Sexual Health Needs Assessment – executive summary

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Lancashire County Council

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Foreword

Across the county of Lancashire the commissioning spend on sexual health services is almost 11 million pounds a year, representing nearly 20% of our total public health budget. There are high levels of investment across a complicated provider landscape, with no understanding of whether they meet need and to what extent. Therefore, a health needs assessment in this area is of paramount importance. Sexual health is a 'must do' commissioning responsibility and it is vital that the budget is allocated in the most appropriate way.

Lancashire residents experience poor sexual health, with investment across Lancashire varying. There is limited evidence of need in relation to this investment with differing levels of access arrangements, service provision and health outcomes. It is of particular note that the investment in the sexual health prevention agenda is considerably lower when contrasted with investment in clinical treatment services.

The core function of the sexual health needs assessment will be to map need and service provision, examine demand and then assess the gaps between these factors. The results will be of significant importance to a range of commissioners, including clinical commissioning groups, NHS England and Public Health England. The re-commissioning of sexual health services will require the comprehensive health needs assessment approach, with some focus on examining the wider determinants of health.

Aidan Kirkpatrick
Consultant in Public Health
Lancashire County Council

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Farhat Abbas, public health knowledge and intelligence analyst
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Alan Orchard, public health coordinator
Jackie Routledge, public health specialist
Christine Tetlow, public health coordinator
Nicki Turner, integrated health officer
Mike Walker, information, intelligence, quality and performance manager

Executive summary

This report is structured into several chapters, with an introduction and context document providing the background and methodology to the needs assessment, a service provision document and more in-depth focus on seven areas of sexual health. These areas are:

- abortion;
- acute sexually transmitted infections;
- cervical screening;
- chlamydia;
- contraception;
- HIV and AIDS; and
- teenage pregnancy.

Each chapter has discrete recommendations, however, for ease of reference these are summarised in the recommendations section at the end of this summary.

The commissioning of comprehensive open-access sexual health services across Lancashire* is a statutory requirement for Lancashire County Council. To support this, a comprehensive sexual health needs assessment (SHNA) has been undertaken as part of the development of an overarching sexual health commissioning strategy for 2014-2016.

This has been done in line with the health and wellbeing strategy and identified national priorities, including the National Framework for Sexual Health Improvement (published by the Department of Health in 2013), and the Sexual and Reproductive Health Profiles (part of the Public Health Outcomes Framework).The aims of the SHNA are:

- to gain an understanding of the sexual health needs of the population and establish whether the current services meet those needs;
- inform commissioning and service design and models of provision; and
- provide a model of effective and value for money interventions and services based on the needs of the population, available evidence base, national best practice and guidance.

In addition to these aims Lancashire County Council has the following commissioning intentions:

- ensure choice and timely access to friendly reproductive health services and all methods of contraception for young people; and
- encourage uptake of chlamydia screening and testing for under-25 year olds.

* Lancashire refers to the 12 districts in the Lancashire County Council area. Lancashire-14 refers to the 12 districts and the two unitary authorities of Blackburn with Darwen and Blackpool.

There are various sexual health services and issues which are outside the scope of this needs assessment and whilst mention has been made, they have not been subject to detailed analysis. These include:

- sex and relationship education;
- child sexual exploitation; and
- sexual assault referral centres (SARC)

A number of different organisations are involved in commissioning sexual health services across Lancashire, including the clinical commissioning groups (CCG) and NHS England. The commissioning spend on sexual health services is in the region of £11 million, which represents almost 20% of the total public health budget, and this investment in sexual health varies across Lancashire. Previously there has been limited evidence of need in relation to this investment, with service providers offering differing levels of access arrangements, service provision and health outcomes, so identifying the gaps and ensuring the budget is apportioned appropriately remains an important priority.

Not all the sexual health services in Lancashire are integrated, with variations between screening, contraception provision, outreach, training and education packages, and psychosexual services. Therefore, the recommendations and proposals contained with the individual chapters of the SHNA are made on the basis of the available service provision, the collected evidence and analysis, in conjunction with other intelligence, such as population estimates, the ethnic make-up of Lancashire, and deprivation levels across the county.

The SHNA assessment is expected to be used by commissioners and other providers of sexual health services. In conjunction with this all the supporting evidence and analysis, alongside other intelligence, can be found on our sexual health pages here, or by clicking on the following link: http://www.lancashire.gov.uk/lancashire-insight/health-and-care/sexual-health.aspx

Recommendations

Abortion

Whilst the commissioning responsibility for abortion care lies with CCGs, the recommendations below relate to the needs as determined by the data within this SHNA.

Access

- Commissioners and providers of abortion services should have local strategies in place for providing information for women and healthcare professionals on routes of access, including self-referral.
- Commissioners should ensure that women have access to abortion services locally.
- Commissioners should ensure that abortion providers do not restrict access on the grounds of age, ethnicity, religious beliefs, disability, sexual orientation, marital status or the number of previous abortions.
- Services should identify issues which make women particularly vulnerable (for example, child protection needs and domestic abuse/gender-based violence) and refer/signpost them on to appropriate support services in a timely manner.
- The total time from seeing the abortion provider to the procedure should not exceed 10 working days.

A few facts

The recent National Survey of Sexual Attitudes and Lifestyle estimate one in six pregnancies are unplanned.

Just over a fifth of pregnancies in the 16-19 age group are unplanned.

Almost a third of abortions in Lancashire were women aged 20-24 years.

No CCG area in Lancashire has abortion rates significantly different from the national average.

Women who have repeat abortions are less likely to be teenagers.

Contraception

- Commissioners should ensure that services meet the recommendations relating to:
    - contraception after the abortion;
    - antibiotic prophylaxis;
    - screening for sexually transmitted infections (STIs); and
    - information provision after the abortion.
- The CCGs need to work with abortion providers to ensure that they are providing contraception services and that they are linked into the wider network of contraceptive services in their area.
- Commissioners should utilise national, regional and local data to inform the referral pathways.
- Service re-design for contraception should include flexible opening times and ensure that all methods of contraception are available at all sites and at all times.
- Provision of additional contraception services via primary care should be promoted and access made easier.
- Commissioners should ensure that contraceptive advice and provision is available in maternity units.

Acute STI (excluding chlamydia)

Over the past decade diagnoses of gonorrhoea, syphilis, genital warts and genital herpes have increased considerably, mostly notably in males. More STI testing will partly explain these increases, although partaking in unsafe sexual behaviour continues to play a role in the spread of disease.

Acute STIs can cause long-term damage to health and fertility, and can be spread quickly. Preventing STI is therefore an important part of the health promotion agenda.

Safer sex is pivotal to combatting the incidence and prevalence of STIs:

- Implement a Lancashire-wide single condom scheme for young people.

Year-to-year changes in the overall acute STI rates are heavily influenced by chlamydia screening activity:

- Ensure trends in STI are monitored without chlamydia, to provide a clearer picture of prevalence.

Rates of STIs have been increasing amongst young people coincidently with increasing levels of alcohol consumption:

- Audit the influences of alcohol on unprotected sex by initially recording whether alcohol was a feature of the sexual episode of all attendees to sexual health services.

Onward transmission of STIs can be mitigated by partner notification

- Ensure that there is a robust and managed partner notification process in all services.

A few facts

There has been a decrease of 0.6% in diagnosed STI between 2012 and 2013.

In England in 2013 among male GUM attendees, 81% of syphilis diagnoses, 63% of gonorrhoea diagnoses and 17% of chlamydia diagnoses were among men who have sex with men (MSM).

The age group most likely to be diagnosed with an acute STI are under-25s.

There were 8,687 new STI diagnoses in Lancashire in 2013, a decrease of 2% from the previous year's figure of 8,862.

82% of 16-30 year-olds reported drinking alcohol before sexual activity.

Lancaster and Preston have higher rates of STI compared to the rest of Lancashire, due in part to the large under-25 university populations and increased testing rates.

Cervical screening

The prevention and early detection of cancer are crucial components of the public health agenda and the government recognises the important contribution made by cervical screening in this area.

Recent analysis has shown that the incidence of cervical cancer in England has decreased by a third over the last 20 years, whilst mortality has more than halved. This reflects the long-term benefits of screening as well as advances in treatment. There is evidence that a higher incidence of, and mortality from, cervical cancer is still linked to disadvantaged groups

Whilst the commissioning responsibility for cervical screening is held by NHS England, the recommendations relate to the needs as determined by the data within this SNA. These recommendations are:

- The NHS cervical screening programme in Lancashire to continue its vital work engaging disadvantaged women at a local level.
- Increase the uptake of screening in primary care.
- Maintain opportunistic screening in sexual health services.
- Ensure recall systems are effective – this is essential.
- Introduce digital technology to enable women to make bookings themselves online.
- To continue the current success in turnaround times for results, which is of paramount importance.

A few facts

Cervical cancer is the eleventh most common cancer among women in the UK, and the most common in those under-35 years.

The biggest risk factor for cervical cancer is non-attendance for screening.

Human Papillomavirus (HPV) is linked to cervical cancer, with it being found in over 99% of cases.

Women who smoke are twice as likely to develop cervical cancer compared to non-smokers.

Cervical screening coverage is significantly lower in Lancashire, compared to England.

Preston has a significantly higher incidence rate compared to Lancashire, whilst Burnley, Lancaster and Wyre account for 42% of deaths from the disease in the county.

Chlamydia

Chlamydia trachomatis is the most common bacterial sexually transmitted infection in the UK, particularly among young people under 25. It often has no symptoms, but if left untreated it may have longer-term consequences including pelvic pain, infertility and ectopic pregnancy (for women) and inflammation, testicular pain and Reiter's syndrome (reactive arthritis) for men.

Chlamydia screening is an important part of the public health agenda and the improvement and development of the National Chlamydia Screening Programme (NCSP) is an important priority for the Department of Health.

For Lancashire, priorities and recommendations around chlamydia include:

- Increase access to chlamydia screening in primary care.
- Testing continues to be offered to all women undergoing abortion.
- Investigate the benefits of widening access through pharmacists, and to include treatment and partner notification services.
- Promote and increase testing in areas where uptake is currently low.
- Embed chlamydia screening in core services and measure and respond to any poor performance.

A few facts

Chlamydia is known as a 'silent' infection because most infected people are asymptomatic and lack abnormal physical examination findings.

Sexually active young adults (under-25) are at the highest risk of infection.

Females accounted for two-thirds (66%) of chlamydia screening tests in Lancashire (2012), the same as for England.

Preston, Lancaster, Fylde and Wyre have higher rates of testing and lower rates of positivity in Lancashire.

Partner notification can be an effective method of reducing transmission of chlamydia: in Lancashire 44% of partner notifications tested were positive (England 37%).

Almost four-fifths (78%) of chlamydia diagnoses in Lancashire are for people aged 15-24 years.

Contraception

The provision of 'open access sexual health services' by upper-tier local authorities includes the offer of free contraception and access to all methods of contraception.

It has been shown that all methods of contraception are cost effective, providing net savings for each pregnancy averted or per couple per year of protection. Investment in contraception therefore makes sense by impacting on the financial burden on the NHS and by improving outcomes by reducing the number of unintended pregnancies and for some barrier methods reducing the spread of STIs.

Recommendations around contraception for Lancashire have been made around the following areas.

Only 25% of contraception and sexual health clinic attendees are under-20 years, with the majority being aged 20-34 years:

- Ensure greater provision of dedicated young people's services in areas with greater populations of young people.

Uptake of long-acting reversible contraception (LARC) is an important feature of contraceptive use, and there is a need to ensure that services, including those for young people, offer all LARC options:

- All services offer all contraceptive methods at all sites and at all times.
- Promotion of LARC is prioritised.

In primary care oral contraception is the most popular form of contraception issued, however this differs across Lancashire. Therefore, recommendations suggest:

- Encourage general practice to provide information regarding all methods of contraception for women.
- Increase the numbers of GPs able to offer LARC.
- Consider inter-practice referral systems to enable GPs to offer the service to both registered and non-registered populations.

Contraception usage in abortion services and maternity services is a clinical commissioning group responsibility

- Maintain and promote access to contraception for women post abortion and post-natal.

A few facts

In 2012/13, oral contraceptives were the most consistently popular method of contraception chosen by women attending NHS community contraceptive clinics.

For every £1 spent on contraception, £11 is saved in other healthcare costs

Oral contraception and the male condom are the most commonly used methods of contraception for women under-20.

For women aged35+, long-acting reversible contraception (such as intrauterine devices, the injection or the implant) is more popular with more than two-thirds choosing one of these methods.

Use of emergency hormonal contraception is linked to reduced rates of unplanned pregnancies for women of all ages.

HIV and AIDS

First identified in the 1980s, Human Immunodeficiency Virus (HIV) targets the white blood cells, damaging the immune system and leaving the infected person susceptible to serious infections and certain types of cancer. Acquired Immunodeficiency Syndrome (AID) occurs when a set of defined illnesses have developed, and is fatal. Despite a widespread perception that HIV and AIDs are no longer a major concern, they remain a serious public health issue. Recommendations around HIV and AIDs include:

- Commission HIV testing and treatment services in an integrated manner across Lancashire.
- Ensure that there are arrangements in place for appropriate onward treatment, care and support if there is a HIV positive diagnosis following a HIV test, which may take place in any setting where HIV diagnostic testing is being carried out.
- The role of the voluntary sector (including the role of peer support networks) needs to continue to be evaluated and strategically considered as part of any future commissioning plans.
- A collaborative approach should be taken with commissioners of other services that impact on HIV prevention (for example with substance misuse services to ensure that investment in high-quality needle exchange services continue).
- HIV prevalence needs to be routinely assessed at a number of geographical levels – including middle-layer super output areas (MSOA) – to ensure that local need can be appropriately matched to local service provision in accordance with national guidance for testing strategies in those areas that have HIV prevalence rates greater than 2/1,000 (15-59 years).
- Monitoring of the offer and/or uptake of HIV testing needs to be undertaken across a broad range of HIV testing service providers.
- All relevant providers of clinical services should engage with 'look back' where patients present to care with advanced immunosuppression (CD4 count < 200 cellsmm3 or AIDS diagnosis).

A few facts

Thousands of individuals are diagnosed with HIV each year in the UK; estimates suggest nearly 100,000 were living with HIV in the UK in 2012.

A person diagnosed early with HIV can now expect to have a near-normal life expectancy.

The lifetime cost of treating someone who is HIV positive is estimated to be between £280,000 and £360,000.

An estimated 54% of HIV infections in Lancashire and Cumbria in 2012 were acquired through sexual contact between men who have sex with men (England 46%); 38% were from heterosexual contact (England 41%).

In Lancashire and Cumbria 74% of new HIV cases were in men and 26% were in females.

Effective interventions – such as needle exchanges – have kept infection rates very low in those who inject drugs.

- Recognising the need to increase levels of testing across a number of settings in line with national guidance, local authority commissioners need to work collaboratively with NHS England, local clinical commissioning groups and local providers to ensure:
  - Uptake of HIV testing within sexual health clinics is monitored and opportunities explored to improve local HIV testing rates.
  - Support is offered to the commissioners of testing in other settings such as termination of pregnancy services, antenatal services, and services for TB, lymphoma and hepatitis B and C.
  - HIV testing within all general practice settings take place in line with national guidance, including those with relevant risk factors, clinical indicator conditions and/or symptoms consistent with primary HIV infection.
  - For those relatively few MSOA areas within Lancashire where the prevalence of HIV is consistently greater than 2/1,000 then consideration should be given for testing to be expanded to include new registrations in general practice.
  - The emerging evidence base for approaches such as home testing and self-testing continue to be assessed and considered in any future commissioning plans.
- The late diagnosis indicator in the PHOF must be routinely reported to the health and wellbeing board in conjunction with other indicators relevant to sexual health.
- All providers must demonstrate full compliance with nationally published standards of care including reporting on the measurable and auditable outcomes aligned to each relevant standard.
- Services should be routinely evaluated across a broad number of dimensions (such as effectiveness, efficiency and quality) in order to inform future service development/provision.
- The allocation of spending for individual programmes of work related to HIV prevention (such as provision of testing services, training, social marketing approaches) should be scoped out and if appropriate readjusted to reflect local need.
- Further work needs to be undertaken to increase levels of professional engagement with HIV particularly as this is a major obstacle to more widespread testing.
- A range of approaches should be considered including the identification of clinical champions, promotion of existing national guidance as well as the equitable provision of accredited training courses.

Teenage pregnancy

Teenage conception is a complex issue and it is has been established that teenage conception and early motherhood is associated with lower educational achievement, poor physical and mental health (for both mother and child), social isolation and poverty. There is also the recognition that socioeconomic disadvantage can be both a cause and a consequence of teenage motherhood.

The majority of teenage pregnancies are unintended and statistics suggest around half lead to abortion. The babies of teenage mothers have a 60% higher infant mortality rate than those born to older women and there can also be problems with low birth weight and neonatal health. In Lancashire there are issues in some districts with teenage conceptions, and the recommendations include:

- Proportionate universalism needs to include targeted approaches in areas and with communities known to have a greater risk of experiencing unplanned pregnancies.
- Develop an approach which is integrated between sexual health and substance misuse.
- All organisations with a role in delivering services to children and young people in Lancashire should ensure that their staff are able to sensitively respond to children and young people about sexual health and signpost them to relevant services.
- Develop and implement a Lancashire-wide training programme around sexual health for those working with children, young people and their families.
- Develop a comprehensive marketing and communications plan in relation to service provision for sexual health.

A few facts

In 2012 just over 26,000 girls aged under-18 became pregnant in England.

Teenage conception is more likely to occur in deprived neighbourhoods, and there are links to the wider determinants of health.

Since 1998 Lancashire has seen a 41% reduction in under-18 conceptions.

Burnley and Hyndburn have significantly higher rates of under-18 conceptions compared to England.

Under-16 conception rates in Lancashire (6.7 per 1,000) are similar to England (6.1 per 1,000).

All districts, excluding Ribble Valley, have 'hotspot' wards where teenage pregnancy rates are higher than the national average.

Service provision

Current sexual health services are located in more than 60 sites across Lancashire. The examples below give an indication of the range of current services and are divided into the following categories:

1. Genitourinary medicine (GUM)
2. Contraception and sexual health services
3. Chlamydia screening services
4. Outreach
5. Young people's services
6. Young people's condom schemes
7. Education and training

The recommendations around service provision encompass the following:

- Simplify the payment mechanisms for sexual health services, ensuring fair and appropriate payment for services delivered.
- Integrate (STI and contraception) services across Lancashire.
- Ensure all methods of contraception are available at all sites at all times.
- Implement a dedicated young people's provision equitably across Lancashire.
- Ensure central hubs offer flexible and longer opening hours, including evening and weekends according to need and demand.
- Ensure localities are served with local service provision based on data within the SHNA.
- Increase uptake of HIV screening in primary care.
- Increase uptake of LARC in both sexual health services and primary care.
- Standardise delivery and branding of condom schemes.
- Ensure IT systems enable information sharing across the different providers, including primary care providers.

A few facts

There are a range of payment mechanisms for sexual health services, ranging from payment by results, to historic 'block' contracts with a fixed yearly payment.

GUM services are separate from contraception services – there are no integrated (STI and contraception) services across Lancashire

Saturday and Sunday opening hours are limited and not available in all localities. Evening clinics are available primarily for contraception services.

Primary care is a main provider of contraception, but undertakes limited, or no STI screening.

IT systems differ and there is no information sharing across the different providers or even between primary care providers.