI diagnoses in Leicester are in young people (15-24), which is higher than the national rate of 49% and may be at least partly reflective of Leicester's higher population of younger people than other similar cities.

Young people in the city are also more at risk of repeat STI diagnosis than other age groups, with 10.5% of 15–19-year-old women and 8.3% of 15–19-year-old men becoming re-infected within 12 months in Leicester between 2016 and 2020. The equivalent figures for England were 10.9% of 15–19-year-old women and 9.8% of 15–19-year-old men.

Rates of new STI diagnosis in the city tend to correlate with deprivation; those living in more deprived areas are more likely to experience a new STI. However, the highest rates are in the City Centre MSOA which is probably reflective of its proportionately larger under 25 population and student population.

Chlamydia remains the most commonly diagnosed STI, and the public health outcomes framework (PHOF) has an indicator of chlamydia diagnosis rate, with a target of 2,300 per 100,000. Rates of chlamydia diagnosis remain very similar to the national average, mirroring the trends closely including the abrupt fall in 2020. Chlamydia diagnosis rates are higher in the west areas of the city.

Nationally, the increase in rates of gonorrhoea has been a concern, and this has been noted in Leicester too with rates barely falling in line with other STIs during the period 2020-21. Leicester still has one of the lowest rates amongst its comparator cities however with a rate of 89.3 per 100,000 compared with Nottingham's 138.2 per 100,000 and the England average of 90.3 per 100,000.

Leicester is considered an HIV prevalent area, with a rate of 4.0 per 1,000 population aged 15-59 years, which is the highest in its comparator group and significantly higher than the England average of 2.3 per 1,000. Leicester is ranked as the 6th highest prevalence of HIV outside London.

Of concern in Leicester are the comparatively higher numbers of late diagnoses of HIV than the England average. It is of note however that these overall numbers are small and therefore must be interpreted with caution. These rates were highest in heterosexual men, followed by heterosexual and bisexual women, suggesting that more work needs to be done with these groups in terms of HIV awareness and prevention.

Leicester City's HIV testing coverage indicators are better than average across the board which may reflect all the work being done in the City to promote testing uptake.

There is currently no commissioned or un-commissioned support specifically for people living with HIV from Leicester's black African communities. In addition, we know that many of Leicester's at risk population are in this group, particularly black African heterosexual men and women. HIV Pre-exposure prophylaxis (PrEP) is now commissioned as part of LA commissioned sexual health services and is an effective way of preventing those at risk from contracting HIV. However uptake has been less than predicted, and particularly so in black African heterosexual men and women, as well as members of other ethnic minority communities, and those for more deprived backgrounds.

Contraception

Nationwide in 2020/21 there were a total of 1 million consults for the purpose of contraception at dedicated NHS Sexual and Reproductive Health (SRH) clinics. This was down 22% from the previous year, continuing a pattern of decreasing numbers since 2014/15. In the year 2020/21, a total of 54% of users opted for a user-dependent method such as the pill, and 46% chose a long-acting reversible method (LARC) such as the implant or coil. Generally speaking, older women tend to favour LARC methods, whereas those in younger age groups tend to prefer user dependent methods.

LARC are recommended by the NHS because they are cost effective and generally well tolerated. They often follow a 'fit and forget' model wherein they can be used for 3-5 years following fitting (12 weeks in the case of depo injections)

In Leicester, there are currently 28 GP practices offering LARC services, and the rate of uptake of LARC is less than the national average, particularly among certain ethnic minority communities. GPs provide contraception as part of their core contract as well as being commissioned by the local authority to provide LARC. Although availability of data makes it difficult to map provision, it seems that there is a year-on-year decrease of prescribing and spend on contraception in general practice. This may reflect the diversification of sexual health provision with younger users preferring to access online services, or to go to the ISHS. There is also an ongoing pilot by NHSE for community pharmacies to provide oral

contraception prescriptions (initially just repeats but eventually primary scripts too) which provides yet another avenue to access contraception and further diluting the numbers in general practice

Termination of Pregnancy

The rate of abortion (termination of pregnancy, TOP) in Leicester in 2020 was 20.6 per 1000 women aged 15-44. This was significantly higher than the England average of 18. This was an increase on previous years. This increase is complicated to interpret since it may represent an increase in unplanned pregnancies (and by extension un-met contraceptive need) but it may also reflect increased access to TOP services where needed, which would be a positive interpretation. Termination services in Leicester are offered by both the British Pregnancy Advisory Service (BPAS) and at University Hospitals Leicester (UHL). Both services can now be accessed by self-referral as well as GP referral.

Teenage Pregnancy

The under 18 conception rate in the city has reduced significantly over the last twenty years, falling a massive 80% between 1999 and 2020. The rate in 2020 was 11.4 per 1,000 15-17 year olds, which is similar to the national average. Teenagers are the most at risk of unplanned pregnancy, with the vast majority of under 18 pregnancies being unplanned, and young parents and their babies suffer disproportionately poorer outcomes. Although the overall Leicester rate is similar to the national average, there is significant variation across the city, with the more deprived wards in the south and west of the city having significantly higher teenage conception rates than the national average. Thus, care provision with a focus on young people is particularly important in these areas.

Vulnerable Groups and Outreach Work

Sexual health is not evenly distributed throughout the population, and certain groups experience disproportionately poorer outcomes. The demography of Leicester creates specific challenges for providing sexual health services; there is a larger than average younger population (the group that traditionally use services more) and this section of the population is forecast to increase at a greater rate than other similar cities. In addition, many of the population of Leicester live in deprived areas; with around 11% of the population living in one of the top 5 most deprived areas nationally. Leicester is an incredibly diverse city and has communities from many different backgrounds, cultures and ethnicities, with hundreds of community languages spoken. This can make designing universally accessible services challenging, when the needs of individual communities can be very different. Sometimes this is related to relatively newly arrived communities for whom there is a language barrier or a misunderstanding of how the health system works, but sometimes this is still the case for our more established communities, where the issue is more one of trust and engagement with health services. Teenage pregnancy rates, STI rates, access to and uptake of contraception, unplanned pregnancies and cervical screening uptake rates all show significant variation across the city and tackling these disparities is a priority. Additionally, our current service undertakes outreach work with some of our particularly vulnerable communities at risk of poor sexual health, including commercial sex workers both on premises and on street, GBMSM in the city, and people newly arrived to the city including refugees and asylum seekers.

Recommendations for commissioners

There is a comprehensive table in the full report containing 33 recommendations based on the findings of the HNA and the previous one, along with who has responsibility to input into that recommendation. However, there are a few key headline recommendations worth highlighting here:

1. There must be equity of access to the service for all our residents, which means a flexibility of approach in terms of online vs face to face provision and bookable and sit and wait appointments
2. A co-production approach is vital to ensure a service which works for all; and this means listening to communities, especially those whose views are less often heard, and those we see over-represented in poorer sexual health outcomes, about what they need from the service
3. Further outreach work is required with specific communities to address disparities in outcomes, such as increasing PrEP uptake in black African heterosexual female populations, encouraging young GBMSM to repeat test for HIV and working with young people and those in the most deprived areas of the city to help decrease repeat STI and teenage pregnancy rates.
4. Use the opportunity offered by the formation of the new ICS to create a more integrated approach to sexual and reproductive health services against the complex commissioning landscape which currently exists
5. Work across the system (including with Community Wellbeing Champions and VCSE network partners) to increase uptake of cervical screening in the City
6. Establish a single point of access (SPA) for women in the City who wish to have a LARC fitted, so that access is simpler and easier which will help to address the current low uptake in some communities.
7. Improve access to and availability of post-natal contraception so that women can leave the hospital after delivery with a fixed plan for their contraception, and even have a LARC fitted on the post-natal ward if desired and suitable.
8. Continue to work towards the new PHOF target of chlamydia detection rate of 3500 per 100000 women under 25
9. Continue surveillance of syphilis and gonorrhoea rates in the population and act promptly on increases
10. Address disparities in STI rates in different ethnic minority communities in the city by working with those communities to find out how to make the service work for them
11. Tackle comparatively high rates of late diagnosis of HIV by considering expansion of HIV testing opportunities such as
    a. Opt-out testing in A+E departments
    b. Offering HIV testing to all women undergoing a termination of pregnancy
    c. Offering HIV testing to new GP registrants in the city
12. Increase HIV prevention by raising awareness and increasing uptake of Pre-exposure prophylaxis (PrEP), particularly in communities who currently are underrepresented in the usage data

1.1 Recommendations for consideration by commissioners

Service Design/Organisation Recommendations				
No.	Recommendation	Leicester City Council	Integrated Care System	NHSE Regional
1.	Ensure equity of access for all Leicester residents with a balance of online, telephone and face to face consultations as per user preference	x	x	
2.	Ensure that the movement of more services online and potential digital exclusion does not lead to the widening of health inequalities	x		
3.	Use a co-production approach to service design and utilise existing community networks to make the most of engagement opportunities to further understand the needs of communities and how they want their sexual health services to look.	x	x	x
4.	Ensure clear patient pathways to and from the ISHS and understand how services commissioned by different partners can be seamlessly linked for straightforward patient journeys.	x	x	x
5.	Ensure a truly integrated approach to sexual health across the system by increased partnership working by LA, the ICB, UHL, the ISHS, the voluntary sector and the community	x	x	x
6.	Develop place-based collaborative commissioning action plan for sexual health services with ICS and other partners	x	x	x
7.	Consider nominating a named lead for sexual health in the ICB to ensure ease of joined up working and commissioning across the system		x	
8.	Increase community outreach and sexual health promotion work, particularly amongst vulnerable user groups, and communities who are underserved/under-represented by the current service	x		
9.	Support schools in their responsibility to provide high quality sex and relationship education (SRE) and ensure provision of high quality SRE in conjunction with the school nursing service and other outreach services. There should be a particular emphasis on specific needs of young people with special educational needs or learning disabilities and looked after children.	x		
10.	Deliver collaborative, holistic and integrated harm reduction interventions that specifically target the most vulnerable communities	x		

11.	Prioritising the training and education needs for local primary care teams including LARC fitting	x		
12.	Cross-system working to enhance cervical screening awareness and improve uptake by improving cervical screening pathways + working with communities	x	x	x
13.	Maintain a flexibility of strategy across the system so that services can respond to the dynamic nature of Leicester's changing demography, including an increasing young population, and inward migration	x	x	x
	Contraception			
14.	Establish a single point of access for long-acting reversible contraception (LARC) across the system to widen access and simplify the process for women seeking this method	x	x	
15.	Improve access to postnatal contraception in the immediate postnatal period (on the postnatal ward) including training staff to fit LARC before a woman leaves hospital	x	x	
16.	Address low uptake of long-acting reversible contraception (LARC) in women from some ethnic groups	x	x	
17.	Review procedures for data entry and reconciliation re LARC from general practice. Inc audit data quality	x	x	x
18.	Increase options for accessing contraception including a telephone service at the ISHS and the NHSE pharmacy pilot for repeat prescribing and initiation of the oral contraceptive pill by pharmacists	x	x	x
19.	Widen pharmacy offer of emergency hormonal contraception (EHC) to include EllaOne as well as the currently offered Levonelle	x		
20.	Consider extending offer of free EHC to over 25s as well as under to tackle rising rate of unintended pregnancies in this age group	x	x	x
21.	Work to address the inequality in teenage pregnancy rates in the City, which sees higher rates in certain areas of the city with higher levels of deprivation	x	x	x
22.	Improved clarity and system working on the pathway for terminations of pregnancy (TOP) to ensure that all partners are aware of the current offer and how to access it	x	x	x
23.	Ensure clarity on referral pathways and commissioner/provider arrangements for vasectomy and tubal ligation procedures	x	x	x

Sexually Transmitted Infections				
24.	Continue focus towards achieving a chlamydia diagnosis rate of at least 3,500 per 100,000 amongst women aged 15-25 years old from 2023	x		
25.	Ensure the National Chlamydia screening programme recommendations are implemented focusing on the screening of women under 25 and their treatment and follow up.	x		
26.	Work to reduce new diagnoses of HIV where diagnosis is classed as 'late' (CD4 count at diagnosis of less than 350)	x	x	
27.	Explore the possibility of HIV testing in • Emergency Departments • New GP registrants And particularly encouraging heterosexual men to test for HIV to reduce incidence of late diagnosis of HIV amongst this group	x	x	x
28.	Increase repeat testing rate for HIV amongst young gay, bisexual or men who have sex with men (GBMSM)	x		
29.	Consider offering HIV testing to women presenting for TOP			
30.	Address the over-representation of certain groups, including people from black African and African Caribbean backgrounds in STI data, and the fact these same groups are often under-represented in service use data	x		
31.	Continue surveillance of syphilis and gonorrhoea rates in the City and encourage repeat testing in at-risk and vulnerable groups.	x		
32.	Increase awareness and uptake of HIV pre-exposure prophylaxis (PrEP) in all eligible groups, but specifically those currently under-represented	x	x	
Recommendations for next HNA				
33.	Work to understand the current level of need in the population around female genital mutilation (FGM) and its effects on physical, mental and sexual wellbeing	x		

2.0 Introduction

Sexual health affects our physical and psychological wellbeing and can have an enduring impact on our overall quality of life. According to the United Nations Populations Fund (UNFPA) 'good' sexual health implies that people are able to have a safe and satisfying sex life, the capability to reproduce and the freedom to decide if, when and how often to do so. 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 disease[i].

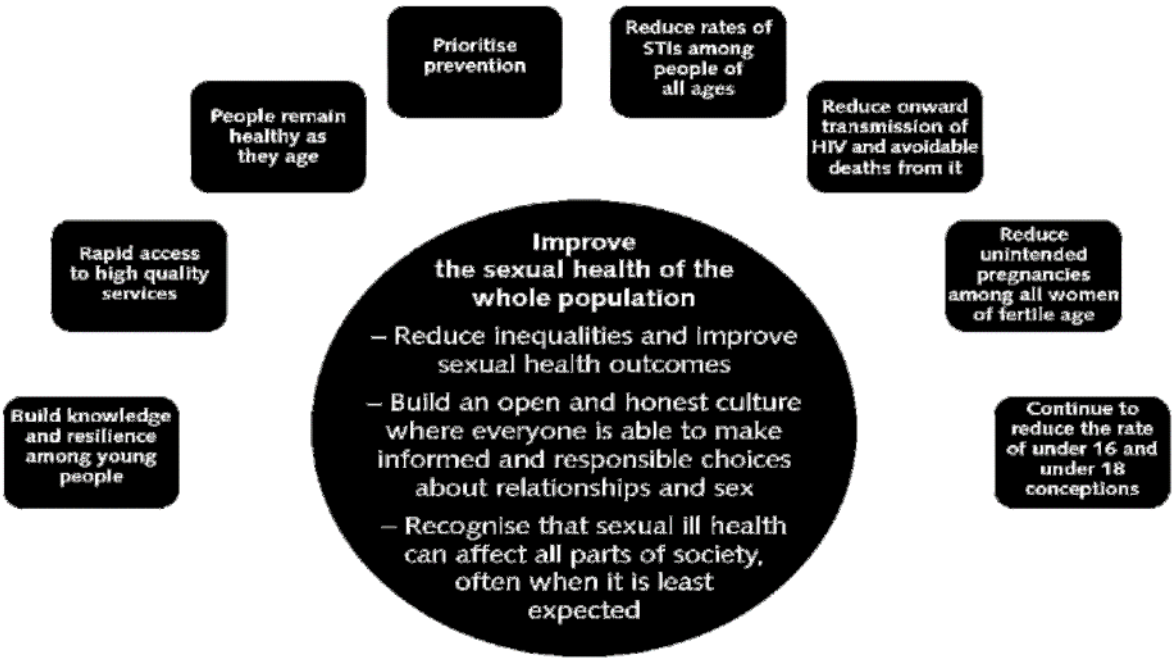
The scope of this document allows discussion about the promotion and maintenance of sexual health including the provision of services. A comprehensive sexual health service includes:

- Provision of all forms of contraception
- Detection and treatment of infections that are transmitted sexually (where sexual intercourse is the most common mode of transmission)
- Access to comprehensive advice and termination of pregnancy services in the event of unplanned pregnancies and teenage conceptions
- Services for people experiencing sexual dysfunction, which can affect self-esteem leading to relationship problems
- Access to appropriate sexual health information, interventions and services.

In 2014 The Department of Health published a *Framework for Sexual Health Improvement in England*[ii] setting out the nation's ambition and objectives as shown below. The framework will be superseded by the National Sexual Health Strategy (still awaited at time of writing), The HIV Action plan (2021)[iii] and the Women's Health Strategy [iv] (2022).

Together, these national documents set a vision and direction for sexual health across England. This is adapted by each area dependent on need and in discussion with the local population to form the Sexual Health Needs Assessment:

Figure 1: ***Framework for Sexual Health***



Another valuable source of information is the British Social Attitudes Survey[v] which is undertaken every year. In 2016 this revealed the further liberalisation of the population's attitudes towards same sex relationships, abortion and sex before marriage

- A significant majority of people (75%) say that sex before marriage is "not at all wrong", an increase of 11 percentage points since 2012, and 5 percentage points since 2015.
- Attitudes towards same-sex relationships have become significantly more liberal with 64% of people saying that they are "not wrong at all", up from 59% in 2015, and 47% in 2012.
- 93% of people think that if a woman's health is seriously endangered, an abortion should be allowed.
- Record-highs of people say an abortion should be allowed if a woman decides on her own she does not want the child (70%) or if a couple cannot afford any more children (65%).
- 41% of people feel some films are too violent or pornographic to be watched even by adults, down from 59% of people in 1996

The current commissioning responsibilities of Sexual Health and HIV services is set out in the *Health and Social Care Act 2012*[vi], as detailed in the table below:

Table 1: Commissioning Responsibilities

Commissioning Responsibilities		
Local authorities	**Clinical Commissioning Groups**	**NHS England**
Comprehensive, open access sexual health services including: 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)	Abortion services Sterilisation Vasectomy Non-sexual health elements of psychosexual services Gynaecology, including contraception for non-contraceptive purposes	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 fetal medicine services

These responsibilities are changing as the new plan for the NHS is developing and Integrated Care systems are being established.

Currently Leicester City Council commissions contraception for non-contraceptive purposes for the former Clinical Commissioning Groups.

The responsibility for the clinical consultations for PrEP became the responsibility of Local Authorities in 2021, whilst the medication for PrEP is commissioned by NHSE. The commissioning landscape in sexual health is complex, and it is hoped that the implementation of the new Integrated Care Systems allows for new ways to collaborate across commissioners and mitigate some of the complexity in the system.

Inequalities in both health and access to services are rife in areas where there is socioeconomic deprivation. Inequity of access and differential use of services also exists between different ethnic minority groups. This is a real issue for a city like Leicester, which has great ethnic diversity but also has some of the most deprived areas in the country; 11% of Leicester residents live in the most deprived 5% of areas nationally. Many national policies and guidance have direct implications for inequalities and Sexual health services and provision:

- Levelling Up[vii]
- The NHS Long-term Plan[viii]
- Promoting the sexual health and wellbeing of people from a Black Caribbean background: an evidence-based resource - GOV.UK (www.gov.uk)[ix]

3.0 Key Issues and Gaps

Sexual Health behaviour is captured in the National Surveys of Sexual Attitudes and Lifestyles (NATSAL[x]). This is carried out every 10 years and due in 2022 with results from 2023 onwards.

The findings of the last NATSAL survey 2011 show that there is a continuing reduction in age of sexual debut, that over their lifetime people are having more sexual partners than in previous generations and that the variety of types of sex is increasing in the population. Despite this there is also a reduction in the number of times people are having sex in a week. 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.

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

The *Framework for Sexual Health*[ii]*, HIV Action plan*[iii] *2021 and Women's Health Strategy 2022*[iv] *all* acknowledge 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 African Heritage communities are the groups most at risk of poorer sexual health in Leicester.

When mapping some elements of sexual health in Leicester, there is a clear disparity in outcomes between the east and west; with the west side of Leicester carrying more of the burden of chlamydia, under 18 conceptions and HIV.

Outcomes:

The following data gives an overview of sexual health outcomes[xi] in Leicester over the period 2019-2021. Because not all data is released together, some data are from a variety of years.

- Overall, there has been a significant decrease in the rate of all new STIs in Leicester (from 929 in 2012 to 571 in 2021)
- In 2021, 1,239 new sexually transmitted infections STIs (excluding chlamydia aged <25) were diagnosed in residents of Leicester (a rate of 350 per 100,000 population) which is significantly lower than the national rate of 394 per 100,000 population)

- Around 61% of new STIs in Leicester are in young people aged 15-24 (2020) (compared to 46% in England)[xi]
- Young people are also more likely to become re-infected with STIs. Between 2016 and 2020, 10.5% of 15-19 year old women and 8.3% of 15-19 year old men were re-infected within 12 months in Leicester (10.9% of 15-19 year old women and 9.8% of 15-19 year old men in England)

- For cases in men where sexual orientation was known, 12.3% of new STIs in Leicester were among gay, bisexual and other men who have sex with men (MSM) (2020). This compared to 23.7% in England (2020)(Splash report UKSHA)[xi]

- In Leicester, an estimated 7.7% of women and 8% of men presenting with a new STI at a sexual health service (SHS) during the 5 year period from 2015 to 2019 were re-infected with a new STI within 12 months. Nationally 7.1% of women and 9.9% of men became re-infected with a new STI within 12 months

- Among specialist SHS patients from Leicester who were eligible to be tested for HIV, 47.6% were tested compared to 45.8% in England in 2021 (HIV testing coverage). Fingertips 2021
- There were 28 new HIV diagnoses (all age groups) in Leicester in 2021. The number of new HIV diagnoses has fallen since the highest number of 85 in 2014.
- The diagnosed HIV prevalence was 4.0 per 1,000 population aged 15-59 years in people in Leicester, which is significantly higher compared to 2.3 per 1,000 in England in 2021.
- In Leicester, between 2019 and 2021, 60% (95% confidence interval [CI] 45.2% -73.6% -56%) of 30 HIV diagnoses (first diagnosed with HIV in the UK) were made at a late stage of infection (CD4 count =<350 cells/mm³) compared with 43.4% overall in England. (Please note that the number of new HIV diagnoses [especially those made at a late stage of infection] are small, therefore these figures must be interpreted with caution)
- In 2020, the total rate of long-acting reversible contraception (LARC) excluding injections prescribed in primary care, specialist SHSs and non-specialist SHSs was 26.3 per 1,000 women in Leicester, and 34.6 per 1,000 women in England. The GP prescribed rate was 17.5 per 1,000 women in Leicester and 21.2 per 1,000 women in England. The rate prescribed in sexual and reproductive health services per 1,000 women aged 15 to 44 years was 8.8 for Leicester, and 13.4 for England
- The total abortion rate per 1,000 female population aged 15-44 in Leicester was 20.6, significantly higher than 18.9 in England in 2020.
- In 2020, the under 18 conception rate per 1,000 females aged 15-17 years in Leicester was 11.4, statistically similar to England at 13.0

Despite a fall in the numbers of new HIV diagnosis, Leicester is the 6th most 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.

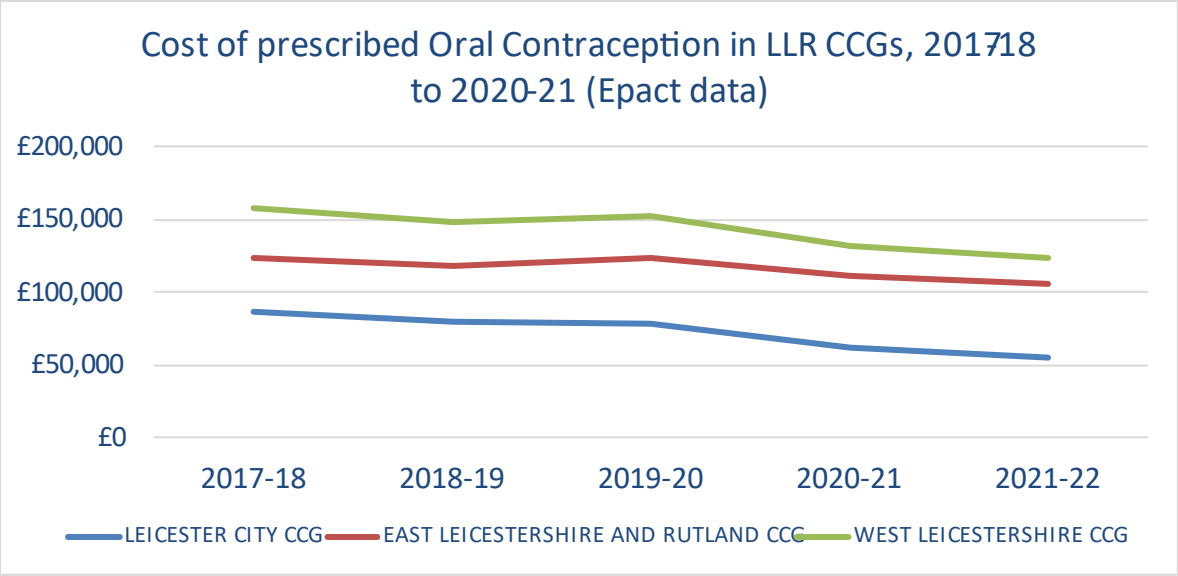
Provision:

A fully Integrated Sexual Health Service (ISHS) has been commissioned by the local authorities across Leicester, Leicestershire and Rutland since 2014. This service enables people to experience a '*one-stop-shop*' of sexual and reproductive health services.

Primary Care remains an important provider of contraception for women providing oral contraception and long-acting contraceptive injections as part of the core GP contract and some practices also provide LARC.

As is shown in the following graphs the provision of Oral contraception and EHC prescribed by GPs has been falling in Leicester

Figure 2: Cost of prescribed oral contraception in LLR Clinical Commissioning Groups (CCGs)



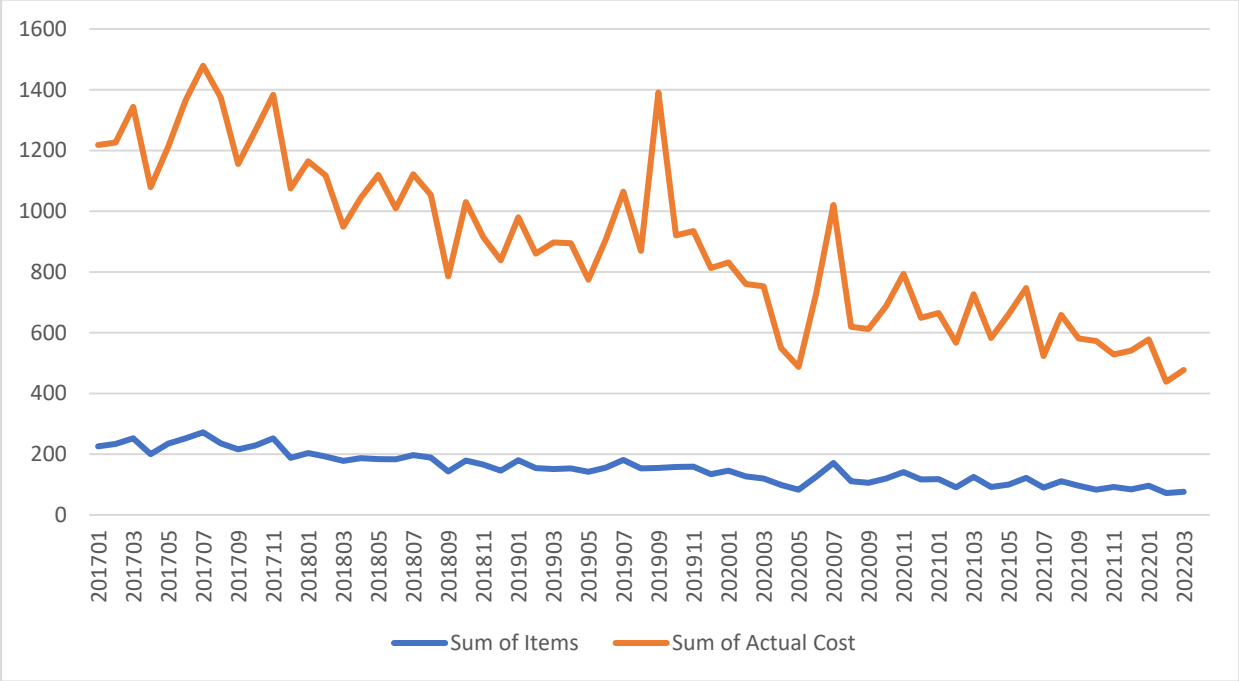
Source: EPACT Prescribing data: Leicester, Leicestershire and Rutland Integrated Care Board

There has been a reduction in the amount of money being spent on oral contraception in Leicester Leicestershire and Rutland since 2017/18.

There is no evidence that this has been replaced by LARC provision across LLR.

As shown in Figure 3 below there is also a reduction year on year in the volume of Emergency Hormonal Contraception provided in general practice. This is also of concern as we are seeing an ongoing rise in rates of terminations of pregnancy across LLR.

Figure 3: ***Costs and volumes of Emergency Hormonal Contraception prescribed by GPs in Leicester 2017-2022***



Source: EPACT Prescribing data: Leicester, Leicestershire and Rutland Integrated Care Board

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.

Relationships and Sex Education (RSE) is now a mandatory part of the National curriculum in state schools. This is from age 5-16 years of age. It is vitally important for young people in order to equip them with a better understanding on how their bodies work and 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. It is important that children whose education has been disrupted or who have recently come to live in Leicester have the same understanding and access to these life skills as those with a more consistent education.

4.0 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)[x] which were done in 1991, 2001,2011, and is planned for 2022 thus showing change over time. The Natsal survey 2011 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
- age of sexual debut has been reducing however frequency of sexual intercourse per week has been reducing.

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[xi]. There could be multiple reasons for this including[xii]

- inadequate service provision or inequity of access to services
- 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
- using ineffective contraceptive methods
- sex whilst under the influence of alcohol or other illicit substances where partners may be disinhibited and more likely to take risks

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 (who are often unaware of their increased fertility)
- older women in stable relationships (due to the misconception that they are no longer at risk)
- those with low educational attainment, which is independent of other factors

It is important to recognise when using the term that 'MSM' are not one homogenous group. They can be, and are, a marginalised and hard to reach group as they come from all different 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, but it is nonetheless an important group to consider. The reasons for this are diverse but set against a backdrop of societal attitudes to homosexuality that remain markedly less liberal than attitudes to premarital sex.

5.0 The level of need in the population

5.1 Sexually Transmitted Infections (STIs)

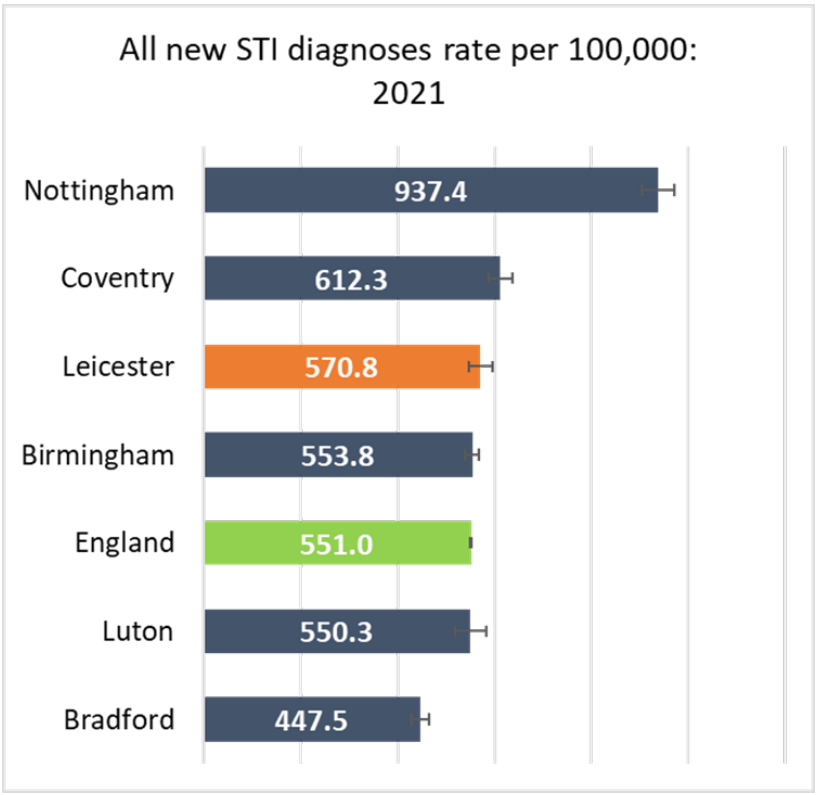
- Leicester ranked 53rd highest out of 149 upper tier local authorities (UTLAs) and unitary authorities (UAs) for new STI diagnoses excluding chlamydia among young people aged 15 to 24 years in 2021, with a rate of 350 per 100,000 residents aged 15 to 64 better than the rate of 394 per 100,000 for England.

The group of infections conventionally considered as acute STIs are:

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

Figure 4 below shows the rate of new STI diagnoses per 100,000 residents for Leicester and ONS comparators for 2021. Leicester is slightly above the national average and the third highest when compared with its peers.

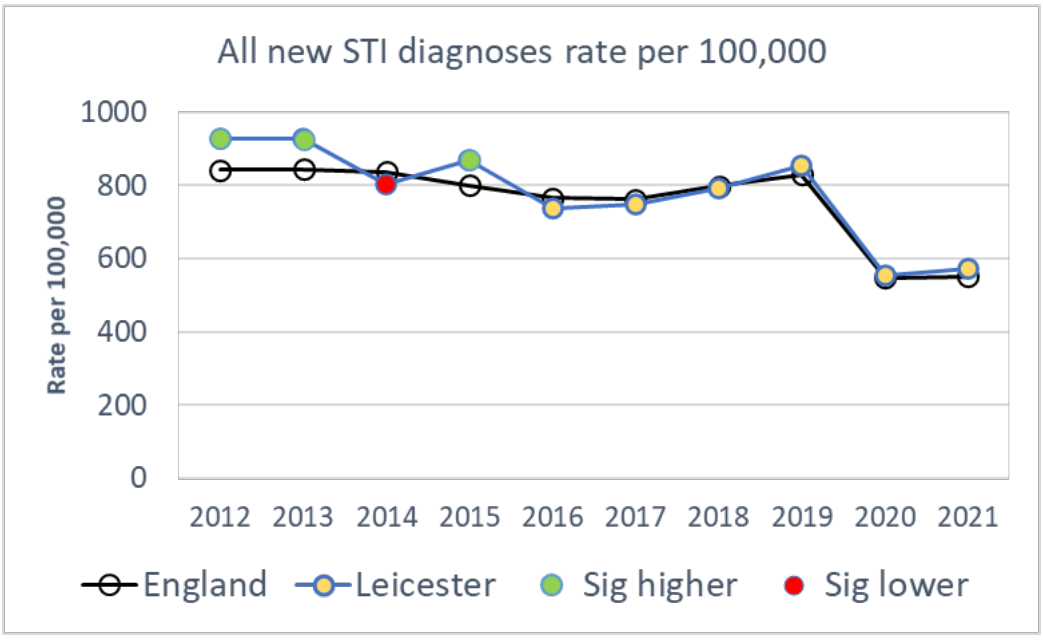
*Figure 4: **Rates of all new STI diagnoses (2021)***



Source: Office for Improvement and Disparities: https://fingertips.phe.org.uk/

Rates of all new STIs in Leicester have shown an overall reduction since 2012 followed by a sudden drop in the rate in 2020. This fall is consistent with the national trend due to the COVID-19 pandemic. Historically, new STI diagnosis rates in Leicester have been similar to national rates; sometimes slightly higher, sometimes slightly lower but not usually by a great margin as per the graph below:

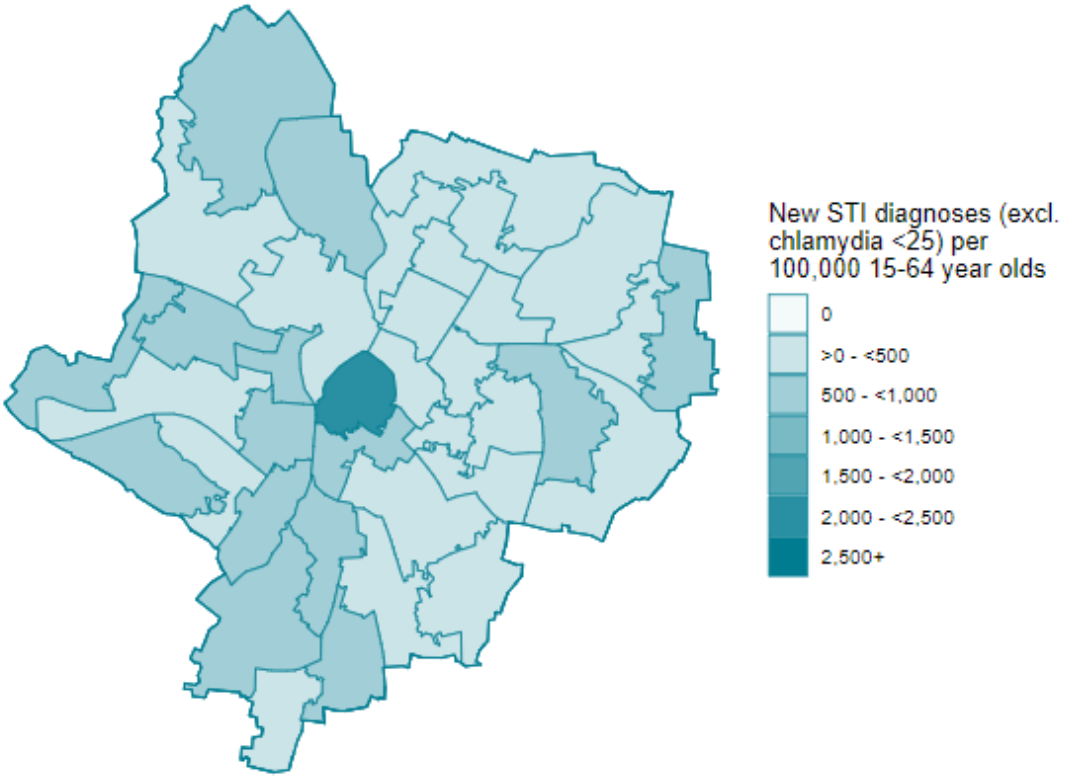
*Figure 5: **Rate of all new STI diagnosis in Leicester and England** (UKSHA)*



Source: Office for Improvement and Disparities: https://fingertips.phe.org.uk/

The distribution of STIs shows a pattern similar to areas of deprivation with the exception of the much higher rates in the City Centre. This may be skewed due to the numbers of under 24s living in the city centre. This is the age group with the highest number of diagnoses.

*Figure 6**: Map of New STI diagnoses (excluding chlamydia in under 25s by MSOAs in Leicester, 2020***



Source: Office for Health Improvement and Disparities: https://fingertips.phe.org.uk/static-reports/sexualhealth-reports/2022/E06000016.html?area-name=Leicester#stis

5.1.1 Re-infection rates

Reinfection with an STI is a marker of persistent risk-taking behaviour. Leicester has a similar rate to the national rate with an estimated 7.7% of women and 8% of men presenting with a new STI at a SHS during the five year period from 2015 to 2019 became re-infected with a new STI within 12 months compared to, 7.1% of women and 9.9% of men became re-infected with a new STI within 12 months nationally in the same time period.

In Leicester, an estimated 3.6% of women and 7.6% of men diagnosed with gonorrhoea at a SHS between 2015 and 2019 became reinfected with gonorrhoea within 12 months. Nationally, an estimated 4.1% of women and 11.5% of men became reinfected with gonorrhoea within 12 months.

However Leicester has previously fared worse than nationally with young people are more likely to become re-infected with STIs, contributing to infection persistence and health service workload. In Leicester, an estimated 12.3% of 15–19-year-old women and 11.3% of 15-19 year old men presenting with a new STI at a SHS during the five year period from 2015 to 2019 became re-infected with a new STI within 12 months. In England, 11.4 % of 15–19-year-old women and 10.4% of 15-19 year old men became reinfected with a new STI within 12 months. If you instead consider the period from 2016-2020, the rates are lower than average (10.5% of 15-19 year old women and 8.3% of 15-19 year old men vs 9% of 15-19 year old women and 9.8% of 15-19 year old men respectively). Since 2020 was an

anomalous year due to the covid-19 pandemic it remains to be seen what happens to this figure in the coming years.

5.1.2 Chlamydia

Chlamydia infection is often asymptomatic or goes undiagnosed leading to complications such as pelvic inflammatory disease which in turn can lead to pelvic scarring, chronic pain and problems with fertility. The long-term consequences of untreated chlamydia infection can cause significant morbidity in the population and so early detection and treatment is vital. The aim of the National Chlamydia Screening Programme (NCSP) is changing to focus on reducing the harms from untreated chlamydia infection. The harmful effects of chlamydia occur predominantly in women so the opportunistic offer of asymptomatic chlamydia screening outside of sexual health services will focus on women, combined with reducing time to test results and treatment, strengthening partner notification and retesting. These changes will mean the programme will be better able to maximise the health benefits. In 2021 there was new guidance produced by the NCSP [xiii] Changes to the National Chlamydia Screening Programme (NCSP) - GOV.UK (www.gov.uk).

Opportunistic screening (that is the proactive offer of a chlamydia test to young people without symptoms) should focus on women*, combined with:

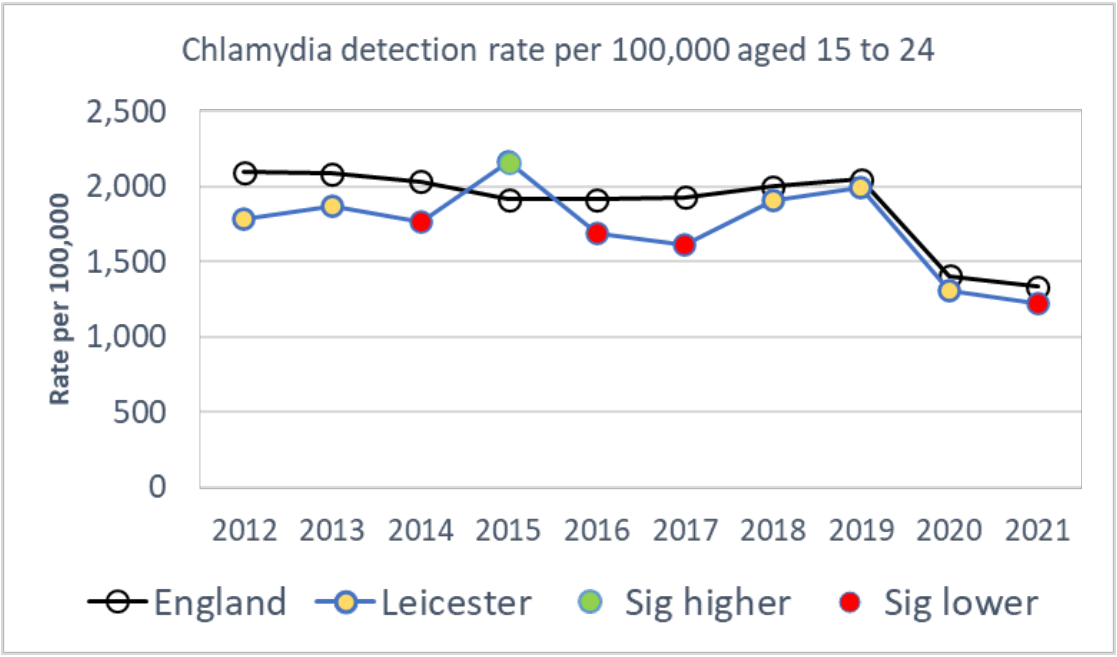
- reducing time to test results and treatment
- strengthening partner notification
- re-testing after treatment

* *These are the recommendations of the national changes to chlamydia screening*

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. Everyone can still get tested if they need, but men will not be proactively offered a test unless an indication has been identified, such as being a partner of someone with chlamydia or having symptoms[xiii]

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 to 24-year-old population (Public Health England, 2013). This changed to a new female only PHOF benchmark diagnosis rate indicator (DRI) of 3,250 per 100,000 aged 15 to 24 (Female) which will be included in the PHOF from January 2022.

Figure 7: Leicester and England Chlamydia detection rate in male and female 15–24-year-olds (2012-2020)

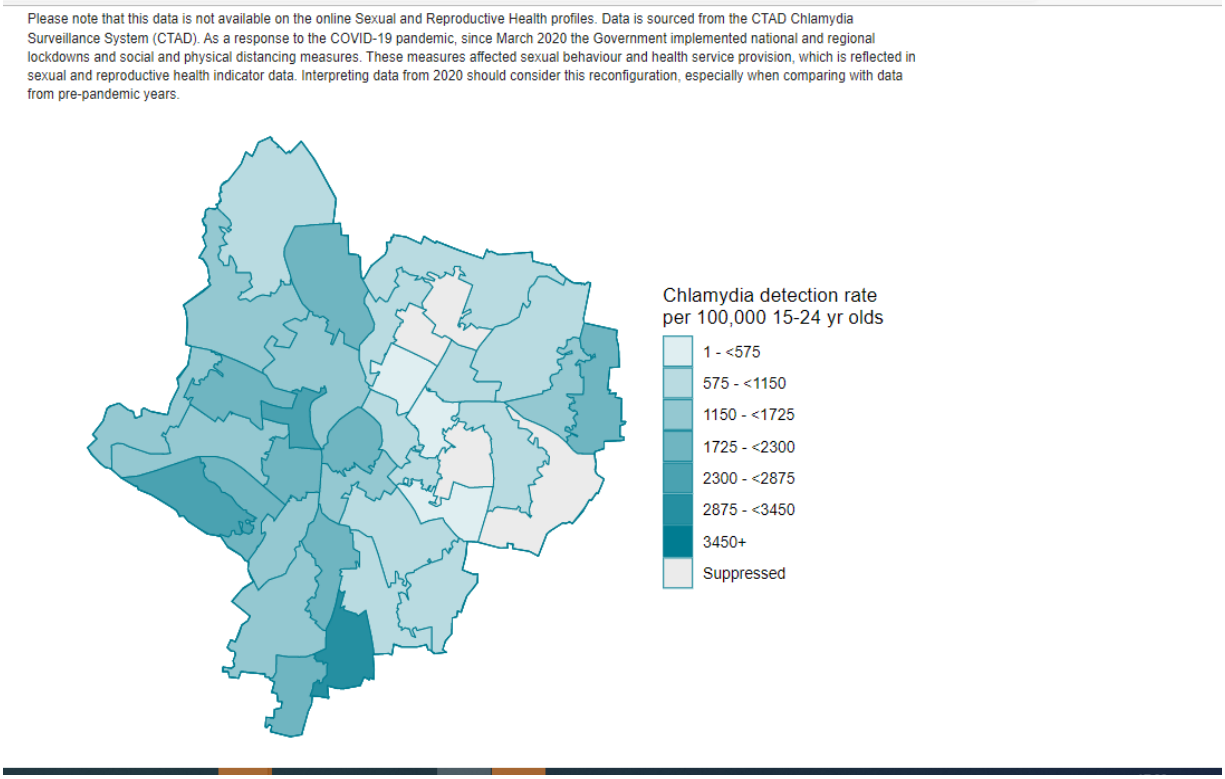


Source: *Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk*

This shows that from 2018 onwards the rate has been similar to the national rate. There was a fall in 2020 during the period that covid-19 restrictions were in place and there have been fewer of the 19- to 24-year-old student population in Leicester than in pre-pandemic times.

Figure 8 shows that the chlamydia positivity rate varies across Leicester wards, with the highest proportion being observed mainly in the west of the city. These areas correlate with both the areas that the student population reside in and areas of high deprivation. This includes Humberstone in the east of Leicester. This pattern mirrors the report in 2012 bar the new increase in positivity in Leicester City Centre. This may be due to the increase in student accommodation in the City centre.

Figure 8: Map of chlamydia detection rate per 100,000 population aged 15-24 years in Leicester by middle super output area, 2020



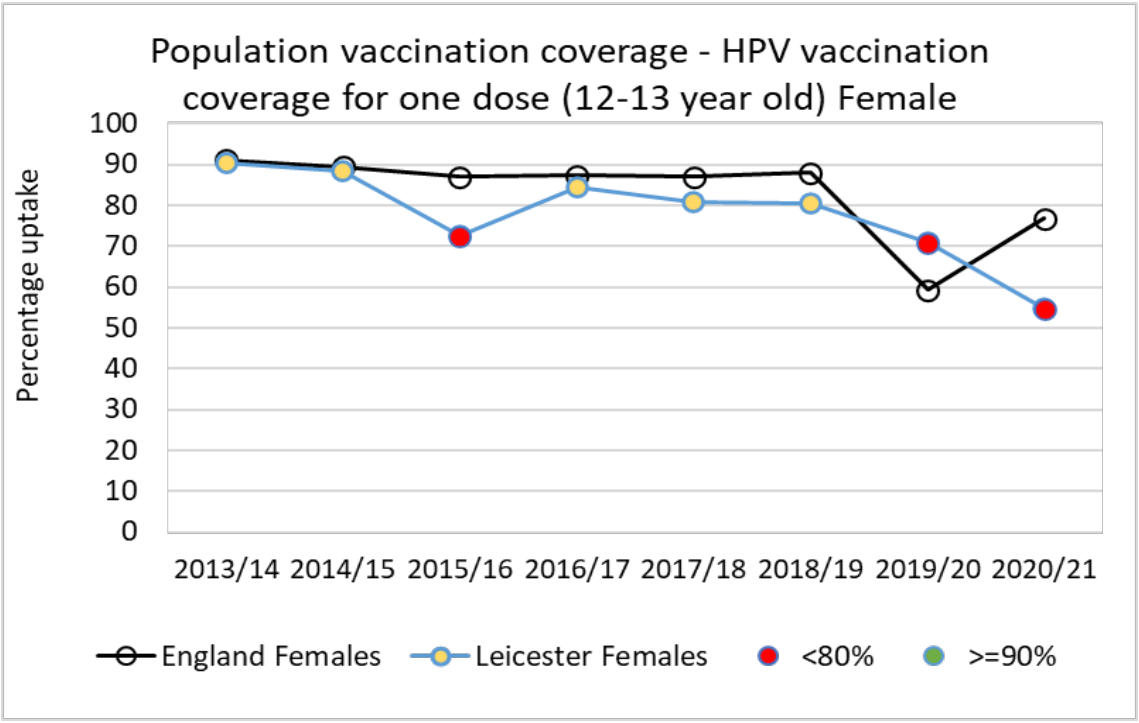
Source: https://fingertips.phe.org.uk/static-reports/sexualhealth-reports/2022/E06000016.html?area-name=Leicester

5.1.3 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, anal or oral) and genital warts. In the UK, all 12- to 13-year-old girls are offered HPV vaccination through a national HPV immunisation programme which confers protection against cervical cancer and genital warts.

There is a trend of reducing vaccination uptake across Leicester and this includes with HPV vaccination as shown below. It is of concern that this is a continuing very steep downward trend.

Figure 9: ***Population vaccination coverage: HPV vaccination coverage for one dose (12- to 13-year-old) (Female) for Leicester***



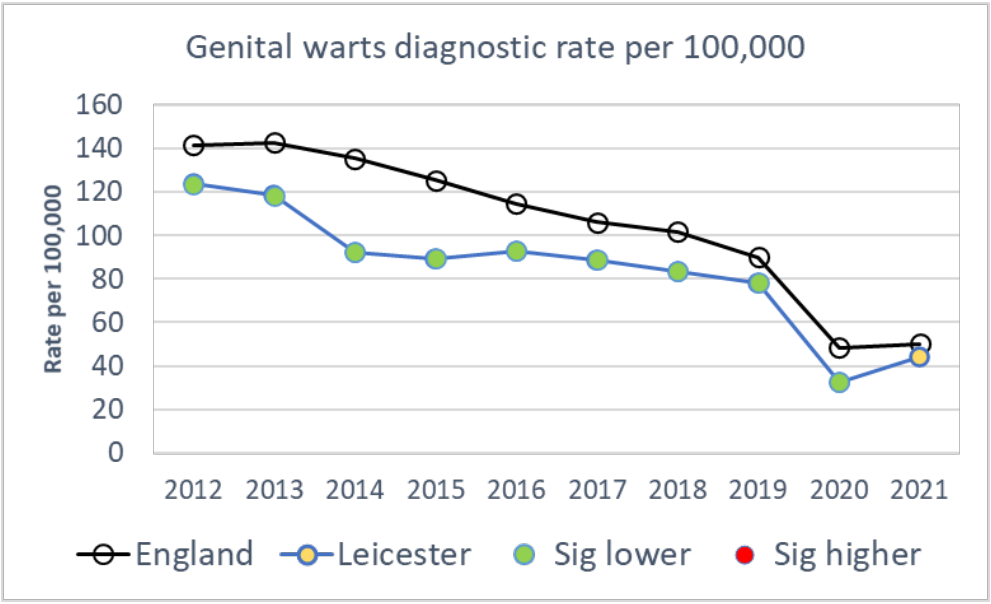
Source: Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

The uptake in Leicestershire is 76.7% compared to 54.6% in Leicester. Leicester uptake is significantly worse than all bar three of its peer comparator areas.

5.1.4 Genital Warts

Genital warts are the second most common STI in the country. Diagnoses of genital warts have been decreasing steadily over the last decade. Figure 11 compares Leicester against its peer comparators and shows that Leicester has a very similar trend for genital wart diagnoses as England.

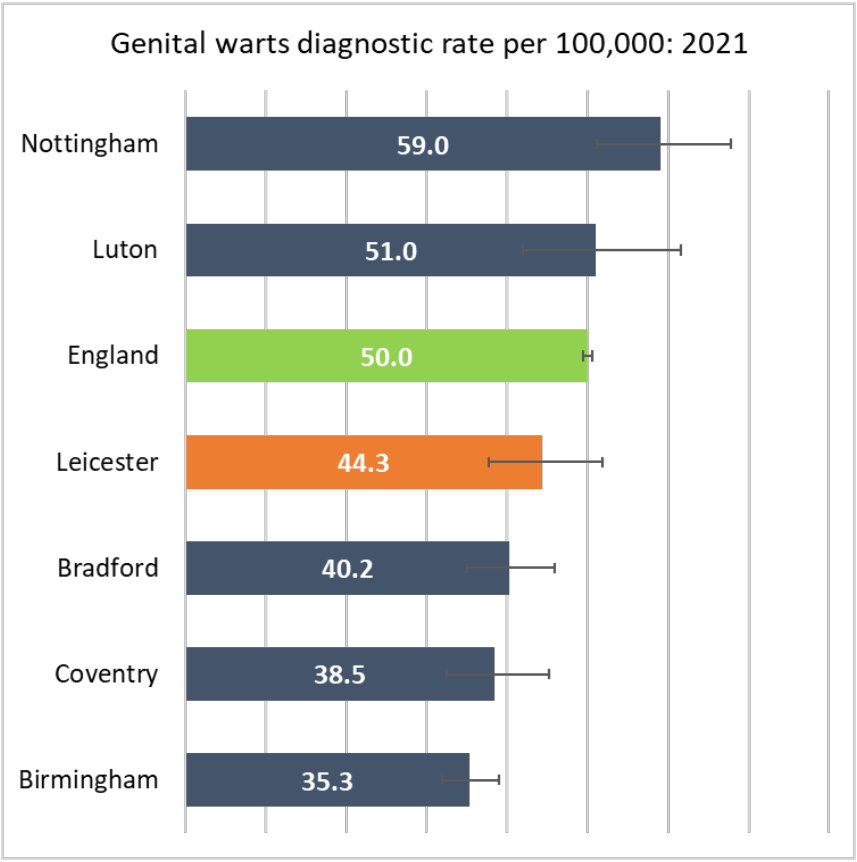
Figure 10: Rates of genital warts diagnosed per 100,000 population



Source: *Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk*

Although Leicester has a lower rate of genital warts than England, numbers of infections rose in 2021 for the first time since 2012.

Figure 11: Rates of genital warts diagnosed per 100,000 for Leicester and peer areas, 2021

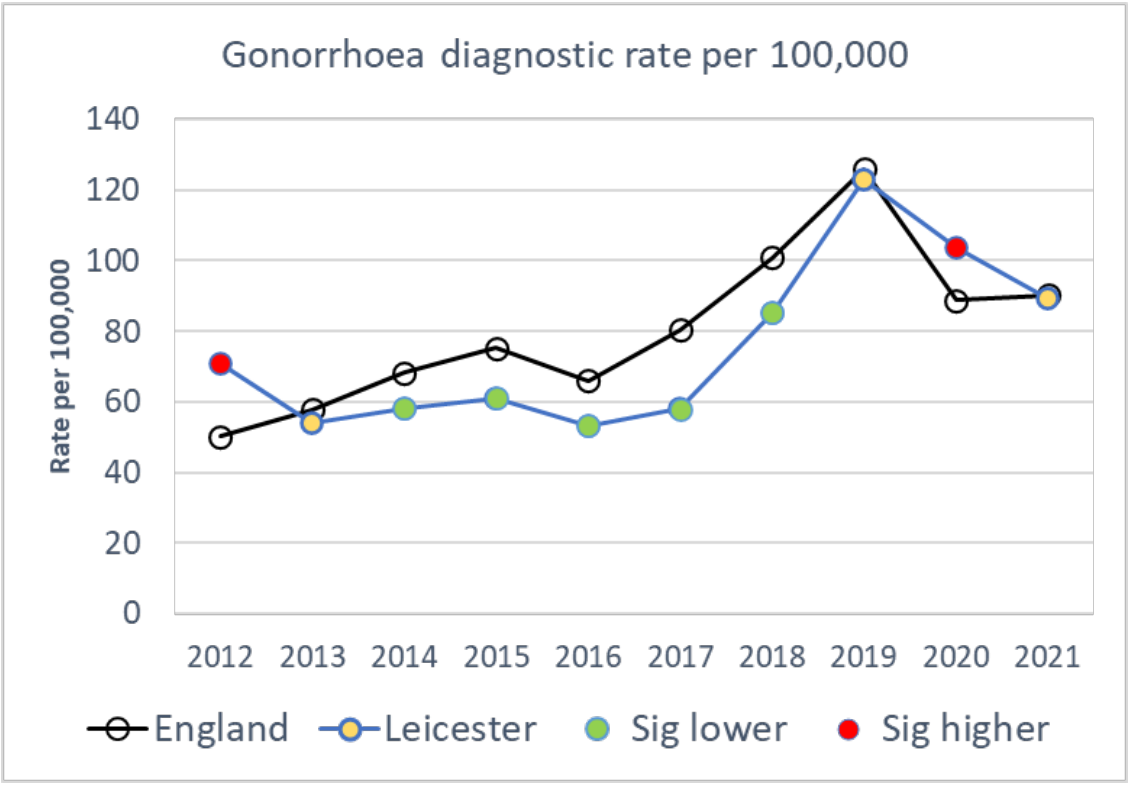


Source: *Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk*

5.1.5 Gonorrhoea

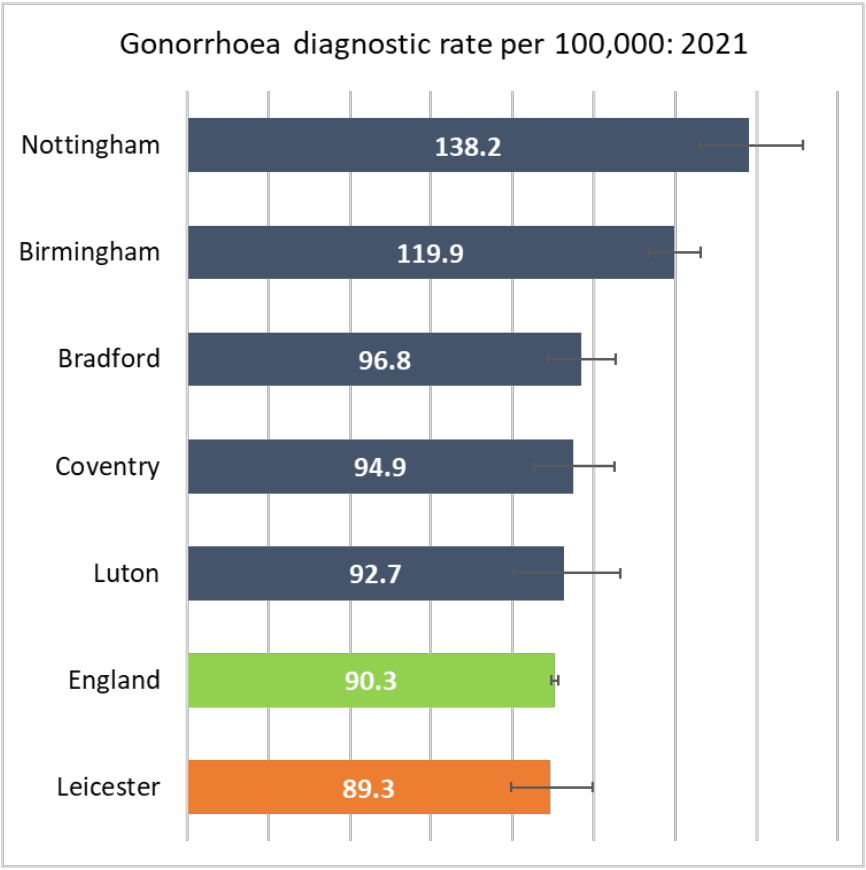
Nationally, the rates of Gonorrhoea infection have been increasing over the last decade. Leicester had a significantly lower gonorrhoea infection rate than nationally. During 2020 and 2021, fewer STIs were diagnosed during the Covid-19 pandemic, but the rate in Leicester didn't fall as quickly. Leicester has the lowest gonorrhoea infection rate compared with peer areas in 2021.

Figure 12: Rates of Gonorrhoea diagnoses per 100,000 population



Source: *Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.ukhttps://fingertips.phe.org.uk*

Figure 13: Gonorrhoea diagnostic rate



Source: *Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk*

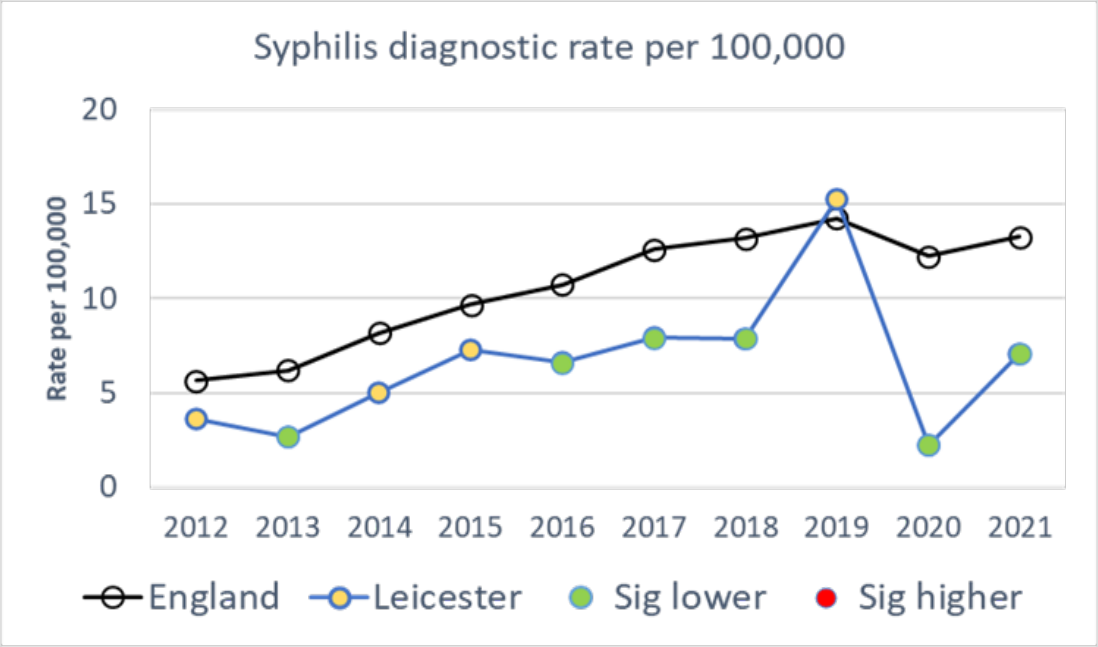
5.1.6 Syphilis

Syphilis is one of the least common STIs in the country with low rates reported locally and nationally, however it is by no means unheard of. Rates have generally increased in the country over the past ten years, though thankfully remain low. Diagnosed cases of syphilis fell sharply in 2020 and are returning to nearer pre-pandemic levels in 2021. Leicester has the second lowest syphilis diagnostic rate compared with peer areas.

The syphilis action plan[xiv] provides guidance to optimise the 4 pillars that are essential to syphilis control and prevention:

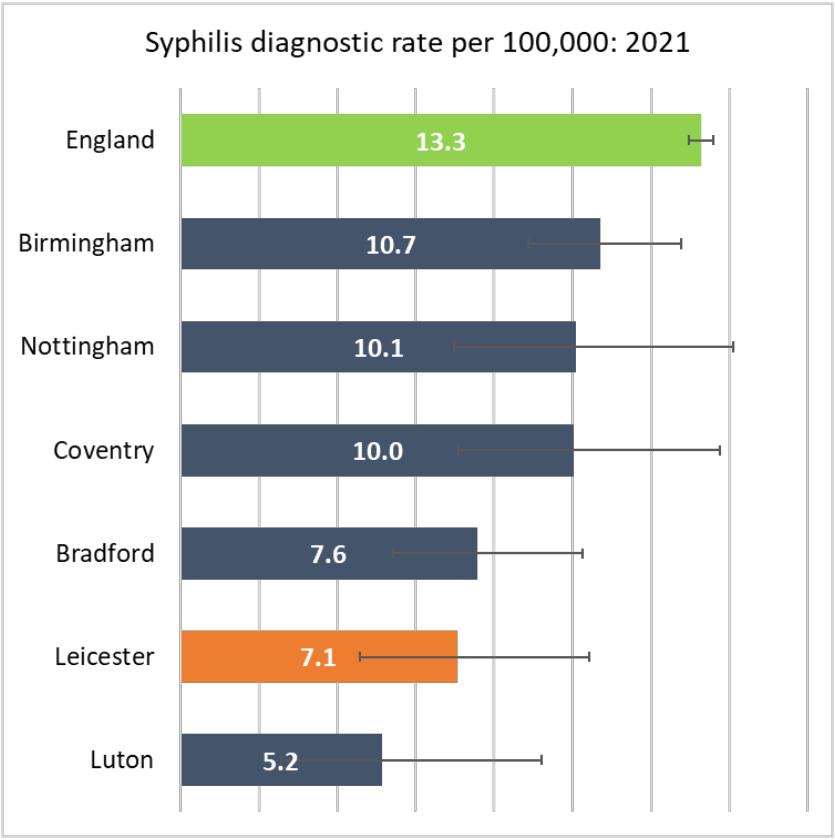
- increase testing frequency of high-risk MSM and re-testing of syphilis cases after treatment
- deliver partner notification to British Association for Sexual Health and HIV (BASHH) standards
- maintain high antenatal screening coverage and vigilance for syphilis throughout antenatal care
- sustain targeted health promotion.

Figure 14: Rates of Syphilis diagnoses per 100,000



Source: *Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk*

Figure 15: ***Rates of Syphilis diagnoses per 100,000 for Leicester and peer areas, 2021***



Source: *Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk*

5.1.7 Human Immunodeficiency Virus (HIV)

HIV infection is a serious health condition. If left untreated, the virus can weaken the immune system, leading to severe infections and illnesses and eventually death. Previously the development of these illnesses after becoming infected with HIV was referred to as Acquired Immune Deficiency Syndrome (AIDS), but now, clinicians in the UK do not often use that term, instead preferring 'advanced HIV' or 'Late-stage HIV'. Over the last decade there have been many improvements in HIV treatments, and very few people in the UK develop serious HIV-related illness, leading to longer life expectancy for those infected with HIV.

The overall HIV prevalence rate for England in 2021 was 2.3 per 1,000 population aged 15-59 years. UK Health Security Agency (previously Public Health England) estimates that 6% of HIV positive people in England are unaware of their diagnosis[xv]. The potential for onward transmission, where unsafe sex is practised or other transmission that shares body fluids, poses a public health risk. With modern antiretroviral treatments, it is possible to reduce circulating levels of virus to undetectable, and importantly for prevention, undetectable levels of virus = untransmissible[xvi]. The two groups most affected by HIV in the UK are Men who have Sex with Men and people who have migrated from regions of the world where HIV is common, such as sub-Saharan Africa. Other methods of transmission such as via contaminated blood or blood product transfusions and vertical transmission (mother to child transmission during pregnancy and birth) are essentially unheard of now in the UK thanks to advancements in care.

Table 2: HIV in Leicester

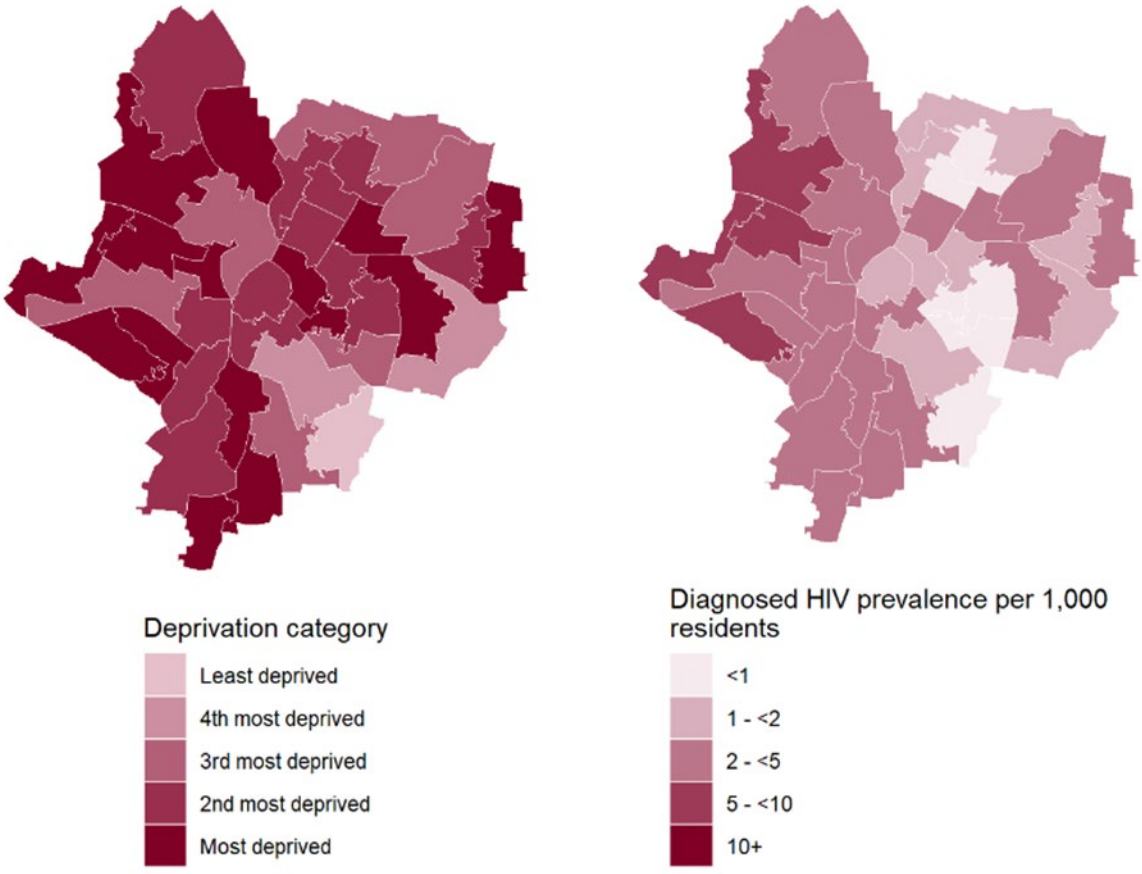
HIV in Leicester
New diagnoses
In 2021, there were 28 Leicester residents newly diagnosed with HIV. This is a rate of 19.4 per 100,000 of the population (all ages) and, higher than the England rate of 10.6 per 100,000 of the population
60.0% of HIV diagnoses in people first diagnosed with HIV in the UK were made a late stage of infection in Leicester (in 2019-2021), higher than the England average (43.4%)
People living with HIV
There are 897 residents diagnosed with HIV in Leicester in 2021 (ages 15-59).
Leicester is considered a high HIV prevalent area, with a rate of 4.0 per 1,000 population aged 15-59 years in 2021, which is significantly higher than the national average of 2.3 per 1,000. Leicester is ranked as the 6th highest prevalence of HIV outside London, with highest rates in Brighton, Manchester, Salford, Blackpool and Luton.
The ethnicities of people living with diagnosed HIV in Leicester between 2015 and 2019: 20% White 2% Black Caribbean 60% Black African 19% Other 0% Not known
The probable route of infection of people living with diagnosed HIV in Leicester between 2015 and 2019: 16% sex between men 76% sex between men and women 2% injecting drug use

7% other/not known
Treatment
Of people newly diagnosed with HIV in Leicester in 2021, 95.2, 92% promptly started (within 91 days) antiretroviral therapy. This is higher than the England average (83.5%).
Of people with HIV in Leicester accessing HIV care, 99.4% are on antiretroviral therapy (main treatment for HIV). This is higher than the England average (98.7%).
Of people with HIV in Leicester accessing HIV, 98.4% have an undetectable viral load (<200 copies/ml). This means they cannot pass on the virus. This is similar to the England average (97.4%).

Source: *HIV and AIDS Reporting System (HARS) 2020,* ***Source:*** *Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles:*

HIV diagnoses are generally higher in the West of the city, which shows some correlation with areas of deprivation:

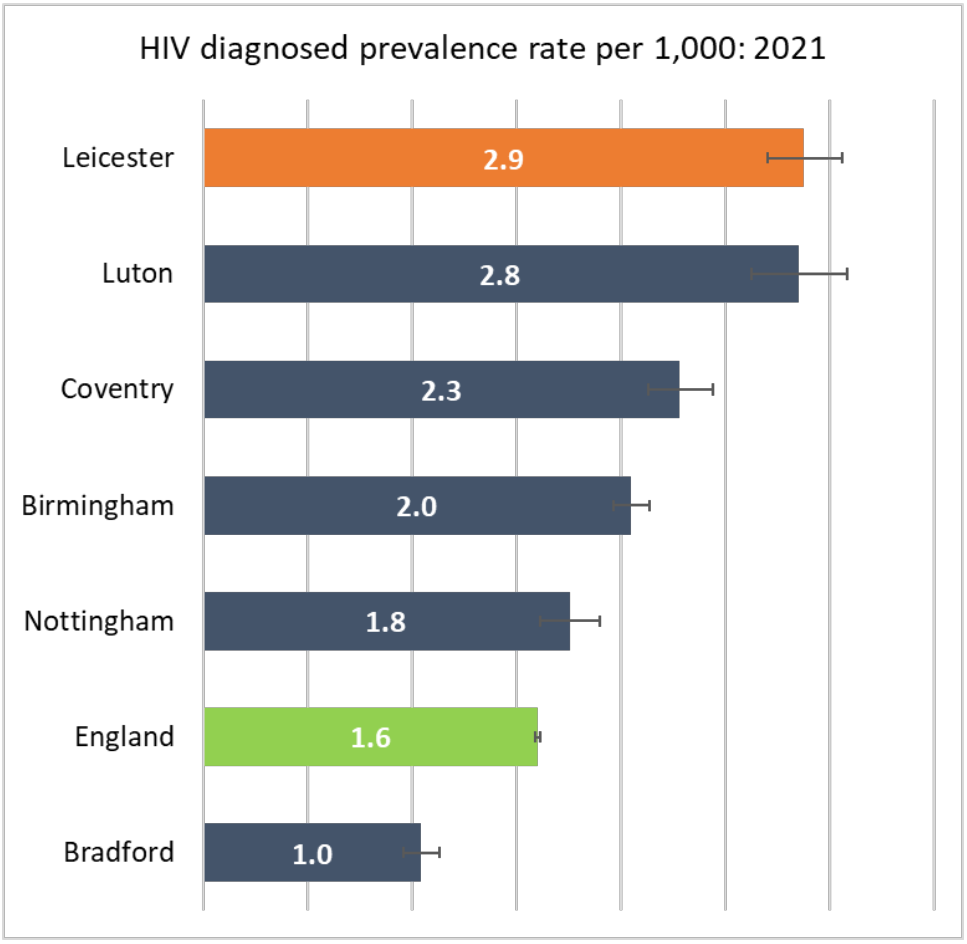
Figure 16: Diagnosed HIV prevalence per 1,000 residents in Leicester by middle super output areas, 2019



Source: *SPLASH Supplement Report, Leicester: https://fingertips.phe.org.uk/profile/sexualhealth/*

Leicester has the 6thhighest HIV prevalence outside London (per 1000 aged 15-59). It has the highest rate within the ONS peer comparator group.

Figure 17: Diagnosed HIV prevalence per 1,000 population by ONS comparator group, 2021



Source: *Office of Health Improvement and Disparities (OHID), Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

5.1.7.1 Age of people with HIV in Leicester

In 2020 the ages of people resident in Leicester with HIV were as shown in the table below:

Figure 18: Age profile of HIV in Leicester

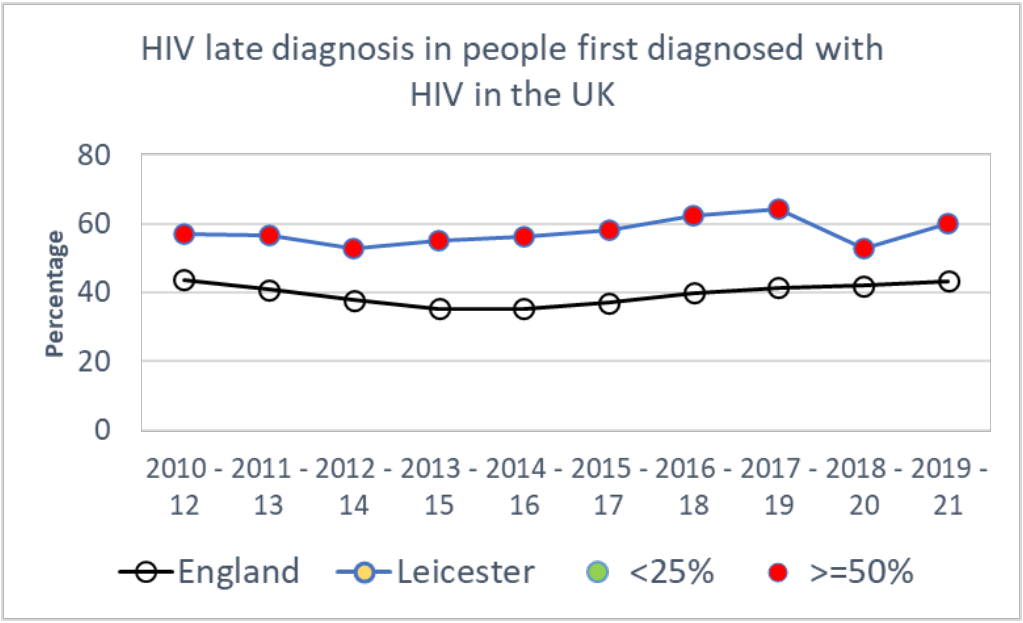
Age	Percentage of HIV positive people
0-14	<1%
15-24	<2%
25-34	8%
35-49	47%
50-64	35%
65+	5%

5.1.7.2 Gender of people with HIV in Leicester

There were 24 people diagnosed with HIV in Leicester in 2020: 15 stated that they are male and 9 stated that they are female. Since 2017 there have been more males than females although the overall numbers have been reducing year on year.

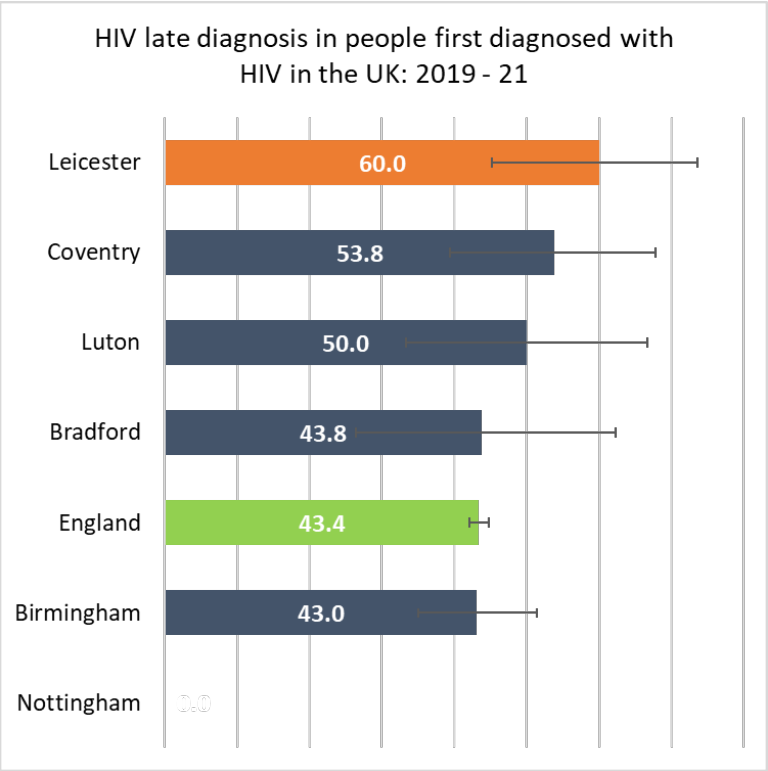
Late-stage HIV diagnosis is defined as someone with a CD4 count of less than 350 per ml. Late diagnosis can result in greater morbidity and earlier mortality. Leicester has shown a significantly higher percentage of people who are diagnosed late for HIV. Between 2019-2021 60% of patients in Leicester were reported with late HIV diagnosis compared with 43% in England.[1] Leicester has the highest proportion of late HIV diagnosis among peer areas.

Figure 19: Late diagnosis of HIV for people first diagnosed within the UK



Source: *Office of Health Improvement and Disparities (OHID), Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

Figure 20: Late diagnosis of HIV for people first diagnosed within the UK comparator CIPFA neighbours



Source: *Office of Health Improvement and Disparities (OHID), Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

Figure 21 below shows HIV late diagnosis percentages for people first diagnosed with HIV in the UK for gay, bisexual or other men who have sex with men (GBMSM), heterosexual men and heterosexual women.

Figure 21: HIV late diagnosis indicators, 2019-21

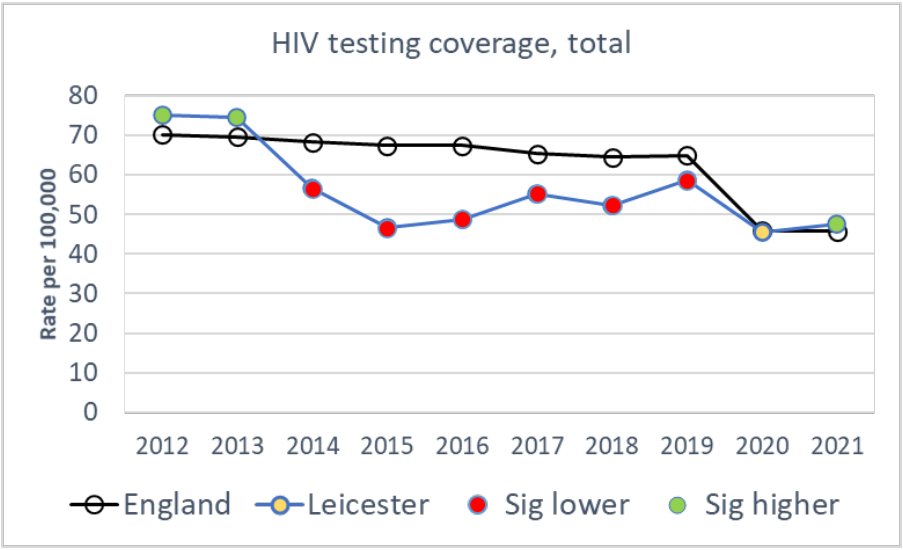
	England	East Midlands	Leicester
HIV late diagnosis in the UK (2019-21)	43.4 %	52.7	60%
Amongst Gay, Bisexual and Men who have sex with men	31.4%	36.4	35.7%
Amongst Heterosexual men	58.1%	65.4	71.4%
Amongst Heterosexual and bisexual women	49.5%	52.5	58.8%
<25% 25% to 50% ≥50%			

Source : *Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)*

Leicester performs worse than England in all areas. Of particular concern is the percentage of heterosexual men who are diagnosed late.

There are national indicators that evidence the degree to which people are offered HIV testing at sexual health services in each area. This is referred to as HIV testing coverage and is the percentage of people offered an HIV test at the sexual health service. Leicester is similar to the associated national averages. However, the national average significantly reduced due to the impact of fewer tests during COVID-19 measures introduced and continued in 2020. In the recent years leading up to this period, the testing coverage for women, for men and total coverage were significantly worse than the England average, with coverage for GBMSM recently being worse than average in 2019.

Figure 22: HIV testing coverage, total



Source: *Office of Health Improvement and Disparities (OHID), Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

Figure 23 shows HIV testing coverage indicators for gay, bisexual or other men who have sex with men (GBMSM), men and women.

Figure 23: HIV testing coverage indicators, 2020-2021

Indicator	Year	England	East Midlands	Leicester
HIV testing coverage, men (%)	2020/21	62.8	50.7	66.4
HIV testing coverage, GBMSM (%)	2020/21	77.8	72.8	75.9
HIV testing coverage, women (%)	2020/21	36.6	24.3	37.9
HIV testing coverage, total (%)	2020/21	45.3	34.3	47.6
In comparison to England		Better	Similar	**Worse**

Source: *OHID, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

Similar to England the HIV testing coverage for women is low and the highest testing coverage is for GBMSM. This may reflect their greater likelihood to attend sexual health services for STI testing. The HIV testing coverage indicators for Leicester have improved over recent years. There is no room for complacency as the repeat testing amongst MSMs is low 36.3% (England 45.3%)

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.

5.1.7.3 Current Services

Commissioning responsibility for HIV prevention, testing and treatment is divided between statutory authorities. HIV prevention is currently commissioned by Leicester City Council, HIV specialised inpatient and outpatient treatment are commissioned by NHS England -Midlands, and HIV testing in primary and secondary care is commissioned by LLR Integrated Commissioning Board (ICB). Commissioning responsibilities for treatment are due to be delegated from NHS England – Midlands to LLR ICB on 1st April 2024. The integration of ICBs and local authorities through Integrated Care Partnerships will give the opportunity to explore greater integration between the commissioning and provision of these services[xvii].

5.1.7.4 Prevention and testing

The Integrated Sexual Health Services (ISHS) is commissioned by the local authorities (Leicester City, Leicestershire County and Rutland County) and is provided by Midlands Partnership Foundation Trust. It commenced on the 1st January 2019 and provides a number of services including HIV testing and C cards providing condoms which are effective against the transmission of HIV. Trade Sexual Health are subcontracted by the ISHS to provide targeted HIV prevention for the LGBTQ+ community and new arrivals (international students, asylum seekers/refugees and economic migrants). They provide education, guidance and HIV testing.

Pre exposure prophylaxis (PrEP) is a course of HIV drugs taken when the person will potentially be exposed to HIV. In 2020, oral PrEP was made available on the NHS in England through sexual health services. The ISHS service provides PrEP-related care and prescriptions to those who are eligible (with the medications funded by NHS England). There is limited data on the uptake of PrEP but evidence from the IMPACT trial [xviii] shows that white gay and bisexual men were by far the most likely to take part in the trial (95%).

Data from the ISHS shows between April 2021 and March 2022, 300 people started PrEP (rounded to nearest 5 people). Those who work with the communities eligible for PrEP indicate that they suspect low uptake by heterosexual people, working class people and those unhappy to identify themselves at risk to sexual health services due to risk of stigma from their communities.

Post-exposure prophylaxis (PEP) is a course of medication taken if someone thinks they have been exposed to HIV. The ISHS can provide PEP to those who been the guidelines for provision. It can also be access at A&E at Leicester Royal Infirmary and at the Sexual Assault Referral Centre.

There is an antenatal screening programme in place in UHL maternity services. All women are offered an HIV test along with other infectious disease tests in order to identify any who need care and minimise risks to their children. Testing in primary and secondary care should be done when clinically indicated. There have been previous efforts to increase testing in secondary care for those likely to be at more risk of HIV infection.

5.1.7.5 Treatment and care

HIV treatment and care is commissioned by NHS England – Midlands using the standard service specification[xix] and is provided through secondary care by the department of Infectious Diseases at University Hospitals of Leicester NHS Trust (UHL). HIV services are not geographically restricted so Leicester residents may attend treatment services elsewhere and people with HIV from other areas can attend the services at UHL.

UHL treatment services are an outlier nationally for having a large number of patients who are women (approximately 45%). 50% of patients are over 50 years old. There are a significant number of patients over the age of 75. The majority of patients are Black African men and women. Compared to other treatment services, UHL patients have higher rates of coinfection with Hepatitis B, tuberculosis and AIDS related diagnoses and lower rates of Hepatitis C coinfection.

The UHL service have an information and guidance worker who supports patients with isolation, benefits, housing, struggles with mental health and other needs who is present for all clinics. Social care is provided by the adult and social care team at the local authority, where housing advice and social care support can be accessed by those living with HIV. Previously there were community groups supporting people with HIV in Leicester but there are no known groups that specifically support people with HIV.

5.1.7.6 Unmet need

Before 2020, testing rates in heterosexual men and women are worse than the England average. The rate of late diagnosis in heterosexual men is higher than the England average. Work targeting these groups for uptake of testing is important to ensure they get care as soon as possible and prevent onward transmission of HIV.

The provision of PrEP through the NHS is an effective support to prevent HIV transmission and the provision needs to be suitable for all those at risk of HIV including heterosexual men and women, those in living in more deprived areas and those who are fearful of revealing their risk to sexual health services.

Compared to previous years in the city, there is less commissioned community support for people at risk of and living with HIV. There is no commissioned or non-commissioned service for prevention for those living with HIV in the Black African community.

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 care 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.

5.1.7.7 Recommendations

Current national policy is governed by the HIV Action Plan for England and the national target is an 80% reduction in transmission by 2025 and zero transmission by 2030[iii]. These recommendations aim to meet the objectives of national HIV Action Plan, utilising the understanding that Leicester's at-risk population is majority Black African heterosexual men and women.

Objective 1: ensure equitable access and uptake of HIV prevention programmes

- Commissioners to utilise further expansion of PrEP access from any national policy changes to encourage uptake in different groups to reduce health inequalities. This

could include provision of PrEP from primary care services and partner agencies or different methods e.g., vaginal rings.

- ISHS and commissioners to undertake campaigns in conjunction with people with HIV/commission group supporting those with HIV to support community understanding, de-stigmatisation and importance of HIV prevention and testing in the most high-risk groups

Objective 2: scale up HIV testing in line with national guidelines

- Local authority commissioners should set a standard for sexual health services to achieve a 90% testing offer rate to first time attendees, as per British HIV Association (BHIVA) guidelines. (BHIVA guidelines are documents setting the UK standard of Care)
- Commissioners utilise learning from financed opt-out testing in emergency departments in the highest prevalence local authority areas and look to support offers to implement opt out testing in Leicester Royal Infirmary emergency department given evidence and funding
- Commissioners to support OHID/UKHSA reviews of clinical testing guidelines to identify opportunities for further testing of high risk groups

Objective 3: optimise rapid access to treatment and retention in care

- Services to work collaboratively to support individuals not attending care. Explore the use of any nationally published protocols for supporting people with HIV to remain in treatment.

Objective 4: improving quality of life for people living with HIV and addressing stigma

- Commissioners to undertake further work in understanding the social and emotional needs of people living with HIV in Leicester and best methods to commission to support these.
- Services and commissioners to work with people with HIV in Leicester on prevention work to ensure stigmatisation is addressed.
- ICB to ensure all health staff are trained on information on HIV transmission, U=U and infection control.

5.2 Contraception

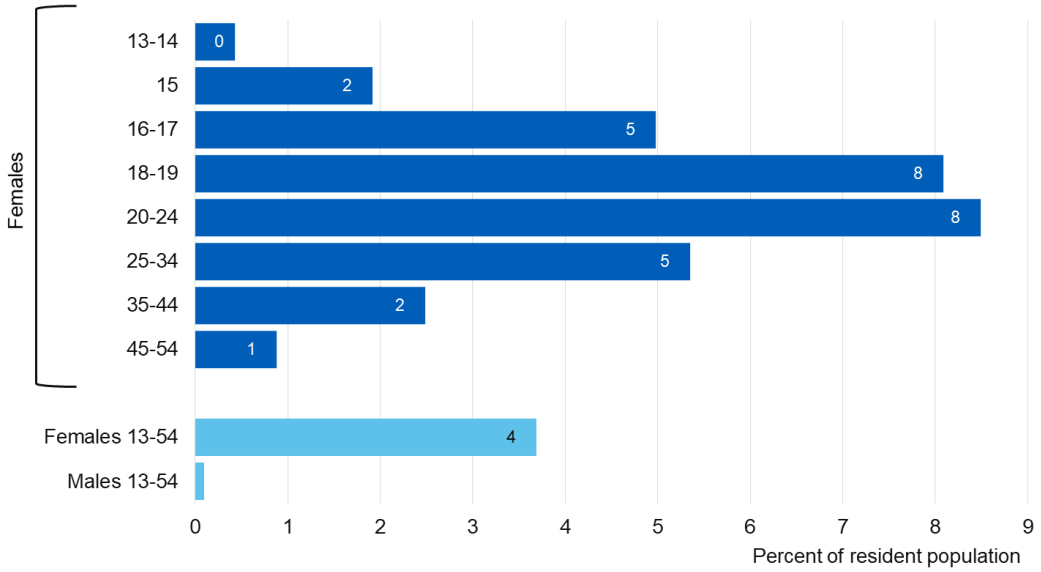
In 2020/21, there were 1.58 million contacts with dedicated SRH services made by 0.83 million individuals. This was a decrease of 20% compared to the number of contacts in 2019/20 (1.97 million). The number of individuals using SRH services decreased by 33% compared to 2019/20 (1.2 million).

The number of contacts per year has fallen 39% since 2010/11 (when there were 2.57 million). Changes over time may be affected by variation in the way services record the non-contraception related activity included in this measure. Provision of SRH services in 2020/21 has also been affected by the impact of the Covid 19 pandemic.

In 2020/21, there were 1 million contacts for reasons of contraception, down 22% compared to 2019/20 (1.29 million), and down 46% compared to 2014/15 (1.87 million). This data is not available prior to 2014/15 due to differences in how the data was collected. Part 1: Contacts with Sexual and Reproductive Health Services - NHS Digital (Part 1: Contacts with Sexual and Reproductive Health Services - NHS Digital

Information on NHS community contraceptive clinics excludes services provided in out-patient clinics and those provided by General Practitioners (GPs). Nationally the likelihood of women accessing the SRH service in a year varies with age.

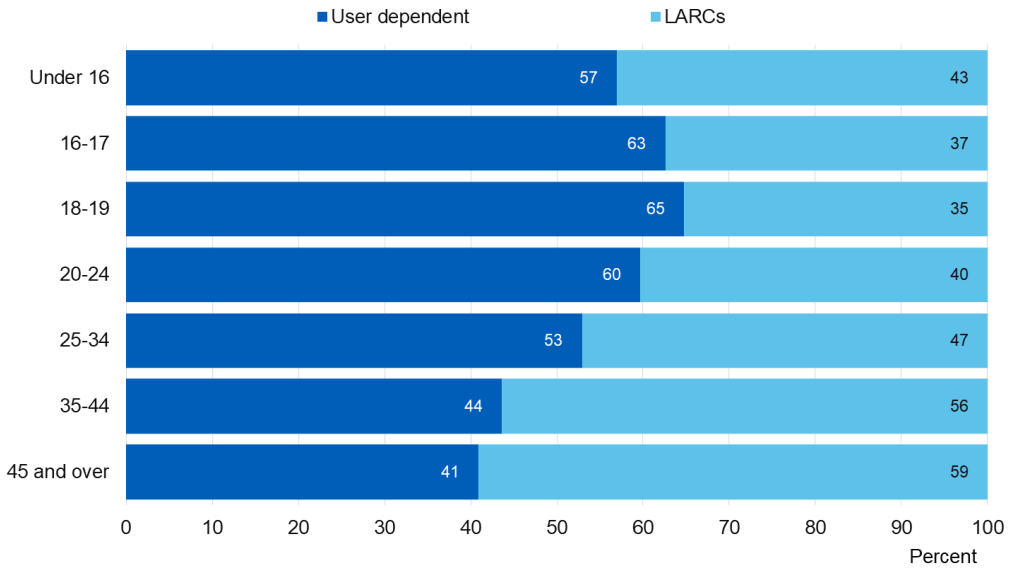
Figure 24: Percentage of population accessing NHS Community Contraception clinics per year by age



Source: Part 1: Contacts with Sexual and Reproductive Health Services - NDRS (digital.nhs.uk)

Nationally in 2020/21 54% of females in contact with SRH services for contraception had a user dependent main method, and 46% were using a LARC. This tends to be age dependent with more older women using LARC methods.

Figure 25: ***Age related ratios of User dependent: LARC contraception***



Source: Part 2: Methods of contraception - NDRS (digital.nhs.uk)

Implants are the most common type of LARC, being the main method of contraception for 18% of females, with younger age groups more likely to use them; 35% of under 16's compared to 12% of those aged 45 and over.

The increase in overall LARC uptake over the last 10 years has been driven by a rise in implants, IU systems and devices. In 2020/21, IU systems were the main method for 12% of females, and IU devices for 9%.

Use of IU devices and systems increases with age, with 43% of those aged 45 and over using one or the other as their main method of contraception. This compares to 15% of 20–24-year-olds and less than 5% of those under 18.

5.2.1 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
- Sub-Dermal implants (SDi) also called implants
- Depo-Provera Injections
- Contraceptive patches

Leicester City Council contracts GP practices across Leicester to provide LARC in the form of SDis and IUS/D. This requires clinicians (either doctors or nurses) to have specific training and ongoing competence to fit these devices. The contract is flexible and enables practices to provide this service for patients who are not registered with them. Currently there are 28 practices who are providing these services.

5.2.2 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)

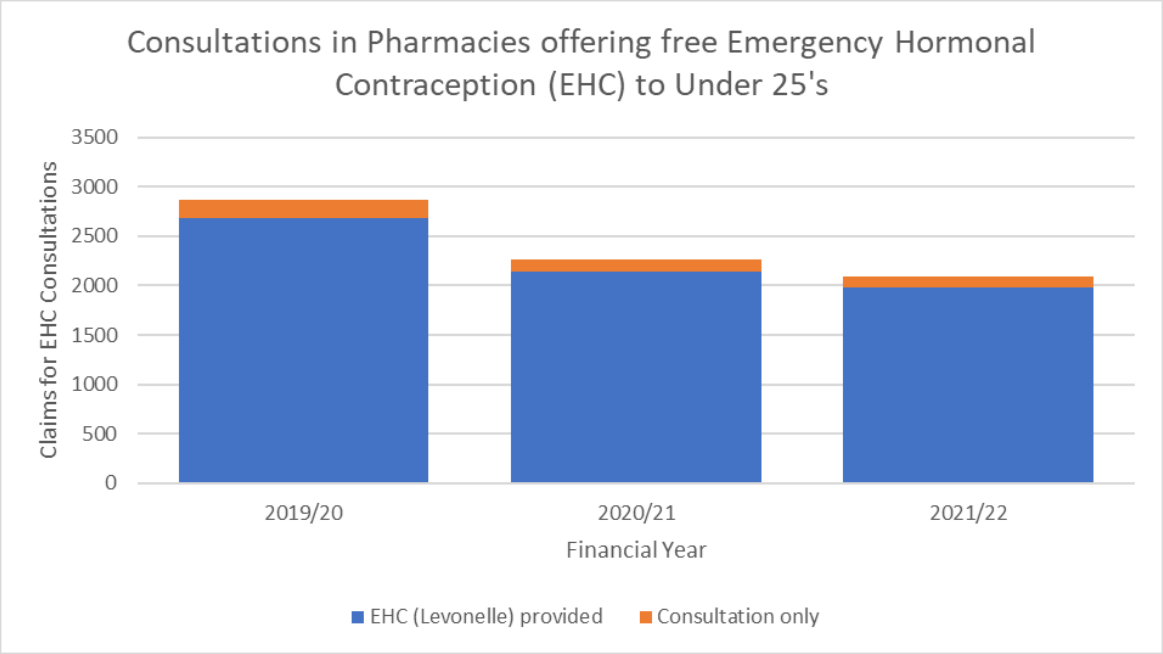
5.2.2.1 Emergency contraceptive pill

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 11 local pharmacies across Leicester. The community pharmacy scheme saw 2,096 women in 2021/22 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 Integrated Sexual Health Service (ISHS) where either ellaOne or the IUD can be provided. According to pharmacy data between 2021/22 98% of women accessing EHC presented before 72 hours of unprotected sexual intercourse. The most common age range for those accessing EHC through the community pharmacy route was 16-24 years of age.

Figure 26: ***Consultations in Pharmacies offering Free EHC***



Source: PHAMAOUTCOMES performance data

5.2.2.2 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.

5.2.3 Condom and pregnancy testing provision

Free condoms and pregnancy tests are available across Leicester to all in Further Education colleges Universities youth and community settings and community pharmacies. Trained workers provide these along with instructions on their use. In 2021, 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.

5.2.4 Teenage Pregnancy

Teenage pregnancy is a health inequality in Leicester. Teenagers have the highest rate of unplanned pregnancy and poorer health outcomes relating to higher rates of stillbirth and infant mortality and higher rates of low birth weights. Children born to teenage mothers have a 63% higher risk of living in poverty, and mothers under 20 have a 30% higher risk of poor mental health in the first 2 years after giving birth.

5.2.4.1 Health implications of teenage pregnancy

Teenage pregnancy is an important public health problem not just because of its personal, family, societal, educational, and economic implications, but also in terms of health risks and consequent implications for the health system. Compared with older women, in women under the age of 20:

- Stillbirths are 30% higher
- infant mortality rate is 60% higher
- sudden unexpected death in infancy is three times higher
- smoking during pregnancy is three times more likely
- breastfeeding at 6 to 8 weeks is half as likely
- rates of poor mental health are higher for up to three years after birth.
- since parental depression is the most prevalent risk factor for negative impact on child development, children of teenage mothers are more likely to have developmental delays
- an estimated 12% of 16–17-year-old females recorded as not in education, employment or training was a teenage parent.

5.4.4.2 Inequalities

Teenage pregnancy rates are higher in England compared with Western Europe. Teenagers are the age-group at highest risk of unplanned pregnancy and most teenage pregnancies are unplanned. Outcomes for young parents and their children are disproportionately poor with teenage mothers less likely to finish their education, more likely to live alone, in poverty and in poor quality housing, and the children more likely to have accidents and behavioural problems.

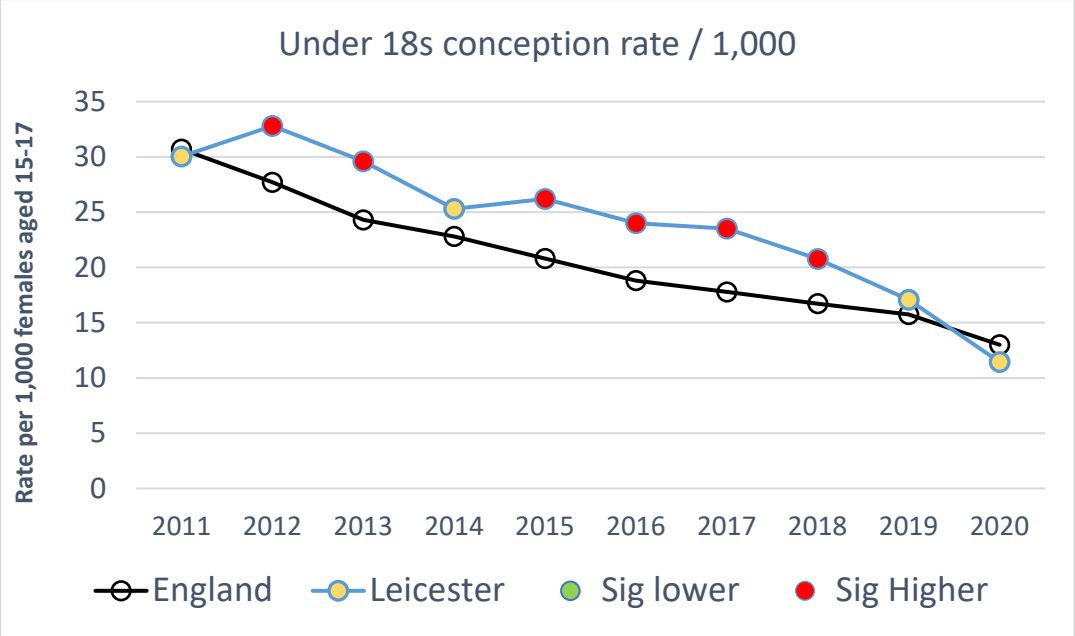
Inequalities also exist in terms of risk factors for teenage pregnancy. Teenage pregnancy is more common in women from poorer families, single-parent households, areas of greater deprivation, and those born to teenage parents. Individual risk factors include looked after children and care leavers, persistent school absence, slower than expected academic progress between ages 11-14, first sex before age 16, alcohol use, experience of sexual abuse and exploitation, and adverse childhood experiences.

In terms of population-level risk factors, compared with national levels, Leicester has comparatively high rates of deprivation and children in low-income families, comparatively low rates of educational attainment as measured by Average Attainment 8 score, and a comparatively lower percentage of people in employment.

Since the Teenage Pregnancy Strategy was introduced in 1999, there has been a 71% reduction in the under 18 conception rate in England overall. The reasons for this improvement are not clear. It could be attributed to the government's Teenage Pregnancy Strategy, however similar improvements have been seen across Western Europe, though many other countries instituted similar strategies at a similar time. In 2018, the government released a Teenage Pregnancy Prevention Framework.

Leicester's under 18 conception rate has reduced from 59.1 in 1999 to 11.4 per 1,000 15-17 year olds in 2020, a reduction of 80.7%. The under 18 conception rate in Leicester is now similar to the national rate.

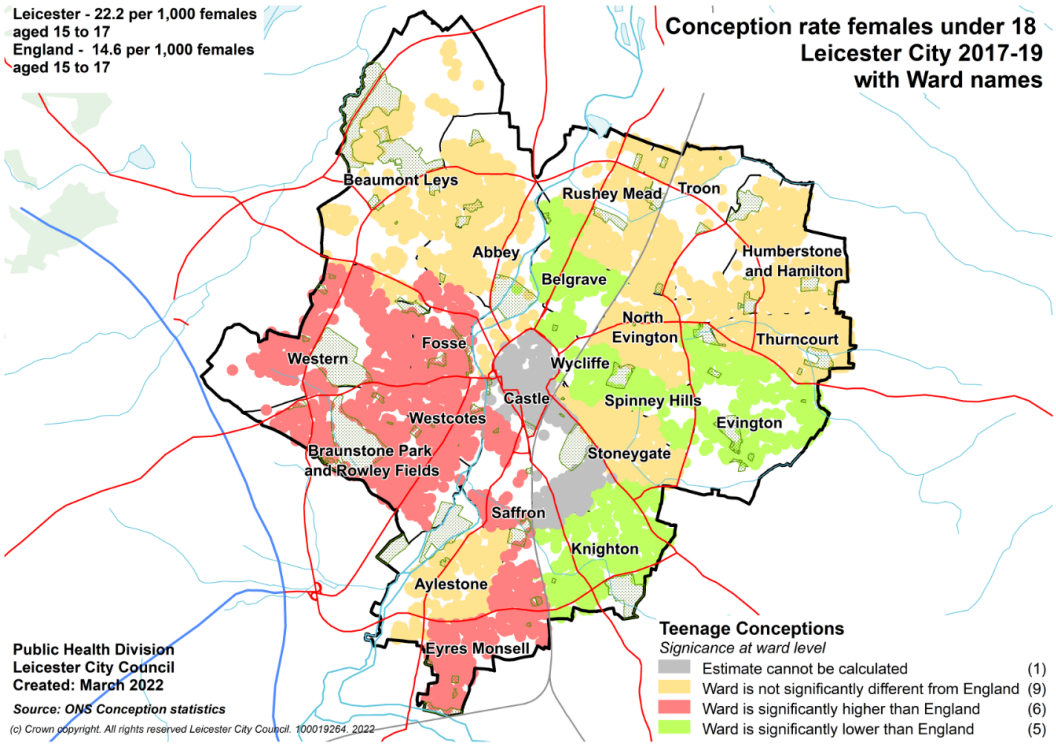
Figure 27: Under 18 conception rate



Source: *Public Health England, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

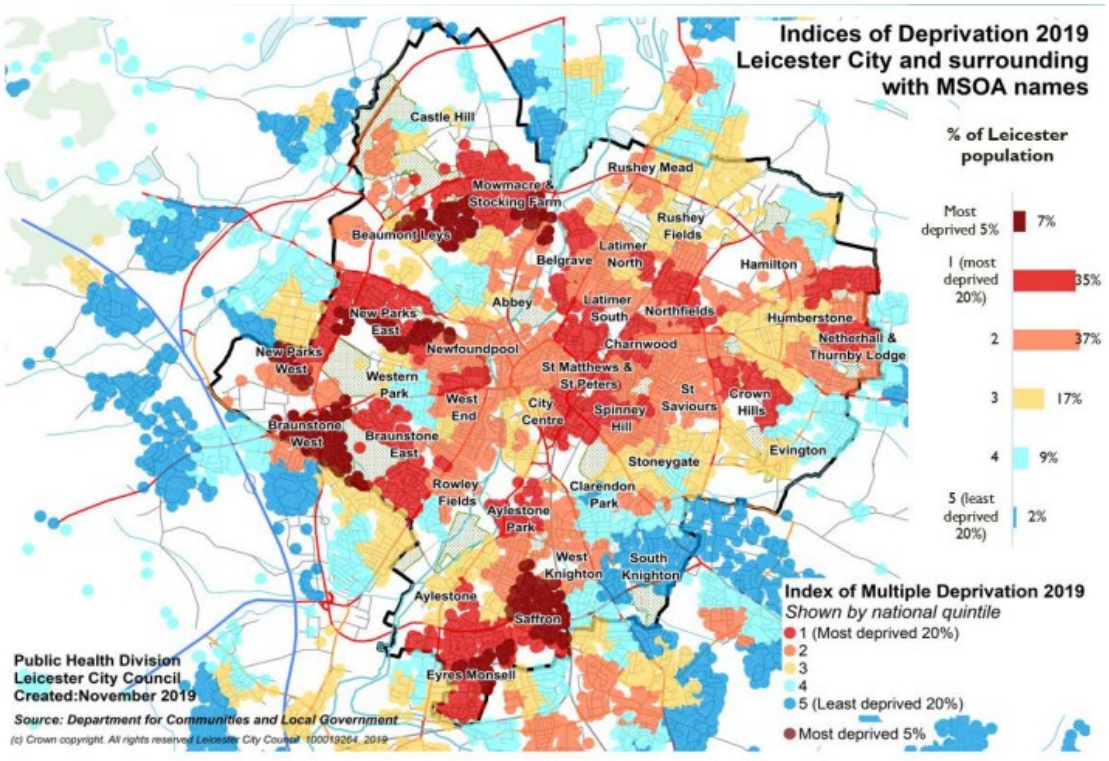
Six wards in the south and west of Leicester have significantly higher rates of Under 18 conceptions than the England average (Western, Fosse, Westcotes, Braunstone Park and Rowley Fields, Saffron and Eyres Monsell). Wards in the east of Leicester are generally similar or lower than the England average.

Figure 28: Teenage pregnancy rates in Leicester 2017-2019



Source: *Office for National Statistics*

Figure 29: Leicester City Area Map by Indices of Multiple Deprivation



Source: Office for National Statistics, English indices of deprivation 2019

Comparison of these two figures reveals that the areas with higher-than-average rates of teenage conception correlate with the most deprived areas in the city. Living in areas of deprivation as well as being from poorer families are recognised risk factors for teenage pregnancy.

5.2.5 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. UHL provides direct- or self-referral access to terminations of pregnancy as follows:

- Early one stop medical termination to 9 weeks + 6 days gestation
- Surgical terminations (STOP) to 14 weeks gestation
- Medical terminations to 16 (MTOP) weeks gestation

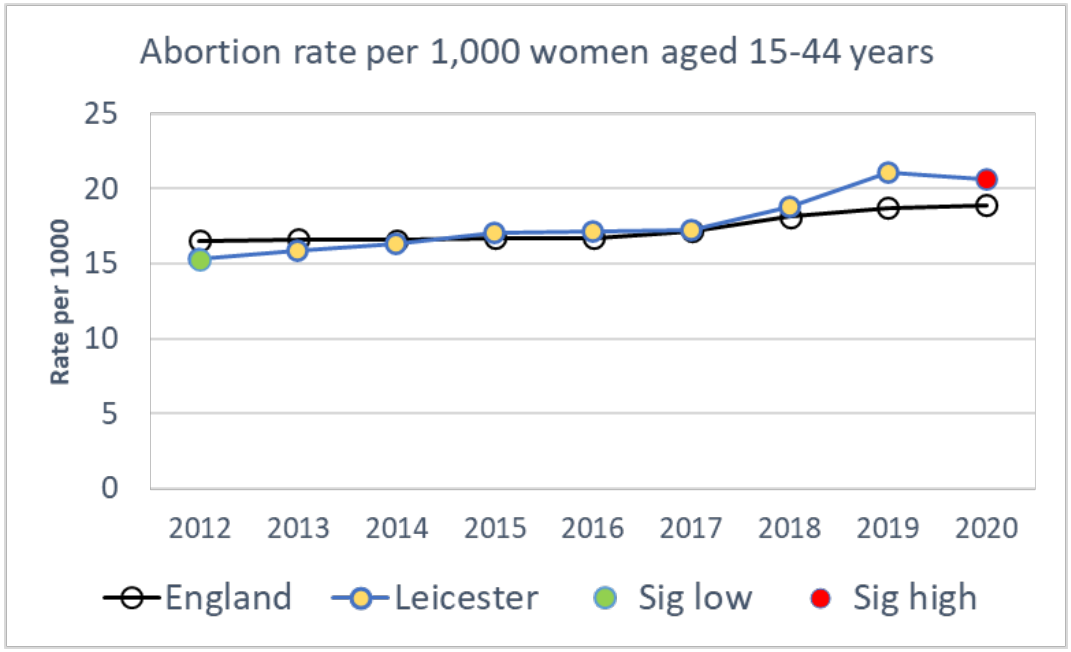
There is now a branch of the British Pregnancy Advisory Service (BPAS) in Leicester. They are another provider of termination services and patients can also be referred or self-refer to BPAS, although they cannot provide terminations for women with complex medical conditions, who must be seen at UHL. BPAS will provide STOP over 14 weeks gestation subject to clinician review. Currently, more than half of TOPs in Leicester are being done through BPAS rather than at UHL, which may be related to lack of knowledge amongst GPs and the public that this service is self-referral, rather than needing a clinician to refer.

TOP care at UHL also offers risk assessment and counselling around chlamydia and gonorrhoea self-testing. HIV testing is not routinely offered, only subsequent to risk assessment and patient request. In addition to STI testing, multiple contraceptive offers are available to those having TOPs at UHL:

- For those undergoing MTOP, IUS/IUD are offered after confirmation of termination of pregnancy, and although depo injection is not a preferred option immediately following MTOP due to slightly increased risk of failure rate, it is still offered if it is the patient's preference.
- For those undergoing STOP, any contraption is offered (subject to individual contraindications) including LARC methods (coils and implants) and oral contraceptive methods.

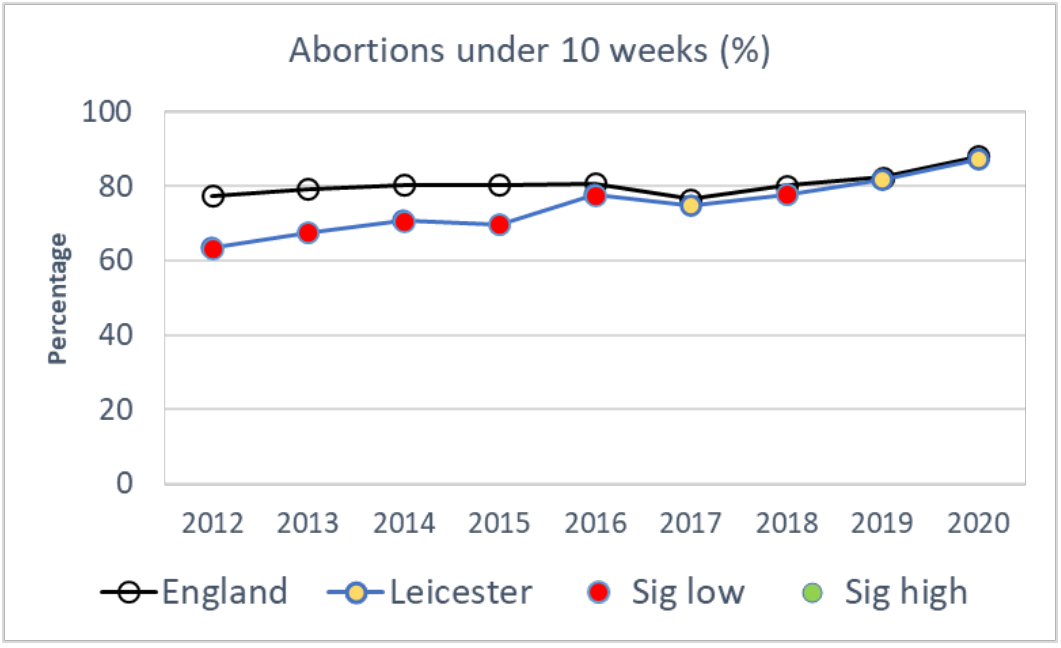
The figures below show that the rate of terminations in Leicester were previously similar to England but have seen an increase in 2019 and 2020. Interpretation of abortion trends can be complicated. An increase in people requesting terminations can indicate increasing un-met contraceptive need (particularly an increase in repeat terminations) however, an increase in early medical termination rates may simply indicate improved access to the service, rather than a higher rate of unwanted pregnancy, and this would obviously be a positive finding.

Figure 30: Termination of pregnancy rate per 1,000 women aged 15-44



Source: *OHID, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

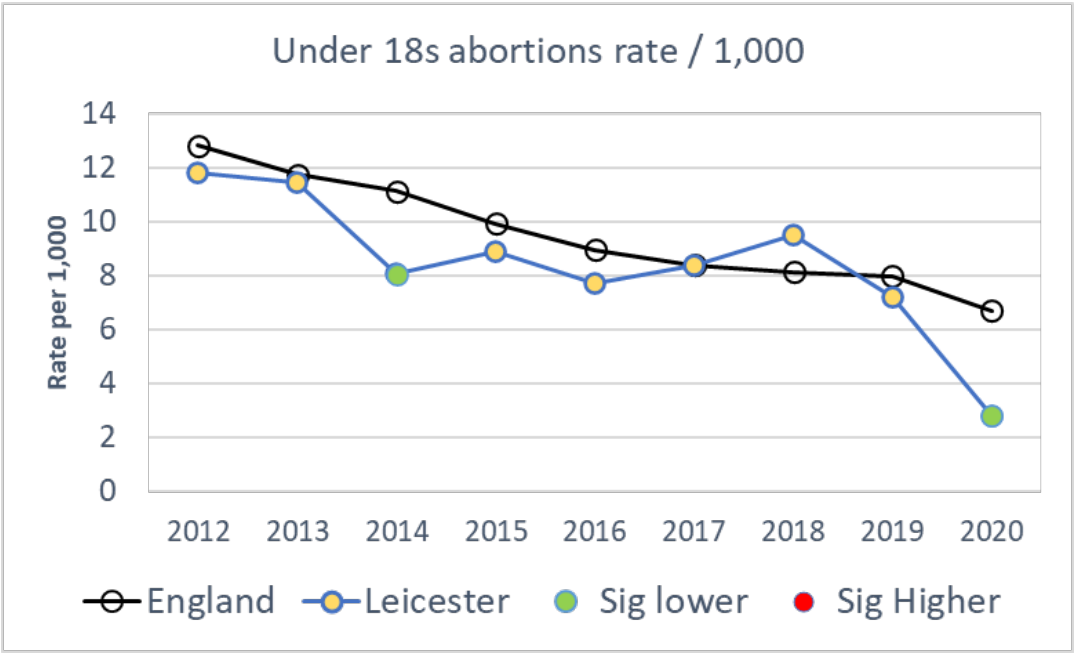
*Figure 31****: NHS funded abortions under 10 weeks***



Source: *OHID, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

The rate of terminations in Leicester for those under 18 (15-17 years of age) has fallen from 11.8 per 1,000 population in 2012 to 2.8 per 1,000 women in 2020 which is significantly below the England rate of 6.7 per 1,000.

Figure 32: Under 18 abortion rate



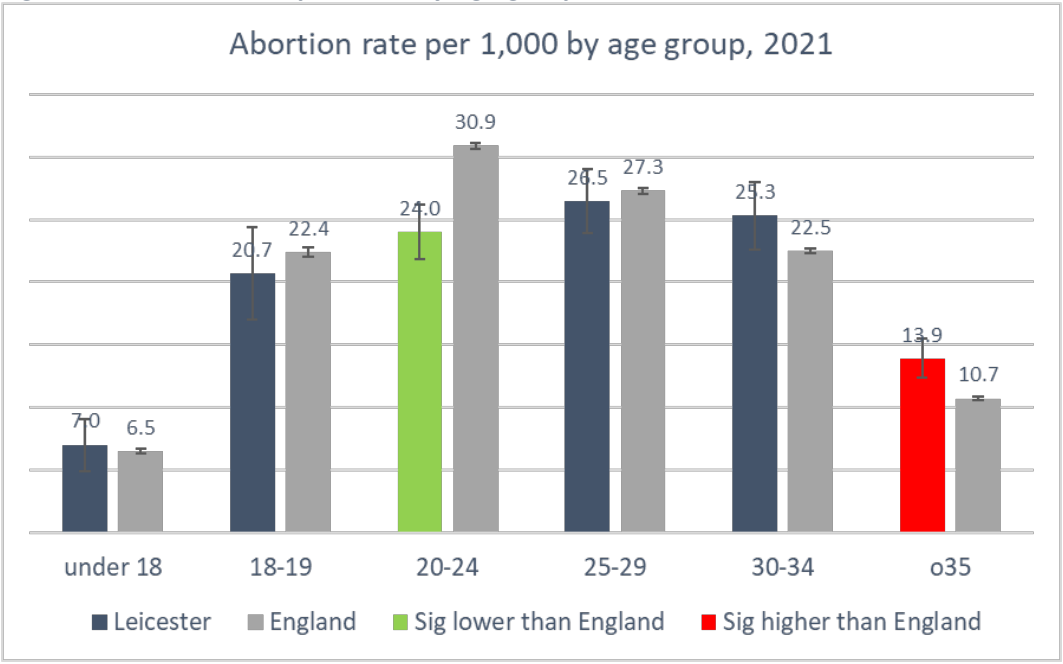
Source: *OHID, Sexual and Reproductive Health Profiles: https://fingertips.phe.org.uk/profile/sexualhealth*

Repeat abortions for those aged under 25 are similar to England and the rates were similar in 2019 and 2020. In 2020 repeat abortions for those aged under 25 during were 28% in Leicester and 29% in England. 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.

5.2.5.1 Termination of pregnancy by age group

Abortion rates are generally lowest in under 18-year-olds, increasing for women in their 20s and decreasing in the over 30s. Leicester shows a similar rate of abortions to England in under 18s and 18-19 year olds. The highest abortion rate in England is seen in 20–24-year-olds, whilst for Leicester the highest rate is seen in 25-29 year olds and the rate in 20-24 year olds in Leicester is significantly lower than England. In over 35s, the abortion rate is significantly higher in Leicester than England.

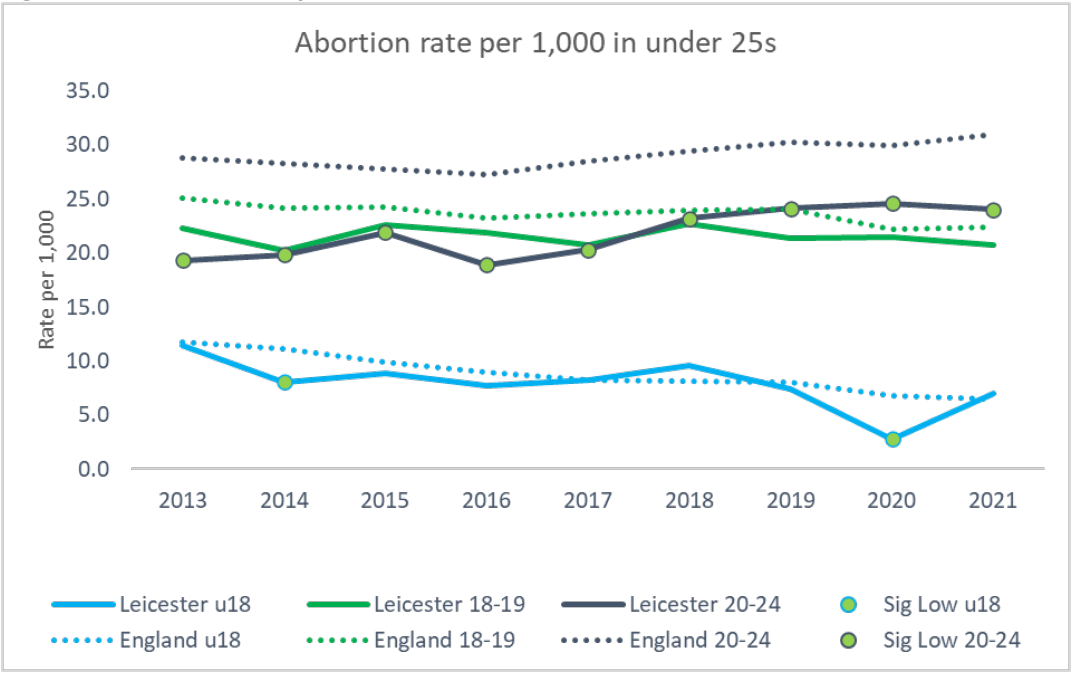
Figure 33: Abortion rate per 1,000 by age group, 2021



Source: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021

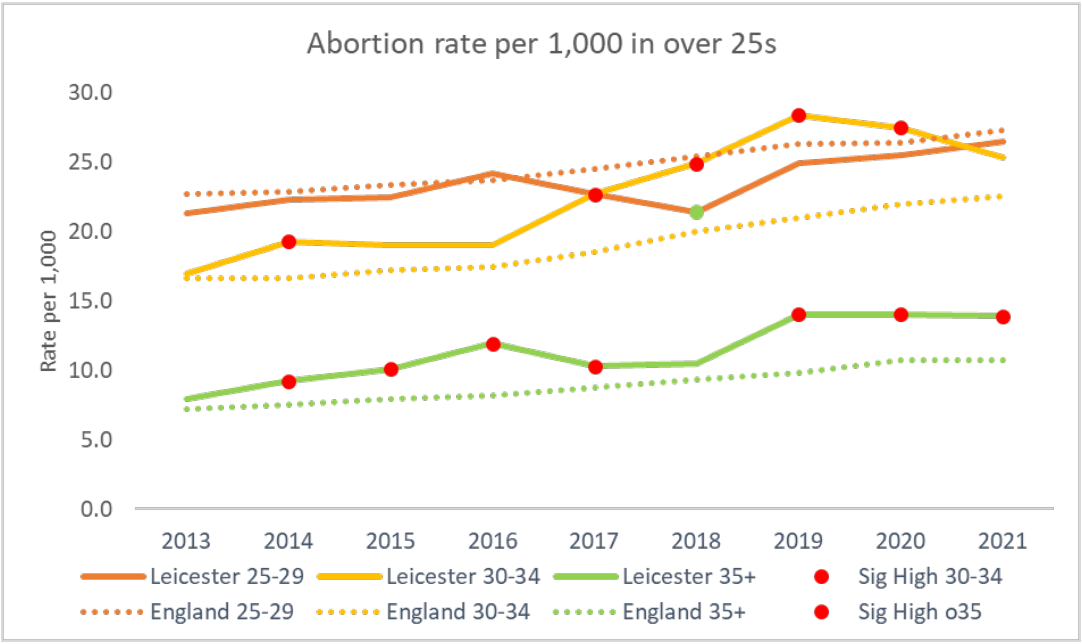
The figures below show the trend in abortion rates over the past few years. There has been an upward trend of increasing rates for abortions in 20-24, 25-29 and over 35-year-olds in Leicester. In 30–35-year-olds there has been a reduction over the most recent years.

Figure 34: Abortion rate per 1,000 in under 25s



Source: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021

Figure 35: Abortion rate per 1,000 in over 25s



Source: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021

The comparatively older demographic of women accessing terminations in Leicester is interesting and as mentioned above, further investigation is needed to ensure that this doesn't actually reflect poor access to service for younger women. It also has implications for commissioning, such as whether or not to extend the upper age limit for obtaining free EHC from pharmacies in the city. Something which has previously stopped at age 25.

5.2.6 Sterilisation

It was not possible to obtain information on these services.

5.2.7 Vasectomy

It was not possible to obtain information on these services.

5.3 Psychosexual counselling

The following data is from the Psychosexual service provision that is provided by the integrated sexual health service. This is a referral only service from GPs and patients identified with need in the service. The data below show that there has been an increase in the number of referrals since 2014 from GPs to this service.

Referrals from:

Year	2014	2015	2016	2017	2018	2019	2020	2021	2022
GP	<5	36	44	53	41	78	61	64	83
Hospital Doctor	N/A	<5	8	N/A	N/A	N/A	N/A	N/A	N/A
Leicester Sexual Health Service	6	64	46	36	16	25	25	14	11

Other *	N/A	N/A	<5	N/A	N/A	<5	<5	<5	<5
Self-Referral	N/A	<5	<5	<5	N/A	N/A	18**	N/A	N/A
Total number of referrals	**10**	**103**	**102**	**90**	**57**	**104**	**105**	**80**	**97**

* "Other" are from Vita Health (supported by GP's). A presentation was delivered some time age and we have the occasional referral via them.

**we permitted self-referral due to the lack of referrals post Covid due to primary care capacity

Please note COVID years will have affected the referral numbers from GPs and capacity within the ISHS

Numbers of 5 or less have been suppressed to avoid deductive disclosure in line with usual data practices

Reason for referral:

Problem	2014	2015	2016	2017	2018	2019	2020	2021	2022
Delayed Ejaculation	N/A	N/A	N/A	N/A	N/A	<5	<5	<5	<5
Erectile Disorder	N/A	32	25	N/A	N/A	19	17	8	25
Female Orgasmic Disorder	N/A	<5		N/A	N/A	<5	<5	<5	<5
Female Sexual Interest/Arousal Disorder	N/A	<5	7	N/A	N/A	<5	<5	<5	6
Genito-Pelvic Pain/Penetration Disorder	N/A	38	29	N/A	N/A	31	35	17	37
Male Hypoactive disorder of desire	N/A	N/A	<5	N/A	N/A	<5	<5	<5	<5
Other specified female dysfunction	N/A	<5	6	N/A	N/A	<5	10	<5	<5
Other specified male dysfunction	N/A	N/A	6	N/A	N/A	<5	<5	<5	<5
Porn Addiction	N/A	N/A		N/A	N/A	<5	N/A	N/A	N/A
Premature (Early) Ejaculation	N/A	N/A	10	N/A	N/A	<5	8	<5	9
Sex Addiction	N/A	N/A		N/A	N/A	<5	N/A	<5	N/A
(blank)	10	26	18	90	57	30	21	38	7
Total number of referrals	**10**	**103**	**102**	**90**	**57**	**105**	**105**	**80**	**97**

Waiting time in days:

Year	Average Waiting time (day)
2014 - Nov-Dec	132
2015	138
2016	61
2017	56
2018	34
2019	30
2020	43
2021	48
2022	96

5.4 Cervical screening

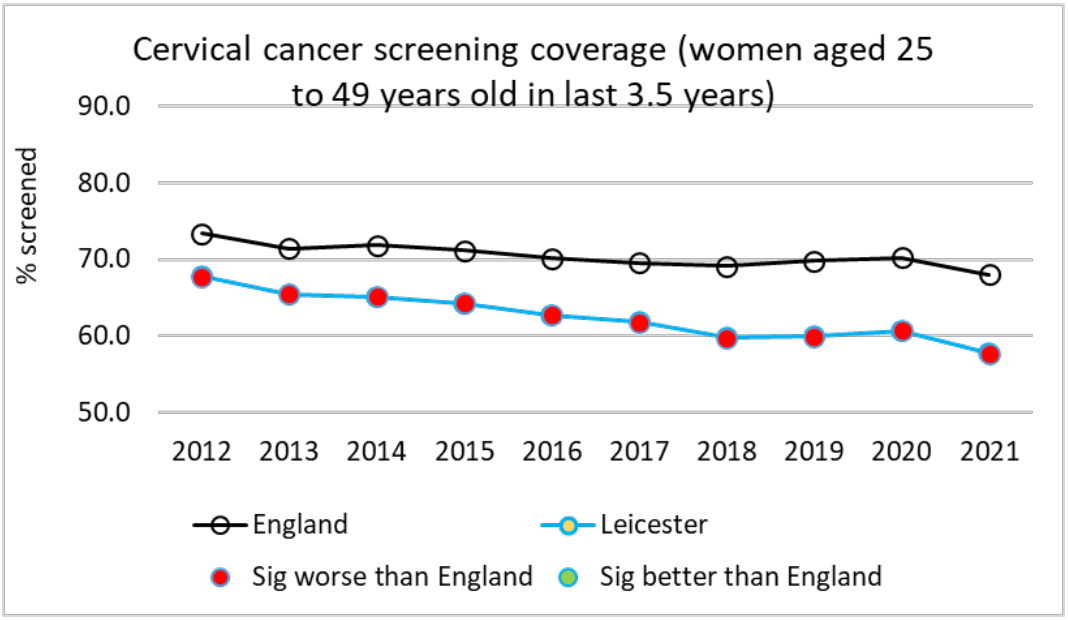
As part of the national screening programme, cervical tests are offered to all women aged 25 to 64 as follows:

- 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.

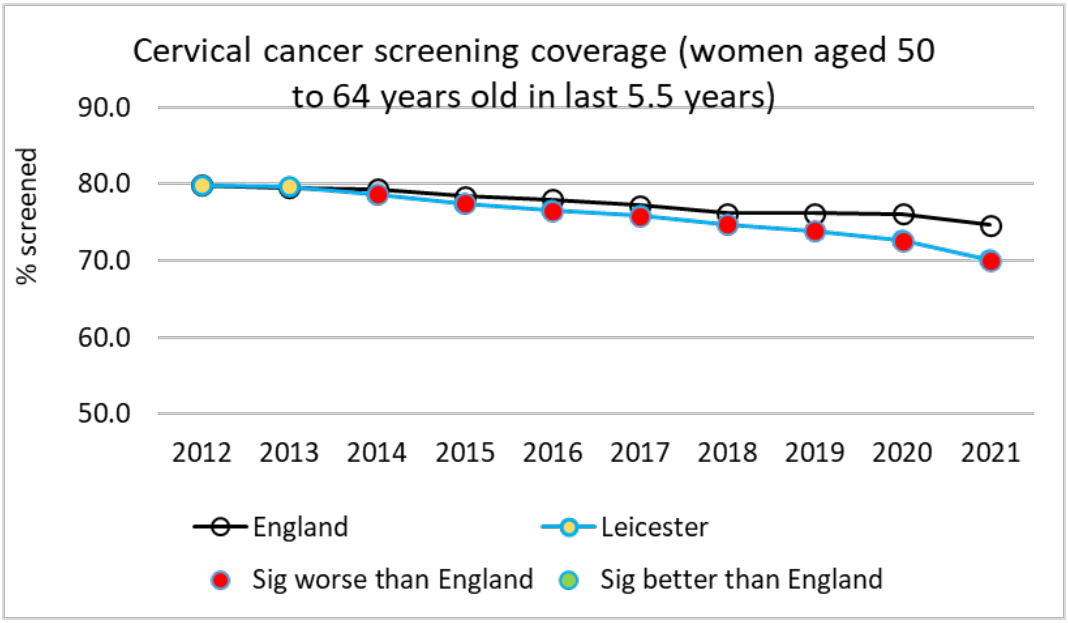
Historically, Leicester has had low uptake rates of cervical screening when compared against the England average. Coverage in Leicester has also been falling steadily since 2010, with coverage statistically significantly lower than England and the gap is widening. In 2021, the rate in Leicester (57.7%) for 25-49 year olds is over 10% lower than nationally 68.0% In 50-64 year olds, the rate is higher but also significantly lower in Leicester (70%) than England (74.7%) and the gap is widening. 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 its peer comparators (Figure 32).

Figure 36: Trend in cervical screening coverage (women aged 25-49, screened within last 3.5 years) in Leicester and England



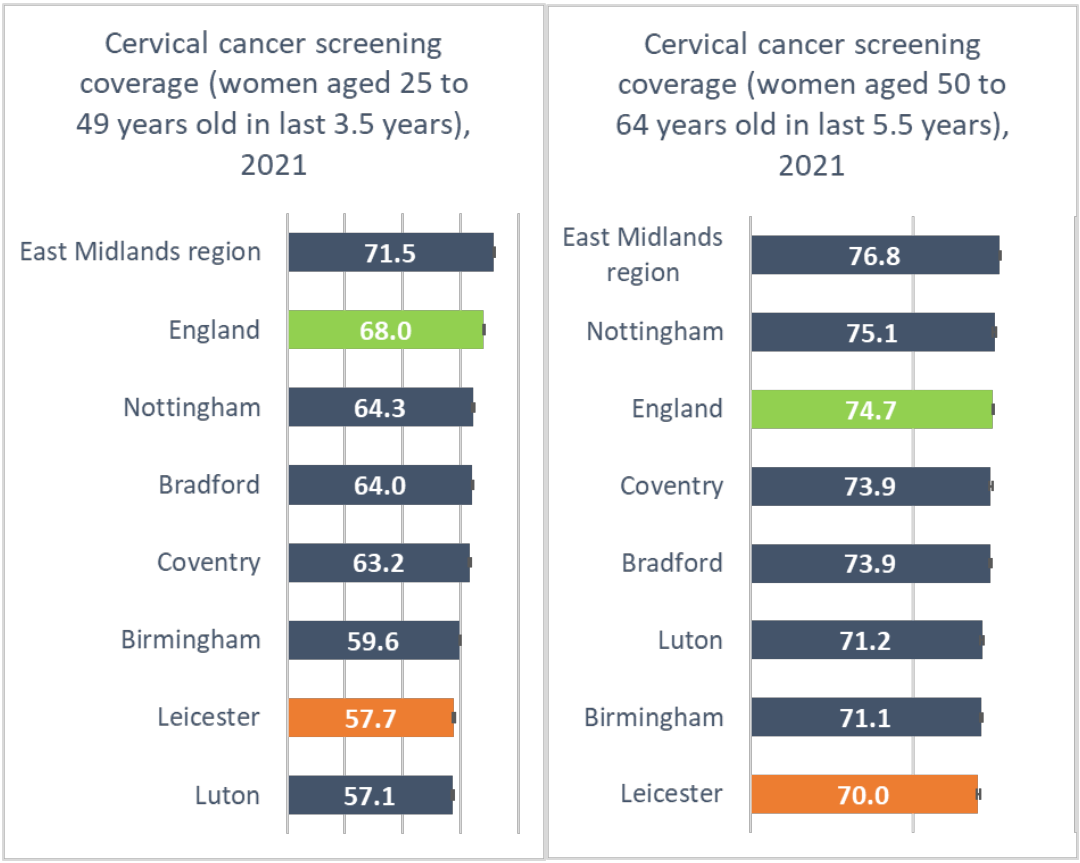
Source: *OHID, Public Health Profiles: https://fingertips.phe.org.uk/profile/*

Figure 37: Trend in cervical screening coverage (women aged 50-64, screened within 5.5 years) in Leicester and England



Source: *OHID, Public Health Profiles: https://fingertips.phe.org.uk/profile/*

Figure 38: Coverage of cervical screening be age group in Leicester, peer comparator areas and England



Source: *OHID, Public Health Profiles: https://fingertips.phe.org.uk/profile/*

5.5 Sexual Violence

National Population-level surveys based on reports from survivors provide the most accurate estimates of the prevalence of intimate partner violence. A 2018 analysis of prevalence data from 2000-2018 across 161 countries and areas, conducted by the World Health Organisation (WHO) on behalf of the United Nations Interagency working group on violence against women, found that worldwide, nearly 1 in 3, or 30%, of women have been subjected to physical and/or sexual violence by an intimate partner or non-partner sexual violence or both.

The Natsal survey (2011)[xii] 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. This English survey is being repeated in 2022.

A study of service responses to BME women and girls experiencing sexual violence ([xx]Thiara, Roy and Ng, 2015) found that services were viewed as inaccessible and under-utilised by BME women even in areas that have higher BME populations. 36 in-depth interviews were conducted with women across diverse ethnicities and ages and the majority of women had been subjected to sexual violence in intimate relationships with higher levels of coercive control. Sexual violence lasted for several years (two to fifteen years) and frequently involved multiple people, including partners and also male members of the family such as fathers-in law and brothers-in law. Disabled women were vulnerable

to repeated/daily rape from non-disabled partners and a large number of women were without any social networks and family support and lived isolated lives.

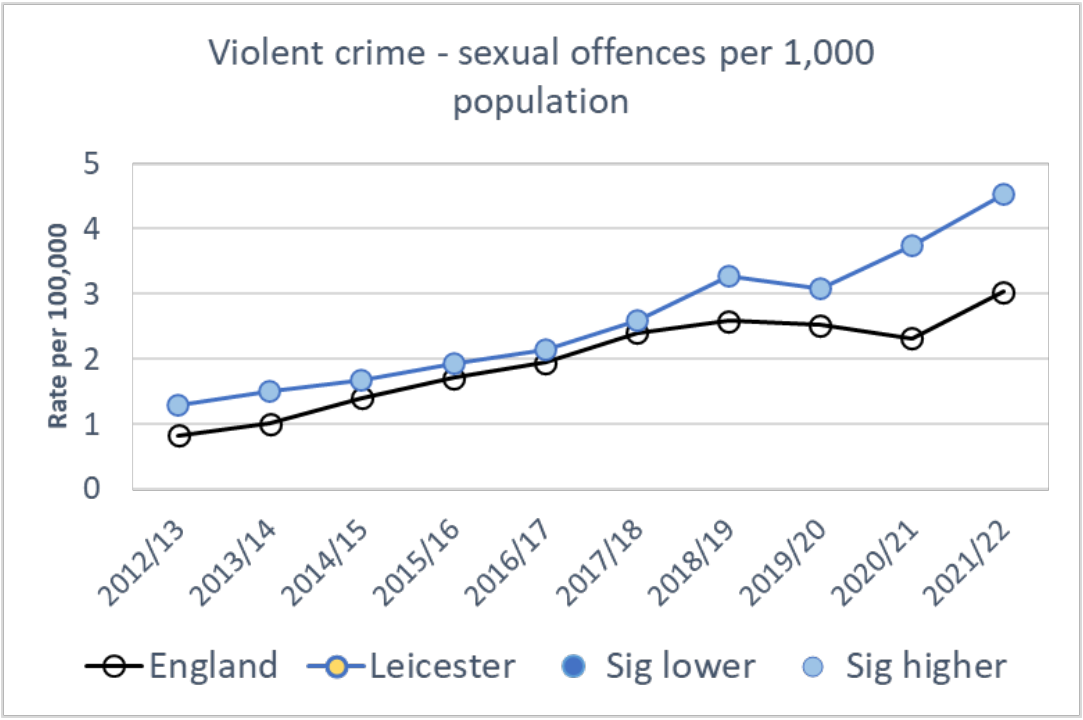
A recent paper that updated this research concluded that many BME women would prefer community-based support but not always provided by their own community. [xxi]

Other barriers to accessing appropriate support included racism and a lack of knowledge about support services; inadequate responses from support providers marked by assumptions about 'culture' (Ahmed et al, 2009; Burman et al, 2004); the reluctance among BME women to involve criminal justice agencies; and the difficulty of discussing sexual violence in particular communities (Gill and Harrison, 2016).

Men and women currently serving in the armed forces, veterans of or reservists for the armed forces may face particular challenges to accessing services for factors which can include repeatedly changing locations and limited ability to build trusted relationships, sense of loyalty, fear of disbelief, exposure, perceived judgement of weakness. There is an emerging body of research in this area which, whilst it currently shows as a population they are no more or less likely to experience domestic abuse or sexual violence, indicates that specific consideration of their needs is required[xxii].

A Domestic Violence Needs Assessment was undertaken for Leicester in 2021. Data collected as part of the national Violence Indicator Profiles in the English Regions (VIPER) data set indicate that the 2020/21 crude rate of recorded sexual offences (3.6 per 1,000 population) for Leicester City is the fourth highest in the East Midlands.

Figure 39: Sexual offences, crude rate per 1,000 population (2020/21)

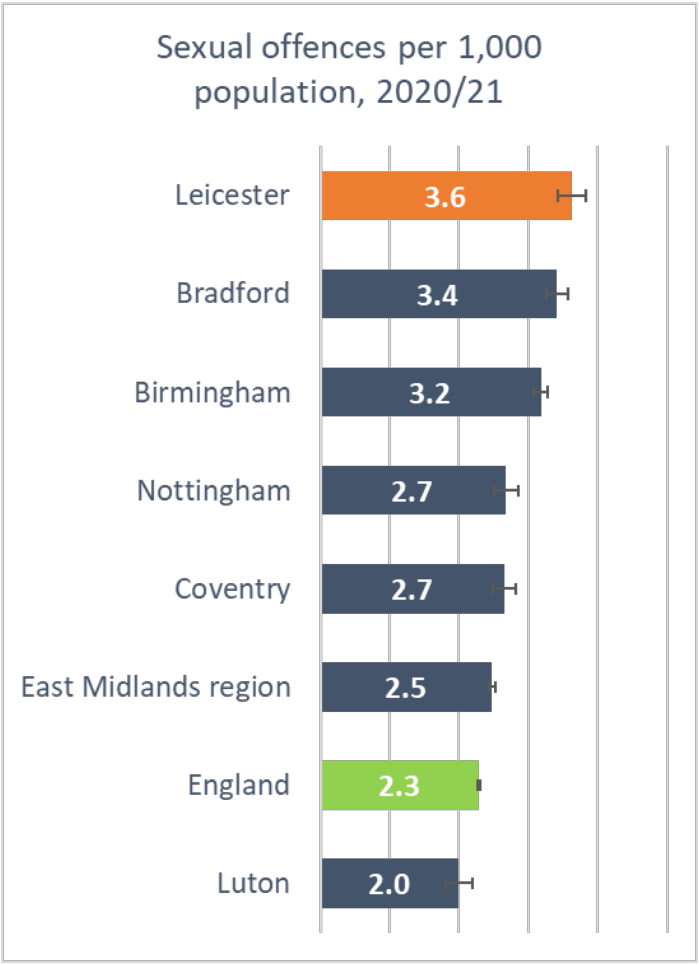


Source: *OHID, Public Health Profiles: https://fingertips.phe.org.uk/profile/*

Data collected as part of the national Violence Indicator Profiles in the English Regions (VIPER) data

set indicate that the 2020/21crude rate of recorded sexual offences 3.6 per 1,000 population) for Leicester City is the highest in the East Midlands and highest of peer comparator areas. The number of sexual offences recorded in Leicester during 2020/21 was 1,285. 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 (ie it cannot be established whether some clients are receiving support from more than one source).

Figure 40: Sexual Offences per 1000 population 2020/21



Source: *OHID, Public Health Profiles: https://fingertips.phe.org.uk/profile/*

Local services:

Sexual Assault Referral Centres (SARC) are c o - commissioned by NHS England and Improvement with Local Police and Crime Commissioners nationally.

Juniper Lodge SARC is accessible 24/7, for individuals over 18 years of age who are residing in LLR. For cases that are not reported to the Police, Juniper Lodge provides a self-referral option where a forensic medical examination is offered, and samples retained for up to 2 years.

The Forensic Practitioners are provided through Care and Custody (A Mitie company) in collaboration with Leicestershire Police who provide the wider SARC staffing including Crisis workers.

The Forensic Practitioners are able to provide Emergency Contraception (Hormonal) Hepatitis B initial injection, HIV PEPSE, which is a 28-day course.

The SARC will assess and support onward referrals based on the individual's needs. Juniper has pathways to refer to FreeVa who provide Independent Sexual Violence Advisors (ISVA) and the Children's ISVA, called CHISVA'S.

Other referrals/pathways can include:

- Sexual Health (Screening and Emergency IUD)
- Adult and Children Safeguarding
- GP's
- Substance misuse
- Local outreach for Sex workers
- Counselling
- Mental health (Primary and Secondary) through our Mental Health Nurse
- Prison Outreach (Includes specialist counselling) in LLR prisons
- University Support (all 3 LLR Universities)
- Emergency Department (ED)

For under 18's, there is the East Midlands Children and Young Persons Sexual Assault Service (EMCYPSAS) The service is accessible through the helpline: 0800 183 0023. The sites for examination are Queens Medical Centre, Nottingham and Serenity SARC in Northampton.

Juniper.Lodge@leics.police.uk: 24/7 line: 0116 273 3330

*Figure 41: **SARC referrals***

2019/20		Q1	Q2	Q3	Q4	
SARC referrals	City	54	43	57	39	193
	County	51	30	45	29	155
	Rutland	0	<5	<5	<5	<5

2020/21		Q1	Q2	Q3	Q4	
SARC referrals	City	27	56	68	56	207
	County	20	24	21	15	80
	Rutland	<5	<5	<5	<5	<5

2021/22		Q1	Q2	Q3	Q4	
SARC referrals	City	68	68	62	65	263
	County	28	37	44	42	151
	Rutland	<5	<5	<5	<5	<5

Source: Leicestershire Police: SARC referral data

5.6 Monkeypox

One of the emerging challenges facing sexual health services over the past year has been the global outbreak of monkeypox virus infection. Due to the nature of transmission in this outbreak where it seems to be spreading within sexual networks, particularly affecting men who have sex with men, gay and bisexual men (GBMSM), initial presentations of cases were often via sexual health services and responsibility for triage, diagnosis and management has largely remained with them.

Background:

Monkeypox is a viral infection which is endemic to west and central Africa. Although the occasional imported case was seen in the UK and Europe, it was previously unusual to see outbreaks of any significant size outside of West and Central Africa.

Monkeypox virus is an orthopoxvirus, so named because it was first identified in monkeys. Animal hosts include wild rodents and non-human primates. The first human case was diagnosed in the 1970s in the Democratic Republic of Congo. It is related to the smallpox virus (variola major) which is why the rash can appear similar, but it is a much milder illness. The west African subtype of the virus; which is the one implicated in this outbreak; generally results in a mild, self-limiting illness in adults. The Central African subtype is a distinct genetic strain and causes more severe disease. Despite the similar name and presentation, monkeypox is not related to chickenpox, which is a virus from the herpesvirus family. This means that previous chickenpox infection does not give immunity to monkeypox.

Clinical Features:

The incubation period of monkeypox (the time from infection to symptom onset) is typically 6-13 days but the range is anywhere from 5-21 days. Initial presentation is usually with a period of fever, headache, malaise, muscle/join pains and lymphadenopathy (swollen lymph glands) before the onset of the rash. The prominence of swollen lymph nodes is something that can help to distinguish monkeypox from other clinically similar illnesses like chickenpox or smallpox, where lymphadenopathy is not typically a major feature.

The rash typically develops 1-3 days after the onset of the fever. It is most often on the face and limbs with relative sparing of the trunk (again, this can be helpful to distinguish the illness from chickenpox) and can involve the palms and soles of the hands and feet, the mucous membranes and genitalia. The rash progresses through from a maculo-papular phase (reddened raised flat-based or nodular areas) through to vesicles (fluid filled blisters- like those in herpes or chickenpox/shingles) which become pus-filled and then eventually crust over.

Generally symptoms resolve in 2-4 weeks, and the mortality rate of this strain is low, particularly in adults. Disease can be more severe in younger patients

Transmission:

This is a zoonotic infection which means that typically the infection exists in an animal host or reservoir but can ‘spill over’ into the human population via various routes.

Human to human transmission is generally via close contact with respiratory secretions, skin lesions or recently contaminated objects. Respiratory transmission requires prolonged face to face contact for example household or sexual contacts. Prior to this outbreak, it was thought that human to human transmission of monkeypox was rare; the longest chain of infection identified was 9 people. Clearly this has now changed. This may reflect declining smallpox immunity (which also offers protection against monkeypox) in populations as we move further away from a time when people were regularly vaccinated or exposed to the disease.

The first case in this UK outbreak was identified in a returning traveller, however very few subsequent cases have been found to have travelled internationally to west and central Africa. Any international travel identified in cases has largely been to Europe and particularly Spain. Many of the cases have been identified in people who identify as gay, bisexual or men who have sex with men

(MSM) leading to the conclusion that the virus was spreading within sexual networks. However, it is not thought that the virus has changed to become sexually transmitted per se, but rather that sexual contacts have facilitated the kind of close physical contact required to transmit and catch the virus. Many of the initial presentations of these cases were via sexual health services with genital lesions- the monkeypox rash involves the genital area in around 30% of monkeypox cases.

Diagnosis:

Clinical diagnosis can be difficult due to the similarity in presentation to other viral infections such as chickenpox and HSV. A confirmed case is defined as a person with a laboratory-confirmed monkeypox infection (monkeypox PCR positive) in 2022

Management:

Clinical management is largely supportive as most cases are mild and self-limiting. International studies found that around 13% of cases in the current outbreak have required inpatient treatment. This has largely been for supportive care (pain relief, treatment of secondary infection of rash) as only 5% in that sample received monkeypox specific antiviral treatment.

Vaccination:

Because the monkeypox virus is similar to the smallpox virus, the smallpox vaccination is expected to prevent or reduce severity of infection. As of June 2022, the UKHSA has advised a pre-exposure vaccination programme to start for people in certain at-risk groups.

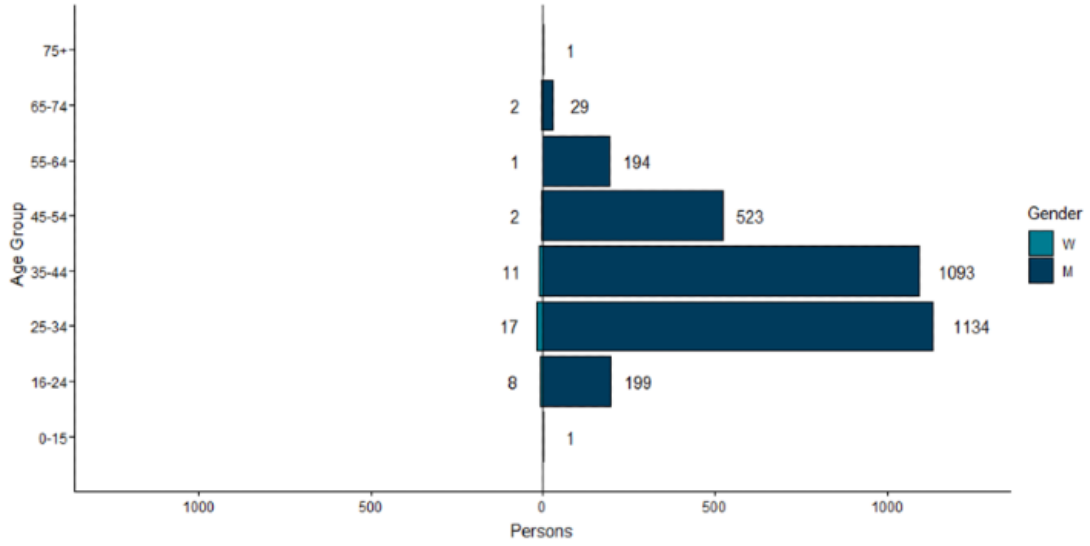
Epidemiology:

As of 12/09/2022 there have been 3,383 cases in total in England of which 3,238 were confirmed and 145 were highly probable.

The burden of cases is still disproportionately in the London and Greater London areas. Leicester (Upper Tier Local Authority Area) has had fewer than 10 confirmed cases so far. The ISHS clinical staff report that the cases they have seen have been clinically well with non-severe illness.

Out of the 3,215 England cases with a documented gender, 99% have cases have been in men, and only 41 cases have been identified in women. The median age of cases is 39. Around 70% of cases are London residents. The East Midlands accounts for around 2% of cases so far.

Figure 42: Age and gender distribution of confirmed and highly probable monkeypox infections by lab result date as of 26th August 2022.



Source: UKHSA Technical Briefing 7

Current data in the UK seems to indicate that:

- 78% identified as 'white' ethnicity, 9% 'mixed', 7% 'asian' and 4% 'black'.
- 96% of respondents identified as gay, bisexual or men who have sex with men (GBMSM).
- The majority of transmission in this outbreak seems to be occurring within the sexual networks of GBMSM, though household and non-sexual close contact transmission has been reported.
- Around 20-30% of cases who filled in questionnaires were living with HIV.
- Clinical presentation appears to be similar between those with an HIV diagnosis and those without.

There have not yet been sufficient case numbers in Leicester to analyse detailed demographic data with any great accuracy.

Challenges for sexual health services:

Although the identified number of confirmed cases in the region has remained small, the workload for sexual health services is still significant since it falls to them to do the triaging and assessment of possible cases, as well as diagnostics and vaccination. Since the triage is a skilled process, it needs to be done by senior clinicians which then takes them away from other duties.

In addition there is an expectation that Sexual Health services will provide vaccination for those seen most at risk.

6.0 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

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 2019 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 2019, Midlands Partnership Foundation NHS Trust became provider for Leicester, Leicestershire and Rutland (LLR) Sexual Health Services (SHS). This contract lasts until 31st March 2024.

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 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.

- 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

Hub opening times and booking modalities have been subject to change in recent times due to first covid and then monkeypox (now called Mpox). For the most up to date information on opening times and clinics, visit the sexual health service website at https://leicestersexualhealth.nhs.uk/

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:
Choices is a nurse led sexual health service for young people up to the age of 25. It is sessional and in places in the community where young people frequent. During COVID these clinics were paused and there has been variable return to use

The current Choices clinics:

- New Parks - St Oswalds Road Leicester LE3 6RJ. Weekly. Operates alongside the youth groups. Flexible clinic across the week to where there is a need. Currently Tuesday 1st and 3rd Thursday 2nd and 4th weeks
- Haymarket - LE1 3YT. Age reduced to 18 and under to encourage those younger to attend. Also dedicated vulnerable yp clinic alongside walk-in clinic. Referrals from professionals, e.g. CSE social workers. Very well utilised and valued by these professionals.
- Abbey Campus, Leicester College - Painter Street Leicester LE1 3WA. College students only. Mixed attendance levels. Works well alongside college C-Card/pregnancy testing offer, promoting each other's provision. Many students have learning difficulties, therefore vulnerabilities to manage.
- Beaumont Leys Health Centre - 1 Little Wood Close Leicester LE4 0UZ. Appointments and some walk-in appointments. The uptake for appointment uptake and walk-in appt's is inconsistent.

There has been a definite shift in attendance at all young people's post Covid despite our efforts through are marketing and communications channels as well as promotion via the c-card packs (info for local clinic added to each pack).

The clinics that have had poor attendance despite ongoing promotional efforts with the college and perseverance have eventually resulted in withdrawal of delivery from are Freemans Campus, Leicester College and Gateway College.

Merridale Medical Centre was a very well attended site prior to Covid restrictions and lockdowns. The medical centre was utilised as a covid vaccination hub for a long time and has not invited the service back into the centre since.

The nurse capacity for the above has all been moved back to the hubs to manage demand due to the nurse vacancies and backfill for internal nurse training.

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.

6.1 Specific Groups with Specific needs:

Leicester City Council has commissioned specific work for groups with specific needs as below:

6.1.1 Sex Workers

People (both men and women) that sell sex for money or other transactional work in various settings:

Street based sex work:
This is located on the street in two or three locations in Leicester. This is predominately women and many have other health needs, predominately mental health and substance misuse issues. There are approximately 35 women at any one time and this has been consistent for many years. The women have many sexual health needs including vaccination for hepatitis. This can be difficult to provide due to the disorganised lives that women may lead.
There is a police officer who works with this group of women and several voluntary sector organisations that support day to day needs. The sexual health service provide an outreach service and a fast access service at the sexual health hub.

Sex on premises – including saunas and massage parlours.
These are mainly located in the West side of the city around Narborough Road. The women that work in the premises require sexual health advice and information. The sexual health service visit the premises on a rotating basis to offer this.

6.1.2 Additional to the ISHS

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.

Pharmacy EHC is currently available free of charge to those under 25 in 11 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).

Termination of pregnancy services are commissioned by the ICS. 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. For more details, see the relevant section of this document.

Vasectomy services are commissioned by the ICS and currently provided in a variety of settings, however it was not possible to obtain any further detailed information.

Sterilisation services are commissioned by the ICS 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): RSHE is important to ensure that both healthy relationships and enjoyable sex lives are nurtured and developed Since September 2021, all schools in England must follow the Government RSHE statutory guidance in full and there is national guidance about how to teach this 1. Schools are free to choose the resources they use. RSE starts at year 1 and is delivered to young people as age appropriate. Leicester Secondary schools delivery of RSHE varies

[1] Teaching about relationships, sex and health - GOV.UK (www.gov.uk)

considerably. As it is not compulsory for the schools to work with anyone to monitor this work it is difficult to ascertain the quality and ensure the work is evidence based and inclusive for all pupils.

Leicester City Council commission some RSHE support to schools in Leicester. This is a small resource and enables each school to access 1.5 hours of support per year. This can be shared with other schools to make morning or day sessions.

The schools delivering excellent work are openly transparent with their strategy, model and delivery. It is not easy to know what is happening with secondary schools not wanting to work with the Sexual Health Services. This is picked up by OFSTED when they visit.

School Nursing Service is no longer supporting schools with this subject as before. Schools are missing this link into sexual health as schools due to cultural/religious reasons do not want the direct link to sexual health services but are comfortable with an outside NHS organisation coming into school and owning it. There are only have 3 secondary schools offering a school nurse sexual health drop in and this is only for 1 to 2 hour per week.

Schools have informally fed back they are missing the support that the school nurses previously offered in relation to sexual heath provision for their students.

Schools have been very keen to improve their knowledge around RSHE delivery for SEN students as they have recognised their students' increased vulnerability within this subject due to the rapid increase of online exploitation. This is an area that needs more support.

Leicester Sexual Health service are working with Leicester FE colleges to see if they would administer a questionnaire to their students asking them about their experience of RSHE delivery at secondary school.

With the recent sexual harassment and sexual abuse highlighted in schools Teachers are still asking for support in gaining the confidence to deliver this topic and requests for regular updates around the NHS sexual services available to their students, which all students should be made aware by Y11/12.

Leicester City Council as part of the RSHE offer commissioned support for looked after children and foster and residential children's homes. The 5 Leicester City Councils - Looked after Children's homes – request support from the ISHS RSE advisors. The staff are very proactive with their RSHE information that they share with the children (age appropriate) and request regular updates around sexual health. The homes where the children have SEN also work with the ISHS RSE advisors using/requesting more specialised resources/information. Schools for SEN students – Ellesmere & Netherhall have worked alongside the RSHE advisors extensively planning their curriculum and delivery At Leicester FE colleges, the SEN staff work regularly with us to improve their curriculum and delivery to this cohort of students.

LAC nursing team, Learning Disabilities teams and School Nursing the homes have asked us for additional support/guidance.

Leicester Partnership School, Carisbrooke (for excluded children age11-16) have also worked extensively with us to plan their RSHE.

Work in the past with asylum unaccompanied young students studying at Leicester college has been very successful and is something that we want to continue with as with their Launch Pad students who are identified as needing extra support.

6.1.3 Gaps Identified:

More work required with vulnerable (social care teams/youth service/County SEN schools/workers).

Offer to the vulnerable across City and County:

Developing City/County SEN-RSHE strategy group to help support them in this work.

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.

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.

Sexpression

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.

7.0 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 a growth in it's local population of 38,800 people (almost 13% increase) between 2011 and 2021. 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 not 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.

8.0 Evidence of what works

The cost of treating STIs nationally (excluding HIV) is estimated at £170 million. 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[xxiii]
- The provision of contraception saves the NHS £5.7 billion in healthcare costs that would otherwise have been spent if no contraception was provided[xxiv]
- 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[xxv]
- Early access to HIV treatment significantly reduces the risk of HIV transmission to an uninfected person with consequential cost savings[xxvi]
- 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[xxvii]
- preventative interventions that build personal resilience and self-esteem whilst promoting healthy choices[xxiii]
- rapid access to confidential, open-access, integrated sexual health services in a range of settings that are accessible at convenient times[xxviii]
- early, accurate and effective diagnosis and treatment of STIs (including HIV), combined with partner notification[xxvii] (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)[xxix]
- LARC methods are much more effective at preventing pregnancy than other methods, although a condom should also always be used to protect against STIs [xxx]
- 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[xxxii]

There is also evidence to show that preventative interventions that focus on behaviour change and are based on behaviour-change theory have been effective in promoting sexual health[xxxii]. 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[xxxiii]. 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[xxxiv]

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[xxxv]. 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[xxvii]
- access to and correct use of effective contraception[xxxvi]
- 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[xxxvii]. Findings from pilot projects indicate that offering HIV tests outside sexual health clinics is feasible and acceptable to patients as well as staff[xxxviii].
- increasing the uptake of HIV testing among black Africans in England[xxxix] and MSM[xl]. A 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[xli].

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.

9.0 Unmet needs and service gaps

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

9.1 HIV testing, diagnosis and care

Significant numbers of HIV cases remain undiagnosed and access to HIV testing requires further improvement. HIV testing is now readily available in a variety of venues however Leicester does not currently have:

- HIV testing for new GP registrants
- HIV opt out testing in A and E

9.2 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. In June 2021, the National Chlamydia Screening Programme (NCSP) changed to focus on reducing the harms from untreated chlamydia infection.

Given the change in programme aim the Public Health Outcomes Framework (PHOF) benchmarking thresholds have been revised and will be measured against females only.

The revised female only PHOF benchmark detection rate indicator (DRI) of 3,250 per 100,000 aged 15 to 24 (Female) will be included from January 2022 (first reported against the 2022 data due to be published in Autumn 2023).

9.3 Termination of pregnancy services

There is a self-referral service for TOP. There are two providers: UHL and British Pregnancy Advice Service. TOPs can be legally accessed up to 24 weeks gestation.

There is a national specification for TOP services that should include pre and post TOP counselling and the provision of HIV testing in high prevalence areas and contraception for all women. TOPS are mainly provided as medical terminations (MTOP) (where medication is taken to terminate the pregnancy) or a surgical intervention (STOP). Over the last 10 years more women have accessed a termination at an earlier gestation allowing the provision of a medical termination.

During the COVID 19 pandemic provision was made for women to be able to access MTOP medication remotely and via online triage receive their medication at home. It is important that these women still have access to post TOP counselling and contraception.

9.4 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.

9.5 Emergency Contraception

The Integrated Sexual Health Service (ISHS) delivered by Midlands Partnership Foundation Trust (MPFT), based at the Haymarket. The ISHS provide a wide range of services to support the needs of the population for areas relating to sexual health. One of these areas is to provide EHC for all ages

and is provided by a specialist clinical team to ensure this service is appropriate for the needs of the service user. There are two approved oral medications currently being used across the services providing EHC, these are Levonorgestrel (Levonelle) and Ulipristal Acetate (EllaOne). Levonorgestrel (Levonelle) needs to be taken within 72 hours of unprotected sex and Ulipristal Acetate (EllaOne) within 120 hours of unprotected sex.

The ISHS provides both forms of EHC, Levonorgestrel (Levonelle) and Ulipristal Acetate (EllaOne) and offers follow up contraception including IUD's (Intrauterine device) for service users. Ulipristal Acetate (EllaOne) is the preferred method of EHC in the ISHS due to its longer window of action and greater clinical efficacy. Leicester City Council currently contract with 11 community pharmacies across the city to provide free EHC for under 25's. (Oral EHC only). Community Pharmacies can administer oral EHC via a Patient Group Direction (PGD). Currently there is only a PGD in place for Levonelle. To ensure we have adequate coverage of EHC we intend to make both forms of EHC available through the community pharmacy route. Ideally therefore, both would be offered however currently, difficulties with creation of an acceptable PGD (patient group directive) for prescription of EllaOne means that pharmacies in Leicester do not currently offer it other than on prescription from a doctor.

9.6 Contraceptive provision in General Practice

Contraceptive provision in general practice is provided as part of GPs core contract. This is the provision of oral contraception, EHC and injectable contraception.
There is little data available about how this is provided and if this is equitably provided. Data shown above shows prescription activity and contraceptive spend over time. This seems to indicate that there is a reduction in both activity and costs.

9.7 Community contraception

Community contraceptive and sexual health services are currently offered on an appointment and drop-in basis. Choices nurses are trained to provide LARC (depo-provera injections and implants), 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.

9.7.1 Postnatal and Post TOP contraception

There is a short time window when women can be given LARC devices post-delivery. This is an optimum form of contraception and prevents postnatal pregnancies. It is known that a short space between pregnancies is detrimental to both mother and child. Fertility often returns before the woman's 6-week postnatal GP check. It would be ideal to have a contraceptive plan prior to birth and the ability to provide the preferred option of contraception to woman prior to their discharge from hospital or after home delivery.

Post TOP contraception is also ideal and should be provided asap after TOP. This should be part of the TOP service.

9.8 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.

9.9 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.

9.10 Teenage pregnancy

There should be a continued focus on reducing teenage conceptions and maintaining the reductions that have been made in recent years by maintaining and where needed expanding the elements of the teenage pregnancy framework that is described above

9.11 Psychosexual services

The extent of population need for this service is not fully understood.

9.12 Sterilisation and Vasectomy

The service delivery and patient pathways are not currently understood.

9.13 Prison Sexual Health services

The service delivery and patient pathways are not currently understood.

9.14 Voluntary care organisations

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

9.15 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.

10.0 Recommendations for consideration by Commissioners

Service Design/Organisation Recommendations				
No.	Recommendation	Leicester City Council	Integrated Care System	NHSE Regional
1.	Ensure equity of access for all Leicester residents with a balance of online, telephone and face to face consultations as per user preference	x	x	
2.	Ensure that the movement of more services online and potential digital exclusion does not lead to the widening of health inequalities	x		
3.	Use a co-production approach to service design and utilise existing community networks to make the most of engagement opportunities to further understand the needs of communities and how they want their sexual health services to look.	x	x	x
4.	Ensure clear patient pathways to and from the ISHS and understand how services commissioned by different partners can be seamlessly linked for straightforward patient journeys.	x	x	x
5.	Ensure a truly integrated approach to sexual health across the system by increased partnership working by LA, the ICB, UHL, the ISHS, the voluntary sector and the community	x	x	x
6.	Develop place-based collaborative commissioning action plan for sexual health services with ICS and other partners	x	x	x
7.	Consider nominating a named lead for sexual health in the ICB to ensure ease of joined up working and commissioning across the system		x	
8.	Increase community outreach and sexual health promotion work, particularly amongst vulnerable user groups, and communities who are underserved/under-represented by the current service	x		
9.	Support schools in their responsibility to provide high quality sex and relationship education (SRE) and ensure provision of high quality SRE in conjunction with the school nursing service and other outreach services. There should be a particular emphasis on specific needs of young people with special educational needs or learning disabilities and looked after children.	x		
10.	Deliver collaborative, holistic and integrated harm reduction interventions that specifically target the most vulnerable communities	x		

11.	Prioritising the training and education needs for local primary care teams including LARC fitting	x		
12.	Cross-system working to enhance cervical screening awareness and improve uptake by improving cervical screening pathways + working with communities	x	x	x
13.	Maintain a flexibility of strategy across the system so that services can respond to the dynamic nature of Leicester's changing demography, including an increasing young population, and inward migration	x	x	x
	Contraception			
14.	Establish a single point of access for long-acting reversible contraception (LARC) across the system to widen access and simpify the process for women seeking this method	x	x	
15.	Improve access to postnatal contraception in the immediate postnatal period (on the postnatal ward) including training staff to fit LARC before a woman leaves hospital	x	x	
16.	Address low uptake of long-acting reversible contraception (LARC) in women from some ethnic groups	x	x	
17.	Review procedures for data entry and reconciliation re LARC from general practice. Inc audit data quality	x	x	x
18.	Increase options for accessing contraception including a telephone service at the ISHS and the NHSE pharmacy pilot for repeat prescribing and initiation of the oral contraceptive pill by pharmacists	x	x	x
19.	Widen pharmacy offer of emergency hormonal contraception (EHC) to include EllaOne as well as the currently offered Levonelle	x		
20.	Consider extending offer of free EHC to over 25s as well as under to tackle rising rate of unintended pregnancies in this age group	x	x	x
21.	Work to address the inequality in teenage pregnancy rates in the City, which sees higher rates in certain areas of the city with higher levels of deprivation	x	x	x
22.	Improved clarity and system working on the pathway for terminations of pregnancy (TOP) to ensure that all partners are aware of the current offer and how to access it	x	x	x
23.	Ensure clarity on referral pathways and commissioner/provider arrangements for vasectomy and tubal ligation procedures	x	x	x

Sexually Transmitted Infections				
24.	Continue focus towards achieving a chlamydia diagnosis rate of at least 3500 per 100000 amongst women aged 15-25 years old from 2023	x		
25.	Ensure the National Chlamydia screening programme recommendations are implemented focusing on the screening of women under 25 and their treatment and follow up.	x		
26.	Work to reduce new diagnoses of HIV where diagnosis is classed as 'late' (CD4 count at diagnosis of less than 350)	x	x	
27.	Explore the possibility of HIV testing in • Emergency Departments • New GP registrants And particularly encouraging heterosexual men to test for HIV to reduce incidence of late diagnosis of HIV amongst this group	x	x	x
28.	Increase repeat testing rate for HIV amongst young GBMSM	x		
29.	Consider offering HIV testing to women presenting for TOP			
30.	Address the over-representation of certain groups, including people from black African and African Caribbean backgrounds in STI data, and the fact these same groups are often under-represented in service use data	x		
31.	Continue surveillance of syphilis and gonorrhoea rates in the City and encourage repeat testing in at-risk and vulnerable groups.	X		
32.	Increase awareness and uptake of HIV pre-exposure prophylaxis (PrEP) in all eligible groups, but specifically those currently under-represented	x	x	
Recommendations for next HNA				
33.	Work to understand the current level of need in the population around female genital mutilation (FGM) and its effects on physical, mental and sexual wellbeing	x		

11.0 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.
- Female Genital Mutilation (FGM)

12.0 Key contacts

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- Helen Reeve, Senior Public Health Information Analyst
- HIV Chapter: Claire Mellon

13.0 Acknowledgements

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