
LEICESTERSHIRE JOINT STRATEGIC NEEDS ASSESSMENT 2018-2021

SEXUAL HEALTH

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FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local National Health Service (NHS) and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare JSNA for Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, CCGs and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCGs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year period. Chapters will be developed in line with CCG and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, involving representation from NHS England, CCGs, Leicestershire Partnership Trust, University Hospitals of Leicester(UHL), District Councils and the voluntary sector, a JSNA Reference Group has been established. This Reference Group supports the JSNA work across the Health and Wellbeing Board. To examine the detail of the chapters, Task and Finish groups have been established to bring together local professionals, where they can share their expert knowledge on the work area being examined.

The outputs of the JSNA will include:

1. Subject-specific chapters of an assessment of current and future health and social care needs.
2. An online infographic summary of each chapter available on the internet.

The JSNA has reviewed the population health needs of the people of Leicestershire in relation to

sexual health. This has involved looking at the determinants of poor sexual health, the sexual health needs of the population in Leicestershire, the impact of poor sexual health, the policy and guidance supporting sexual health, existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

Please note, most indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. The term significance is used throughout the report and refers to statistical significance. This examines if the result presented is different to the national result, due to something other than chance. Most often, this is calculated using 95% confidence intervals.

EXECUTIVE SUMMARY

There are variations in need for sexual health services and interventions for different individuals and groups in Leicestershire. Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health.

Leicestershire is generally more affluent than the England average and performs well for many public health indicators related to sexual health, this is evidenced by continuing lower rates of new sexually transmitted infections (STIs), under 18 conceptions and newly diagnosed Human Immunodeficiency Virus (HIV). However, the trend for gonorrhoea and syphilis diagnosis show that rates are increasing significantly and getting worse, although it is important to note that this is a similar pattern to that nationally and absolute numbers for syphilis are small locally. Charnwood and Oadby and Wigston have a high percentage of STI reinfection in females compared to the national percentage change, this could be due to the student population residing within these two districts.

Although, Chlamydia detection rates in 15-24-year olds in Leicestershire are below the national Public Health England (PHE) benchmarking goal, the trend shows that the detection rate is increasing significantly. Leicestershire remains a low HIV prevalent area, however, both nationally and locally the trend has increased significantly over time. This increasing trend is likely to reflect the status of HIV changing from an acute, life-limiting illness to a chronic condition. The total abortion rate in Leicestershire has increased significantly over the past six years, a pattern also witnessed nationally. Although the rate of abortions in over 25s has increased since 2014, the rate remains below the national rate.

General Practice (GP) nationally continues to be the most preferred place to obtain contraception, with around 80% of women choosing to access their contraception from GPs. In Leicestershire since 2014, the total prescribed Long Acting Reversible Contraception (LARC) excluding injections rate has remained significantly lower than the national rate, however there has been an increase since 2016, which reflects an increase in over 300 prescribed Sub-dermal implants (SDIs), Intrauterine systems (IUS) and Intrauterine devices (IUDs). The GP prescribed LARC excluding injections rate has remained significantly higher than the national rate.

A new integrated sexual health service (ISHS) model has been commissioned by Leicestershire County Council in 2019.

Key recommendations from the JSNA chapter include:

1. Maintain a strategic approach to sexual health improvement across the Leicestershire, Leicester & Rutland (LLR) system.

This will include engagement with NHS, Local Authorities and other partners to support the development and implementation of the revised Sexual Health Strategy 2020-2023 and action plans, in line with recommendations from evaluation of the Leicestershire and Rutland Sexual Health Strategies 2016-2019.

2. Prioritise the reduction of STIs in at risk groups.

This includes young people aged between 15-24, men who have sex with men (MSM), specific Black and minority ethnic groups, vulnerable people (including Looked After Children (LAC), those with physical and learning disabilities and those who had adverse childhood experience.).

3. Review HIV service pathway to reduce HIV transmission, late diagnosis and ensure services meet the needs of the ageing population.

This will include;

- Review new model of service delivery (ISHS) in relation to access to HIV testing and diagnoses
- Improve data quality of HIV testing coverage and uptake in ISHS, especially in MSM.
- Work with NHS England to review PrEP (pre-exposure prophylaxis) trial progress/findings to inform future commissioning approaches.

4. Reverse the trend of increasing abortion rates

By improving access to contraception, particularly LARC in abortion and maternity services, specifically in over 25s. This will include completing the PHE abortion pathway review to inform future commissioning model and action plans.

5. Increase access and uptake of LARC

Especially across primary care and in under 25s within the ISHS. This will include;

- Review model of delivery of LARC in primary care with the development of primary care networks, exploring opportunities for greater inter-practice referrals and equity of access across the county.

- Develop capacity of trained practitioners to deliver LARC and IUS for non-contraceptive purposes in primary care. Include focused work with primary care and community-based staff to better understand their knowledge and competence in delivering effective sexual health messages and supporting referral and signposting into more specialist services

6. Completion of PHE Teenage Pregnancy Self-Assessment toolkit to identify gaps and actions needed to improve the outcomes of young parents.

7. Review the latest trends in young people’s attitudes to sexual health and how they access contraceptive services.

For example, explore the reductions in demands for emergency hormonal contraception (EHC) from Pharmacy services in under 25s, C-card in under 19s and sexual Reproductive Health (SRH) standard in ISHS. Consider a behavior insights piece of work including qualitative insight with young people to determine where future efforts and resource should be focused to “empower young people to make positive choices about their relationships and sexual health”.

8. Reduce stigma and discrimination associated with sexual health matters.

Use the opportunity presented by consultation on the next strategy (2020-2023) to engage meaningfully with patient and public groups to assess felt need in relation to sexual health and prioritise further partnership actions.

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1. Introduction

This JSNA Chapter updates the sexual health needs assessment for Leicestershire undertaken in 2015¹ and will inform development of a new sexual health strategy further to expiry of the Leicestershire Sexual Health Strategy 2016-2019.²

Sexual relationships are essentially private matters, however good sexual health is important to individuals and to society. The World Health Organisation (WHO), 2002 defines sexual health as:

‘Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.’³

Our definition of sexual health and reproductive health includes the provision of advice and services around contraception, STIs, HIV and termination of pregnancy.

The consequences of poor sexual health include:

- unintended pregnancies and abortions;
- psychological consequences of sexual coercion and abuse;
- poor educational, social and economic opportunities for teenage mothers, young fathers and their children;
- HIV;
- cervical and other genital cancers;
- hepatitis, chronic liver disease and liver cancer;
- recurrent genital herpes and;
- pelvic inflammatory disease, which can cause ectopic pregnancies and infertility.

Sexual and reproductive health is not just about preventing disease or infection. It also means promoting good sexual health in a wider context, including relationships, sexuality and sexual rights.⁴ It is about developing positive relationships that support individuals to make safe and healthy choices, including if and when to start their own families.

Sexual behaviour and relationships are key components of wellbeing and are affected by social norms, attitudes and health. Sexual lifestyles have changed substantially in the past

60 years, with changes in behaviour seeming greater in women than men. The National Survey of Sexual Attitudes and Lifestyle (Natsal) have found that in the last ten years, women have increased the average number of male sexual partners over a lifetime and the proportion of women reporting at least one female sexual partner in the past 5 years. Natsal also reported an expansion of heterosexual repertoires, particularly in oral and anal sex over time. The survey provided evidence that sexual activity continued into later life, albeit reduced in range and frequency. This emphasises that attention to sexual health and wellbeing is needed throughout the life course.⁵

Sexual ill-health can also affect all parts of society – often when it is least expected. For example, an unplanned pregnancy or diagnosis of a complex STI (such as HIV) can have a significant impact not only for the individual in terms of health, stigma and discrimination but may also have knock-on effects on education, employment, housing and social care needs. Poor sexual health is also linked to broader health inequalities, with higher rates of STIs transmission found in the most deprived areas of Leicestershire.

Achieving good sexual health is complex and there are variations in need for services and interventions for different individuals and groups. Prevention work is important to help people to make healthy decisions and to reduce prejudice, stigma and discrimination that can be linked to sexual ill-health.

2. Who is at risk?

Any sexually active individual is at risk of unintended conception and STIs, including HIV. There are certain groups within the population who are known to be at greater risk of poor sexual health which can also be linked to other poor health outcomes. This section explores these groups/risk factors.

2.1. Protected characteristics and individual characteristics

2.1.1.Age

The burden of STIs continues to be greatest in young people. Young people aged between 15-24 in England have higher rates of poor sexual health, including the highest diagnoses rates of the most common STIs.⁶ In 2017, the rate for new STI diagnoses within 15-19-year olds was 2,263.0 (per 100,000 population) and 3,872.5 (per 100,000 population) for 20-24-year olds⁷. Some groups are at a greater risk of unplanned pregnancy, including young people. According to Natsal 2010/2012,⁵ the median age of first intercourse was 17 for both sexes, but it was 16 in those aged 16–24 at interview. Between one-quarter and one-third of all young people are thought to have sex before 16. The proportion of 15-24-year olds in Leicestershire is 12% (85,393), this is in line with the proportion of 15-24-year olds in

England.⁸

2.1.2.Disability

Sexual health is recognized as a human right by many international health organisations including the WHO. Consequently, all people, including those with disabilities, should have the right to pursue opportunities for healthy sex and sexual expression. A physical disability is any impairment which limits the physical function of one or more limbs or motor ability, including sensory impairments and impairments which limit other areas of daily living, such as cardiovascular or respiratory disorders. In 2012, an estimated 11.6% of 16-64-year olds in Leicestershire had a moderate to severe physical disability, this is a higher prevalence than nationally (11.1%).²⁴

Data from the 2003 National Survey of Family Growth indicated that all people with disabilities are more likely to experience forced vaginal and anal intercourse, to be more likely to report greater than 10 sexual partners over a lifetime, to identify other than heterosexual, and to have more same sex sexual partners than people without disabilities.⁹ These activities contribute to people with disabilities experiencing increased rates of STIs, unintended pregnancies, and sexual violence than those without disabilities.¹⁰ Therefore additional work is needed to ensure that sexual health information and services are available for people with physical disabilities.

People with learning disabilities may find it difficult to cope with sexual identity, sexual feelings and puberty as they may be struggling to comprehend their emotions and body. People with learning disabilities may have limited access to sexual health services. They are often excluded from society, either because they are 'segregated' within specialist support services in the community or because they live in isolation with carers.¹¹ In 2015/16, the rate for adults with learning disabilities getting long term support from Local Authorities in Leicestershire was 2.9 (per 1,000 population aged 18 and over), this is significantly lower in comparison to the England rate (3.3 per 1,000 population).

The 2011 Census examined the proportion of the population that have a health problem or disability that limits their day-to-day activities and has lasted, or is expected to last, at least 12 months. In Leicestershire over 105,000 residents reported to have a long-term health problem or disability equating to 16.2% of the population. This is significantly lower than the national percentage of 17.6%.¹²

2.1.3.Mental health

As highlighted in the national strategy, 'No health without mental health,' (DH, 2011), it is important to consider both the cause and effect of mental health on an individual's overall

sexual health and wellbeing in particular the impact of stigma and discrimination, and mental health support following sexual violence or termination of pregnancy.

The prevalence of mental health problems in England is significant; at least one in four people will experience a mental health problem at some point in their life and at any one time, one in six adults have a mental health problem.¹³

In 2017/18, 781 people aged 18 and over that responded to the GP Patient Survey stated that they had a long-term mental health problem (9.4%) in Leicestershire. This is similar to the England average (9.1%).

For further information on mental health of adults in Leicestershire, please visit the published JSNA chapter, available here: <http://www.lsr-online.org/leicestershire-2018-2021-jsna.html>

Teenage mothers have higher rates of poor mental health for up to three years after the birth and are more likely to experience postnatal depression compared with older mothers.¹⁴

2.1.4. Stigma and embarrassment

Stigma is still associated with poor sexual health. Feelings of embarrassment or fear of being judged stop some people from getting information or from asking for early help. This can have a very real impact.

- Discrimination resulting from sexual health status can influence quality of life and mental health.
- Stigma linked to HIV can deter people from getting tested and taking their treatment.
- If STIs, including HIV, are not diagnosed and treated early, there is a greater risk of onward transmission to uninfected partners, and a greater risk that complications might occur.
- Not using contraception significantly increases the risk of unintended pregnancy.
- Some healthcare professionals feel embarrassed to offer a HIV (or STI) test, even if a patient is presenting with possible symptoms.
- Distressing sexual function problems are reported by a sizeable minority of sexually active young people. Education is required, and counselling should be available, to prevent lack of knowledge, anxiety, and shame progressing into lifelong sexual difficulties.¹⁵

- Painful sex is reported by a sizeable minority of women in Britain and is linked to poorer sexual, physical, relational and mental health. Health professionals should be supported to undertake holistic assessment and treatment which takes account of the sexual, relationship and health context of symptoms.¹⁶

Therefore, additional work is needed to reduce the stigma associated with accessing sexual health services to increase timely diagnosis and treatment which will reduce the likelihood of complications from unintended pregnancy, STIs and HIV.

2.1.5. Victims of sexual assault

Sexual Assault and Referral Centres (SARCs) aim to promote recovery and health following a rape or sexual assault, whether or not the victim wishes to report it to the police. A SARC typically provides specialist clinical care and follow-up to victims of acute sexual violence, including sexual health screening and emergency contraception, usually in one place, regardless of gender, age, ethnicity or disability. In addition, victims can choose to undergo a forensic medical examination if they want. Additional ongoing mental health support may be needed (for example counselling) following an incident of sexual assault.

In 2017/18 410 Leicestershire adults accessed SARC services. This increased to 426 in 2018/19. Breakdown by local authority of residence of the client is not available. Data relating to the number of LLR children accessing SARC services is not available.

2.1.6. Post-abortion counselling and support needs

Every woman will experience different feelings and emotions after an abortion, and some will require additional support. While research indicates that having an abortion does not lead to long-term emotional or psychological problems, some women will benefit from counselling to discuss how they are feeling. Provision should be made for post-abortion counselling, particularly within abortion services and for those with a diagnosed mental health condition.¹⁷

2.1.7. Ethnicity – Black and minority ethnic groups

The burden of STI/HIV varies amongst different ethnic groups depending on cultural factors, deprivation and common sexual norms. New HIV diagnoses in the UK for both black African and black Caribbean heterosexuals have been decreasing steadily over the past 10 years (black African: 78%, from 2,424 in 2008 to 542 in 2017; black Caribbean: 77%, from 231 to 52).¹⁸ More than half of people diagnosed with HIV in 2017 were white (52%) and 16% were black African. 2% of new diagnoses in the UK were among black Caribbean people, despite this group making up only 1% of the UK population.¹⁹

Bacterial STI diagnosis rates are higher in people of black Caribbean or black 'other' ethnic groups and those born in Latin America and the Caribbean. People of black African, black Caribbean and mixed ethnicities are most likely to report concurrent or multiple partners. STI and HIV co-infection is more common in non-white gay, bisexual and other MSM or those born in Latin America and the Caribbean.

Nationally, the number of syphilis diagnoses have increased from 2014 to 2018 for all ethnic groups. Asian or Asian British have increased by 96%, mixed by 77% and black or black British by 43%. This is compared to the white ethnic group which has increased by 65% from 2014 to 2018.

At the same time, the number of gonorrhoea diagnoses have increased from 2014 to 2018 for all ethnic groups. Asian or Asian British have increased by 66%, mixed by 61% and black or black British by 47%. This is compared to white ethnic group which has increased by 43% from 2014 to 2018.²⁰

2.1.8. Sexual orientation

MSM are known to be one of the highest risk groups for HIV transmission in the UK.²¹ There has been a continuation of the decline in new HIV diagnoses among gay and bisexual men (31% decline, from 3,390 in 2015 to 2,330 in 2017). Previously, diagnoses among this group had been increasing year on year from 2,820 in 2008 to 3,390 in 2015.

Nationally, the number of syphilis diagnoses for gay, bisexual and other MSM has increased by 38% from 2014 to 2018. At the same time, the number of gonorrhoea diagnoses for gay, bisexual and other MSM has increased by 30% from 2014 to 2018.²²

During the 2016-17 reporting period, 23% (n=362/1,555) of gay or bisexual men presenting to drug treatment in England reported problematic use of one of the three substances most commonly used in relation to 'Chemsex' (GBL, methamphetamine and/or mephedrone). This proportion was much higher than among heterosexual men (0.6%). Among individuals who used these drugs, rates of current injecting were also much higher among MSM than among heterosexual men (42% compared to 16%).⁶

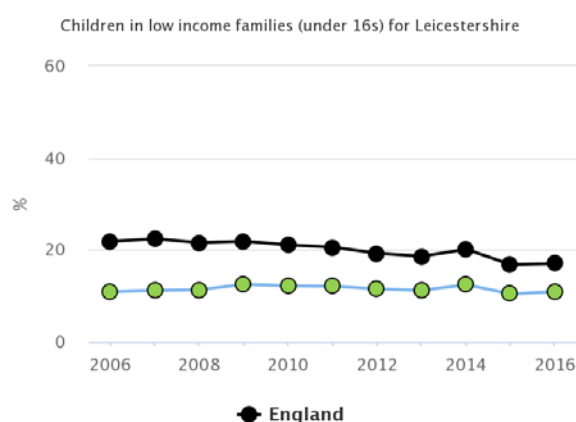
2.2. Poverty and deprivation

The Marmot Review (2010)²³ clearly identified the social gradient in England between deprivation and life expectancy, with the most deprived having lower life expectancy and disability free life expectancy than the least deprived communities. These correlations are also seen with sexual health outcomes, where those living in the most deprived areas of Leicestershire are at greater risk of poorer sexual health. It is therefore important to ensure

that all sexual health services are equitably distributed across Leicestershire to ensure high levels of access across the counties. Since the majority of Leicestershire's population (43%) is classified as 'Suburbanites', services must be geographically located across the county in areas of greatest need. Due to Charnwood and North West Leicestershire having some areas in the most deprived 20% in the country, these areas should be prioritised for sexual health service delivery.

The percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) has remained significantly lower (better) than the national average since data recording (in 2006) – see Figure 1. The latest data shows in 2016 there were 12,415 children aged under 16 living in families in receipt of Child Tax Credit whose reported income is less than 60% of the median income or in receipt of Income Support or (Income-Based) Job Seeker's Allowance. This represents 10.9% of all children aged under 16 in Leicestershire.²⁴

Figure 1: Trend of children in poverty in Leicestershire



Source: Public Health England, Public Health Outcomes Framework, 2019

For further information on the population and deprivation that exists throughout Leicestershire, please visit the Demographics JSNA chapter, available here: <http://www.lsr-online.org/leicestershire-2018-2021-jsna.html>

2.3. Vulnerable people

2.3.1. Learning disabilities

People with learning disabilities are amongst the most vulnerable in our society and have greater health needs than the rest of the population. They are more likely to experience mental illness and are more prone to chronic health problems, epilepsy, and physical and sensory disabilities. Historically, people with learning disabilities have often been invisible to mainstream health services and experienced poor levels of care. Research has found that young people with learning disabilities do not have good access to sex and relationship

education or information.²⁵ It is recommended that there be more accessible information and support for young people with learning disabilities and for their parents. This needs to include information about sexuality, abuse and consent and practical information about contraception and safer sex where appropriate.

In 2017/18, 2,786 people within the registered population (18+) were diagnosed with a learning disability (0.4%) in Leicestershire, this is significantly lower in comparison to the national rate of 0.5%.²⁶

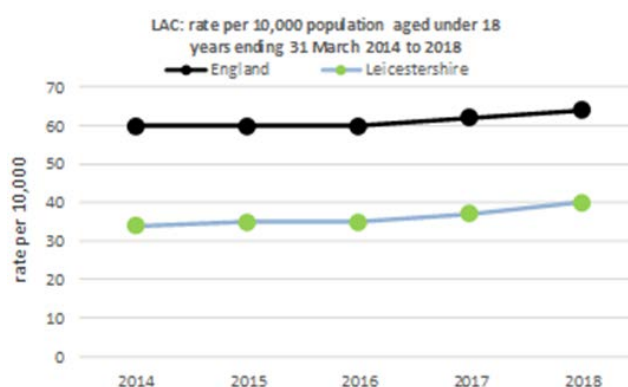
2.3.2. Looked after children

The term 'looked after' was introduced by the Children Act 1989 and refers to children and young people under the age of 18 who live away from their parents or family and are supervised by a social worker. A 'looked-after child' may either be accommodated or subject to an order made by the family courts.²⁷

In Leicestershire the numbers and rates for LAC aged under 18 have been increasing since 2016. The rate of LAC has increased from 35 (per 10,000 children aged under 18) in 2016 to 40 (per 10,000 children aged under 18) in 2018. The rate for LAC aged under 18 has remained significantly lower in comparison to the national rate since 2014.²⁸

Young people who are looked after are recognised as being vulnerable to risk taking behaviour²⁹ including early and unprotected sexual activity, self-harming, misusing illegal and/or volatile substances and alcohol. These early risk-taking behaviours are very often indicators of poor emotional health and well-being and may be the forerunner of wider social exclusion such as homelessness and unemployment. Young people in and leaving care are more likely than their peers to be teenage parents. One study found almost half of young women leaving care became pregnant within 18-24 months and another reported that a quarter were pregnant or young parents within a year of leaving care.³⁰ LAC are 3 times more likely to be a parent by 18.¹⁴

Figure 2: Trend of LAC in Leicestershire aged under 18



Source: Department for Education, 2017/18

2.3.3. Adverse childhood experiences (ACEs)

Adverse Childhood Experiences (ACEs) impacts on childhood development and future mental and physical health. The term ACEs incorporates a wide range of stressful events that children can be exposed to whilst growing up. While the types of adversities defined as ACEs may vary across contexts, typically, they include harms that affect the child directly, such as neglect and physical, verbal and sexual abuse; and harms that affect the environment in which the child lives, including exposure to domestic violence, parental separation or divorce, or living in a home with someone affected by mental illness, substance abuse, or who has been incarcerated. Experiencing four or more ACEs can result in being five times more likely to have had sex under 16-years of age and being 16 times more likely to have been pregnant (or got someone accidentally pregnant) under 18-years of age.³⁹

2.3.4.Domestic and sexual abuse

In 2016 there were 18.7 domestic abuse incidents per 1,000 population reported to the police force area which covers LLR compared to 22.5 per 1,000 nationally. Please note these rates relate to all incidents and are not restricted to those involving households containing children or pregnant women.

In 2017/18, the rate of sexual offences per 1,000 population in Leicestershire was 1.4, this is lower in comparison to the national rate of 2.4. The rate of sexual offences in Leicestershire has increased since 2016/17 where the rate was 1.1 offences per 1,000 population.

2.3.5.Child sexual exploitation (CSE)

CSE is a type of child abuse. It happens when a young person is encouraged, or forced, to take part in sexual activity in exchange for something. In Leicestershire between 2017/18 there were 161 CSE crimes and 336 CSE incidents in the county.³¹ Sexual health services have an important role in identification of safeguarding issues, including CSE. In 2018 the local ISHS made 17 child safeguarding referrals of which 9 were related to CSE concern.

2.3.6.Prison population

Prisoners are at a higher risk of contracting STIs and HIV because of injecting drug use and high risk sexual behaviour.³² In March 2019, HMP Gartree had a population of 698 males, against an operational capacity of 708. The majority of inmates were British nationals (586, 84%). Two-thirds of inmates were White (67%), followed by Black ethnic groups (19%).

2.3.7. Sex workers

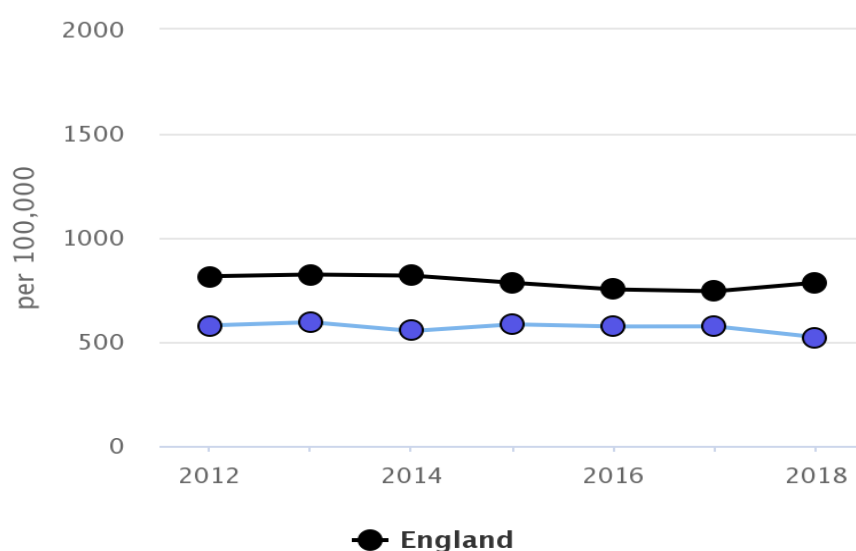
Sex work or prostitution carries a high risk of STIs for both the sex worker and their customers.³³ The people involved in sex work often face challenges such as substance use, limited access to services, violence and exploitation. Community based work also indicates a number of sex workers operating in the Loughborough area. Work to support this group, including accessing sexual health services is in development.

3. Level of need in Leicestershire

3.1. STIs

Over the past decade, diagnoses of gonorrhoea and syphilis have increased considerably in England, most notably in males, while diagnoses of genital warts have decreased. Of all age-groups, the highest STI diagnosis rates in England are in young people aged 15-24-years. In 2018, overall 3,603 new STIs were diagnosed in residents of Leicestershire, a rate of 522 per 100,000 residents (compared to 784 per 100,000 in England). Overall, of all those diagnosed in 2018 with a new STI in Leicestershire, 54% were men and 46% were women. Since 2012, in Leicestershire the rate of new STI diagnosis has remained significantly lower than the national rate throughout this time.³⁴

Figure 3: Trend of all new STI diagnosis rate in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

Table 1 examines the rates of new STIs in Leicestershire and England. This shows in 2018, (excluding chlamydia), genital warts is the most prevalent STI in Leicestershire, followed by gonorrhoea and herpes, whereas at a national level genital warts followed by gonorrhoea and herpes is the most prevalent.³⁴ All Leicestershire individual STI rates are lower than the national rates.

Table 1: Rates per 100,000 population of new STIs in Leicestershire and England 2017 and 2018

Indicator	Leicestershire Rate: 2017	Leicestershire Rate: 2018	% Change	England Rate: 2017	England Rate: 2018	% Change
New STIs	574	522	-9.1%	743	784	5.5%
Chlamydia	338	311	-8.0%	363	384	5.8%
Gonorrhoea	33	40	21.2%	78.5	98.5	25.5%
Herpes	46.8	30.9	-34.0%	56.4	59	4.6%
Syphilis	5.2	4.2	-19.2%	12.4	13.1	5.6%
Warts	82.9	82.4	-0.6%	103.3	100.1	-3.1%
	Significant decrease from 2017					
	Significant increase from 2017					

Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

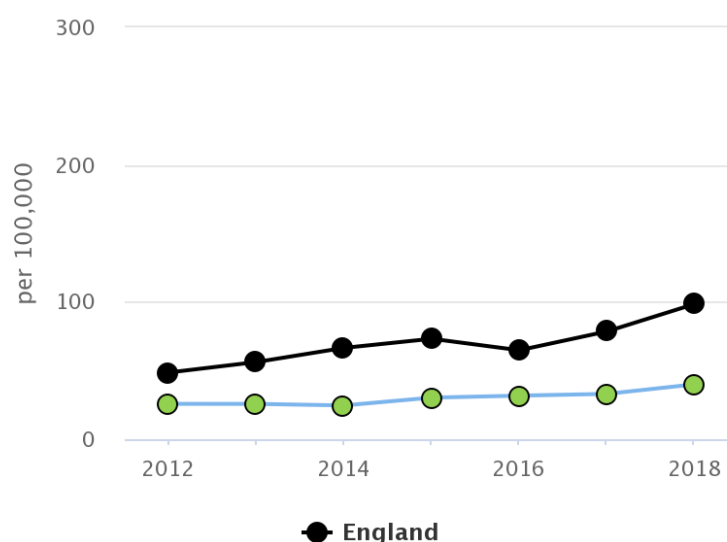
3.1.1. Gonorrhoea

The gonorrhoea diagnostic rate has remained significantly better than the national average since 2012. However, nationally and locally the trend in gonorrhoea diagnoses has significantly increased over the last five years. High levels of gonorrhoea transmission are of concern given the emergence of gonococcal resistance, including high-level resistance to azithromycin (HiLAzi-R). Additionally, the first detected case of extensively drug resistant *Neisseria gonorrhoeae* with resistance to ceftriaxone and high-level resistance to azithromycin, the two antibiotics currently used as first-line dual therapy, was detected in the UK in March 2018.⁶

In Leicestershire, the rate of gonorrhoea has increased for three consecutive years also. Any increase in gonorrhoea diagnoses may be influenced by the increased use of highly sensitive Nucleic Acid Amplification Tests and additional screening of extra-genital sites in MSM.

The latest data in 2018 shows 40.0 per 100,000 population in Leicestershire had a diagnosis of gonorrhoea, this is less than half of the national rate of 98.5 per 100,000 population.³⁴

Figure 4: Trend of gonorrhoea diagnostic rate in Leicestershire

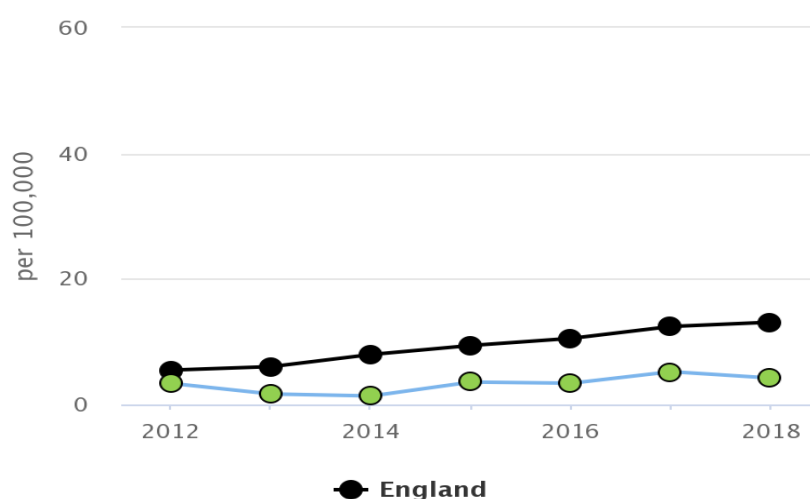


Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.1.2. Syphilis

Over the last five years, the trend of syphilis diagnostic rate in Leicestershire has significantly increased over time, a pattern witnessed nationally also. Nationally the rate has increased year on year from 5.5 per 100,000 population in 2012 to 13.1 per 100,000 population in 2018. The rate in Leicestershire has increased at a slower rate than nationally and has remained significantly better (lower) than the national average since 2012. It must be noted that counts of diagnoses are small locally. In 2014, there were 9 diagnosed cases, increasing to 29 in the 2018. The latest data for Leicestershire shows in 2018, 4.2 per 100,000 population were diagnosed with syphilis, this is less than half the rate of the national average of 13.1 per 100,000 population.³⁴

Figure 5: Trend of syphilis diagnostic rate in Leicestershire

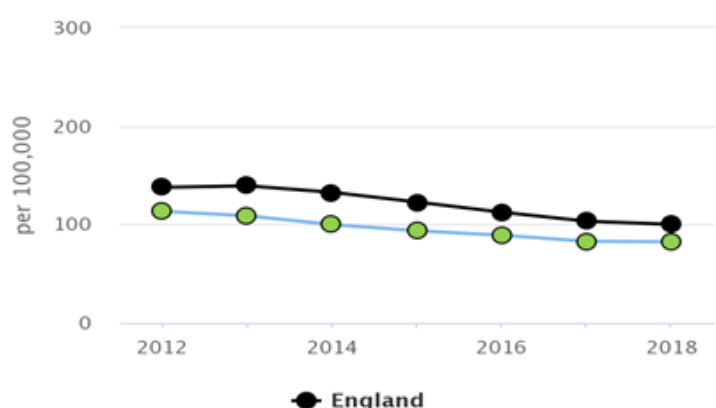


Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.1.3. Genital warts

The rate of first episode of genital warts diagnoses in Leicestershire has decreased for the sixth consecutive year. Nationally the trend has also decreased significantly over the last five years. Since 2012, the rate has remained significantly better (lower) than the national average. The latest data for Leicestershire shows that in 2018, 82.4 per 100,000 population were diagnosed with genital warts.³⁴

Figure 6: Trend of genital warts diagnostic rate in Leicestershire

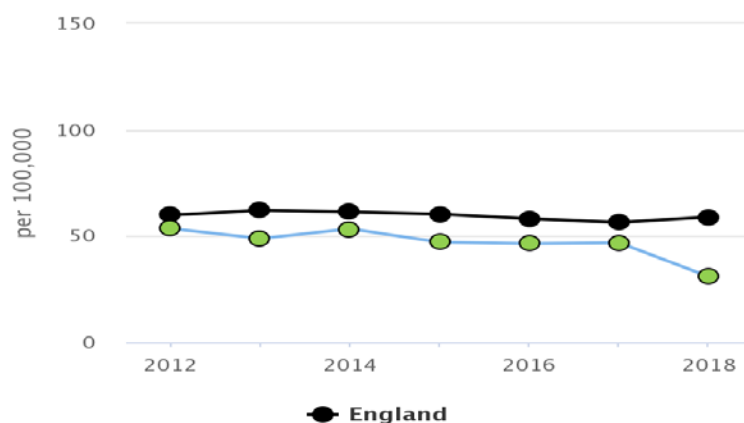


Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.1.4. Genital herpes

For the seventh consecutive year Leicestershire has performed significantly better than the England average for the genital herpes diagnoses rate. At a national level, although there has been an increase since 2017 from a rate of 56.4 per 100,000 population to 59.0 per 100,000 population, the trend over the last five years shows that rates are significantly decreasing, this trend is mirrored locally too. In Leicestershire, the rate of first episode of genital herpes diagnoses has decreased from 46.8 per 100,000 population in 2017 to 30.9 per 100,000 population in 2018.³⁴

Figure 7: Trend of genital herpes diagnostic rate in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.1.5. Reinfection of STIs

Nationally, for the five-year period from 2013 to 2017, an estimated 7.0% of women and 9.4% of men presenting with a new STI at a SHS became re-infected with a new STI within 12 months, and an estimated 3.7% of women and 11.2% of men became re-infected with gonorrhoea within 12 months over the same period.

Young people are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload. Teenagers may be at increased risk of re-infection because they lack the skills and confidence to negotiate safer sex.

No districts in Leicestershire have a higher percentage of STI re-infection in males than the national percentage. In Charnwood, Oadby and Wigston however, both districts have a high percentage of STI reinfection in females compared to the national percentage change, this could be due to the student population residing within these two districts.

Table 2: STI and gonorrhoea reinfection over a 5-year period 2013-17 (estimated)

Area	STI Reinfection		Gonorrhoea Reinfection	
	% Male	% Female	% Male	% Female
Blaby	6.4	5.2	7.7	6.6
Charnwood	9.3	7.2	9.6	5.4
Harborough	4.7	4.1	6.3	0
Hinckley	7.9	4.9	5.4	2.0
Melton	7.6	2.2	26.7	0
NW Leics	7.1	6.6	12.4	0
Oadby & Wigston	8.6	8.8	9.7	5.0
Nationally	9.4	7.0	11.2	3.7

Source: Public Health England HIV and STI Portal-Laser Report, 2017

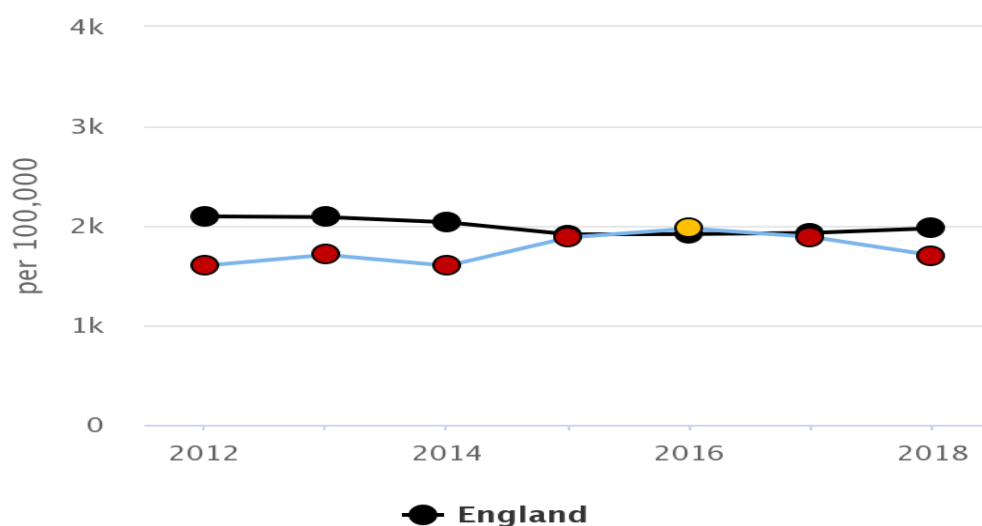
3.1.6. Chlamydia

Since the full-scale implementation of the National Chlamydia Screening Programme in 2008, diagnosis rates of chlamydia have increased in men and women.

In 2018 the chlamydia detection rate in 15-24- year olds in Leicestershire was 1,703 per 100,000 population, this is lower in comparison to the England average of 1,975 per 100,000 population. However, PHE recommend that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15-24. At a local level, Leicestershire perform worse than the benchmark of a detection rate of less than 1,900 per 100,000 population aged 15-24.³⁴

Compared to the previous year, in Leicestershire the chlamydia detection rate decreased (got worse) from a rate of 1,888 per 100,000 population aged 15-24-years in 2017 to 1,703 per 100,000 population aged 15-24-years in 2018. A decline in rate between 2017 and 2018 was witnessed in both males and females in Leicestershire. However, the local trend has significantly increased over the last seven-time periods whereas at a national level the trend has significantly decreased.³⁴

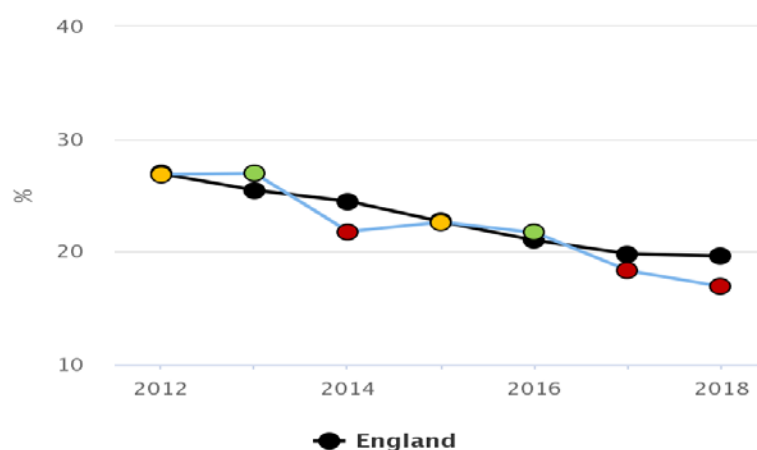
Figure 8: Trend of chlamydia detection rate per 100,000 population in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

In 2018, the proportion of the population aged 15-24 screened for chlamydia in Leicestershire was 16.9%, this was significantly worse in comparison to the national percentage of 19.6%. In 2016, Leicestershire performed significantly better than the national percentage. This represented a decrease of almost 3,000 screens in this population in 2017, this could be due to the change in chlamydia screening approach to online. Figure 9 shows both nationally and locally the trend has significantly declined over the last five years.³⁴ In 2018 the rate of STI testing (excluding chlamydia in under 25-year olds) in sexual health services in Leicestershire was 13,439 per 100,000 aged 15-64-years old, this is significantly worse in comparison to the England rate of 18,053 per 100,000.³⁴

Figure 9: Trend of Chlamydia proportion aged 15-24 screened in Leicestershire

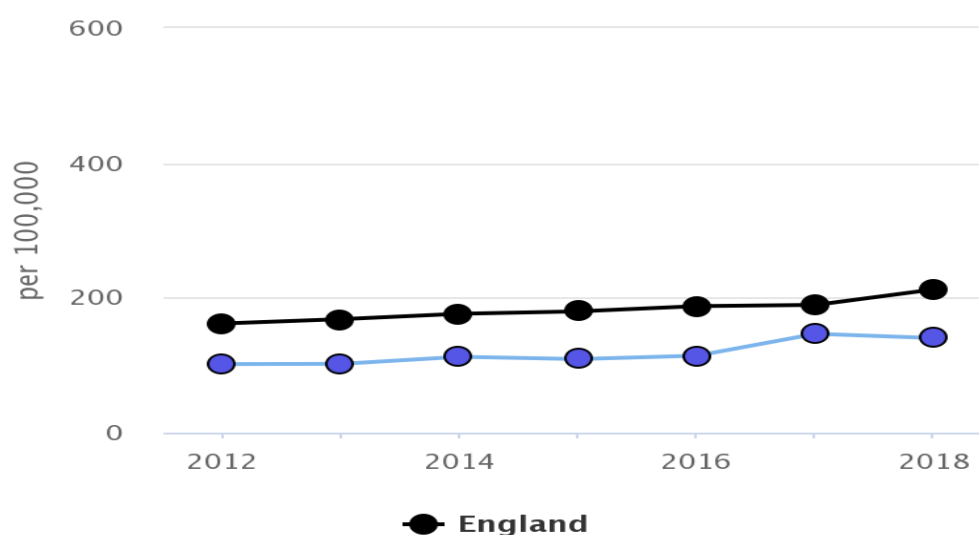


Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

The positivity percentage for 15-24-year olds who were tested for chlamydia in Leicestershire in 2018 was 10.3%. This is higher than the national positivity percentage of 9.7%.³⁴

While chlamydial infections are more commonly found among young adults aged under 25-years, women and men aged 25-years and over are also at-risk of chlamydia. In Leicestershire the chlamydia diagnostic rate for people aged 25-years and over has remained significantly lower than England average for the seventh consecutive year. However, at a national and local level, the trend has significantly increased over the last five-time periods. In 2018, the chlamydia diagnostic rate in Leicestershire was 140 per 100,000 population aged 25 and above, representing 686 diagnoses in patients over 25-years in 2018.³⁴

Figure 10: Trend in chlamydia diagnostic rate aged 25 and above in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

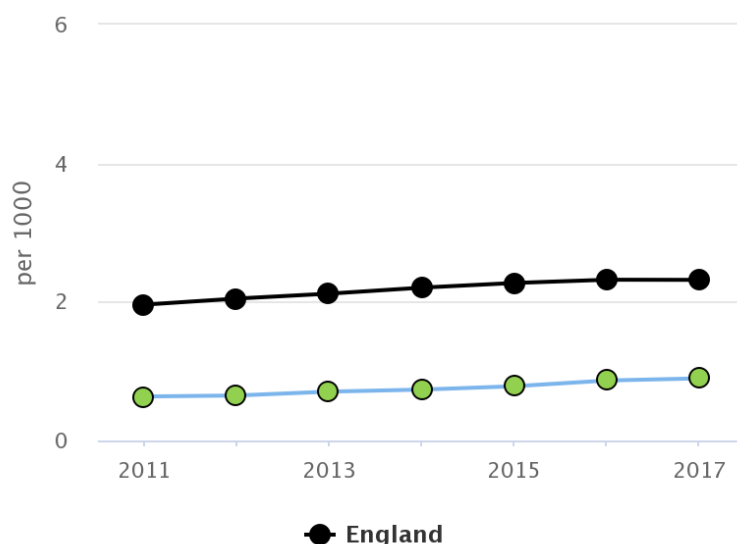
3.2. HIV

In 2017, an estimated 101,600 (95% confidence interval 99,300-106,400) people were living with HIV infection in the UK and the UNAIDS 90:90:90 targets have been met. An estimated 92% of people living with HIV in the UK were diagnosed, 98% of those diagnosed were on treatment, and 97% of those on treatment were virally suppressed. Overall, 87% of people living with HIV in 2017 had an undetectable viral load and were unable to pass on their infection.⁶

3.2.1. HIV diagnosed prevalence

Figure 11 shows the trend of HIV diagnosed prevalence in Leicestershire. Since 2011, the HIV diagnosed prevalence rate has remained lower than the national benchmark of a rate less than 2 per 1,000 population. However, over the last five years, both nationally and locally the trend has significantly increased over time. This increasing trend is likely to reflect the status of HIV changing from an acute, life-limiting illness to a chronic condition. The latest data for Leicestershire in 2017 shows there were 354 residents diagnosed with the condition. Blaby is the only district in Leicestershire which has increased significantly over the past seven years, like the pattern reflected nationally. All other districts have shown no significant increase.³⁴

Figure 11: Trend of HIV diagnosed prevalence rate in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

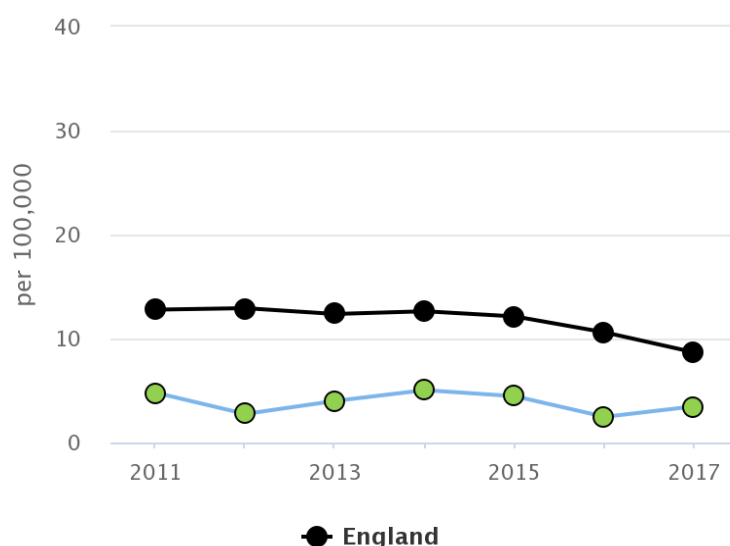
3.2.2. New HIV diagnoses

In 2017, 20 adult residents of Leicestershire were newly diagnosed with HIV. The rate of new HIV diagnosis per 100,000 population among people aged 15-years or above in

Leicestershire was 3.5 per 100,000 population, significantly better to 8.7 per 100,000 population in England.³⁴

Unfortunately, due to small numbers in many local authorities it is not possible to present a breakdown of new HIV diagnoses by route of transmission in this report. In England in 2017, 48% of new HIV diagnoses were in gay and bisexual men, 15% in male heterosexuals and 19% in female heterosexuals. 53% of new HIV diagnoses were in white and 20% in black African populations.³⁴

Figure 12: Trend of new HIV diagnosis rate in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.2.3. HIV late diagnoses

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a critical component of the Public Health Outcomes Framework and monitoring is essential to evaluate the success of local HIV testing efforts.

The definition of a late HIV diagnosis was updated from a CD4 count <200 cells/mm³ within 91 days of diagnosis to <350 cells/mm³ to reflect the 2008 BHIVA treatment guidelines which recommend patients should begin anti-retroviral therapy when CD4 cells counts drop <350 cells/mm³. Of the 16 new diagnoses that had a valid CD4 count, 8 (50%) had a CD4 count less than 350 cells per mm³.³⁵

The latest data in 2015-17 for the percentage of HIV late diagnosis in Leicestershire was suppressed due to small numbers at district level. However, Table 3 shows throughout the districts, variation exists. Three districts (Blaby, Harborough and Hinckley and Bosworth) perform worse than the benchmark of $\geq 50\%$ whereas Charnwood and Melton perform

similar to the benchmark, between 25-50%. The highest percentage of HIV late diagnosis was in Blaby and Harborough (57.1%) and the lowest in Charnwood (30.8%).³⁴

Table 3: Percentage of HIV late diagnosis in Leicestershire, 2015-17

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	—	4,461	41.1	40.2	42.1
Leicestershire	—	-	*	-	-
Blaby	—	4	57.1	18.4	90.1
Charnwood	—	4	30.8	9.1	61.4
Harborough	—	4	57.1	18.4	90.1
Hinckley and Bosworth	—	4	40.0	12.2	73.8
Melton	—	3	50.0	11.8	88.2
North West Leicestershire	—	-	*	-	-
Oadby and Wigston	—	-	*	-	-

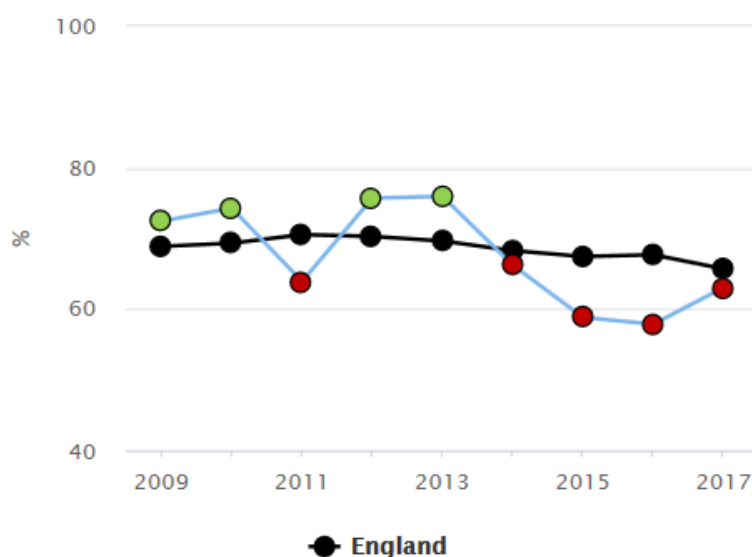
Source: Public Health England

Source: Public Health England, Public Health Outcomes Framework profile, 2019.

3.2.4. Access to HIV testing at sexual health clinics

In 2017, an HIV test was offered at 63.1% of eligible attendances at specialist ISHSs among residents of Leicestershire and, where offered, an HIV test was done in 78.4% of these attendances.³⁴

Figure 13: Trend of HIV testing coverage in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

Figure 14: Trend of HIV testing uptake in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

The HIV testing coverage for Leicestershire has remained significantly worse than England for the last four years. When examining by sex, HIV testing coverage for females in Leicestershire has mirrored the Leicestershire population trend, remaining significantly worse than the national rate over the last five years. Meanwhile, MSM have performed significantly worse than the national rate for the last three years and males (including MSM) have remained significantly worse than England for the last four years. There have been some coding issues with regards to this indicator which should be resolved from 2019 onwards. There is a significant decreasing trend for males and females in Leicestershire, however MSM have shown no significant change in trend. The percentage gap between Leicestershire males and the England average has remained smaller than the percentage gap between Leicestershire females and the England average over the past four years.³⁴

Leicestershire has consistently performed significantly better than the national percentage of HIV testing uptake over time, however there is a significant declining trend, with the percentage decreasing year on year for the last five years. When examining males, the HIV testing uptake has been declining significantly and the percentage in 2017 is now similar to the national percentage. This is the first time we have declined to this RAG rating for this indicator, having remained significantly better than national since 2009. The uptake percentage of MSM has shown no significant change in trend and remained significantly better than national. This suggests the decrease is witnessed in heterosexual males.³⁴

Nationally, a HIV test was offered at 78.5% of eligible attendances at specialist ISHS and, where offered, a test was done in 77.0% of these attendances. Among gay and bisexual men a HIV test was offered at 86.1% of specialist SHS attendances, of which 94.8% had a test.³⁴

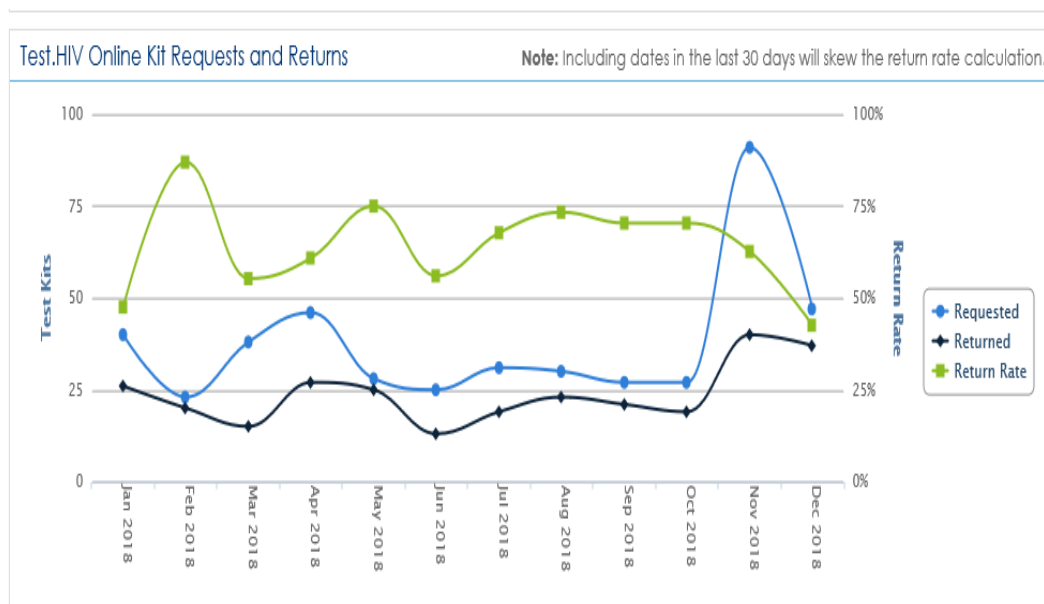
In 2017, among specialist ISHS patients from Leicestershire who were eligible to be tested for HIV, 63.1% were tested. Nationally, 65.7% of specialist ISHS patients who were eligible to be tested for HIV were tested.³⁴

3.2.5. HIV online self-sampling testing

3.2.5.1. PHE Framework for HIV online testing

Leicestershire County Council commissions self-sampling HIV tests as part of an online service co-ordinated nationally by PHE. In 2018, a total of 453 HIV testing kits were requested online, out of these, 281 kits were returned (62.0%). Figure 15 below shows a monthly breakdown of online testing kits ordered and returned in 2018. There is an increase in the number of kits requested during the month of November, this is due to national and local campaigns associated with HIV testing week in October. The return rate for online kits has remained above 50% between the months of February and November 2018.

Figure 15: HIV Online Testing in Leicestershire, 2018³⁶



Source: Preventx Integrated diagnostics

Demographic data related to online testing requests show that 78.2% of requests were from males in 2018, 81.1% of requests were from those of White British ethnicity and 59.3% of requests were from those with a sexual orientation of homosexual, followed by 26.3% heterosexual. The numbers for those clients testing positive have not been included due to small numbers.

3.2.5.2. ISHS online self-sampling for HIV

Self-sampling HIV and STI test kits have also been available, for those aged over 25-years, via online request as part of the Leicester, Leicestershire and Rutland ISHS since February 2017. In 2017 there were 1148 self-sampling tests undertaken by Leicestershire residents that included an HIV test and 2027 in 2018.³⁷

3.3. Unplanned pregnancy

Unplanned pregnancies can end in abortion, maternity or miscarriage. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children. Restricting access to contraceptive provision by age can therefore be counterproductive and ultimately increase costs. Publicly funded contraception is extremely cost effective. When considering the total cost savings across the public sector, including healthcare and non-healthcare settings, the return on investment for every £1 spent is £4.64 over a four-year period, and £9.00 over ten years. Evidence also suggests that £1 investment in contraception saves £11.09 in averted outcomes (NHS savings) £1 invested in LARC saves £13.42 in averted outcomes (NHS savings).³⁸

The Third NATSAL, which was carried out in Britain in 2010-12, found that 16.2% of all pregnancies in the year before the study interview were unplanned. The key findings from this survey were:

- Pregnancies among 16-19-year olds accounted for 7.5% of the total number of pregnancies, but 21.2% of the total number that were unplanned.
- The highest numbers of unplanned pregnancies occur in the 20-34-year age group.
- 42% of the unplanned pregnancies ended in an abortion, 32% ended in a miscarriage and 25% went on to a full-term pregnancy.

3.4. Teenage pregnancy

Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes. Over 50% of under-18 conceptions end in abortion and inequalities remain between and within local authorities.⁶

Babies born to mothers under 20-years have a 24% higher rate of stillbirth than average, 75% higher rate of infant mortality and 30% higher rate of low birth weight. Mothers under 20- years old have a higher risk of poor mental health up to 3 years after giving birth. This affects their own wellbeing, and their ability to form a secure attachment with their baby,

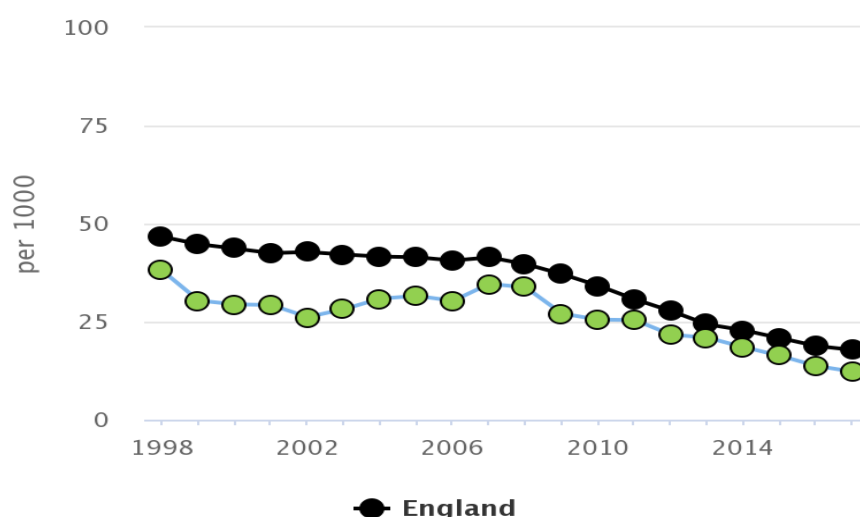
recognised as a key foundation stone for positive child outcomes.³⁹

Children born to teenage mothers have a 63% higher risk of living in poverty. Teenage mothers are more likely than other young people to not be in education, employment or training; and by the age of 30-years, are 22% more likely to be living in poverty than mothers giving birth aged 24-years or over.

Young fathers are twice as likely to be unemployed aged 30-years, even after taking account of deprivation. Recent analysis of the Next Steps data shows that some of these poor outcomes are also experienced by young parents up to the age of 25-years.⁴⁰

Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 61.8% reduction in the under-18 conception rate between 1998 and 2017 whereas Leicestershire has achieved a higher decrease, at 67.6% reduction. This equates to ten consecutive years that the rate of teenage pregnancies both nationally and locally has decreased. Throughout this time, the under-18 conception rate in Leicestershire has remained significantly better (lower) than the national average. The latest data shows in 2017 the under-18 conception rate per 1,000 females aged 15-17-years was 12.3 per 1,000 females aged 15-17-years, significantly better than the England rate of 17.8 per 1,000 females aged 15-17-years. This equates to 135 under 18 conceptions in Leicestershire in 2017.³⁴

Figure 16: Trend of under 18 conception rates per 1,000 females aged 15-17 years in Leicestershire

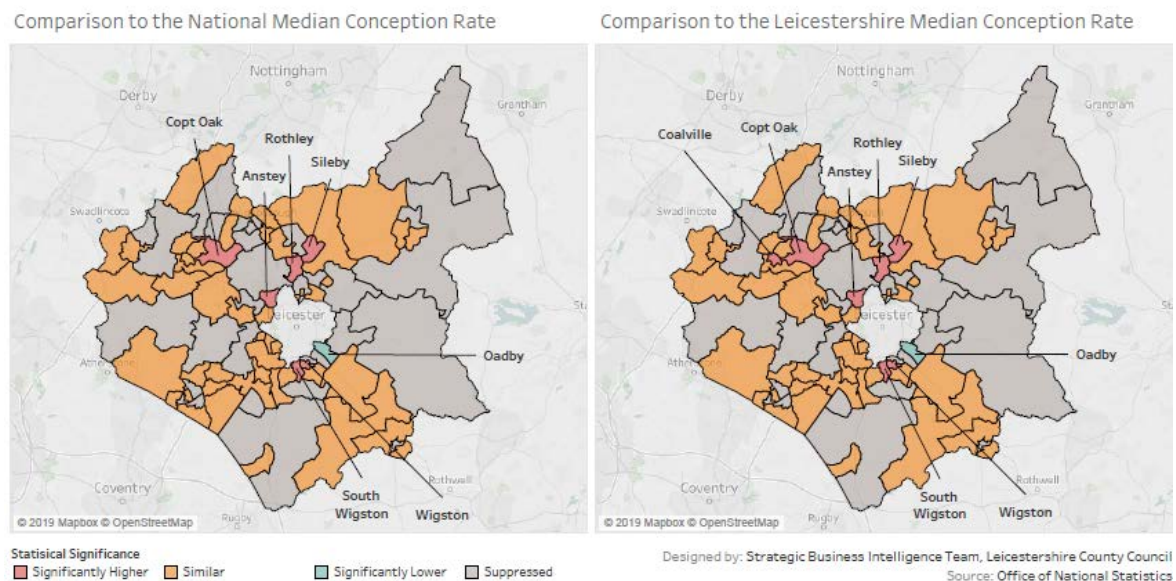


Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

Figure 17 shows under 18 conception rates by Middle Super Output Area (MSOA) in Leicestershire in 2015-2017. There are significantly higher levels of teenage conceptions in Coalville, Copt Oak, Anstey, Rothley, Sileby, Wigston and South Wigston when comparing to

the Leicestershire median. The same areas apart from Coalville have significantly higher levels of teenage pregnancy in comparison to the national median. Oadby has a significantly lower rate than both the National and Leicestershire medians.

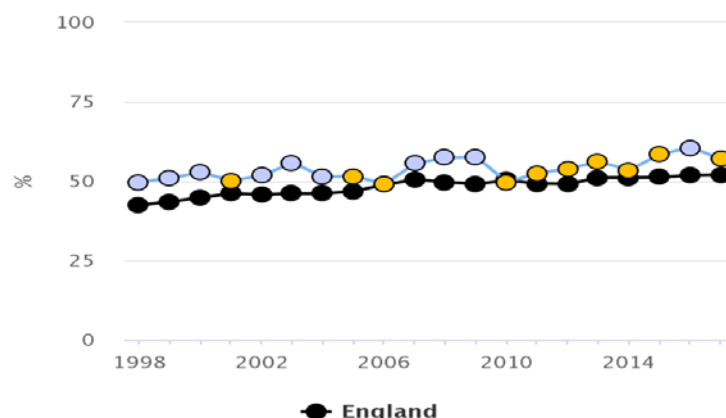
Figure 17: Under 18 conception rates by MSOA, Leicestershire, 2015-2017



Source: Office of National Statistics, 2019

In Leicestershire over the last twenty years, the trend in under 18 conceptions leading to abortion has shown no significant change. Over the last six years at a national level, the trend has increased significantly. Since 2011, the absolute number of under 18 conceptions leading to abortion has decreased year on year in Leicestershire. The percentage of under 18 conceptions leading to abortions has decreased since 2016 from 60.0% to 57.0% in 2017, this is similar to the national average (52.0%).³⁴

Figure 18: Trend in under 18s conceptions leading to abortion in Leicestershire

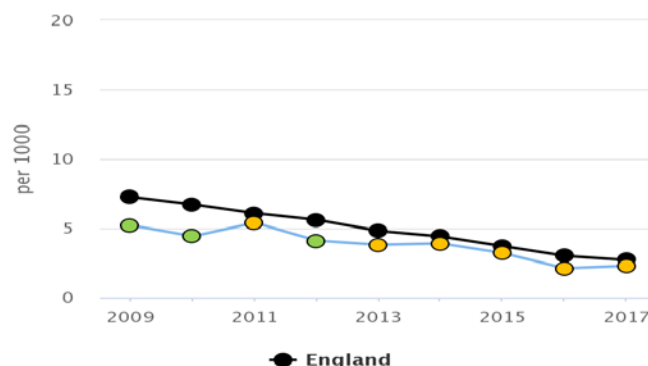


Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

Over the last five years, the rate of under 16 conceptions has significantly declined at both a national and local level. In England the rate has decreased for eight consecutive years

between 2009 and 2017 whereas in Leicestershire, decreases have been witnessed between 2014 to 2016. The most recent data in 2017 for Leicestershire shows there were 25 conceptions to females under the age of 16-years, this equates to a rate of 2.3 per 1,000 females aged 13-15. This was similar to the national rate of 2.7 per 1,000 females aged 13-15 years.³⁴

Figure 19: Trend of under 16 conception rates per 1,000 females aged 13 to 15 years in Leicestershire



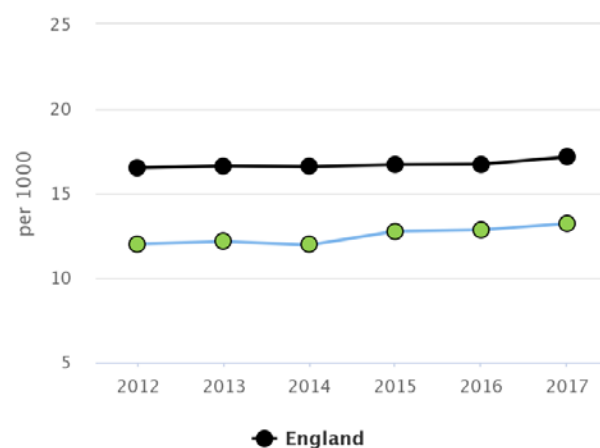
Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.5. Abortion

The total abortion rate has increased significantly over the past six years in Leicestershire, a pattern also witnessed nationally. Since 2014, the total number of abortions has increased year on year in Leicestershire but has continued to have a significantly lower rate than England (since 2012). The total abortion rate for Leicestershire was 13.2 per 1,000 female population age 15-44-years, significantly better than the England rate of 17.2 per 1,000 female population aged 15-44-years.³⁴

The latest available data shows that the total abortion rate in 2018 was 13.1 compared to an England rate of 17.5 per 1,000 female population aged 15-44-years.⁴¹

Figure 20: Trend of total abortion rate in Leicestershire



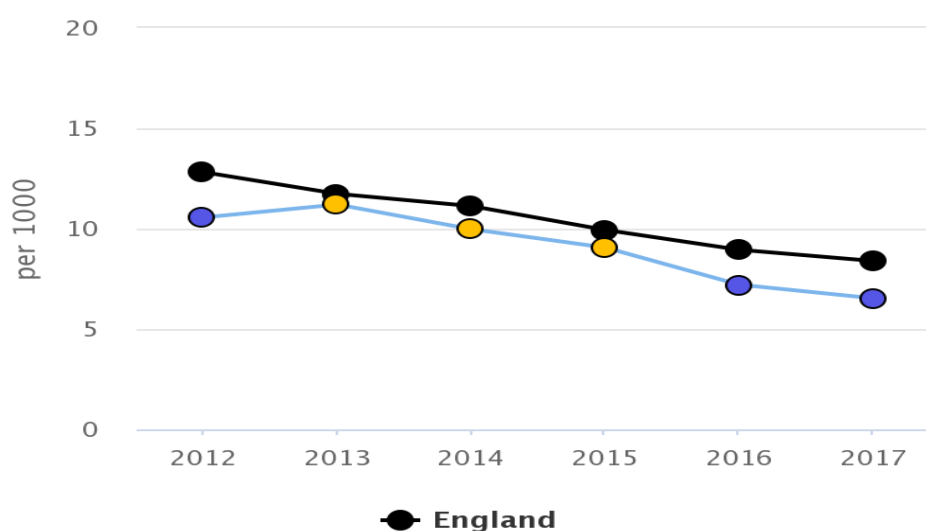
Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.5.1. Abortion by age

Over the last five years, both nationally and locally, the trend of under 18 abortions rate has significantly declined. The rate of under 18 abortions has decreased year on year in Leicestershire and for the past three years, the rate has remained significantly lower than the national average. The number of under 18 abortions decreased from a rate of 7.2 per 1,000 females in 2016 to 6.5 per 1,000 females in 2017, this is a decrease of 10 abortions for females under 18 years.³⁴

The latest available data shows that the under 18 abortion rate for Leicestershire in 2018 has risen back to 7.2 per 1,000 female population.⁴¹

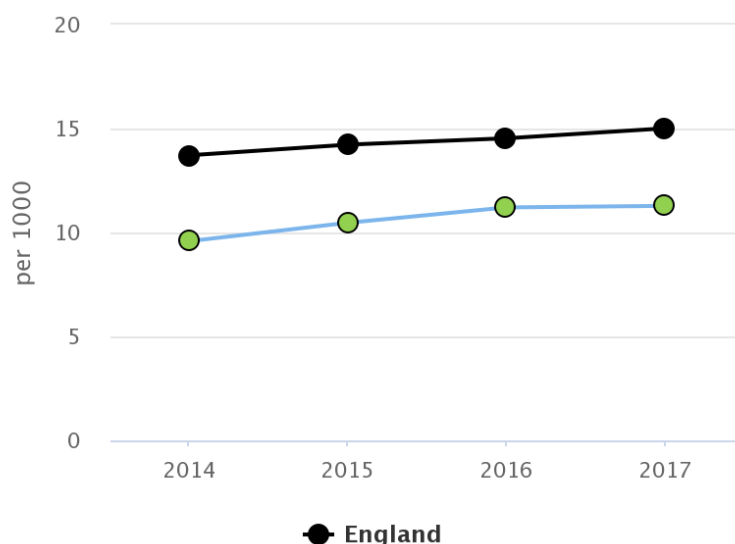
Figure 21: Trend of under-18 abortion rate for Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

Over the last four years the rate of over 25s abortions has increased year on year both nationally and locally. The rate of over 25 abortions in Leicestershire increased from 9.6 per 1,000 females in 2014 to 11.3 per 1,000 females in 2017. This equates to an increase of 155 abortions since 2014. Despite this, the rate has remained significantly lower (better) than the national average.³⁴

Figure 22: Trend of over 25 abortion rate for Leicestershire



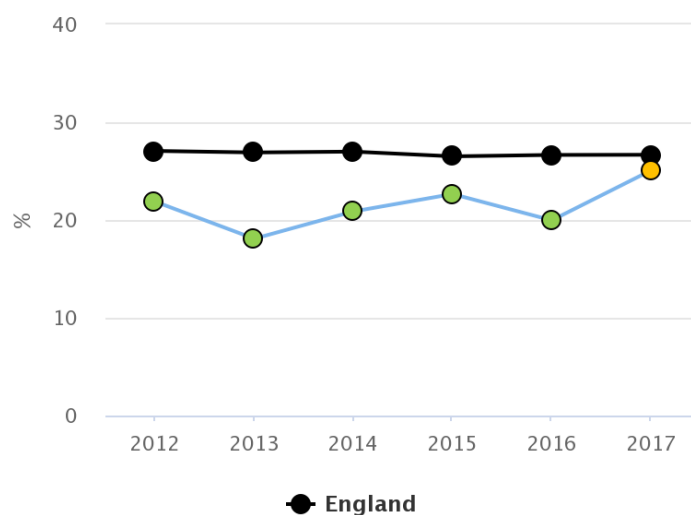
Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.5.2. Previous abortions

In 2017 a quarter (25.1%) of women aged under 25-years in Leicestershire had a previous abortion, this is similar to the England percentage of 26.7%. Between 2012 and 2016, Leicestershire has performed significantly better for under 25s repeat abortions compared to the England average.³⁴

The latest available data shows that the percentage of under 25-year olds who had had a previous abortion was 20.6% in 2018. This is lower than the percentage for England of 26.8%.⁴¹

Figure 23: Trend in under 25s repeat abortions in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.5.3. Gestation length

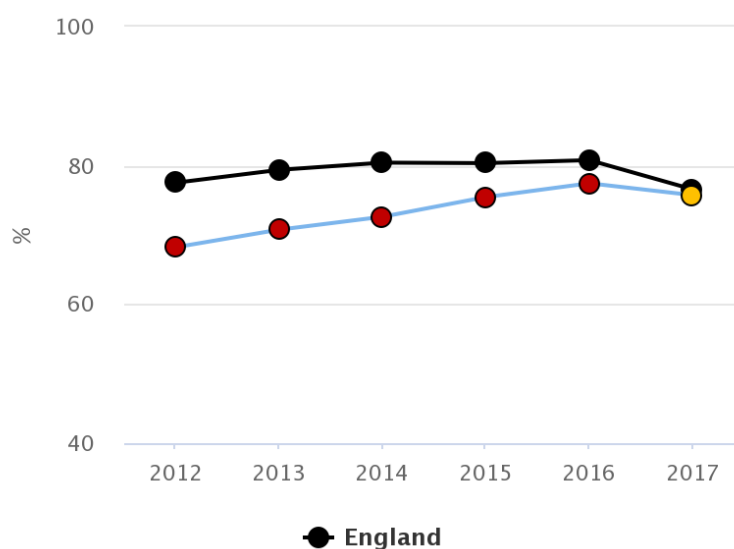
3.5.3.1. NHS funded abortions

Early medical abortion is less invasive than a surgical procedure and carries less risk as it does not involve instrumentation or use of anaesthetics

Among NHS funded abortions, the percentage of those under 10 weeks gestation in 2017 was 75.7%, which was similar to England percentage of 76.6%. The trend increased between 2012 and 2016 but remained significantly worse than the national average throughout this time. In 2017, the percentage of abortions under 10 weeks declined compared to the previous year; this pattern was also witnessed nationally. The local trend has significantly increased over the last five years in Leicestershire whereas nationally the rate has significantly declined.⁴²

The latest available data shows that the percentage of abortions under 10 weeks was 79.3% in 2018. This is lower than the percentage for England of 80.3%.⁴¹

Figure 24: Trend in abortions under 10 weeks in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.5.3.2. All purchasers

The percentage of abortions that took place between 3 to 9 weeks gestation has increased year on year, from 71.2% in 2013 to 77.8% in 2016. However, data from 2017 shows the percentage has declined to 76.0% in Leicestershire, this is similar to the national percentage of 76.9%. Between 2013 and 2016 the percentage of abortions that took place between 10 to 12 weeks gestation has decreased year on year from 18.5% to 12.1%. In 2017, the

percentage increased to 14.0% in Leicestershire, this is similar to the national percentage of 12.8%. The percentage of abortions that took place over 13 weeks gestation in 2017 (10.1%) is similar to the national percentage of 10.2%.⁴²

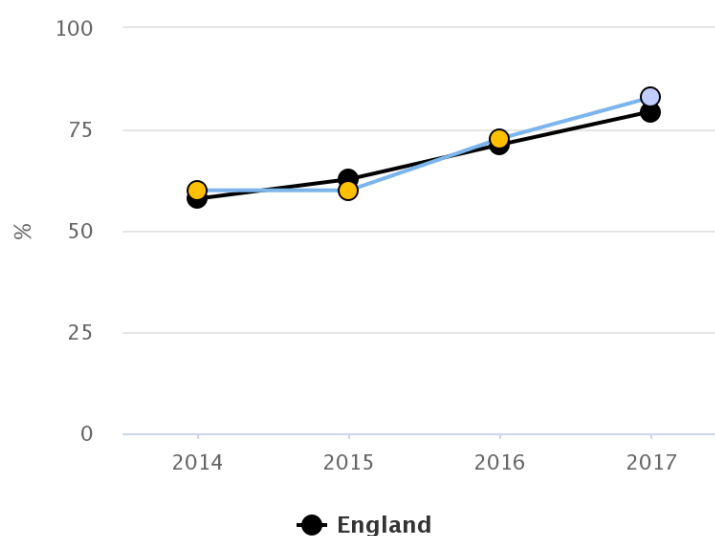
The latest available data for 2018 shows that, compared to 2017, the percentage of abortions that took place between 3 to 9 weeks gestation has risen to 79.5% for Leicestershire (80.4% for England), whilst the percentage taking place between 10 and 12 weeks gestation has decreased to 10.4% (10.7% for England). The percentage taking place over 13 weeks gestation has remained the same for Leicestershire at 10.1% (9.0% for England).⁴¹

3.5.4. Procedure

The choice of early medical abortion as a method of abortion is likely to have contributed to the increase in the overall England percentage of abortions performed at under 10 weeks gestation. Early medical abortion is less invasive than a surgical procedure and carries less risk as it does not involve instrumentation or the use of anaesthetics. Medical abortions are also cheaper than surgical interventions.

Among NHS funded abortions under 10 weeks gestation, the proportion that were performed using a medical procedure in 2017 was 82.9%, which was significantly higher than the England percentage of 79.4%. Figure 25 shows the percentage has increased in Leicestershire year on year between 2015 and 2017, a pattern also witnessed nationally.³⁴

Figure 25: Trend of abortions under 10 weeks that are medical in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

3.5.5. Abortion funding

In 2017 the percentage of NHS funded abortions that took place in an NHS hospital was 32.1%, significantly higher than the national percentage of 25.9%. Over the past four years, the percentage of abortions funded by NHS hospital has decreased year on year in Leicestershire, from 56.1% in 2013. At a national level, the percentage hovered around a 27% between 2014 to 2016 before decreasing in 2017.⁴²

In 2017, the percentage of abortions that took place in the independent sector under the NHS contract in Leicestershire was 65.0%, significantly lower than the national percentage of 71.9%. Locally, over the past four years there has been a 24-percentage point increase in the number of abortions in the independent sector whereas nationally the increase is 6.0 percentage points over the same period of time. Nationally and locally the independent sector has seen the greatest increase in the percentage of abortions when compared to NHS hospitals and the private sector.⁴²

The percentage of privately funded abortions in Leicestershire (2.9%) is significantly higher than the national percentage (2.2%) in 2017.⁴²

3.6. FGM (Female Genital Mutilation)

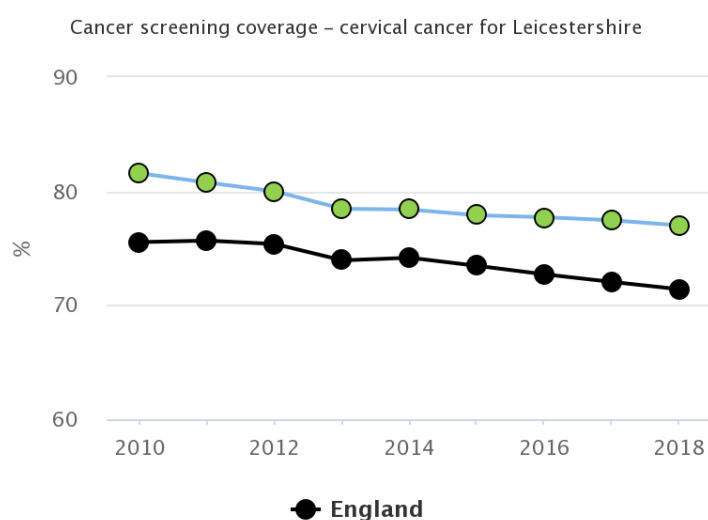
FGM (also referred to as, female circumcision or cutting) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.⁴³ Procedures are mostly carried out on young girls sometime between infancy and age 15, and occasionally on adult women. The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East, and among migrants from these areas. In Africa, more than three million girls have been estimated to be at risk for FGM annually.⁴⁴

During 2018/19, approximately 5 women aged 25-29 attended UHL with Type 1 FGM (partial or total removal of the clitoris and/or prepuce), and approximately 5 women aged 30-34 attended with Type 4 FGM (all other harmful procedures to the female genitalia for non-medical purposes, including pricking, piercing, incising, scraping and cauterisation).⁴⁵

3.7. Cervical screening

Cervical screening rates are calculated for the proportion of women eligible for cervical screening aged 25-64-years at end of period reported who were screened within the previous 3.5 years. The cervical screening rate for Leicestershire in 2018 was 77.0%. This is significantly better than the England rate of 71.4%. However, screening rates have decreased over the past eight years from 81.6% in 2010 to 77.0% in 2018 as seen below.

Figure 26: Trend of cancer screening coverage in Leicestershire

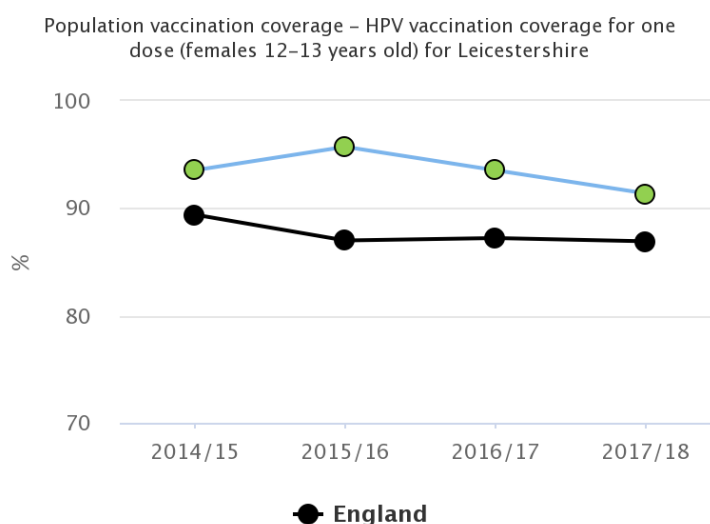


Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

The national human papillomavirus (HPV) immunisation programme was introduced in 2008 for secondary school year 8 females (12-13-years old) to protect them against the main causes of cervical cancer. While it was initially a three-dose vaccination programme, it was run as a two-dose schedule from September 2014 following expert advice. The first HPV vaccine dose is usually offered to females in Year 8 (aged 12-13-years old) and the second dose 12 months later in Year 9.

In Leicestershire in 2017/18, 91.4% of females 12-13-years old received the one dose HPV vaccination. This is higher than the benchmarked goal of 80-90%. However, 91.4% is a decrease from 93.5% in 2014/15 and 95.7% in 2015/16 as shown in figure 27

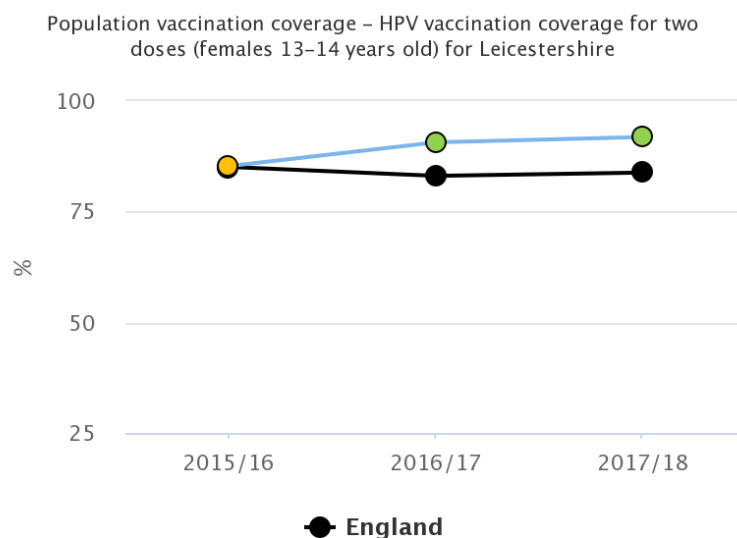
Figure 27: Trend of HPV vaccination coverage for one dose in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

Meanwhile, 91.9% of females 13-14-years old received the two dose HPV vaccination. This is an increase from the proportion in 2015/16 (85.3%) and higher than the benchmarked goal of 80-90%.

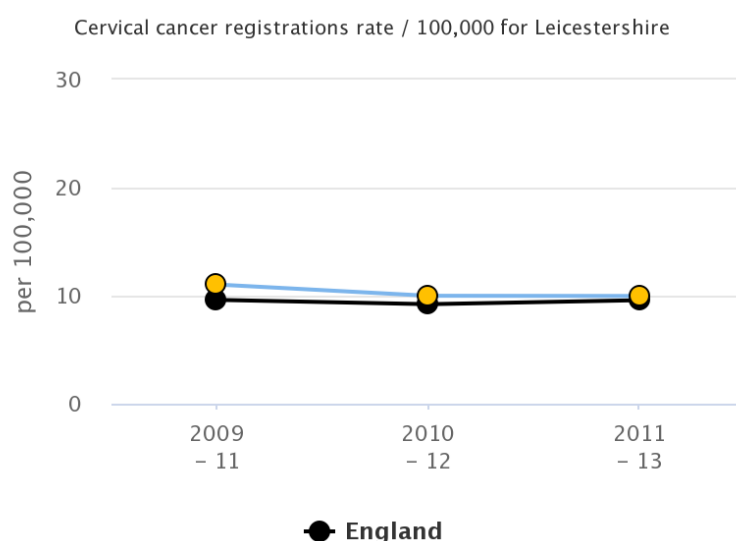
Figure 28: Trend of HPV vaccination coverage for two doses in Leicestershire



Source: Public Health England, Sexual and Reproductive Health Profiles, 2019.

The cervical cancer registration rate was 10.0 per 100,000 population (95 registrations) in 2011/13. This was similar to the England rate of 9.6 per 100,000 population, and a decrease from the Leicestershire rate of 11.0 per 100,000 population (104 registrations) in 2009/11.

Figure 29: Trend of cervical cancer registrations in Leicestershire



Source: Public Health England, Sexual and reproductive health profiles, 2019

3.8. LARC

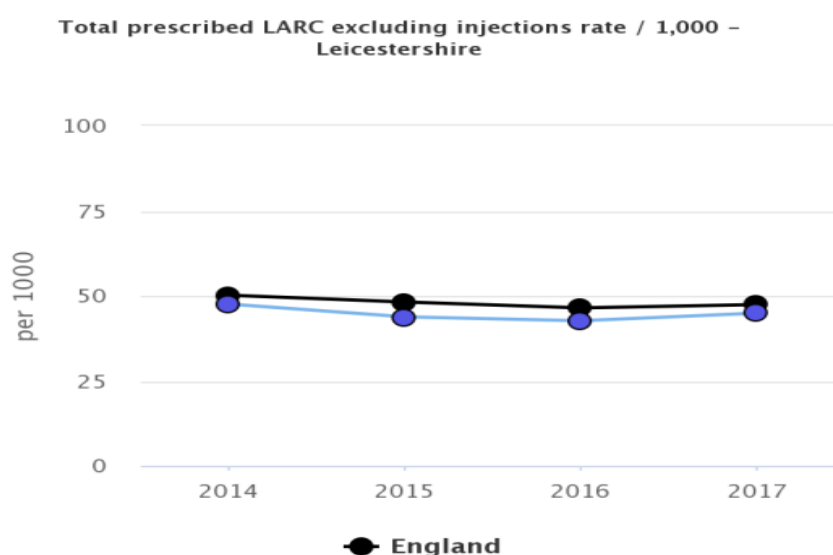
3.8.1. Total prescribed LARC

The total prescribed LARC excluding injections rate per 1,000 females aged 15-44-years old was 44.9, this is broken down by GP prescribed LARC rate of 31.4 and SRH services prescribed LARC rate of 13.5 per 1,000. In England the total prescribed LARC excluding injections rate was 47.4 per 1,000 females aged 15-44-years old. Leicestershire has been significantly lower than East Midlands and England averages for the past four years.

Nationally the total prescribed LARC excluding injections rate showed a year on year decline between 2014 and 2016 but increased in 2017.

In Leicestershire since 2014, the total prescribed LARC excluding injections rate has remained significantly lower than the national rate. The rate showed a year on year decline between 2014 and 2016 but increased from 42.7 per 1,000 females in 2016 to 44.9 per 1,000 females in 2017. This reflects an increase in 304 prescribed SDIs, IUS and IUDs prescribed in females aged 15-44-years old.

Figure 30: Total prescribed LARC excluding injections rate / 1,000 - Leicestershire



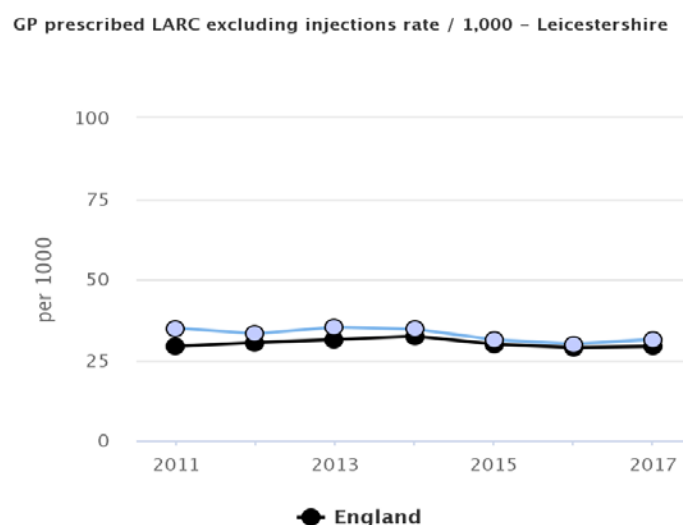
Source: Public Health England, Sexual and reproductive health profiles, 2019

3.8.2. GP Prescribed LARC excluding injections rate

The trend for the GP prescribed LARC excluding injections rate in Leicestershire has significantly decreased over the last five years. Nationally the trend has also significantly declined over this time period.

Since 2011, the GP prescribed LARC excluding injections rate has remained significantly higher than the national rate. The rate has increased from 29.9 per 1,000 females in 2016 to 31.4 per 1,000 females in 2017. This reflects an increase in 198 GP prescribed SDIs, IUS and IUDs prescribed in females aged 15-44-years old.

Figure 31: GP prescribed LARC excluding injections rate / 1,000 – Leicestershire



Source: Public Health England, Sexual and reproductive health profiles, 2019

3.8. LLR ISHS

Robust epidemiological information to inform local commissioning is reliant on good quality data from Genito-Urinary Medicine (GUM) clinics. The ISHS provides a range of accessible, high-quality, responsive, cost effective, confidential services across LLR which support and provide elements of delivery of sexual health services in primary care and other community settings. The service is open access and provides the following key elements of service:

- GUM, including STI testing & treatment
- Contraceptive and reproductive health services
- Chlamydia screening programme (15-24-year olds)
- Specific Young People's services for under 25's (Choices)
- Community Safer Sex Project (Leicester City only)
- Outreach and health promotion
- Psychosexual counselling

3.8.1. Patient flow for sexual health services

Table 4 shows information on attendances by Leicestershire residents for LLR commissioned sexual health services. Of the total residents attending LLR commissioned services, just under half attended Loughborough Health Centre There was a total of 18,559 attendances for a service commissioned by LLR, out of these, 82.9% were new attendances and 17.1% were follow up attendances.

Table 4: LLR commissioned sexual health clinics attended by Leicestershire residents in 2017

Area of Clinic	Clinic	Number of patients attending clinic	% of total patients attending a LLR commissioned clinic	Total Number of attendances by LLR commissioned clinic	% of total attendances that was a new attendance	% of total attendances that had a follow-up attendance
Leicestershire	Loughborough Health Centre	6302	47%	9428	82.2%	17.8%
LLR Online	Preventx	1637	12%	1637	100%	0.00%
Leicester	St Peter's Health Centre - Leicester	5094	38%	7152	79.9%	20.1%
Leicester	Choices Young people sexual health services	251	2%	342	80.1%	19.9%
LLR commissioned Services Total		13284	100%	18559	82.9%	17.1%

Source: Public Health England, HIV and STI Portal, 2019.

Table 5 shows information on the ten most popular clinics attended by residents of Leicestershire. Of the total residents attending ISHS in Leicestershire, over a third attended Loughborough Health Centre and just under a third attended St Peter's Health Centre in Leicester. A smaller percentage of patients living in Leicestershire (1.6%) attended young people, sexual health services in Leicester. The remaining patients attended clinics outside of Leicester and Leicestershire County.

There was a total of 9428 attendances at Loughborough Health Centre from Leicestershire residents, out of these, 82.2% were new attendances and 17.8% were follow-up attendances. There was a total of 7152 attendances at St Peter's Health Centre from Leicestershire residents, out of these, 79.9% were new attendances and 20.1% were follow-up attendances.

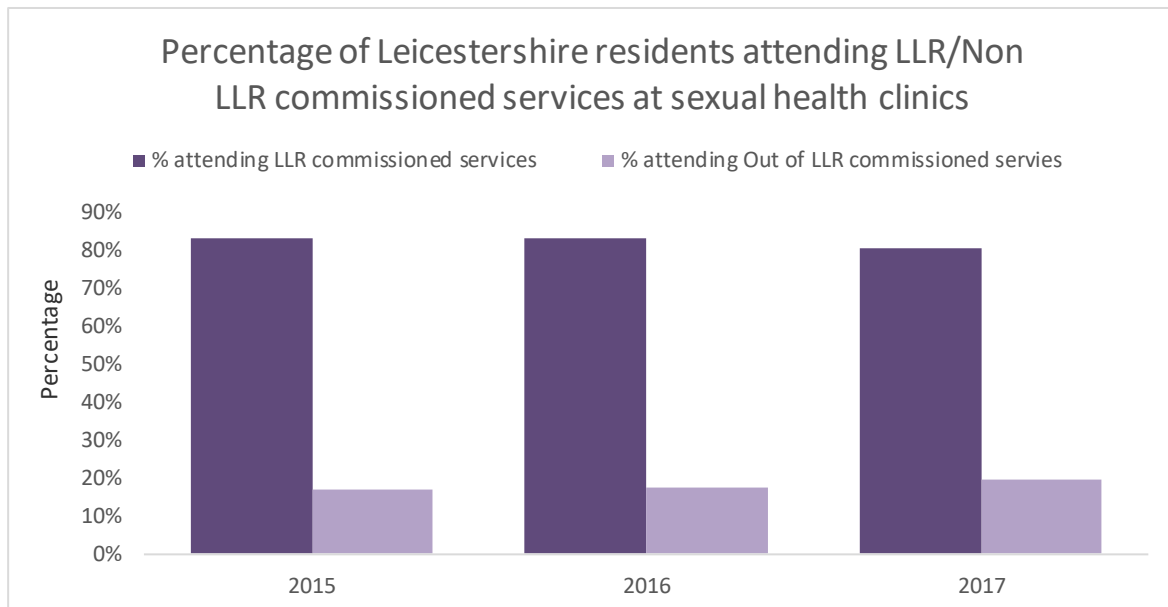
Table 5: Top ten sexual health clinics attended by Leicestershire residents in 2017.

Area of Clinic	Clinic	Number of patients attending clinic	% of total patients attending a clinic	Total number of attendances by clinic	% of total attendances that was a new attendance	% of total attendances that had a follow-up attendance
Leicestershire	Loughborough Health Centre	6302	39.3%	9428	82.2%	17.8%
LLR Online	Preventx	1637	10.2%	1637	100%	0.0%
Leicester	St Peter's Health Centre - Leicester	5094	31.7%	7152	79.9%	20.1%
Leicester	Choices Young people sexual health services	251	1.6%	342	80.1%	19.9%
Warwickshire	George Eliot Hospital	890	5.5%	1584	65.5%	34.5%
Staffordshire	Delia Morris Centre	246	1.5%	401	75.8%	24.2%
Northamptonshire	Ashwood Centre	211	1.3%	435	58.9%	41.1%
Warwickshire	Hospital of St Cross	196	1.2%	326	66.6%	33.4%
Derby	Sexual Health @ London Road	161	1.0%	232	87.1%	12.9%
Nottingham	Victoria Health Centre	130	0.8%	150	92.0%	8.0%
Other Areas	Other Clinics	929	5.8%	1346	81.1%	18.9%
Total Clinics		16047	100%	23033	80.9%	19.1%

Source: Public Health England, HIV and STI Portal, 2019.

Figure 32 below shows the percentage of Leicestershire residents attending clinics commissioned and not commissioned by LLR. In 2017, 4474 (19%) of Leicestershire residents attended clinics that were not commissioned by LLR. Since 2015, the percentage of Leicestershire residents attending clinics that were not commissioned by LLR has remained under 20%.

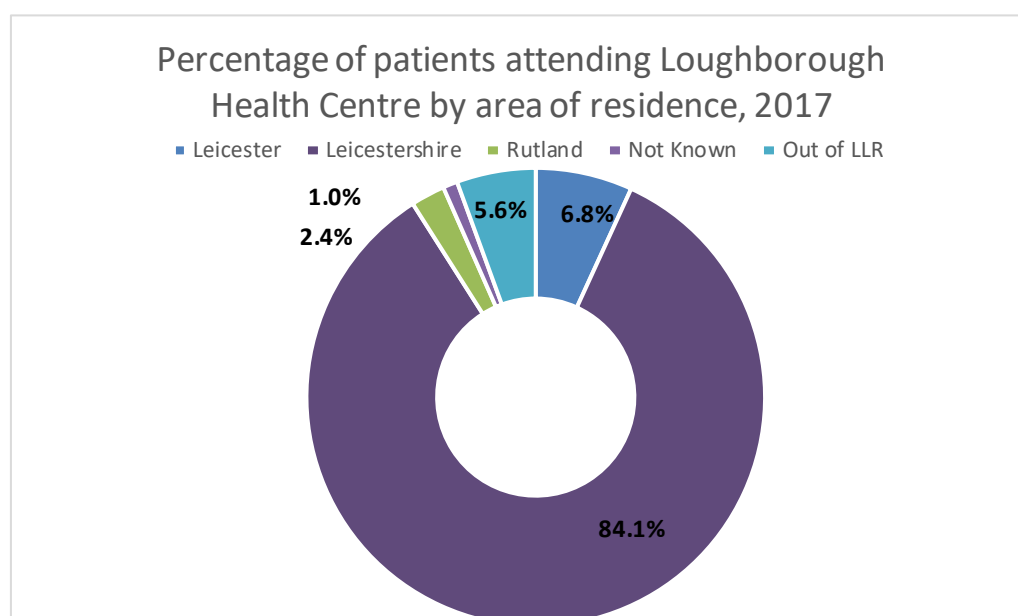
Figure 32: Attendance by Leicestershire residents for LLR/Non LLR commissioned services, 2015-2017



Source: Public Health England, HIV and STI Portal, 2019.

Figure 33 below shows in 2017, 84.1% of the patients attending Loughborough Health Centre were residents of Leicestershire, and 6.8% lived in Leicester City.

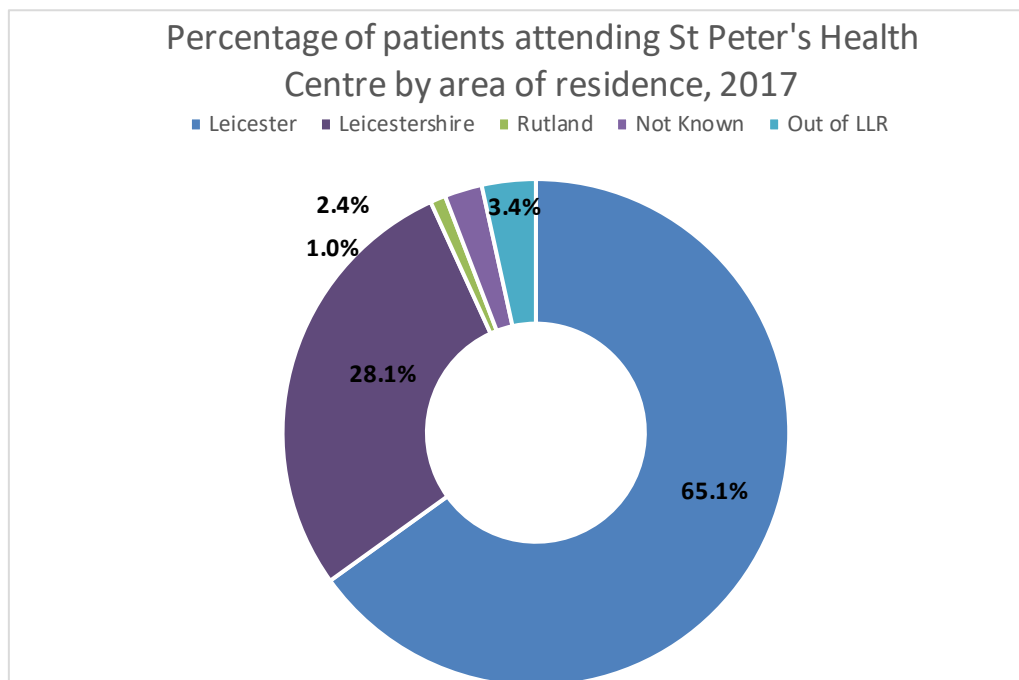
Figure 33: Patient flow of those attending Loughborough Health Centre by area of residence



Source: Public Health England, HIV and STI Portal, 2019.

Figure 34 shows in 2017, 65.1% of the patients attending St Peter's Health Centre were residents of Leicester City and 28.1% lived in Leicestershire

Figure 34: Patient flow of those attending St Peter's Health Centre by area of residence



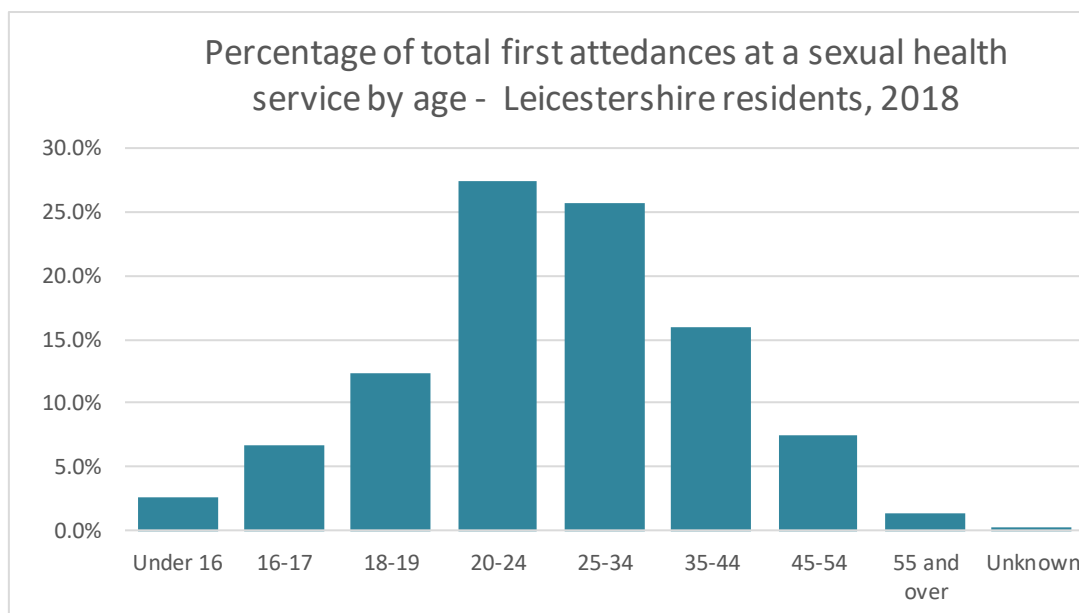
Source: Public Health England, HIV and STI Portal, 2019.

3.8.2. Sexual health contraception services – Sexual and Reproductive Health Activity Data Set (SHRAD)

In 2018, there was a total of 6,732 attendees from Leicestershire attending a sexual health service in England, of these 4156 (61.7%) were first time attendees. Males accounted for 5.2% of first time attendees and females accounted for 94.8%.

Figure 35 show the percentage of first time attendees by age in Leicestershire. It can be seen that the highest percentage of first time attendees were from those patients aged between 20-24-years (27.5%), followed by those aged between 25-34-years (25.7%).

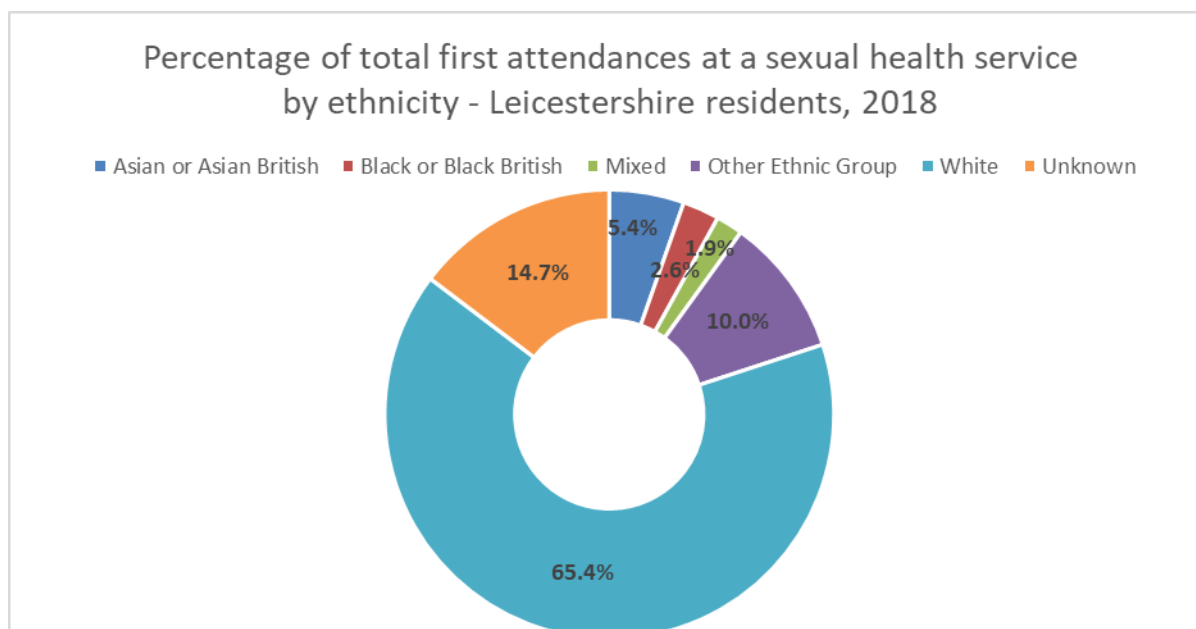
Figure 35: Percentage of first time attendees at a Sexual Health Service by residents of Leicestershire by Age, 2018



Source: Midlands Partnership NHS Foundation Trust - SHRAD, 2019

Figure 36 below shows the percentage of first time attendees by ethnicity in Leicestershire. In 2018, a majority of first time attendees were of White ethnicity (65.4%), followed by those where the ethnicity was unknown (14.7%).

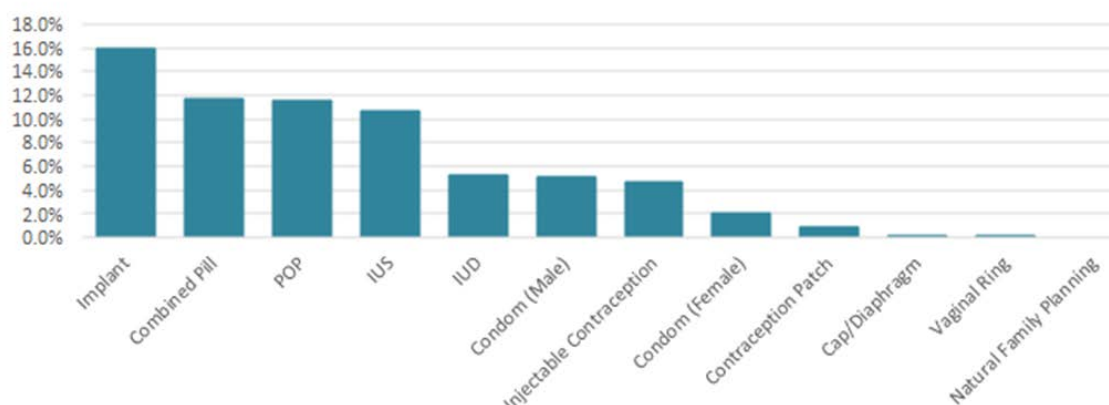
Figure 36: Percentage of first time attendees to a Sexual Health Service by residents of Leicestershire by Ethnicity, 2018



Source: Midlands Partnership NHS Foundation Trust - SHRAD, 2019

Figure 37 below shows the percentage of first time attendees by method of contraception in Leicestershire. In 2018, 15.9% of first time attendances were for SDIs, followed by 11.7% for the combined pill.

Figure 37: Percentage of first time attendees at a Sexual Health Service by residents of Leicestershire by method of contraception, 2018

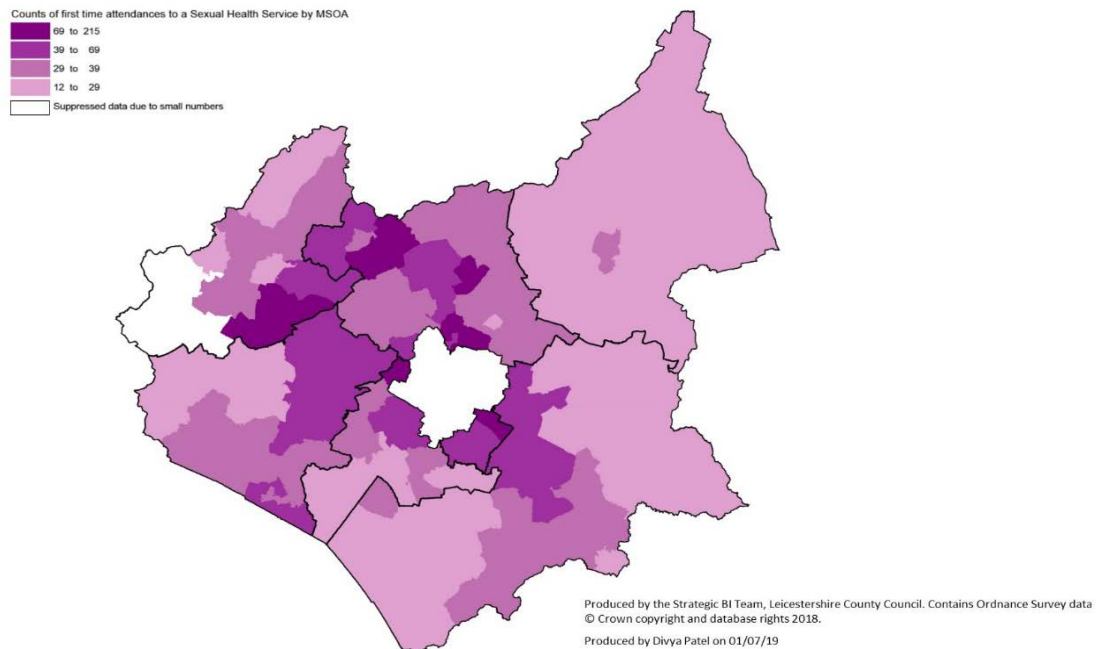


Source: Midlands Partnership NHS Foundation Trust - SHRAD, 2019

Figure 38 shows a majority of first time attendances were from those resident within Loughborough, Glenfield, Thurmaston and Oadby.

Figure 37: Map of first attendees by MSOA of residence

Counts of First Time Attendances to a Sexual Health Service by MSOA of Residence in Leicestershire, 2018



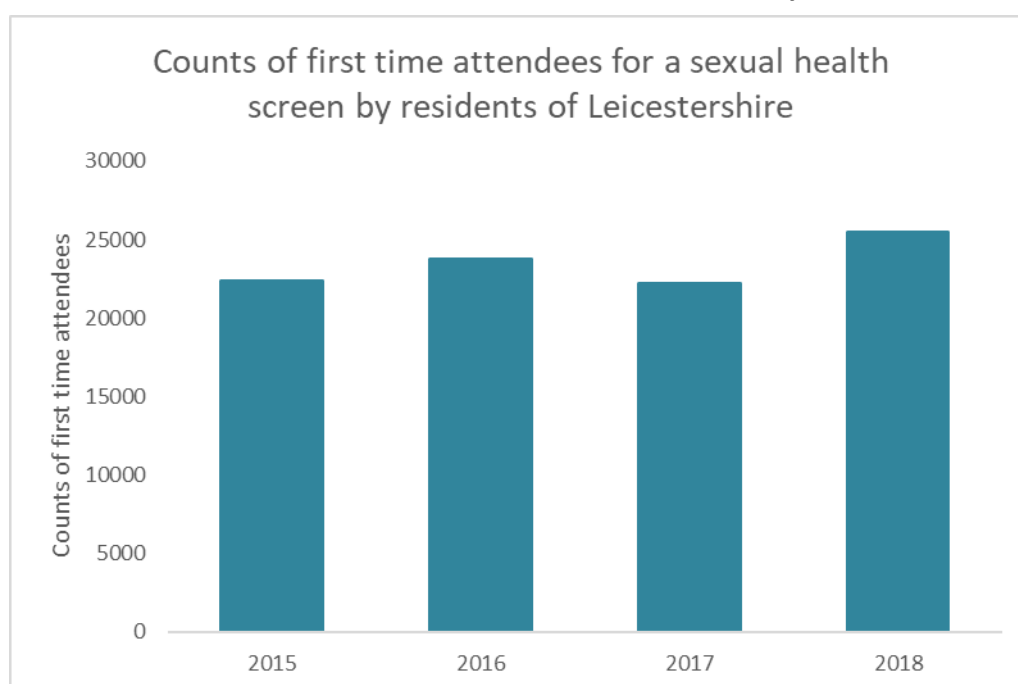
Source: Midlands Partnership NHS Foundation Trust-SHRAD, 2019

3.8.3. Sexual health screens – GUMCAD (Genitourinary Medicine Clinical Activity Dataset)

In 2018, there was a total of 29,433 attendees from Leicestershire attending a sexual health clinic in England, of these, 25,468 (86.5%) were first time attendees. Males accounted for 43.1% of first time attendances and females accounted for 56.8%.

Figure 39 shows there has been a percentage increase of 14.5% in the number of first time attendees since 2017, from 22,236 to 25,468 in 2018.

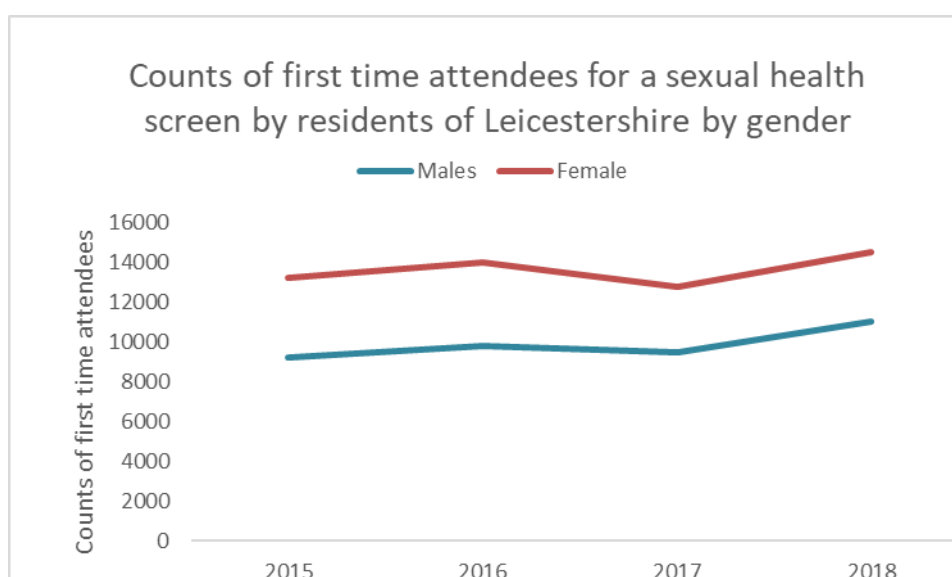
Figure 38: Counts of first time attendees for a Sexual Health Screen by residents of Leicestershire



Source: Midlands Partnership NHS Foundation Trust - GUMCAD Activity Data, 2019

Figure 40 shows the trend in first time attendees by males and females in Leicestershire. It can be seen that since 2015, there has been a higher number of first time attendees by females in comparison to males. There has been an increase in both males and females since 2017.

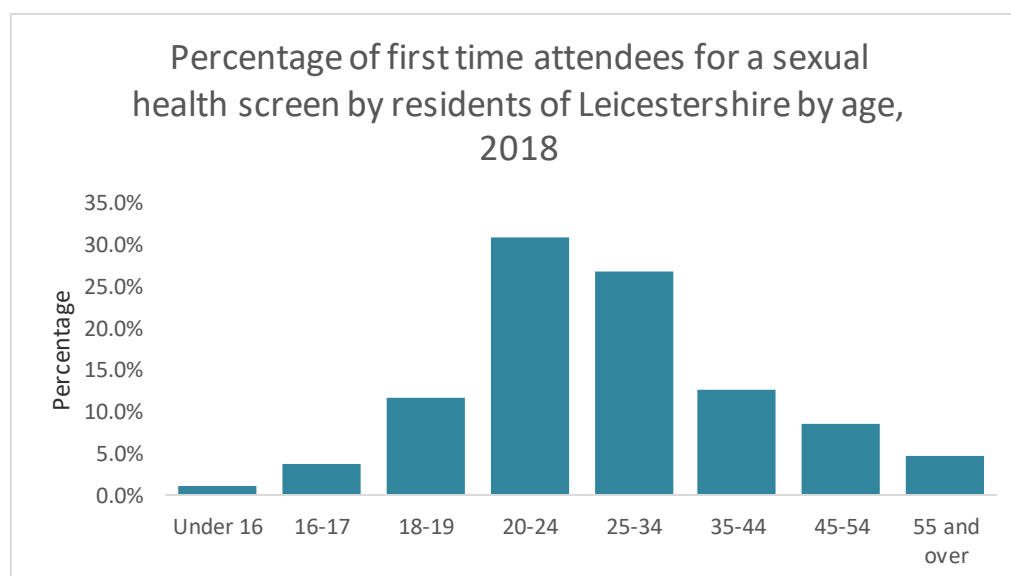
Figure 39: Counts of first time attendees for a sexual health screen by residents of Leicestershire by gender



Source: Midlands Partnership NHS Foundation Trust - GUMCAD Activity Data, 2019

Figure 41 shows the percentage of first time attendees by age in Leicestershire. It can be seen that the highest percentage of first time attendees were from those patients aged between 20-24 -ears (31%), followed by those aged between 25-34-years (26.8%).

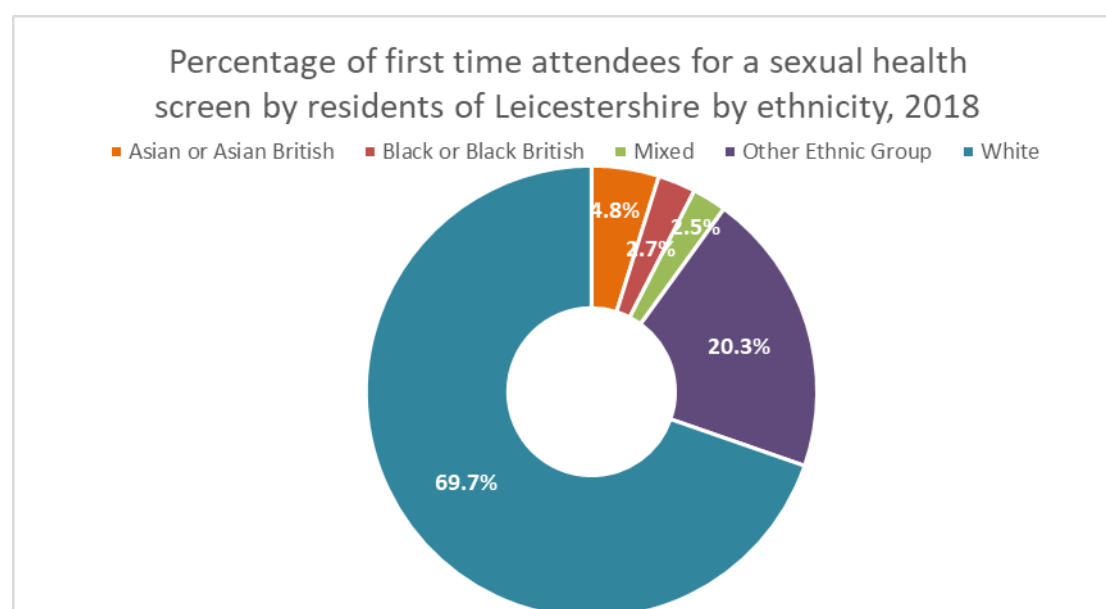
Figure 40: Percentage of first time attendees for a sexual health screen by residents of Leicestershire by age, 2018



Source: Midlands Partnership NHS Foundation Trust - GUMCAD Activity Data, 2019

Figure 42 below shows the percentage of first time attendees by ethnicity in Leicestershire. In 2018, a majority of first time attendees were of White ethnicity (69.7%), followed by those of other ethnicity (20.3%).

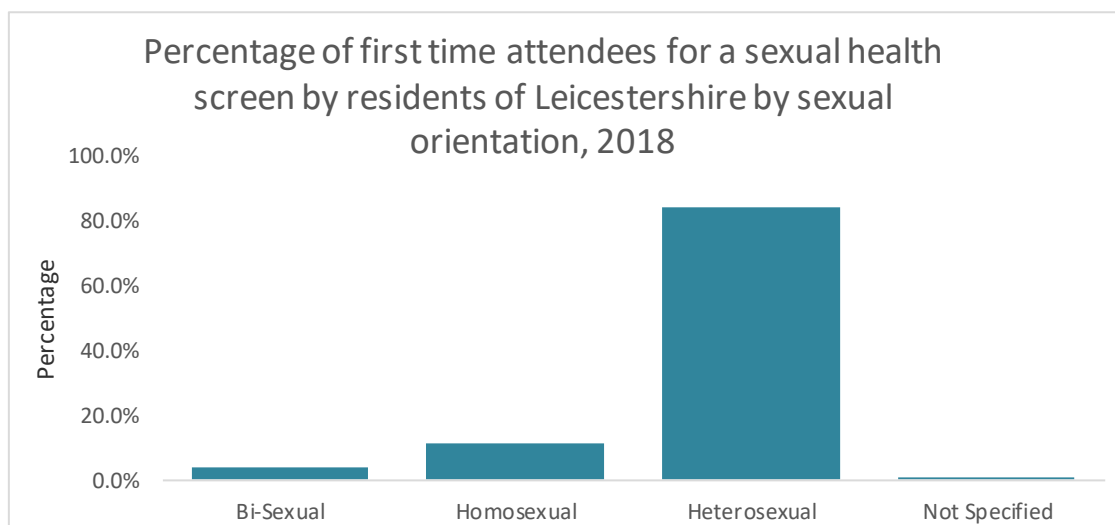
Figure 41: Percentage of first time attendees for a sexual health screen by residents of Leicestershire by Ethnicity, 2018



Source: Midlands Partnership NHS Foundation Trust - GUMCAD Activity Data, 2019

Figure 43 below shows the percentage of first time attendees by sexual orientation in Leicestershire. In 2018, a majority of first time attendees were of those with a heterosexual orientation (84.1%), followed by those with a homosexual sexual orientation (11.3%).

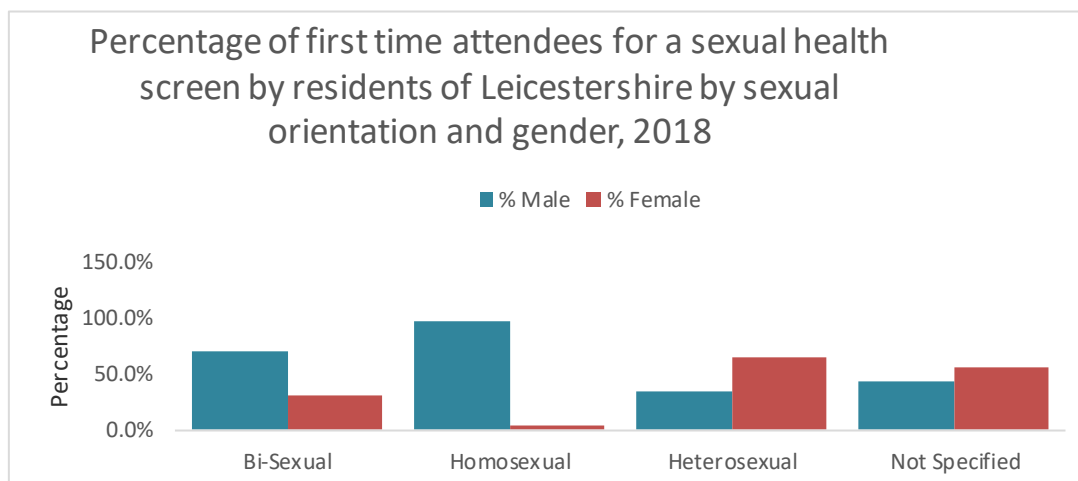
Figure 42: Percentage of first time attendees for a sexual health screen by residents of Leicestershire by sexual orientation, 2018



Source: Midlands Partnership NHS Foundation Trust - GUMCAD Activity Data, 2019

Figure 44 below shows the percentage of first time attendees by sexual orientation and gender in Leicestershire. In 2018, a higher proportion of males accounted for first attendees amongst those of a bi-sexual (69.7%) sexual orientation and those of homosexual (96.6%) sexual orientation. Whereas females accounted for a higher proportion of first attendees amongst those of a heterosexual (65.3%) sexual orientation.

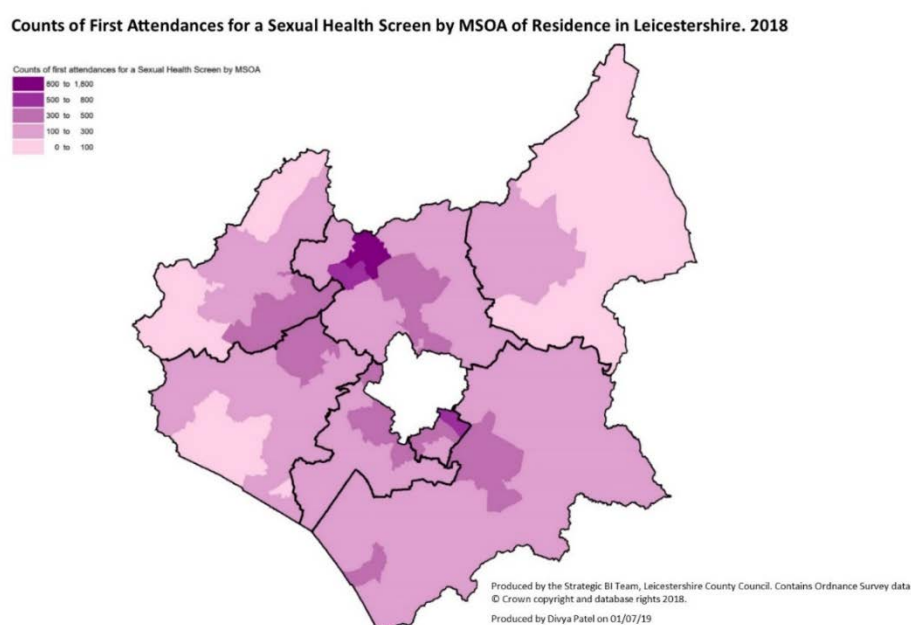
Figure 43: Percentage of first time attendees for a sexual health screen by residents of Leicestershire by sexual orientation and gender, 2018



Source: Midlands Partnership NHS Foundation Trust - GUMCAD Activity Data, 2019

Figure 45 shows a majority of first time attendances were from those resident within the Loughborough area.

Figure 44: Map of first attendees by MSOA of residence

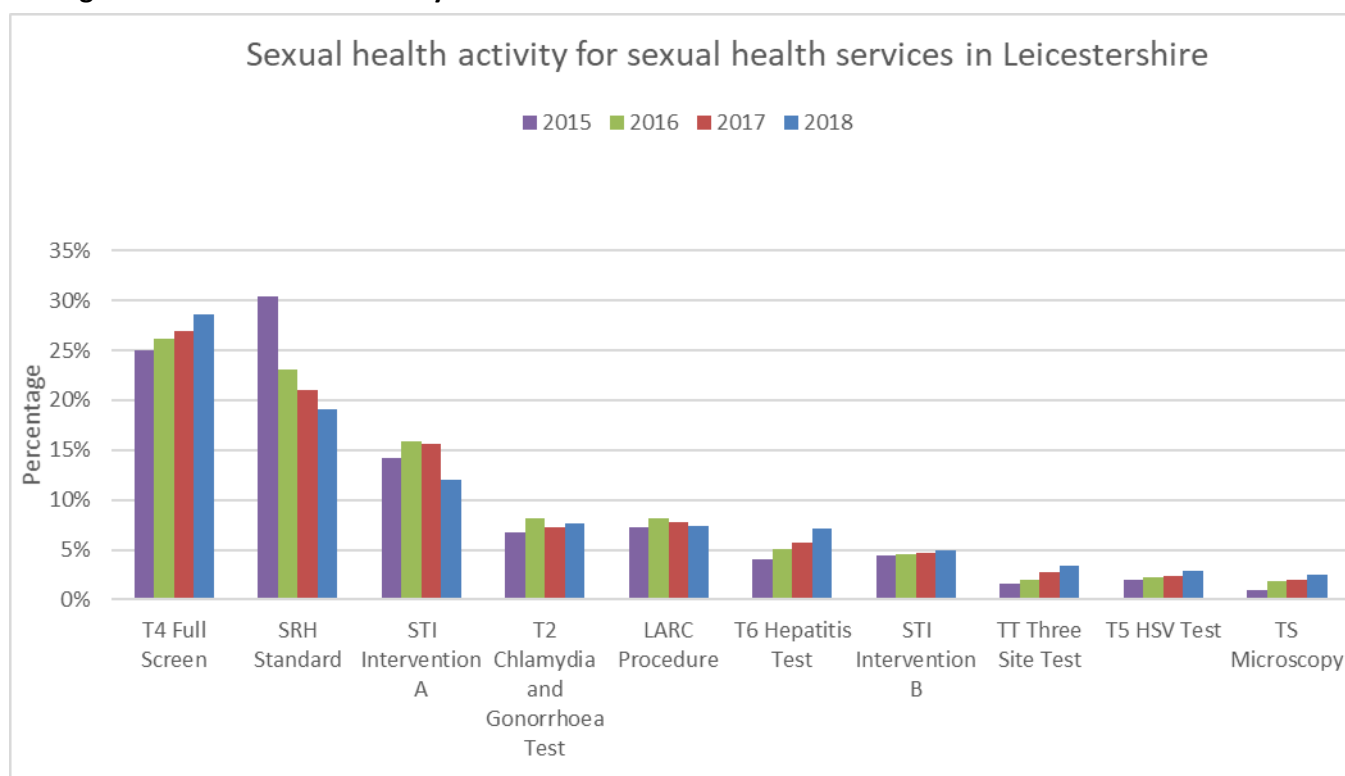


Source: Midlands Partnership NHS Foundation Trust - GUMCAD Activity Data, 2019

3.8.4. ISHS Activity

Figure 46 below shows the top ten percentage of total activity for sexual health services in Leicestershire. It can be seen that there has been an increase in activity for full screens since 2015 from 25% to 29% in 2018 and also for Hepatitis tests from 4% in 2015 to 7% in 2018. There has been a decrease in activity for SRH standard from 30% in 2015 to 19% in 2018.

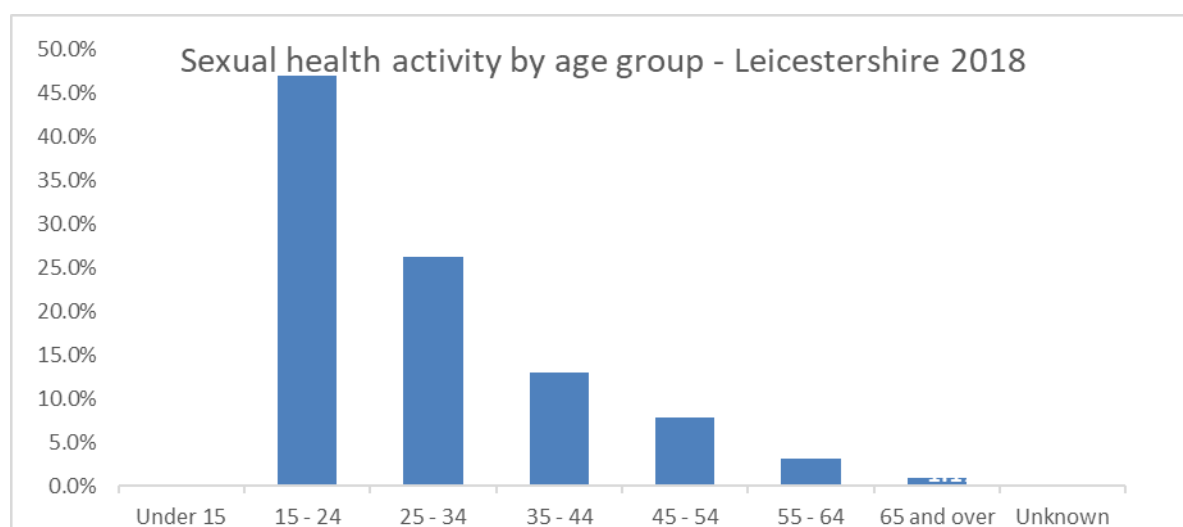
Figure 45: Sexual health activity for sexual health services in Leicestershire



Source: Midlands Partnership Foundation Trust, 2019

Figure 47 shows sexual health activity by age group in Leicestershire. It can be seen that in 2018, the highest proportion of those attending sexual health services was amongst those aged 15-24-years (47.3%), followed by those aged 25-34-years (26.5%).

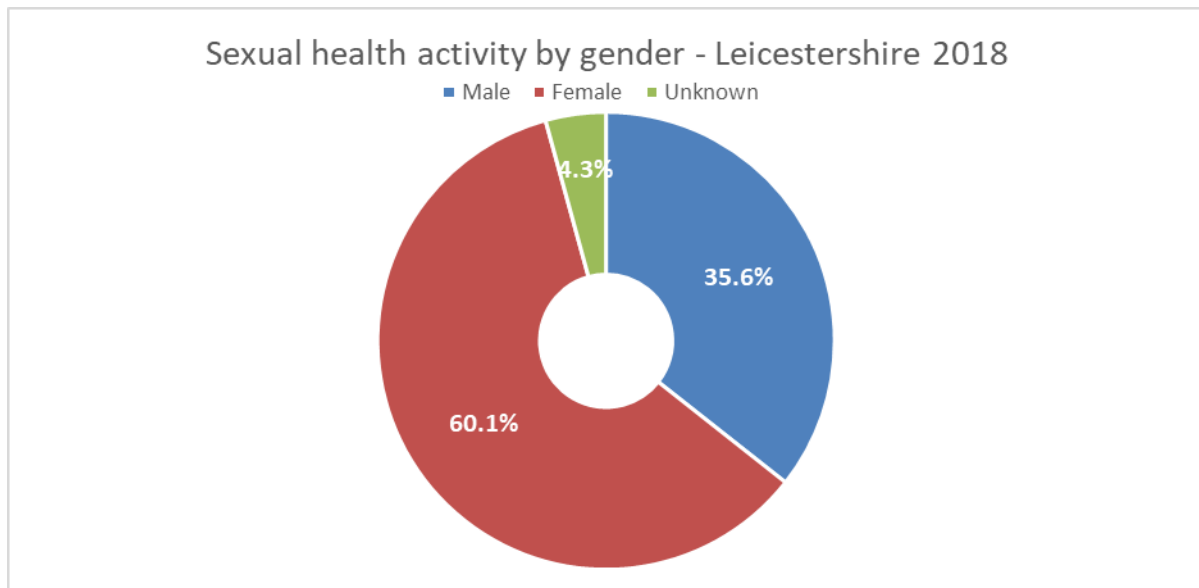
Figure 46: Sexual health activity for sexual health services in Leicestershire by age, 2018



Source: Midlands Partnership Foundation Trust, 2019

Figure 48 shows sexual health activity by age gender in Leicestershire. It can be seen that in 2018, the highest proportion of those attending sexual health services was amongst females (60.1%) followed by males (35.6%).

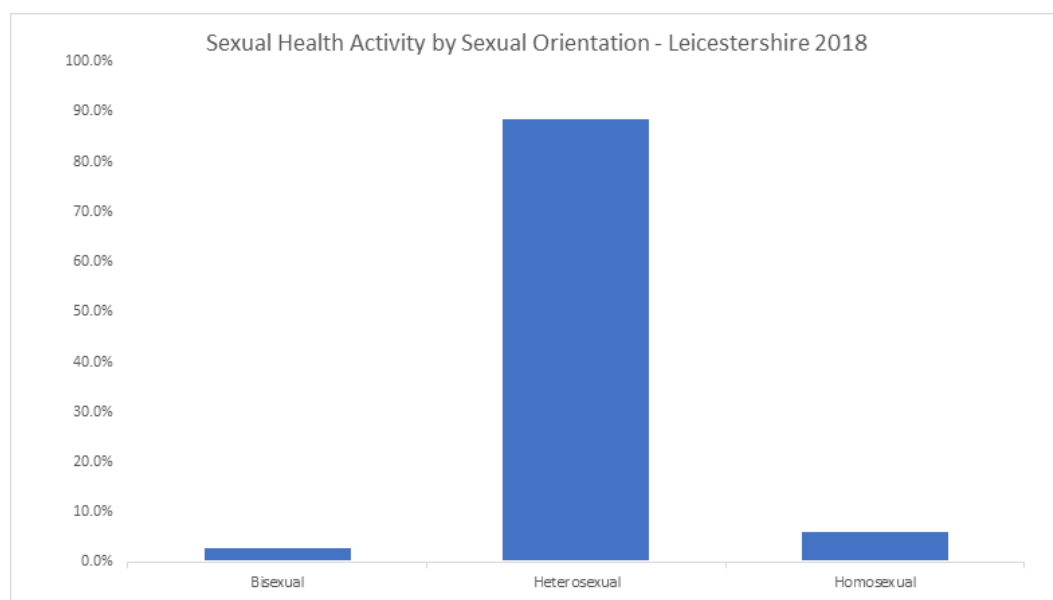
Figure 47: Sexual health activity for sexual health services in Leicestershire by gender, 2018



Source: Midlands Partnership Foundation Trust, 2019

In 2018, 88.8% of people attending sexual health services in Leicestershire were heterosexual, 6.3% were homosexual and 3.0% bisexual. The proportions differed by gender, for males: 75.3% were heterosexual, 16.6% were homosexual and 5.3% bisexual. For females: 96.7% were heterosexual, 0.4% were homosexual and 1.6% bisexual.

Figure 48: Sexual health activity for sexual health services in Leicestershire by sexual orientation, 2018



Source: Midlands Partnership Foundation Trust, 2019

In 2018, 64.3% of people attending sexual health services in Leicestershire were white British, 4.3% were Indian, 2.9% white Irish and 2% black African. 20.4% did not state an ethnic group.

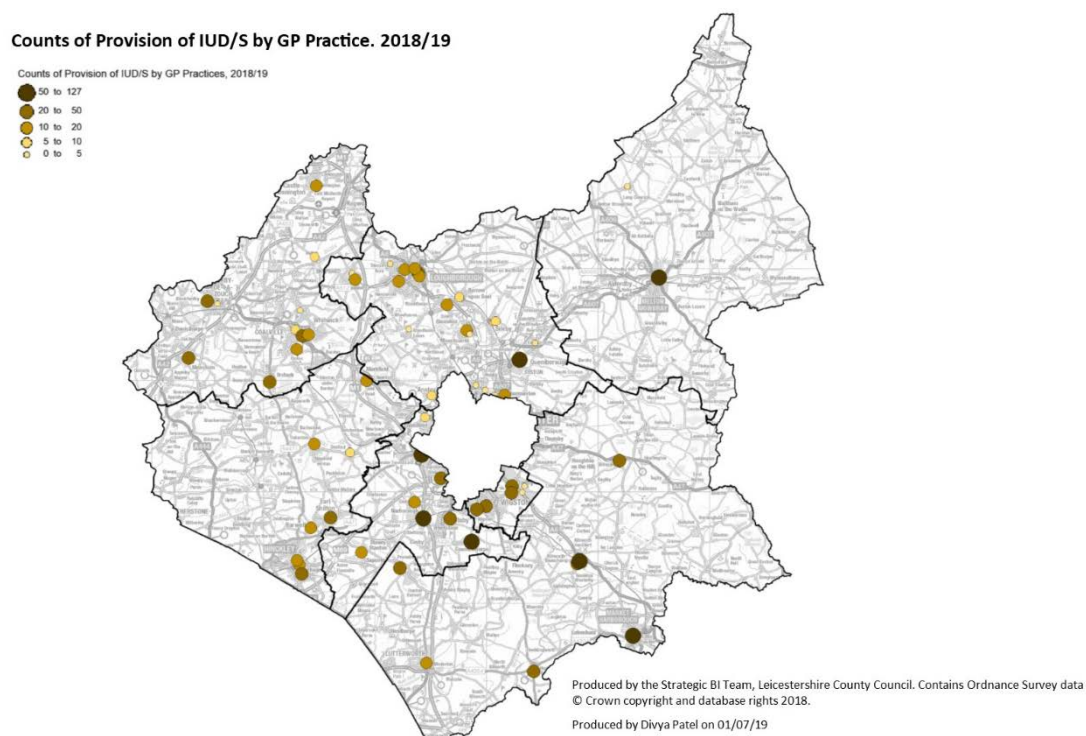
3.9. Community-based services (CBS)

Leicestershire County Council commissions community-based services that are delivered by primary care providers across Leicestershire. The CBS services relating to sexual health are provision of IUS, IUD and SDI in GP, and provision of free oral emergency contraception for under 25s in a range of pharmacies.

3.9.1. IUD/IUS provision in GP Practices

In 2018/19, there were a total of 1480 IUD/IUS fits and 771 SDI prescribed by GPs in Leicestershire. Figure 50 below shows IUD/IUS provision in GP Practices using GP Prescribing data. Latham House in Melton Mowbray provided the highest number of IUD/IUS, followed by Market Harborough Medical Centre.

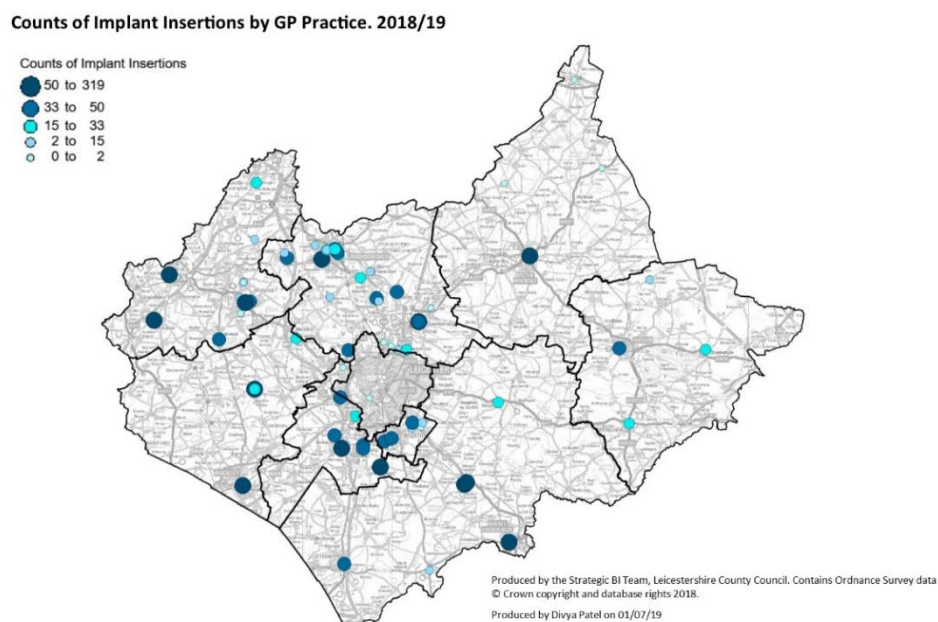
Figure 49: Map showing IUD/S fittings by GP Practice for 2018/19



Source: CCG Prescribing Claims Data, 2019

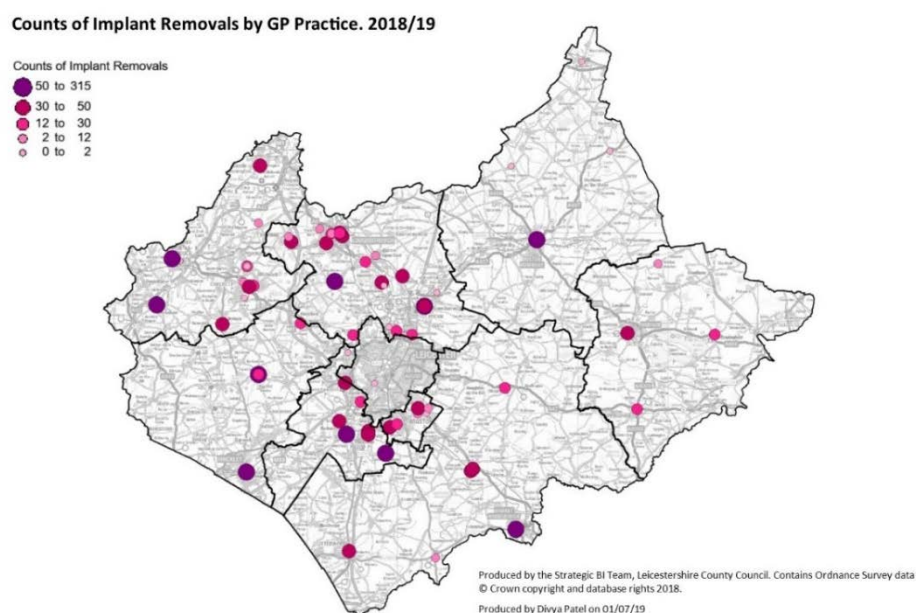
Figure 51 and Figure 52 examine the counts of implant insertions and implant removals in 2018/19 using community-based services data. In 2018/19 there was a total of 2353 implant insertions and 2173 implant removals in GP Practices in Leicestershire and Rutland. Hinckley and Bosworth Medical Alliance practice had the highest number of implant insertions and removals, followed by Latham House in Melton Mowbray. Out of the 72 GP Practices providing implants, 17 practices removed more implants than provided.

Figure 50: Counts of Implant Insertions by GP Practice, Leicestershire and Rutland



Source: Community Based Services Claims Data, 2019

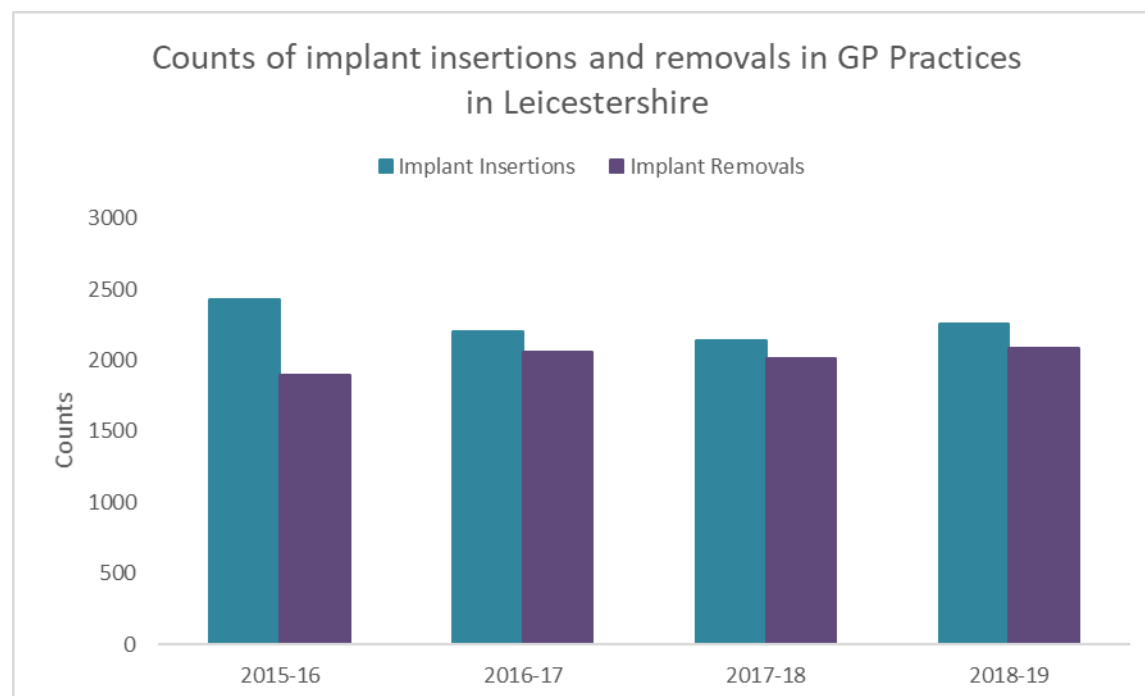
Figure 51: Counts of Implant Removals by GP Practice, Leicestershire and Rutland



Source: Community Based Services Claims Data, 2019

Figure 53 below shows the trend in the number of implant insertions and removals in Leicestershire GP Practices. There has been an increase in the number of implant insertions from 2142 in 2017/18 to 2256 in 2018/19. There has also been an increase in the number of implant insertions from 2013 in 2017/18 to 2081 in 2018/19

Figure 52: Counts of implant insertions and removals in GP Practices in Leicestershire



Source: Community Based Services Claims Data, 2019

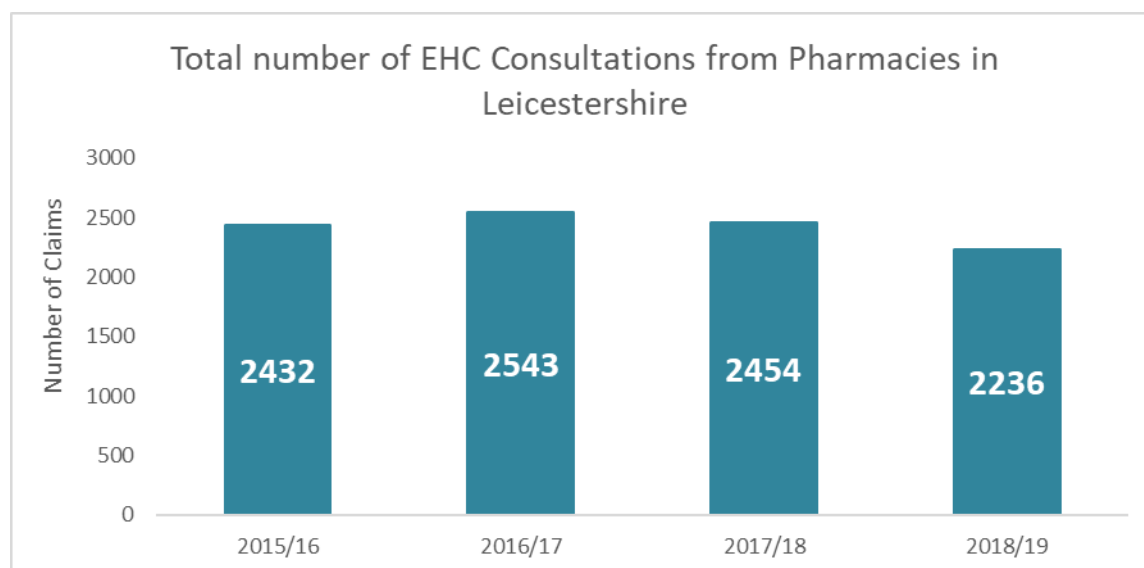
3.9.2. Emergency Hormonal Contraception in pharmacy

Pharmacists will supply Levonelle EHC when appropriate to clients in line with the requirements of a locally agreed Patient Group Direction (PGD). The PGD have specified the age range of clients that are eligible for the service as females between 13-25-years old. Those aged 16-years or under may be supplied Levonelle if the young person is assessed as Fraser competent, although the supply of EHC is dependent on the pharmacist's clinical judgement. For children aged 13-years and under the pharmacist has a duty to seek further advice and onward referral to address child protection issues.

Those patients presenting to pharmacies will also be given advice on the avoidance of pregnancy and STIs through safer sex and condom use, advice on the use of regular contraceptive methods and provide onward signposting to services that provide long-term contraceptive methods and diagnosis and management of STIs.

Figure 54 shows there has been a decrease of 12% in the number of EHC claims since 2016/17 from 2543 to 2236 in 2018/19.

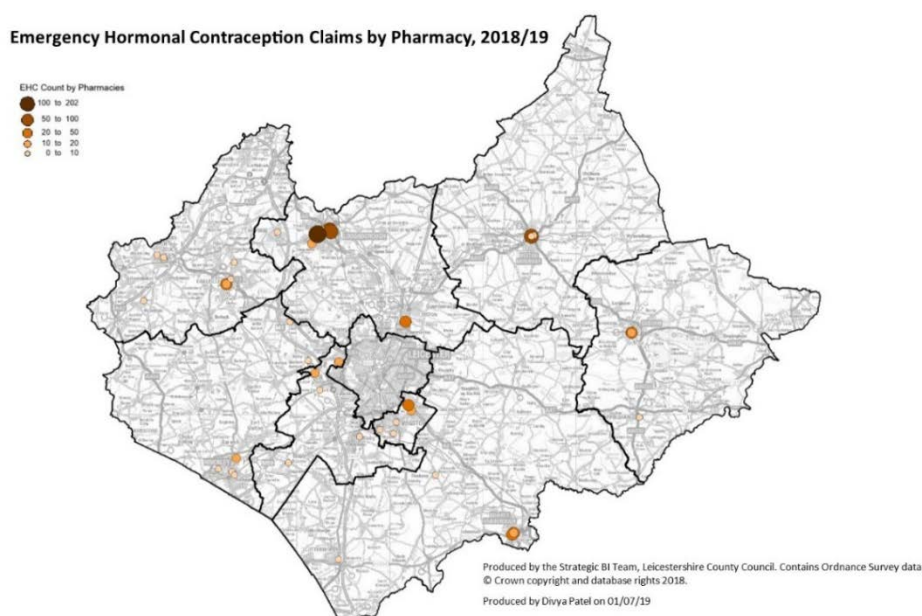
Figure 53: Total number of EHC Consultations in Leicestershire



Source: Community Based Services Claims Data, 2019

Figure 55 below shows the number of EHC claims by pharmacies in 2018/19 in Leicestershire and Rutland. The medicine box in Loughborough Student Union had the highest number of claims in 2018/19. The top three pharmacies with the highest volume of EHC Consultations in Leicestershire occurred in the Loughborough area, which is likely due to the university site in this location with a high population at risk.

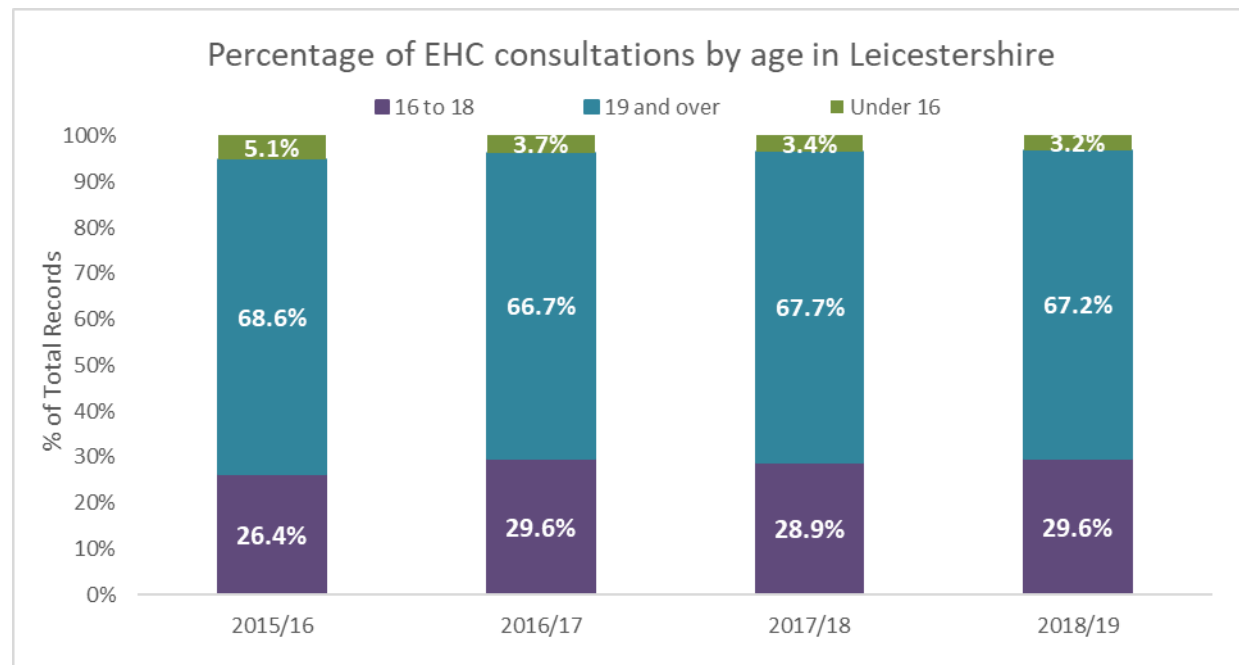
Figure 54: Claims of EHC by pharmacy location, 2018/19



Source: Community Based Services Claims Data, 2019

Figure 56 below shows from 2015/16 to 2018/19 a majority (over 65%) of EHC consultations occur with females aged 19-years and over and over 25% of all consultations were with females aged between 16-18-years old. The percentage of EHC consultations in the under 16 age group has decreased from 5.1% in 2015/16 to 3.2% in 2018/19. The percentage of EHC consultations in the 19-years and over age group has also decreased from 68.6% in 2015/16 to 67.2% in 2018/19. There has been an increase in the percentage of EHC consultations in the 16-18-years age group from 26.4% in 2015/16 to 29.6% in 2018/19.

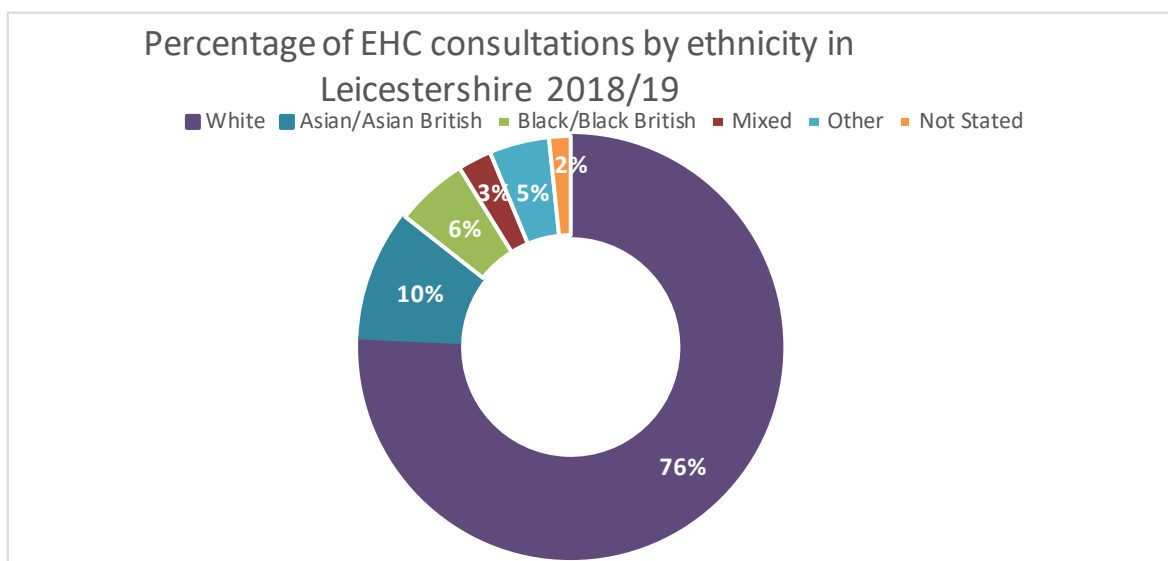
Figure 55: Percentage of EHC consultations by age in Leicestershire



Source: Community Based Services Claims Data, 2019

Figure 57 below shows the percentage of EHC consultations by ethnic groups. In 2018/19, 76% of all EHC consultations occurred with females from the White ethnic group followed by 10% with females from the Asian/Asian British ethnic group.

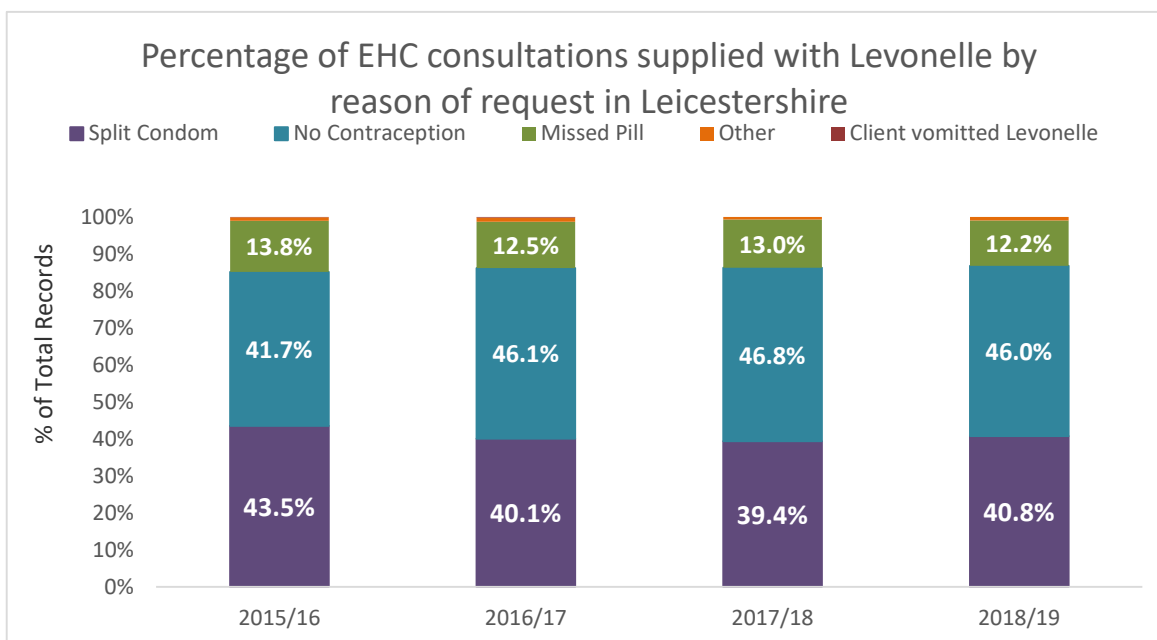
Figure 56: Percentage of EHC consultations by ethnicity in Leicestershire, 2018/19



Source: Community Based Services Claims Data, 2019

Figure 58 below shows that between 2015/16 and 2018/19, the top two reasons for requesting Levonelle was due to a spilt condom or no contraception used. Since 2016/17, the percentages for the reason of request for Levonelle where no contraception was used has remained similar around 46% and around 40% for split condom.

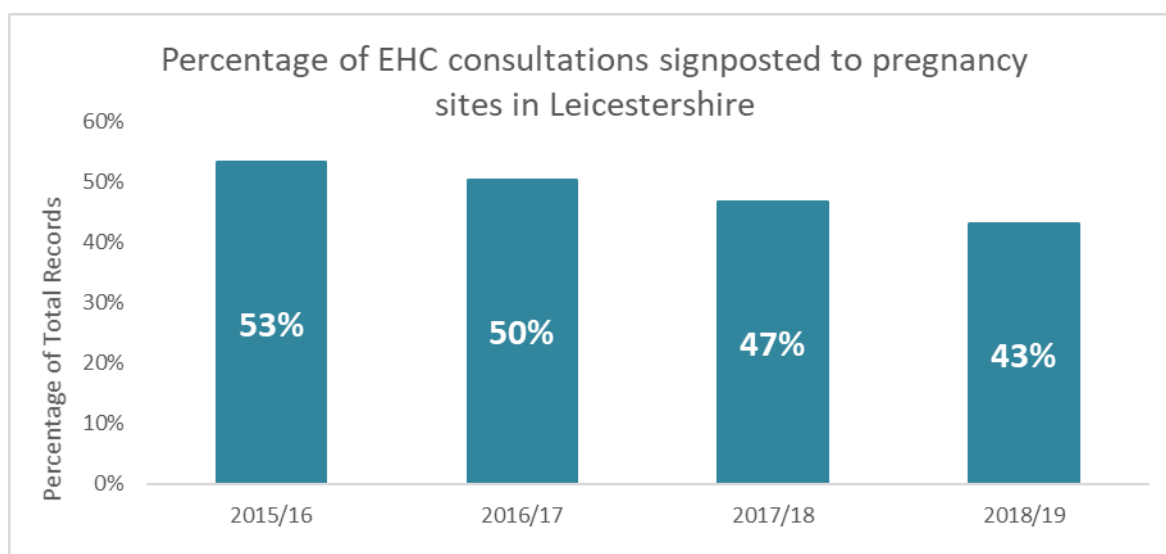
Figure 57: Percentage of EHC consultations supplied with Levonelle by reason of request in Leicestershire



Source: Community Based Services Claims Data, 2019

Figure 59 shows there has been a decline in the percentage of females that were signposted to pregnancy sites since 2015/16 from 53% to 43% in 2018/19.

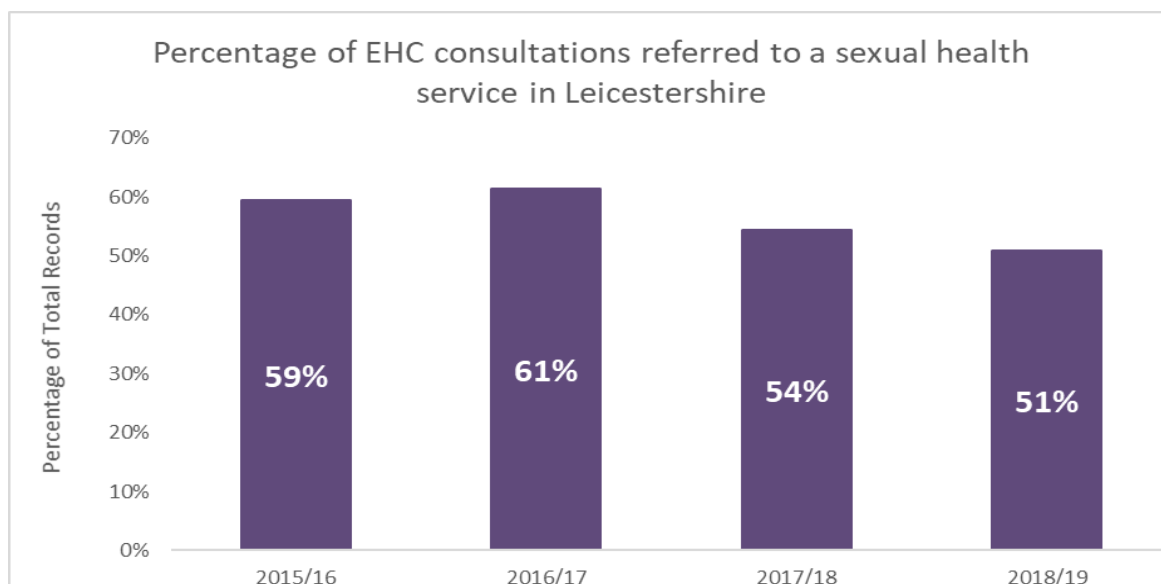
Figure 58: Percentage of EHC consultations signposted to pregnancy sites in Leicestershire



Source: Community Based Services Claims Data, 2019

Figure 60 shows there has been a decline in the percentage of females referred to a sexual health service since 2016/17 from 61% to 51% in 2018/19.

Figure 59: Percentage of EHC consultations referred to sexual health services in Leicestershire



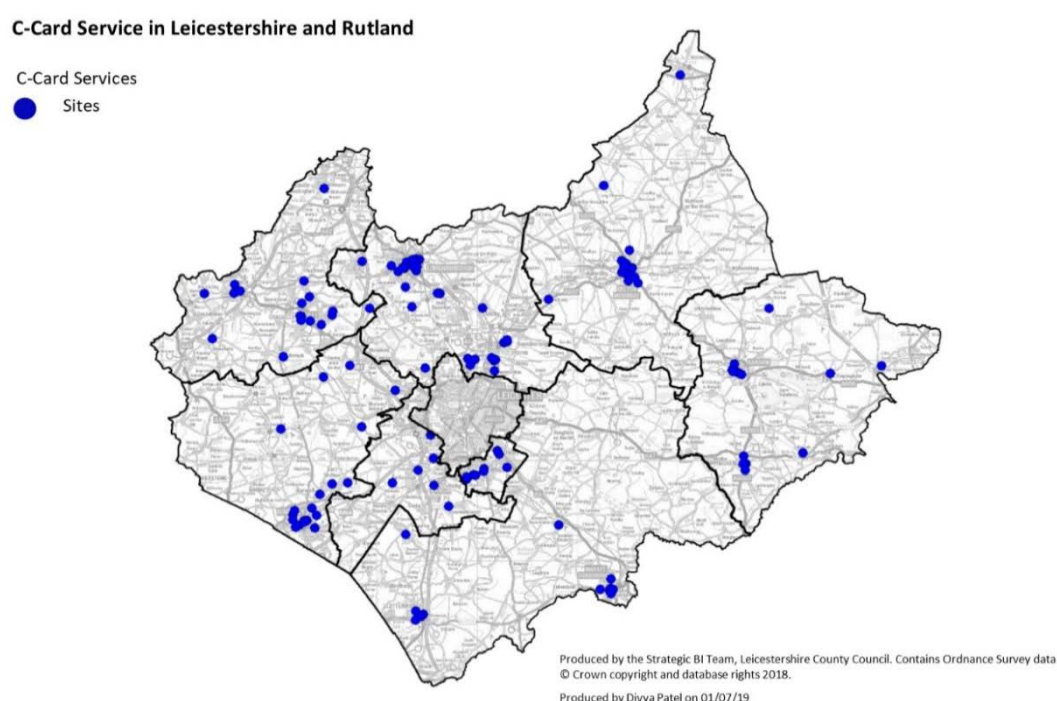
Source: Community Based Services Claims Data, 2019

In 2017/18, a total of 43 requests were for a double dose of Levonelle, 41 (95%) of these were due to those with a Body Mass Index (BMI)>26 or weight >70kg. In 2018/19 the number of requests for a double dose of Levonelle increased to 133 (over three times the number in 2017/18), out of these 129 (97%) were due to those with a BMI>26 or weight >70kg.

3.9.3. C-Card Scheme

The C-Card Scheme provides access to condoms for young people aged 13-24 via community venues. Young people are assessed as competent and issued a C-Card at one of the registration sites and able to visit distribution sites to collect additional condoms without having a formal contact with a practitioner for a maximum of 10 visits (when a new C-Card is needed). Figure 61 below shows the current C-Card service sites in Leicestershire and Rutland.

Figure 60: C-Card service sites in Leicestershire and Rutland



Source: Sexual Health Service monitoring data report, 2018

Table 6 shows the percentage of contacts accessing the C-Card services in Leicestershire for those aged under 19. There has been a decrease in the percentage of under 19-year olds accessing the C-Card services from 85.3% in 2016/17 to 54.6% in 2017/18.

Table 6: Percentage of contacts for C-Card services in Leicestershire in those aged under 19

Leicestershire	2016/17	2017/18
Number of Contacts	4240	4347
Under 19 Contacts	3615	2375
% of Under 19	85.3%	54.6%

Source: Sexual Health Service monitoring data report, 2018

4. How does this impact?

It is important that local areas use the surveillance data available to them to keep up to date with emerging challenges in sexual health and respond accordingly. High-quality information is key for the measurement of sexual health morbidity, to identify and target high-risk groups, for service planning, and to monitor and evaluate initiatives designed to improve sexual health. The data and information presented in this JSNA chapter describes a complex picture of sexual health needs, service provision and commissioning landscape in Leicestershire. Whilst Leicestershire is generally more affluent than the England average and performs well for many public health indicators related to sexual health, there are variations in need for services and interventions for different individuals and groups. Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. The implications of specific findings are described within the relevant chapters of this document.

People should be able to live their lives free from prejudice and discrimination. However, while individuals' needs may vary, there are certain core needs that are common to everyone. There is ample evidence that sexual health outcomes can be improved by:⁴⁶

- accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health;
- preventative interventions that build personal resilience and self-esteem and promote healthy choices;
- rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times;
- early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk; and
- joined-up provision that enables seamless patient journeys across a range of sexual health and other services. Effective commissioning of interventions and services is key to improving outcomes.

The health economic evidence resource (HEER)⁴⁷ tool shows cost-effectiveness and return on investment evidence in relation to sexual health. Current evidence includes;

- £1 invested in contraception saves £11.09 and £1 invested in LARC methods of contraception saves £13.42 in averted outcomes, comprising healthcare costs saved

due to unplanned pregnancies avoided (in terms of terminations, antenatal and maternity care).

- Switching⁴⁸ from oral contraceptive pill to LARCs is estimated to save £29 per annum per woman (£143 over 5 years) through avoided unplanned pregnancies.⁴⁹
- Addressing teenage pregnancy can save money, with £4 saved in welfare costs for every £1 spent.⁵⁰

Furthermore, every young mother who returns to Education, Employment & Training (EET) saves agencies £4,500 a year and for every child prevented from going into care, social services would save on average £65,000 a year.³⁹

HIV services for patients diagnosed early is cost-effective (cost per life year gained of £1,776). Early diagnosis provides better outcomes for early treatment and is cost-effective (£4,639 per life year gained). Cost savings accrue due to prevented onward HIV transmission and reduced, expensive late diagnosis.⁵¹

Targeted annual HIV testing (annual testing for MSM), people who inject drugs (PWID), people from HIV-endemic countries and one-time testing to other adults) prevents infections and requires less tests to diagnose people living with HIV.⁵¹

Further work is currently underway nationally to strengthen the health economic evidence base.

5. Policy and Guidance

5.1. Health and Social Care Act 2012

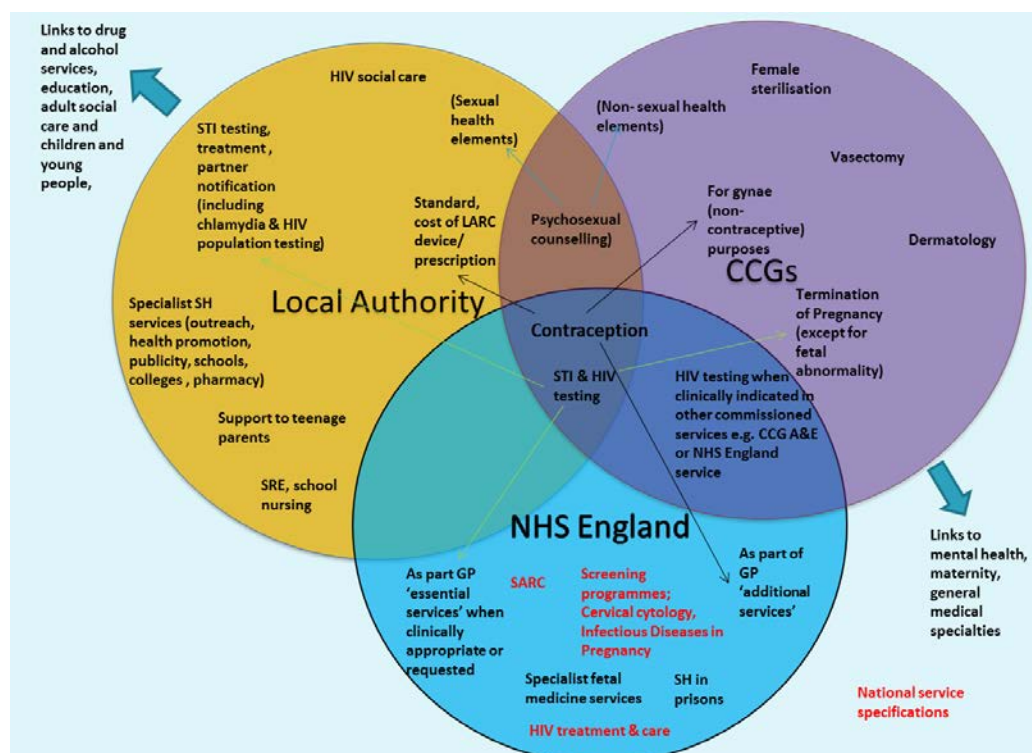
The Health and Social Care Act 2012 generated significant changes to the local health system and commissioning responsibilities in relation to sexual health services. One of the key implications of the Act on sexual health services was the development of the Local Authorities Regulations 2013 which required local authorities to arrange for the provision of certain services, including sexual health services. This means local authorities are required to provide;

*'open access sexual health services for everyone present in their area, covering; free sexually transmitted infections (STI) testing and treatment, and notification of sexual partners of infected persons; and free contraception, and reasonable access to all methods of contraception'*⁵²

5.2. Commissioning guidance

Making it Work: A guide to whole system commissioning for sexual health, reproduction health and HIV (PHE, 2015) discussed the interfaces in commissioning responsibilities and the need for commissioning bodies to work together to ensure that the individual experiences seamless services.

Figure 61: Sexual health commissioning system from April 2013, following implementation of the Health and Social Care Act, 2012.



Source: Public Health England, *Sexual, Reproductive health and HIV: commissioning review, 2017*.

Sexual health, reproductive health and HIV: Commissioning review (PHE, 2017) identified areas of concern:

- fragmentation of commissioning;
- ensuring access to services, particularly for those at greatest risk;
- contracting problems including cross-charging for patients attending services outside of area;
- workforce concerns – clinical expertise both in service delivery but also in commissioning;
- increasing demand for some services and;

- financial pressures due to reductions in budgets – particularly in local authorities

Having identified key issues from the analysis, PHE has produced an action plan, requiring the cooperation of commissioners and input from Department of Health, as well as work from PHE. There are also key leadership requirements for national system leaders.

PHE acknowledges that improving the commissioning process will only go so far in improving clinical outcomes. There is a need to look carefully at a wide range of issues, including how to affect behavioural change, targeted use of marketing, tackling skills shortages in clinical staff and ongoing education. Leadership across the system - within clinical communities and nationally, within local authorities, NHS England, CCGs and providers - is essential. Without improvement in this wider environment, changes in commissioning will not deliver the step-change that is required to alter some of the negative trends and to accelerate those that are going in the right direction but have not reached the levels we would like when compared with international comparators. To address this, PHE has worked with partners to produce a plan of action for sexual and reproductive health and HIV which addresses the wider fundamental issues.

Six actions are proposed to improve commissioning. These are:

- Developing a model of 'lead integrated commissioning' in each locality, including developing models for out of area tariffs.
- Testing two models of local delivery based on examples of local practice to assist in the effective commissioning of sexual health, reproductive health and HIV care.
- Revising and enhancing current commissioning guidance, including a new service specification for pregnancy and termination of pregnancy services.
- Facilitating the development of sexual health networks across the country to address pan-organisational issues, such as 'cross boundary flows'.
- Developing a framework for sector-led improvement for sexual health services that is consistent with the wider work on sector-led improvement.
- Enhancing data and other commissioning support tools.

5.3. NHS Long Term Plan

The NHS Long Term Plan 2019 states that action by the NHS is a complement to, but cannot be a substitute for, the important role for local government. This acknowledges the local authority role in commissioning preventive health services, including sexual health services and impact of quality and access to these services on potential demand for NHS services. As part of the NHS long Term Plan the government committed to reviewing commissioning arrangements for some local authority-commissioned public health services. The outcome of the review of commissioning arrangements for sexual health, health visiting, and school nursing was announced by the Secretary of State on 7th June 2019. In his statement the

Secretary of State confirmed that local authorities will continue to lead on commissioning of public health services. He also stated that the review recommended that the NHS work much more closely with local authorities on public health so that commissioning is more joined-up and prevention is embedded into a wider range of health services. The Department of Health and Social Care will be seeking views in a forthcoming prevention green paper about how action can be taken forward.

5.4. Advancing our health: Prevention in the 2020s

The Government has published a Prevention Green Paper ['Advancing our health: prevention in the 2020s'](#)⁵³ setting out how it plans to embed the principle 'prevention is better than cure' across wider society. The document includes proposals for actions relating to sexual health, including:

- Considering how to mainstream PrEP for HIV prevention.
- Promotion of condom use in response to increases in certain STIs such as Gonorrhea.
- Ensuring that those at risk of STIs have rapid access to services, including online testing.
- Considering development of a new national Sexual & Reproductive Health strategy.

5.5. Reproductive health

PHE has identified improving the reproductive health of the population as a strategic priority. Three documents have been published to support development of an action plan.

5.5.1. A consensus statement: Reproductive health is a public health issue (PHE, 2018)

The consensus aim is for the population to have the ability and freedom to make choices about the aspects of their reproductive lives that they have reason to value, regardless of age, ethnicity, gender and sexuality. This is divided into 6 pillars of reproductive health:

1. Positive approach: The opportunity for reproductive health and access to reproductive healthcare, to be free from stigma and embarrassment.
2. Knowledge and Resilience: The ability to make informed choices and exercise freedom of expression in all aspects of reproductive health.
3. Free from violence and coercion: The ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation.

4. Proportionate universalism: The ability to optimize reproductive health, and social and psychological well-being through support and care that is proportionate to need.
5. User-centred: The ability to participate effectively and at every level in decisions that affect reproductive lives.
6. Wider determinants: The opportunity to experience good reproductive health and ability to access to reproductive healthcare when needed free from the wider factors that directly and indirectly impact on reproductive well-being.

5.5.2. “What do women say?” - an analysis of women’s experiences of reproductive health and healthcare (PHE 2018)

This document presents the findings from a survey of more than 7,500 women and focus group discussions to find out how women experience reproductive health issues and some of the choices they make. This study has highlighted that women desire that reproductive health issues are normalised and destigmatised so that they can be discussed openly and self-managed where possible. Where care is needed, information is needed to know when and how to seek appropriate care with confidence that this would be managed and communicated effectively.

Knowledge of their reproductive health was viewed as a key factor in women being able to both manage unwanted symptoms and having a voice in making positive reproductive choices.

5.5.3. “What does the data tell us?” a baseline assessment of the reproductive health of the population through data. (PHE,2018)

These documents are intended to:

- introduce reproductive health as a public health issue;
- inform local prioritisation and planning and;
- provide a baseline for the upcoming reproductive health action plan

The national women’s Reproductive Health Action Plan, a cross sectoral plan, is due to be published in 2019. It focuses on the period between puberty to menopause and the three central themes of fulfilling reproductive intentions, reproductive wellness and early identification for prevention. The main priorities for action in the first year will be a review of the reproductive health metrics with a view to developing a basket of indicators for local use and behavioural insights work to help shape a communications strategy.

5.6. Teenage pregnancy

The Teenage Pregnancy Strategy for England, which ran from 1999-2010, led to a 60% reduction in the under-18 conception rate (1998-2016), to the lowest level for over 40 years.

The Government has asked local areas to maintain their focus as part of tackling inequalities and maximising the life chances for young people and giving every child the best start in life.

PHE and the Local Government Association have published two pieces of national guidance to support local areas continue their progress.

The Teenage Pregnancy Prevention Framework and the Framework for Supporting Teenage Mothers and Young Fathers are designed to:

- help local areas assess their local programmes to see what's working well;
- identify and address any gaps in services;
- strengthen the prevention and support pathways for young people, young parents and their children and;
- maximise all the assets in the local area.

Both frameworks provide an evidence-based structure for a collaborative whole system approach to prevent teenage pregnancies and support teenage parents.

A self-assessment against the key actions as recommended in the Framework for Supporting Teenage Mothers and Young Fathers is being undertaken for Leicestershire to identify gaps in services and inform future action plans.

5.7. Syphilis action plan

There has been a substantial increase in the number of infectious syphilis diagnoses made in England between 2008 and 2018. PHE published the Syphilis Action Plan in response to the need to strengthen public health measures to reduce transmission of syphilis. The action plan identifies that a successful response to the current increase in syphilis incidence is dependent upon action that optimises 4 prevention pillars fundamental to syphilis control and prevention:

1. Increase testing frequency of high-risk MSM and re-testing of syphilis cases after treatment.
2. Deliver partner notification to BASHH standards.

3. Maintain high antenatal screening coverage and vigilance for syphilis throughout antenatal care.

4. Sustain targeted health promotion.

The detailed actions set out in this report need to be underpinned by maintaining professional awareness and knowledge of syphilis, by improving epidemiological intelligence, and by developing diagnostics and research. Available at: <https://www.gov.uk/government/publications/syphilis-public-health-england-action-plan>

5.8. DofE statutory guidance: Relationships Education, Relationships & Sex Education & Health Education (June 2019)

In March 2017, Government laid an amendment via the Children and Social Work Act (2017) to introduce compulsory relationships education in primary schools and compulsory relationships and sex education (RSE) in all secondary schools from September 2019. The Department for Education's policy statement sets out Government's rationale, approach and timeline for the proposed statutory changes and highlights the overwhelming support from parents and young people for high quality statutory RSE. This new statutory guidance from the Department for Education is issued under Section 80A of the Education Act 2002 and section 403 of the Education Act 1996.

This guidance contains information on what schools should do and sets out the legal duties with which schools must comply when teaching Relationships Education, RSE and Health Education.

Unless otherwise specified, 'school' means all schools, whether maintained, non-maintained or independent schools, including academies and free schools, non-maintained special schools, maintained special schools and alternative provision, including pupil referral units.

It provides detail of the topics to be covered in relationships education by the end of primary school and the RSE topics to be covered by the end of secondary school.⁵⁴

5.9. Leicestershire Sexual Health Strategy 2016-19

The Leicestershire Sexual Health Strategy 2016-2019 (available at <http://www.lsr-online.org/sexual-health-joint-strategic-ne.html>) was agreed by Leicestershire County Council Cabinet on 19th April 2016. The strategy outlined the vision and strategic approach of sexual health services across the sexual health commissioning system for the three-year period. The overall aim of this strategy was to empower the Leicestershire & Rutland population to have informed, positive relationships that result in reduced rates of unplanned pregnancy and STIs including HIV.

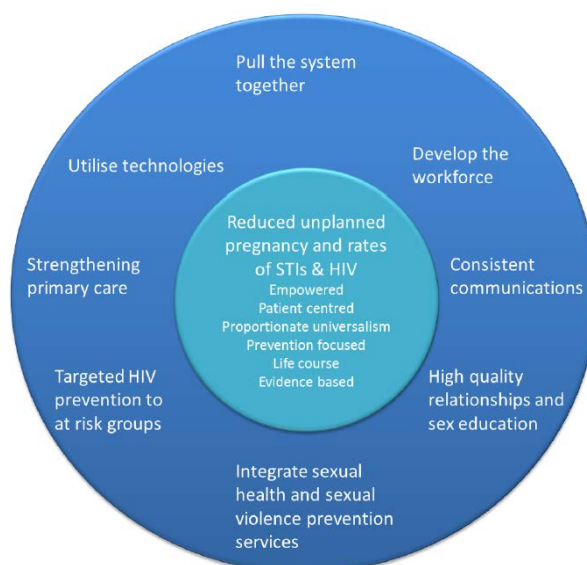
Eight strategic priorities were identified, being:

1. A co-ordinated approach to sexual health commissioning and partnership work.
2. Develop a highly skilled local workforce.
3. Coordinated, consistent sexual health communications.
4. Support schools to deliver high quality RSE
5. Increase links between sexual violence prevention and sexual health services.
6. Increase access to sexual health improvement and HIV prevention to at-risk groups.
7. Strengthen the role of primary care. (GPs)
8. Utilise new technologies to support sexual health delivery.

The strategy also identified the following cross cutting themes to be considered across all strategic priorities:

- Empowerment;
- Patient centred, integrated pathways;
- Equitable;
- Prevention focused;
- Life course approach and;
- Evidence based

Figure 62: Summary of the vision and key sexual health priorities across Leicestershire/ Rutland



Source: Leicestershire County Council, Leicestershire Sexual Health Strategy, 2016-2019.

A similar strategic approach was in place for Rutland County Council and the strategies were aligned with the sexual health strategic priorities for Leicester City Council to ensure a wider LLR system approach.

5.10. Evaluation of Sexual Health Strategy 2016-2019

Evaluation of the Strategies has been undertaken during March to July 2019 to determine the achievements of these strategies within and across the region, with a view of informing subsequent strategic sexual health approaches across and within the patch. The evaluation identified that several changes, outside the control of the Leicestershire and Rutland Sexual Health strategies, have happened in the sexual health environment between 2016 and 2019. Key points of note include:

- Whilst partners have continued to engage and develop sexual health work streams throughout the period of the sexual health strategies, the membership of key stakeholder groups has altered, which may have affected progress in some areas.
- The local authorities' sexual health budgets have reduced over the previous three years and this has resulted in reduced funding for the ISHS.
- RSE has remained a voluntary part of the education curriculum, however, it is due to become statutory (for some year groups).
- Although sexual health commissioning responsibilities have not changed significantly over the previous three years, the publication of the NHS long term plan in early 2019 has called for local authorities and NHS organisations to develop a co-commissioning model for sexual health services.
- Patterns of sexual health need and associated service use have altered over the last 3 years. These will be identified in this updated JSNA.

The extent to which the Leicestershire and Rutland Sexual Health strategies have delivered against the eight pre-determined key strategy themes has been appraised. Key findings are as follows;

Theme 1: “Coordinated approach to sexual health commissioning and partnership work”

There is readily available evidence of agreement to an integrated approach to sexual health commissioning across LLR. It has not been possible in this evaluation to determine whether sexual health pathways are “seamless”, from a patient perspective. However, there is evidence of in-depth work, undertaken to progress key pathways and align interventions/treatments for both sexual and reproductive health. There are still outstanding actions in some areas- such as psychosexual health and termination of pregnancy pathways.

Theme 2: “Develop a highly skilled local workforce”

It is too early to say whether a sustainable and high-quality sexual health workforce is now in place across Leicestershire and Rutland. Work has been completed to understand the needs of the workforce and the development opportunities available are detailed and categorised. However, it is difficult to ascertain, from available documentary evidence, how this has impacted frontline staff progression and professional development.

Theme 3: “Coordinated, consistent sexual health communications”

This priority area appears to be one where there have been delays in bringing together the right people and teams to determine a shared vision and deliver against the commitments in the strategies. Changes in job roles, specifically at Leicestershire County Council, appear to have impacted on the momentum and activity in this area. Key stakeholders questioned whether clear, consistent sexual health communication messages across LLR are agreed and being delivered.

Theme 4: “Support schools to deliver high quality RSE”

RSE training has been recommissioned since the start of these strategies. This provides a model to deliver training in schools and young people’s settings. It is too early to say what the impact of changes has been on improving children’s understanding of sexual health and relationships.

Theme 5: “Increase links between sexual violence prevention and sexual health services”

It is not apparent (from this evaluation) whether the sexual health strategies have resulted in sexual violence becoming an integral consideration for the wider sexual health system- either through recognition of the issues surrounding it or through expanding the capability of wider workforce groups in identifying and responding to it. There was recognition that this priority area had been informally deprioritised during the life course of the strategies.

Theme 6: “Increase access to sexual health improvement and HIV prevention to at risk groups”

There was general agreement that there was a focus on “increasing access to sexual health improvement and HIV prevention to at risk groups” in the delivery of the sexual health strategies. Fluctuations in key sexual health measures have been observed through descriptive quantitative data analysis. There could be a number of reasons, outside the control of the sexual health strategies, for the variation in these figures. This could include data reporting and coding variations. It is reassuring to see that the proportion of people

diagnosed with an STI in the 2015-2018 period below the age of 25 has decreased across both Leicestershire and Rutland and that late HIV diagnoses has continued to fall in Leicestershire (data unavailable for Rutland).

Theme 7: “Strengthen the role of primary care”

There was consensus, amongst stakeholders, that the strategies focused efforts on sexual health service delivery in primary care. However, barriers, including workforce requirements, have limited progress in this priority area. An example is the sustainability of the local primary care model for insertion and clinical management of LARC. Through the sexual health strategic approach there appears to be greater understanding of specific issues related to sexual and reproductive primary care services and recognition of the requirement for further action in this area.

Theme 8: “Utilise new technologies to support sexual health delivery”

The ISHS appears to be used as the vehicle for adopting innovative approaches to deliver the most cost effective sexual health service. Further work is planned in this area as the contract with the ISHS matures. It is therefore too early to be able to fully assess what the impact of these approaches have been on increasing and improving access to STI and HIV testing or more broadly, sexual health services.

Overall, the evaluation identifies that it is too early to see marked improvements in sexual health measures that can be attributed to new initiatives, adopted due to the strategic approach taken. The lack of available quantifiable measures in some areas has meant that it has not been possible to measure changes in all sexual health priority areas in which improvements were expected.

Whilst the strategies provided a framework and direction of travel for a joined-up approach to improving sexual health across Leicestershire and Rutland, and the regular standardised approach to data review was regarded positively, partnership working was also perceived to be challenging at times. The division of workload has not always seen to fall fairly on partner organisations. Additionally, the project management approach took capacity to complete. It was felt that a lack of focus on certain areas may have led to a de-prioritisation and falling off the radar of some priorities.

One of the key limitations of this strategy evaluation is that it has not been possible, within the time and resources available, to conduct in-depth interviews or focus groups with sexual health service users or Leicestershire and Rutland residents. This has meant that it has not been possible to determine if representatives of the population feel more empowered to have informed, positive relationships. Only 50% of eligible stakeholders took part in the

evaluation survey and the mix of participation was not equally split by organisation. The use of a survey in this evaluation has failed to capture the depth and breadth of views about the impact of this approach to improving sexual health across Leicestershire and Rutland.

There was suggestion that a multi-agency rather than local authority centric strategy could be more impactful in the future. This chimes well with the requirement in the 2019 NHS Long Term Plan for Local authorities to adopt a co-commissioning model with the NHS for sexual health services. Whilst it will be important to ensure that the prevention and education/ information aspects of sexual health improvement are not overlooked (due to requirements to optimise patient pathways), it may provide the opportunity for more equal joint working - capitalising on the unique vantage point and remit that each organisation has.

The Leicestershire and Rutland sexual health strategies have been limited by certain factors including, ultimately, the infancy of a long term, strategic approach coupled with current pressures in public health funding. Both may have confounded the capacity of sexual health strategy leads to push for progress in all priority areas. However, some of the developments (such as a dashboard of sexual health indicators), achieved through delivery of these strategies appears to have galvanised partnership work. These approaches should be maintained, further standardised (to reduce the workforce capacity required to complete it) and optimised for future strategic sexual health commissioning and joint working. This could help further inform an outcome-based commissioning model.

The evaluation findings recommend five areas to prioritise to support the development of a high quality and accessible sexual health system across Leicestershire and Rutland.

Priority area 1: Strategic system leadership and governance arrangements

- Decide and jointly agree the strategic system leadership model (and governance arrangements) for delivering sexual health improvements across Leicestershire and Rutland in the next 3 years. Use this agreed approach to guide the development of a co-commissioned model of sexual health service delivery. Consider the role of workforce leads, specifically Health Education England in the East Midlands, in this group.
- Consider and support the use of technology across the wider sexual health environment in order to ensure that partner organisations are making best use of innovative solutions as well as data to inform and deliver sexual health improvements.
-

Priority area 2: Ongoing service development and delivery

- Prioritise development of primary care sexual and reproductive health services in order to ensure alignment of these aspects with delivery of the ISHS. Consider and capitalise on the opportunities available due to the infancy (and current development) of primary care networks to set out requirements for a sustainable, high quality sexual health services.
- Map all projects across Leicestershire and Rutland that aim to increase access to sexual health improvement and HIV prevention for high risk groups as well as assess the influence and impact of variations in delivery of the community-based services on early uptake of prevention and diagnostic testing in primary care settings. Use findings to identify any gaps and plan actions to ensure needs-based service delivery for high risk population groups.
- Continue to monitor achievements of the ISHS via contract management approaches and assess patient case-mix at least a year post start of the contract to help indicate both progress and further work required to improving quality and access across the patch in relation to sexual health services.

Priority area 3: Develop the capacity and capability of the sexual health workforce

- Undertake focused work with primary care and community-based staff to better understand their knowledge and competence in delivering effective sexual health messages and supporting referral and signposting into more specialist services.
- Work closely with the clinical directors of each newly established primary care network to ensure the skill set for primary sexual and reproductive health services is considered and plans in place to reduce any gaps in capacity or capability.
- Review progress in delivering the recommendations of the training needs assessment specifically with regards the specialist workforce. When appropriate, consider a follow up assessment to measure impact and ensure the training and development pathway has been fully established across Leicestershire and Rutland.

Priority area 4: Develop sexual health knowledge base and use of intelligence

- Appraise the information and educational needs of young people in Leicestershire and Rutland through focus group sessions (or similar) to determine where future efforts and resource should be focused in order to “empower young people to make positive choices about their relationships and sexual health”.

- Repeat the Equality & Human Rights Impact Assessment (EHRIA) as part of the strategy development/ 1 year after the commencement of the ISHS contract to assess whether reductions in barriers to access STI and HIV testing have been achieved. Use findings to identify any gaps and plan actions to ensure equitable service delivery which is proportionate to need.
- Consider developing further indicators for future sexual health strategy dashboards that inform strategic commissioning decisions and ensure a focus on outcome improvements.

Priority area 5: Communicate with the public and professionals

- Join up and coordinate sexual health communications and information sharing. Consider the resource required to deliver progress in this priority area. This may include: the leadership of a cross-organisational group, optimisation of various communication channels (including the sexual health services website) and budget for innovative campaigns.
- Use the opportunity that the next strategy consultation presents to engage meaningfully with patient and public groups in order to assess felt need in relation to sexual health and prioritise further partnership action.

6. Current Services

This section describes the main services offering sexual health provision for Leicestershire residents. Sexual health related services may be delivered as part of other service offers and hence not all provision is included in this document.

6.1. ISHS

Leicestershire County Council, Leicester City Council and Rutland County Council recommissioned an ISHS to provide sexual health services across the three local authority areas.

The new service commenced from 1 January 2019. The ISHS provides:

- Open access ISHS.
- Both contraception and GUM in one consultation (wherever possible).
- Level 1-3 (all levels of sexual health including complex care) at two geographical hubs.
- Sessional clinics in specific geographical areas.
- Sessional young people's service.

- Outreach and health promotion for vulnerable, targeted and high-risk groups.
- Clinical Outreach which will include work in male saunas, female sex worker locations, and domiciliary work.
- C-card, condom service.
- Psychosexual Counselling service.
- Training and education.
- With increased emphasis on the provision of self-managed care including online STI testing, pick up facilities for self-sampling STI test kits, condoms STI testing and pregnancy tests, telephone consultations.
- Sexual health improvement and HIV prevention specific to MSM, including outreach (Leicestershire only).
- Publicity, public education and information (for sexual health and other lifestyle services).
- Vulnerable and Black & Minority ethnicity communities work.

The ISHS continues to operate from two main sites, a purpose built new clinic in Leicester City, in the Haymarket Shopping Centre and one at Loughborough Health Centre, offering a combination of walk in appointments and pre-booked appointments. Opportunity to access self-service options will be available at the main clinics, this will offer some patients the opportunity to increased access to services without the need to see a clinician where appropriate, such as STI testing, condoms and repeat pills.

There are weekly sessional clinics for under 25's in Market Harborough, Coalville and Hinckley and a weekly sessional clinic in Oakham for all ages.

Outreach services are delivered to meet the needs of specific groups.

The new service model provides increased opportunities to access services without attending a clinic such as ordering online STI testing and this offer will expand over time to include vending machines for STI test kits and condoms.

All self-serve elements have safeguarding mechanisms in place to ensure appropriate follow up as necessary.

6.2. Out of area sexual health services.

Sexual Health Services are required to be open access for attendees from any local authority of residence. Leicestershire residents attend services around the country, with services just outside the Leicestershire border being most commonly accessed.

6.3. HIV self-sampling online testing

Residents of Leicestershire can also access self-sampling HIV test kits via an online service. This service is part of a national framework, set up to increase access to HIV testing. It is promoted as part of national campaign such as HIV testing week and World AIDS day.

6.4. Community-based services.

The following services are commissioned by Leicestershire County Council:

6.4.1. Provision of IUD/IUS and SDIs in Primary Care

Services to provide IUD/IUS and SDI are in place from 79 GPs across Leicestershire and Rutland. Some practices have arrangements with other practices to fit IUD/IUS and/or SDI for their patients. From July 2019 GP practices will come together into groups of 30-50,000 populations called Primary Care Networks. This will provide new opportunities to further develop inter-practice referral for LARC.

6.4.2. Provision of oral emergency contraception, free to under 25 years.

104 pharmacies in Leicestershire (and Rutland) are contracted to provide oral emergency contraception free of charge for those under 25 years. This service improves access to emergency contraception whilst supporting referral to longer term contraception.

6.5. Sexual health services within Primary Care contract.

The Standard General Medical Services Contract 2019-20⁵⁵ includes an additional services element which requires the Contractor to make the following services available to all of its patients who request those services:

- a) The giving of advice about the full range of contraceptive methods;
- b) Where appropriate, the medical examination of patients seeking such advice;
- c) The treatment of such patients for contraceptive purposes and the prescribing of contraceptive substances and appliances (excluding the fitting and implanting of IUDs and SDIs);
- d) The giving of advice about emergency contraception and, where appropriate, the supplying or prescribing of EHC or, where the Contractor has a conscientious objection to emergency contraception, prompt referral to another contractor who does not have such an objection;

- e) The provision of advice and referral in cases of unplanned or unwanted pregnancy, including advice about the availability of free pregnancy testing in the *practice area* and, where appropriate, where the Contractor has a conscientious objection to the termination of pregnancy, prompt referral to another provider of *primary medical services* who does not have such conscientious objections;
- f) The giving of initial advice about sexual health promotion and STIs; and
- g) The referral as necessary to specialist sexual health services, including tests for STIs.

This service is the commissioning responsibility of NHS England and NHS Improvement, with aspects of delegated responsibility to CCGs. All practices within Leicestershire are contracted to deliver this additional service. From October 2019, contraception services will no longer be an Additional Service under the Regulations but will become part of Essential Services. There will be no opt-out or reduction of global sum payments as a result.

A large proportion of care is provided in GPs, often being the first access point for individuals with contraceptive concerns or needs. It is estimated that between 75-80% of NHS contraceptive care is provided in GPs.⁵⁶ Access to GPs is of importance in the context of a large geographic area such as Leicestershire.

6.6. Abortion services

Abortion services are the commissioning responsibility of CCGs. Abortion services are commissioned across Leicester City, East Leicestershire & Rutland CCG and West Leicestershire CCG. There are two providers, UHL and British Pregnancy Advisory Services.

6.7. Prison based sexual health services

Sexual health services in prisons are commissioned by NHS England and NHS Improvement. There is one prison in Leicestershire, being Gartree Category B male prison. Glen Parva Young Offenders Institute has closed. Sexual health services at Gartree are delivered as part of the primary care contract.

6.8. SARC

SARC provision in Leicestershire is from Juniper Lodge. These new premises officially opened in February 2016. The facilities include three forensic medical suites, three Video Interview rooms, Studio, Counselling rooms, family room and an outdoor area. Access to forensic medical providers is available through the SARC. The service is available for persons aged over 18 years. This service is commissioned by NHS England and NHS Improvement

6.9. HIV treatment service

Adult specialist services for patients infected with HIV include inpatient care for HIV related conditions in Adult Specialist HIV Treatment Centres and outpatient care provided by these Specialist Centres including outreach when delivered as part of a provider network. Specialist services for children and young people with HIV include services provided by Specialist Infectious Diseases Paediatric Centres.

The aim of the service is to provide a consistent, effective and appropriate family-centred paediatric HIV outpatient and inpatient service which ensures that children remain safe and well (reduced morbidity from the complications of HIV infection and its treatment and continuing low mortality) and have access to the same standards of care wherever they live in the UK. This service is commissioned by NHS England and NHS Improvement

6.10. Screening and vaccination programmes

NHS England and NHS Improvement commission screening and vaccination programmes, including cervical cytology and the HPV vaccination programme.

The NHS cervical screening programme is available to women aged 25 to 64 in England. All eligible women who are registered with a GP automatically receive an invitation by mail. Women aged 25 to 49 receive invitations every 3 years. Women aged 50 to 64 receive invitations every 5 years. Women living with HIV are recommended to screen annually. NHS England and NHS Improvement has commissioned the ISHS to provide cervical screening sessions to improve uptake.

HPV is responsible for over 99% of cervical cancers, there is also evidence of an association between HPV infection and anogenital and oropharyngeal cancers. An HPV vaccination programme for girls was introduced in 2008, the number of diagnoses of genital warts has fallen sharply in both girls and boys. In addition, roll out of the vaccination programme commenced in April 2018, for MSM up to the age of 45 who attend sexual health clinics.

From September 2019, the programme will be extended to include adolescent boys this will help to prevent more cases of HPV related cancers in boys and girls and will also strengthen herd protection.

6.11. Sex and relationship education

A comprehensive menu of free RSE training is available to primary, secondary and special schools, post 16 setting and alternative education settings, and training for community practitioners. Plus, bespoke training for up to four secondary schools in teenage pregnancy

hot spot wards.

A PSHE Coordinator Network meeting is held once a term, to support PSHE Coordinators to prepare for statutory relationships, sex and health education.

6.12. Leicestershire healthy schools programme:

Personal Social Health education (PSHE) including RSE is one of the four core themes of the Leicestershire Healthy Schools Programme. Schools have to fulfil the criteria regarding RSE in the Whole School Review document in order to renew their healthy school status.

Sexual health is one of the Public Health priority areas that schools can work on to achieve meaningful health and wellbeing outcomes and therefore achieve enhanced healthy school status (Healthy Schools Plus).

6.13. Support for young parents

A wide range of services offer support for young parents including maternity services, school nursing, health visiting, children & family wellbeing services and GP. The contribution of services locally is being assessed against the Framework for Supporting Teenage Mothers and Young Fathers (PHE, 2019) as detailed in 5.4. The Leicestershire County Council's Children & Families Wellbeing Service Coordinates 'Teenagers with Babies Action Group' (TBAG) meetings across each district/ borough council area in the county. The TBAG approach aims to enable early access of support for young parents/parents-to-be, support the development and maintenance of seamless support pathways for young parents to ensure their engagement with appropriate services and a reduction in negative outcomes and improve access of educational opportunities for young parents. This is supported by the Baby Box Scheme, provided by the Centre for Fun and Families, which distributes Baby Boxes to Teenage Mothers to be. The Baby box provides 'Teenage Mothers to be' with items needed to look after their baby and information to steer and refer pregnant women under 20 into relevant support services. Consent is sought from the 'mother to be' to share relevant data with the Teenagers with Babies Action Group to enable more robust referral routes between agencies.

6.14. Voluntary Community Sector (VCS) Services

Despite a difficult funding climate with less voluntary & community-based services being commissioned Leicestershire continues to be home to a number of innovative front-line services providing a broad range of sexual health support services across Leicestershire. These include:

Leicester LGBT Centre: supports lesbian, gay, bisexual and transgender people. The Centre exists to provide a safe social and support space to combat the social isolation, exclusion and discrimination that LGBT+ people face. The Centre offers a variety of services including: advice, guidance and support to both the LGBT+ and wider communities and partner agencies, support to strategic partners within the public, private and voluntary sector, a Counselling Service, provision of LGBT+ Awareness Training, Transgender Awareness Training and bespoke training sessions, advocacy for LGBT+ people, provision of LGBT+ education and support packages for school & college students and service users from a range of organisations, support to Anti-Hate Crime campaigns within the region, all age LGBT+ Inclusive Relationships, Sex & Health Education (RSHE) and the C Card Scheme and condom distribution. <https://leicesterlgbtcentre.org/>

Trade Sexual Health is a health and sexual health charity, providing free, confidential health advice, information, services and support for lesbian, gay, bisexual and trans (LGB&T) communities of Leicestershire. They offer a range of services including information and support on sexual health and HIV; one-to-one emotional and practical support; support around sexuality, gender, relationships and 'coming out'; rapid HIV testing; community based sexual health clinics; safer-sex packs; social and support groups; outreach services, and a fully qualified counselling service <http://www.tradesexualhealth.com/>

Leicestershire AIDS Support Services (LASS) Provide a range of services for people in Leicestershire, affected by or living with HIV/AIDS. LASS responds to the challenges of HIV. They provide support, information, advice and advocacy to people affected by HIV/AIDS. LASS works in partnership with others to promote positive sexual health and well-being, raise awareness about HIV/AIDS and empower people who are affected to live safe and fulfilling lives.

7. Unmet needs/Gaps

This chapter summarises the key issues, as identified from the JSNA data and information, that indicate unmet need or gaps in services for Leicestershire.

7.1. HIV & STIs

7.1.1. New diagnosis STIs

Overall diagnosis rates of new STIs reduced from 582 to 522 per 100,000 residents, remaining significantly lower than the England rate of 784 per 100,000.

However, the rate of gonorrhoea diagnosis in Leicestershire has increased for three consecutive years. The latest 2018 data reports this as 40.0 per 100,000 population in

Leicestershire, less than half the rate of the national rate of 98.5 per 100,000 population.³⁴ Nationally and locally, MSM have higher rates of gonorrhoea diagnosis. Concerns of emerging drug resistant strains make monitoring of strains and treatment regimes of particular importance and will need to be carefully monitored across Leicestershire.

Over the last five years, the trend of syphilis diagnostic rate in Leicestershire has significantly increased over time, a pattern witnessed nationally also. The rate in Leicestershire has increased at a slower rate than nationally and has remained significantly better (lower) than the national average since 2012. It must be noted that counts of diagnoses are small locally. The latest data for the county shows in 2018, 4.2 per 100,000 population were diagnosed with syphilis, this is less than half the rate of the national average of 13.1 per 100,000 population.³⁴

Nationally, most (75%) syphilis diagnoses are made in gay, bisexual and other MSM but there has also been an increase in the number of diagnoses among heterosexuals between 2013 and 2018 (775 to 1,391), as well as in cases of congenital syphilis. Implementation of the syphilis action plan may help combat these small but increasing numbers of syphilis across the County.

Nationally, for the 5-year period from 2013 to 2017, an estimated 7.0% of women and 9.4% of men presenting with a new STI at a SHS became re-infected with a new STI within 12 months, and an estimated 3.7% of women and 11.2% of men became re-infected with gonorrhoea within 12 months over the same period. No districts in Leicestershire have a higher percentage of STI re-infection in males than the national percentage. In Charnwood, Oadby and Wigston however, both districts have a high percentage of STI reinfection in females compared to the national percentage change, this could be due to the student population residing within these two districts. Targeted health promotion work with young women from these areas should be considered to reduce the reinfection rates in these districts.

Compared to the previous year, in Leicestershire the chlamydia detection rate decreased (got worse) from a rate of 1,888 per 100,000 population aged 15-24-years old in 2017 to 1,703 per 100,000 population aged 15-24-years old in 2018. A decline in rate between 2017 and 2018 was witnessed in both males and females in Leicestershire. However, the local trend has significantly increased over the last seven time periods whereas at a national level the trend has significantly decreased.³⁴ In 2018, the proportion of the population aged 15-24 screened for chlamydia in Leicestershire was 16.9%, this was significantly worse in comparison to the national percentage of 19.6%. Further work is needed to understand the differing trends in Chlamydia detection rate and ways to further increase access to online STI testing for those most at risk of Chlamydia.

7.1.2. HIV testing

The HIV testing coverage for Leicestershire has remained significantly worse than England for the last four years. Leicestershire has consistently performed significantly better than the national percentage of HIV testing uptake over time, however there is a significant declining trend, with the percentage decreasing year on year for the last five years. When examining males, the HIV testing uptake has been declining significantly and the percentage in 2017 is now similar to the national percentage. This is the first time we have declined to this RAG rating for this indicator, having remained significantly better than national since 2009. Issues with data reporting became apparent in 2017, resulting from the integrated delivery model of the local sexual health service. Work was undertaken in 2018, with the support of PHE, to rectify the coding issue. The actions however did not fully address the problem and further changes to reported codes are to be implemented in 2019. It is anticipated that this will correctly represent the position in Leicestershire with regards to HIV testing offer and uptake, however further analysis is needed to understand the decline in male HIV testing uptake.

7.1.3. HIV diagnosis

In 2017, 20 adult residents of Leicestershire were newly diagnosed with HIV. The rate of new HIV diagnosis per 100,000 population among people aged 15-years or above in Leicestershire was 3.5 per 100,000 population, significantly better than 8.7 per 100,000 population in England. Unfortunately, due to small numbers in many local authorities it is not possible to present a breakdown of new HIV diagnoses by route of transmission in this report. In England in 2017 most new HIV diagnoses were in MSM. (48% of new HIV diagnoses were in gay and bisexual men, 15% in male heterosexuals and 19% in female heterosexuals.) Black African populations were over represented in relation to new diagnosis of HIV. (53% of new HIV diagnoses were in white and 20% in black African populations.)³⁴

The ISHS is participating in the national PrEP trial using HIV treatment drugs to prevent HIV transmission. Leicestershire residents are participating in the trial which is likely to put additional demand onto local SHS. As the trial progresses further work is needed to understand the outcomes and impact of the trial on the STI and HIV prevalence and local SHS.

The latest data in 2015-17 for the percentage of HIV late diagnosis in Leicestershire was suppressed due to small numbers at district level. However, variation exists across the Districts in Leicester with three districts (Blaby, Harborough & Hinckley and Bosworth) performing worse than the benchmark of ≥ 50 . The highest percentage of HIV late diagnosis

was in Blaby and Harborough (57.1%). Auditing of late diagnosis cases particularly from these districts may indicate areas to improve the HIV diagnosis pathway.

Since 2011, the HIV diagnosed prevalence rate has remained lower than the national benchmark of a rate less than 2 per 1,000 population and hence Leicestershire remains a low prevalence area. However, over the last five years, both nationally and locally the trend has significantly increased over time. This increasing trend is likely to reflect the status of HIV changing from an acute, life-limiting illness to a chronic condition. The population living with HIV in Leicestershire is aging, therefore health and care services will need to consider any amendments to meet this patient group's needs, this may be through the currently evolving integrated neighbourhood teams and working more closely with NHS England regarding HIV service commissioning.

7.2. Reproductive health

7.2.1. Access to contraception

It is estimated that 80% of women access contraception from GPs. GP is often more accessible geographically and evidence suggests that for most women the preferred place to obtain contraception including for the SDI or IUD, although a significant minority preferred a sexual health setting. Anecdotal reports indicate that pressures on primary care are making access for contraceptive services more difficult, potentially resulting in activity shifting to sexual health services. There is limited data related to GP contraception provision.

The proportion of residents attending a SRH centre in Leicestershire and Rutland is lower than the national percentage, however this may be due to the rural geography of the county. In Leicestershire, the attendance rate of unique females aged 15-24-years old attending contraceptive services is around twenty times higher than in males. For both sexes, the rates have remained significantly lower than the national rate since 2014. The local rates for males have remained stable over time, whereas the rate for females has shown a gradual increasing trend.³⁴

There has been a decrease of 12% in the oral emergency contraception provision through pharmacy community-based services since 2016/17 from 2543 to 2236 in 2018/19. It is not known whether this is because of change in demand or whether services are being accessed elsewhere such as from GP or sexual health services. The highest volume of activity is in the Loughborough area. There has been a decrease in the percentage of those under 16-years and over 19-years of age accessing emergency contraception in pharmacy. There has also been a reported decline in the percentage of service users referred on to sexual health services. Further work to understand the change in provision and demographics of patients

accessing the service will help confirm if changes are needed to the service provision.

The C-Card Scheme provided as part of the ISHS gives access to condoms for young people aged 13-24 via community venues. There has been a decrease in use of c-card in the under 19 age group from 3615 contacts in 2016/17 to 2375 contacts in 2017/18. Condom use is also important in reducing risk of transmission of STIs. Again, further work is needed to understand if young people are accessing contraception in a different way (i.e. through LARC etc) or whether further work is needed to increase access and promotion of services to young people.

7.2.2. LARC excluding injections

LARC provision can be accessed via sexual health services or from GP. In Leicestershire since 2014, the total prescribed LARC excluding injections rate has remained significantly lower than the national rate. The rate showed a year on year decline between 2014 and 2016 but increased from 42.7 per 1,000 females in 2016 to 44.9 per 1,000 females in 2017. This reflects an increase in 304 prescribed SDIs, IUS and IUDs.

Nationally the SRH services prescribed LARC excluding injections rate has broadly stabilised between 2014 and 2017. In Leicestershire since 2014, the total prescribed LARC excluding injections rate has remained significantly lower than the national rate, despite slowly increasing year on year between 2015 and 2017.³⁴ This is an increase of 106 in SRH services provision.³⁴ Therefore increase LARC remains a priority for the county. The percentage of under 25s and over 25s choosing LARCs in SRH services in Leicestershire has remained significantly higher than the national percentage since 2014, although, the percentage of under 25s choosing LARCs in SRH services has declined year on year, from 32.9% in 2016 to 30.0%.³⁴ Therefore overall a good proportion of women who access the SRH are choosing LARC, however further work could be completed to to increase this percentage in under 25s.

The trend for the GP prescribed LARC excluding injections rate in Leicestershire has significantly decreased over the last five years, in line with the Nationally trend. However, since 2011, the GP prescribed LARC excluding injections rate has remained significantly higher than the national rate. The rate has increased from 29.9 per 1,000 females in 2016 to 31.4 per 1,000 females in 2017. This reflects an increase in 198 GP prescribed SDIs, IUS and IUDs. Activity data from the community-based service contract for provision of IUD/IUS and SDIs in GP indicates an increase in Implant fitting and removal in 2018/19 compared to 2017/18. Trend data for IUD/IUS is not available. Due to the proportions of women accessing contraception through GP and the rural nature of the county, further increasing access to LARC through GP is an important way to improve access to these highly effective

contraceptive methods.

7.2.3. Abortions

The total abortion rate has increased significantly over the past six years in Leicestershire, a pattern also witnessed nationally. Since 2014, the total number of abortions has increased year on year in Leicestershire but has continued to have a significantly lower rate than England (since 2012). The latest data for Leicestershire shows the total abortion rate in 2017 was 13.2 per 1,000 female populations aged 15-44-years old, significantly better than the England rate of 17.2 per 1,000 female population aged 15-44-years old.³⁴

Over the last four years the rate of over 25s abortions has increased year on year both nationally and locally. The rate of over 25 abortions in Leicestershire increased from 9.6 per 1,000 females in 2014 to 11.3 per 1,000 females in 2017. This equates to an increase of 155 abortions since 2014. Despite this, the rate has remained significantly lower (better) than the national average.³⁴

In 2017 a quarter (25.1%) of women aged under 25-years in Leicestershire had a previous abortion, this is similar to the England percentage of 26.7%. A holistic preventative sexual and reproductive approach, aligned with the new national strategy is needed to further develop the abortion pathway. By increasing access and awareness to LARC particularly in those aged over 25 and at risk of repeat unplanned conceptions (i.e. through abortion or maternity services), targeted health promotion work may reduce this current trend. For those that do need abortion services, access can be streamlined to increase the proportion seen under 10 weeks and through medical intervention to reduce the risk of complications for the woman.

7.2.4. Under 18 conceptions

There has been considerable success in Leicestershire in relation to teenage pregnancy, with reductions in under 18 conception rates remaining significantly better (lower) than the national average and consistently reducing for ten consecutive years. Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 61.8% reduction in the under-18 conception rate between 1998 and 2017 whereas Leicestershire has achieved a higher decrease, at 67.6% reduction. The latest data shows in 2017 the under-18 conception rate per 1,000 females aged 15-17-years old was 12.3 per 1,000 females aged 15-17-years old, significantly better than the England rate of 17.8 per 1,000 females aged 15-17-years old. This equates to 135 under 18 conceptions in Leicestershire in 2017.³⁴ However, there are some areas in Leicestershire with significantly higher levels of teenage conceptions when comparing to the England or Leicestershire average. Localities with

relatively higher rates are Ibstock, Heather, Ellistown and Wigston, Coalville and Barwell. Targeted work in these areas should be considered.

Over the last five years, both nationally and locally, the trend of under 18 abortions rate has significantly declined. The rate of under 18 abortions has decreased year on year in Leicestershire and for the past three years, the rate has remained significantly lower than the national average. The latest data shows the number of under 18 abortions decreased from a rate of 7.2 per 1,000 females in 2016 to 6.5 per 1,000 females in 2017, this is a decrease of 10 abortions for females under 18-years.³⁴

Self-assessment against the recommendations in the Framework for Supporting Teenage Mothers and Young Fathers (PHE, 2019) is in progress. Initial work suggests gaps in relation to young parent/young people friendly GP services; access to contraception, including in maternity services; young people/young parent engagement in evaluation of services; and work with young fathers.

7.2.5. Other

7.2.5.1. Cervical screening

The cervical screening rate for Leicestershire in 2018 was 77.0%. This is significantly better than the England rate of 71.4%. However, cervical cancer screening rates have decreased over the past eight years from 81.6% in 2010 to 77.0% in 2018. Local and national campaigns have been developed to increase uptake.

7.2.5.2. HPV vaccination

In Leicestershire in 2017/18, 91.4% of females 12-13-years old received the one dose HPV vaccination. This is higher than the benchmarked goal of 80-90%. However, 91.4% is a decrease from 93.5% in 2014/15 and 95.7% in 2015/16. Continue monitoring of HPV uptake will be important to maintain coverage especially with the roll out of the programme to males from September 2019.

7.3. ISHS

A new service model has been commissioned by Leicestershire County Council together with Leicester City Council and Rutland County Council, commencing 1 January 2019. This model increases access to self-service provision and operates from a new Leicester city hub location in Haymarket Shopping Centre. Leicestershire residents can access services from all clinic sites and in 2017, 39% patients of all patients accessing the ISHS attended at the Loughborough clinic and 32% at the Leicester city hub.

From 2015-18, there was an increase in full STI testing (T4), a decrease in Sexual and Reproductive Health standard activity which includes a range of provision such as basic contraception (excluding IUD/IUS and SDI) and pregnancy testing, and an increase in self-sampling online STI testing. GUM activity overall increased in 2018 from 2017, with higher counts from Loughborough area. The 20-34-year age group represented 58% of attendances in 2017. It is too early to review the impact of the new model of delivery however further work will be considered with regards to increasing access to service through online platforms for STI testing, oral contraception and some STI treatment.

7.4. Groups at risk of poorer sexual health

Any sexually active individual is at risk of unintended conception and STIs, including HIV. There are certain groups within the population who are known to be at greater risk of poor sexual health which can also be linked to other poor health outcomes. These include young people aged between 15-24, MSM, specific Black and minority ethnic groups, vulnerable people (including LAC, those physical and learning disabilities and those who had ACEs.)

Stigma is still associated with poor sexual health. Feelings of embarrassment or fear of being judged stop some people from getting information or from asking for early help. Multiple stigma and prejudice can compound the impact of poor sexual health. Targeted health promotion works to reduce stigma and to increase awareness and access to services for these groups may help reduce the inequalities in sexual health outcomes currently identified.

8. Recommendations

The findings of the JSNA have identified local needs and gaps in services alongside the national and local strategic context in relation to sexual health. The following recommendations support the improvement of the sexual health outcomes of people in Leicestershire.

8.1. Maintain a strategic approach to sexual health improvement across the LLR system.

This will include engagement with NHS, Local Authorities and other partners to support the development and implementation of the revised Sexual Health Strategy 2020-2023 and action plans, in line with recommendations from evaluation of the Leicestershire and Rutland Sexual Health Strategies 2016-2019. This would include:

- Reviewing the LLR Sexual Health Commissioners terms of reference and

consideration of co-commissioning models of sexual health, use of partners data and the role of workforce leads, such as Health Education East Midlands.

- Join up and coordinate sexual health communications and information sharing. Consider leadership approach needed to drive this agenda.
- Considering a sexual and reproductive health pathway approach from puberty to menopause and beyond. To include reviewing the PHE Sexual and Reproductive action plan due to be published in Autumn 2019 and development of local plan/ commissioning intentions in collaboration with partners.
- Review progress in delivering the recommendations of the training needs assessment specifically with regards the specialist workforce. When appropriate, consider a follow up assessment to measure impact and ensure the training and development pathway has been fully established across Leicestershire and Rutland.
- Consider developing further indicators for future sexual health strategy dashboards that inform strategic commissioning decisions and ensure a focus on outcome improvements.

8.2. Prioritise the reduction of STIs in at risk groups.

This includes young people aged between 15-24, MSM, specific Black and minority ethnic groups, vulnerable people (including LAC, those with physical and learning disabilities and those who had ACEs.). This would include:

- Reviewing the new model of ISHS delivery (including digital) in relation to access to testing and diagnoses and how these meet the specific needs of the whole population and at-risk groups through case mix review.
- Map all projects across Leicestershire and Rutland that aim to increase access to sexual health improvement and HIV prevention for high risk groups.
- Targeted health promotion using behavioral insights for specific at-risk groups and in relation to STI re-infection rates particularly in Charnwood and Oadby and Wigston.
- Progress LLR chlamydia care pathway action plan and review annually to increase the proportion of young people screened and detection rate.
- Implement PHE syphilis action plan as appropriate for Leicestershire including increased frequency of STI testing for high risk MSM, improved partner notification, antenatal testing, targeted health promotion.

- Support PHE enhanced surveillance for Gonorrhea resistance, targeted health promotion and communication to GP.

8.3. Review HIV service pathway to reduce HIV transmission, late diagnosis and ensure services meet the needs of the aging population.

This will include:

- Review new model of service delivery (ISHS) in relation to access to HIV testing and diagnoses
- Improve data quality of HIV testing coverage and uptake in ISHS, especially in MSM.
- Work with NHS England to review PrEP trial progress/findings to inform future commissioning approaches.
- Develop process for case review of late HIV diagnoses to enable learning from missed diagnosis opportunities, in particular cases from Blaby, Charnwood and Hinckley and Bosworth.
- Consider how health and care services may need to meet the future demands of an aging HIV population. For example, linking into work on multimorbidity and integrated neighborhood teams.

8.4. Reverse the trend of increasing abortion rates

Including improving access to contraception, particularly LARC in abortion and maternity services, specifically in over 25s. This will include completing the PHE abortion pathway review to inform future commissioning model and action plans.

8.5. Increase access and uptake of LARC

Especially across primary care and in under 25s within the ISHS. This will include:

- Review model of delivery of LARC in primary care with the development of primary care networks, exploring opportunities for greater inter-practice referrals and equity of access across the county.
- Develop capacity of trained practitioners to deliver LARC and IUS for non-contraceptive purposes in primary care. Include focused work with primary care and community-based staff to better understand their knowledge and competence in delivering effective sexual health messages and supporting referral and signposting into more specialist services

- Apply behavioral change theory to inform actions to enable women (specifically aged over 25) to make informed contraception choices that include LARC.
- Review the reproductive pathway, including access to LARC, in maternity and abortion services, especially for high risk groups.

8.6. Completion of PHE Teenage Pregnancy Self-Assessment toolkit

To identify gaps and actions needed to improve the outcomes of young parents.

8.7. Review the latest trends in young people's attitudes to sexual health and how they access contraceptive services.

For example, explore the reductions in demands for EHC from Pharmacy services in under 25s, C-card in under 19s and SRH standard in ISHS. Consider a behavior insights piece of work including qualitative insight with young people to determine where future efforts and resource should be focused to “empower young people to make positive choices about their relationships and sexual health”. This could be linked to evaluation of the schools RSE programme, online delivery of some contraceptive services and understanding why a high proportion of under 18 conceptions lead to abortion.

8.8. Reduce stigma and discrimination associated with sexual health matters.

Including:

- Use the opportunity presented by consultation on the next strategy (2020-2023) to engage meaningfully with patient and public groups to assess felt need in relation to sexual health and prioritise further partnership actions.
- Repeat the Equality & Human Rights Impact Assessment (EHRIA) as part of the 2020-2023 strategy development and one year after the commencement of the ISHS contract to assess whether reductions in barriers to access STI and HIV testing have been achieved and what further action is needed.
- Develop a communication strategy to reduce stigma, in particular for those at greatest risk of stigma and poor sexual health.

GLOSSARY OF TERMS

ACEs	Adverse Childhood Experiences
BMI	Body Mass Index
CCG	Clinical Commissioning Group
CSE	Child Sexual Exploitation
EHC	Emergency Hormonal Contraception
FGM	Female Genital Mutilation
GP	General Practice
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
ISHS	Integrated Sexual Health Services
IUD	Intrauterine Device
IUS	Intrauterine System
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Children
LARC	Long Acting Reversible Contraception
LLR	Leicester, Leicestershire and Rutland
MSM	Men who have sex with men
MSOA	Middle Super Output Area
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NHS	National Health Service
PHE	Public Health England
PrEP	Pre-exposure prophylaxis
RSE	Relationships and Sex Education
SARC	Sexual Assault and Referral Centre
SDI	Subdermal Implant
SHRAD	Sexual and Reproductive Health Activity Data Set
SRH	Sexual Reproductive Health

STI	Sexually Transmitted Infection
UHL	University Hospitals of Leicester
WHO	World Health Organization

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